CHIROPRACTIC MEDICAL SYSTEM:
THE MAKING OF A CLIENTELE

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

IN

THE FACULTY OF GRADUATE STUDIES
(Department of Anthropology and Sociology)

We accept this dissertation as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
April, 1987

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ABSTRACT

Most sociological explanations for the success of chiropractic in attracting and maintaining its clientele have failed to consider the clinical context and the nature of the interaction between chiropractors and clients. Rather, most studies have focused on leadership qualities, the professionalization process, and the ancillary role of chiropractic in health care to account for its success with clients.

This study argues that chiropractic in British Columbia is successful in making its clientele because: (1) it is able to persuade new clients toward chiropractic health care by using strategies that are designed to minimize the political, social and economic constraints upon it; (2) chiropractors are able to negotiate successfully, the differences in the health and illness beliefs [HMs] that are held by new clients and chiropractors as well as differences in explanations [EMs] for "present" health problems; and (c) chiropractors are able to provide potential patients with "positive" experiences in chiropractic clinics, which are different, in some respects, from experiences they have had elsewhere, for example, in their relationships with allopathic medicine. This study, therefore, describes how new clients are socialized in chiropractic clinical relationships and subsequently become chiropractic patients.

20 randomly selected chiropractors and a total of 60 new clients were interviewed for their impressions of chiropractic as well as their health beliefs and explanations for "present" health problems prior to encountering each other in the clinical setting. Their interactions were observed in the twenty clinical settings, with special focus on the negotiation of explanatory models. The patients were interviewed again, regarding their experiences and
impressions, following their fourth visit to the clinic after their initial encounter. 20 "regular" or long-term chiropractic patients, one from each clinic, were also interviewed regarding their experiences.

Data were analyzed by comparing pre- and post-interview results and by describing the nature of clinical interactions, relationships, and negotiation of explanatory models in the context of Kleinman's ethno-medical perspective and Goffman's social ethnographic perspective on interactions in everyday life.

It was found that chiropractors (1) provide potential patients with "adequate" information and the opportunity to ask questions; (2) express non-judgemental views on the health problems of clients, which provides new clients with the opportunity to fully explain their health concerns; (3) utilize persuasive interaction structures and processes to minimize both the constraints upon chiropractic and the effects of deviancy and marginality labels, and to manage the impressions of potential patients; and (4) negotiate with potential patients over explanations for the causes of their health problems, which enables the delivery of chiropractic treatment by integrating, "shifting" and modifying clients' explanatory models and, to some extent, their own.

These techniques for 'making' the chiropractic clientele appear to be successful. In this study, 53 of the 60 new clients were retained beyond the fifth visit. More generally, chiropractic is now the second largest primary health care provider-group in B.C., next to allopathy, and is attracting an increasing number of patients.
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ACKNOWLEDGEMENTS

This study would not have been possible in its present form but for the encouragement and support of many individuals during some very trying periods.

I would like to thank the members of my Thesis Committee for their help, patience and encouragement: Professor Nancy Waxler-Morrison for "kindling" my interest in Medical Sociology, Professor Adrian Marriage for providing me with initial guidance during my search for a "home" within sociology, and Professor R.S. (Bob) Ratner for "sharpening" my academic mind beyond biomedicine and for chairing my Thesis Committee through years of personal tragedy.

I am grateful to Professor Arthur Kleinman for his comments and advice. I would also like to express my special thanks to my family for their support, and to Miss Irene Korosec for the many hours she spent deciphering my handwriting and typing the various copies of this thesis.
This Thesis is dedicated to my daughter

PEARL (CHI-CHI) CHINYERE

whose courageous battles with bone cancer and the seemingly unending hospitalizations and therapies during the process of this study, have taught me more about the Sociology of Medicine than I wanted to know.
CHAPTER 1

1.0 INTRODUCTION

This study is about how persons who seek help from chiropractic during illness are socialized into chiropractic care, and subsequently become chiropractic patients. It describes what goes on before and during the clinical encounter and the healing process, especially the symbolic and expressive aspects of the encounter which lead to client socialization. I have taken the view, after Kleinman (1980), and Kleinman et al. (1978), that the clinical art is essentially a negotiative process in which individual practitioner and client negotiate explanation and treatment for an illness problem. I also take the view that chiropractors have refined the "clinical art" in a manner that has helped sustain the success of chiropractic in the face of social, political and legal constraints as well as dramatic improvements in biomedical theory and treatment. Because the individual chiropractor, moreso than a doctor of medicine, faces greater constraints in his clinical practice, he not only negotiates common grounds for the treatment of illness, he also uses various "persuasive interaction strategies" to socialize new clients. This study, therefore, describes socialization aspects of persuasive interaction strategies used by twenty chiropractors in the three municipalities of Vancouver, British Columbia, in socializing sixty new clients into becoming chiropractic clientele. It examines the way chiropractors interact with potential clients in clinical settings, how new clients are "convinced" of chiropractic care, and, in
particular, the manner in which treatment is negotiated to enable ongoing care.

In recent years, chiropractic has emerged as a visible feature of health care delivery in Canada. This is evident from the growing number of chiropractors in Canada, the number of persons who seek and receive chiropractic treatment for their health problems, the continuing public debate regarding the nature of chiropractic care, and the kind of limitations that surround the practice of chiropractic. In spite of constraints under which chiropractors must legally practice in different Canadian provinces, a large number of Canadians have continued to subscribe to chiropractic care (Kelner et al. 1980). Consequently, more chiropractors are being trained every year, and chiropractic as a system of medical care has continued to grow and attract public attention.

Of all the health care professions which function as an initial portal of entry in the Canadian primary health care system, chiropractic has shown the most increase in manpower in recent times. From 1973 to 1983 the number of chiropractors in Canada increased by 59% from 1269 to 2019. The corresponding increase for medical doctors [M.Ds] during the same ten-year period is 36% while the number of osteopaths decreased nationally by 44% from 87 to 43. The rate of growth for chiropractors is more visible in the province of British Columbia where during the same ten-year period, the number of chiropractors increased by 86%, from 182 in 1973 to 330 in 1983, or 27% above the national growth trend. In the same period, the number of allopathic physicians [M.Ds] in the province increased by 45% while the number of osteopaths decreased by 75% (Health and Welfare Canada, 1984).
As the ranks of chiropractors grew, so did the number of persons who received chiropractic care. It has been estimated that about 1.8 million Canadians subscribe to chiropractic treatment in any given year (Kelner et al., 1980). In 1986, the number of Canadians who will seek and receive chiropractic treatment will likely exceed 2.0 million. The 339 chiropractors in British Columbia in 1983 accounted for 342,222 treatments in the province and 20% of all back-injury treatments for the Workmen's Compensation Board. It is estimated that at the end of 1985, 353 chiropractors in British Columbia would have accounted for more than 400,000 treatments for different kinds of illness problems. Nationally, it has been found that 34% of consultations in Canada for musculoskeletal and related disorders are carried out by chiropractors (Lee et al., 1985).

The emergence of chiropractic as a visible feature of health care delivery is not limited to the Canadian scene. In the United States, over 7.5 million Americans have been estimated to receive chiropractic treatment each year (U.S. DHEW, 1978). It has also been suggested that from 10% to 15% of all Americans will at some time in their lives, seek chiropractic care (Inglis, 1969). This development has prompted some authors to view chiropractic as a profession which has achieved social and political acceptance despite opposition from "orthodox medicine" (Silver, 1980). In general, opposition to chiropractic has, for many years, been based on the contention that it is an unscientific healing cult which makes unsubstantiated, "grandiose" claims in conflict with medical science (Wolinsky, 1980; Relman, 1979; Ballantine, 1972). In 1979, allopathic opposition to chiropractic led the Government of New Zealand to appoint a Royal Commission of Inquiry on chiropractic to examine the reasons behind chiropractic
claims of success with certain remedies. The Commission found that "Chiropractic is a branch of healing arts specializing in the correction of the spine by spinal manual therapy...." but that "the precise nature of the biochemical dysfunction which chiropractors claim to treat has not yet been demonstrated scientifically..." (New Zealand Report of the Royal Commission, 1979:3-4).

In British Columbia, as in all of Canada, chiropractors have not been granted the same rights of general clinical practice as allopathic physicians. They do not have hospital privileges for their clients and medical doctors are prohibited by their organization from referring patients to chiropractors (Kelner et al, 1980). The British Columbia College of Physicians and Surgeons prohibits the renting of offices to chiropractors in office buildings that are owned by physicians. Reimbursement for chiropractic services under the provincial health insurance scheme is limited to twelve visits per person per year, or fifteen visits for persons over 65 years old. Officially, chiropractors in British Columbia are permitted to use only their hands in the treatment of patients, unlike in the province of Ontario where chiropractors may use electrical and mechanical devices in treatment. It was not until 1982 in British Columbia that chiropractors were legally allowed to work on body extremities.

In the face of these limitations, chiropractors must find ways by which to transmit positive information about chiropractic health care. They must, of necessity, elevate the valuation of chiropractic as a profession in the public mind if they are to further the course of their profession. They must, therefore, develop strategies, individually and collectively, for convincing sceptical and wary individuals and the public about the merits of the chiropractic healing system.
As I have noted earlier, constraints on chiropractic healing have not retarded growth in the number of chiropractors nor have they led to fewer persons seeking chiropractic care. Rather, evidence suggests that increasingly more persons continue to seek chiropractic care and are satisfied by the care they receive (Kelner et al, 1980, Kane et al, 1974). Consequently, chiropractic has emerged in Canada and the United States as the largest alternate healing profession to allopathy (Coulehan, 1985; Kelner et al., 1980). How, therefore, has chiropractic been able to negate its opposition, overcome limitations on its practice and emerge as a visible feature of health care delivery? In particular, what features of chiropractic healing have enabled it to succeed with persons who seek chiropractic help for their health problems? How is the chiropractic clientele made?

Early writers have described chiropractic patients as rural, unsophisticated folk with little access to conventional medical treatment (McCorkle, 1961). Consequently, these patients are said to have little choice but to remain chiropractic patients. However, recent studies have shown that chiropractic serves patients of all ages, occupations, and socio-economic groups (Yesalis et al, 1980; Cleary, 1985; Breen, 1977; Kelner et al, 1980). Yesalis et al. (1980) have found that despite the addition of 14 new medical doctors [M.Ds] in rural Iowa, the number of persons who visited a chiropractor in 1972 increased by 2% in 1977. Kelner et al (1980) have also noted that in Canada, 56% of chiropractic patients had previously sought help from medical doctors for their current problems and 85% had a family physician with whom they were satisfied.
Unlike the United States, Canada has a universally funded public health insurance scheme. More than 90% of all Canadians are covered for medical treatment under universal health insurance plan. Therefore, socio-economic factors, especially regarding ability to pay for treatment, are not as important as they could be in the United States where there is no universal insurance for health care. Therefore, the success of chiropractic with their clients in Canada and the United States should be understood not in terms of the reimbursement characteristics of different health care systems, but in relation to the clinical process, especially at the level of individual interactions when the chiropractor and the client address a particular health problem.

I argue that although the socialization of chiropractic clients may begin much earlier during the help-seeking process, it is during personal, individualized encounters with the chiropractor in a clinical setting that socialization is maximized. It is during the healing process, especially during the initial encounter with new clients that chiropractors are presented with the opportunity to remedy whatever "negative image" or perception they encounter individually or as a group. This includes not only the tangible aspects of allopathic opposition to chiropractic, but also the fears or concerns clients may have about chiropractic. The clinical encounter, therefore, presents an opportunity for a chiropractor to educate the client as well as learn about the client's most cherished beliefs and values with a view to negotiating common grounds from which chiropractic care can be effected. It also provides a potential patient with the opportunity to acquire first-hand and direct information about chiropractic care, its philosophy, and its treatment methods.
1.1 Society and the Healing Process

It has been argued that the process of healing the sick occurs in, and creates particular social worlds which in themselves are culturally constructed (Mishler et al, 1981; Kleinman, 1980). Clients and healers bring to the healing encounter a set of beliefs, values, and orientations about sickness which have become major aspects of individual life experiences. What a person believes about his sickness, how he behaves as a sick person, and how his family, friends and healers respond to his sickness behaviour constitute social as well as cultural realities. These realities are distinctly shaped in different societies and in different social settings within societies (Kleinman, 1980).

One domain in which the conception and management of sickness episodes have become social as well as cultural realities is the professional approach to healing. Located in the professional sector of health care are health-services professions and bureaucracies which base healing and clinical practice on highly developed and complex professional health cultures. For example, medical doctors or allopaths believe in "scientific medicine", the germ theory of disease causation, the use of drugs as therapy, and bodily intrusive measures in the treatment of diseases. Naturopaths believe in the use of naturally occurring substances in combating disease and in promoting health.

Although different health services professions co-exist in different societies, very often there is competition among distinctive health care providers for access to limited resources, reimbursement for care, choice of treatment techniques, and in particular, competition for patients and clients (Unschuld, 1979). These types of competition have been known to occur, for
example, in the field of mental health between psychiatrists, psychologists and social workers (Chrisman and Kleinman, 1980).

In societies where there are plural systems of professional medical care, governments have tended to recognize one system of care as the "official" system by granting that system greater authority in matters affecting the health of citizens (Kunstadler, 1978). In western societies such as Canada and the United States one group of health services providers comprised of allopathic physicians with a particular set of beliefs regarding the healing process, has been granted the right, through legislation, to claim disease and illness as social objects (Denzin, 1968). They claim, as a legal right, a licence to cure, control, and eliminate disease and illness and to define what is proper conduct for other medical workers towards their own work (Friedson, 1970a; 1970b).

The main problem has been that the authority and power to "create" and treat illness as social phenomena, and to legitimate a particular construction of reality as the only socially-based reality have not been equally distributed among different healing groups. Because social power is, to some extent, a function of institutionalization, the professional sector of health care becomes important especially when the state has chosen to grant greater control and authority in healing activities to one group of care providers and not to the others.

In Canada, the United States, and most of the western world, the professional sector of health care has been heavily institutionalized (Lee, 1976). This institutionalization has favoured allopathic medicine. Consequently, it
has used its state legitimated authority and control over all types of health problems to further its dominance over other healing groups. Friedson (1970b) has described how modern medicine or allopathy has used legal and political means to gain professional dominance in health care by forcing other healing traditions such as homeopathy to disband, submit to its professional control, or retreat into marginal health care. In the United States, osteopathy has been absorbed by allopathic medicine. In Canada, osteopathic healing tradition does not have legal status in a majority of the provinces and the number of its practitioners in British Columbia have declined by 75% in the ten-year period from 1973 to 1983.

A healing tradition which has continued to survive in both the United States and Canada is chiropractic. Chiropractic has probably survived simply because it has too many adherents to be abolished, and because its clientele has continued to grow in the face of opposition from allopathy and institutional constraints on its practice. It is the making of chiropractic clientele as part of the "survival" or "success" of chiropractic as a medical system in British Columbia that is addressed in this study.

1.2 History and Development of Chiropractic as a Medical Specialty

Hildebrandt (1978) has observed that therapeutic manipulation began to evolve as an identifiable form of health care during the time of Hippocrates at about 400 B.C. Over the centuries, the concepts and methods of manipulation as a form of treatment became well known and comprised the primary method of
health care. Formal knowledge of the beneficial effects of manipulation gradually became known through its initial use to satisfy the instinctive sensory urge of the sick to experience feelings of comfort and well-being.

From the knowledge gained from these initial experiences, there gradually emerged the development of organized systems of application, the most notable of which was bonesetting, a manipulative art passed on through families for centuries, especially in Great Britain and Europe. Later, bonesetters emigrated to North America where their procedures became popular during the early part of the 19th century.

Osteopathy and chiropractic have been seen as direct descendants from bonesetters, the latter becoming primarily concerned with the human spine.

In 1895, in Davenport, Iowa, a Canadian born immigrant, David Palmer, announced the formal beginning of chiropractic as a separate form of health care following a case in which he claimed to have alleviated a condition of deafness with a manipulative technique he called "adjustment". In his book, "The Chiropractor's Adjuster", published in 1910, Palmer reported on his historic encounter with a man who had been deaf for seventeen years. According to Palmer, he was told that the apparently healthy man became deaf as a result of something giving way in his back as he stooped in a cramped position. On examination, Palmer is said to have found a vertebrae that was dislodged from its normal position. He reasoned that replacement of the vertebrae would restore the man's hearing. Palmer claims that by using the spinous process as a
lever in replacing the displaced vertebrae, he was able to restore the man's hearing. Since the result he expected was realized, Palmer concluded that the restoration of hearing was not an accident (Lomax, 1975). Within three years, Palmer began a school of chiropractic in Davenport, Iowa to produce practitioners of the new method of healing. This occurred during a very stormy period in the history of health care in North America. Consequently, early relations between chiropractic and organized medicine, the dominant part of the health care system, became acrimonious and have remained so ever since.

By the end of the 19th century, medical care in the United States was not a flourishing enterprise. Hospitals were poorly equipped to handle illness and medical staff were selected in a haphazard manner. Dogmatic struggles between the allopaths or the dominant group, and homeopaths, the insurgent group, divided the medical profession. Homeopaths challenged the heavy dosages of drugs in vogue at that time, pointing out that more modest doses reduced death rates. It was during this period of meagre hospital care, heroic surgery, poor medical evaluation and heavy dosages of drugs, that chiropractic emerged as an alternative system of healing.

Palmer was opposed to the practices of medical doctors of the times, as he was convinced of both the uselessness of most drugs administered and of the dangers of surgery. But he remained in almost complete obscurity until he had the opportunity to practice spinal manipulation. Palmer's revelation as to the value of chiropractic ostensibly occurred with his first patient whose deafness he claimed to have cured by pushing a misaligned vertebra back into place.
It is doubtful that the appeal of chiropractic could be attributed solely to Palmer's discovery. Conditions were already ripe for the emergence of a variety of new forms of medical practice. Some prevailing popular sentiments in the middle and latter part of the nineteenth century were fear and distrust of the heroic surgeries of orthodox medicine and resentment of high fees charged by medical doctors. A shortage of physicians, especially in rural areas, also paved the way for the development of chiropractic and other alternative medical sects (Inglis, 1964).

Chiropractic bears strong similarities to the Thomsonian movement, which had sprung up in reaction to the excesses and incompetencies of the regular medical practitioners. In the 1830's and 1840's, the Thomsonian movement acquired a large following, especially among the lower classes of the Mid-west and South. Thomsonian practitioners relied on relatively harmless botanical remedies, as opposed to the frightening employment of cathartics, bloodletting, and blistering characteristic of the regular medical practitioners. The success of the movement can also be attributed to the encouragement given to patient self-education and patient participation in the treatment process. Thomsonianism gave the patient a greater sense of control over his own fate. The remedies advocated were easily available and easily applied. In contrast to orthodox medicine, which was becoming increasingly formalized and specialized, Thomsonianism was based on practices and precepts familiar and comprehensible to the general populace. In 1832, Samuel Thomson published his New Guide to Health: or Botanic Family Physicians, containing a Complete System of Practice, on a Plan Entirely New; with a Description of the Vegetables made use of, and
Directions for Preparing and Administering Them, to Cure Disease, to which is prefixed, a Narrative of the Life and Medical Discoveries of the Author. With the aid of Thomson's book, each man was to be "his own physician", capable of activating the healing forces within his body through the appropriate botanical remedies. The widespread use of all types of patent medicines reflects the same spirit of lay self-sufficiency characterizing the nineteenth century (Rothstein, 1972: 125-150).

In similar fashion, chiropractic theory asserts that the ministrations of the chiropractor serve primarily as a catalyst; chiropractic adjustment merely sets the healing forces within the individual into motion. Thus, the patient is not reduced to the level of a passive object.

It is also likely that chiropractic borrowed from the newly emergent osteopathic theory, with only minor modifications. Osteopathy exercised popular appeal for the same reason that Thomsonianism did. In that it posited a relatively straightforward, monocausal theory of disease, osteopathy was easily comprehensible to the average person. By way of contrast, orthodox medical practice was characterized by an elitist mystification of diagnosis and treatment, with the patient effectively precluded from any informed decision-making (Rothstein, 1972).

According to osteopathic theory of the late nineteenth century, all disease was due to impeded circulation. In similar fashion, Palmer posited that all disease resulted from obstruction of the "nerve force". Both schools of healing advocated manipulation as a means of cure. Interestingly, Davenport, Iowa was only 150 miles removed from Kirksville, Missouri, where osteopathy originated,
just prior to chiropractic. An excerpt from the August, 1897 Journal of Osteopathy follows:

"There is one fake magnetic healer in Iowa who issued a paper devoted to his alleged new system, and who, until recently, made up his entire publication from the contents of the Journal of Osteopathy, changing it only to insert the name of his own practice." (Reed, 1932: 18)

Both chiropractic and osteopathy are closely related to the bone-setting tradition. Bonesetters were simply individuals who had demonstrated a knack for setting broken bones. Often bonesetting was merely a sideline or hobby and not a major source of income. Interestingly, bonesetting incurred little opposition from orthodox medicine, at least in the first half of the nineteenth century, because "doctors rarely attempted to practice it, because they regarded it as a knack, rather than as a craft and a vulgar knack at that" (Inglis, 1964: 94-95). The manipulative techniques employed by the bonesetters were never incorporated into the mainstream of orthodox medicine, although orthopedists later assumed responsibility for bonesetting.

Thus, chiropractic combines a number of antecedent treatment modalities, all of which represented alternatives to the elitist character of orthodoxy and its practitioners.

Today, in the United States and in some Canadian provinces, allopathy has absorbed osteopathy and, to some extent, homeopathy, into the mainstream of organized medicine - a scheme of treatment which consists mainly of drugs and surgery to be carried out primarily in hospitals. By contrast, chiropractic has maintained its identity and has allowed medical work to continue in individual
offices rather than in hospitals. The principal method of chiropractic care has been the use of hands which requires a great deal of personal attention to the person and body structures of their patients.

1.2.1 Chiropractic Philosophy

Chiropractic philosophy is based primarily on the notion that "Each individual possesses an intrinsic, biological dynamic that interacts with and greatly modifies the external forces with which it comes in contact" (Strang, 1984:22). The human body, therefore, is conceptualized as a

"structural and functional unit - a living, metabolizing, self-perpetuating composite being - which, under appropriate circumstances, has an inborn capacity to sustain itself while fulfilling its objectives (whatever they might be for an individual) for a predestined span of years, and during that time reproduce itself for perpetuation of the species". (Hildebrandt, 1980).

According to chiropractic theory, almost all diseases result from the vertebrae impinging on a nerve. The primary challenge is to locate the deranged vertebrae impinging on the nerve and push them back into proper position using mainly the process of "adjustment" (Strang, 1984; Haldeman, 1980; Kelner et al, 1980; New Zealand Royal Commission on Chiropractic, 1979).

The philosophical underpinning of chiropractic is based on the notion that disease arises from spinal misalignment. Through adjustment of body structures, primarily the spine, by manipulation, normal nerve function is restored and pain in the affected part or organ relieved (Pollack, 1972). Unlike orthodox
medicine, diagnosis is not a prominent feature of chiropractic because according to its theory, almost all disease results from vertebrae impinging on a nerve. The primary challenge is to locate the deranged vertebrae and push them back into proper position (Reed, 1932). Thus, diagnosis is unambiguous and treatment strategy fundamentally the same for all symptoms.

Allopathic physicians [M.Ds] have traditionally scoffed at the notion that organ dysfunction could be attributed to spinal misalignment and they have also doubted that most back pain can be traced to vertebra impinging on nerves (Crelin, 1973).

Chiropractic also maintains that health is expressed through the nervous system with the brain as the control station. Normal health, therefore, is a state in which there is no disturbance to nerve-energy flow channels. This vital nerve-energy must flow freely from brain cells to tissue cells in order that glands, muscles, and organs may function normally (British Columbia Chiropractic Association publication, undated).

Until 1930, the National Chiropractic Association in the United States did not acknowledge the role of germs in disease causation. In recent times, some chiropractors have modified their views to accommodate the germ theory of disease as well as the role of genetic factors in the aetiology of disease. Lack of clear articulation and uniformity of views regarding causes of biological health problems among chiropractors has become problematic for the profession. The New Zealand Royal Commission (1979:43) which probed into chiropractic in that country finds that "A general theory of chiropractic is not easy to distill from the evidence we received....In the Commission's view,
chiropractic theories have only just begun to evolve on a scientific basis...."
Nevertheless, the Commission finds that "Spinal manual therapy can be effective in relieving musculo-skeletal symptoms such as back pain and other symptoms known to respond to such therapy such as migraine" (p.3).

1.2.2 Chiropractic Model of Health Care

In order to understand the logic and distinctiveness of chiropractic model of health care, it is necessary to contrast it with its major alternative, the medical model of health care. Chiropractic developed in response to allopathic medicine and its entire history has been marked by conflict and debate between followers of the two health care models.

The success of allopathic medicine began with the emergence of the germ theory in the 19th century which brought medicine and science together. Consequently, the nature of medical practice was transformed from guess-work and heroic surgery to application of reductionist, scientific paradigms, thus establishing medicine as a dominant force in matters of health. The importance of the germ theory is that it enabled the treatment of killer diseases.

Coulter (1983a, 1983b) argues, however, that it was the articulation of treatment methodology rather than the germ theory that provided the roots of scientific medicine. Increasingly, scientific medicine became less of a purely clinical endeavour and more a matter of scientific research and quest for wonder drugs.
Along with the scientific approach to health care and reductionism came specialization and consequent "atomization" of the human body into parts. Diagnosis became a complex exercise as more and more functions were relegated to dependent occupations such as radiographers and laboratory technologists, and some clinical functions to physiotherapists, respiratory technologists and occupational therapists, among others. What the germ theory seem to have achieved is the introduction of a methodology, an approach to isolating the causes and treatment of "disease" and not of "illness". This transformation has not only transformed the social settings of medicine, it has also fundamentally altered the relationship between the practitioner and the patient, at great cost in terms of human relationships.

Society at large, by becoming enamoured of things scientific encouraged by advances in medicine, has chosen to grant "organized medicine" a special controlling role in health care. Other medical systems, therefore, became marginal to the "official" system which jealously guarded its powerful position against intruders and alternative healing systems. More importantly, the focus in healing is no longer located primarily in human relationships, but in the identification of causes of disease symptoms and their scientific remediation.

In contrast, chiropractic as a profession did not, initially, and some chiropractors still do not, subscribe to the germ theory of disease. However, the fundamental aspect of the chiropractic model of health care has remained the same. That is, the body when functioning normally is able to combat disease processes naturally. According to the model, when disease occurs, it is because of a failure in the body's natural restorative power. The seat of this power is
the nervous system, which when functioning normally, is able to help the body combat disease. In general, the body is an integral unit which is capable of maintaining its own health (Strang, 1984). Sometimes disease occurs because of lowered resistance which therefore allows micro-organisms to be effective. For chiropractors, traditional "organized" medicine combats the symptoms of illnesses and not the predisposing factor or cause of illnesses.

Chiropractors claim that they do not, in the strict sense, treat diseases. Rather, they treat the patient, the object being to restore the body to a normal state which will enable it to combat disease. In this model, disease is interpreted as symptom, not cause.

Chiropractic did not develop from reliance on pure science as medicine did, nor was its treatment derived from science in the manner in which drug treatment was derived. It is primarily at the level of conceptual theories that treatment rationale developed. Chiropractic treatment was derived almost entirely from clinical experience or experience which was based on human interaction and relationships. As a consequence, it did not adopt the technical jargon of science, rather, it developed its own distinct language and concepts which appear to have been more accessible to the patient than those of medicine. For example, "adjustment", the primary method of chiropractic care, conjures an image of an auto mechanic adjusting a valve in an automobile engine to get it working properly.

It appears that in general, organized medicine is located on the extreme end of the health-illness-disease continuum while chiropractic appears to locate
in the middle. Most of the models of health care espoused by family medicine practitioners bear some resemblance to the chiropractic model of health care.

Each group of practitioners has its own definition and classification of health problems (Webster, 1984). Family medicine practitioners recognize that health care is holistic and that at their point on the health-illness-disease continuum, the cause-effect research models of the disease paradigm do not always suffice.

Sacks (1977) has called for a new type of community practitioner. He envisaged a primary contact practitioner who, while competent to treat manifest disease, would actively promote health and prevent disease by client-patient education. The quality of this new practitioner's work would be assessed in terms not only of technical skills but also in terms of compassion, humanity and patient satisfaction.

Practitioners in the illness sector of the health-illness-disease continuum, therefore, have a model of health care which is characterized by a holistic or comprehensive approach to patient care, a person-oriented approach to clinical practice, sustained continuity of care, and a disease prevention and health promotion focus (Jamison, 1985).

1.2.3 Contemporary Chiropractic

In recent times, some chiropractors believe in supplementing chiropractic adjustment techniques with other kinds of treatment modalities such as heat therapy, diet regulation, electrotherapy, and so on. Thus, conflict has
developed between those who follow this view, otherwise known as the "mixers", and those who adhere to the traditional view that spinal adjustment is the only permissable method of treatment, otherwise known as "straights" (Kelner et al., 1980; Baer, 1984; New Zealand Royal Commission, 1979).

In the United States, as the new movement grows, it attracts "more and more members who are interested in making a good living and in raising their status in the outerworld. This means that they become more concerned with obtaining respectable credentials and providing services that more closely follow the medical model, and eventually even developing working relationships with the orthodox medical world" (Roth, 1976:40-41).

Because of the views of the "mixers", the body of treatment procedures taught in chiropractic schools has been expanded to include adjustments of a much greater range of joints, and a device introduced to measure variation in body temperatures. Also, the range of biological studies and diagnostic procedures has widened. More importantly, most contemporary chiropractors use auxilliary equipments such as X-rays, ultrasound and other devices and treatment methods.

In British Columbia, chiropractors are not legally allowed to use most of these equipments and different methods of treatment in treating patients. In the words of one chiropractor, "B.C. is a straight country. Some of us explore the margins of straights and mixers, but never admit it."
1.2.4 Chiropractic in British Columbia

Chiropractic, as a system of health care was formally recognized in British Columbia via the Chiropractic Act in 1934. At that time, the few chiropractors in the province did not constitute a significant threat to organized medicine since their number was less than a dozen. There were no major developments until 1950 when the Workers' Compensation Board of British Columbia included chiropractic care among approved health care services for injured workers. This development did not occur without quiet and persistent lobbying of politicians and bureaucrats by few leaders of chiropractic. It was not until fifteen years later in 1965, after extensive lobbying by chiropractors, that the Province's Medical Services Plan included minimum coverage for chiropractic care to eight weeks. Presently, coverage has been extended to twelve visits per person, or fifteen visits for persons over sixty-five years old.

The Workers' Compensation Act of 1968 deemed chiropractors as "Qualified Practitioners", and employees covered under the Act are free to select their own "qualified practitioner" whether chiropractic or "medical". In 1960, the British Columbia Chiropractic Act defined chiropractic as follows:

"'Chiropractic' means the science of palpating and adjusting the articulations of the human spinal column by hand only, and includes the manipulation and adjustment by hand of the ribs and articulations thereof for the purpose of adjusting the articulations of the human spinal column".

The definition as stated, effectively limits chiropractors to only the use of their hands in providing treatment to the spinal column and its articulations, notably the ribs. Chiropractors, unlike their colleagues in the Province
of Ontario, are limited to the technique of "adjustment" as a modality of treatment. In Ontario, under the Drugless Practitioners' Act, chiropractors are free to utilize electrotherapeutic devices such as Short Wave Diathermy, Ultrasound and mechanical devices in treating clients.\textsuperscript{15}

In 1972, Chiropractic Services were included in the British Columbia Automobile Insurance Act. Following quiet, non-confrontive lobbying of politicians and bureaucrats in government by the Chiropractic Association, the Chiropractic Act was twice amended in the last three years to allow for adjustment of all articulations by hand only and a technical change to permit chiropractors to use the prefix "Dr." with their names.

Because of opposition from organized medicine in British Columbia, political, social and economic changes in the lot of chiropractors in British Columbia have been slow in coming about. The context of opposition is reflected in the following newspaper headlines and reports in the past few years.

"City Chiropractors Shut Out"  
Vancouver Sun, March 14, 1984.

The report discusses the decision by the British Columbia College of Physicians and Surgeons not to rent office space to chiropractors in buildings owned by college members. The Register of the College at the time defended the decision in the "Medical News" by stating a concern that the public may perceive the two health care professions in association with each other. "It tends to
give credence to their philosophy" adding that the philosophies of the two professions are different.

"Handout pays for helping Hand"
Vancouver Sun, August 4, 1984.

In this account, a paralyzed client who was unable to pay for chiropractic services beyond the allowable twelve visits received free care from his chiropractor. The report called attention to limits placed on public insurance reimbursement for chiropractic services.

"Chiropractors Want Fair Shake from M.D's"
The Province, March 27, 1983

This report by a journalist details a number of constraints on chiropractic services and the role played by organized medicine in British Columbia in fostering limitations on chiropractic.

"Ruling Gets M.D's Back Up"
The Province, April 3, 1983

The case of an allopathic physician who was denied permission to start a "centre for manipulative therapy" was discussed. The College of Physicians and Surgeons had denied him permission because of his intention to associate with one or more chiropractors. The irony here is that the allopathic physician is also a chiropractor, having been trained initially in chiropractic. He was interviewed for this study with respect to his views and experiences.

"Medical Outsiders Seek Recognition"
The Province, March 27, 1983
In this report, a number of non-allopathic medical systems in British Columbia were discussed with regard to the lack of adequate recognition by organized medicine and by political decision-makers of the role non-traditional health care systems play in British Columbia society. Among featured groups are Acupuncturists, Midwives and Homeopathic physicians who technically do not exist in the province. Chiropractors were also discussed with respect to their struggles to obtain cooperation from organized medicine and their plea for the removal of barriers to chiropractic professional services by the state.

"Chiropractors Win"
The Vancouver Sun, March 26, 1983

The case of a chiropractor who had been charged in the court with using the title "Dr." as prefix to his name was dismissed by a provincial court. The College of Physicians and Surgeons had prosecuted the chiropractor in court before the change in the Chiropractic Act which allowed chiropractors to use the word "Doctor" in describing themselves.

From time to time, public debate about chiropractic emerges to engage the attention of the public in British Columbia (The Vancouver Sun, August 25, 1975; Nanaimo Times, October 13, October 25, 1984; Nanaimo Free Press, December 10, 1984; Kamloops News, December 13, 1984; The Province, March 9, 1984; Vancouver North Shore News, April 8, 1984; Trail Daily Times, August 23, 1984; The Elder Statesman, 1985). Bureaucrats in the provincial Ministry of Health and leaders of the Chiropractic Association whom I interviewed noted the continuing
existence of political and professional opposition to chiropractic and the slow rate of change in improving relationships or removing barriers to change.

1.3 Constraints and Issues Relating to Chiropractic

Differences in perceptions of chiropractic as a deviant, marginal or stigmatized professional group may have been, in large measure, due to particular issues and types of constraints chiropractors are faced with in different communities and political environments (McCorkle, 1961; Cowie & Roebuck, 1975; Gardner, 1975). When issues are not embedded in prevailing ideological values of the society, such as scientism in medicine, they are, to a large extent, mediated or influenced by political, social and economic activities of organized medicine or local associations of allopathic practitioners. These activities often find strength in the official recognition that allopathy enjoys from the state or in structured regulations in medical acts which provide allopathic practitioners with diverse sources of power, prestige and political influence.

In the United States, the competitive free-market ideological orientation is a strongly held value system. Consequently, unlike in Canada, health care is regarded as a market commodity, subject to requirements of free-market competition. Providers of health care are therefore in competition for clientele as well as for maximization of economic benefits. Because chiropractic emerged in the United States at a time when "organized" medicine was facing competition from osteopaths, among others, an adversary relationship developed first on philosophical grounds and later, for the survival of each healing orientation.
This adversary relationship has been championed by successive leaders of each health care orientation, especially since allopathy has assimilated many rival competing health care groups, such as osteopathy, to the exclusion of chiropractic.

The situation is somewhat different in Great Britain. In that country, there are fewer chiropractors compared to tens of thousands of allopathic physicians (Baer, 1984). The second largest group of primary health care practitioners in Great Britain are osteopaths, unlike in Canada and the United States where chiropractors constitute the second largest group to allopaths. Consequently, chiropractors are not seen as posing great threats to the powerful role of organized medicine in Great Britain. Unlike Canada and the United States, issues relating to chiropractic do not seem to make headlines, nor do they engage public attention to the degree such issues are discussed in North American media.

In Canada, "socialized medicine", defined to mean state-sponsored universal health care, appears to have lessened the sort of competiveness that characterizes relationships among health care providers in the United States. Even so, one may view the reaction of allopathic medicine towards chiropractic in Canada as systematic erection of structural and political barriers on chiropractic. Many of the constraints on chiropractic in Canada reflect the level of political and professional activities of provincial medical associations as well as the degree of success each provincial medical association has attained in placing limitations on the healing activities of local chiropractors. One reason why organized medicine may view chiropractic as problematic may be partly due to its
inability to exert professional control over chiropractors, unlike allied health occupations whose work must be legitimated by allopathy (Friedson, 1970b). For example, in Canadian hospitals, physiotherapists treat patients only on referral from allopaths. In general, all health care activities in hospitals come under the control of allopaths directly or indirectly since only allopaths are legally allowed to admit patients.

In order to understand chiropractic clinical and healing practices, it will be necessary to take into consideration the nature of issues and constraints which the individual chiropractor must deal with locally in order to maximize professional worth and output. In British Columbia, local issues and constraints can be categorized into five areas, namely: politico-legal, social, economic, self-imposed, and clinical.

1.3.1 Politico-Legal Constraints

In British Columbia, problems of health and illness must be legitimated under the Medical Act by a licenced member of the College of Physicians and Surgeons. This legal authority puts individual members of the College in positions of influence with persons who interact with the official healing system. A special relationship may develop between practitioner and patient, thus helping to foster positive attitude towards organized medicine. The intimate, close and personal relationship developed during moments of illness provides an important avenue for influencing the behaviour of politicians via the perceptions of members of the society. The doctor-patient relationship has often been characterized as a "private" relationship.
Allopathic physicians have high social prestige which may help in influencing the political attitude of voters. Because institutional arrangements have been set up to support this high prestige, such as exclusive use of publicly funded hospitals, it is problematic for other medical systems, for example, chiropractic, naturopathy and homeopathy to influence political behaviour in the same manner possible for allopaths. This places chiropractors and other healing systems at some disadvantage. One leader of chiropractic whom I interviewed has called these exclusionary institutional structures "discriminatory practices".

Other interviewed leaders of chiropractic are of the general view that political and legal issues relating to chiropractic are located within the historical context and in the political activities of organized medicine. Opposition from organized medicine is seen as the major contributor to the nature of political, legal and professional constraints on chiropractic in Canada, and in particular, in British Columbia. Local and national medical associations are viewed as powerful organizations which have not hesitated to use their social prestige and power in influencing the direction of change within Canadian health care, or to impede progress directed at maximizing the role of chiropractors in health care.

A major issue is the various differences regarding the definition and scope of chiropractic medical care in Canadian provinces. One leader of chiropractic interviewed comments:

"Every Chiropractic Act in the land is different. In British Columbia, chiropractors are limited to only the use of their hands in treatment, at first, of the spine,
and more recently including extremities. In Ontario, chiropractors have wider scope of practice but no Act. There, they can use different treatment modalities and are grouped together with allied health professions under the Drugless Practitioners Act. I can tell you that differences in provincial Chiropractic Acts are reflections of varying degrees of political activities by provincial medical associations and the measure of success in the struggle by us to achieve recognition and acceptance."

Although chiropractic has, over the years, gradually been included in various provincial health insurance reimbursement plans for services, unlike the case for organized medicine, these provisions are disparate and lack uniformity across Canada. Provincial policy makers have either placed dollar limits, visit limits, or no limits for reimbursing chiropractic services. For example, in the Province of Saskatchewan, public insurance coverage for chiropractic services is unlimited. In British Columbia, insurance coverage is limited by the number of treatment visits a person is allowed to make to a chiropractic clinic: twelve visits for persons under sixty-five years and fifteen visits for persons over sixty-five years old. In the Province of Ontario, chiropractic services are covered for all procedures to a limit of $185 including electrotherapy services, although there is no separate Chiropractic Act in the province. In British Columbia, chiropractic services do not legally include electrotherapy, and only treatments that are delivered by hand are covered by the provincial public health insurance scheme. One leader of chiropractic comments:

"Chiropractors are so limited by variations in the scope of practice in Canadian provinces that they are susceptible to infringement of the laws of trespass. Various local medical associations have consistently opposed improving provincial Acts and Statutes to accommodate chiropractors."
In British Columbia, where the relationship between leaders of chiropractic and bureaucrats in the provincial Ministry of Health is said to be cordial and responsible, there have been some changes in some aspects of chiropractic services. Chiropractors can now call themselves "Doctors" - a right they won in a court of law. The definition and scope of practice has been extended to include extremities. The number of visits a sick person can make to a chiropractor for treatment to be paid out of public funds has now been extended from nine visits to twelve visits per citizen per year.

One highly placed bureaucrat whom I interviewed has described the relationship chiropractors have cultivated with the Ministry of Health as "responsible, and of low visibility, a low key approach, not confrontative and a classical lobbying technique...". Both the Minister of Health and the Deputy Minister of Health in the province are said to have received chiropractic care.

In spite of the "good" relationship between the leaders of chiropractic and bureaucrats in British Columbia, chiropractic is still officially regarded as a treatment modality, much like massage, surgery, or tonsillectomy, and not as a comprehensive medical system. Bureaucrats in the Ministry admit that the Chiropractic Act is very old and in need of amendment, but they are powerless to initiate changes because of the views of organized medicine in the province.

Officially, the provincial College of Physicians and Surgeons does not allow allopathic physicians to refer patients to chiropractors although privately, some individual allopaths have cross-referral arrangements with some chiropractors. One allopath, who is also a chiropractor, was prevented from
hiring or going into partnership with a chiropractor, but can only make such an arrangement with the wife of the chiropractor, who happens to be an allopathic physician. The president of the only chiropractic college in Canada comments that there are three allopaths in the college faculty with teaching responsibilities but there are no chiropractors in medical schools in any recognized position.

Officials in the provincial government and leaders of chiropractic agree that chiropractors have limited or no access to public health facilities. Federal and provincial governments do not fund the training of chiropractors, nor do chiropractors have access to universities and research funding. The President of the Canadian Chiropractic Association calls these practices "discriminatory, exclusionary practices" aimed at "further minimizing the part chiropractic plays in the health care of Canadians". In a significant way, structures have been set up to prevent access to public resources and facilities by chiropractors. No chiropractors work for the government even though the government spent about twenty-five million dollars for chiropractic services in 1985. The provincial Medical Advisory Committee has no chiropractor sitting as a member, ostensibly because chiropractors do not work in hospitals. According to one leader of chiropractic, the Medical Advisory Committee "advises on health care matters outside of the hospital environment, and chiropractors, like allopaths, are primary health care providers". The Workers' Compensation Board reimburses chiropractors for services, but "allopathic physicians sit in judgement as to what is proper service by a chiropractor".
Legal and political constraints on chiropractic are evident in the recent refusals by all one hundred and fifteen provincial hospitals to allow chiropractors to visit their hospitalized patients even when such visits are requested by the patients (The Vancouver Sun, September 16, 1986). According to the Executive Director of the Provincial Chiropractic Association, it is the provincial College of Physicians and Surgeons that has determined that medical doctors not practice "in conjunction or in association with Chiropractors". He continues: "This has more to do with politics than it does with health" (The Vancouver Sun, September 16, 1986).

It is illegal under the Hospital Act to allow anyone who is not a member of the College of Physicians and Surgeons or the College of Dental Surgeons to admit and treat patients in hospitals. Although the provincial Minister of Health publicly supports the idea of chiropractors being allowed into hospitals at the request of patients, he stipulates that such requests must have "the support of the medical doctor treating the patient" (The Vancouver Sun, September 17, 1986). Mike Tytherleigh, a journalist, comments that not allowing his chiropractor to visit him in hospital is:

"discrimination...a denial of my right to health care in a public facility paid for with my tax money. That denial is because the College of Physicians and Surgeons has told doctors thou shalt not cooperate with chiropractors... The problem is basically emotional prejudice that has nothing to do with delivery of health care...The solution is for the provincial government to show some moral responsibility, amending the Hospital Act to allow chiropractic care in hospitals." (The Province, September 18, 1986)
The legal and political dilemma facing chiropractic is perhaps, best reflected in a recent amendment to the Federal Medical Act which bans extra-billing for medical services. Under the previous Medical Act, medical practitioners are prohibited from extra-billing patients for their services. The new act refers to health practitioners rather than medical practitioners prompting one leader of chiropractic to ask "What are we?". It is not certain whether the new act has been intended to include chiropractors although the problem with extra-billing of patients for services is located primarily among allopathic physicians.

The depth of emotional feelings among chiropractors regarding the political and legal constraints on them is reflected in the following comment by a chiropractic educator:

"For 90 years, the group has faced every major trick in the books...from quackery accusations to unethical relationships with M.D.s...a chiropractor cannot rent space from an M.D. but can only marry her. We have to be aware of political and legal matters at all times. What is legal in Ontario is not legal in British Columbia...one slip, then you provide a reason for organized medicine to say to the public 'we told you so'."

Regardless of political and legal constraints, leaders of chiropractic admit that there have been some ethical concerns. One leader interviewed describes the case of a chiropractor who treats painful knees by wrapping them in cabbage leaves over-night. Another leader of chiropractic knows of the use of acupuncture procedures among "a few chiropractors". A more serious observation describes one chiropractor who was "so enamoured of vibrators that
rather than buy an expensive one, he wrapped a saber (electric) with foam rubber and used it".

Leaders of chiropractic emphasize that they do not condone these unethical practices and note that every profession contends with a few of their members who stretch the margins of ethical conduct.

1.3.2 Social Constraints

Since its beginning in Davenport, Iowa in 1895, through the seminal works of Wardwell (1952) and McCorkle (1961), chiropractors have faced long-term stigmatization as a deviant group. Consequently, public knowledge of chiropractic has been limited and the role of chiropractors in healing systems in Canada and North America has been treated with scepticism, apprehension and doubt. The President of the Canadian Chiropractic Association comments:

"Chiropractors have to work much harder. People do not know what a chiropractor does even when they see him on television. Most chiropractic patients do not usually make a decision to visit a chiropractor themselves. The family or a friend gets tired of hearing about 'bad backs' or pain and asks them to visit a chiropractor."

The perception of chiropractors as "medical outsiders" seeking recognition (The Vancouver Province, March 27, 1983) has been fostered, not only in popular culture but also by the way the public media reports about chiropractic. Quite often, the media in British Columbia continually reminds people about the plight of chiropractic and its struggles for social recognition and acceptance. The President of the Provincial Chiropractic Association puts it this way:
"When you call yourself a doctor, people think of Allopathy. In the minds of people, allopathy is the only healing group, all others are fake or guesswork. In spite of the work we have done in the last 15 years, people are still skeptical about us. Sure we've made some progress, but it doesn't help when allopaths tell them (patients) before they come to us that chiropractic is unscientific and not beneficial. We see people become fearful of condemnation from their peers, family or friends because they are seeing a chiropractor. Most patients do not want their family doctors to know they are receiving treatment from a chiropractor."

The social constraint on chiropractic is further supported by clients' responses in this study. When asked to compare chiropractic with other professions, only 3% of new clients rate chiropractors high amongst health professions, and a few clients view chiropractic and physiotherapy as similar. It is well known that physiotherapy, as a paramedical occupation is dependent on allopathy for legitimation of its role, especially in health institutions such as hospitals. Only 11.7% of new clients think chiropractors are similar to their own family doctors once they have encountered chiropractic. 60% of new clients say it was difficult for them to "come to see a chiropractor" because "they don't know enough" about it, because they are "scared", or because their family doctors discouraged them.

The lower social prestige of chiropractors compared to that of allopathic physicians as well as the labels of marginality and deviancy conferred on chiropractic by early writers contribute to the public's unfavourable view of chiropractic. To overcome social constraints, chiropractors need to re-orient the public at large through image-enhancing strategies which will put them in good stead socially, professionally and economically.
1.3.3 Economic Constraints

Provincial regulations relating to payment for professional health care services by the government allows each citizen under sixty-five years of age to have twelve visits a year to a chiropractor which may be paid for by the government. Persons over sixty-five years old are allowed fifteen visits a year. Thus, regardless of the nature of illness, a chiropractor must provide twelve treatments during twelve visits in order to be reimbursed from public funds under the provincial health insurance plan. Allopathic physicians are under no such constraint, as they may provide any number of treatments as long as a "medical condition" exists and the client continues to visit the clinic or hospital. Other healing groups with similar restrictions in the province are naturopaths and physiotherapists in private practice outside of hospitals. All chiropractors interviewed experience outstanding debts in their practices, yet none of them enforces debt-collection because of the possibility of "bad professional image".

It seems, therefore, that chiropractors in British Columbia would be compelled to treat a large number of clients in order to maximize their incomes. A majority of chiropractors rent office space and employ receptionists or attendants. Much like the allopathic family doctor, the chiropractor must provide for those assisting him in his practice as well as earn enough overhead to make it worthwhile to remain in practice. Consequently, chiropractors in British Columbia extend their services beyond twelve allowable client visits in order to receive private reimbursement for services. The difficulty is that not
all clients will readily pay for services beyond the allowable twelve visits. One implication of state sponsored health insurance plan for citizens is that people get used to it and expect all of their medical expenses to be covered through public funds. For the chiropractor, income maximization beyond twelve client visits would mean some uncollected debts, and any effort to collect same would further alienate the clients. The chiropractor must, therefore, absorb some of these losses as well as keep up with image-enhancing strategies in order to attract new clientele.

One example of economic constraint on chiropractors in British Columbia is that the state will pay lower fees to an orthopaedist whose patient has been referred to him by a chiropractor but a much higher fee if the patient has been referred by a family doctor. Thus, orthopaedic medical specialists would be encouraged to reroute their patients through family physicians if they are to maximize their claims under the provincial public health insurance scheme.

1.3.4 Self-Imposed Constraints

Some leaders of chiropractic in Canada and in British Columbia consider some constraints on chiropractic, "self-imposed" constraints. One chiropractor educator comments as follows: "Having been rejected or not wanting to be rejected again, chiropractors are shy of participating in policy making bodies". For example, chiropractors did not take part in discussions leading to universal health insurance plans in Canada and in Canadian provinces. Consequently, health insurance plans are silent on chiropractic and had to be negotiated
through bureaucratic channels. Chiropractic associations neither participated in nor presented briefs at the Hall Commission of Inquiry in 1982 which re-examined the Canadian health care system. For some leaders of chiropractic, "these are signs of lack of self-confidence" resulting from decades of marginality at the edges of organized allopathic medicine.

It seems that many chiropractors are reluctant to explore avenues for ongoing relationships with allopathic physicians within the locale of their clinics. There are a few instances where some chiropractors have successfully established rapport with neighbourhood allopaths to the extent of engaging in cross-referral of patients (Kelner et al., 1980). Perhaps, many chiropractors have been reluctant to initiate such relationships with allopaths because they have come to view the adversarial relationship between the two professions as a major block to the establishment of individual relationships.

Some of the gains chiropractors have made professionally and economically, for example, the inclusion of chiropractic in the provincial health insurance scheme, have been achieved in spite of opposition from allopathy. These gains tend to reflect the view that perhaps chiropractors feel that they can be more successful in lobbying the provincial government than in building lasting relationships with allopathy.

By not participating in public discussions relating to the future of health services such as the Royal Commissions of Inquiry, and by not increasing its effort in encouraging individual relationships between allopaths and chiropractors to enable cooperation in patient care, chiropractic in British Columbia
appears to have imposed a measure of self-constraint on its ability to improve public relations.

1.3.5 Constraints on Practice

When asked about his views regarding the constraints chiropractors are faced with in their clinical practice, the President of the only chiropractic college in Canada commented as follows:

"The hostility of medicine has not harmed chiropractors professionally in some ways. Rather, it has made chiropractic more cohesive, and more united against a common problem, but it hurts when it comes to what a chiropractor can do clinically, how he diagnoses a problem, what he uses in doing so and his contacts in trying to help a sick person."

One of the major constraints on chiropractic care is the inability of chiropractors to function as a primary care, first contact health care providers. Officially, chiropractic is seen as a "treatment modality" such as a massage, an amputation, or bed rest, rather than as a medical system with its own theory of disease and treatment rationale. Consequently, chiropractors are unable to take full advantage of procedures normally available to primary health care allopathic practitioners such as access to hospital X-rays, laboratory tests, and referrals to other specialists, without incurring economic and clinical penalties. Allopathic practitioners do not share X-ray or other pertinent patient-related information with chiropractors. Chiropractors do not have access to hospital medical records, and according to one chiropractic leader, "they cannot send clients to Worker's Compensation Board X-ray labora-
tories because radiology technicians will not assist them". The implication is that para-medical occupations such as radiographers and physiotherapists may not be free to act contrary to the wishes of organized medicine in their relationship with chiropractors.

In British Columbia, chiropractors are legally limited to using 'only' their hands in treating clients. Unlike their counterparts in Ontario who may use different treatment modalities such as electrotherapy and mechanical devices, chiropractors in British Columbia may not treat client problems for which these modalities are indicated, although they have received training in their use. This limitation puts more pressure on a chiropractor in British Columbia than in Ontario to succeed in clinical practice. His range of treatment options and modalities is limited. Of necessity, he must find ways to compensate for this limitation, probably moreso than his counterpart in other Canadian provinces. The President of the Canadian training college for chiropractors puts it this way:

"Chiropractic graduates have to work hard in terms of building up a network....all kinds of community services will tell you how to get patients, but will not tell you how to keep them. At the College we teach good clinical organization and practice development. Because every Canadian province is different regarding regulations on Chiropractic, we tell them to make the best use of the situation, especially what they've got or are allowed to do clinically....(they) must know how to operate a business and get patients....otherwise, unlike M.D.'s, they cannot do something else".

Economic, social and political limitations on professional conduct and practice do not pertain only to chiropractors. All healing groups in bureau-
ocratic societies contend with varying degrees of legal, social, political and economic limitations, moreso in societies such as British Columbia where, much as in other Canadian provinces, the state not only controls resources, but also is responsible for the health care of citizens.

From time to time, the public is made aware of demands from allopathic physicians regarding the right to extra-bill patients beyond what they have negotiated with the provincial government under various public health insurance schemes. Recent fiscal restraint in the health care system in British Columbia has led to complaints from hospital-based allopaths that the quality of their work is being compromised. More importantly, the argument is generally made by leaders of the "official" medical association that reimbursement fees for their services are too low compared to other Canadian provinces. Although allopathy is the official medical system in the province, like other medical systems, it also contends with some constraints resulting from the nature of institutional, bureaucratic and political structures in place in the society, but not to the same extent as are faced by chiropractors in British Columbia.

Naturopaths, although few in number compared to allopaths and chiropractors, are also constrained in their work. Much like chiropractors, they are reimbursed for twelve visits a year per client by the state regardless of the nature of the health problem and the need to continue therapy beyond twelve visits. Like chiropractors, they must find ways to supplement their income by finding ways to increase the number of clients in need of naturopathic services. However, the fourteen naturopaths in the province are too few to command public attention. Moreover, it appears that they have not been the subject of vigorous
opposition from the dominant allopathic group of healers partly because their
disease theory does not threaten the scientific rationale of biomedicine, and
also because their numbers are too small to pose threats to allopathy.

Chiropractors have more reasons for wanting to thrive, survive and succeed
as a profession than either the official medical system or any other "marginal"
group of health care providers in British Columbia. From the beginning in its
history, chiropractic has been opposed by allopathy (New Zealand Royal
Commission 1979). Other rival groups to allopathy such as osteopathy have been
absorbed over the years by allopathic professional organizations, especially in
the United States. Also, some research studies seem to have, from the
beginning, labelled chiropractic with deviant and marginal status, thus helping
to foster negative social valuation in the minds of the public at large. In
spite of recent studies which appear to support the professional status of
chiropractic (Leis, 1971; Lin, 1972), the public at large continues to view
chiropractic as a deviant or marginal occupational group (Appendix XIX). As the
second largest healing group in the province of British Columbia, as well as in
North America, chiropractic may be said to threaten the continuing domination of
the health care arena by allopathy, especially now that governments are seeking
ways to reduce the escalating cost of health care. In the first place,
chiropractic may opt for cheaper ways to deliver care without the highly priced
medical technology of modern hospitals. In the second place, the growing number
of chiropractors in the province could result in large numbers of chiropractors
competing with family [M.D.] doctors for the treatment of "minor" health
complaints. Yet it appears that the effects of legal, political, social and
economic constraints on chiropractic as well as vigorous opposition from organized medicine have not led to fewer persons seeking chiropractic services. Rather, recent evidence indicates that Canadians are not only going to chiropractors in increasing numbers, but they are also satisfied with the care they receive (Kelner et al., 1980).

Since the late nineteenth century, no other healing group has been subject to such high levels of opposition and structural limitations in their work. Chiropractors have been "inferiorized" by state officialdom, while allopathy has been accorded far more respect and responsibility. Even so, the popularity of chiropractic has increased markedly.

1.4 Sociological Studies on Chiropractic

It has been through the early works of Walter Wardwell that interest in the sociological study of chiropractic was introduced. In his original article, Wardwell (1952:340) adopted the concept of "marginality" which had been used previously to describe the marginal man or a person who was marginal to two cultures. However, Wardwell did not use the concept in that sense. For him it meant simply that the chiropractor's role, vis-a-vis allopathy, was marginal. He writes: "The role of the Chiropractor is structurally comparable to that of the Negro for it is marginal to the well-institutionalized role of the doctor."

The importance of the concept for Wardwell was that it indicated a role that was imperfectly institutionalized, and therefore, created ambiguity over legitimate behaviour for those who occupied it. Such roles usually resulted in personality
strain for the role occupant. The areas in which the chiropractic role is considered marginal include: the degree of technical competence which chiropractors possess, the scope of practice, its legal status, the income of chiropractors, and prestige. In all of these areas, the chiropractor is said to be inferior to the allopathic physician.

In his first study, Wardwell focused on marginality and social structure. He dealt with the adjustment problems of the role player in his subsequent article (Wardwell, 1955).

Wardwell (1963) moved from writing about the marginal role to the marginal profession and he presents a scheme for classifying health related practitioners as follows: ancilliary, limited medical practitioners, quasi-practitioners, and marginal practitioners. It can be argued that including chiropractic under any of these categories or even as "alternate practitioners" is problematic, since chiropractic has its own theory of health, disease and illness.

Although initially, Wardwell (1972) characterized chiropractic as a limited, marginal, quasi-practitioner group, he later attempted to delineate the social factors which have allowed chiropractic to evolve as a separate, distinct, health care profession. He argues that critical factors in its survival and growth include charismatic leadership and a distinctive focus on spinal manipulation. One may, however, argue that there are few charismatic leaders of chiropractic beyond its founder, B.J. Palmer. It is doubtful whether chiropractic clients are aware of who B.J. Palmer was, or that they make their decision to seek chiropractic care on the basis of charismatic leadership rather than particular health concerns. Also, manipulation as a distinctive focus of
chiropractic treatment has not only been labelled "a lethal device" but also it has been subjected to a number of state-sponsored public enquiries (Lacroix, 1965; New Zealand Royal Commission on Chiropractic, 1979). It is doubtful, therefore, whether the success of chiropractic with its clientele, can be attributed to either its leadership or to its treatment methodology.

McCorkle (1961) is the first sociologist to characterize chiropractic theory of health and illness as "deviant" theory, although he fails to state his reasons for such a characterization. A likely explanation for his characterization would be that chiropractic theory is "deviant" compared to the theory of the "official" allopathic theory of health and disease. In seeking to explain the survival of chiropractic, McCorkle attempts to establish an affinity between the rural culture of Iowa, the beliefs of chiropractic, and its development within Iowa. He maintains that chiropractic is especially well-designed to appeal to the thrifty, down-to-earth Iowan in that it offers to rapidly normalize a sick person, allowing him to go right back to work. This argument no longer holds in view of more recent findings that demonstrate the appeal of chiropractic to all levels of social, economic and political classes, including city dwellers (Gardner, 1975; Kelner et al., 1980; Coulter, 1984).

Cowie and Roebuck (1975:4) draw from labelling theory in defining deviant "behaviour as behaviour that people so label" and proceed to isolate labelling bodies within the health care field in the United States. Statements are produced from five labelling bodies including a private interest group, which label chiropractic as deviant. They conclude that these statements illustrate
that chiropractors suffer a deviant or at least marginal role-identity in the United States.

The study by Cowie and Roebuck is limited in the sense that generalizations cannot be made regarding chiropractors and chiropractic clinics because their study is limited to one clinic; but, as a descriptive study, it lays the foundation for future studies of chiropractic clinics.

Some have argued, after Friedson (1970a) that the autonomy of a profession to be self-directive and self-regulative is the key to its success (Evans, 1973, 1975). In general, a profession should have control over its governance, be able to determine the features of its education and practice, and be able to self-regulate its members. It is this form of autonomy that has been regarded as important for full-fledged professionalization.

The professionalization issue interests sociologists because chiropractic has elements of professionalism combined with elements of stigma. Leis (1971) and Lin (1972) have focused on chiropractic from the standpoint of professionalization. Although neither researcher explicitly refers to the concept of "deviancy", that concept is implicit in their work. While Leis explores the extent to which chiropractic has struggled to acquire the characteristics of a profession, Lin argues that chiropractic has already acquired those characteristics.

Mills and Larsen (1981) have found that a combination of characteristics contribute to the success of chiropractic. They have noted that the label "chiropractic" provides a unique identity compared to the identity of most healing occupations. The professional role of chiropractic is distinctive in
that the unique and contentious knowledge-base allows its practitioners to deliver a unique service. Moreover, Mills and Larsen note that chiropractors have gained occupational autonomy and have been given the right to self-regulation by provincial legislative acts. All of these characteristics have enabled chiropractic to provide a specialized service to clients and to the larger community, a service which would be otherwise unavailable. In their view, the result is the enhancement of professional status. Mills and Larsen note that the status of chiropractors appears to be rising in recent years (Blishen and McRoberts, 1976).

Sternberg (1969) has provided a descriptive analysis of the socialization of chiropractic students. His analysis deals with how chiropractic students confront the stigma that some groups apply to the chiropractor and he notes that the chiropractic role is one of the few roles in society that is both professional and stigmatized at the same time.

Firman and Goldstein (1975:640-641) try to explain the appeal of chiropractic by providing an analysis of its social functions. They argue as follows that:
(a) chiropractic "fits well into the value system of the rural and poorer population" because, according to McCorkle (1961), chiropractors use a common sense approach to a single-cause theory of disease which is capable of being presented effectively by mechanical analogy:
b) "Chiropractic features treatment modalities that are less time-consuming and expensive than those applied by physicians." In British Columbia, as in all of Canada, personal health expenditure for chiropractic treatment during the first
twelve visits to a chiropractic clinic is not a major factor due to the
universal medical insurance scheme which covers about 98% of the citizens;
(c) "The chiropractor functions to fulfill a need by 'legitimizing' the sick
status of patients with whom physicians can find nothing wrong." The authors do
not provide evidence in support of this observation, but they note that a
chiropractor may "fulfill a patient's need by validating the patient's
beliefs....by empathizing with the patient's idea how serious the condition is,
and by impressing on the patient that the chiropractor will cure the disease by
direct intervention";
(d) the chiropractor is successful because he succeeds "in treatment when other
practitioners have failed". However, Firman and Goldstein are not certain
whether this success is due to greater professional skill and knowledge, or more
positive feeling engendered in the patient by the "illness orientation" of the
chiropractor as opposed to the "disease orientation" of the allopathic
physician, or to a placebo effect of the laying of hands (White and Skipper,
1971; Kane et al., 1974; Parsons, 1951a; Bloom, 1963). They note that "the
practice of chiropractic is structured in such a way as to be considered along
with many other techniques of 'persuasion' that have 'healing' as a goal";
(e) chiropractors offer alternative channels of therapeutic innovation such as
manipulation and (f) that "they serve establishment medicine by providing an
outlet for many potentially time-consuming and trouble-making patients".

It has since been shown that clients simultaneously visit allopathic
physicians and chiropractors (Kelner et al., 1980; Gardner, 1975). 78.4% of new
chiropractic clients observed in clinics and interviewed in this study continued
to visit their allopathic physicians. It is doubtful whether the success of chiropractic can be explained simply on the basis of legitimation of the "sick role", or by chiropractic functioning as an outlet for "troublesome patients". Chiropractic is but one of many other healing groups in society. Other healing groups such as naturopathy and homeopathy among others have not been as successful as chiropractic in "making their clientele." They also may be said to function socially in the same manner Firman and Goldstein have attributed to chiropractic.

Another explanation for the success of chiropractic with clients has been provided by Coulehan (1985). He argues that "specific 'clinical action' is not a sufficient explanation for the success of chiropractic care. It is not even a necessary condition in individual cases because very often persons with aches and pains are not helped by manipulative technique but may benefit from clinical process..." (p.363). Rather, the attitude of the chiropractor and the immediacy of his therapeutic action are what is important in successful healing. Coulehan reasons that if a positive attitude or plan of action is helpful, then a negative or indifferent attitude is clearly harmful. The focus in his argument is that by projecting positive attitudes, chiropractors help their ailing clients. What remains to be explained is how the positive attitude is projected. What is it that the chiropractor does that helps to project a positive attitude? Is the projection of positive attitudes sufficient explanation for the success of chiropractic in clinical settings, considering the limitations and constraints chiropractors have faced in the historical development of the profession and in different social and political environments?
Coulehan (1985:353) finds that "the clinical art, as manifested in the chiropractor-patient interaction, contributes greatly to chiropractic healing. This process promotes patient acceptance and validation, fulfills expectations, provides explanations and engages the patient's commitment". Coulehan does not discuss how the patient is led to accept and validate chiropractic or how his expectations are fulfilled or health problems explained. Rather he has based his reasoning on the works of Cowie and Roebuck (1975), and Luce (1978) among others in coming to the conclusion that "the attitude of the practitioner and the immediacy of his action are important in healing" (p.363).

In Coulehan's view, chiropractic clinical interaction involves a scenario in which there is the acceptance and validation of the patients' illness problem; the fulfillment of his expectations by use of understandable explanations; the delivery of concrete clinical action; and the development of a plan which requires patients to commit themselves and to cooperate via frequent follow-up visits and telephone calls.

Coulehan's views may partly hold in general terms, but they do not tell us how chiropractors and their patients reconcile individual "realities" of the clinical situation, especially the beliefs that each person holds about illness and its treatment, or how chiropractors overcome perceptions of deviancy in "convincing" new clients to become chiropractic patients.

In another study, Parker and Tupling (1976:375) have speculated that "it is likely that a more complex interaction is occurring between the chiropractor and the patient than one which is restricted to a general concept of 'faith' in the therapist, and an 'expectation of therapeutic gain'". 
Parker and Tupling (1976), like Coulehan (1985), do not describe how this "complex interaction" occurs. None of the sociological studies of recent knowledge including those discussed above examine the manner in which chiropractors socialize new clients in trying to explain the success of chiropractic. One study, Cowie and Roebuck (1975) looked at one chiropractic clinic in an attempt to describe what chiropractors do. To generalize on the work of chiropractors from a study of one clinic in a specific social, political and economic environment would be, at best, rather inconclusive because chiropractors face different professional and local obstacles in their work.

This study adds to existing knowledge by examining the processual nature of successful chiropractic in a given locality. It does so by describing what goes on before and during individual interactions between new clients and chiropractors. It assumes that in order for chiropractors to be successful in the face of social, political, economic and legal constraints, they must "convince" new clients to become patients of chiropractic. Individual chiropractors, therefore, are assumed to act in ways that seek to overcome these constraints.

In order to make a new client, it is assumed that a chiropractor tries to understand the "health beliefs" of the client and then attempts to negotiate some common ground for treatment and continuing utilization of chiropractic care. Unlike allopathic practitioners, chiropractors must promote their services for reasons discussed earlier. Unlike naturopaths and other healing groups, chiropractors face concerted opposition from allopathy. Particularly, in the province of British Columbia, chiropractors confront challenges and
problems which appear to place greater requirements on the need for socializing new clients than would be so even for chiropractors in other Canadian provinces (such as Ontario) where treatment modalities other than the use of hands are permitted.

1.5 Purpose of Study

Broadly conceived, the purpose of this study is to contribute to existing knowledge regarding the "success" of chiropractic in British Columbia by describing how chiropractors in a particular political environment "convince" new clients to become their patients. Specifically, this study focuses on the nature of the relationship, or what Parker and Tupling (1976:374) have termed "the complex interaction" between a client and a chiropractor that enables the client to become a patient. "Successful socialization" of a new client is, therefore, considered to have been achieved when the client has continued in chiropractic treatment for four or more visits to the chiropractor.

In examining why chiropractors are successful with their clients, I argue that such factors as professionalism, charismatic leadership, and professional autonomy do not adequately account for the success of chiropractic in British Columbia, especially in the presence of the political, economic, legal and social constraints on chiropractic care. I also argue, after Coulehan (1985), that specific clinical action as demonstrated by "manipulation" does not provide sufficient explanation for the success of chiropractic. These factors may, of course, contribute in various ways to the success of chiropractic, but client
satisfaction is achieved primarily in the relationship between individual chiropractors and their clients in clinical settings. These settings provide the key site for "socialization" of new clients, a process in which "persuasive interaction strategies" can be used to "negotiate" compliance to treatment. In these settings, all participants in the interaction exchange personal or professional beliefs and explanations for illness problems based on individual experiences, psychological profile, sociocultural factors, economic considerations, interpersonal relationships, and for chiropractors, professional culture and training.

I argue that because of the relatively acute constraints on chiropractors in British Columbia, they, of necessity, develop "persuasive strategies", individually or collectively, for socializing sick persons who come to them for help. In other words, the fate of chiropractic, particularly in the one locality of the province of British Columbia, can be accounted for by examining and describing how individual chiropractors "convince" new clients to become their patients. Although client "socialization" often begins prior to the actual office contact, it is maximized during the clinical interaction between the chiropractor and the new client. It is during this encounter that treatment is "negotiated" in order to encourage continued utilization of chiropractic.

Unlike any other healing group outside of the "official" allopathic group, chiropractors have more need to enhance their social image by devising different strategies for reorienting potential clients toward accepting chiropractic health care.
In recent years, a number of newspaper articles have commented on the restrictions chiropractors have faced in British Columbia. (The Vancouver Sun: August 4, 1984, September 4, 1984, March 25, 1983, March 26, 1983; The Province: May 27, 1983, March 27, 1983). In one article captioned, "Chiropractors Want Fair Shake from MDs" (The Vancouver Sun, August 4, 1984), Nicole Parton, a popular consumer reporter observed that:

(a) "Doctors who refer patients to chiropractors or who accept referrals from them face disciplinary action and fines. A 1972 resolution by the Canadian Medical Association concerning chiropractic and other forms of medical quackery also prevents doctors from passing patient information, laboratory results or X-rays."

(b) The provincial "College of Physicians and Surgeons will not permit medical labs to release X-rays to chiropractors..."

(c) "Hospital boards don't allow chiropractors to use hospital facilities or practice on hospital premises..."

(d) "The College of Physicians and Surgeons bars its members from renting office space to chiropractors in buildings owned and occupied by medical doctors."

(e) Until May 1984, when the provincial medical act was changed, "Chiropractors in the province were not legally allowed to call themselves 'doctors'."

Regardless of these obstacles, persons with health problems have continued to seek help from chiropractors in increasing numbers. Consequently, chiropractic has continued to experience growth in its ranks accompanied by increasing "official" acknowledgement of this healing group. Nowadays, chiropractic services are included in government sponsored insurance plans, and there is legislative recognition of chiropractic in all but one Canadian province. Furthermore, two government commissions of inquiry that examined chiropractic
services, while not passing judgement on the merits of chiropractic theory of disease, found merit in the treatment of certain conditions by chiropractic methods. Over 75% of chiropractic patients reported that they were satisfied with treatments they received (New Zealand Royal Commission on Chiropractic, 1979; Lacroix, 1964; Kane et al., 1974; Kelner et al., 1980).

What, therefore, accounts for the ability of chiropractors in British Columbia to satisfy their patients in spite of formidable restrictions? How do they interact with their clients in clinical settings so as to foster high levels of satisfaction? In short, how are chiropractic clients socialized towards becoming chiropractic patients?

Figure 1 illustrates the conceptual relationships between a new client and a chiropractor prior to, during, and after both have interacted in clinical settings. The new client brings to the clinical setting his personally held "explanation" [Explanatory Model: EM] regarding the cause, course, reasons why a particular health problem has occurred, and the kind of treatment he should receive (Kleinman, 1980, 1976, 1974b; Kleinman et al., 1975, 1978). The "explanation" an individual holds for a particular health problem is based on characteristics such as psychological profile, sociocultural factors, past experiences with illness and treatment, economic adequacy, the social significance of the health problem, and relationships with family and friends. These factors provide an individual with a "health model" (HM) from which he derives the explanation for a specific or recent health problem (see Chapter 2).

A Health Model [HM] is defined in this study as the general beliefs a person has about sickness and health care which exist prior to a given sickness
### The Relationship of Health and Explanatory Models of Clients and Chiropractors for Healing Activities

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<tr>
<th>THE CLIENT</th>
<th>HEALTH MODEL</th>
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<th>THE CHIROPRACTOR</th>
<th>HEALTH MODEL</th>
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<td>- Individual Characteristics</td>
<td>1. Beliefs about:</td>
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episode. In this study, health model includes beliefs about the human body and how it functions, beliefs about causes of illness including signs and symptoms, and beliefs about treatment systems and healers including personal health habits.

An Explanatory Model [EM] is the total understanding an individual has regarding the cause of a particular illness, its pathophysiology, the course it will take, and the assumed remedy (Kleinman, 1980, 1975; Kleinman et al., 1978). (For more discussion, see Chapter 2).

Explanatory Models are derived from Health Models (Figure 1). Various factors can influence the extent to which an individual's explanatory model is a "true" reflection of his health model. For example, a person who believes in "natural" remedy for a particular illness episode may be "forced" to accept medication or surgery because of the prevailing orientation of the society at large and a general belief in "scientism", unless the person's EM is consistent with the EM of the physician. The acquisition of "medical" and related knowledge through education can mediate or change a person's HM, therefore leading to the alteration of his EM. The history of an illness such as the frequency with which the illness has occurred in a family over time can lead to the alteration of an EM. More importantly, the context in which a particular illness has occurred, influences the health and illness beliefs [HM] of an individual, and in turn, alter the explanation the person has for the reasons why the illness has occurred. For example, sudden and intermittent joint pains may be attributed to seasonal changes in weather conditions, especially if pain
is experienced more often during cold weather following a hot spell (see Chapter 2 for more discussion).

Generally, a chiropractor's health model is mediated by his professional training and culture, which in turn mediates the "explanation" (EM) he has for particular illness episodes. A new client's health model is mediated by his personal characteristics including past experiences, and social relationships which, in turn, mediate the explanation [EM] he has for his sickness.

Both the new client and the chiropractor bring to the clinical setting their "explanatory models" [EMs] which become part of the definition of "clinical reality" (see Chapter 2). It is during interaction in the clinical setting that the chiropractor and the new client negotiate a "common understanding" or "shared explanatory model" which enables treatment and ongoing care, and it is during these clinical encounters that new chiropractic clients are "convinced" of and "socialized" towards accepting chiropractic care.

Crucial to an understanding of this negotiative process is the fact that parties to this and any other negotiative process are rarely of equal strength so that the negotiative process is usually occurring in the context of asymmetrical power relationships which may be either overt and known to the parties or covert and veiled by hidden agendas. This is a crucial feature of negotiation and must be taken into account in trying to explain their outcomes.

Also crucial to an understanding of the negotiative process in clinical interactive settings is how people, in general, behave in the course of their normal "life" activities, within which the interaction between a practitioner and a client is embedded. Goffman (1959, 1967, 1969) has made observations
about how people present themselves and interact in the course of their daily activities, in particular, the definition and structuring of situations. According to Goffman (1959), one way of creating an impression is through the use of specific techniques of interaction and "presentational" devices. In order to overcome the limitations that have constrained chiropractic care, chiropractors may use specific persuasive interaction structures and processes as well as presentational devices to "attract" and "impress" new clients.

Of central importance in this study is how a new chiropractic client perceives his health problem, and whether his perception is consistent with that of the chiropractor. Because the decision has been made to seek chiropractic help, the new client has taken the first step towards interacting with chiropractic, and thus, is "open" to the acquisition of personal impressions about this type of healing.

Central to the initial clinical interaction between the new client and the chiropractor are three factors, namely: the degree of prior knowledge the client has about chiropractic, what happens when he makes the first contact, especially with a medical system he knows little about, and his beliefs, expectations and explanations regarding his present health problem.

In conceptualizing the negotiation of health and explanatory models between a chiropractor and a new client, certain questions inevitably arise, such as whether clients and chiropractors have similar HMs and EMs, whether ethnic and cultural differences between the two groups affect the negotiation process, and whether changes in the negotiative process may be equated with changes in personal beliefs. Such questions are considered in the analysis of the study.
data, bearing in mind, however, that the main thrust of the study is to identify commonalities in chiropractor responses to the problem of client socialization.

This study, therefore, describes the socialization of persons who seek "help" for their health problems from chiropractic for the first time in the three municipalities of Vancouver, focusing on the processes by which they are converted from clients to patients.

The following assumptions have been made:
(a) that the health care of a society is a sociocultural system which comprises different medical systems;
(b) that clients and healers have personal health habits and beliefs about health and illness from which they derive personal health models [HM];
(c) that clients and healers have individual explanations for specific illness episodes [EM] which are derived from individual health models;
(d) that during the first encounter, clients and practitioners negotiate for common explanation and treatment for a particular illness complaint;
(e) and that successful negotiations occur when clients adhere to suggested treatments for, at least, four visits to the clinic.

It is also assumed that client "socialization" begins earlier than the initial chiropractor-client encounter via different "presentational devices" and "office routines" that the client experiences just before his first encounter with the chiropractor.

It is therefore argued that whether or not new clients will continue to receive chiropractic treatment for at least four visits to chiropractic clinics (a measure of "success"), will largely depend on their personal
impressions regarding the clinical settings, interactions with chiropractors, especially during initial visits, and how their health beliefs and explanations for their present health problems have been taken into consideration or satisfactorily negotiated to enable ongoing treatment.

In this study, "socialization", broadly conceived, means the successful conversion of new clients from the statuses of potential patients to those of subscribing patients as determined by at least four visits to chiropractors. The process of negotiating explanatory models is considered a key aspect of the socialization process. Therefore, the successful negotiation of explanatory models is considered necessary for chiropractic treatments to occur, and is discussed in the context of Goffman's (1959, 1967) views regarding everyday behaviour and relationships.

1.6 Summary

In this chapter, I have discussed the emergence of chiropractic as a visible feature of the Canadian health system. In doing so, I have characterized its growth as the result of an increasing number of satisfied clientele who seek help from chiropractic for particular health problems.

Chiropractors have more need than any other healing group in British Columbia to elevate their social valuation and to acquire new patients, given the opposition from allopathy as well as the political, legal, social and economic limitations on chiropractic care. In British Columbia, public attention has often been called by the media to issues and debates on chiropractic.
Unlike the situation in other Canadian provinces, chiropractors in British Columbia are limited to the use of hands in treatment. They have often gone to the courts to win certain rights, such as the right to call themselves "doctors". As the second largest healing group to allopathic [M.D.] physicians in British Columbia, chiropractors may be viewed as posing a threat to the domination of the health care system by the "official" medical system.

I have argued that previous sociological explanations for the "success" of chiropractic are inadequate. These explanations fail to examine and describe "what goes on" during the interaction between a prospective patient and a chiropractor.

I have also argued that in British Columbia, socialization of clients is dependent on the kinds of limitation chiropractic faces as a profession. Individual successes at client socialization depend on individual approaches to commonly held strategies - approaches which may have been devised because of constraints on chiropractic care.

I have noted that beliefs individuals hold about health and illness [HM] are influenced by such factors as individual characteristics, psychological profile, sociocultural factors, past experiences, economic needs and relationships with family and friends, and for chiropractors, by professional culture and training. These beliefs help to provide explanations [EMs] for particular illness episodes, which may be altered because of the context in which the illness has occurred or is perceived.

I have argued that the success of chiropractic in convincing new clients is determined by the ability of chiropractors to "convince" clients to continue in
treatment for at least four visits to the clinics via the successful negotiation of explanatory models that will enable treatments to occur, as well as via persuasive interaction strategies that are designed to convert new clients to become subscribing patients.

This thesis is organized as follows: In Chapter 2, the sociocultural aspects of health care systems are discussed, in particular, Health and Explanatory Models. The notion of "clinical reality" is discussed in relation to its importance in practitioner-client interactions. In Chapter 3, practitioner-client interactions are discussed as well as socialization via negotiation. The method of study is presented in Chapter 4. Interview data are presented in Chapter 5. Observational data for modifying client perceptions and negotiation of Explanatory models are described in Chapters 6 and 7. Study results are analysed in Chapter 8 along with suggestions for future studies and for policy innovations in the sociology of health care.
NOTES

1. Chiropractic has been defined variously as an art, a science, or both. It is "that branch of the healing arts concerned with the restoration and maintenance of health by the adjustment of the articulations and related structures of the body, more especially the spinal column, and is involved primarily with the relationship of the spinal column to the nervous system...." Board of Directors: The British Columbia Chiropractic Association (1978:4).

It has also been defined as "the science which concerns itself with the relationship between structure, primarily the spine, and function, primarily the nervous system, of the human body as that relationship may affect the restoration and preservation of health". British Columbia Chiropractic Association (Undated:6).

Chiropractic has also been defined as "that science and art which utilizes the inherent recuperative powers of the body, and deals with the relationship between the nervous system and the spinal column, including its immediate articulations, and the role of this relationship in the maintenance of health". Palmer College of Chiropractic (1978:25).

In this study, the word "Chiropractic" has been used both as an adjective and as a noun. The usage is consistent with its use in the literature on chiropractic as well as its use by chiropractors themselves.

2. Chiropractors are faced with different limitations to their clinical practice in different environments. In the United States, chiropractors are licensed in forty-five states and they face different state regulations as they compete with "official" allopathic physicians for clients within the free-market system. In Canada, there is no uniform regulation for the practice of chiropractic. Provincial laws differ considerably and what is legal in the Province of Ontario may not be legal in the Province of British Columbia. The Province of British Columbia has the strictest laws regulating chiropractic. For example, while a chiropractor in Ontario may use electrical and mechanical devices in treatment, a chiropractor in British Columbia is allowed to use his hands only in treatment. Therefore, differences in provincial regulations on chiropractic treatment therefore necessitate the development of local strategies for client socialization.

3. During the course of this study, especially during the twenty-two months of field observation, sixteen headlines and six full-length articles on issues related to chiropractic appeared in the two daily newspapers in Vancouver in addition to radio and television features.
4. The first points of contact by clients in the Canadian health care system are considered "Portals of Entry" into the system. These are primary health care providers who are in first contact with clients prior to referrals to specialists or secondary care providers. Initial Portals of Entry practitioners include family doctors, and chiropractors, among others (see Soderstrom, L., 1978:4).

5. Primary health care in Canada comprises health care services that are provided outside of health care institutions, such as hospitals, by health care providers. Officially, primary health care includes everything that the family doctor does in treating individuals' health problems in the community. Sociologically, primary health care would include the totality of all that every healer, such as family doctors, shamans, chiropractors and other individuals do in a given society in order to alleviate the social burden of illness.

6. Osteopathy is treatment that is aimed at correcting supposed deformation of skeleton as a cause of many diseases. Skeletal deformations are thought to impede circulation. There are no schools of osteopathy in Canada. Unlike in the United States, where osteopathy has its own hospitals and collaborative clinical practices with "official" [M.D.] medicine, osteopathy in Canada is marginal and declining in numbers. New osteopathic physicians are not being licensed in Canada anymore. It is possible that by the end of this century, osteopathy, as a medical specialty in Canada, will have ceased to exist when the few remaining osteopaths are no longer able to practice.

7. Allopathy is treatment of disease by inducing an opposite condition to that disease. For example, in a case of high body temperature, a drug may be administered to lower the temperature. Chiropractors generally refer to conventional physicians [M.Ds] as allopaths or allopathic physicians and to themselves, usually sometimes as chiropractors or as chiropractic physicians.

8. These figures do not reflect the number of persons who have visited or will visit chiropractors in 1983 and 1985 respectively. According to published reports (THE VANCOUVER SUN, March 27, 1983), the total number of treatments by chiropractors in British Columbia include repeat visits by regular patients for any number of occasions.

9. Chiropractic has variously been described as a "marginal", "quasi", or "deviant" profession compared to the more established medical [M.D.] profession. More recently, several authors have concluded that chiropractic has attained the full status of profession. See for example: Leis (1971); Lin (1972); and Mills and Larsen (1981).
10. The notion of social reality is based on the work of Peter Berger and Thomas Luckmann (1967) which itself is conceptually related to the work of Alfred Schutz (1970). Eliot Freidson (1970a) is most responsible for transposing the "social reality" concept to the health care field.

11. There are three different sectors in which healing activities occur in society, namely: the popular, the folk, and the professional sectors (Kleinman, 1980; Chrisman and Kleinman, 1980). The popular sector consists of diagnosis and care by sick persons themselves. The shared meanings of illness within this sector has been called "popular health care culture" by Polgar (1962:46). In the popular sector, illness is first perceived and labeled, treatment applied, and most sickness episodes receive care. Individual and collective beliefs about sickness result in the use of a variety of remedies such as herbs, diet, exercises, humidifiers and blankets, as well as off-the-counter patent medicines.

Folk medicine is a mixture of many different components, some of which are closely related to popular and folk sectors of healing activities. It includes non-professional, non-bureaucratic, and often quasi-legal or sometimes illegal forms of health care which are based on various folk health cultures. Very often, these folk cultures shade imperceptibly into professional practice on the one side, and popular care on the other side. Examples of folk medicine are shamanism, herbalism, traditional surgical and manipulative treatments, special exercise systems such as yoga for health, and symbolic non-sacred healing activities.

12. Homeopathy is the treatment of disease using drugs that would, in a healthy person, produce symptoms like those of the disease.

13. The dichotomy between two aspects of sickness are disease and illness. Kleinman (1980:72-73) has defined disease as "a malfunctioning of biological and/or psychological processes". It affects single individuals even when whole populations are attacked, unlike illness which most often affects others such as family members, and social networks.

Illness is "the psychosocial experience and meaning of perceived disease...(including) secondary personal and social responses to a primary malfunctioning (disease) in the individual's physiological or psychological status (or both)". It is the experience of disease and suffering and involves "attention, perception, affective response, cognition, and valuation directed at the disease and its manifestations" such as symptoms and role impairment. Illness, therefore, is created by personal, social and cultural reactions to disease. The construction of
illness from disease has been called "a central function of health care systems (a coping function) at the first stage of healing (Kleinman, 1980:72).

Disease and illness are explanatory concepts and not entities. Kleinman (1980:73) has observed that disease and illness exist as "constructs in particular configurations of social reality" and "can only be understood within defined contexts of meaning and social relationships". It is our explanatory models [EMs] which enable us "to identify, assemble and interpret the clinical evidence that confirms the relationships".

Kleinman et al. (1978:251) have commented that "modern physicians diagnose and treat diseases (abnormalities in the structure and function of body organs and systems) whereas patients suffer illnesses (experiences of disvalued changes in states of being and in social function) the human experience of sickness...illness may occur in the absence of disease".

14. The terminologies "organized medicine", "official medicine", and "allopathic medicine" are used interchangeably to refer to the dominant group of healers [M.Ds] in the Western world whose members and organizations have been granted greater state sponsorship via legislation than members of any other group of healers. The group is organized in two separate units: One unit, the College of Physicians and Surgeons, is responsible for regulatory control of members through such activities as monitoring infringements relating to the Medical Act, licensing and discipline of members, as well as introduction of new regulations on practice. It is an autonomous body with delegated powers from the state. The second unit, such as local medical associations, function more or less as labour unions for members. It negotiates reimbursement fees with provincial governments for services provided by members. Both units are strongly opposed to chiropractic in British Columbia as elsewhere in Canada.

The terminology "official medicine" is used to denote the group of health care providers that is most favoured by the state through licensing, control and regulatory laws in matters affecting health and the treatment of disease.

15. Chiropractors in the Province of Ontario have greater freedom in their choice of treatment techniques and methods. Like hospital-based physiotherapists, they are allowed to use a variety of hospital-oriented treatment techniques such as electrical stimulation of muscles, traction devices, ultraviolet radiation, and so forth. Physiotherapists and chiropractors come under the same Provincial Act, and are similarly regulated. Chiropractors in Ontario have a much wider range of treatment options to use and they are not as constrained, in this regard, as their colleagues in the Province of British Columbia.
16. The physician in question had initially trained as a chiropractor prior to his medical education as an allopath. He has been involved on both sides of the debate. The provincial medical association has been cautious in dealing with him. On the other hand, the provincial Chiropractic Association is pleased to have him as an ally but also very cautious of his role. Disapproval from the College of Physicians and Surgeons in permitting him joint clinical practice with a chiropractor, but approval in allowing him to collaborate in such a venture with the allopathic wife of another chiropractor led one leader of chiropractic in the province to comment: "In British Columbia, a chiropractor is not allowed to establish joint practice with a medical doctor, but he can marry one".

17. The Canadian Memorial Chiropractic College [CMCC] in Toronto is the only training institution for chiropractors in Canada. There are half a dozen chiropractic schools in the United States. 75% of chiropractors in this study received their training at CMCC and 15% in U.S. colleges.

18. Freidson (1970b:48) defines "paramedical occupations" as "occupations organized around the work of healing which are ultimately controlled by physicians". Physiotherapy and nursing are examples of hospital-based para-medical occupations.

19. The Province of Nova Scotia has yet to legislate a chiropractic act or provide official recognition of chiropractic as a form of health care.

20. The criterion of four visits were determined on the basis of information from two chiropractors in the study area. They noted that new clients who wish to discontinue chiropractic treatments usually do so after the first, and no later than the second visit to their clinics, and that patients who continue treatment do so beyond the second visit. Therefore, it was assumed that a much higher number of visits, in this case, four visits, will be used to ensure that new clients who will be dropping out of the relationship, have done so.
2.0 SOCIOCULTURAL CONTEXT OF HEALING ACTIVITIES

Sociological research has shown that the medical culture of patients and their families, including their medical understandings, theories and values, affect their evaluation, experience and method for expressing symptoms (Mechanic, 1972), their pattern of help-seeking (Chrisman, 1977; Lin et al, 1978; Mechanic, 1978), and their evaluation of the outcome of the treatment they receive for their suffering (Kleinman, 1980). A likely critical factor in assessing the social and cultural affects on an ill-person appear to be the meaning a symptom has for the individual and the "idiom" or language in which distress is experienced and communicated.

Interpretive sociology involves conscious translation across meaning systems to arrive at understanding of the realities of others. For example, a new, "ethnic" chiropractic client living in Canada would draw the meaning of his illness from his ethnic background, merge it with the prevailing Canadian culture in terms of the meaning that is socially accepted for that particular problem, in coming to terms with what he should or should not convey to the chiropractor. Similarly, the chiropractor would, in order to successfully socialize the new client, understand the client's predicament and resolve his own response in relation to his own therapeutic beliefs. Thus, an interpretive approach to clinical practice is not a reflection of causal products of somatic and physical processes but a reflection of meaningful human realities. Healing,
therefore, is viewed as transaction across meaning systems which results in the construction of socioculturally specific illness realities and a treatment effort to transform these realities.

Kleinman (1980:41) has coined the term "clinical reality" to designate the socially constructed contexts that influence illness and clinical care. His argument is that health care systems are not only socially and culturally constructed systems, but they are also forms of social reality. According to Kleinman (1980:35):

"Social reality signifies the world of human interactions existing outside the individual and between individuals. It is the transactional world in which everyday life is enacted, in which social roles are defined and performed and in which people negotiate with each other in established social relationships under a system of cultural rules."

Viewed in this way, social reality is constituted from, and in turn, is part of the meanings and relationships between people and institutions. Social reality is absorbed and internalized by an individual as part of a system of symbolic meanings, norms and values which govern his behaviour, his view of the world, his communication with others and his understanding of the environment in which he finds himself. Thus, a person undergoes a process of socialization, not only within his family and among his friends, but also within other social groupings.

There is a "bridging reality" that links social and cultural worlds with biological and psychological reality. Kleinman (1980:41-42) has referred to this bridging link as "symbolic reality". "Symbolic reality" is formed when an
individual acquires language and systems of meaning during the course of his life. Although socialization through language acquisition and symbolic systems enables an individual to respond behaviorally to interpersonal relationships and to social institutions, the internalization of symbolic reality (Mead, 1934) also plays a key role in orienting the individual to his own inner world (Berger, 1973; Cicourel, 1973). In other words, symbolic reality helps an individual to make sense of his inner experience, especially in shaping his identity in accordance with sociocultural norms. Thus, basic psychological processes, such as state of consciousness, attention, cognition, motivation, memory and perception are influenced by symbolic meanings.

Kleinman (1980) observes that clinical reality is mediated by symbolic reality, and that as much as language can be thought of as a cultural system linking thought and action, medical symbolic systems can be considered cultural systems linking illness and treatment. The two cultural systems are forms of symbolic reality. Both are situated in social roles, relationships, and cultural beliefs, as well as in individual experience and behaviour.

A person who seeks help from a particular medical institution will have to contend with the clinical reality of that system. A new chiropractic client, therefore, brings to the clinical setting, not only his illness problem or the psychobiological reality underpinning his illness, but also his system of meaning or the symbolic reality which mediates his sickness and care. These realities then encounter the "reality" of chiropractic care or the social, structural and cultural contexts in which chiropractors offer help to sick persons.
I have argued, in Chapter 1, that several factors influence a person's health beliefs as well as his explanation regarding why a particular illness has occurred and the type of treatment that he expects (Figure 1). I have also argued that the "success" of chiropractic in converting new clients to patients can be understood by examining how chiropractors and new clients reconcile their health beliefs and explanations for specific illness problems. In this chapter, the concepts of health and explanatory models are elaborated upon and discussed. In order to understand, more fully, the nature of the relationship between healer and client, the institution of medicine is also discussed, especially how its organization relates to the experience of patients and to the relationships between healing groups.

2.1 HEALTH MODEL [H.M.]

Health Model, is defined in Chapter 1 to mean the general beliefs a person has about sickness and health care which exist prior to a given sickness episode. A health model is specific for an individual and several factors which influence it were identified in Figure 1. These factors are discussed in the context of the beliefs individuals hold about health, illness and treatment systems.

In this study, the Health Model is defined to include health habits, beliefs about the human body and its functions, beliefs about the causes of illness and disease including signs and symptoms, and beliefs about treatment systems and healers. One often hears the statement "A person lives what he
preaches". In other words, if a person holds certain beliefs about good health care, he will be expected to demonstrate these beliefs through his health habits. A person who believes cigarette smoking is dangerous to good health is not expected to smoke cigarettes. Moreover, a person may develop personal explanations about why a particular health problem has occurred by organizing his health and illness beliefs in a way that makes sense to him. His health model acts as reference points in his search regarding why the problem has occurred, its cause and outcome, and the type of remedy he feels he should receive.

Individual and psychological characteristics and the way a person thinks of his health and his personal beliefs about life and living influence his health and illness beliefs. People have opinions on a number of things that go on in life, from politics to food additives and lifestyle. According to Becker (1974), a person's ideological stance contributes to whether or not he will comply with a particular form of treatment. Similarly, it has been shown that psychological characteristics, namely, characteristics that are not personality traits but rather characteristics which relate more to the way people think and what they believe, have some relationship to whether or not they will comply with recommended treatment (Rosenstock, 1974; Becker, 1974; Becker et al., 1979). For example, it has been found that patients who do not cooperate with their medical treatment believe themselves to be less susceptible to and less threatened by their illness or possible future illness (Becker et al., 1979). To these people, the physician's assessment of the danger of their illness does not matter very much. Rather, to them, it is their own perception of the severity of the illness that is important.
Social and cultural factors influence views about health and illness and about the type of treatment that is acceptable. For example, Davitz and his colleagues (1976) have shown that cultural factors have an enormous influence upon people's interpretation of symptoms and their responses to these symptoms. Moreover, anthropological work has shown that conceptions of illness in any culture are part of a learned cultural complex and that responses to symptoms are culturally conditioned as are responses to any other environmental threat (Clark, 1970; Saunders, 1954). In comparing Anglo- and Spanish-speaking cultures, these authors find that the "Anglos" tend to prefer medical sciences and hospitalization for dealing with illness, while many Mexican-Americans tend to rely more heavily upon folk medicine and family care as important aspects of treatment. It has been shown that to many Mexican-Americans, illness relates to their life, to their community, and to their family and interpersonal relationships (Kiev, 1968). Furthermore, Mexican-Americans traditionally believe that illness exists only when there is pain or visible symptoms (Clark, 1970).

Zola (1966) and Zborowski (1958) suggest that among certain caucasian ethnic groups, the complaint of pain may be used to communicate personal and interpersonal distress in a culturally acceptable way. Zola has found that illness behaviours can influence how health care professionals evaluate the medical conditions of patients. In his study of patients who voluntarily went to the ear, nose, and throat clinics for symptoms for which no medical disease could be found, Zola found that the modes of cultural expression by the patient strongly influenced the way in which they expressed the symptoms, which in turn, strongly influenced the physicians' decision about their care. In other words,
patients' usual methods for expressing symptoms affect how they are viewed and evaluated by the physician, especially if the methods of expression are primarily culturally based.

In a study about how people respond to pain, Zborowski (1952) found that Jewish and Italian patients tended to exaggerate pain experiences by responding in an emotional manner, while patients of English or Irish descent were inclined to be more stoical and to deny pain. While the outward expressions of Jewish and Italian patients were usually similarly emotional, there was a difference in the meaning of pain to patients in these two ethnic groups. The Jewish patients were concerned with the cause of pain and its future significance, whereas the Italian patients tended to seek relief from the pain and were satisfied when they felt better regardless of future consequences (Zborowski, 1952).

How pain is described is influenced by a number of other factors including language facility, familiarity with medical terms, individual experiences of pain, and lay beliefs about the structure and function of the body (Helman 1984). Once a person has made public his pain, there exists an implied social relationship of some duration between the sufferer and another person or persons. The nature of this relationship will determine whether the pain is revealed in the first place, how it is revealed, and the nature of response to it. As Lewis (1981:153) has noted, the expectations of the sufferer are important here, particularly the likely response to his pain and the social costs and benefits of revealing it. "Possibilities of care, of sympathy, the allocation of responsibility for sickness in others, affect how people show their illness". People will receive maximum attention and sympathy if their pain
behaviour matches the views of the society regarding how people in pain should draw attention to their suffering, whether by an extravagant display of emotions or by a quiet change in behaviour. As Zola (1966:622) puts it, "It is the 'fit' of certain signs with a society's major values which accounts for the degree of attention they receive". Therefore, there is a certain kind of dynamic process between the individual and society whereby illness and pain behaviours as well as reactions to them influence each other over time or lead to help-seeking.

Therefore, the ways in which people perceive, evaluate, and act upon their symptoms depend to a great extent upon their cultural and social backgrounds as well as early experiences.

Very often, the presence of a particular health problem will limit that ability of an individual to fulfill his social role. For example, an active player of the game of tennis will be prevented from undertaking this social activity with his friends if he has a nagging backache. Consequently, his main focus in treatment may concentrate on the relief of pain to enable him to meet his social obligation even when there could exist a more serious underlying health problem such as generalized rheumatoid arthritis. Similarly, in the United States where there is no universal health insurance for all citizens, a worker whose monthly earnings barely cover the expenses required for basic necessities is unlikely to readily define a symptom as needing medical attention or warranting a day off from work with the resultant loss of a day's pay. In this case, the decision about the seriousness of the symptom is made in the context of the resources of the individual or the entire family.
In many cultures, including the western culture to a lesser degree, the family is frequently involved in labeling and treatment of an illness. An ill person may seek advice from a family member or vice versa. Martin (1981) has pointed out that in native American healing, the patient's sickness places a responsibility on both patient and family to participate in healing rites. The focus of attention is not only on the patient, as in Western medicine, but also the reaction of the family and others to the illness. Also, responses to childhood illnesses may influence a person's experience as an adult in ways which, over time, may lead him to favour specific types of remedies.

Kleinman (1980) has noted that unpleasant emotional states such as depression, or the experience of social stresses, is often expressed in the form of physical symptoms. Kleinman refers to this observation as "somatization" (p.138). His studies in Taiwan led him to observe that because mental illness is heavily stigmatized, depression is often presented in the form of physical symptoms.

Finally, the professional training, culture and healing activities of a healer influence his beliefs about health and illness and the kind of treatment that he will favour.

2.1.1 Conceptions of the Structure and Function of the Human Body

In general, the beliefs people have about the structure and function of the human body, the causes, signs and symptoms of illnesses, professional healers and treatment systems as well as the health habits they observe, are therefore
derived from sociocultural factors, past experiences with illnesses, the
influence of peers, family and friends as well as other life events that may
have contributed in shaping these beliefs (Figure 1).

The belief a person has about the structure, function and the inside of the
body can influence his perception and presentation of bodily complaints as well
as his response to treatment (Helman, 1984). Waddell and his colleagues (1980)
have shown that the manner in which a person views his body may affect the
clinical labeling of his condition, especially when physicians are considering
non-organic and psychogenic signs and symptoms.

The healthy working of the body is thought, by some people, to depend on
the harmonious balance between two or more forces or elements within the body.
To some extent, the balance is dependent upon external influences such as diet
or supernatural agents as well as internal forces such as inherited weakness or
state of mind.

According to Ayurvedic medicine (Kleinman et al., 1974), the body contains
four liquids or humours: blood, phlegm, yellow bile and black bile. Health is
a result of the four humours being in optimal proportion to one another.
Ill-health, therefore, results from an excess or deficiency of one of them.
Diet and environment can affect this balance as can the seasons of the year.
Treatment of the imbalance or disease consists of the restoration of optimal
proportion of the humours by removing excess via bleeding, purging, vomiting or
starvation, or by replacing the deficiency via special diets and medicines
(Kleinman et al, 1975).
In the "plumbing-model" of body function (Boyle, 1970), the body is conceived of as a series of hollow cavities or chambers, connected with one another, and with the body's orifices, by a series of "pipes" or "tubes". The major cavities are usually the chest and the stomach which almost completely fill the thoracic and abdominal cavities respectively.

The plumbing model deals mainly with the respiratory, cardiovascular, gastro-intestinal, and genito-urinary functions of the body and does not necessarily pertain to all aspects of anatomy and physiology of the body. It is usually a series of metaphors that are used to explain the function of the body. Very often, different physiologic systems are lumped together. One often hears the expression: "I always swallow a bit to loosen the cough". (Helman, 1978). From the point of view of scientific biomedicine, swallowing goes to the stomach and coughing relates to the chest. Sometimes the plumbing model is used to express emotional states, especially lay notions of "stress" or "pressure" via expressions such as: "I blew my top" "I have to let off some steam".

The function of the body is also conceptualized as an internal combustion engine, or as a battery-driven engine. These machine or engine metaphors are often reinforced by doctors and nurses. It is common to hear a doctor or a nurse say to a patient: "Your right chamber is not pumping well", or "You have had a nervous breakdown". Central to the notion of the body as a machine is the idea of a renewable "fuel" or "battery-power" needed to provide energy for the smooth working of the body. Such "fuels" include different food-stuffs or beverages such as tea, coffee and vitamins. Alcohol may also be viewed as
"fuel". One often hears of the comment: "I need to rest because my batteries need recharging".

The concept of the body as machine implies that individual parts of the body, like parts of an automobile, may "fail" or stop working and can sometimes be repaired or replaced. Recently accomplished heart and kidney transplants tend to reinforce this notion.

2.1.2 Lay Theories of Illness Causation

Helman (1984) has identified four categories in which lay people locate the cause of ill-health. These are: the individual person; the natural world; the social world; and the supernatural world. Helman observes that people in non-western societies tend to ascribe the causes of their health problems to social and supernatural causes.

Person-centred lay theories generally locate the cause of illness within the individual. Sometimes the theories are about malfunctions within the body, changes in behaviour or dietary habits. Ill-health may be blamed on wrong diet, hygiene, life-style, social relationships, smoking, drinking habits, and physical exercise. Other causes of ill-health may be attributed to stigmatized personal conditions such as obesity, alcoholism, and venereal disease.

Other lay causes of illness may include: hereditary proneness or the genetic transmission of a particular illness; degeneration in the structure and function of body tissues or organs such as occur in the aging process; invasion in which illness is due to either external invasion by a germ or other object, or internal spread from existing problems such as cancer; imbalance or a state
of disequilibrium, excess or depletion of, say, vitamins or blood; mechanical
disorder such as abnormal functioning of organs or circulatory system; damage to
parts of body; blockage of organ or vessels, and pressure in organs or
particular parts of the body.

In many non-Western societies, the most common causes of ill-health are
located in the social world. The usual forms are witchcraft and sorcery. In
all of these causes, illness and other forms of suffering and misfortune are
ascribed to interpersonal malevolence, whether conscious or unconscious (Foster
and Anderson, 1980).

It is from the beliefs people hold about the functions of the human body,
the causes, signs and symptoms of illness, treatment systems and professional
healers as well as health habits that Health Models are derived. Health Models
[HMs], in turn, give rise to the explanations people have about a particular
illness (Fig.1).

2.2 Explanatory Model [EM]

Explanatory model pertains to a specific illness episode which is set in
the context of the person's health model [HM].

In response to the miscommunications caused by the different professional
and lay cultures as well as to the crucial psychological and social influences
on sickness and care, Kleinman (1980) has suggested a useful way for examining
the process by which illness is patterned, interpreted, and treated. Kleinman
has termed this perspective "Explanatory Model" [EM] which he has defined as
"the notions about an episode of sickness and its treatment that are employed by
The explanatory model, therefore, contains a sick person's understanding of the cause of his illness, its pathophysiology, expected course and prognosis, and the treatment that he believes will be or should be administered.

Kleinman (1980), based his notion of explanatory model on the following considerations:

(a) That the institution of medicine is a social institution of which the manner of its organization has important influences on medical care and the experiences of clients and patients (see Section 2.3 for more detailed discussion).

(b) That clinical practice occurs in and creates particular social worlds in which beliefs about sickness, the behaviours exhibited by sick persons, including their treatment expectations, and the ways in which sick persons are responded to by family and healers are all aspects of social reality. These, like the institution of medicine itself, are social and cultural constructions which are shaped distinctly in different social structural settings.

(c) That each sector of the health care system (see Note 11, Chapter 1), or each healing profession, creates its own clinical reality. Kleinman (1980:52) comments:

"Once people decide to enter the professional or folk sector, they encounter different beliefs and values in the cognitive structures of professional or folk practitioners. They make these encounters in the process of entering or exiting from healing agencies. The clinical realities of the different sectors and their components differ considerably."
(d) That there is a distinction between disease and illness. In the Western medical paradigm, disease is the malfunctioning or maladaptation of biologic and psychophysioologic processes in the individual whereas illness represents personal, interpersonal and sociocultural reactions to disease or discomfort. In other words, "illness is shaped by sociocultural factors governing perception, labeling, explanation, and valuation of the discomforting experience" (Kleinman et al., 1978:252).

(e) That conflicting interpretations of clinical reality are partly the result of the social and cultural organization of medical institutions and partly due to discrepancies between the health beliefs and values held by members of different professions and sectors of health care.

(f) That beliefs about illness are closely tied to beliefs about treatment.

(g) That individuals are in contact with different belief and normative systems as they move from one sector of health care or one profession to the other. As they move between distinct clinical realities of health care they carry with them their own cognitive and value orientations and also encounter other cognitive and value frameworks. Contact with another system of meanings and norms may mean simply a shift between conceptual frameworks and behavioural styles via the process of "negotiation". Thus, contact with a different conceptual framework entails conflict between divergent orientations.

Kleinman (1980:105) notes that EMs are held by both patients and practitioners. The EM of a practitioner tells us something about "how the practitioners understand and treat sickness". The study of patient and family EMs "tells us how they make sense of given episodes of illness and how they
choose and evaluate particular treatments" (p.105). EMs, therefore, "offer explanations of sickness and treatment to guide choices among available therapies and therapists and to cast personal and social meaning on the experience of sickness". Belief in holistic treatment for health problems might lead to the choice of holistic care from a holistic practitioner. Belief in scientific medicine might lead to the choice of modern allopathic care from allopathic physicians.

An Explanatory Model, therefore, is a person's understanding of (a) the cause of his illness, (b) the timing and mode of the onset of symptoms, (c) the pathophysiological processes involved, (d) the natural history and severity of the illness, and (e) the appropriate treatment for the condition. EMs provide explanations for these five aspects of illness and they are marshalled in response to a particular illness episode and are not identical to the wider beliefs about illness that are held by society in general or by the individual, his [HM] in particular (Kleinman, 1980).

Since EMs draw from the belief systems of the individual and the society, and are employed to cope with a specific health problem, Kleinman (1980) suggests that they need to be studied in clinical settings in order to analyse them more precisely.

Client EMs are also influenced not only by "popular culture" EM, but also by the family EM. On the other hand, chiropractor EM may be influenced primarily by the professional EM which has a theoretical base. Client EMs tend to be idiosyncratic and changeable, and to be heavily influenced by both personality and cultural factors. They are partly conscious and partly outside of
awareness, and are characterized by "vagueness, multiplicity of meanings, frequent changes, and lack of sharp boundaries between ideas and experience" (Kleinman, 1980:107). By contrast, practitioner EMs which are also marshalled to deal with a particular illness episode, are "mostly based on single causal trains of scientific logic", and I would also add, work constraints, economic constraints and individual experiences, thus extending Kleinman's view.

Clinical consultations and practitioner-client interactions are actually transactions between client and practitioner EMs. Explanatory models, therefore, are used by individuals to explain, organize, and manage particular episodes of impaired well-being, and can only be understood by examining the specific circumstances in which they are employed.

One way of looking at this process according to Kleinman (1980), is to examine the sort of questions that people ask themselves when they perceive themselves to be ill. These are: (a) What has happened? - which includes organizing the signs and symptoms into a recognizable pattern, and giving it a name or identity, (b) Why has it happened? - explaining the cause of the condition, (c) Why has it happened to me? - trying to relate the illness to aspects of the client or patient such as behaviour, diet, body-build, social and supernatural factors, personality or heredity, (d) Why now? - relating to the timing of the illness and its mode of onset, whether sudden or slow, (e) What would happen if nothing were done about it? - it's likely course, outcome, prognosis and dangers, and (f) What should I do about it? - strategies for treating the condition, including self-medication, consultation with friends and family, or going to seek help from a particular healing orientation or healer.
A person suffering from a "head-cold" might answer the questions as follows: "I have picked up a cold because I went out into the rain on a cold night directly after a hot bath when I was feeling low. If I leave it alone, it may go down to my chest and make me more ill. I have tried some hot soup and some sleep. I better see a doctor in order to get some medicine for it." Before these questions can be answered, the client must have experienced certain signs and symptoms as abnormal such as "runny nose", shivering, and muscle aches and pains, before grouping them into the recognizable patterns of "a cold". This implies fairly widespread belief in the client's community about what a cold is and how it can be recognized, even though the EM of a particular cold is likely to have personal and idiosyncratic elements. Where many people in a culture or community agree about a pattern of symptoms and signs including its origin, significance and treatment, it becomes an illness entity with recurring identity. This identity is more loosely defined than biomedical diseases, and it is greatly influenced by the sociocultural context in which it appears.

Kleinman (1980:106) argues that although EMs can be distinguished from general beliefs about sickness and health care, they draw upon these beliefs and belief systems as they are "marshalled in response to particular illness episodes". Thus, EMs "formed and employed to cope with a specific health problem", therefore need to be analyzed in "concrete settings". He further comments that in practice, people do not volunteer their EMs to health care professionals, and when they do, they report them as short single-phrase explanations because they are embarrassed about revealing their beliefs in "formal health care settings". Individual and family EMs often do not possess
single referrents but represent semantic networks that "closely link a variety of concepts and experiences" (p.107).

In Kleinman's framework, EMs interrelate illness beliefs, norms, and experiences and they function as clinical guides to decisions that he has termed "hierarchies of resort" or "structures of relevance". It is "the EM and the semantic sickness network it constitutes and expresses for a given sickness episode that socially produce the natural history of illness and assure that it, unlike the natural history of disease, will differ for different health care systems" (Kleinman, 1980:107).

The metaphors that are used by people and practitioners to articulate their EMs disclose cultural patterning. For example, popular and professional EMs in western societies contain metaphors of war such as: "fighting", infection, "vanquishing" disease, "invasion" by pathogens, and immunological "defenses". Kleinman (1980:109) notes that Taiwanese popular EMs "frequently employ the metaphor of a person being "hit by ghosts and then becoming ill".

Kleinman (1980:111) has conceptualized the patient-doctor relationship as a transaction between patient explanatory model [EMP] and doctor's or practitioner's explanatory model [EMd]. He has explicated four types of outcomes in the transaction as follows - outcomes meaning what the patient holds:

(a) EMP + EMd - both the original patient model and the medical model together are held by the patient.

(b) EMP > EMd - in this outcome, there is systematic distortion, usually in favour of the patient's original model.

(c) EMP or EMd - either the original patient model or the medical model is held alone by the patient, and
(d) EMn - a totally new model is reported by the patient, usually based on a new source of information.

A fifth outcome may also be considered, namely, EMd > EMp or transaction in which there is systematic distortion of outcome in favour of the practitioner. In other words, I envisage a transaction in which a doctor could modify his EM as a result of what he has learned from the patient's EM.

Conceivably, there could emerge a sixth outcome in which the doctor's EM changes to the patient's EM. Admittedly, such an outcome may not be realizable in allopathic transaction but may be realized with non-allopathic transactions. A seventh outcome would require the practitioner to acquire a totally new EM which is based on a new source of information.

It is also conceivable that both the doctor and the patient will continue to hold on to their original models when there is no common agreement.

Kleinman (1980:113) suggests that by eliciting the patient EM before the doctor and the patient interact with each other and then comparing that EM [EMp₁] with the EM the doctor transmits to the patient [EMd₂] for the five major questions they concern (relating to cause, course, pathophysiology, expected outcome and expected treatment) it may be possible to estimate the initial cognitive distance between them - Distance A = EMp₁ - EMd₂. Similarly, the cognitive distance following patient-doctor interactions can be calculated by comparing the model the doctor communicates to the patient [EMd₂] with the model the patient holds subsequent to the interaction [EMp₂] - Distance B = EMd₂ - EMp₂.
According to Kleinman, the distance B is a rough measure of the communication between practitioner and patient. If distance A is compared to distance B, the efficacy of the communication between practitioner and patient will be revealed as to the degree to which the discrepancies are reduced or widened in clinical communication. Similarly, family EMs can be included in other combinations of the equation.

In this study, there is no attempt to calculate cognitive distances by quantifiable means nor of the elicitation of family EMs. Rather, discrepancies in client and chiropractor EMs are described and tabulated as observed in percentage terms according to the frequency of occurrence. The primary goal is first to identify clients' and chiropractors' HMs and EMs and then to describe how discrepancies in EMs are negotiated in chiropractic-client interactions.

2.2.1 The Elicitation of Explanatory Models

Kleinman (1980) and Kleinman et al. (1978) have commented that the explanatory model outcomes are the result of a transactional process which, in theory, might be likened to a paradigm for translation between two languages, although, in practice, the actual translation rarely takes place. However, in principle, there is a process of elicitation, followed by processes of analysis, transfer restructuring (in the new language or EM) and feedback.

Elicitation is the process by which client or practitioner may obtain the other's EM through questioning. Kleinman (1980:111) notes that in clinical transactions, "practitioners commonly do not elicit the patient's EM but
spontaneously transmit at least part of their EM". Perhaps Kleinman's comment is relevant when one considers the nature of allopathic medical transactions and the authority relationship that have been seen to characterize the way allopathic medicine is organized (see Chapter 3). Other health care practitioners who do not enjoy much authority relationships or who are constrained in one way or the another, may exhibit different forms of clinical transactions from that proposed by Kleinman.

In this perspective, analysis is the process by which the patient's EM is analysed in terms of the doctor's EM, and transfer means that the analysed EM is transferred into the other EM, which as a consequence, is restructured.

Katon and Kleinman (1980) have suggested that client's EM should be elicited by open-ended questions in layman's terms, or questions which do not contaminate the client's perspective with the practitioner's assumptions. They suggest that in order to elicit such information, the practitioner must demonstrate warmth, empathy, and persistence, and he must be non-judgemental. The practitioner must have a genuine interest in the meaning the sickness has for the client and make explicit to the client his intention to draw on this information in "constructing an appropriate treatment plan" (p.259).

The elicitation of the client's EM is followed by an assessment of the meaning of the illness for the client such as loss, gain, threat, opportunity for growth or no significance (Lipowski, 1969).

Katon and Kleinman (1980) also suggest that the practitioner should determine the client's illness (as opposed to disease) problems such as the experiential, family, economic, interpersonal, occupational and daily life
problems created by the disease and its treatment. The key to a successful clinical transaction, determined by compliance to treatment by the client, is measured by the ability to successfully negotiate between differing perceptions of illness goals of treatment and conflicts. "The objective is neither to dominate patients nor convert them to the physician's value orientation, but to enlist the patient as a therapeutic ally and provide care for problems patients regard as important in ways that patients desire" (p.262). The goal is to provide less "doctor-centred" transaction. Katon and Kleinman further comment:

"Crucial to this shift in the structure of clinical relationships is the recognition that clinical care should involve a genuine negotiation between physicians and patients." (p.262)

The implication of this enjoinder is that both the client and the practitioner would negotiate as "equals" for a satisfactory outcome. The significance of this observation is further discussed in Chapter 3 where negotiation is discussed as part of an overall strategy for client socialization.

In this study, Explanatory Models [EMs] are taken to be derived from Health Models [HMs] (Figure 1). The practitioner and client bring to the clinical encounter, their respective EMs for negotiating a shared EM in order to enable treatment. Failure to successfully negotiate a shared EM would lead to non-compliance with treatment by the client, or dropping out, at least after the initial encounter and treatment. Failure to successfully negotiate a shared EM would also lead to the doctor referring the client to another doctor or in discouraging the patient from chiropractic care. Successful negotiation of a
shared EM would lead to the socialization of the client and the latter's transformation from client to patient as evidenced by adherence to treatment over a period of time (Table 1). In each instance, negotiation occurs in the clinical setting within the context of "individual meaning" for each participant, client and practitioner. According to Kleinman (1980:110), "EMs are the main vehicle for the clinical confirmation of reality, and they help to reveal the historicity and specificity of socially produced 'clinical reality' regardless of the form of knowledge on which the healing process is based".

2.3 The Social Organization of Medical Care

Kleinman (1980:25) has commented that "the health care system is a concept, not an entity", hence, a conceptual model that is held by a society or an individual. Therefore, it is important to understand how actors in a particular social setting think about health care, how decisions are made, their beliefs about sickness, how responses to illness episodes are structured and what particular kinds of structures and processes are put together in the system. By examining the way the institution of medicine is organized and how it functions, it is possible to analyse the social and cultural rules and meanings which shape medical care in a society, at least certain of its key components.

Janzen (1977) has argued that models of medical systems must deal with both micro- and macro-analysis. Thus, they should examine specific episodes of sickness and treatment, showing how small-scale events within healing systems relate to large-scale social structures and processes of change.
The following discussion relates principally to the institution, organization and processes of allopathic medicine. Because allopathy is the dominant group of health care providers in Canada and the western world, it provides the yardstick against which the performances of marginal healing groups are measured. More importantly, allopathy plays a much greater role in the social and cultural lives of the inhabitants of western societies. In these societies, as in the province of British Columbia, allopathy has been granted greater rights and autonomy, via legislation, over health and illness than any other healing group. As I have noted in Chapter 1, it is allopathic medical system that, in the view of chiropractors, has encouraged and fostered political, legal and practice constraints on chiropractic health care. The focus of our discussion, however, relates primarily to the relationships and interactive behaviours in allopathic medical settings and institutions, as a way of understanding what goes on in chiropractic clinical settings.

Allopathic medical care is a social institution which is dominated by physicians [M.Ds] as a particular profession. The principal function of medicine is the regulation and control of one type of deviance, namely, sickness. In carrying out this function, allopathy has been granted, by society, the right to define criteria of sickness, to determine appropriate modes of treatment and management, and to engage in practices that are consistent with these definitions and determinations. However, the specific organizational forms and practices vary as a function of relationships between allopathy and other social institutions. For example, in British Columbia, only allopathic physicians can provide legal and acceptable medical evidence in the
law courts, legitimate the rights of disabled persons for access to guaranteed income for need (GAIN, 1978), admit patients to publicly-funded hospitals, and practice acupuncture to the exclusion of trained acupuncturists.

Friedson (1970a) has reviewed the historical development of organized medicine and argues that its status as a profession depended on establishing a monopoly over the exercise of its work. Friedson observes that the profession of medicine is one of the most successful in achieving this autonomy and in establishing the freedom to work without outside regulation. It is perhaps, only allopaths [M.Ds] among health care professions who have been vested with the responsibility of monitoring one another's performance. In the United States, and to a certain degree in Canada, this organizational structure reinforces the performance of procedures for profit, prestige and control rather than the performance of procedures for health. The consumer of allopathic medical services, unlike the consumer of any other product of service, has a very small voice in determining health care practices and policies.

There is a growing body of critical literature that outlines in great detail the flaws in the health-care-delivery system, their roots in the structure of society and their manifestation in the organizational arrangements of the field of medicine (Ehrenreich and Ehrenreich, 1971; Waitzkin and Waterman, 1974; Illich, 1977; and Navarro, 1976). Although the volumes of critical literature vary in their particulars, nevertheless, they share an orientation which is marked by their use of such key terms as "power" and "politics". These terms help to position health care as a topic within the structure of the political power in society and they reflect the central
question relating to "who gets what?" In this context, the referrent "what" is not restricted to the standard goals of health care such as the cure of illness and the remission of symptoms, but it is expanded to include, or to focus on such social and economic benefits as status and profits. It is the distribution of these benefits among various health professionals, such as allopathy and chiropractic, and between other groups in society that becomes the main focus of attention.

Homowy (1981) has described how during the history and development of medicine in Canada, allopathy used political relationships, exclusionary tactics, and restricted entry to prevent the development and growth of competing medical systems such as Osteopathy, Homeopathy and Chiropractic. In recent times, these approaches have continued to be used by allopathy in British Columbia against chiropractic, the second largest healing group to allopathy, perhaps in an effort to minimize chiropractic role in the health care system of the province (see Chapter 1, Section 1.3).

Critical literature has suggested that the allopathic profession has not only pursued its own special interest, but, at the same time it represents the dominant groups and classes in the society, therefore serving its special interest as well. In British Columbia, of all the primary health care groups in the province, only allopathic physicians sit in the highest level of state committees which adjudicates and evaluates the role of other primary health care groups. For example, whereas both allopaths and chiropractors are entitled to provide health care to injured workers and be compensated for their services by the Worker's Compensation Board, only allopathic physicians sit on the Ministry
of Health's committee that monitors, evaluates and approves all claims for payment for services. Asked why there is no chiropractor or any other primary health care group sitting on the committee, one senior official of the Ministry of Health interviewed for this study commented that the College of Physicians and Surgeons in the province would not allow it. A leader of chiropractic in the province, also interviewed, noted that "a significant number of reimbursement claims from chiropractors are rejected each year", and that the stringent scrutiny with which chiropractic treatments are reviewed by the Ministry of Health's committee has necessitated the development of a "special claims manual" for chiropractors.

The way medical care is organized also has social implications for society and for individual members of society. Illich (1977) has noted that one of the social consequences of the monopolistic control by the medical profession of so many important areas of life is the erosion of individual autonomy for self-care and of community processes for mutual care. Because of the increasing reliance on allopathic medicine and experts, individuals become less competent in taking care of themselves or of others without medical intervention. Otherwise such self-care and care of others may be treated as an illegal act by the courts.

The recent struggle by midwives in British Columbia to obtain recognition as a socially and medically acceptable health care occupation has met with very strong opposition from allopathic medicine as well as legal intervention by the law courts (The Vancouver Sun, November 20, 1986). It is well known that, for centuries, the occupation of midwifery has been in existence, and that in many Western countries, for example, Holland and Denmark, midwives are part of the
health care system. Some people may consider the act of midwifery a natural occupation for a naturally occurring phenomenon, child-birth, even before the advent of organized medicine.

Organizations and institutions which have been designed and developed for certain specific purposes, sometimes come to serve other aims and imperatives. Friedson (1970a, 1970b) has argued that the demand for monopoly control of the profession by the profession may have less to do with the corpus of specialized and technical knowledge of medicine, which is used to justify this demand, than with efforts to sustain the position of power and status of allopathic physicians, vis-a-vis other health professions and their patients. We have discussed in Chapter 1 how the allopathic profession in British Columbia has used its position of power to prevent chiropractic, and also midwifery, from making significant impact on the health-care-delivery system. According to the views of Friedson (1970a:350), "social policy is coming to be formulated on the basis of the profession's conception of need and to be embodied in support of the profession's institutions".

The general values about health and health care about which Illich (1977) is concerned and the specific interests of medicine as a profession which is examined by Friedson (1970a), are actualized in the work settings through which health care is organized and "delivered" to patients.

In discussing the labeling perspective on illness, Waxler (1980:294) has commented that the "ways in which the institution operates has an important and selective effect on the negotiation of illness". She noted how some hospitals which rely on "patient fees, may organize admission procedures in such a way as
to produce the numbers of 'ill' people that are required to keep the system going. She went on to show how the organizational working of a hospital "produces illnesses that might not exist if, for example, social workers did night duty" (p.295).

Waxler (1980) uses the findings of several studies to argue that illness labels originate as a result of social negotiations between professionals and individuals within institutional and social contexts, and that "the ideologies and organizational procedures as well as the relative power and interests of the negotiating parties contribute to the label of illness" (p.296). The occurrence of initial labeling depends on the prevailing norms of the society, an individual's social position, and the characteristics of the organization. Waxler notes that alcoholism in the United States is no longer considered a crime but an illness, and that homosexuality is no longer regarded as an illness by the American Psychiatric Association but simply as the "lack of sexual desire" (p.289).

On the role of knowledge and social position of individuals in the labeling of illness, Waxler (1980:293) states:

"...some individuals learn through experience with particular treatment systems how to state their case (regardless of symptoms) in order to get what they want, either hospital admission or discharge....the social and economic position of the potentially 'ill' person along with his family or spokesmen may have a significant impact on the negotiation of the problem."

The focus of Waxler's argument is that illness labels are the result of negotiation between physician, patient and significant others in the context of
an institution and organizational arrangements, and that illness labels have important implications for the individual.

Allopathy "produces" illness labels. A person who is "uncomfortable" with a given label or whose health beliefs are inconsistent with the label may opt to seek an alternative explanation from another healing system such as chiropractic.

In order to gain more understanding of what takes place in medical work settings, we shall use the practitioner-client interactions and studies that have examined these interactions to compare allopathic and chiropractic beliefs, norms and roles, especially aspects of their respective health models. The focus is on how allopathic practitioners conduct their relationships, some of the reasons why allopathic-client relationships are the way they are, how they are often perceived, and how chiropractic-client interactions might differ from that of allopathic interactions.

2.3.1 Practitioner-Client Interactions

There are fundamental differences in the basic beliefs of modern allopathic and chiropractic treatment systems. Modern medicine is based on and dominated by concepts, methods, and principles of the biological sciences. As Engel (1977:130) has noted, "the dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biologic (somatic) variables". Coupled to the narrow biomedical definition of disease is the concept of specific cause for every disease and the assumption that disease has
specific and distinguishing features that are universal to the human species. In other words, the symptoms and processes of disease are expected to be the same in different historical periods and in different cultures and societies. Moreover, physician [M.Ds] tend to see themselves as, and often acquire the self-image of, bioscientists, therefore reflecting the view of medicine as a discipline that has adopted not only the rationality of the scientific method but also the concomitant values of the scientist, namely, objectivity and neutrality (Coulter, 1983; Mishler et al., 1981).

The biomedical definition of disease ignores the importance of socio-cultural factors such as individual beliefs about health and disease, and the dichotomy between disease and illness, especially the role of institutional factors in the aetiology of illness and its remedy (Waxler, 1980; Kleinman, 1980). Balint (1957:40) also has suggested that the diagnosed disease is not simply "out there" in the patient, but is in the result of negotiation between physician and patient. Thus, diseases are not found; they are socially constructed.

Coulter (1983) has commented that the scientific approach of biomedicine has necessitated a form of reductionism in treatment in which the germ theory has introduced an approach isolating the cause and treatment of specific diseases. Thus, rather than focus on the patient, allopahs tend to focus on the biological aspects of the body and disease, thus transforming the social setting of medicine. Consequently, this transformation has altered, in a fundamental way, the nature of practitioner-client relationship from one which takes human relationships into consideration to one which alienates individuals.
On the other hand, chiropractic philosophy is "holistic" and it considers the body an integral unit. According to the chiropractic orientation, the human body, when functioning normally, is able to combat disease processes naturally, and the occurrence of disease is the result of a failure in the body's natural restorative power. Chiropractic treatment, therefore, takes the whole body into consideration. In this regard, a person's physiological make-up, his state of mind, as well as intervening social problems such as unemployment or stressful marital relationships, are predisposing factors to illness (Strang, 1984; Haldeman, 1980; also see Chapter 1, Subsection 1.2.2).

In the chiropractic model of treatment, disease is interpreted as symptom and chiropractors claim not to treat disease. Rather, they claim to treat the "cause" of the disease by treating the patient, "the object being to restore the body, including mental processes, to a normal state" (Coulter, 1983:153). Since the body has the natural ability to restore itself to normal function; it should, therefore, not be tampered with drugs which may affect the ailment but not remove the cause. Chiropractic, therefore, is conceived as a natural therapy without the use of drugs.

The focus of the chiropractic-client interaction is on human relationships and the psychological and social factors which mediate the ability of the "whole" individual to restore his own body to normal health. The chiropractic model of care, therefore, encourages the mutual participation of the client in the discovery, explanation and treatment of illness, in contrast to the "activity-passitivity" model of allopathic-patient relationships in which the
patient is totally passive, or sometimes the guidance-cooperation model adopted by some allopasts in which the physician tells the patient what to do and the patient is expected to cooperate (Szasz and Hollender, 1956).

It is conceivable that both the chiropractor and the client may not be operating from the same power-relationships that characterize allopathic care - one in which the physician [M.D.] has greater legislated power compared to the patient or the chiropractor. It goes without saying that in Western societies, the physician [M.D.] has come to be viewed as "powerful" in society and this perception of power is often actualized through the social control and gatekeeping functions of allopathy (Parsons, 1951; Ehrenreich and Ehrenreich, 1971).

In relation to the client, the chiropractor may be viewed as relatively less powerful in view of the historic deviant perceptions chiropractic has faced over the years, its marginal status compared to allopathy, and especially the special constraints that have confronted the work of chiropractors in British Columbia. An important question in this study is whether chiropractors and their clients negotiate as equals in the chiropractic clinical settings or whether one of the partners in the negotiation is in a commanding position during the negotiation of explanatory models and treatment.

The organization of chiropractic care is modelled along the lines of that of family [M.D.] practitioners in solo and group practices. There are no specialized subgroups in chiropractic, unlike allopathic care in which different specialists lay claim to the treatment of different parts of the body, and in some instances, different diseases such as rheumatoid arthritis or cancer.
Therefore, the need to consider all of the "presenting problems" of a client is enhanced for the chiropractor who is expected to provide total care and not depend on some other para-professionals to assist in treatment. Friedson (1970a) has noted how physicians [M.Ds] rely on and control the work of paramedical professions such as physiotherapists and nurses.

Finally, unlike allopathic physicians, chiropractors do not, and are not, legally allowed to use treatment institutions such as hospitals. Physicians [M.Ds] often admit patients to hospitals for "observation", thus disrupting the social link and social support the person has depended upon in the community. A chiropractor provides treatment in the community, the client returns to his home and family and important social supports are maintained.

It appears that chiropractic would be potentially appealing to patients because there is no hospitalization for the individual patient. People are treated in the community, therefore enabling them to continue to take advantage of support from their family members and friends. They can return to their work, especially when they have "minor" ailments for which a physician [M.D.] may have recommended hospitalization for "observation". The absence of such considerations in allopathic care has led Frankel (1983:19) to comment that "the organizational settings for recommending allopathic treatment are often more remote from the actions and treatments recommended". More importantly, the orientation of chiropractic seem to be person-centred with emphasis on human relationships. It is also possible that the absence of drugs and surgery in chiropractic treatment, together with the "soothing" and "comforting" effects of treatment by hand only, may encourage people to try chiropractic form of care.
Their subsequent experience of chiropractic, and whether or not they will continue in chiropractic treatment, would depend on the experience they acquire in coming in contact with chiropractors in chiropractic clinical settings.

How, therefore, are chiropractic-client interactions different from those of allopathic medicine? What are the possible "occurrences" in allopathic-patient interactions that may lead subscribing patients of allopathic to consider chiropractic care? What significant factors influence the cognitive and affective aspects of physician-patient relationships? And what is the impact of the physician-patient relationship on treatment and its subsequent outcome?

The answers to these questions may be found by discussing the results of some of the studies which have examined the processes of allopathic-patient interactions in order to assist our understanding of the chiropractic-client interactions.

Studies of physician [M.D.]-patient relationships extend over a wide range of areas, in particular, the communication of medical information, distortions of understanding, patients' compliance with doctors' instructions, and affective behaviour.

(a) Communication Problems between Doctors [M.D.] and Patients: Asking questions

West (1983) examined the overall distribution of questions between physicians and patients engaged in 21 two-party exchanges in a family practice centre in the United States. She observed 773 questions in the 21 exchanges of which 91% or 705 questions were initiated by physicians and only 68 or 9% of the
total number of questions were initiated by patients. Neither the sex nor the race of physicians and patients seemed to influence the distribution of questions between the parties. Moreover, the proportion of physician-initiated questions answered by patients, 98%, and the proportion of patient-initiated questions answered by physicians, 87%, was not equal.

West (1983), therefore, concluded that patient-initiated questions were dispreferred in physician-patient interactions, and that while questions do, in most cases, elicit answers from their recipients, patients answer doctors' questions more often than doctors answered theirs (p.89).

West also found that "doctor-talk" (that is when doctors ask questions and engage in conversations) is more constrained by "utterance-type" and "speaker identity" than casual conversation. For example, physicians would chain questions together with no intervening slots for answers, therefore causing the patients to fail to answer some of the questions in the chain (p.89). Goffman (1981) has noted that the construction of multiple-question utterance-types can itself place constraints on opportunities for answers. Therefore, both the numbers of physician-initiated questions and the ways they are constructed display their orientation to a normative order of medical exchange in which physician-initiated questions are preferred. West (1983) also found that when physicians' "next" questions were posed over patients' attempted answers to their "last" questions, incomplete answers often appear within states of simultaneous speech, and "that doctors who were asked fewer questions also answered fewer of those they were asked" (pp. 90-99).
In another study, Wallen et al. (1979:145) found that "patients who ask the most questions are necessarily the ones to receive most explaining time". Korsch and Morris (1969); Korsch and Negrete (1972) and Freeman et al. (1970) investigated aspects of communication gaps in 800 pediatric emergency room visits using tape-recordings of medical consultations, follow-up interviews, and the review of medical records. The patients were children between the ages of 6 months and 10 years, but it was their mothers who were engaged in consultations with physicians. They found that sufficient information was not made available to the patients or mothers. 19% of the mothers did not receive a clear statement of what was "wrong" with their child. 50% were still wondering when they left the doctors what the cause of their child's illness was. The analysis of tape-recordings indicated that the doctors had failed to provide a clear statement of diagnosis and they often did not offer prognosis.

Korsch and her colleagues (1969, 1972) also found that physicians were not attentive to the remarks of mothers, therefore disregarding their remarks about what worried them most about their children; that physicians gave almost all the instructions while the mothers asked few questions; that physicians did nothing to encourage mothers to take a more active role in solving the medical problems; and that mothers expressed more tension, disagreement and hostility than physicians because of a feeling of helplessness.
(b) Language Differences and Distortions of Meaning

Hauser (1981) comments that an important aspect of communication problems between doctors and patients is that they include the dimension of the level of awareness.

Plaja and Cohen (1968:161-162) analysed interviews between physicians and their patients in three out-patient clinics in Colombia and they found a range of distinct interaction styles associated with communication problems. They noted that, by far, the most common orientation of doctors was "bureaucratic task-oriented" - a style characterized by "efficiency" and "limited sensitivity". They observed little or no variation in the manner of questioning patients, and 80% of the patients interviewed by "bureaucratic task-oriented" physicians responded with a "matter of fact collaboration" style by answering questions in the exact order asked and expressing little initiative or concern in the way the physician guided the interviews. The remaining patients interviewed by these physicians responded in ways that were "rambling and elusive; vague and difficult to pin down". Few of the physicians were classified as "amiable or person-oriented" (p.110).

In another study, Shuy (1974) found that the largest portion of medical interviews are dominated by physicians' language and perspective. He also found that the most serious breakdown in communication between physicians and patients occurred "when patients would (or could) not speak the doctors' (medical) language and the doctors could (or would) not understand the patients' (everyday) language" (p.5).

Physician-patient communication problems are not limited to outpatient clinics. In a study of various medical and surgical services in a general
hospital, Golden and Johnson (1970) concluded that "the most dramatic finding related to the massive amounts of anxiety experienced by patients, and lamentably, the lack of recognition of their anxiety by the doctors" (p.137).

(c) Following Doctors' Orders

DiMatteo and Friedman (1982:38) have observed that "one-third of all patients fail to cooperate with their medical regimens according to the results of many studies. In some situations, the percentage of non-cooperation is as high as 50 percent".

In their analysis of 165 studies, Dunbar and Stunkard (1979) report that clinicians should "expect to find between 20 and 82 percent of their patients are not following their regimens". Among the factors that influence compliance are medical setting, type of illness, characteristics of the patient, and characteristics of the treatment regimen. One other influence on compliance which has been identified in earlier studies is the nature of physician-patient relationships (Davis, 1968). Davis found that the patients with the lowest compliance scores had physicians who passively accepted the patients active participation in the interview, gathered information without feedback to the patient, and were highly formal and distant while with the patients.

(d) Doctor-Patient Relationships: Affective Components

Friedman (1979) has found that much of the communication, especially between doctors and patients, occur through non-verbal channels. A study of non-verbal cues in physician-patient relationships indicates that physicians' feelings about alcoholic patients may be expressed by "how" they speak rather
than "what" they say. Milmoe (1967) has found that when physicians' voices conveyed anger, patients did not follow through on referrals.

(e) Doctor-Patient Relationships: The Social Context

Mizrahi (1986:167) has examined the ways by which house officers (resident doctors) in the department of medicine at a university hospital "get rid of patients". Some of the ways they used to get rid of patients due to heavy work assignments included transferring patients to other hospitals, releasing patients as quickly as possible, passing along the unwanted patient-related task to another person or by using psychological means such as intimidation and avoidance. The social and psychological effects on the patient who is aware that his doctor is doing his best to get rid of him may be said to have devastating effects including feelings of alienation and rejection.

Drawing on the observations of the communication between doctors and patients during medical appointments, Fisher (1986) has demonstrated that doctors work from a position of power and women from a position of vulnerability. She found that doctors rarely felt obliged to present women with all the information they needed to make informed choices about their health care, and that women rarely asserted their rights to know. Fisher found that a large number of hysterectomies recommended by physicians and agreed to by the patients were not necessary on medical grounds. She also noted an alarming number of cases where pap smears were needed but not performed. More importantly, she observed that doctors began and concluded conversational exchanges, asked the most questions, initiated most of the topics, and held the floor more success-
fully than their patients. The scenario was a replication of the mainstream of behaviours and relationships in a male-dominated society and male-dominated medical profession.

To what degree is the relationship between chiropractors and their clients similar to those that have been shown to characterize allopathic care? As Freidl (1978) has speculated, the emotional distancing style of allopathic physicians is said to contrast strongly with the emotionally close, personal style of alternative practitioners. As alternative practitioners, chiropractors may deliberately promote close and personal interaction style as a collective way of relating to clients in view of the constraints on their practice and the emotionally distancing style of the "official" practitioners.

In this study, the nature of chiropractic-client relationship is observed and described with respect to communication characteristics, language differences, and affective components (see Chapter 4).

2.4 Summary

I have introduced some of the factors which influence the beliefs people have about health and illness by discussing how these factors help to shape their health models [HMs], which, in turn, are used as a basis for constructing explanations or explanatory models [EMs] for specific health problems.

From personal factors such as individual characteristics, psychological profile, sociocultural factors, past experiences, economic adequacy, relationship with friends and family and the nature of a health problem, people
"acquire" personal beliefs about the structure and functions of the human body, the causes, signs and symptoms of illness, treatment systems and healers, and about personal health habits. Practitioners supplement these factors with their professional training and culture as well as the preferred method of treatment.

The notion of clinical reality is used to designate the socioculturally constructed contexts that influence illness and care. Thus, different medical systems as well as individuals have different clinical realities which link illness to treatment.

The clinical setting provides an opportunity for bringing together the EMs of the chiropractor and the new client. It is in the clinical arena that a common EM is negotiated which will enable treatment to occur.

There are a number of possible outcomes resulting from the negotiation of chiropractor and client EMs. Each participant may hold on to his own EM, modify the EM by accepting aspects of the other's EM, acquire a new EM which is different from the previously held EM, or integrate both EMs as a compromise.

One implication of Kleinman's (1980) perspective on the clinical negotiation of EMs is that it is doctor-centred. Another implication is that participants negotiate genuinely, yet one invariable outcome of the negotiation involves the shifting of the patient's EM in order to receive treatment.

I have discussed how the institution of medicine and its organization have social implications for patients. In particular, I have contrasted allopathic and chiropractic models of medical care. The doctrine of scientific rationality of allopathy together with its assumption of generic diseases, scientific
neutrality and objectivity, contrasts with the "holistic" and relatively uncomplicated chiropractic view of the causes of disease, as well as its humanistic approach to the whole of the human body. While one model encourages detached reductionism to diagnoses and treatment, the other is person-centred.

I have discussed problems with allopathic-patient relationships as a way to help us understand the chiropractic-client relationships. A number of problems have been identified, especially in the area of communication. For example, assymetry in questions and answers between the parties, non-disclosure of information by physicians, "bureaucratic" interaction style of allopathic physicians, the domination of medical interviews by doctors, and the use of non-verbal cues to show disapproval. More importantly, doctors work from a position of power and they tend to control the interaction in the clinical settings. Some of the effects of problems of physician-patient interaction has been shown to be non-compliance and dissatisfaction with treatment by patients.

To what extent are the chiropractic-client interactions different from those of allopathic-patient interactions? I have taken the view in this study that because of the constraints faced by chiropractors in the study area, they would, of necessity, interact with new clients in ways that are different from those of "official" allopathic medicine in order to convert their new clients to patients. Chiropractors also espouse "holistic" health care which pushes them toward negotiations of a certain kind. I have also argued that one way in which chiropractors try to achieve their objective is to satisfactorily negotiate "common" explanatory models with new clients.

In Chapter 3, socialization of clients via negotiation is discussed. Because the organization of health care is socially based, and all activities in
it have social implications as they are operated in the context of every day "life activities", socialization via negotiation is discussed in the context of Goffman's observations (1959, 1963, 1967, 1969). What people do in face-to-face interactions is used to further discuss Kleinman's perspective on explanatory models, the purpose being to integrate Kleinman's perspective with Goffman's observations of face-to-face interactions and behaviour. Viewed in this way, we may gain a better understanding of how chiropractors interact with potential patients.
CHAPTER 3

3.0 THE SOCIALIZATION PERSPECTIVE

DiRenzo (1977:266) has defined socialization as "the purely processual and/or structural dimension of social learning in which uniquely human attributes are developed and/or actualized". The particular concerns are how and what must be transmitted or acquired by the individual in terms of social learning, in order to permit him to assume and to maintain the social statuses that he will achieve or that will be ascribed to him in society and its sub-units. In this respect, socialization is primarily a matter of learning any social role (Goslin, 1969). Children are socialized into becoming adults (Inkeles and Levinson, 1969), medical students learn to become and behave like physicians (Mumford, 1970), and clients learn to become patients.

In this study, "socialization" of a new chiropractic client is achieved when the client becomes a patient of chiropractic for not less than four treatment visits to the chiropractor. It is assumed that the chiropractor will direct his effort towards socializing the new client. The negotiation of explanatory models (Chapter 2) is considered an integral part of the chiropractic socialization process.

3.1 Socialization Processes

Processes of socialization can be found in most activities of daily living, from childhood to adulthood, student to professor, medical intern to medical
specialist. However, socialization in clinical settings, such as those structured for the purpose of providing help with illness, takes on special considerations. The relationship between the healer and the ill person involves a professional power relationship. While one actor in the relationship is seeking help, the other is providing help. This kind of relationship has been studied in the allopathic clinical setting (Mishler et al., 1980; Eisenberg and Kleinman, 1981; Kleinman, 1980). One often hears about nurses in hospitals talking about "Doctor's orders" for "his patient". A legitimating sentence in a work situation to avoid strenuous duties often goes like this: "My doctor says I should not lift things". In other words, society members learn how to respect the professional power of the allopathic physician.

The situation is somewhat different for the chiropractor, who for reasons discussed earlier, must find ways to attract professional respect due to historically conferred "professional" deviancy status and opposition from allopathic medicine. Thus, socialization of new chiropractic clients must take on some urgent as well as carefully structured processes although these processes may be largely tacit. Where there are existing social structures, chiropractors may seek to reinforce them towards positive valuation of their work. For example, people mostly rely on family and friends for advice. This relationship can be used as a socializing process. Also, primary care givers such as family doctors generally have waiting rooms and reception areas. Again, this first contact area can be effectively used in client socialization. More
importantly, the first contact or interaction a chiropractor has with a new client is rife with socialization potential. If he succeeds, the client's friend and family will hear about it. If he fails, at least for the particular client, the professional deviancy label will be sustained.

Allopathic physicians may also engage in these socialization practices if they are establishing new clinics. However, allopaths do not face the same constraints as chiropractors. The urgency or the desire to "succeed" in making their clientele is greater for chiropractors than for allopaths.

For chiropractic in British Columbia, the crucial client socialization processes include education, the creation of positive impressions via situational interactions, and negotiation.

3.1.1 Education of Clients

Clients, who, for the first time, visit a chiropractic clinic, will expect to acquire necessary information about chiropractic to enable them to become informed. This is especially true of new clients who either have no previous knowledge of chiropractic or who have been somehow aware of its deviant label. Most clients of chiropractic have been to other healing systems (Kelner et al., 1980). Some clients may also have been cautioned against chiropractic either by practitioners belonging to the "official" medical association or by their friends and family who see chiropractic as deviant. Thus, there is a natural curiosity on the part of uninformed new clients to become informed.
The need to educate the client is recognized in the training of chiropractic students. First, they are made aware of the deviant label that has been conferred on chiropractic as an impetus to correct such notions. As noted by Kelner et al., (1980:80) regarding the training of chiropractic students at the Canadian Memorial Chiropractic College [CMCC]:

"By the time they are ready to leave chiropractic college, students have had a good deal of experience in coping with the negative attitudes expressed by the medical world and by some sections of the general public. They have begun to develop the defense mechanisms which will serve them throughout their careers, and have managed to deal with disapproval they may have encountered from personal friends or family members. They have learned to respond to attacks in the media by disregarding accusations of incompetence and irresponsibility."

Kelner and her colleagues go on to describe how, as interns, chiropractic students are "required to handle a specified number of patients, and are held responsible for attracting the required number....are compelled to take an active role in bringing patients to treatment" (p.71). These requirements and responsibilities make it very necessary for chiropractic students, who later become chiropractors, to work very hard at "convincing" new and "curious" clients to become regular patients. As observed by Kelner and her associates (p.71):

"They become adept at explaining to patients the value of the care they are getting, and at educating them in the importance of returning for regular treatment until their problem is resolved."
In learning to educate and to "convince" potential patients about chiropractic care, chiropractic students also are learning the art of impression-management. Their success in obtaining sufficient numbers of clients for their clinics upon graduation will depend upon how "good" they are in impressing potential patients.

3.1.2 Managing Impressions

Goffman (1959, 1963, 1967, 1969) has described how individuals or groups structure their interaction with others in public places, private encounters or in everyday life by using ritualized behaviours. Goffman (1967:5,12) uses the concept of "face" to designate "the positive values a person effectively claims for himself by the line others assume he has taken during a particular contact". He uses "face-work" to "designate actions taken by a person to make whatever he is doing consistent with "face", in order "to counteract 'incidents' - that is, "events whose effective symbolic implications threaten face". In other words, "face" is the personal image a person has of himself or the type of image he wants to convey to others during interpersonal relationships. Thus, a person's actions, "face-work", will be largely directed at protecting his "face" and counteracting "incidents" which will tend to discredit, or give wrong impressions of his "face".

Goffman (1967:13) notes that "face-saving actions" often become "habitual and standardized practices". He writes:

"If a person is to employ his repertoire of face-saving practices, obviously he must first become aware of the interpretations that
others have placed upon his acts and the interpretations that he ought, perhaps, to place upon theirs. In other words, he must exercise perceptiveness.

Perceptions of chiropractic as a deviant profession dictate that chiropractors develop a collective "face" for chiropractic which should become the self-image of the chiropractic medical system. However, an individual chiropractor may function within the collective face in ways that complement the collective face and at the same time respond to the local situation in which his clinic is located. New clients of chiropractic must, therefore, be presented with both the collective and individual "faces" depending on local circumstances. It is through these presentations that new clients learn about the "images" that are important to chiropractic as a step towards their socialization. Goffman (1967:12) further comments as follows:

"To study face-saving is to study the traffic rules of social interaction; one learns about the code the person adheres to in his movement across paths and designs of others...."

"Face-work" also involves "expression games" (Goffman, 1959:2). This relates to the expression that a person "gives" and "gives off", involving symbols and a wide range of actions that "others can treat as symptomatic of the actor". Through these expressions, an individual undertakes "performances" or purposeful activities that occur during the period the person is in the "continuous presence of a set of observers" (p.22). Goffman uses the terminology "front" to describe "that part of the individual's performance which regularly functions in a general and fixed fashion to define the situation for
those who observe the performance. It involves a "setting" - decor, physical layout, background items "which supply the scenery and stage props for the spate of human action played out before, within and upon it" (Goffman, 1959:12).

The setting, appearance and manner of a chiropractic clinic may be described, after Goffman (1959:29) as the "social front". The front comprises the waiting room, the reception area, the chiropractor's office and the location of the practice. The contents and appearance of these areas create the first impressions on a new client. These impressions may lead a client to infer to himself how professional the practitioner is and what kind of a person he is likely to be. A sparsely decorated office may lead a new client to think of a "struggling" and unsuccessful practitioner, meaning that not enough clients request his services. In other words, such a chiropractor appears to be a marginal professional which confirms attributions of deviance. On the other hand, a tastefully decorated office, especially one that is similar to that of an allopathic family physician, or one consistent with others in the same community, would help to convey an impression of medical and professional competence. The aim is to reduce the level of anxiety in a new client prior to the actual clinical encounter.

Another setting which provides the chiropractor with the best opportunity for managing the impressions of clients is the clinical encounter. The first clinical interaction between the chiropractor and a new client provides the opportunity for mutual formation of impressions about the interactants and an opportunity to evaluate each other's acceptability. It is during the first encounter that "face-work" is first initiated in a personal way. In this context, the result of creating and "managing impressions" about chiropractic,
especially by the chiropractor, will either be successful or end in failure. By successful management of impression, I mean that the new client has been so positively influenced that he has decided to receive treatment and to continue in chiropractic treatment. The chiropractor would have succeeded in mobilizing his activity to express, "during interaction, what he wishes to convey" (Goffman, 1959:30). The social situation is one which has forced both the chiropractor and the new client to interact. The reward for the chiropractor will be to "convert" the new client towards positive views of his work and profession, that is to negate deviancy perceptions, and for the client, relief from pain. In general, the most significant outcome may be the learning of social coping strategies by client and chiropractor, that is, how to respond to social situations and exert some control over them (Goffman, 1959; Weinstein, 1969).

Interaction between the new client and the chiropractor becomes complex in the sense that intended and unintended activities and symbols take on special meanings. As noted by Goffman (1969:5), in strategic interaction, "individuals offer more than expressions; they also offer communications" such as "the use of language - like signs, to transmit information". There is also "intentional effort" to produce expressions that the individual "thinks will improve his situation if they are gleaned by the observer". Goffman (1969:12) called this intentional effort "control move". The implication is that intentional production of expressions, "body language", and other signs and symbols, are specifically targeted for certain results. For example, a chiropractor may use concentrated listening attention to convey the impression that he is not only
listening to the client but also sympathetic to his troubles especially if the client has shopped around different treatment systems. A nod could mean agreement, a clasped hand could mean respect, and sitting very close to the client could mean caring or affection. Again, to quote Goffman (1969:85):

"Individuals typically make observations of their situation in order to assess what is relevantly happening around them and what is likely to occur. Once this is done, they often go on to exercise another capacity of human intelligence, that of making a choice from among a set of possible lines of response".

The decision by a new chiropractic client to receive and continue treatment is a positive response and testament of the ability of a particular chiropractor to socialize the client given the social, political, and economic environment in which he practices his chosen calling.

3.2 Socialization via Negotiation

People bring different beliefs and values to any social situation which significantly affects their lives. Political parties, and cultural systems are examples of human collectivities with like-minded beliefs and values. In Chapter 2, I discussed the importance of belief systems in the health care system of a society, and how people's beliefs help guide their "help-seeking" and illness behaviours. I also discussed notions of Health and Explanatory Models, [HM] and [EM] from which people make sense of their illness problems using their internalized beliefs about health, illness and treatment. These
models are located in individualized clinical realities when ill-people are situated in particular treatment environments.

Because people are different in many respects, conflicts arise, especially when there are competing values. Nader and Todd (1978) list several methods for dealing with conflict, ranging from avoidance, coercion, or negotiation, the latter being a bilateral arrangement in which two principal parties attempt to work out a solution. Others have defined negotiation in various ways. For example, Guralnik (1968) defines it simply as conferring, discussing or bargaining to reach an agreement. Johnson and Johnson (1975:171) view negotiation as a way to reduce conflict and promote cooperation. They comment that it is "a process in which people who want to come to an agreement but disagree on the nature of the agreement try to work out a settlement" aimed "at achieving an agreement that determines what each party gives and receives in a transaction between them".

The negotiation model is, therefore, crucial in the two party practitioner-client relationship which has two possibly opposing health and explanatory models. This is especially true of the chiropractor - new client relationship in which the chiropractor may be viewed as practicing deviant medicine and the new client comes as an adherent of "official" scientific medicine. Given the social, political and economic constraints discussed in Chapter 1 which mediate chiropractic clinical effort in British Columbia, there is probably no clinical healing encounter which is more ripe for negotiation than the chiropractor-new client encounter.
The role of negotiation in medical work has been recognized by several social scientists (Strauss et al., 1963; Glazer and Strauss, 1964; Scheff, 1968; Kleinman, 1975; Kleinman et al., 1978; Katon and Kleinman, 1981; and Kleinman, 1980). Strauss and his colleagues (1963) have noted that in order to obtain certain desired outcomes, hospital personnel develop various strategies in response to problematic situations. These negotiation strategies are, to some extent, patterned by the general mandate of the hospital to help the sick, and the collective orientation of this mandate provides a measure of organizational cohesion. Glazer and Strauss (1964) and Scheff (1968) have called attention to the importance of the degree of shared awareness and the structure of interaction as important factors which direct the nature of negotiation.

Kleinman (1975, 1976, 1980) and Kleinman et al. (1978) view the clinical process as essentially a negotiation process. Because health care involves exchanges between the holders and users of different explanatory models, the practitioner and client negotiate as "therapeutic allies" for treatment. In this study, clinical negotiation between chiropractor and new client is viewed as the key arena for client socialization. Negotiation is important because it may engage the client's trust, prevent major discrepancies in the evaluation of treatment outcomes, promote compliance, and reduce client dissatisfaction.

There are, however, some barriers to negotiation in medical care. To begin with, and as I have discussed in Chapter 2, the roots of contemporary allopathic doctor-patient relationships are in the authoritarian power structure of traditional practitioner and patient interactions. Professional biomedical relationships have always been hierarchical. Therefore, the social class and
prestige of the client can influence how much "power" or influence he is accorded in the clinical encounter.

The situation is somewhat different for chiropractic. Not being the "official" medical system, clients are not mandated to visit chiropractors in order to legitimate ill-health. Rather, clients visit chiropractors because a friend, family member or colleague has asked them to do so or because the client has decided on his own. Sometimes they visit because they have read about it in newspapers. Even when they have decided to visit a chiropractor, they often experience difficulties either because they lack knowledge of chiropractic or because they are unable to easily locate one. Given the deviant perceptions of chiropractic that have been fostered over time, it would seem that greater authority in the relationship would be enjoyed by the client. If this is indeed true, it becomes all the more necessary for the chiropractor to "please" the client and work hard at negotiating compliance to chiropractic treatment.

For successful clinical negotiation to occur, both the practitioner and the client must develop a therapeutic or working alliance. Greenson (1967:191) has defined therapeutic alliance as "the relatively non-neurotic rational rapport that the patient has with his analyst". In the traditional allopathic doctor-centred approach, this alliance is helped by "the patient's motivation to overcome his illness, his sense of helplessness, his conscious and rational willingness to cooperate and his ability to follow directions". However, Meissner and Nicholi (1978) stress that the working alliance is based on both
the patient and physician's explicit agreement to work together toward a mutually desired objective, the improvement of the patient.

In order to carry out a negotiation, certain fundamental characteristics of an effective practitioner-client relationship are essential. These include setting up and establishing a milieu that is warm and accepting, in which the client can express troublesome feelings, values and beliefs. The central feature in this milieu may be the practitioner's empathy. Empathic feelings on the part of the practitioner could help elicit the client's explanatory model, and, therefore, increase the affective bonds between the practitioner and client.

Sometimes, the formation of a working alliance may be hindered by negative feelings arising either in the client or the practitioner. These feelings can be based on such things as the client's or practitioner's appearance, personality and behaviour, or on conflicts in perspectives and expectations that emerge but are not resolved. Also, negative feelings can be based on unconscious processes whereby the client or practitioner transfers experiences and emotions they have had towards people in past situations. For example, a client may react negatively to a practitioner because he is reminded of unpleasant past experiences with another practitioner or other individuals. In general, negative feelings can arise from "distrust" on the part of either partner in the relationship.

Katon and Kleinman (1981) observe that some conceptual differences can exist between client and practitioner. These include situations in which the client and practitioner use the same term but actually mean different things;
use the same term, apply it to the same phenomenon, but have different aetiologic concepts; use different nosologies for the same referents; have different emotive meanings attached to same illness condition; or simply do not use the same terms. They suggest a model of clinical negotiation in which the practitioner first elicits the client's explanatory model as the basis for further progress. Through negotiation, each participant may shift his own explanatory model until there is agreement on treatment, or at least some form of compromise has been realized. Katon and Kleinman caution that some areas of conflict may persist, but in all instances, negotiation must involve ongoing monitoring of the agreement.

The elicitation and presentation of the client's and the chiropractor's EMs, as suggested by Kleinman, occur in the context of how people "usually" relate to each other or how they present themselves during the process of "normal" interactions. Regarding everyday contacts between two individuals and the associated behaviours, reactions and expectations, Goffman (1959:249) comments as follows:

"When one individual enters the presence of others, he will want to discover the facts of the situation. Were he to possess this information, he could know, and make allowances for what will come to happen and he could give the others present as much of their due as is consistent with his enlightened interest. To uncover fully the factual nature of the situation, it would be necessary for the individual to know all the relevant social data about the others..... full information of this order is rarely available: in its absence the individual tends to employ substitutes - cues, tests, hints, expressive gestures, status symbols, etc. - as predictive devices."
Goffman further comments "that since the reality that the individual is concerned with is unperceivable at the moment, appearances must be relied upon in its stead. The more the individual is concerned with the reality that is not available to perception, the more must he concentrate his attention on appearances" (p.249).

The implication of Goffman's comment is that the negotiation of EMs by chiropractors and new clients is undertaken in the context of what people usually do when they interact. They define the "reality" of the situation and the communication that is being presented. They also use "appearances" to define the environment. These cognitive behaviours are the starting points in the socialization process prior to the negotiation of EMs. How the parties in the interaction appear to each other as well as the appearance of the chiropractic clinic are important aspects of forming the impressions that influence the "reality" of the negotiation. Both the expressions that are given off and the symbolic gestures that are used in the interaction such as cues, hints, expressive gestures and symbols are used as sources of information and as predictive devices for evaluating the reality of the interaction.

How "genuine" is the negotiation of EMs between the chiropractor and the new client? Kleinman (1980) and Katon and Kleinman (1980) have indicated that crucial to the "shift" in EMs and in the structure of clinical relationships is a recognition that clinical care should involve a genuine negotiation between the practitioner and the patient. However, Goffman (1959) has noted that in the Anglo-American culture, there are two common-sense models according to which people formulate their conceptions of behaviour, namely, "the real, sincere or
honest performance; and the false one that thorough fabricators assemble -
whether meant to be taken unseriously as in the work of stage actors, or
seriously as in the work of confidence men" (p.70). Goffman writes about
"contrived performance" or something which has been "painstakingly pasted
together". Thus, in the "real world" of face-to-face interactions, performances
such as negotiations for some particular purposes may be, in part, "contrived
performances" by one or both participants in the interaction. Goffman (1959:46-
47) writes:

"...performers often foster the impression that they had
ideal motives....(they) may even attempt to give the
impression that their present poise and proficiency are
something they have always had and that they have never
had to fumble their way through...."

Viewed in this way, it is possible that some aspects of the process of EM
negotiation may be "contrived performances" and other aspects, real or genuine
negotiations. In clinical interactions, individuals present products (beliefs,
norms, habits) to others, and sometimes they will tend to show others only the
end product with which they wish to be evaluated, such as "something that has
been finished, polished and packaged" (Goffman, 1959:44). Thus, "there is a
tendency for performers to offer their observers an impression that is
idealized" (p.35).

On the decision to take a course of action, Goffman (1969:15) writes:

"If the subject has not decided on a course of action yet,
he can feign that he has, or he can feign that he hasn't
when he has....feigning refers to beliefs, attitudes and
preferences misrepresented strategically."
In chiropractic-client interaction, a client may "feign" agreement with the outcome of the negotiation without "actually" being in agreement with the decision. In such an instance, the client may withdraw from treatment soon after the initial visit to the chiropractor. Similarly, a chiropractor may "feign" interest in the patient's explanation of "cause" in order to develop an argument against it.

3.3 Language, Normal Conversation and Negotiations in Clinical Settings

In this section, I am specifying how one can examine clinical negotiations by considering the structuring of language in conversation which is more detailed than Kleinman's method for understanding the negotiation process.

When listening to conversation, one is impressed with the variety of ways that information is exchanged. When analyzing discourse, one is equally impressed with its organized character. Theory and research suggest that language is a social production in which different linguistic arrangements are visible in different situations and in which there is a relationship between the spoken word, the actions performed, and the structure of talk (Fisher and Todd, 1983; West, 1983; Fisher, 1986). More recently, language has been analyzed as discourse - a naturally occurring, locally organized, social production - both in ordinary conversation (Fisher, 1986) and in medicine (Mishler, 1984).

The function of language in medical interviews is to assist in the negotiation of illness labels and in arriving at treatment decisions. Language, therefore, provides information, moulds the decision-making process, and influences medical outcomes, while at the same time, reflecting and sustaining institutional authority.
It has been shown that in normal conversation, there is balanced participation among all conversational partners (Shuy, 1983). Each of the partners in the conversation ask questions, initiate topics, and they interrupt each other about equally. In other words, ordinary conversation is characterized by a symmetrical discourse structure. If, in ordinary conversation, a greeting is initiated by one conversational partner and is not followed by a greeting response by the other partner, the absence is noticeable. The first greeting calls for the second greeting and the second greeting reinforces the appropriateness of the other (Schegloff and Sacks, 1973).

In ordinary conversation, this asymmetry is disrupted when one partner has more status and power than the other. For example, Zimmerman and West (1975) have demonstrated that when men are talking with men or women with women, the interruptions are about equally distributed across the conversational pair. But when men and women talk with each other, men do the most interrupting. Zimmerman and West conclude that this finding reflects the higher status of men in society. By implication, in situations in which conversational partners have unequal status, such as in physician-patient relationships, the most interrupting will be carried out by the higher status interactant, in this case, the physician.

Practitioners and clients each have information that the other needs in order to reach a "diagnosis" and/or decide upon a treatment. They exchange their information through the negotiation process of initiation and response. Clients describe symptoms and ask for clarification about their health problems while the health practitioner makes a diagnosis and recommends treatment. Clients react. They can either agree, disagree, or negotiate. According to
Fisher (1986), the entire conversation contains four separate discourse forms which serve different functions, namely: "corrections, comments on the interaction, back channel utterances, and overlaps" (p.68).

(a) Corrections

These are similar to evaluations and are performed by the person in authority and they basically serve a teaching function. They are "attempts to get the facts straight by filling in the appropriate medical term or correcting a mistaken impression" (Fisher, 1986:68).

Fisher (1986) argues that in the physician-patient conversation, the dominant partner - the physician - is more likely to interrupt the less dominant partner - the patient, whereas in casual conversations, interruptions are shared relatively equally by partners in the conversation (West, 1983). However, Shuy (1983) disagrees and suggests that in medical interactions, patients more often interrupt doctors. He goes on to argue that dominance is usually displayed, not in the interruption, but in who keeps the floor afterwards. In the same context, Fisher (1986) argues that when the doctor wants the floor, he claims it and gets it; thus, demonstrating dominance.

(b) Comments

Although comments on the interaction are made by both physicians and patients, Fisher (1986) finds that "they display that the hearer is following the interaction, has additional information to add or is competing for control" (p.69). Fisher finds that in her study, the patient wrestles with the doctor
for control. After each comment act, the doctor maintains or reclaims the floor to continue the topic under discussion or to initiate a new one.

(c) Back Channel

Duncan (1972:45) has observed that back channel comments are similar to comments on interaction, except that they take the form of "clucking" noises such as "uh", "um", "hum", and they do not usually mark the end of sequences.

In everyday conversations, back channel comments are used to indicate that the hearer is listening and understands the preceding "chunk" of information.

During a medical interview, "yes" or "no" would be strong responses. "Yeah", "uh-hum" or "huh-uh" are weaker responses and they may indicate uncertainty. Fisher (1986:73) notes that "the doctor either recycles the utterance immediately preceding the back channel comment, or he continues as if he has not heard it".

(d) Overlaps or Simultaneous Speech

These are similar to back channel comments except that they occur in the foreground or main channel, thus, they represent a struggle for the floor. For example, a patient may request information from a doctor, and while the doctor is trying to provide it, the patient interrupts him, challenging the information he has just given or vice versa.

The institution of medicine lends authority to its dominant actors - the allopaths. This authority shapes the structure and form of medical discourse and it has consequences for the delivery of care. Several studies (West, 1983;
Fisher, 1983,1986; Shuy, 1974) have shown that although the style of doctors can
vary, patients can have input into the decision making process but the asymmetry
of the medical relationship remains constant. The institutional authority of
the medical role and the control it provides for allopathic physicians does not
change. What, therefore, is the nature of the relationship between chiroprac­
tors and their clients? Is it so different from that of allopathic physicians
that clients do indeed "prefer" the relationship and opt to remain as chiroprac-
tic patients?

One of the ways to understand differences in allopathic and chiropractic
relationships with patients and clients is by examining the asymmetry of the
relationships. All four forms of the comment act - correction, comments on the
interaction, back channel, and overlap - reflect the asymmetry of the
practitioner-client relationship and they show how the asymmetry is enacted in
ongoing interactions between them. Corrections are much like evaluations. The
doctor or the person with the most authority corrects patients' pronunciation of
medical terms, correct their understandings of their medical problems, and have
the last word on the definition of the problem. All of the other comment acts
share one feature with corrections (or evaluations). They display the authority
of the doctor. They can signal the completion of a sequence, they can be used
to hold the floor, and they can be used to add or reinforce information.

The negotiation between the concerns of doctors and patients, structures
the exchange of information necessary to make a diagnosis and reach a treatment
decision. They may also discuss topics that are not directly oriented to
treatment decisions, but which also contribute general information to the
decision-making process. Thus, medical interviews are assembled through the
production of topics, and both the medical interview and the production of
topics are influenced by the practical concerns of the participants, negotiated
as they communicate, and structured by the asymmetry of their relationship,
unlike ordinary conversation (Shuy, 1983) in which one conversational partner
does not ask all, or even most, of the questions or initiate all or most of the
topics.

Fisher (1986) has noted that although doctors and patients negotiate
medical decisions, the negotiations are heavily weighted in the doctor's favour.
How do chiropractors and new clients negotiate treatment decisions? What
aspects of the chiropractic-client relationship encourage new clients to remain
in chiropractic treatment? How are chiropractic clientele made?

I have argued that answers to these questions can be obtained by describing
and analysing the chiropractic treatment environment, the relationship between
chiropractors and new clients, the negotiation of explanations for illness
problems and the nature of conversational discourse between clients and
chiropractors, and by comparing the findings with what one knows about the
processes of the "official" allopathic medical care. The thrust of the study is
to look for those factors which lead new clients to become chiropractic patients
by examining what chiropractors do to convince them, bearing in mind the nature
of the constraints that are faced by chiropractic, as a healing profession in
the province of British Columbia.

I, therefore, argue that the success of chiropractic depends upon its
ability to socialize new clients during the initial set of clinical encounters
and interactions such that the social stigma of chiropractic and the various political legal and economic constraints imposed upon chiropractic, are effectively dismissed in the chiropractic-client relationship.
4.0 METHOD OF STUDY

Very little research has been done on chiropractors at work. The main exceptions are the studies of chiropractic by Wardwell (1951), which employed a Parsonian approach in analyzing the phenomena of strain reduction, and the more recent work by Cowie and Roebuck (1975) which described chiropractic clinic as a 'deviant' enterprise.

Because little knowledge yet exists on chiropractors in clinical settings, it is important to study multiple clinical interactive settings in order to add to existing knowledge regarding chiropractic medical care. Much of the existing sociological work on chiropractic (see Chapter 1, Section 1.4) has examined issues such as marginality, statuses, deviant roles, professionalism and student socialization, all of which are largely outside the context of clinical behaviour and interactions.

The contributions of this study are not only to document chiropractic clinical interactions in a local setting, but also to explain how chiropractors successfully socialize their clientele, given the historical limitations and social stigma affecting their work. Because there is little information on chiropractic clinical interaction with clients, and because most other studies have utilized one approach to examine the complex issue of "success" of chiropractic, it was decided to use multiple approaches in order to minimize the methodological limitations of one approach (Forcese and Richer, 1973).
Preliminary inquiry three years earlier indicated that a pilot study would not be possible. Chiropractors are generally suspicious of studies about themselves because of "past experiences". A number of previous studies, in their opinion, merely sought to confirm their 'deviant' professional status and to provide "official" allopathic medicine with "slanted" reasons for opposing chiropractic. One leader of chiropractic put it this way:

"We know from experience that many of the so called experts have made up their minds against us before they come to us. Some of them do not bother to visit a chiropractic clinic, or talk to us, yet they come up with expert conclusions about us. When we talk to them, they select just the information that suits them....I think their jobs will be at stake if they do not find something against us. After all, allopathic physicians dictate and influence their thinking and money."

The situation may not be as accurate as the above comment indicates, however, it reflects the general view that is held by chiropractors that there are few studies which have examined them in clinical settings or which have shown a positive light on their work.

Given these views by chiropractors about research, a pilot study was not possible. Nevertheless, it was vitally important that I obtain the utmost cooperation from chiropractors in my own research, especially since my own training, many years ago, had been within biomedicine and allopathic health care. This cooperation was obtained by soliciting support for the study from the President of the provincial Chiropractic Association. The purpose of the study was explained and a letter from my faculty advisor helped to convince him that this was essentially a "university study" (Appendix 1). At the time, I had been responsible for administering the Department of Rehabilitation Services at
the local university hospital, so there was some understandable concern by the Association's President regarding the purposes of the study. I explained to each of the participating chiropractors that I was not evaluating chiropractic treatment per se. Instead, I was interested in chiropractic as a "medical system", in particular, how they "organize and carry out their work".

The approach to the study combines different methods, each aimed at particular aspects of the research. The work routines of chiropractors are described through the techniques of interview, observation of chiropractic clinical settings and clinical interactions including "backstage" behaviours, and the examination of professional and clinical records.

4.1 Methodological Orientation

Forcese and Richer (1973:79) have noted that the objective of descriptive enquiry is "the exploration and clarification of some phenomena where accurate information is lacking". They view descriptive studies as necessarily intended "to provide description, as thorough as possible, often with a view to providing material and guidance for subsequent research".

Sociological studies on chiropractic have largely utilized methods such as survey techniques, usually conducted outside of the chiropractic clinical setting (Kelner et al., 1980; Parker and Tupling, 1976; Gardner, 1975). When observation of clinics have been undertaken, they have involved a single clinic in a particular locale (Cowie and Roebuck, 1975). In other instances, some social scientists have based the analysis of the success of chiropractic on prior conceptions of chiropractic which have been formulated without direct
observation of clinical interactions (Coulehan, 1975; Firman and Goldstein, 1975). Thus, there is lack of basic information of a descriptive nature on chiropractic clinical interaction with clients. In other words, additional information, from the point of view of chiropractors and their clients, is required to guide further development of knowledge about chiropractic.

A descriptive as opposed to a quantitative methodology is chosen because, as Schwartz and Jacobs assert (1979:7), "the only 'real' social reality is the reality from within". Quantifications of reality are inventories of the social world, of lists of things to be found in societies, sub-cultures, institutions, hospitals, and universities. Things that are measured can be individual persons, groups, whole societies, speech "acts" and so on, all of which are extrapolations from reality. Qualitative methods, on the other hand, provide observations of actual behaviour in natural settings. The basic goal of sociology, is to develop ways of gaining access to the life-world of individuals. It is important to discover the daily activities, the motives and meanings, and the actions and reactions of the individual "actor" in the context of his daily life. Thus qualitative methods, which rely upon natural language, are best for gaining access into the life-world of individuals. By life-world, I mean emotions, meanings and other subjective aspects of the lives of individuals and groups. This includes their daily actions and behaviour in ordinary settings and situations, the structure of those actions and the conditions that accompany and influence them.

In the qualitative orientation, the lay person becomes the expert about his world. As Schwartz and Jacobs note (1979:7):
"Instead of trying to discover things about a social world that those within it do not know....we want to know what the authors know, see what they see, understand what they understand. As a result, our data attempt to describe their vocabularies, their ways of looking, their sense of the important and unimportant and so on".

The basic orientation of this study, therefore, is that in order to understand social phenomena, the researcher needs to discover the actors' definition of the situation, or his perception and interpretation of reality. Their interpretations of reality lead to ongoing interpretations of social interactions that they and others participate in, and which involve the use of language in symbolic ways. Therefore, in order to understand social interactions, language and meanings, the researcher needs to place himself within the social situation, either through participation or observation or both.

From this orientation, social meanings which guide human behaviour do not only inhere in activities, institutions, or social objects themselves. Rather, meanings are also conferred upon social events by interacting individuals who must first interpret what is going on from the social context in which these events occur. The emerging definition of the situation is seen to result from the interplay of biography, situation, non-verbal communication and linguistic exchange that characterizes all social interactions (Cicourel, 1974, Kleinman, 1980).

It has been argued that researchers should spend less time cataloguing different kinds of social settings and more time describing the forms of interaction within these settings (Kleinman, 1975). Ultimately, it is the form and extent of interaction, not the setting per se, that are of greatest interest. Similar social settings often produce very different patterns of
interaction, while patterns produced by different settings may be quite similar (Jacobs, 1975).

Ball (1967:295) has proposed that we go "directly to the unconventional actors and their subcultures; it is only within such procedures that the natural context of deviance (or any social interaction) can be studied without the skewedness typical of the sources of data". This orientation is an outgrowth of the Chicago School of Symbolic Interactionism as set forth primarily in the work of George Herbert Mead and especially of Herbert Blumer. Blumer summarizes three premises of symbolic interaction (1969:2):

"...human beings act towards things on the basis of meanings that the things have for them. Such things include everything that the human being may note in this world...."

"...the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows".

"...these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters".

Using these principles as a basis, this study is specifically concerned with description of the interaction of all actors in chiropractic behaviour settings otherwise known as chiropractic clinics, and which exemplify chiropractors' and new clients' definitions of that situation. These definitions are considered important in the socialization of clients. It is assumed that both chiropractors and their new clients have definitions of the situation regarding healing, which are manifest in their interaction. Consequently, it is assumed that chiropractors and new clients create and
maintain rationalizations for their conduct in order to make that conduct credible to themselves and to others. Therefore, the main concerns of this study are descriptions of chiropractic-new client interactional patterns which occur in chiropractic clinic settings, and which serve as the focus for client socialization.

Because exclusive use of questionnaires and attitude surveys fail to capture the emergent and novel aspects of human behaviour (Denzin, 1970), a combination of research techniques is adopted for this study. Firstly, it is necessary to determine the health and explanatory models of chiropractors and their new clients as well as their views regarding treatment systems, professional healers and constraints on chiropractic. This calls for responses to interview questions aimed at eliciting such information. Secondly, interactions which take place in behaviour settings or chiropractic clinics need to be recorded from the perspectives of the participants via observation. Thirdly, relevant background interaction about chiropractic must be obtained through the examination of documents.

The three study techniques are used in complementary fashion, although the research is essentially located within the context of ethnomedical studies. Kleinman (1980:84), in using the ethnomedical approach, describes it as one which "overcomes the limitations of the biomedical model precisely because it studies medicine as an inherently semantic subject inseparable from conceptualizations of it held by patients, communities, and practitioners".

1
4.2 Study Design

The design and methodology of study were guided by two general principles. The first principle was to approach the study with as few conceptions as possible. As preliminary work progressed, the research strategies gradually emerged. Although the theoretical framework of the study was not decided prior to the preliminary data collection, an interactionist perspective was eventually adopted.

The second methodological and design guideline emphasized eclecticism. I wanted to devise research strategies which would yield raw data relevant to basic interests and understandings of chiropractic. Consequently, the type of data required for the several segments of the study differed and necessitated more than one research technique. For different segments of the study, either quantitative data or qualitative data were collected. Although the various stages of the study have been described separately, during the actual research process, these components were interrelated and were often undertaken concurrently.

Study objectives required the elicitation of (a) the nature of constraints on chiropractic clinical practice, (b) the health and explanatory models of new clients and chiropractors, and (c) the general impressions that are held about chiropractic before and after clinical interactions. Study objectives also required that the findings be compared with the experiences of new clients and chiropractors during clinical interactions. A specific objective was to observe the clinical interactions and relationships between new clients and chiropractors in order to examine the characteristics of the interactions, to find out how chiropractors present themselves so as to attract new clients to chiropractic, and especially to describe how new clients and chiropractors negotiate the
explanations and treatments for "present" health problems. An important question was whether or not new clients felt differently after they have encountered chiropractic, and how their pre- and post-interaction feelings were related.

I want to emphasize that although the chiropractor-client interactions were observed for each individual or face-to-face encounter, and although individual responses to interview questions were sought and obtained, it was the general, collective, or shared orientation and strategies of chiropractors and new clients that were of primary consideration in the study. Aggregate data rather than individual data are used in comparing interview responses of new clients and chiropractors. Individual comparisons of both clients and chiropractors were not made when it became apparent that the overwhelming majority of new clients in the research sample continued beyond the fourth visit. However, as much as possible, individual differences and orientations have been used to complement findings and discussions of collective views, strategies and experiences of clients and chiropractors.

Figure 2 is a schematic representation of the design of study. It shows the various stages as well as the duration of each stage. The main features of the design called for the comparison of pre- and post-interaction results of interviews - A, B and D, E - as well as the observation of clinical interactions - C.

The study was conducted in three stages. In Stage I, the following people were interviewed: 3 leaders of the chiropractic profession, a representative of the provincial Ministry of Health at a senior level of the bureaucracy, 20 chiropractors and 60 new clients. The observation of clinical interactions between the individual client and the chiropractor was conducted in Stage II. Post-interaction interviews of all of the 20 chiropractors and 60 new clients
FIGURE 2: DESIGN OF STUDY

MONTHS

STAGE I
(Pre-interaction Interviews)

A. Interview
   1. Leaders of Chiropractic

STAGE II
(Observation of clinical settings and interactions)

B. Interview
   1. Chiropractors
   2. New Clients

C. Observation of clinical interactions: Chiropractors/New Clients

STAGE III
(Post-interaction Interviews)

D. Post-interaction Interviews
   1. Chiropractors
   2. New Clients

E. Interviews:
   1. Regular Patients

Review of Records
   1. Professional
   2. Clinical
were conducted after at least four visits by the clients to the clinics.

Preliminary information from two chiropractors had indicated that "non-subscribing" patients, meaning patients who were not convinced or "enthusiastic" about chiropractic, usually discontinued their treatments after the first or second visit. Four visits were chosen as the minimum number of visits that would indicate that a client would remain a patient. The third visit was considered a "buffer" between the "usual" two visits when most new clients drop off. By the fourth visit, clients were assumed to have made up their minds to continue in treatment.

20 "regular" patients of chiropractors were also interviewed during the third stage of the study. A "regular patient" is defined as someone who was not a new client of chiropractic but who was familiar with chiropractic treatment and has made not less than four visits to the same chiropractor. Regular patients were patients who were seen in chiropractic clinics at the time of the study.

The pre-interaction interviews in Stage I focussed on the nature of the constraints, and the impressions people held about chiropractic as well as the health and illness beliefs [HMs] and explanatory models of new clients and chiropractors. How new clients and chiropractors negotiated explanatory models or reconciled their differences were observed in Stage II. The post-interaction interviews in Stage III were aimed at obtaining the views and experiences of new clients regarding their impressions of chiropractic, relationship with chiropractors, and relevant experiences that had contributed to their continuing or discontinuing chiropractic treatment.
The interviews with regular chiropractic patients was to ascertain whether these patients had experiences similar to that of new clients during their early relationships and experiences with chiropractors.

The durations of the three stages of the study were 8, 7 and 5 months respectively, and there were some "overlaps" between the stages (Figure 2).

Throughout the study, relevant professional and clinical records and documents were examined as they became available. Also, at the conclusion of the study, some "backstage" observations were made during further contacts with chiropractors in their social and professional events. These observations have been included in the analysis of data.

4.2.1 Construction of Interview Questions

One objective in constructing the interview questions was to obtain as much information as possible in the context of relaxed, casual conversation. People who have health problems, especially those with painful conditions, may be tense and uncomfortable. Another objective was to link the views, health beliefs and explanatory models of new clients and chiropractors with their experiences during the interactions.

It was intended, at the beginning of the study, to use open-ended interview questions to encourage "free-flowing" responses in order to obtain more complete views of the interactants. Closed interview questions would have limited response options (Forcese and Richer, 1973).

The interview questions for new clients and chiropractors were identical in many respects except when it was deemed necessary to specify the "roles" of
client or healer. For example, a new client was asked: "What did he (the chiropractor) do or say during your first (or other visits) to convince you that he did (or did not) understand your problem?" The chiropractor was asked: "Did you know what to do about Mr/Mrs/Ms ______ problem? What did you do or say to convince him/her that you understood (or did not understand) his or her problem?" In general, most questions for new clients and chiropractors were identical in their wordings in order to minimize variations in their comprehension and interpretation (Appendix V).

Similarly, the same questions were used to interview all three leaders of the chiropractic profession for the same reason (Appendix III).

In order to verify the consistency of responses, a few questions were repeated in different forms during the course of the interview. For example, in asking about a person's belief about the human body and its functions, a new client was asked "What habits are good for bodily health and what habits are not good?" Later, when asking about personal health habits, a new client was again asked, "Are there things you do every day to keep healthy?" While these questions are not identical or targeted to the same purpose, nevertheless, they provide some indication of consistency in responses, although a client may not necessarily practice what he professes to believe (Appendix V).

The purpose of post-interaction interview questions was to obtain the perceptions, impressions and experiences of clients and chiropractors following clinical interactions. In general, the questions were aimed at finding out whether new clients had changed their pre-interaction impressions about chiropractic, the reasons, if any, for doing so, what their experiences had been, what chiropractors did to influence their views of chiropractic, whether they
would continue to receive treatment, and the reason for discontinuing contact with chiropractic. Chiropractors were asked about their views regarding their interaction with clients, the resolution of any differences, knowledge of clients' explanatory models (and health problems), and about specific observations that were made during the clinical encounters.

The observation of clinical encounters between chiropractors and new clients was to examine, record and describe the nature of the relationship, especially the negotiation process in which incongruencies in explanatory models were negotiated.

Questions about health models were constructed specifically for each of the six areas, namely; beliefs about the human body and its functions, beliefs about illness and disease, the cause(s) of illness, signs and symptoms, and beliefs about treatment systems and healers (Figure 1). The ordering of the questions as well as the sequencing of major areas may have influenced some of the responses that were provided. Questions on beliefs about illness and disease may have been viewed by clients as synonymous with questions about treatment systems and healers. This was clearly the case in some instances, necessitating the probing of responses. Such factors may have influenced the responses to questions.

The duration of each pre-interaction interview with some clients and chiropractors was quite long. The average length of an interview was 60 minutes, about 15 minutes longer than was estimated at the beginning of the study. It is possible that responses to questions, especially during the latter part of the interviews, did not command the same attention as earlier questions and responses.
The questions that were used to ask about explanatory models [EMS] were suggested by Kleinman (1980), Kleinman et al. (1978) and used in Kleinman's studies in Taiwan. The questions focussed on the cause, course, pathophysiology, onset, expectations and treatment of "present" health problems (Appendix VB). Kleinman has reported a high degree of consistency in patients' responses to the questions.

4.2.2 The Setting

Although the totality of features of interactional patterns within any behaviour setting may be subject to scrutiny, in this study, the following specific foci have been considered.

(a) The physical layout of the behaviour setting such as front entrance, waiting room, hallway, main office area, reception area, treatment area, X-ray room where applicable, and private office of the chiropractor (Kleinman, 1975).

(b) The rhetoric used in managing impressions and negotiating treatment designed to convey to the client and to others the work of chiropractic. These include written materials such as posters, signs, diplomas, pamphlets, professional magazines and periodicals, oral presentations, and office paraphernalia such as charts of the nervous system, a skeleton and treatment appurtenances (Goffman, 1959; Cowie and Roebuck, 1975).

(c) General expectations within the setting including standing behaviour patterns and ground rules.

(d) The form and content of encounters between the chiropractor and the new client as well as those involving significant others such as assistants and receptionists.

(e) Problematic behaviours including disruptive behaviours such as disputes with office assistants, and client dissatisfaction.
4.2.3 Selection of Chiropractic Clinics

Five clinics from each of five regions of Vancouver totalling 20 chiropractors, 19 males and 1 female, were randomly selected from a list of chiropractic clinics published in the directory of the British Columbia Chiropractic Association, [BCCA]. The clinics are located in Central, Eastern, Southern, Western and Northern Vancouver. 86 or 24% of the 353 chiropractors in British Columbia have located their practices in the study area. The 20 chiropractors who participated in the study constituted approximately 23% of all chiropractors in the study area.

Permission to gather data was sought and obtained from key officials of the British Columbia Chiropractic Association. The President of the Canadian Chiropractic Association, the President and Executive Director of the British Columbia Chiropractic Association and the President of Canadian Chiropractic Memorial College were interviewed on the nature of constraints on chiropractic in Canada and in British Columbia. The three leaders of chiropractic were interviewed on separate occasions at the office of the provincial association. All of the three interviewees agreed to be tape-recorded$^2$ (Appendices I, III).

4.2.4 Selection and Recruitment of Chiropractors

20 chiropractors were randomly selected from the provincial association's list of chiropractors and interviewed in their offices and clinics (Appendix II). 7 chiropractors, or 26% of the total number of chiropractors who were initially selected for the interviews, refused to participate in the study.
Those who refused or were "unavailable" were replaced by further random selection of chiropractors from the same region of Vancouver. Some of the reasons given by some chiropractors for refusing to participate in the study were as follows: "I don't want anyone around when I interview my patients. It may make them nervous...it's a private matter." "I don't feel comfortable with you guys from the University. You lie a lot about us to help the doctors [M.D.s]." "I am going on vacation." "Let me think it over and get back to you." Or, "I'm too busy."

The structured interview of chiropractors focused on demographic characteristics of the practitioner, educational background, beliefs regarding health and illness, health habits, Health and Explanatory models, views regarding other treatment systems, and constraints on professional practice or chiropractic in general (Appendix Vc).

4.2.5 Selection and Recruitment of New Clients

Permission to contact and to interview three new clients before they made their first visits to the clinics were obtained from each chiropractor. An arrangement was set up with the receptionists, secretaries, or chiropractic assistant responsible for "patient contacts" to telephone me at home or at the university whenever a new client called to enquire or to make an appointment. I telephoned potential clients at home, at work, or wherever they wished to be contacted for permission to interview them. The purpose of the study was usually discussed on the telephone or before the initial interview. Those who declined to be interviewed were no longer contacted. 11 of the 71 new clients,
or 15.5% of all new clients who were contacted for interviews, declined to participate. Those persons who agreed to be interviewed were either interviewed at their homes, 23%, or during the first visit to the clinic, 77%, before actual contact and interaction with the chiropractor or any of his assistants or receptionist. 9 or 15% of the 60 initial interviews, were conducted in nearby restaurants approximately one hour before the patient's scheduled appointment at the clinic. During the interview, the potential client was told that the chiropractor had agreed to allow the researcher to observe him and the new client in the clinic. In all cases, the new clients also gave their permission for me "to be present during their visits to the clinics" and also to be interviewed again sometime afterwards.

60 potential or "new" chiropractic clients, 38 males and 22 females, or 3 new clients for each of the 20 clinics in the study were interviewed and later observed in chiropractic behaviour settings. The "new" clients were persons visiting a chiropractic clinic for the first time with individual health problems, and who had never before received chiropractic care (Appendix V).

39 or 65% of all new clients and 6 or 30% of the chiropractors agreed to tape-recording of the interviews. Notes were also taken to supplement tape-recorded information.

4.2.6 Selection and Recruitment of Regular Patients

Permission was obtained from each participating chiropractor to interview one "regular patient". 4 of the 24, or 17% of all regular patients who were approached, declined to participate.
The general purposes of the study were explained to each regular patient who agreed to be interviewed. Most regular patients agreed to be interviewed after they had been told that the chiropractor had given his permission to obtain the interview. A total of 20 regular chiropractic patients, 7 males, and 13 females, were interviewed. These patients had been receiving chiropractic care on a continuing basis and, therefore, were not new clients.

The general purpose of the interview was to determine the reasons why they were seeing the chiropractor, how they became aware of chiropractic, their impressions of the chiropractor, whether they thought the chiropractor understood their health problems, how they evaluated the treatment they received, how long they were in treatment, whether or not they received other kinds of treatment before chiropractic, whether or not there had been changes in treatment since they began to receive chiropractic care, how any differences with the chiropractor were resolved, and any general impressions they had about chiropractic.

A senior official of the Provincial Ministry of Health at the rank of Assistant Deputy Minister with responsibility for chiropractic issues was interviewed in his office in Victoria, the capital of British Columbia (Appendix IV). He declined to allow a tape-recording of the interview, but agreed to "note-taking". He elaborated on how chiropractic is perceived in the province, and on the various interpretations of regulations governing chiropractic in British Columbia. He also discussed the various relationships between officials of government and provincial leaders of chiropractic. More importantly, he clarified differences in perceptions of allopathic and chiropractic health care from the point of view of the bureaucracy and legal statutes, especially why
chiropractors, more than other healing groups in British Columbia, may feel "constrained" in their work.

4.2.7 Procedure

Arrangements were made with chiropractors and their receptionists or secretaries for the researcher to be informed by telephone about changes in appointment dates with new clients and for observation of clinic activities on appointment dates. The researcher usually arrived approximately one hour before the time of scheduled appointments in order to observe the behaviour setting and any activities within it.

The chiropractors introduced me with varying comments such as: "You know Mr. ____." "This graduate student from UBC is here to learn something about what I do." "Take a seat Mr. _____. Please don't ask any questions until I finish with Mr. ____ or Mrs. ____." "Has Mr. ____ spoken to you? So you know him?"

Each initial interaction between a chiropractor and each of the three new patients to the clinic - a total of - 60 client-chiropractor interactions were observed. The duration of observations, including the pre- and post-interaction interviewing of all participating clients, patients and chiropractors, extended over a period of 12 months (Figure 2).

Whenever possible, chiropractors were interviewed immediately following their initial session with new clients in order to obtain clarification of any gestures or "activities" that seemed obscure regarding intention or meaning.
Chiropractors and new clients were again interviewed after at least four visits had been made by each client to the clinic or after some clients "dropped out" of treatment. The follow-up interview for each of the 20 chiropractors in the study was conducted after all three new or potential clients had either completed at least four visits for ongoing care or had dropped out of the behaviour setting. 18 chiropractors were interviewed in their offices, one in an adjacent coffee shop, and another at his home.

New clients who were observed in chiropractic clinics were contacted by telephone either at their home or in their workplaces to find out whether or not they were still attending chiropractic care, whether they completed four visits following the initial visit to the clinic, and to arrange for a second or follow-up interview. 26 or 44% of all new clients were interviewed in their homes, 17 or 28% in their workplaces, and 17 or 28% in chiropractic offices, or in adjacent restaurants during visits to the chiropractors for treatment.

During each visit, the clinics were closely observed regarding their structure, operations, and relationships with new clients. The physical setting as well as the nature of the social interactions and treatments that occurred within the setting were especially noted. Detailed lists of what to observe were prepared in advance and separate reports were written for each clinic immediately following observation. A composite "picture" of the chiropractic clinic showing how each clinic relates to new clients was compiled from the results of interviews and observations.
4.3 Data Collection and Analysis

Data were collected from the following eight areas as follows: the constraints on chiropractic; the impressions that were held by new clients and chiropractors regarding chiropractic care; the health models of new clients and chiropractors; the explanatory models of new clients and chiropractors for the "present" illness problems; the internal and external appearances of the clinics or chiropractic behaviour settings; the interactions and relationships between chiropractors and new clients; the post-interaction views and interaction experiences of chiropractors, new clients and regular patients; and the nature of communication and language that characterize the clinical relationship between chiropractors and new clients.

Figure 3 shows the relationships between the various data files. Data collection was achieved through recorded observations, note-taking, responses to interview questions, tape-recording, and direct observation of interactions and clinical settings.

(a) Constraints and Impressions on Chiropractic

Data relating to the general constraints on chiropractic were obtained via tape-recorded interviews of leaders of chiropractic. The interview of a senior official of the Ministry of Health which was not tape-recorded, provided details of the policy and statutory limitations on chiropractic care in British Columbia. Data were categorized into political, legal, social, and economic constraints (Chapter 1, Section 1.3, p.28).

The responses on the nature of constraints on chiropractic by new clients and chiropractors, as well as their pre-interaction impressions of chiropractic, were categorized and compared in percentage terms (Figure 3 (i)).
FIGURE 3: THE RELATIONSHIPS BETWEEN DATA FILES

THE CHIROPRACTIC - NEW CLIENTS RELATIONSHIP

NEW CLIENTS

<table>
<thead>
<tr>
<th>A</th>
<th>PRE-INTERACTION INTERVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Constraints</td>
<td></td>
</tr>
<tr>
<td>b) Impressions</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>B</th>
<th>EXPLANATORY MODELS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW CLIENTS</td>
<td></td>
</tr>
<tr>
<td>[EMₙ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>POST-INTERACTION INTERVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Views and Reactions</td>
<td></td>
</tr>
<tr>
<td>b) Post-interaction responses</td>
<td></td>
</tr>
</tbody>
</table>

| HEALTH MODELS |
| NEW CLIENTS |
| [HMₙ] |

| HEALTH MODELS: |
| CHIROPRACTORS |
| [HMₚ] |

| COMMUNICATION AND LANGUAGE |

<table>
<thead>
<tr>
<th>POST-INTERACTION INTERVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Views and Reactions</td>
</tr>
<tr>
<td>b) Problem resolution/responses</td>
</tr>
</tbody>
</table>

[Regular Chiropractic Patients]
impressions of new clients before and after interactions with chiropractors were compared by describing the pre- and post-interaction responses, and the reasons for any changes in the impressions.

(b) Health Models [HMs]

The responses to interview questions relating to specific components of the health models [HMs] of clients and chiropractors were compared in percentage terms between new clients' and chiropractors' responses in order to document congruencies or incongruencies (Figure 3 (ii)). The relationship between the health and explanatory models of new clients ($HM_n$, $EM_n$) (Figure 3 (iii)) and that between the health and explanatory models of chiropractors ($HM_p$, $EM_p$) were examined and described (Figure 3 (iv)) (see Appendix VA, VC).

(c) Explanatory Models [EMs]

Similarly, the responses to interview questions on explanatory models by new clients (Appendix VB) were compared in percentage terms with those of chiropractors (Appendix VD). From these responses, the explanations of new clients regarding their "present" illnesses were compared with those of chiropractors.

The negotiation of differences in the explanatory models ($EM_n$ and $EM_p$) of clients and chiropractors were observed during the clinical interactions. The process is described in the context of Goffman's (1959,1967) observations regarding interactions in everyday life, and in terms of Kleinman's (1980) clinical negotiation paradigm for "shifts" and compromises (Figure 3 (v)). The "power relationships in the chiropractic-client interactions were
observed and recorded according to the following criteria: the degree of mutual
participation in the negotiations, the orientation of the interaction, for
example, person-centred versus illness-centred orientation, the "human
dimension" of the interaction with respect to the extent to which non-medical/
chiropractic factors affecting the health problems were considered, and the
nature of the communication and language.

6 chiropractors allowed the tape-recording of their clinical encounters,
conversations and negotiations with new clients. A total of 18 clinical
negotiations were tape-recorded. The data provided the source for more detailed
analysis of communication in chiropractic clinical interactions. The tape-
recordings were analysed according to the following criteria: the number of
questions asked and the number of questions initiated by each interactant; the
"chaining" or superimposition of questions; the extent to which "full
information" was provided to questions that were asked by each partner in the
negotiation; attentiveness to question as indicated by "back-channel" utterances
(Chapter 3, p.134); language differences as indicated by the use of "bureau-
cratic" or ordinary language; the affective components, or how judgemental each
partner in the relationship had been; the number of interruptions of each other;
the number of corrections, comments and "overlaps" in sentences by each partner
(see Chapter 2, Subsection 2.3.1, p.100, and Chapter 3, Section 3.4, p.131).

It was assumed that the analysis of the mode of communication and the use
of language in chiropractic clinical relationships (Figure 3 (vi)) would provide
additional explanations regarding how chiropractors communicate with clients in
order to "convince" them to become subscribing chiropractic patients. It has
been speculated that one reason why allopathic patients seek help from chiropractic health care was dissatisfaction with relationships in allopathic health care (Firman and Goldstein, 1975; Coulter, 1983). The analysis of the mode of communication and use of language in chiropractic relationships would, for the first time, provide the basis for comparing allopathic and chiropractic clinical negotiations.

(d) Views and experiences regarding the nature of the interactions

Interview data on the views and experiences of new clients and chiropractic patients focussed on whether or not new clients were satisfied, the resolution of any differences, the "current" impressions about chiropractic, the realization of expectations, expectations for continuing in treatment, and whether they would recommend chiropractic to other people.

Interview data for chiropractors related to whether they were able to elicit client's health problems, if disagreements were resolved and how, what they did to convince the clients about chiropractic health care, and whether at any time they had some ideas regarding the cause, course, pathophysiology, clients' expectations, and treatment of "presenting" clients' health problems [EMs] (Figure 3 (vii)).

The responses of clients and chiropractors were compared in percentage terms and the results provided varying degrees of substantiation for the observations of clinical negotiations that were made by the researcher. Also, the post-interaction responses of regular patients relating to their experiences with chiropractors were used to validate the responses of new clients.
(e) The Chiropractic Behaviour Setting

Information relating to the following aspects of the chiropractic treatment clinics were recorded and described: the general appearances of the clinics - waiting rooms, treatment rooms and offices including decorations and adornments, entrances, hallways, reception areas and x-ray rooms, where applicable, as well as the relationships, including behaviours within the setting (see Chapter 4, Subsection 4.2.2).

The behaviour setting comprised the "social front" from which the chiropractic "face" was presented. The behaviour setting was observed and described in the context of Goffman's (1959, 1963, 1967, 1969) observations relating to the management of impressions and everyday interactive behaviours.

Although data were collected on individual chiropractor-client relationships, their analyses were focussed on commonalities within individual relationships. No attempt has been made to compare individually, new clients and chiropractors. The main objective of the study has been to describe the collective or shared strategies of chiropractic in the making of chiropractic clientele.

4.4 Methodological Problems

Problems inevitably arise both in the manner in which a study has been conceptualized and the method or design approach used in conducting it. From the beginning, the researcher in this study has been burdened by his own experiences as a clinical physiotherapist and health services administrator, as well as his socialization into biomedical and allopathic perspectives resulting,
inevitably, from twenty years of hospital work. Indeed, the choice of a descriptive framework for the study is partly an attempt to minimize the effects of previously held personal opinions about "alternate" medical systems.

By conceptualizing chiropractic as a medical system rather than a treatment modality, immediate attention is called to how chiropractic compares to the "official" allopathic medical system, especially in its scientific functions. Chiropractic is shown to be a disease theory system with its own explanations regarding cause, cure and pathophysiology of disease.

Methodologically, a key problem with natural observation is that data usually reflect the perception of one individual. Since it is practically impossible to record all relevant facets of the client's or chiropractor's behaviour, some events will be missed. Furthermore, certain aspects of the situation deemed important by one observer might be perceived as trivial by another.

It has been suggested that to increase reliability, the number of observers should be increased (Forcse and Richer, 1973). In this study, variability has been minimized through repeated, consistent, and focused observation by one observer.

A conceptual framework for this study is Goffman's (1959, 1963, 1967) dramaturgical model in which the world of interaction is conceived in terms of front stage, back stage, stage management, stage presence, competent actors, audiences and so forth. Indeed, formal features of interaction such as stagings, audiences, and actors can be found in a variety of social settings. Unfortunately, while such a framework is useful in describing forms of interaction, it does not necessarily reflect actors' own perceptions. In other
words, societal members do not always see themselves as actors who perform for the benefit of audiences. However, chiropractors may be said to have a heightened consciousness of the deviant perceptions of their role, and this becomes an impetus for manipulating their role-image in behaviour settings.

The examination of impression-formation is problematic because factors which influence impression-formation are often unknown, making it difficult to anticipate the social context in which the process is revealed. It is not only that some situations are ostensibly natural and some are patently contrived, rather, it is that we do not yet know what the range and variety of "situations" in "everyday life" are in the first place.

Methodological problems also arise both in the development and execution of this study. From the beginning, there was a certain degree of apprehension on the part of chiropractors as to the motives of the study. Consequently, seven chiropractors who were randomly selected for study declined to participate. It was then suggested by their provincial director that the researcher accept pre-selected members of the profession rather than undertake random selection. This suggestion was rejected because it would have compromised the study by including only practitioners who may have been "judged" by the leaders as capable of projecting the "appropriate professional image". Even with random sampling, the sample may have been skewed due to the unwillingness of some randomly selected practitioners to participate in the study. Continuing random selection until twenty chiropractors were selected could mean that only chiropractors confident enough to "defend the profession" or "demonstrate good clinical expertise" agreed to take part in the study; however, this problem is
probably not very serious since only 7 of the 27 chiropractors who were randomly selected declined to participate.

All of the chiropractors who participated in the study were aware of the time and dates of observation of their clinics. This was necessary in order to ensure minimal disruption of office routines, especially the scheduling of client appointments. It is conceivable that practitioners may have become more conscious of the particular interaction that was being observed and thus "put their best foot forward". Some routine persuasive interaction behaviours, which under normal circumstances would have been part of the interaction, may have been minimized or even eliminated because of my presence.

One important consideration is the effect of my presence on the new client during the initial clinical encounter between the chiropractor and the client. Some new clients may have been hesitant to relate their health problems, especially when causal factors and beliefs were attributable to lifestyle. It is also possible that for some clients, my presence may have given them more confidence in their relationship with the chiropractor since I had come to know them prior to their visits to the clinics. In this instance, some patients may overstate their beliefs or try to make them consistent with what they had related to me during my previous interview with them.

It is possible that the activities in the clinical behaviour settings were arranged and conducted by the chiropractors in order to conform to a perceived ideal when I was present. To minimize this occurrence, I often visited some clinics without making a formal appointment ostensibly to "pick up more chiropractic literature". During these visits there did not appear to be any alterations in the usual routine activities. However, during some visits, I did
see some mechanical devices which might have been used for treatment, and
which were not present during my other visits to the clinics. Chiropractors in
British Columbia are limited to using only their hands in providing treatment,
and it was not possible to establish the reason for the presence of these
devices without wearing out my welcome.

In general, as the study progressed there was increasing willingness by the
chiropractors and their office staff to cooperate and provide assistance. More
and more, ready access was provided to all areas of the clinics, especially
access to some of the chiropractors' clinical notes. Although I had no
recognizable health problem at the time, I asked to undergo treatment by
"adjustment", which is the primary treatment modality in chiropractic. Five
chiropractors to whom I made the request offered to provide me with the treat­
ment experience, which I did undergo in all cases.

Because one cannot adequately describe reality, especially the meanings
individuals attach to events and circumstances, I have provided, as much as
possible, the actual words used in interview responses and clinical inter­
actions along with the tables and appendices. Wide discrepancies commonly exist
in definitions of specific situations depending on the viewers. It is possible,
therefore, that observers and clients may perceive the same situation or
behaviour quite differently.

Any researcher tends to project his own values onto the definition of the
situation, and this compromises research methodology. However, careful
attention to face-to-face interaction and acceptance of personalized accounts
can minimize bias.
NOTES

1. It should be noted that while Kleinman emphasizes the advantages of the "ethnomedical" over the 'biomedical' research model, his own research does not fully separate the two orientations since his conception of clinical negotiations appear to be doctor-centred.

2. Preliminary enquiry indicated a general reluctance on the part of chiropractors to allow participant observation of their clinics on the basis that no suitable role could be found in a chiropractic clinic without "extensive professional training". Moreover, some chiropractors were only willing to allow me to function as a receptionist which would have denied me access to treatment rooms.

3. At the beginning, I was not sure how much cooperation I would receive from chiropractors. Consequently, it was not possible to "fit" a method of study in the process without knowing what data and information will be available. Fortunately, as the leadership of the Provincial Chiropractic Association began to see the merits and usefulness of the study, greater cooperation was made available. One leader comments:

   "It is funny that you, being a physiotherapist as well as an allopathic health care administrator, to be allowed to study chiropractic. If you are sure you aren't going to lose your job, it's fine with me. I guess it will be OK for someone like you to understand what we do...there has been a lot of misconceptions and if you can help correct some of it from the other side, I have no problem asking our members to give you full cooperation."

4. This self-verification had to serve in lieu of a reliability check since it was not possible within the time and budgetary constraints of the study to engage another trained student to review the tapes.
5.0 HEALTH BELIEFS AND EXPLANATORY MODELS OF NEW CLIENTS AND CHIROPRACTORS

The demographic characteristics of new clients and chiropractors and the results of pre- and post-clinical interaction interviews are presented in this chapter.

The results and discussions are presented in a manner that would allow for the comparison of the views, beliefs, and experiences of clients and chiropractors. In doing so, some of the actual words that were used in responding to interview questions are reported in the appendices rather than in the tables or in the text. References to the appendices during the discussion of the results will help to capture the meaning and context of the responses.

The volume of data, as well as the descriptive nature of the report, have made it very difficult to report all of the actual words that were used by new clients and chiropractors to respond to interview questions. Consequently, while some descriptions are lacking the full sentences in which they have been reported, others contain phrases, abbreviated sentences or words. In general, the data is presented so as to minimize any perceptual bias that may be held by the researcher.
5.1 General Characteristics: Chiropractors and New Clients

60 new clients of chiropractic (38 male, 22 female), average age 40.5 years (44.3 years male, 36.6 years female), were interviewed and observed during initial interactions with 20 chiropractors (19 male, 1 female), average age 36.5 years (Appendix V). 30% of clients were married, 36.7% single, 11.7% separated and the rest were either divorced, widowed or living common-law with other persons. 75% of chiropractors were married, 15% single, and 10% either separated or divorced.

More than half the number of clients or 55% live in rented homes or rented apartments compared to 35% of chiropractors. 40% of clients own their homes compared to 65% of chiropractors. 5% of clients live in homes owned by their parents.

About the same number of clients and chiropractors, 43.3% and 50.0% respectively, live in the central part of the city of Vancouver. 25% of clients live in East Vancouver, 10% in West Vancouver, 10% in North Vancouver, 5% in Richmond, 5% in Burnaby, and 1.7% in Delta. Clients who live outside of the Vancouver area work in businesses located within the study area and visited chiropractors from their workplaces. The residences of chiropractors are distributed as follows: 60% West Vancouver, 10% North Vancouver, and 5% Burnaby.

34% and 90% of clients and chiropractors respectively, have lived in Canada for more than 20 years. The majority of clients, 59.47%, have lived in Canada between 10 and 20 years, while none of the chiropractors have lived in Canada for less than 10 years. 54% and 75% of clients and chiropractors respectively, have lived in British Columbia for more than 15 years. 45% of clients and 25% of chiropractors have lived in British Columbia for less than 15 years. Again,
while the majority of chiropractors, 75%, have lived in Vancouver or in neighbouring municipalities for more than 15 years, only 55% of clients have lived in the same areas. In particular, 65% of chiropractors have lived in the study area for over 20 years compared to 26.7% of new clients.

These figures suggest that chiropractors have lived longer in Canada, British Columbia, and in the study area in particular, and may be said to be more "aware" of the local environment in which they live.

The national origin and ethnicity of fathers of clients span 19 countries and 16 ethnic classifications respectively. Corresponding figures for chiropractors are 5 national origins and 3 ethnic groups. Therefore, it may be suggested that considerable ethnic differences exist between new clients and chiropractors in the study area.

All of the chiropractors are Canadian citizens compared to 81.7% of clients. The second largest group of naturalized citizens are from China, comprising 5% of all new clients. Others are: 3.3% United States; 3.3% Indian (non-native Indians); 3.3% English; 1.7% Sri Lankan; and 1.7% Italian. All new clients without Canadian citizenship have landed immigrant residency status in Canada.

While all 20 chiropractors are self-employed or in partnership arrangements with other chiropractors, 80% of clients are employed, 11.7% unemployed, 3.3% retired, and 5.0% students. Thus, the ability of clients to reimburse the chiropractors beyond approved 12 or 15 visits paid for by the government, is not guaranteed in every instance.

20% of chiropractors are university graduates with degrees in biochemistry, psychology, chemistry and political science. 75% of them received their
professional training at the Canadian Memorial Chiropractic College, while 10% and 15%, respectively, received their professional education in the United States at the Palmer College of Chiropractic in Iowa, and the Logan Chiropractic College in St. Louis, Missouri. Since graduation from chiropractic colleges, 35% have had five years or less experience in clinical practice, 35%, 6 to 10 years, 20%, 11 to 20 years, and 10%, over 20 years experience. All 20 chiropractors have been in their present location of practice since graduation, indicating that chiropractors, once established in a particular environment, very rarely relocate to new environments. Relocation of clinical services, once established, would require a "fresh start" at client socialization which is problematic in British Columbia because of legal and political constraints on chiropractic health care.

In contrast, 23.3% of new clients are university graduates, 11.7% have professional education, 21.7% secondary school education, 30.0% primary school level education and 13.3% have no formal schooling. There is, therefore, very little differences in the educational background of chiropractors and new clients.

Only 18 or 30% of all new clients responded to the question on the highest level of education of their spouses. Of these, 22.2% of the spouses have university level education, 16.6% professional training, 27.8% secondary education, 27.8% primary education, and 5.6% no formal schooling. In contrast, 20% of spouses of chiropractors have university level education, 20.0% are trained as chiropractic assistants, 5% have secretarial training and 50% are housewives. The spouse of one chiropractor is an allopathic (M.D.) physician. 33.2% of spouses of the remainder of new clients are housewives, 22.2%, school
teachers (secondary and primary schools), 22.2% are businessmen or businesswomen, and 5.6% are engaged in various endeavours such as automechanics, education, secretarial services, and politics. The usual occupation of new clients include sales representation, law, management, accountancy, university professorship, engineering, social work, taxi driving, bank managing, company executive, labouring or casual work, storekeeping, student, urban planning, hairdressing, secretarial work and housewifery. One new client is unemployed.

These data support the finding that clients of chiropractors come from all socio-economic groups in society (Kelner et al., 1980). However, half of the spouses of chiropractors are housewives compared to a third of the spouses of clients.

95% of chiropractors are Christians, compared to 68.3% of new clients. There are seven different religious affiliations among new clients indicative of their various ethnic backgrounds. Therefore, about one-third of new clients have religious backgrounds different from those of chiropractors.

Regarding political party preference, 80% of chiropractors vote Federally for the Liberal Party, 60% vote Provincially for the New Democratic Party, and 65% vote Municipally for the Committee of Progressive Electors. The latter two political organizations are oriented more to the "left" or said to subscribe to socialist values. Only 9 or 15% of new clients responded to the question on political affiliation. There was general reluctance by new clients to respond to questions relating to their political beliefs. No probing for responses was undertaken once a client had indicated reluctance in answering questions on religious affiliation. Of the 9 clients, 7 favour the Progressive Conservative Party federally, 5 favour the Social Credit Party provincially, and 8 favour the
Committee of Progressive Electors municipally. These figures are too small to generalize regarding the political orientation of new clients.

5.2 Constraints on Chiropractic: Views of Clients and Chiropractors

81% of new clients became aware of chiropractic as a treatment system less than 12 months before their first visit to chiropractors. Most new clients (58%), became aware of chiropractic treatment for their "present" health complaint less than 6 months prior to their initial visit to a chiropractic clinic (Table 1). The largest number of new clients, 45%, learned about chiropractic treatment from former chiropractic patients. Altogether, 76% of potential clients learned about chiropractic from friends, family members, business partners, co-workers, and former patients, 15% learned about it from the media, and 3% from family physicians [M.D's]. Therefore, the single most important source of information about chiropractic was former chiropractic patients who may have been business partners, co-workers, or friends of family. Secondary to former patients as a source of knowledge, was the media, such as television, newspapers and chiropractic publications. Allopathic physicians were the least likely source of information about chiropractic or the least likely group to encourage patients to visit chiropractors (Table 2).

All of the chiropractors depended on the following avenues for information about chiropractic and for obtaining new chiropractic clients: referrals from former patients, current patients receiving chiropractic treatment, friends and acquaintances, "word of mouth" as well as various other activities such as educational and visual presentations, slide presentations, visual displays,
Table 1
Knowledge of Chiropractic: New Clients

Question: When did you first learn about Chiropractic as a treatment system? How long ago?

<table>
<thead>
<tr>
<th>Period</th>
<th>No. of Clients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 6 months</td>
<td>35</td>
<td>58.0</td>
</tr>
<tr>
<td>7 - 12 months</td>
<td>14</td>
<td>23.7</td>
</tr>
<tr>
<td>13 - 36 months</td>
<td>8</td>
<td>13.3</td>
</tr>
<tr>
<td>Over 36 months</td>
<td>3</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Question: What do you know about Chiropractic?

- Nothing                10  17.0
- Not very much           4   7.0
- Manipulation: back and joints 25  42.0
- "Back Doctors"/"A kind of doctor" 6   10.0
- "Naturalist" healing     5   8.0
- "Holistic healing"       2   3.0
- "Adjustment Therapy"     5   8.0
- "A type of therapist"    3   5.0

Question: What does your family doctor think?

- "Poor judgement", "caution", "apprehensive" 11  18.0
- "Supportive", "encouraging" 11  18.0
- Advise against treatment 1   3.0
- Indifferent               3   5.0
- Don't Know                 34  56.0

Question: Does your Doctor [M.D.] know you are seeing a Chiropractor?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>44</td>
</tr>
<tr>
<td>Don't Know/Not Sure</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>74.0</td>
</tr>
<tr>
<td></td>
<td>23.0</td>
</tr>
</tbody>
</table>
Table 2

Channels for Chiropractic Information

Comparison of methods for acquiring or disseminating information about chiropractic by clients and chiropractors

<table>
<thead>
<tr>
<th>Method</th>
<th>Acquisition of Information Clients</th>
<th>Dissemination of Information Chiropractors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend</td>
<td>12.0</td>
<td>90</td>
</tr>
<tr>
<td>Family</td>
<td>12.0</td>
<td>-</td>
</tr>
<tr>
<td>Medical Doctor</td>
<td>3.0</td>
<td>-</td>
</tr>
<tr>
<td>Television/Radio</td>
<td>10.0</td>
<td>45</td>
</tr>
<tr>
<td>Newspaper</td>
<td>5.0</td>
<td>-</td>
</tr>
<tr>
<td>Chiropractic patients</td>
<td>45.0</td>
<td>100</td>
</tr>
<tr>
<td>Social gathering/service clubs</td>
<td>3.0</td>
<td>70</td>
</tr>
<tr>
<td>Word of mouth/co-workers/business partner</td>
<td>4.0</td>
<td>100</td>
</tr>
<tr>
<td>Chiropractic leaflet</td>
<td>6.0</td>
<td>100</td>
</tr>
<tr>
<td>Educational activities</td>
<td>-</td>
<td>100</td>
</tr>
</tbody>
</table>

*Methods shade into each other and no rigid boundaries have been established.*
discussions, brochures and booklets (Table 2). One 28 year old chiropractor comments:

"Luckily I am fairly athletic and interested in most social and charity causes....therefore I participate in six team sports and twelve social and charitable organizations....I talk to a lot of people, they know me and I help them when they get hurt. In fact, you can say I am the equivalent of a sports chiropractor, if there is one. Nearly all my patients know about me from my various social and athletic activities... Sure I promote what I do...I have got to because of all the misinformation about us."

He later adds:

"....I had a hard time getting started when I left college. If you wait, nobody comes to you. A medical graduate [M.D.] can do something else....such as work in hospital for pay, manage a clinic for a company, become an emergency service doctor while waiting to build up his or her practice....I have to do something or my training will be for nothing."

Generally, chiropractors mostly depend on satisfied former patients for information about themselves or individual chiropractors in particular. Unlike cases involving "official" allopathic physicians, citizens of the province are not legally bound to obtain legitimation for their illness from chiropractors. Such mandatory requirements as pre-employment medical proof of well-being, absences due to sickness, qualification for eligibility for Guaranteed Annual Income for Need [GAIN] for handicapped persons, and other state sanctioned legal obligations, do not involve chiropractors although, like allopathic physicians, they are primary health care practitioners. The net effect has been to minimize the visibility of chiropractors as well as their role in providing health care to the public of British Columbia.
More than half or 55% of chiropractors said it had been difficult to recruit enough patients for their clinics. 75% said it had been both easy as well as difficult for them to recruit enough patients. The 25% of chiropractors who found it easy to recruit were much older, well established practitioners. However, some claimed that it "was rough when I began soon after college", or that it "has taken me twelve years to get where I am now". More recent chiropractic graduates felt that "lots of people do not know where to get (chiropractic) help". According to a recent graduate of two year's experience: I have "got to prove myself, get people to know me, get around before I can get going" (Appendix VIII).

Prior to the first visits to chiropractors, 52% of new clients thought that chiropractors manipulate backs and joints, or they regarded them as "a kind of back doctor". 27% knew nothing or knew very little about chiropractic. 16% thought chiropractors were "naturalists", "holistic" healers or some "type of therapist". Only 8% used the terminology "adjustment therapy" in referring to chiropractors (Table 1).

There was a considerable knowledge gap between what new clients knew about chiropractic and what chiropractors actually did or saw themselves as doing. When asked specifically what they knew about chiropractic treatment, 43% of new clients said they manipulate, bend or stretch mostly the back and joints. Others saw them as providing painful therapy (22%), and no surgery (10%). 13% knew little or nothing about what they did. 5% thought they gave exercises or corrected the spine, and 2% saw them as giving advice on health and therapy.

From these data, it may be concluded that new clients did not have consistent and uniform knowledge about chiropractic treatment and that
individual clients had different perceptions of chiropractic and chiropractic treatment. The lack of adequate uniform information about chiropractic treatment was a major constraint. Most citizens in British Columbia would know what a family doctor [M.D.] does by way of treatment of illness, but not what a chiropractor does.

43.3% of new clients commented that their friends and family had opinions about their decision to seek chiropractic treatment. Of these, 18% said their friends and family members regarded their decision a "poor judgement", or they were "apprehensive" of their "gamble" and "cautioned" them of the risks involved. 18% were "supportive" or "encouraging", 3% advised against receiving treatment, and 5% were indifferent. More importantly, 74% of all new clients said that their family doctors [M.D's] did not know that they planned to seek help from chiropractic (Tables 1).

The general impression from these data has been that the majority of new clients responding to the question were not encouraged by their friends and family members to seek chiropractic treatment. Some new clients were actually discouraged, but more significantly, the majority of new clients did not inform their family doctors of their wish to try chiropractic treatment. The lack of support from relevant friends and family, and the inability to obtain relevant clinical information from family physicians appear to constrain chiropractic clinical practice. Consequently, it was difficult for 60% of all new clients to visit a chiropractor, largely because, as some commented: they "don't know about the therapy", "Been told they are quacks", "My sister who is married to a regular doctor [M.D.], says I will get hurt"....and that regular doctors end up correcting their mistakes", "my doctor told me I am better off treating myself
than going to a chiropractor", "scared of what I don't know" or "worried about their training" (Appendix IX).

Individual expectations regarding "advice" and "treatment" varied. 42% of new clients expected to receive advice regarding what to do about "pain" or about different health problems, 12% about how to take care of their backs, 8% about nutrition, 8% about how to lose weight, 5% about exercise and health maintenance, and 18% did not know what kind of advice to expect. Only 2% expected advice about treatment.

The kinds of treatment new clients expected were as follows: manipulation or stretching (28%), adjustment (13%), some form of exercise (12%), and 22% of new clients did not know what kind of treatment to expect. Small percentages of new clients expected heat and massage, massage and "rubbing", massage and "stimulation", traction and stretching, exercise and manipulation, and medication.

The variety of client expectations regarding advice and treatment seem to indicate a general lack of "adequate" knowledge by new clients regarding what kind of treatments chiropractors usually provide.

95% of new clients depended on public health insurance plans for payment of chiropractic services. 5% did not know how they would pay for the treatments they would receive. When asked how they would pay for chiropractic services beyond state insured universal health plan or beyond the legally allowable 12 visits or 15 visits a year for those over 65 years old, 35% of new clients indicated that they would not require services beyond the number paid for by the government, 28% did not know how they would pay "at the present time", 30% said they would issue personal bank cheques, and 5% expected to take out a bank loan.
More than 50% of all new clients were not aware of legal limitations to the number of visits to chiropractors for which the government would pay.

Chiropractors expected to have problems collecting bills for services beyond 12 or 15 visits a year and, at the same time, persuade new clients to continue in treatment. All of the chiropractors indicated that they accept personal cheques when issued for extended treatments. In some cases, the receptionist would arrange for future installment payments. A few chiropractors said that "some 5% of patients refuse to pay" beyond the allowable number of office visits. 30% of chiropractors said they would take "rainchecks" or hoped that they would be reimbursed for services sometime in the future. 30% said some patients often paid for treatments one year after they have stopped treatments. 75% would accept incremental payments, but all of the chiropractors would "write off" unpaid bills (Appendix X).

14 of the 20 chiropractors interviewed said they experienced varying difficulties with payment for treatments or services they provided to patients. Remarkably, none of them used collection agencies for outstanding debts. One middle-aged chiropractor put it this way: "The idea is not to stop anyone from seeking or receiving chiropractic" whether or not they are able to "pay more than the government pays" (Appendix X).

It seemed that the need to satisfy the client and to enhance and maintain positive, personal, public image were more important for individual chiropractors than the need for reimbursement for services beyond number of treatments allowed and paid for by the state. Regardless, the range of advice chiropractors gave their patients included stress management, home management of health
problems, lifestyle, work-habits, smoking habits, advice on back care, alcoholism, vitamins, nutrition, exercises and posture correction.

Chiropractors and new clients in particular, perceived some constraints because of the lack of knowledge and information about chiropractic. The Chiropractic Association seems to provide the most information for new clients, which is supplemented with individual effort by chiropractors such as through extensive use of brochures, pamphlets and presentations (Table 2). Since people generally depend on advice from friends and family during illness, new clients confirm that they did not have that support regarding their decision to try chiropractic. This lack of support constrains some of the efforts of chiropractors in making new clientele, especially since the support of friends and family could be crucial for continued utilization of chiropractic treatment beyond the initial treatment.

Client expectations regarding advice and treatment differed from advice and treatment chiropractors said they provide. Expectations of new clients varied considerably, thus necessitating individual and personalized attention by chiropractors in order to clarify these expectations. Chiropractors seemed to have little choice, under the circumstances, but to personalize their services in order to attract clients.

By not pursuing and collecting outstanding bills beyond the approved number of treatments, chiropractors give the impression that it is more important for them to please, satisfy and impress new clients, than to promote any negative feelings such as may arise from debt collection. This emphasis is particularly important since the prime source of new clientele is through "regular" patients, who may, occasionally, be unable to pay for scheduled treatments.
5.3 Impressions about Chiropractic: New Clients and Chiropractors (Tables 3, 4)

The general impressions held by new clients about chiropractic prior to their initial visits to clinics, as well as those held by chiropractors, are presented in Tables 3 and 4, respectively.

63% of new clients did not know enough about chiropractic to compare or rate it with other healing groups in the province. Of those who expressed their opinions, only 3% rate chiropractic high. 5% rated it above average, 19% average, and 10% below average or lower than other healing groups. In contrast, 80% of chiropractors rate chiropractic either high as a profession or above average compared to other professions. Only 10% of chiropractors felt that chiropractic was average compared to other professions. Thus, while chiropractors have high ratings for their work and profession, new clients, at least before they experience chiropractic, felt quite the opposite (Table 4).

Chiropractors were aware that new clients lack adequate information about chiropractic (Table 4). Most new clients tended to be either "nervous and afraid", "scared to come in" and had different individual perceptions about chiropractic. In the words of some of the chiropractors:

"...you have to be very careful with new patients. You don't know what they've been told."
"Nervous patients are special problems. You must relax them, get them to trust you, be gentle and very understanding."
"Once in a while, a smart alec shows up just to give you a hard time. These people claim they know everything. I often smell them a mile away and not bother too much. The problem is getting the new patients. I can always allay their fears."
Table 3
General Impressions about Chiropractic: Views of New Clients

Question: What is your impression of the standing of Chiropractors amongst other health professions in the province? How do you rate them as a group...amongst professions in the province?

<table>
<thead>
<tr>
<th>No. of Clients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>2</td>
</tr>
<tr>
<td>Above Average</td>
<td>3</td>
</tr>
<tr>
<td>Average</td>
<td>11</td>
</tr>
<tr>
<td>Low</td>
<td>6</td>
</tr>
<tr>
<td>Don't know enough about chiropractic</td>
<td>38</td>
</tr>
</tbody>
</table>

Question: How would you compare Chiropractic to other professions such as:

<table>
<thead>
<tr>
<th>No. and % of Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Medicine</td>
</tr>
<tr>
<td>Law</td>
</tr>
<tr>
<td>Dentistry</td>
</tr>
<tr>
<td>Pharmacy</td>
</tr>
</tbody>
</table>

Question: Do you have any expectations about a Chiropractor on meeting him/her for the first time?

<table>
<thead>
<tr>
<th>No. of Clients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>23</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
</tr>
<tr>
<td>Not particularly</td>
<td>18</td>
</tr>
</tbody>
</table>
Table 4

General Impressions about Chiropractic: Views of Chiropractors

Question: What are your clients' perceptions and attitudes about Chiropractic?

<table>
<thead>
<tr>
<th>No. of Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;They think we just treat backs, especially new patients&quot;</td>
<td>18</td>
</tr>
<tr>
<td>&quot;...Holistic practitioners&quot;</td>
<td>15</td>
</tr>
<tr>
<td>&quot;Naturalistic care&quot;</td>
<td>15</td>
</tr>
<tr>
<td>&quot;Nervous and afraid that it will hurt&quot;</td>
<td>17</td>
</tr>
<tr>
<td>&quot;Scared to come in&quot;</td>
<td>13</td>
</tr>
<tr>
<td>&quot;All new patients come in with nervousness&quot;</td>
<td>12</td>
</tr>
<tr>
<td>&quot;Some patients are open-minded&quot;</td>
<td>6</td>
</tr>
<tr>
<td>&quot;...from no knowledge at all to wrong impressions until they come to know about chiropractic&quot;</td>
<td>18</td>
</tr>
</tbody>
</table>

Question: Do most of your clients always feel this way?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Most of them</td>
<td>15</td>
<td>75.0</td>
</tr>
<tr>
<td>Some of them</td>
<td>4</td>
<td>20.0</td>
</tr>
<tr>
<td>A few of them</td>
<td>1</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Question: Does that pose any problems?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Poses problems</td>
<td>9</td>
<td>45.0</td>
</tr>
<tr>
<td>Does not pose problems</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Sometimes poses problems</td>
<td>8</td>
<td>40.0</td>
</tr>
</tbody>
</table>

Question: How do you rate chiropractic compared with other professions in general in this province?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>13</td>
<td>65.0</td>
</tr>
<tr>
<td>Above Average</td>
<td>5</td>
<td>25.0</td>
</tr>
<tr>
<td>Average</td>
<td>2</td>
<td>10.0</td>
</tr>
</tbody>
</table>
The last comment shows considerable confidence, on the part of chiropractors, in allaying the fears and concerns of new clients, confidence which has been cultivated through experience over a long period of time dealing with difficult, nervous and apprehensive clients.

Because negative impressions that are held by new clients "pose problems" or "sometimes poses problems" for 85% of chiropractors interviewed (Table 4), much effort will have to be exerted by chiropractors to "try hard to understand" new clients and their problems, to "find out what he wants from you....maybe he doesn't want to go back to work...especially if his doctor [M.D.] is telling him he is OK"...and "to give him accurate information about chiropractic".

The above comments appear to indicate that at least some chiropractors were willing to please clients by "giving them what they want", and to try hard to understand their problems. It is this extra effort to understand and to sometimes please clients that provides the margin of difference between what all practitioners engaged in the healing process do to get by, and what chiropractors do very well in order to keep the clientele. In any case, new clients of chiropractic did not view chiropractic as the only source of help for their health problems. Other sources of help included allopathic physicians, physiotherapists, pharmacists, acupuncturists, spiritual healing, medication, exercise and dieting. Similarly, chiropractors did not view "spinal adjustment" as the prime treatment technique of chiropractic, or as the only way to treat most illnesses or the kinds of illness they often saw in their clinics. Other sources of treatment included allopathy, naturopathy, osteopathy, and acupuncture. One chiropractor viewed medication as a "good alternate type" of treatment and another chiropractor suggested spiritual healing.
More than half of new clients would not mind if the chiropractor referred them to another kind of healer "if he does not know what he is doing" rather "than kill me", but would not like to be referred to "another chiropractor". Slightly less than half of new clients would mind if the chiropractor referred them to another kind of healer if he had not told them why he was doing so and "depending on where he is sending" them. However, less than half of the number of chiropractors would refer patients to allopathic physicians, physiotherapists, naturopaths, and to any of the following practitioners: accupuncturists, naturopaths, and dietitians. They reasoned that a patient was entitled to getting "the full benefit of all available help", in order to avoid "the possibility of more serious ill-health such as cancer", and because they have been legally prohibited from providing electrotherapy to patients in British Columbia although they have been trained to do so.

All chiropractors interviewed would accept referrals from other kinds of health professionals because they see themselves as capable of "helping some patients". Only a third of the chiropractors claimed to receive occasional referrals from allopathic physicians [M.Ds] through individualized private arrangements. None of the chiropractors indicated that they had received any client referrals from physiotherapists, whose work sometimes shades into chiropractic.

Before their first visits, 38% of new clients did have expectations about the chiropractor. Some of them expected "him" to be "more like a bone doctor" wearing "white coat and all", or "like a dentist... (causing) a lot of pain". It seemed that some new clients formed their expectations about chiropractors in relation to orthopaedic physicians who are usually bone specialists in white coats. Some new clients used pain as a point of reference in their perception
of chiropractors, since dentists have generally been associated with pain in pulling defective or infected teeth (Table 3).

32% of new clients said they did not have any particular expectations because they did not know what to expect. 30% of them had vague expectations which they were unable to articulate (Table 3).

For chiropractors it was important that, in presenting themselves to clients, they were "clean-shaven" 50%, "well dressed" 70%, had a "professional appearance" 85%, had "a positive and directive attitude" 55%, worked in "nice modern offices" 15%, were "friendly" 100%, "relaxed" 100%, and "sincere" 100%. Thus, friendliness, relaxation, sincerity, appropriate grooming and professional appearance were at the top of qualities and impressions chiropractors had about themselves. These qualities were aimed at inspiring confidence and trust in new clients.

To what extent, therefore, were these qualities and expectations reflected in chiropractic behaviour settings and in clinical interactive activities? In other words, to what extent did chiropractors in the study area act out their beliefs and impressions in socializing new clients? What particular structures and processes which reflect the beliefs and expectations of chiropractors are located in chiropractic behaviour settings and used in "making" new clientele? New clients, as I have noted, had very different beliefs, expectations and impressions about health and illness, treatment systems and about chiropractic. Within the constraints of their work, how did chiropractors "react" in order to "convince" new clients to become their patients.
5.4 Beliefs About the Human Body and its Functions

Chiropractors and new clients used mechanical analogies to describe the functions of the human body (see Chapter 2, Subsection 2.1.1, p.78). However, they differed in their views regarding how the body keeps healthy. For the majority of new clients, the key to a healthy body is the blood and the circulatory system. For chiropractors, it is the nervous system.

11 new clients responded that their own bodies are able to keep healthy by getting rid of poisons, germs and foreign bodies (21.7%); ensuring adequate blood supply (18.3%); "attacking" and "killing" germs (11.7%); expelling waste products or "bad water" (8.3%); and by making new "healthy blood" (5.0%) (Table 5). They reasoned that their bodies are able to perform these functions because poisons, foreign bodies and waste materials are alien to them and must be expelled (41.1%); enough "good food" must be carried by blood to all body parts "to get them all working together" (21.4%); human body requires food and "oxygen" to survive (8.9%); and that new blood with more energy must replace old "worn out" blood with the necessary energy to "attack and kill" germs (7.1%) (Appendix XI). Therefore, in order to keep the body in good functional order, a person should exercise and eat "appropriate diets" (40.2%), especially fibrous and natural foods (14.9%); check with the doctor" (11.5%), have sufficient sleep (10.4%), and drink lots of water to clean the body of waste products (1.2%) (Table 6). New clients reasoned that dieting prevents the accumulation of excess fat which causes such sicknesses as heart attacks (24.1%); while exercise ensures blood circulation which helps to keep body organs healthy and functioning well (16.1%). They also reasoned that "good healthy, fibrous foods"
Table 5

The Human Body's Ability to Remain Healthy

Question: In your view, how does your own body keep healthy?

<table>
<thead>
<tr>
<th>Responses</th>
<th>New Clients (n=60)</th>
<th>%</th>
<th>*Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Gets rid of poisons/foreign bodies</td>
<td>13</td>
<td>21.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Adequate blood circulation</td>
<td>11</td>
<td>18.3%</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>- &quot;Attacks&quot;, &quot;kills&quot; germs</td>
<td>7</td>
<td>11.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Use of &quot;right foods&quot;</td>
<td>7</td>
<td>11.7%</td>
<td>10</td>
<td>50%</td>
</tr>
<tr>
<td>- Expels waste products, &quot;bad water&quot;</td>
<td>5</td>
<td>8.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Constant repair of damaged parts</td>
<td>5</td>
<td>8.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Little abuse of body parts/organs</td>
<td>3</td>
<td>5.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Makes new &quot;healthy blood&quot;</td>
<td>3</td>
<td>5.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Sufficient rest</td>
<td>1</td>
<td>1.7%</td>
<td>11</td>
<td>55%</td>
</tr>
<tr>
<td>- Little exposure to &quot;bad weather&quot;</td>
<td>1</td>
<td>1.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- &quot;Master Control&quot; of nervous system</td>
<td>-</td>
<td>-</td>
<td>20</td>
<td>100%</td>
</tr>
<tr>
<td>- Exercises</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>50%</td>
</tr>
<tr>
<td>- Good lifestyle</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>30%</td>
</tr>
<tr>
<td>- Daily vitamin intake</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>35%</td>
</tr>
<tr>
<td>- &quot;Cell regeneration&quot;, use of energy</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>25%</td>
</tr>
<tr>
<td>- &quot;Regular chiropractic adjustment&quot;</td>
<td>-</td>
<td>-</td>
<td>15</td>
<td>75%</td>
</tr>
</tbody>
</table>

* All 20 Chiropractors provided more than 1 response and 12 or 60% of them gave 3 or more responses.
Table 6

MAINTENANCE OF A HEALTHY BODY

Question: So what needs to be done to keep (own body) well?

<table>
<thead>
<tr>
<th>Responses</th>
<th>New Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercises (and dieting)</td>
<td>35</td>
<td>40.2</td>
<td>18</td>
<td>90.0</td>
</tr>
<tr>
<td>Eating &quot;fibrous&quot;, &quot;natural&quot; foods</td>
<td>13</td>
<td>14.9</td>
<td>14</td>
<td>70.0</td>
</tr>
<tr>
<td>&quot;Check with doctor&quot; [M.D.] annually</td>
<td>10</td>
<td>11.5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sufficient sleep: 8-10 hrs. daily</td>
<td>9</td>
<td>10.4</td>
<td>14</td>
<td>70.0</td>
</tr>
<tr>
<td>No smoking, moderate sex/alcohol</td>
<td>7</td>
<td>8.0</td>
<td>10</td>
<td>50.0</td>
</tr>
<tr>
<td>Mind/body &quot;harmony&quot;, &quot;stress-free&quot;</td>
<td>6</td>
<td>6.9</td>
<td>10</td>
<td>50.0</td>
</tr>
<tr>
<td>Blood free of poisons/drugs</td>
<td>5</td>
<td>5.7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Drinking lots of water to &quot;clean body&quot;</td>
<td>1</td>
<td>1.2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Underexposure to sunlight/heat/cold</td>
<td>1</td>
<td>1.2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Regular chiropractic adjustment</td>
<td>-</td>
<td>-</td>
<td>11</td>
<td>55.0</td>
</tr>
<tr>
<td>Intake of daily vitamins (A&amp;D)</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>30.0</td>
</tr>
</tbody>
</table>

* More than one response per subject in some instances.
nourish body cells and organs "as it is supposed to be", thus providing them with more energy (14.9%). The accumulation of waste products impair body functions and cause disease, therefore, drinking enough water would help "wash them out" (1.2%) (Appendix XII).

A few new clients were of the view that their bodies are able to keep healthy by constantly repairing damaged parts (8.3%); not being "abused" (5.0%); not being exposed for a long time to inclement or "bad weather" (1.7%); and by being rested "sufficiently" (1.7%). These clients reasoned that overusing the body and its parts results in "wear and tear" and damage to cells or in "fatigue" (5.4%); that bad weather causes internal and external changes in the body (1.8%); and that inadequate rest prevents the body from recovering from previous activities (1.8%) (Appendix XI). 6.6% of all new clients did not know how their own bodies keep healthy.

All of the chiropractors responded that the nervous system has the "primary" responsibility for keeping their own bodies in healthy states. They also provided other reasons, all related to the nervous system, why their own bodies are able to remain healthy. All of the chiropractors attributed the mechanism for a healthy body to "master control" functions of the nervous system; good mental health including a "healthy mind" (50%) and exercises (75%) (Table 5). They reasoned that the nervous system controls and "balances" body energy thus keeping the neural systems functioning "normally" and "more naturally" allowing the body "to take care of itself" (85%); the mind influences the nervous system thus bringing all body organs under the control of the nervous system (55%); that exercise "tones muscles and organs" by "tuning the nervous system" (80%); and that the ingestion of vitamins "charge the nerves
with energy" (30%) (Table 7). In order to achieve these they would exercise regularly; rest for a minimum of 8 hours daily; maintain a "stress-free", healthy mind; and receive regular chiropractic adjustment. They would do all these to ensure that muscles are "toned" and "energy levels raised" (90%); that the body is able to defend itself with high enough energy levels (85%); that there is "no pressure on the nervous system" by maintaining a "stress-free" and healthy mind (55%); and that the body is more able to take care of and defend itself through regular chiropractic adjustment (55%) (Appendix XIII).

Almost all chiropractors also responded that the body is able to "fix itself in a healthy equilibrium" if not abused (85%); by eating proper diets; and by living a "good lifestyle" (Table 8).

68.3% of new clients and 85% of chiropractors were of the view that the body is able to take care of itself. 31.7% and 5% of new clients and chiropractors respectively, felt that the body is not able to take care of itself (Table 8). Therefore, fewer new clients than chiropractors tended to view the body as capable of curing itself. However, those who felt that the body can cure itself agreed on the reason why they thought so. 70.7% and 85% respectively, of new clients and chiropractors, reasoned that the human body has the properties which will enable it to cure itself. New clients referred to "God given", "ingrained" abilities of the living organism to "cure", "regenerate" and "nourish" itself. Chiropractors were of the view that the body is "programmed" to regenerate. The major difference among the two views was that new clients referred to "germs", poisons and foreign bodies in the blood as disease-causing agents which the body must expel. Chiropractors viewed "homeostatic" properties of the body as the essential protective mechanism
Table 7

Mechanisms for the Maintenance of "Own" Healthy Body: Chiropractors

<table>
<thead>
<tr>
<th>Explanation</th>
<th>Chiropractors *No. of Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervous System Control: &quot;Balances body energy&quot;. Keeps neural systems functioning &quot;normally&quot; and &quot;more naturally&quot; allowing body &quot;to take care of itself&quot;.</td>
<td>17</td>
<td>85.0</td>
</tr>
<tr>
<td>Good Mental Health: The &quot;mind influences the nervous system&quot; especially the &quot;autonomic system&quot;, thus exert influence on all body organs under the control of nervous system. &quot;Healthy mind, healthy body&quot;.</td>
<td>11</td>
<td>55.0</td>
</tr>
<tr>
<td>Excess Habits: &quot;Overloads the body cells and systems leading to disease and illness&quot;.</td>
<td>9</td>
<td>45.0</td>
</tr>
<tr>
<td>Regular Chiropractic Adjustment: &quot;Tones the nervous system&quot;. &quot;Balances body energy uniformly&quot;.</td>
<td>4</td>
<td>20.0</td>
</tr>
<tr>
<td>Exercises: &quot;Tones muscles and organ functions&quot; to keep both at peak &quot;natural performance&quot;. Re-establishes &quot;adequate energy levels in body&quot;. &quot;Promotes rejuvenation&quot; and &quot;elimination of wastes&quot;. &quot;Tunes the nervous system&quot; and &quot;ductless glands&quot;.</td>
<td>16</td>
<td>80.0</td>
</tr>
<tr>
<td>Good Lifestyle: Keeps away poisons from processed foods, alcohol, and smoke, thus enabling body to function naturally without illness.</td>
<td>8</td>
<td>40.0</td>
</tr>
<tr>
<td>Adequate Daily Rest: &quot;Re-establishment of uniform body energy levels&quot;. &quot;Unclogs the mind&quot;. &quot;Gives nervous system latent rest period&quot;.</td>
<td>14</td>
<td>70.0</td>
</tr>
<tr>
<td>Proper Dietary Habits: Not to &quot;overburden the cells&quot; or &quot;poison&quot; them, and &quot;reduce fat content&quot;.</td>
<td>12</td>
<td>60.0</td>
</tr>
<tr>
<td>Daily Vitamin Intake: &quot;Charge the nerves with energy&quot;. &quot;Essential for blood cells to work better&quot;. &quot;Replacement of natural component of body&quot;. &quot;A catalyst which helps uniform energy balance&quot;.</td>
<td>6</td>
<td>30.0</td>
</tr>
</tbody>
</table>

* More than one response.
### Table 8

**Ability of the Human Body to Care for Itself**

**Question:** Do you feel the body is able to care for itself? For example, if you get a cold, it will naturally get healthy?

<table>
<thead>
<tr>
<th></th>
<th>No. of Clients</th>
<th>%</th>
<th>No. of Chiropractors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>41</td>
<td>68.3</td>
<td>17</td>
<td>85.0</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>31.7</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>10.0</td>
</tr>
</tbody>
</table>

**Question:** If yes, how?

- Has natural "god-given", "ingrained" ability as a living organism to "cure", "regenerate" and "nourish itself." (n=41)
  - 29 70.7
- "Self-containing", has "programmed" ability to "regenerate, eliminate waste, replace cells and get rid of poisons". "In the wild, animals do not require drugs to survive." (n=41)
  - 17 85.0
- Body "cells" "attack" and "kill" cold-causing "germs", "virus". (n=41)
  - 12 29.3
- Body to be assisted when unable to "cure" itself - good care, not abused. (n=41)
  - 2 10.0

**Question:** If yes, why?

- Cold causing germs are "foreign bodies to body cells or poisons to blood." (n=41)
  - 29 70.7
- Body tries to "protect" or strengthen weak cells and organs. (n=41)
  - 12 29.3
- Homeostatic properties of body. (n=41)
  - 17 85.0
which prevents germs or anything else from causing disease, provided the nerves are in good working condition (Table 8).

In general, chiropractors and new clients differ in their views of how the human body functions. New clients locate the source of body function in the blood and the circulatory system. They view blood as a source of food energy necessary for body function and as a source of "attack" on germs and foreign bodies. On the other hand, chiropractors view the nervous system as the prime control centre for all body functions responsible for energy accumulation and energy use. The body, therefore, maintains a healthy homeostatic equilibrium of its organs under the influence of the nervous system. Also, the "mind" plays an important part in helping to maintain a healthy body through its influence on the nervous system. At least, in these two areas, chiropractors and new clients do not have the same beliefs regarding the functions of the human body.

5.5 Beliefs About Illness and Disease

The majority of new clients (85%) agreed with chiropractors (100%) that there are many causes of illness (Table 9). They also agreed on some of the causes: for example, germs, virus, infection, trauma, "lifestyle", drug abuse, and lack of regular exercises. However, new clients and chiropractors differed in their emphasis on where the major causes begin and how they function, as well as in the range of causes of illness. Chiropractors included in their list "social causes such as unemployment and related stress" as well as hereditary factors. But the major difference in the views of chiropractors and new clients is that 75% of chiropractors emphasized that illness is caused by a breakdown of
Table 9

Cause(s) of Illness

Question: In your opinion, is there one or more causes of illness(es) such as cold, headache, heart disease?

<table>
<thead>
<tr>
<th></th>
<th>No. of Clients (n=60)</th>
<th>%</th>
<th>No. of Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Cause</td>
<td>9</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>More than one cause</td>
<td>51</td>
<td>85</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

Question: Explain

One Cause:

- Interference with normal working of body, eg. drugs, trauma, etc. 1 1.7
- Disturbance in nervous system 1 1.7
- Invasion by foreign bodies, eg. germs 3 5.0
- "Overuse" or overindulgence 1 1.7
- Poor nutrition, "wrong diet", etc. 2 3.3
- "Damage" to body 1 1.7

*More than one Cause:*

<table>
<thead>
<tr>
<th></th>
<th># Responses</th>
<th>%</th>
<th># Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germs, virus, infection</td>
<td>49</td>
<td>81.6</td>
<td>12</td>
<td>60.0</td>
</tr>
<tr>
<td>Trauma/physical causes</td>
<td>6</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Drug abuse&quot;, certain &quot;drugs&quot; and chemicals</td>
<td>20</td>
<td>33.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atmospheric causes, pollution in air</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Dietary causes&quot;, &quot;unprocessed foods&quot;, &quot;fatty foods&quot;, &quot;salt&quot;, &quot;sugar&quot;, etc.</td>
<td>31</td>
<td>51.6</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Modern lifestyle: &quot;laziness due to automation&quot;, lack of exercise</td>
<td>15</td>
<td>25.0</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Mental stress, life pressures</td>
<td>-</td>
<td>-</td>
<td>12</td>
<td>60.0</td>
</tr>
<tr>
<td>Poorly performing nervous system</td>
<td>-</td>
<td>-</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>Poor mental attitude, social causes eg. unemployment, related stress, hereditary factors</td>
<td>-</td>
<td>-</td>
<td>12</td>
<td>60.0</td>
</tr>
</tbody>
</table>

* Includes items from one cause of illness.
the nervous system. Only 3 of 9 new clients who were of the view that there is one cause of illness attributed the cause to a "disturbance in the nervous system" (Table 9).

While the majority of chiropractors were of the view that "mental stress", "poorly performing nervous system" and "poor mental attitude" cause illness, about the same proportion of new clients responded that "drug abuse", "chemicals", dietary factors, "processed food", air pollution, the effects of modern automation, "salt" and "sugar" are causes of illness (Table 9).

Over two-thirds of new clients explained that germs compete for the same food as body cells which they also "kill", "poison the blood" and destroy organs. They also explained that trauma "injures healthy body cells and organs"; drugs alter the natural body and blood "chemistry"; air pollutants get into blood through the lungs; fatty foods "clog blood vessels" and lack of exercise results in poor blood circulation in the body (Table 10). Therefore, in order to avoid becoming ill, a person should "keep blood cells circulating in the body, free of poisons, germs and foreign bodies"; exercise regularly (52%); avoid sources of infection (43%); avoid smoking cigarettes (43%); and eat sensible foods (42%) (Table 11). Only 10% of the total number of responses from new clients were of the view that the nervous system should be kept free of "blockage" and "interference".

Chiropractors explained in different ways that the nervous system is affected by any cause(s) of illness, therefore, the body would also be affected. For example, most chiropractors were of the opinion that drugs, germs and physical causes of illness influence the coordinating functions of the nervous system, among other things, resulting in inefficiency of function. Other
### Table 10

**Internal Effects of the Cause(s) of Illness: New Clients**

**Question:** How does this cause (or causes) affect the body?  

(n=60)

<table>
<thead>
<tr>
<th>One Cause</th>
<th>No. of Clients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Offsets &quot;natural body rhythm&quot;, either &quot;slows it down&quot; or &quot;quickens it&quot;, clearing the way for disease.</td>
<td>9</td>
<td>15.0</td>
</tr>
<tr>
<td>(b) Organs and cells &quot;not able to function normally&quot; because of foreign body and germs, hence illness or disease.</td>
<td>[Aggregate data for categories (a)-(e)]</td>
<td></td>
</tr>
<tr>
<td>(c) Susceptability to illness when body is &quot;run down&quot; - much like a car.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) Concentration of wrong kind of food in one place, eg. fat, cause illness. Also too little of right kind of food. &quot;Blocks arteries&quot; leading to &quot;poor circulation&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e) Damage to nerves &quot;shuts&quot; down parts of body.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**More than one Cause**

| (a) Germs compete for same food with body cells, "kill body cells", "poison the blood", "destroy organs". | 51 | 85.0 |
| (b) Trauma "injures healthy body cells and organs", sometimes "allows infection or reduced function of affected part". | |
| (c) Drugs alter the natural body and blood "chemistry", "poison the cells" and lead to "damage to nervous system". | |
| (d) Pollutants in air settle in body and lungs, get into blood and cause illness. After a while, body unable to cope, hence illness. | |
| (e) Fat in food "clogs blood vessels", thus, blood unable to "reach all over the body especially the heart". Salt and sugar "thicken the blood", "cause hypertension and diabetes", also chemicals in processed foods. | [Aggregate data for categories (a)-(f)] |
| (f) Body nerves and muscles not fully used because of cars, elevators, dishwashers, all automation. Disuse causes illness, exercise strengthens muscles, improves circulation. | |
Table 11

Avoidance of Illness

Question: How can one avoid being ill?

<table>
<thead>
<tr>
<th>Responses</th>
<th>New Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular or periodic exercises</td>
<td>39</td>
<td>65.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Sensible foods&quot;, &quot;proper nutrition and diet&quot;</td>
<td>25</td>
<td>42.0</td>
<td>19</td>
<td>95.0</td>
</tr>
<tr>
<td>Abstention from alcohol and drugs</td>
<td>31</td>
<td>52.0</td>
<td>12</td>
<td>60.0</td>
</tr>
<tr>
<td>No smoking</td>
<td>26</td>
<td>43.0</td>
<td>19</td>
<td>95.0</td>
</tr>
<tr>
<td>Rest and &quot;adequate sleep&quot;</td>
<td>14</td>
<td>23.0</td>
<td>19</td>
<td>95.0</td>
</tr>
<tr>
<td>Healthy mind, body and thoughts</td>
<td>3</td>
<td>5.0</td>
<td>18</td>
<td>90.0</td>
</tr>
<tr>
<td>&quot;Sensible work habits&quot;, &quot;avoid overwork&quot;</td>
<td>1</td>
<td>2.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Regular [M.D.] checkups</td>
<td>2</td>
<td>3.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Healthy nervous system, &quot;no interference&quot;</td>
<td>6</td>
<td>10.0</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>Well-circulating blood, poison-free</td>
<td>50</td>
<td>83.0</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>Avoid atmospheric pollution</td>
<td>3</td>
<td>5.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Avoid overexposure to temperature extremes</td>
<td>2</td>
<td>3.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Avoid sources of infection, germs, etc.</td>
<td>26</td>
<td>43.0</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>Less dependence on modern automation</td>
<td>1</td>
<td>2.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Daily vitamin intake</td>
<td>2</td>
<td>3.0</td>
<td>16</td>
<td>80.0</td>
</tr>
<tr>
<td>Regular spinal hygiene</td>
<td>-</td>
<td>-</td>
<td>19</td>
<td>95.0</td>
</tr>
<tr>
<td>Meditation</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>5.0</td>
</tr>
</tbody>
</table>
explanations from chiropractors were that unemployment produces mental stress resulting in poor neural function and disease; and that "life pressures" lead to mental stress which leads to uncoordinated functions of the nervous system and "over-activity" due to the release of more body hormones than necessary, for example, adrenalin. Therefore, in order to avoid becoming ill, a person should receive "regular spinal hygiene" ("chiropractic preventive care in which all body nerves are toned"), exercise regularly, diet properly, avoid alcohol, take daily vitamins, avoid smoking, and maintain adequate daily restful periods and, an especially "positive mental attitude". One chiropractor was of the view that "meditation", in addition to regular spinal hygiene and good nutrition, are essential behaviours necessary to keep a healthy body (Table 11).

Overall, chiropractors and new clients differ in some of their views regarding causes of illness, how these causes affect the body, and how to avoid becoming ill. New clients locate causes of illness in blood and the circulatory system where "germs and poisons" attack healthy cells. Chiropractors relate the causes of illness directly or indirectly to the nervous system which is responsible for coordinating all body functions. While the majority of new clients would seek to maintain a healthy body by avoiding germs and poisons and by ensuring that blood is well circulated throughout the body, chiropractors on the other hand, suggest "regular spinal hygiene" or "spinal care" as well as the maintenance of a positive mental attitude (Table 12).
Table 12

Internal Effects of the Cause(s) of Illness: Chiropractors

<table>
<thead>
<tr>
<th>Explanation</th>
<th>No. of Chiropractors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Drugs, trauma, germs, virus: physical causes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Invasion and destruction of body cells and organs.&quot;</td>
<td>13</td>
<td>65.5%</td>
</tr>
<tr>
<td>&quot;Changing of the chemical components of blood and cells.&quot; Release of toxins, overwhelming of protective cells.&quot; Reduction in function of organs. &quot;Influence on nervous systems such as subluxation.&quot; &quot;Uncoordinated activities of cells and organs.&quot; Inefficiency of function.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Mental Stress, Life Pressures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Influences the coordinating centre of the nervous system.&quot; Inefficient coordination and slowness leading to illness from poor neural functions. Sometimes, overactivity releases more hormones than necessary, e.g. adrenalin.</td>
<td>2</td>
<td>10.0%</td>
</tr>
<tr>
<td>(c) Environmental Factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Pollutants are poisons to body and produce disease.&quot;</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td>(d) Social Causes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Unemployment produces mental stress which produces poor neural function followed by disease.&quot; &quot;Overcrowding facilitates cross-infection.&quot;</td>
<td>4</td>
<td>20.0%</td>
</tr>
</tbody>
</table>
5.6 Beliefs About Signs and Symptoms

Chiropractors and new clients have similar beliefs regarding signs and symptoms.

New clients and chiropractors agreed that they "can always tell when they are about to become ill". 8.3% of new clients and 15% of chiropractors said that they "sometimes" can tell when they are about to be ill. One chiropractor responded that he has never become ill in his life (Table 13).

New clients were of the view that they know when they are about to become ill by "intuition" or a "certain feeling"; feeling weak, "not being myself", "unable to do the usual things"; "loss of appetite"; vague aches and pains; "irritability" or "nerves"; experiencing headache; feeling "heaviness" in body and joints; sleeplessness at night; or by experiencing a bad taste in the mouth, dry skin, and frequent perspiration (Table 13).

All chiropractors said they know whether they are about to become ill by a general feeling of unwell, sluggishness, rundown feeling, nauseous feeling and "a lack of energy". In general, they experience the same types of symptoms as new clients (Table 13). However, chiropractors emphasized that "the reduction of energy threshold" during usual activities is an important way to feel the onset of illness.

In general, there are no major differences in personal perceptions and experiences of the signs and symptoms of illness between chiropractors and new clients.
Table 13

Signs and Symptoms

Question: How do you know whether you are about to become ill?

<table>
<thead>
<tr>
<th>Responses</th>
<th>No. of Clients (n=60)</th>
<th>%</th>
<th>No. of Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Intuition, &quot;a certain feeling&quot;, &quot;nauseous&quot;</td>
<td>20</td>
<td>33.3</td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>- &quot;Loss of energy&quot;, weakness, &quot;not being myself&quot;, &quot;unable to do the usual things&quot;</td>
<td>17</td>
<td>28.3</td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>- Vague &quot;aches and pains&quot;</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- &quot;Diminished&quot; or &quot;loss of appetite&quot;</td>
<td>6</td>
<td>10.0</td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>- Sleeplessness at night</td>
<td>2</td>
<td>3.3</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>- &quot;Irritability&quot;, &quot;nerves&quot;</td>
<td>4</td>
<td>6.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Perspiration</td>
<td>1</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Headache</td>
<td>2</td>
<td>3.3</td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>- A feeling of heaviness in body or joints</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dry skin</td>
<td>1</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Bad taste in mouth</td>
<td>1</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- General malaise</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>- Does &quot;not get ill&quot;</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1.7</td>
</tr>
</tbody>
</table>
5.7 Health Habits

Chiropractors and new clients essentially agree on what constitutes good and bad health habits, but they differ in the regularity with which they observe the good habits, and some of their reasons as to why they should observe good health habits.

Higher percentages of chiropractors were of the view that good health habits include regular exercises; ingestion of natural, fibrous foods; abstention from alcohol; judicious or non-use of drugs; not smoking cigarettes; "adequate" rest; and "good thoughts", "open mind" or a positive mental attitude.

An important consideration in the views of chiropractors is that 45% of them considered "regular or periodic chiropractic spinal hygiene" a good habit which every healthy or ill person should observe.

Chiropractors listed 11 bad habits in contrast to 7 bad habits listed by new clients. "Bad" health habits which were included by chiropractors, but not included by new clients are: mental stress, physical stress, irregular medical or chiropractic care, and poor postural habit (Table 14). However, while nearly all chiropractors say that they observe good health habits, less than half the number of new clients do so (Table 15).

New clients reasoned that: exercises improve blood circulation, makes a person fit and personally disciplined; drugs impair circulation and blood function by introducing poisons and foreign chemicals resulting in changes in blood composition; smoking causes lung cancer; fibrous foods prevent cancer; adequate rest allows the body to recover and be able to "fight disease"; and good thoughts "makes you feel good" (Table 16).
Table 14

Beliefs about Good and Bad Health Habits

<table>
<thead>
<tr>
<th></th>
<th>New Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Good Habits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular exercises</td>
<td>32</td>
<td>53.3</td>
<td>19</td>
<td>95.0</td>
</tr>
<tr>
<td>Eating of natural and fibrous</td>
<td>18</td>
<td>30.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>foods</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dieting and &quot;proper nutrition&quot;</td>
<td>-</td>
<td>-</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>Abstinence from alcohol/moderate</td>
<td>10</td>
<td>16.7</td>
<td>18</td>
<td>90.0</td>
</tr>
<tr>
<td>alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non or judicious use of drugs</td>
<td>10</td>
<td>16.7</td>
<td>18</td>
<td>90.0</td>
</tr>
<tr>
<td>Not smoking</td>
<td>31</td>
<td>51.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Adequate&quot; daily rest periods</td>
<td>6</td>
<td>10.0</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>&quot;Good thoughts&quot;, &quot;open mind&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and positive mental attitude</td>
<td>2</td>
<td>3.3</td>
<td>16</td>
<td>80.0</td>
</tr>
<tr>
<td>Regular/Periodic chiropractic</td>
<td>-</td>
<td>-</td>
<td>9</td>
<td>45.0</td>
</tr>
<tr>
<td>spinal hygiene</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bad Habits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of regular exercise routine</td>
<td>38</td>
<td>63.3</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>Eating &quot;processed&quot;, &quot;junk&quot; foods</td>
<td>16</td>
<td>26.7</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>12</td>
<td>20.0</td>
<td>19</td>
<td>95.0</td>
</tr>
<tr>
<td>Drug abuse/addiction</td>
<td>11</td>
<td>18.3</td>
<td>10</td>
<td>50.0</td>
</tr>
<tr>
<td>Smoking</td>
<td>43</td>
<td>71.2</td>
<td>19</td>
<td>95.0</td>
</tr>
<tr>
<td>Sexual promiscuity</td>
<td>2</td>
<td>3.3</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>Overworking, inadequate rest</td>
<td>4</td>
<td>6.7</td>
<td>16</td>
<td>80.0</td>
</tr>
<tr>
<td>Physical and mental stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improper dietary habits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irregular medical or chiropractic</td>
<td>9</td>
<td>45.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor postural habits</td>
<td>7</td>
<td>35.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative attitude</td>
<td>5</td>
<td>25.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Reckless&quot; lifestyle</td>
<td>9</td>
<td>45.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Includes more than one response.
Table 15

Adherence to "Good Health Habits"

Question: Do you follow these (good) health habits?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Sometimes</th>
<th>No. of Clients (n=60)</th>
<th>%</th>
<th>No. of Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>21</td>
<td>12</td>
<td>27</td>
<td>45.0</td>
<td>16</td>
<td>80.0</td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
<td>21</td>
<td>35.0</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td>12</td>
<td>20.0</td>
<td>2</td>
<td>10.0</td>
</tr>
</tbody>
</table>

Reasons for not following good habits

<table>
<thead>
<tr>
<th>Reason</th>
<th>No. of Clients (n=33)</th>
<th>%</th>
<th>No. of Chiropractors (n=4)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too busy, &quot;too busy of late&quot;</td>
<td>15</td>
<td>45.5</td>
<td>2</td>
<td>50.0</td>
</tr>
<tr>
<td>&quot;Laziness&quot;, &quot;procrastination&quot;</td>
<td>11</td>
<td>33.3</td>
<td>1</td>
<td>25.0</td>
</tr>
<tr>
<td>Life pressures (raising children, divorce, relocation)</td>
<td>6</td>
<td>18.2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>&quot;No good reason&quot;</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>25.0</td>
</tr>
</tbody>
</table>
Table 16

Reasons for Good Health Habit Beliefs: New Clients

Question: Let's take the good habits you mentioned first. Explain why they are good habits? (n=60)

<table>
<thead>
<tr>
<th>Habit</th>
<th>Reason</th>
<th>No. of Clients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercises</td>
<td>1. Fitness</td>
<td>10</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>2. Improve blood circulation</td>
<td>18</td>
<td>30.0</td>
</tr>
<tr>
<td></td>
<td>3. Strength, therefore health</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>4. Personal discipline</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>Natural &amp; Fibrous Foods</td>
<td>1. Prevents Cancer</td>
<td>6</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>2. Stomach is entry point to whole body so, must work naturally without disease.</td>
<td>10</td>
<td>16.7</td>
</tr>
<tr>
<td>Little or no Alcohol</td>
<td>1. Alcohol is drug or poison.</td>
<td>8</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>2. &quot;Slows you down&quot;, hence, susceptibility to illness.</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>Little or no Drugs</td>
<td>1. Drug impairs blood function by changing blood composition.</td>
<td>8</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>2. Introduces foreign chemicals to body which cause illness.</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>No Smoking</td>
<td>1. Smoking causes cancer</td>
<td>21</td>
<td>35.0</td>
</tr>
<tr>
<td></td>
<td>2. Smoking retards lung function and impairs breathing, hence, cause illness.</td>
<td>10</td>
<td>16.7</td>
</tr>
<tr>
<td>Adequate Rest</td>
<td>1. Lets body recover and be able to &quot;fight next disease battle&quot;</td>
<td>4</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>2. Promotes healthy &quot;brain&quot;, hence, healthy body.</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>Good Thoughts and Open Mind</td>
<td>1. &quot;Makes you feel good, hence, body will feel good and healthy.</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In contrast, chiropractors reasoned that exercises help the body to maintain "flexibility" and "body motion", "strengthens" and keeps the body in a state of readiness, as well as improves blood circulation and nutrient supply to body cells; alcohol "muddies up" the mental faculty; smoking causes cancer, and drugs poison body cells (Table 17).

Chiropractors also reasoned that good health habits are related to energy levels and functions of the nervous system. For example, they were of the view that adequate rest restored energy levels, ensures equitable energy distribution, and allows the nervous system to rest in order to enhance function later on. "Proper" nutrition is said to increase energy levels, thus, allowing the body to work more efficiently, while positive mental attitude "promotes harmony in the nervous system". To ensure that the body remains healthy, chiropractors suggested that "regular or periodic chiropractic spinal hygiene" or "check up" will tone the nerves and muscles and prevent a breakdown of the nervous system, especially after subluxation. 75% to 100% of chiropractors interviewed were in agreement with most or all of these beliefs.

80% of chiropractors in contrast to 36.7% of new clients, said that there are certain things they "do every day to keep healthy". 63.3% of new clients do not observe daily health habits. More chiropractors, 75%, than new clients, 41%, exercise daily. 55% of chiropractors rest for a minimum of 2 hours daily compared to 4.5% of new clients. More importantly, 55% of chiropractors have practiced daily health habits for over 5 years compared to 9.2% of new clients.

New clients said they undertake these habits in order to "improve blood circulation" or "keep the blood flowing to weak parts of the body", "to
Table 17
Reasons for Good Health Habit Beliefs: Chiropractors

**Question:** Let's take the good habits you mentioned first, please explain why they are good habits?

<table>
<thead>
<tr>
<th>Good Habits</th>
<th>No. of Chiropractors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exercises</strong></td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>1. Maintains &quot;flexibility&quot; and &quot;body motion&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. &quot;Strengthens&quot; the organism.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Improves blood circulation, &quot;keeps same at &quot;good levels&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. &quot;Rids body of waste products.&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Nutrient supply to cells.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Abstinence from Alcohol/Moderate alcohol</strong></td>
<td>15</td>
<td>75</td>
</tr>
<tr>
<td>1. Damage to internal organs, eg. liver.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Keeps mental faculty clear.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Does not deteriorate nutrients to body.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Not Smoking</strong></td>
<td>18</td>
<td>90</td>
</tr>
<tr>
<td>1. Prevents Lung cancer.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Expensive habit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Retards lung function/less oxygen intake.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adequate Rest</strong></td>
<td>18</td>
<td>90</td>
</tr>
<tr>
<td>1. Restores energy level to overworked body.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Equitable energy distribution in body.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Rests nervous system thus enhances function.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>&quot;Proper&quot; Nutrition and Diet</strong></td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>1. Body works more efficiently without harm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Increases body energy levels.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Positive Mental Attitude</strong></td>
<td>17</td>
<td>85</td>
</tr>
<tr>
<td>1. Helps set a &quot;healthy&quot; goal without &quot;too much anxiety&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Promotes harmony in nervous system.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Regular or Periodic Chiropractic Spinal Hygiene</strong></td>
<td>16</td>
<td>80</td>
</tr>
<tr>
<td>1. Tones nerves and muscles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Prevents breakdown of nervous system.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Prevents subluxation and nerve pressure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Use of Drugs</strong></td>
<td>17</td>
<td>85</td>
</tr>
<tr>
<td>Poison to healthy cells and organs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
strengthen body against disease", to prevent "heart attack", "not to get sick", to keep cells "well nourished with right foods", and to supply "vitamin strength" to cells.

Chiropractors, on the other hand, said they practice personal health habits in order to "tone the central nervous system and muscles", rejuvenate mental energy" by keeping the body "in a state of readiness", ensure "right amount of body nutrients, "to sustain energy", "to recharge the nervous system", and "harmonize mind and body".

New clients felt that their "conditions" would "get worse", there could be more pain, or that they would not be strong enough to do things if they did not observe good personal health habits. On the other hand, chiropractors felt that they needed to "keep the nervous system at "optimum function" necessary for "optimum coordination of body functions". They felt that failure to observe personal health habits could also lead to "inefficiency" of body cells including nerve cells, muscle "atrophy from disuse", and a possibility of subluxation in the spinal column.

In summary, fewer new clients than chiropractors were more convinced about their beliefs regarding good and bad habits, as well as the importance of the daily observation of good habits. Chiropractors identify more areas of good and bad habits than clients. They suggest "regular chiropractic check-up" as a way to maintain good health. Chiropractors also considered mental stress and poor posture as bad habits. An important difference between the beliefs of chiropractors and new clients were the identified locations of the prime "vehicles" for ensuring a healthy body. New clients locate theirs in the blood and the circulatory system, chiropractors locate theirs in the nervous system. Also,
chiropractors introduced the notion of "energy" in the maintenance of good health habits and a healthy body, and they also located energy in the nervous system, while new clients locate energy in the blood and the circulatory system.

5.8 Beliefs About Treatment Systems and Professional Healers

Chiropractors and new clients both show variation regarding choice of treatment systems and healers. Nevertheless, there are some important differences in their respective beliefs.

The majority of new clients generally preferred to be treated with the following when they become ill: drugs, exercises, and dietary regimes. All chiropractors generally preferred rest, chiropractic adjustment, medication including surgery, vitamins, and "fluids" (Table 18). Most chiropractors noted that the type of treatment would depend on the nature of ill-health, but most would undergo surgery if necessary.

When new clients and chiropractors were provided with a list of treatment types, and asked to indicate the type of treatment they most preferred, about half the number of new clients, and none of the chiropractors, most preferred medication with drugs. A few new clients and more than half the number of chiropractors most preferred herbs and naturally occurring substances and no chiropractor most preferred surgery. However, more chiropractors than new clients most preferred using the hands in treatment. The belief of chiropractors in the ability of the body to cure itself and to heal naturally is


Table 18
Preferences for Treatment Types

Question: Can you tell me what type of treatment you generally prefer when you are ill?

<table>
<thead>
<tr>
<th></th>
<th>Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupressure</td>
<td>-</td>
<td>-</td>
<td>16</td>
<td>20.0</td>
</tr>
<tr>
<td>Medication/drugs</td>
<td>32</td>
<td>53.3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rest</td>
<td>2</td>
<td>3.3</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>Dietary/Nutritional</td>
<td>5</td>
<td>8.4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Treatment with naturally occurring substances</td>
<td>3</td>
<td>5.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Exercises</td>
<td>10</td>
<td>16.7</td>
<td>7</td>
<td>35</td>
</tr>
<tr>
<td>Contrast baths</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Massage</td>
<td>3</td>
<td>5.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Meditation</td>
<td>2</td>
<td>3.3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prayer/Spiritual healing</td>
<td>1</td>
<td>1.7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Adjustment/Manipulation</td>
<td>2</td>
<td>3.3</td>
<td>17</td>
<td>85.0</td>
</tr>
<tr>
<td>Vitamins</td>
<td>-</td>
<td>-</td>
<td>13</td>
<td>65.0</td>
</tr>
<tr>
<td>Medical Doctor [M.D.] including drugs/surgery</td>
<td>-</td>
<td>-</td>
<td>14</td>
<td>70.0</td>
</tr>
<tr>
<td>Fluids</td>
<td>-</td>
<td>-</td>
<td>8</td>
<td>40.0</td>
</tr>
<tr>
<td>Cryotherapy (ice treatment)</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>Don't Know</td>
<td>7</td>
<td>11.7</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Question: Which of the following types of treatment do you most prefer?

<table>
<thead>
<tr>
<th></th>
<th>Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of drugs/medication</td>
<td>29</td>
<td>48.3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Natural herbs and naturally occurring substances</td>
<td>9</td>
<td>15.0</td>
<td>12</td>
<td>60.0</td>
</tr>
<tr>
<td>Opening the body and removing whatever is thought to cause the problem</td>
<td>4</td>
<td>6.7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Using hands to fix the body</td>
<td>11</td>
<td>18.3</td>
<td>8</td>
<td>40.0</td>
</tr>
<tr>
<td>Other:</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>3</td>
<td>5.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Spiritual Healing</td>
<td>3</td>
<td>5.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Meditation</td>
<td>1</td>
<td>1.7</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* Contains more than one response by Chiropractors.
reflected in their belief in using herbs and naturally occurring substances in treatment. "Hands" only assist the process.

About half of all new clients most preferred medication because it relieves pain, provides fast and quick treatment, has "immediate results", can be taken home, "fights" and "kills" germs, and "correction ant internal problems". New clients also most preferred surgery because it is fast and immediate, localized, and results in the removal of the problem. No chiropractor most preferred either medication or surgery (Table 19).

Chiropractors most preferred naturally occurring substances and herbs in treatment because the human body is "a natural thing itself", and because herbs encourage natural healing because natural cells of herbs will be more "in tune" with natural cells of the body than "artificial products". Some clients, although fewer in number, held the same views (Table 19).

Chiropractors most prefer using the hand in treatment because it "puts the human feel" in it, it is "a more accurate way to feel tension", it's "less threatening than machines", and it provides a "soothing act from one human being to another". Some of the new clients agreed.

The majority of new clients and chiropractors, 70% and 90%, respectively, have received treatment from allopathic physicians [M.D.]. However, some new clients and chiropractors have also sought treatment from physiotherapists, naturopaths, acupuncturists, nutritionists and faith healers.

In conclusion, chiropractors and new clients have different beliefs about types of treatments. The majority of clients "most prefer" medication with drugs and surgery. None of the chiropractors "most prefer" these types of treatment although they are willing to receive them under emergency conditions.
## Table 19

### Reason for Most Preferred Type of Treatment

**Question:** Why do you most prefer this treatment?

<table>
<thead>
<tr>
<th>NEW CLIENTS</th>
<th>No. of Clients (n=60)</th>
<th>%</th>
<th>No. of Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medication/Drugs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relief of pain, &quot;fast and quick treatment&quot;, &quot;immediate results&quot;, &quot;can be taken at home&quot;, &quot;fights&quot; and &quot;killed&quot; germs, &quot;corrects internal problems&quot;</td>
<td>29</td>
<td>48.3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Natural Herbs/Substances</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;More natural&quot; like body, less likely to cause internal problem or &quot;poison body&quot;, &quot;closer to human body cells&quot;</td>
<td>9</td>
<td>15.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Opening the Body/Removing Cause of Problem</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fast and immediate, localized treatment and solution, removes source of problem or corrects it</td>
<td>3</td>
<td>6.7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Using Hands to Fix the Body</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Not artificial&quot;, &quot;Better feel from body to body, &quot;Soothing&quot;</td>
<td>11</td>
<td>18.3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture: Immediate relief.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual healing: &quot;Tends to body and soul, supernatural&quot;, Meditation: Self-mobilization of energy</td>
<td>7</td>
<td>11.7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>CHIROPRACTORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Natural Herbs/Substances</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body - &quot;a natural thing itself&quot;, promotes the healing powers of the body. Body cells more in time with natural than artificial products</td>
<td>12</td>
<td>60.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Using Hands to Fix the Body</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Hands put the human feel in treatment&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A more &quot;accurate way to feel tension&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Less threatening than machines&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Soothing act from one human being to another&quot;</td>
<td>8</td>
<td>40.0</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Rather, they most prefer herbs, natural substances, and use of hands, as treatments for health problems.

5.9 Explanatory Models of New Clients and Chiropractors (Tables 20-30)

Explanatory models [EMs] are about the "present" health problems of new clients, how new clients make sense of their sufferings, and how they explain them. Explanatory models also are about the meaning and understanding that chiropractors apply to the "resolution" and treatment of clients' health problems.

I have shown in Section 5.7 that there are important differences between the health beliefs of new clients and chiropractors - differences which appear to predict different clinical realities for each group.

In order to reconcile the different realities and expectations during clinical interactions, new clients and chiropractors must negotiate their differences, in a process of "give and take", if each of the partners in the negotiation is to achieve a measure of his or her objective, and more importantly, if their relationship is to continue.

In presenting the pre-interaction data on explanatory models [EMs] of new clients and chiropractors, I have used a format which allows for direct comparisons of responses to interview questions. Each of the ten tables focuses on an aspect of the explanatory models. As much as possible, I have used some of the actual words and phrases as well as the questions in order to minimize errors in the interpretation of responses.
Prior to visiting a chiropractic clinic, almost all of the new clients have tried to alleviate their pain and suffering through a variety of means. Many of them tried to "self-medicate", 32%, and modify their eating habits, 12%, while some tried to reduce their work and daily activities, 4%. A few clients tried different remedies including spiritual healing (Table 20).

The range of "activities" that were aimed at obtaining some relief from pain and suffering indicated some degree of desperation. Although the majority of new clients preferred medication with drugs (Tables 18 and 19), they sought the help of an alternative health care practitioner - the chiropractor - although almost all of them were still visiting their family doctors [M.Ds] (Table 21).

Some chiropractors agree with some of the remedies new clients have used to try to alleviate their pain and suffering, for example, heat therapy and rest. However, the majority of the chiropractors would advise new clients to take their health complaints to the chiropractor (80%) and seek counsel on posture management (60%) (Table 20). Thus, while many new patients would rather self-medicate and diet, many chiropractors would recommend chiropractic treatment.

About 92% of new clients sought help from ten different sources, primarily from allopathic physicians and friends. Chiropractors thought that new clients should be seeking help from chiropractic as well as from allopathic physicians (Table 21). They were, however, less enthusiastic in suggesting that new clients seek help from other ancillary or alternate health care groups, for example, naturopaths, nutritionists, and physiotherapists.
Table 20

Behaviours Relating to "Present" Health Problem

Question: [Clients] What have you done by yourself about the problem before now?
[Chiropractors] What will you suggest patients with these kinds of problem do before going to see a professional healer?

<table>
<thead>
<tr>
<th>Behaviours</th>
<th>Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-medicate with patent medicines, etc.</td>
<td>19</td>
<td>31.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modification of dietary habits</td>
<td>7</td>
<td>11.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Application of heat and cold remedies</td>
<td>6</td>
<td>10.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased rest periods</td>
<td>2</td>
<td>3.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce work activities</td>
<td>2</td>
<td>3.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual healing</td>
<td>4</td>
<td>6.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Ignore it&quot;, &quot;leave it alone&quot; to heal itself</td>
<td>1</td>
<td>1.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased exercise activities, eg. swimming</td>
<td>4</td>
<td>6.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carry out pain relief activities, eg. lying down</td>
<td>7</td>
<td>11.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Ask around for help&quot;</td>
<td>1</td>
<td>1.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No action</td>
<td>7</td>
<td>11.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seek counsel on posture management</td>
<td>12</td>
<td>60.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtain first aid treatment if acute injury</td>
<td>14</td>
<td>70.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visit hospital emergency if acute injury</td>
<td>10</td>
<td>50.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visit the nearest chiropractor</td>
<td>16</td>
<td>80.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rest, then visit a chiropractor</td>
<td>11</td>
<td>55.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apply heat or ice pack to area, then visit a chiropractor</td>
<td>9</td>
<td>45.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate positioning</td>
<td>5</td>
<td>25.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elastic bandaging if acute injury</td>
<td>4</td>
<td>20.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immobilize if concerned about fracture</td>
<td>3</td>
<td>15.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;A matter of ethics, people get sued&quot;</td>
<td>1</td>
<td>5.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Contains more than one response by all Chiropractors.
Table 21

Help-Seeking for "Present" Illness

Question: [Clients] Have you sought help from other people? [Chiropractors] Do you think (new clients) should seek help from other people?

<table>
<thead>
<tr>
<th></th>
<th>Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sought help</td>
<td>55</td>
<td>91.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not seek help</td>
<td>5</td>
<td>8.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractors:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>20</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

Question: If yes, what other kinds of help?

<table>
<thead>
<tr>
<th>Kind of Help</th>
<th>Clients</th>
<th>%</th>
<th>Chiropractors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Doctor [M.D.]</td>
<td>45</td>
<td>75.0</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>Spiritual healer</td>
<td>3</td>
<td>5.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>5</td>
<td>9.0</td>
<td>4</td>
<td>20.0</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>3</td>
<td>5.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Naturopath</td>
<td>4</td>
<td>6.7</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>Accupuncturist</td>
<td>4</td>
<td>6.7</td>
<td>8</td>
<td>40.0</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>2</td>
<td>3.3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Family member</td>
<td>8</td>
<td>13.3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Friend</td>
<td>19</td>
<td>31.7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Two or more of the above</td>
<td>7</td>
<td>11.7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other health service if available</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>30.0</td>
</tr>
<tr>
<td>Osteopath</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>35.0</td>
</tr>
</tbody>
</table>
In general, prior to the actual interaction with chiropractors, almost all new clients expressed some concerns about chiropractic treatment. The main concerns were whether they would experience "more pain" and discomfort, 23%, not knowing what to expect, 27%, the possibility of further "damage" to the healthier parts of the body, 18%, and the possibility of "quackery", 5% (Table 22). Some of them worried about their ignorance of chiropractic health care, whether they had made mistakes in seeking chiropractic treatment, as well as "the characteristics of the chiropractor". Also, there was the possibility that chiropractic treatment may not help their health problems.

Clients' concerns and apprehensions about chiropractic were supported by the concerns of chiropractors themselves. Sixteen of the twenty chiropractors worried about accidental damage to body structures. As one young chiropractor put it: "People get sued!" The other chiropractors worried about "bad" or inappropriate procedures, 75%, failure in obtaining appropriate "history" of the health problem, 100%, the general health status of the new clients, 100%, the presence of serious medical problems such as osteoporosis or bone with depleted calcium content, 95%, and the danger of "stroke" while providing treatment by manipulation, 65% (Table 22).

It appeared, therefore, that both the new clients and chiropractors were equally apprehensive of the clinical encounters. It appeared also that both groups would be entering the clinical interaction setting on "equal" grounds, at least from the point of view of the concerns and apprehensions each group had shown. Both interactants wanted something from the other - new clients sought some relief from pain or discomfort, chiropractors wanted to make them chiropractic patients. Whether or not both groups would negotiate their EMs as
Table 22

Concerns about Chiropractic Treatment

Question: [Client] What kind of concern do you have, if any, about undergoing Chiropractic treatment?
[Chiropractors] What are your concerns, if any, about the administration of these kinds of treatment?

<table>
<thead>
<tr>
<th>Concern</th>
<th>Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause &quot;more pain&quot; and discomfort</td>
<td>14</td>
<td>23.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;May cause more damage&quot;</td>
<td>7</td>
<td>11.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;May damage&quot; healthy parts of body</td>
<td>4</td>
<td>6.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May not help the problem</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>1</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear of unknown</td>
<td>16</td>
<td>26.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possibility of &quot;quackery&quot;</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Lack of medical knowledge&quot;</td>
<td>1</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionalism</td>
<td>1</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal ignorance about chiropractic</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Characteristics of the chiropractor&quot;</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No concerns</td>
<td>4</td>
<td>6.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment by untrained persons</td>
<td></td>
<td></td>
<td>18</td>
<td>90.0</td>
</tr>
<tr>
<td>Accidental damage to body structures</td>
<td>16</td>
<td>80.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inability to rule out other medical problems</td>
<td>19</td>
<td>95.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Bad&quot; or inappropriate procedure</td>
<td>15</td>
<td>75.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inability to obtain appropriate history</td>
<td>20</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General health status of patient</td>
<td>20</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Danger of stroke during cervical manipulation</td>
<td></td>
<td></td>
<td>13</td>
<td>65.0</td>
</tr>
</tbody>
</table>
"equal partners" would depend on their separate definitions of the situation in the behaviour settings, and what compromises would be important enough to be made in order for each to realize a measure of his objectives.

Chiropractors and new clients agree essentially on the broad definitions of clients' health problems. The majority of new clients reported back and joint problems. During the initial visits of new clients to chiropractic clinics, most of their health complaints were labelled back and joint problems by chiropractors. However, chiropractors were more specific in their characterization of clients' health complaints. For example, terms such as "nerve root pressure", "postural deformities" and "pinched nerve" were used at some point during the physical examination (Table 23).

An unusual observation in the responses of chiropractors is the categorization of subluxation as a health complaint. It is generally accepted by chiropractors and their critics that subluxation is a major cause of different health problems such as dizziness, headaches and other problems. By identifying subluxation as a separate health problem, chiropractors may be emphasizing the modern day belief that there are many causes of illness. In general, the health complaints of new clients and those reported by chiropractors themselves, may be said to be similar.

(a) Cause of "Present" Illness

About two-thirds of new clients claimed to know the cause of the illness for which they wished to see a chiropractor. Most of the new clients who felt they knew the cause of their "current" health problems attributed the cause to blood and circulatory problems, "germs" and "infection", 42% (Table 24). Other
### Table 23

**Health Complaints of New Clients**

**Question:** What is the problem for which you want to see a chiropractor?

<table>
<thead>
<tr>
<th>Reported by New Clients prior to Initial Visit</th>
<th>No. of Clients (n=60)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pain or discomfort in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General back</td>
<td>18</td>
<td>30.0</td>
</tr>
<tr>
<td>Lower back</td>
<td>11</td>
<td>18.3</td>
</tr>
<tr>
<td>Muscles and/or bones</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td>Neck and shoulder</td>
<td>8</td>
<td>13.4</td>
</tr>
<tr>
<td>Extremities (arm, leg joints)</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td>2. Tension, &quot;nerves&quot;</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>3. &quot;Dizziness&quot;</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>4. &quot;Stomach problem&quot;</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>5. Headache/Migraine</td>
<td>4</td>
<td>6.7</td>
</tr>
<tr>
<td>6. Weakness (generalized)</td>
<td>4</td>
<td>6.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Labeled by Chiropractors at Time of Initial Visit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lower Back (&quot;nerve root pressure&quot;, &quot;pinched nerves&quot;)</td>
<td>8</td>
</tr>
<tr>
<td>2. General Back (&quot;Subluxation&quot;, &quot;Scoliosis&quot;, &quot;Postural deformities&quot;)</td>
<td>14</td>
</tr>
<tr>
<td>4. &quot;Nerve Tension&quot;</td>
<td></td>
</tr>
<tr>
<td>5. General Malaise/Weakness (Poor health habit/diet, poor spinal hygiene)</td>
<td>5</td>
</tr>
<tr>
<td>6. Rheumatism</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 24

Cause of Present Illness

Question: What do you think has caused your problem?

<table>
<thead>
<tr>
<th>Know</th>
<th>No. of Clients (n=60)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>68.3</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>31.7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Don't Know</th>
<th>No. of Chiropractors (n=22)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Question: What do you think has caused your problem? (n=41)

| Poor habits | 2 | 4.9 |
| Germs/infection | 5 | 12.1 |
| Blood and circulatory problems | 12 | 29.3 |
| Accident/trauma | 7 | 17.1 |
| Changes in weather conditions | 7 | 17.1 |
| Occupation | 7 | 17.1 |
| Cultural/hereditary | 1 | 2.4 |

Question: [Chiropractors] What is the cause or causes of illness(es) you see most often in your practice? *No. of Responses

| Trauma/injuries (sports, occupation, leisure) | 20 | 100.0 |
| "Subluxation" from poor posture/injuries | 20 | 100.0 |
| Lack of knowledge of body mechanics | 17 | 85.0 |
| "Lack of spinal hygiene" | 18 | 90.0 |
| Old or chronic injuries | 13 | 65.0 |
| Poor dietary habits | 11 | 55.0 |
| "Postural strain" and "tension" | 16 | 80.0 |
| Lifestyle | 18 | 90.0 |

* Each Chiropractor gave more than four responses.
causes related to accidents, changes in climatic conditions, occupational hazards, and hereditary factors.

By contrast, chiropractors attributed the causes of illnesses they saw "most often" in their clinics to subluxation from poor posture, 100%, "postural strain and tension", 80%, trauma, 100%, lifestyle, 90%, and old, chronic injuries, 65% (Table 24).

The main difference in the attribution of causes to the "present" illness problems is the location of cause in blood and the circulatory system by new clients in contrast to subluxation, which, at least in the context of this study, fulfills the role of a "cause" of illness rather than that of a health problem, in the view of chiropractors.

(b) Onset of Illness

About half or 50% of new clients thought that their illnesses began when they did because of poor health habits, for example, cigarette smoking and lack of regular exercise routine, sleeplessness, "overwork", "overweight" and "recent overindulgence", for example, "partying" and "sexual promiscuity". A few clients were of the view that the separation from their spouses or divorces, 5%, or "adverse weather conditions", 5%, triggered their illnesses (Table 25).

By contrast, chiropractors were of the view that the onset of the various illnesses were the result of "poor spinal hygiene" - a sort of chiropractic health maintenance therapy, 100%, "nerve-root pressure", 95%, "pinched nerve", 70%, injury, 100%, and poor health habits leading to the "deterioration of the protective and the defensive mechanisms of the body", 65% (Table 25).
Table 25

Reasons for the Onset of Illness(es)

Question: [New Client] Why do you think it (your problem) started when it did?

<table>
<thead>
<tr>
<th>Reason</th>
<th>No. of Clients (n=60)</th>
<th>%</th>
<th>No. of Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor personal care</td>
<td>5</td>
<td>8.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor habits (diet, smoking, lack of exercise)</td>
<td>9</td>
<td>15.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heredity (family trait)</td>
<td>1</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Recent overindulgence&quot; (&quot;partying&quot;, &quot;sexual&quot;)</td>
<td>6</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleeplessness</td>
<td>7</td>
<td>11.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Overwork&quot;</td>
<td>2</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Adverse weather condition&quot;</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spousal separation/divorce</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal body changes (non-specific)</td>
<td>2</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overweight</td>
<td>8</td>
<td>13.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don't know</td>
<td>14</td>
<td>23.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Question: [Chiropractors] Why do you think illness(es) that you see begin when they do?

<table>
<thead>
<tr>
<th>Reason</th>
<th>No. of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor spinal hygiene, leading to poor posture</td>
<td>20</td>
</tr>
<tr>
<td>&quot;Nerve root pressure&quot;</td>
<td>19</td>
</tr>
<tr>
<td>&quot;Pinched nerve&quot;</td>
<td>14</td>
</tr>
<tr>
<td>Injury, trauma, accidents</td>
<td>20</td>
</tr>
<tr>
<td>Inadequate initial medical/health care</td>
<td>15</td>
</tr>
<tr>
<td>Poor health habits &quot;leading to deterioration of defensive and protective mechanisms&quot;</td>
<td>13</td>
</tr>
<tr>
<td>&quot;Loss of energy&quot;/&quot;energy imbalance&quot;</td>
<td>16</td>
</tr>
<tr>
<td>Cumulative results of poor dietary habits</td>
<td>9</td>
</tr>
<tr>
<td>Cumulative effects of lifestyle and habits</td>
<td>17</td>
</tr>
<tr>
<td>Accumulation of toxic substances in body structures, organ and blood</td>
<td>11</td>
</tr>
<tr>
<td>Wear and tear of body structures</td>
<td>13</td>
</tr>
</tbody>
</table>
An important and significant view by 16 of the 20 chiropractors is that the "loss of energy" and "energy imbalance" in the body triggers illness.

(c) The "Working" of Illness in the Body

New clients used a mechanical analogy to describe the process or the "working" of illness in their body, and to relate these to functional abilities. In contrast, chiropractors offered explanations couched in "scientific" jargon largely unfamiliar to clients.

Most new clients were of the view that their illness travels "up and down", "moves around", "attacks" body organs and joints, "blocks blood flow", "thickens" blood or makes it "watery", "stops" blood supply to painful area, "kills" or "poisons" healthy cells, organ and blood and "prevents" food from reaching the organs (Table 26). About 28% of new clients did not present any views about the working of illness in the body.

In general, the views of new clients about how their "present" illnesses work in the body is consistent with their health beliefs [HMs] regarding their views regarding the ability of the human body to remain healthy (see Table 5).

By contrast, chiropractors used such terms as "subluxation", "faulty musculo-skeletal relationships", "homeostasis"\(^1\), and "innate intelligence"\(^3\) to explain the workings of illness in the body (Table 26). Relatedly, 80% of chiropractors saw illness as disturbances in the working and functions of the nervous system.

The major differences in the views and explanations of new clients and chiropractors regarding the "working" of illness in the body pertain to both the location of the illness and its processes. New clients locate illness in blood
Table 26

The "Working" of Illness(es) in the Body

Question: [Clients] How do you think illness works in your body?

<table>
<thead>
<tr>
<th>No. of Responses</th>
<th>Clients (n=60)</th>
<th>Chiropractors (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Travels &quot;up and down&quot;, &quot;moves around&quot;</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>&quot;Tightens&quot;, &quot;stops&quot; or &quot;slows down&quot; nerves/muscles</td>
<td>5</td>
<td>8.4</td>
</tr>
<tr>
<td>&quot;Attacks&quot; body organs and joints</td>
<td>12</td>
<td>20.0</td>
</tr>
<tr>
<td>Stays in place and &quot;blocks blood flow&quot;</td>
<td>3</td>
<td>5.0</td>
</tr>
<tr>
<td>&quot;Prevents food&quot; and nutrient supply to organs</td>
<td>14</td>
<td>23.4</td>
</tr>
<tr>
<td>&quot;Thickens&quot; blood or makes it &quot;watery&quot;</td>
<td>3</td>
<td>5.0</td>
</tr>
<tr>
<td>&quot;Stops blood supply&quot; to painful area</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>&quot;Kills&quot; or &quot;poisons&quot; healthy cells, organs or blood</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>Don't know</td>
<td>17</td>
<td>28.3</td>
</tr>
</tbody>
</table>

Question: [Chiropractors] How do you think illness works in the body?

- "Innate intelligence": Disturbances in the coordinating functions of the nervous system leading to release of minute quantities of substances which alter body and organ functions, eg. ductless glands. 16 80.0
- "Homeostasis": Problems in the ability of the body to return to "normal state" through a system of control mechanisms activated by "negative feedback" 18 90.0
- "Faulty Musculoskeletal relationships" which cause "nervous system dysfunctions", eg. "disk problems", "nerve root pressure", "compression" 20 100.0
- "Subluxation": "Skeletal disrelations" in the spinal structures leading to "loss of integrity of the nervous system, hence, loss of health elsewhere in the body" 20 100.0
- "Poor mental health" leading to "tired" nervous system which causes problems to the organs they supply 5 25.0
and the circulatory system or in the "transportation system" of the body, chiropractors locate illness in the nervous system or in the "control mechanisms" of the body. While new clients use descriptions such as travelling, preventing, tightening, attacking, thickening, killing and blocking, chiropractors refer to coordination functions, control functions, and "negative feedback".

In the clinical encounter between chiropractor and client, these perceptual differences need to be negotiated in order for treatment to occur.

(d) The Effects of Illness in the Body

The majority of new clients were of the view that their "present" illness slowed down their body functions, caused the organs to work in "bits and pieces", locked their joints, "sapped" energy, and generally caused feelings of "jumpiness", "tension" and "irritability".

Chiropractors referred to the biological, physiological, and biochemical changes that are associated with illness. Unlike new clients, chiropractors used "scientific" explanations to describe the effect of illness within the body. It is significant that nearly all chiropractors, 90%, viewed the effect of illness as resulting in change in the "balance of forces" and "energy", including mental energy (Table 27).

Again, a new concept has been included in the EM of chiropractors, namely, the concept of force, which in other situations has been used synonymously with the concept of "energy". These concepts appear to occupy central locations in the chiropractic philosophy, and they appear to be covered by the general
### Table 27

**Effects of Illness in the Body**

**Question: [Clients] What effect do you think your illness has within your body?**

<table>
<thead>
<tr>
<th>Effect Description</th>
<th>No. of Responses (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slows down body functions</td>
<td>6</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body functions working in &quot;bits and pieces&quot;</td>
<td>7</td>
<td>11.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Locks&quot; the bone, spine, nerves, body</td>
<td>11</td>
<td>18.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Saps&quot; energy, &quot;Draining&quot;</td>
<td>4</td>
<td>6.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling of &quot;heaviness&quot;</td>
<td>5</td>
<td>8.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Tightness&quot; or &quot;knot&quot; in the area</td>
<td>5</td>
<td>8.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Jumpiness&quot;, &quot;tension&quot;, &quot;irritability of nerves&quot;</td>
<td>7</td>
<td>11.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don't know</td>
<td>15</td>
<td>25.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Question: [Chiropractors] What effect do you think an illness or illnesses have within the body?**

<table>
<thead>
<tr>
<th>Effect Description</th>
<th>No. of Responses (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nerve irritation</td>
<td>15</td>
<td>75.0</td>
</tr>
<tr>
<td>Damage to or &quot;wear and tear of body structures&quot;</td>
<td>15</td>
<td>75.0</td>
</tr>
<tr>
<td>Pain leading to &quot;muscle spasm of vertebral system&quot; which spills over to other areas</td>
<td>18</td>
<td>90.0</td>
</tr>
<tr>
<td>Biological change</td>
<td>7</td>
<td>35.0</td>
</tr>
<tr>
<td>Physiological change</td>
<td>4</td>
<td>20.0</td>
</tr>
<tr>
<td>Change in the balance of &quot;forces&quot; and &quot;energy&quot; including mental energy. Also leading to other kinds of health problems</td>
<td>18</td>
<td>90.0</td>
</tr>
<tr>
<td>Biomechanical change</td>
<td>13</td>
<td>65.0</td>
</tr>
</tbody>
</table>
concept of "innate intelligence". However, chiropractors and new clients have different explanations about the effect of illness in the body (Table 27).

(e) Severity and Duration of Illness

Both new clients and chiropractors considered the illnesses they "presently" had or saw in the clinics as severe or very severe. However, 80% of chiropractors, in contrast to 65% of new clients thought that the illnesses they "presently" had or saw in the clinics would have a short course. Chiropractors were, therefore, slightly more optimistic than new clients about the course an illness would take. Both new clients, 73%, and chiropractors, 80%, estimated the illnesses to last for short durations of less than 12 months (Table 28).

There were, therefore, no major differences in the perceptions of new clients and chiropractors regarding the severity and duration of "present" illnesses.

(f) Expected Treatment for "Present" Illness

New clients and chiropractors preferred different types of treatments for "present" illness problems. About a quarter of new clients preferred medication or treatment with drugs; others preferred surgery; counselling; exercises, medication, massage or any combination of these. 12% of new clients did not have or know of any preferred treatments (Table 29). In contrast, most chiropractors recommended adjustment or manipulation, exercises, massage, "full spine technique", bed rest, spinal hygiene, and special activities. In addition, chiropractors endorsed cryotherapy or ice treatment, Japanese "Shiatzu"
Table 28

Severity and Duration of Illness

**Question: [Clients] How severe is your sickness? [Chiropractors] ...the illness you see in your practice?**

<table>
<thead>
<tr>
<th></th>
<th>Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>2</td>
<td>3.3</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>Severe</td>
<td>23</td>
<td>38.4</td>
<td>14</td>
<td>70.0</td>
</tr>
<tr>
<td>Very Severe</td>
<td>27</td>
<td>45.0</td>
<td>17</td>
<td>85.0</td>
</tr>
<tr>
<td>Not Severe</td>
<td>6</td>
<td>10.0</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>Inconvenient</td>
<td>2</td>
<td>3.3</td>
<td>17</td>
<td>85.0</td>
</tr>
</tbody>
</table>

**Question: [Clients] Do you think it will have a long or short course? [Chiropractors] Do they (the illnesses) have a long or short course?**

<table>
<thead>
<tr>
<th></th>
<th>Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Course</td>
<td>15</td>
<td>25.0</td>
<td>4</td>
<td>20.0</td>
</tr>
<tr>
<td>Short Course</td>
<td>39</td>
<td>65.0</td>
<td>16</td>
<td>80.0</td>
</tr>
<tr>
<td>Long and Short Courses</td>
<td>-</td>
<td>-</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>Don't Know</td>
<td>6</td>
<td>10.0</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Question: [Clients] How long do you think? [Chiropractors] How long or short a course?**

<table>
<thead>
<tr>
<th></th>
<th>Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-6 months</td>
<td>26</td>
<td>43.0</td>
<td>12</td>
<td>60.0</td>
</tr>
<tr>
<td>7-12 months</td>
<td>18</td>
<td>30.0</td>
<td>4</td>
<td>20.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-36 months</td>
<td>11</td>
<td>18.0</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Over 36 months</td>
<td>1</td>
<td>2.0</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>Don't Know</td>
<td>4</td>
<td>7.0</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
### Table 29

**Expected Treatment for "Present" Illness**

**Question:**
- **Clients:** What kind of treatment do you think you should receive?
- **Chiropractors:** What kind of treatment(s) do you give for this or these illnesses?

<table>
<thead>
<tr>
<th>Treatment/Therapy</th>
<th>No. of Responses</th>
<th>Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication/Drug</td>
<td></td>
<td>13</td>
<td>21.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td>8</td>
<td>13.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication and Surgery</td>
<td></td>
<td>2</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise with either medication or surgery</td>
<td></td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise</td>
<td></td>
<td>7</td>
<td>11.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise with Massage or adjustment</td>
<td></td>
<td>1</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massage</td>
<td></td>
<td>2</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustment/Manipulation</td>
<td></td>
<td>1</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustment/Exercise/Massage/Massage</td>
<td></td>
<td>2</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietary/Nutritional advice</td>
<td></td>
<td>5</td>
<td>8.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling (with or without exercise)</td>
<td></td>
<td>5</td>
<td>8.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don't know</td>
<td></td>
<td>11</td>
<td>18.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupressure (fingerpoint therapy)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shiatsu (Japanese therapy)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Full Spine technique&quot;/&quot;Spinal hygiene&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed rest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cryotherapy (ice treatment)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special activities, eg. lifting technique</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supportive devices, eg. braces</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual Traction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heat Therapy (hot packs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contrast baths</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
treatment, manual traction, contrast baths, heat therapy, supportive devices, and accupressure (Table 29).

The difference in the explanatory models of new clients and chiropractors regarding treatment, is reflected in the clients' choice of traditional allopathic treatments such as drugs and surgery, in contrast to the wide range of treatment services offered or recommended by chiropractors.

While many new clients expected medication with drugs or massage, most chiropractors preferred to offer chiropractic adjustment, accupressure, full-spine technique and contrast baths. Therefore, clients' expectations about treatment for present illnesses differ from those of chiropractors and these differences are also matters for negotiation during the clinical encounters.

(g) Expected Results

Chiropractors appeared to be more optimistic about the outcome of treatments than new clients. All of the chiropractors interviewed expected partial relief from pain or discomfort and 85% of them expected cure or complete relief from pain (Table 30). By contrast, only 52% of new clients expected complete cure or complete relief from pain with their "present" health problem, and no client was expecting partial relief from pain. The indication, therefore, was that chiropractors felt a great deal of confidence in their ability to cure or relieve pain and discomfort. Overall, both new clients and chiropractors expected some sort of functional improvement as the outcome of treatment. Again, there was a higher degree of optimism in this respect by chiropractors than by new clients (Table 30).
Table 30

Expected Results from Treatment

Question: [Clients] What are the most important results you hope to receive from this treatment? [Chiropractors] With what expected results?

<table>
<thead>
<tr>
<th>Expected Results</th>
<th>Clients (n=60)</th>
<th>%</th>
<th>Chiropractors (n=20)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cure or complete or partial relief from pain</td>
<td>31</td>
<td>51.7</td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>Functional independence</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Return to normal activities</td>
<td>3</td>
<td>5.0</td>
<td>14</td>
<td>70.0</td>
</tr>
<tr>
<td>Improved mobility/ease of movement</td>
<td>6</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Enjoyment of life&quot;</td>
<td>1</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Sit for longer periods of time&quot;</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in leisure/housework activities</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual activity without pain/discomfort</td>
<td>1</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take better care of self</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Help&quot; with chronic condition</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don't Know</td>
<td>3</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Patient feeling better&quot;</td>
<td></td>
<td></td>
<td>20</td>
<td>100.0</td>
</tr>
<tr>
<td>Long term &quot;renormalization&quot; or &quot;restoration of function for normal activities&quot;</td>
<td>16</td>
<td>80.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial resumption of normal life activities</td>
<td></td>
<td></td>
<td>16</td>
<td>80.0</td>
</tr>
</tbody>
</table>

* Responses from Chiropractors contain two or more responses.
5.10 Summary: Discrepant Perceptions to be Negotiated

(a) The belief held by new clients that their own good health is linked with a "transportation mechanism" chiefly consisting of blood and the circulatory system which "gets rid of" poisons, must be reconciled with the chiropractic belief of "master control mechanisms" of the central nervous system in maintaining body health, although as I have noted in Chapter 2 (Section 2.2, pp.88-89), it may not always be possible to negotiate a common treatment EM. Conceivably, clients can retain personal beliefs, yet still follow the treatment recommendations of either a chiropractor or an allopathic physician, but this is less likely when EMs are incongruent.

New clients viewed illness as an invasion of the body by something foreign which must be "attacked", "killed" or "gotten rid of". Treatment, therefore, should concentrate on detecting and "eliminating" harmful foreign bodies such as germs, regardless of lifestyle. Chiropractors believe in "homeostasis" or the ability of the body to treat itself, heal without drugs and independently maintain good health with reasonable assistance. These differing views then, would also need to be reconciled during the clinical negotiation process.

New clients located the source of bodily energy in blood, while chiropractors located same in the nervous system. For prospective clients it was food energy in blood which accounts for bodily energy. For chiropractors, energy was essentially "innate" and involved mental processes as well. Chiropractors also viewed the involuntary autonomic nervous system as exerting control over body organs and in keeping the body healthy, thus, promoting the notion of "involuntary" healing.
Chiropractors would need to educate new clients to perceive that the nervous system, especially "mental attitude", was the cause of their illness. Terminologies such as "neural disrelationships" and "mental dysfunctions" must be explained to the satisfaction of new clients. New clients would have to be made aware of how the balancing of "forces" and "energy" relate to their health problems and of the opposite treatment.

An overwhelming majority of the chiropractors claimed to observe good personal health habits compared to 36% of new clients. Thus, a major focus for chiropractors in clinical interactions would be to convince new clients to observe good personal health habits.

(b) "Subluxation" as an illness category and as a cause of health problems would be a new phenomenon to a majority of new clients. While new clients attributed causes of their particular illnesses to "poor health habits", "germs and infection" and circulatory problems, chiropractors viewed the causes of most illnesses as the result of "subluxation", "poor postural habits", lack of "spinal hygiene", disrelationships of musculoskeletal structures" and "negative mental attitude". Here again, chiropractors and new clients could find it necessary to negotiate acceptable cause(s) of illness to allow for ongoing treatment. New clients would have to be exposed to different explanations of cause, course, pathophysiology and onset of illness, in particular, the role of the nervous system and "energy forces" in health and disease.

Chiropractors must, therefore, negotiate explanations for "present" health problems of new clients. They may be required to explain what is meant by "innate intelligence" or disturbances of the coordinating functions of the
nervous system, "homeostasis" or the ability of the body to regulate itself, adjust and return to normal state, and "faulty musculoskeletal disrelationships such as "subluxation" of the vertebral spine.

Chiropractors may also deal with new clients' preference for medication and surgery as treatments for health problems. Potential clients must be convinced that "adjustment" rather than medication or surgery is the best treatment for their health problem, that they can anticipate cure or relief from discomfort within a period of less than 12 months, and that they would then be "renormalized" or "restored to normal life and lifestyle".

New clients' "fear the unknown", possible damage to their bodies, possible increase in pain, and that they may not be helped by the treatment they receive. On the other hand, the fear, doubt and apprehension of new clients is countered by the chiropractors' own concerns about professional image, dispensing the "right" information, offering the right treatment technique, and avoiding law suits. Chiropractors need to relax new clients and gain their confidence if they are to retain them as clients beyond the first visits to their clinics.

All differences in EMs may not be completely resolved during clinical negotiations, but if chiropractors succeed in resolving crucial areas of potential disagreement, then they would likely succeed in 'making their clientele'.
1. Homeostasis is usually taken to mean the tendency of a system such as a physiological system to maintain internal stability because of the coordinated response of its parts to any disruptive stimulus or situation. Chiropractic philosophy is based on the control function of the nervous system to maintain a balance or physiological equilibrium of body organs and their functions in relation to each other (see Strang, 1984:48).

2. "Subluxation" of the vertebrae is the main diagnostic terminology of chiropractic. It is defined as "a condition in which the joint surfaces are slightly changed in position although the articular surfaces are still in contact" (Haldeman, 1980, p.331).

3. The meaning of "innate intelligence" is not quite clear. One chiropractor described it as "nature...something of an aura about and within all of us which knows about us and controls the nervous system". Another chiropractor referred to it in terms of "deity...not God, but I have heard some people call it 'the God in us'". Yet another chiropractor said it is what keeps us alive and controls, regulates, and is sensitive to what we do...much like a computer...it's programmed to respond to dysfunctions by calling on the nerves to correct whatever is wrong".
Potential clients of chiropractic may not be different from those of other healing groups such as allopathic and naturopathic medicines, especially regarding the impressions they hold about professional healers in general. Yet it is possible that differences do exist in client perceptions and impressions of particular healing traditions or particular groups of healers. In Chapter 1, I commented on the nature of constraints facing chiropractic in British Columbia. These constraints are evidence of the need for chiropractors to engage in resocialization strategies for the purpose of making their clientele. The constraints set legal boundaries for clinical practice. These boundaries limit new and "well established" chiropractors and require them to continue to maintain public interest in chiropractic as well as to explore avenues for "making" new clientele.

In Chapter 1, it was noted that three leaders of chiropractic and a government representative were interviewed in order to elicit their views regarding the nature of constraints on chiropractic. The results of these interviews formed the basis for my argument that chiropractors engage in "unique" strategies in order to make their clientele. The interviews led me to believe that an important factor in the clinical behaviour setting is the general impression of new clients about chiropractic health care, and what chiropractors do in order to overcome any negative impressions.
6.1 Persuasive Interaction Structures

In this section, I will describe the "persuasive interaction structures" that are found within the behaviour setting of chiropractic, otherwise known as "the front" (Goffman, 1959:22-24). The "front" represents structures through which information is communicated to potential clients. The behaviour setting as part of the "front" includes the exterior characteristics, waiting rooms, hallways, reception area, treatment area, private offices of chiropractors, waiting rooms and x-ray rooms where applicable. The behaviour setting is defined after Gump (1971:130-134) as consisting of three elements, namely: (a) the "non-behavioural factors of milieu and time" which includes space, bounded in some manner, that sets it aside from other behaviour settings or subsettings which are located within the general space reserved for specialized activities and time limits. Such bounded areas serve as starting and stopping points for behaviours: for example, waiting rooms, treatment rooms, receptionist area, hallways, and rooms for x-rays; (b) "standing behaviour patterns" which consist of stable, recurring, and taken-for-granted activities of the actors and the interrelated ground rules which support those activities; and (c) the "relationship between the behavioural and the non-behavioural factors".

Chiropractic behaviour settings, therefore, consisted of, more or less, the stable elements that those who interact or act within it relied upon and used as the basis of action as well as the particular organization of elements within the setting (Zimmerman and Polner, 1970). This study identifies the practices of chiropractors, new clients and relevant others in the chiropractic behaviour setting as they respond to it situationally.
In order to discover those practices that were aimed at client socialization, each sector of the behaviour setting has been examined in order to show how chiropractors and their staff utilize presentational devices or "stage props" within the setting to inspire new clients with a feeling of trust and confidence.

6.1.1 Physical Layout and External Characteristics

Eighteen of the twenty chiropractic clinics were located in office or commercial buildings, generally in the business or commercial sections of North Vancouver, West Vancouver or the City of Vancouver. Two clinics were located in private residential homes owned by the practitioners themselves. None of the chiropractic clinics studied were located in the same building as an allopathic clinic [M.D.]. Of the twenty chiropractic clinics, fourteen were engaged in group practices of two or more practitioners and six were solo practitioners.

The general public perception is that more affluent citizens tend to live in West and North Vancouver, and that ethnic minorities and poorer citizens tend to live in the eastern, central and southern parts of the City of Vancouver.

Chiropractic clinics in North and West Vancouver appeared to reflect the public perception of these areas. The offices were expensively furnished. The heavy glass doors did not have "Hours of Work" posted on them with the exception of the one clinic which had "Open" or "Closed" signs discreetly placed at the lower top left corner of the entrance door. Eight of the clinic signs had the word "CHIROPRACTOR" boldly printed over the top of the entrance way. The names
of chiropractors were inscribed on glass doors in simple, direct manner, for example "Dr. _______ D.C.".

The majority of clinics in other parts of the study area, especially in the central, eastern and southern parts of Vancouver had extensive visual signs which called attention to the clinics. More importantly, the names of chiropractors, either in solo practice or group practice, were very prominently inscribed on either separate "sign plates" or on doors, along with details of office hours. This conveyed the notion that chiropractors wanted passersby to remember such information. Unlike my visits to clinics in West and North Vancouver, it was much easier for me to locate clinics in central, eastern and southern Vancouver because of the prominence of the signs. Perhaps, clients in the wealthier parts of the study area would not favour an ostentatious display of business signs, thus, chiropractors may have felt compelled to conform to local norms. Hence, the display of chiropractic signs in these areas were consistent with the general appearance of other business notices in the area.

Patients entered directly from sidewalks into the clinics except for clinics in tall office buildings. However, clinics in North and West Vancouver had more parking spaces than those in other parts of the study area. This may have been due to the intensity of business competition or to the commercial competition for parking spaces in central and eastern parts of Vancouver.

6.1.2 The Waiting Rooms

The waiting rooms of all the chiropractic offices were not very different in their layout compared to the waiting rooms of my family doctor or the waiting
rooms of allopathic physicians [M.Ds] engaged in group practice that I have visited over the years. Like those of allopathic physicians, they varied in physical dimensions as well as furnishings. The major differences between waiting rooms of chiropractors and those of medical doctors were (a) the large numbers of printed chiropractic booklets, pamphlets and professional newsletters which are exhibited at various points in chiropractic clinics, and; (b) the large number of noticeboards which had clippings from newspapers, journals and other written or visual information for the benefit of chiropractic clients and visitors.

Eleven clinics were carpeted, and some of them in north, west and central Vancouver were more expensively furnished. This difference in furnishings may have been a reflection of the social class of clients who live in these areas. Expensive and well decorated waiting rooms would, therefore, be consistent with the general expectation and living standards of the wealthier residents of north, west and some parts of central Vancouver.

Houseplants were abundantly and generously used in twelve of the twenty clinics. Six clinics had coffee makers for free coffee to clients who were waiting to be seen by chiropractors. In the majority of the clinics, there were side tables and centre-tables for the convenience of clients. Although the dimensions of the waiting rooms varied, many of them were directly visible from the sidewalk.

At various corners of some of the waiting rooms were entrances to the offices of the chiropractors, a holding room or treatment room, and different entrances to two or more of these rooms. The receptionists were seated behind the counter in separate corners of the waiting room, usually opposite the main
entrance. In group practice clinics, there were approximately two or three assistants in the reception area. Well-established group practices have different categories of support personnel such as receptionists, secretary and accounts clerk. Six clinics have chiropractic assistants. In one clinic, the wife of the chiropractor is both the receptionist/secretary as well as the chiropractic assistant.

Fourteen clinics had Visa or Master Card signs displayed on the reception counter. Also, displayed in all of the clinics were the various fee schedules for services that are covered under the provincial public health insurance plan. In eleven clinics, radios played soft, relaxing music which was used to convey the impression of serious but comfortable quietude.

The general "message" from the appearances, decorations and decor of the waiting rooms was a message of competent professionalism. A new client would have had the impression of a professional atmosphere that was reminiscent of the waiting rooms of family doctors, especially one in which extra care had been taken to cater to the comfort of clients. During many of my visits, twelve of the chiropractic clinics did not have many clients who were waiting to see the chiropractors. The busier ones had timed appointments which overlapped by a few minutes between treatments. It was possible that most of the chiropractors organized their appointments to avoid overcrowding in waiting rooms, a frequent and annoying occurrence during visits to allopathic family doctors.

By far, the most visible source of client information and education was through printed materials such as leaflets and newspapers. All clinics had extensive displays of chiropractic pamphlets and favourable excerpts from news-
papers and magazines for the benefit of clients. A total of thirty-four different leaflets, pamphlets and monographs were identified in chiropractic behaviour settings during the study. Each clinic displayed an average of eighteen chiropractic information materials as well as varying numbers of excerpts from newspapers. Some of the titles of pamphlets and leaflets calculated to educate the new client about chiropractic were as follows:

"Welcome to our Office"

This 4-page booklet tells you what usually happens in a chiropractic clinic "if you have never visited before"; "in every case"; what chiropractors treat; "after the consultation and interview"; "on the second visit"; "your treatment program"; "if your case is acute or chronic"; and information about "some spinal disorders which seem to run in families". On the front of the booklet is a diagram of the spinal column and on the back is a 6-point suggestion commentary on how to build "Good Family Health Habits". The booklet suggests that the client should "Have regular spinal check-ups" from a chiropractor, "stress good posture habits", "plan regular exercise", "provide a well-balanced diet", "insist upon adequate rest", and "set a good example yourself".

The booklet, which is issued to all chiropractors by the Canadian Chiropractic Association, was found in all clinics. It was one example among a large number of booklets and leaflets that were aimed to relax, encourage and educate new clients prior to encountering chiropractors. More importantly, it was used to introduce new clients to "good health habits", which chiropractors in the study have said they regularly observe, but which most new clients have failed to observe.
This 10" x 8" "spread" leaflet issued by the "Parker Chiropractic Research Foundation" in the United States, is specifically directed to new clients. On the front third of the cover page is the picture of a red rose, ostensibly an invitation, or a goodwill gesture. The opening sentence reads as follows:

"May we welcome you to this chiropractic office. You are to be commended for reaching out and venturing into a profession that may be unfamiliar to you...you may have learned the name that doctors have given your problem, but the CAUSE of this problem may not yet have been found."

The new client is immediately commended for "deviating" from orthodox or official medical care towards a "deviant" or "alternate" form of care, in this case, chiropractic. The client is immediately told that chiropractors treat "CAUSE" and not symptoms or "names of diseases". Under the heading "Chiropractic, the Different Approach", the leaflet observes:

"The reception room of the Doctor of Chiropractic seems to be quite similar to the offices of other doctors. There is a pleasant receptionist, an attractive room with professional type furniture; but there is a different approach to illness in the chiropractor's office."

The new client is made aware of the difference between chiropractic and orthodox medical care, namely, the treatment of illness as opposed to the treatment of disease. But the similarities between chiropractic reception rooms and those of "other doctors" are aimed at minimizing any expectations of "deviant status" the new client may have been entertaining. The message for
some new clients (63%) who did not know what to expect seems to be: "We are not different from any other doctors you may have known".

The leaflet proceeds to display various pictures of the spinal column, nerves and associated organs to explain the role of the nervous system, especially misalignment" of spinal column, in illness causation. The fears of new clients regarding painful chiropractic treatment is allayed with the statement that "there is very little, if any, discomfort from a chiropractic adjustment, it is relaxing to most". Anatomical diagrams of the spinal column seem to reinforce the message of "competent knowledge and professionalism". Initial signals favouring discussion of the nervous system are, therefore, communicated to the new client at this early stage.

Further doubts and apprehensions a new client may suffer were met by many other leaflets that were displayed on tables, and on special stands. For example, if a new client was still skeptical of chiropractic after reading the leaflets, "Welcome to Our Office" or "To the New Patient", he would likely pick up another leaflet on "Why Chiropractic: This May Answer Your Question". This leaflet informs him that he has chosen "a new road to health....made a radical change to regain your health - just as more than fifty-five million satisfied chiropractic patients have done", and that "some of your friends may be skeptical; a few may be unknowledgeable of modern chiropractic and its benefits - just as you may been at one time. Occasionally, well-meaning friends will try to discourage you on your new road to health".

It would seem that the recruitment "campaign" has begun. Discouragement from family and friends has been alluded to as "unknowledgeable". The new
client is clearly being commended for embarking on a "new road to health".

According to the leaflet, the new client "needs to understand" that "there are scientific reasons why the maintenance of your spine is a requisite for good health", and that "many prejudiced people are just uninformed about the merits and principles of modern chiropractic. The issue regarding the scientific nature of chiropractic is confronted "head-on", and the new client is assured that chiropractic is indeed a scientific discipline.

One leaflet profiles the chiropractor as a "Very Special Specialist", another leaflet titled, "You and Your D.C." discusses basic principles of chiropractic. The latter leaflet comments: "Chiropractic holds that your basic health comes from within YOU. It maintains that this health principle is expressed through the nervous system - with the brain as the receiving and sending station. Normal health is a state in which there is no disturbance to nerve energy channels".

Clearly, all of this is an attempt to prepare the new client for discussions with the chiropractor during the clinical encounter. As I have noted in Chapter 5 and Section 5.10, one of the tasks of chiropractors is to explain the role of the nervous system, energy and, especially, mental energy in health and disease, given that new clients hold quite different views on these matters than do chiropractors. By "sensitizing" new clients to chiropractic philosophy while in the waiting rooms, chiropractors seem to be preparing the grounds for the subsequent indoctrination during the actual clinical encounter.

The titles of these leaflets and their contents demonstrate the seriousness with which chiropractors in the study area wished to (a) minimize the effect of the lack of public information on chiropractic, (b) educate the new client, and (c) relax and reassure clients of the "correctness" of the client's decision to seek chiropractic help. These were preparatory "moves" which laid the foundation for the actual interaction with the chiropractor and the negotiation that would take place.

Another means for client education and information was through excerpts from newspapers, journals and magazines which contained positive reviews on chiropractic. The British Columbia Chiropractic Association publishes its own professional newspaper "for the benefit of patients" under the title, "IN TOUCH". The paper is designed to contain all types of "positive" information and developments within chiropractic circles, and it was found in every clinic that was studied. "IN TOUCH" is provided free to all patients and clients of chiropractic. Some of the topics and issues included were "breakthrough for
chiropractic research", "right and wrong way to lift and carry", an interview with the provincial Minister of Health, and the effort by chiropractors to obtain hospital visiting privileges.

Every clinic that was studied had at least one notice board on a waiting room wall. Twelve clinics have at least two notice boards in different parts of the clinic. On these notice boards were displayed "cut-outs" from newspapers which discussed chiropractic issues, letters from satisfied patients, testimonials from satisfied public figures such as professional football and hockey athletes, letters from medical researchers who had cooperated with chiropractors in clinical research, and journal articles that favoured chiropractic views of health care or supported its struggle to gain general acceptance. One article written by an allopathic psychiatrist in the "Medical Post" of September 18, 1984, titled "How Sports Medicine Drove Me to a Chiropractor", was featured in eighteen of the twenty chiropractic waiting rooms. A letter from a prominent orthopaedic surgeon from the University of Saskatchewan Medical School was a popular fixture on the notice boards of most waiting rooms. In the letter, written on May 10, 1984 to the Chairman of Workers' Compensation Board of the Province of Ontario, the Surgeon reported that manipulative treatment for chronic conditions by chiropractors was an effective treatment.

Individual chiropractors used different presentational devices to educate and re-orient new clients. For example, "Back Support Chairs" and "Pregnancy Wedges" were prominently displayed at some corners in a few waiting rooms. The message seemed to be that these chiropractors not only treated back complaints but they could also provide advice to pregnant women regarding correct posture. Those involved in community fitness activities were on display in the form of
signs, advertisements, "Participation" fitness posters, and the "Rick Hansen World Tour" fund raising announcements and posters. These posters helped to fuse images of "good" citizenship, physical fitness, and community involvement, an apparent motivational objective intended by many chiropractors.

Individual tastes also varied on artistic work. Some chiropractors decorated waiting room walls with "picture perfect" posters of athletic-looking joggers. A caption under one of the pictures read as follows:

"Tell a Friend. Discover the Benefits of Modern Chiropractic. It's a natural!!"

The emphasis on the word modern was probably an attempt to disassociate past notions about "holistic chiropractic" as advocated by its founder, David Palmer, from the present day scientific orientation which some chiropractors wanted to promote.

In summary, chiropractic waiting rooms served the following functions: (a) They helped to present an image of the clinic which was as close as possible to the experience new clients may have had of the waiting rooms of family doctors [M.D's]. This image may have reduced apprehension and tension and prepared new clients for further indoctrination by chiropractors during the clinical encounter. They also helped to negate any deviancy perceptions of chiropractic that clients may have held previously. (b) The waiting-rooms helped to project an air of professionalism, thus helping to elevate the status of chiropractors and, (c) the waiting rooms were "classrooms" in which the first lessons about chiropractic were learned by new clients. The primary function of prior education on chiropractic in waiting rooms was to reduce doubts, and to prepare
new clients for interaction and continued indoctrination by chiropractors. They provided information from a chiropractic point of view, along with endorsements of chiropractic by prominent citizens and even some allopathic physicians. The waiting room, therefore, served as the "Front" for the individual chiropractor, and as an initial image-maker.

6.1.3 Treatment Rooms and Other Subsettings

In all clinics, treatment rooms were separate from the offices of practitioners. Depending on the topography of the physical layout or the building's architecture, a few clinics had hallways with "wall support" railings leading from waiting rooms to practitioners' offices, to treatment rooms or to both areas. Framed chiropractic educational posters and "fitness" pictures were hung on walls of hallways. In fourteen clinics, anatomical pictures of human skeletons and muscles were also hung on walls of hallways. In all clinics, there were "full structure" models of human skeletons in treatment rooms which were used to point out areas of affectation when negotiating the illness label with clients.

Two clinics had small holding rooms or cubicles of about 4 feet by 6 feet where clients whose turn it was to see the chiropractor waited after leaving the larger waiting rooms. In the cubicles were hung more pictorial information about chiropractic, for example, a poster with the title, "Profile of a Chiropractor" which seems to be a popular poster in many waiting rooms and cubicles.
Five clinics had metronomes or frequency counting devices in the treatment rooms. Four clinics had medical stethoscopes lying "casually" on desks or instrument cupboards in treatment rooms or practitioner offices. The function of the metronomes and stethoscopes were not established. However, stethoscopes are usually associated with allopathic medicine. It may be that they are also used as a legitimating symbol of chiropractic as a medical discipline.

Treatment rooms or "adjustment rooms" varied in dimensions but they were usually large enough to situate an "adjustment table" at the centre and still allow for the free movement of the practitioner around it. The examination table had multiple adjustments from lying positions, through various inclinations, to full standing positions. With it, the chiropractor could rotate the head and neck, the spinal column as well as extend the neck of a client during examination or treatment. Different instruments such as vibrators, skin temperature measurement devices, and towels or gowns were displayed on tables or "instrument" cupboards in treatment rooms. Some treatment rooms were bare except for life-size anatomical models, the adjustment table, a chair, and wall posters.

The private offices of chiropractors were not unlike those of family physicians with the usual bookcase, a desk, filing cabinet, client chair, plants, wall pictures, telephones, and, in some cases, stethoscopes laid out on the table.

Four clinics had x-ray rooms which were fairly small compared to the larger treatment rooms, or compared to the practitioners' offices. Each x-ray room was filled with a standard but complex x-ray machine, a rack of exposed negatives many of which hung on walls, several charts filled with mathematical figures,
diagrams and procedural instructions, and a "lead backdrop shield" for protection from radiation.

All clinics had washrooms which were conveniently located. Most of them were accessible from waiting rooms, offices and treatment rooms, or were located at the end of hallways.

Returning now to Goffman's analysis of the "front", he defined it as "that part of the individual's performance which regularly functions in a general and fixed fashion to define the situation for those who observe the performance.... expressive equipment of a standard kind intentionally or unwittingly employed by the individual during performance". It has two parts, the "setting" involving "furniture decor, physical layout and other background items which supply the scenery and stage props" and the "personal front" which includes personal characteristics, posture, speech patterns, facial expressions, bodily gestures and the like" (Goffman, 1959:22-24).

In this section, I have described in a general way, common characteristics of the "front" or "setting" of chiropractic clinics. The behaviour settings of waiting rooms, treatment rooms, hallways and practitioner offices help define the chiropractic situation for the new client. Individual variations were matters of taste as well dependent upon the location of practice. In general, the behaviour settings helped to present a conservative image of chiropractors, an image that was quite different from that expected of "deviant" healers. In particular, the behaviour setting approximated the behaviour settings of "official" allopathic practitioners. However, like behaviour settings in dental clinics, chiropractic behaviour settings were "uniquely chiropractic" with large
supplies of educational materials, and posters of the spine, the skeleton, and of the human body. Chiropractic behaviour settings seemed to be structured to relax the new client, build his confidence, minimize negative conceptions and most of all, educate and persuade the client towards chiropractic health care.

6.1.4 Sociopolitical Linkages

On another "front", an important goal of chiropractic has been to improve its status within the wider community. Crucial to the promotion of competent professional image are the various linkages chiropractors have maintained with the wider socio-political community. Firstly, as a professional group, the chiropractic association in British Columbia has maintained a good, positive relationship with politicians and bureaucrats in the provincial government. The provincial Minister of Health has often been featured in special interviews in the professional newspaper "IN TOUCH". Such features are intended to confer a degree of "legitimacy" on the profession. Also, the profession has made some special efforts to educate politicians and bureaucrats about chiropractic. One leader of chiropractic pointed out with pride that the Minister of Health has received chiropractic treatment, and that many senior bureaucrats in the Ministry have become "very aware of chiropractic". In fact, part of my arrangement to interview the Deputy Minister of Health (the most senior bureaucrat in the Ministry of Health) was in part facilitated by a telephone call by one of the leaders of chiropractic. During the interview with this senior bureaucrat, it became clear that the provincial chiropractic association
had fostered very positive relationships with government officials. The senior bureaucrat commented as follows:

"Chiropractors represent the classical textbook lobbying technique....non-controversial, patient, cooperative, supportive....and lets you know ahead of time what the issue will be and then wait for you to help them or understand it....Unlike physiotherapists who are very vocal, confrontative and somewhat impatient in dealing with issues, chiropractors are cooperative and understanding of the other side and what the fallouts are likely to be in any given instance."

It may be said that chiropractors in British Columbia have built important linkages with politicians and bureaucrats which have enabled them to persuade those in authority towards their professional views regarding issues of importance to chiropractic. Consequently, they have made headway on some of the issues that had been hampering their clinical practice in the province. For example, early in 1986, the Chiropractic Act was amended to allow chiropractors to provide treatment to parts of the human body other than the spinal column, such as the "articulations" and joints. Their struggle to visit their patients in provincial hospitals has received some public sympathy from the Minister of Health who has recognized "certain constraints" under the Medical Act.

Chiropractors have maintained linkages with the wider sociopolitical community through memberships in voluntary, recreational and charitable organizations. In order for new clients to subscribe to chiropractic care they need to obtain information about chiropractic from someone who knows about it, or from a chiropractor. It has been established that the majority of new chiropractic clients often learn about chiropractic from former patients (Table 2). Many chiropractors have supplemented this avenue by making themselves known
and visible in small community groups such as sporting clubs. This has made it much easier for club members to recommend chiropractors to friends because such members have known the chiropractor personally. Through the personal knowledge of a friend or acquaintance, a new client may become more confident in choosing to visit a chiropractor at least on a trial basis. Once the client has come in through the door, his indoctrination will commence, first in the waiting room and then afterwards.

Structural linkages to the wider sociopolitical community were demonstrated by the guidelines made available to chiropractors by the Board of Directors of the British Columbia Chiropractic Association. Page 15 of the handbook titled, "INFORMATION: For Chiropractors in Province of British Columbia, 1978", outlines various ways for establishing a practice. Chiropractors have been advised to "discuss principle, not comparative technique, with patients" and "never hesitate to consult with a chiropractor and ask his advice on practice matters, office location, office furnishings, floor plan, etc." It has further been suggested that chiropractors,

"join the local Board of Trade or Chamber of Commerce.... to consider joining service clubs that you consider will do you and your profession the most honor....take an active part in your church."

Regarding the location of office, the booklet advises chiropractors to

"locate your office on the ground floor....not necessarily in the centre of town or on the main street, but on or near a bus route."
On offices:

"Your office should always be meticulously clean, well lighted, and should be freshly painted in pleasant colours of light shades. Endeavour to make the office environment hospitable and attractive."

On Public Relations:

"Visit the editor of your local paper. It may be that he will consider your arrival in the community as subject material for a newsworthy story."

These excerpts from the Professional Information Handbook for Chiropractors in British Columbia illustrate the importance chiropractors attach to wider sociopolitical linkages in providing visibility to the profession and in persuading new clients to become aware of chiropractic. Most activities were directed towards minimizing negative perceptions that may be held about chiropractic while at the same time persuading new clients towards accepting chiropractic philosophy of health care. The focus is on "converting" the client into a patient of chiropractic.

6.2 Persuasive Interaction Processes

In order to observe the "normal" operations of the various clinics, I often arrived at the clinics an hour prior to scheduled first appointments. This enabled me to observe and record interaction and behaviour patterns in the behaviour setting. Particular attention was paid to admission processes and interactions between receptionists, secretaries, chiropractic assistants, and chiropractors in waiting rooms, "holding rooms", treatment rooms, and offices of practitioners. I observed the rhetoric used in managing impressions and in
negotiating treatment as well as the general expectations within the setting such as any unwritten rules which may govern the behaviour of people in chiropractic clinics.

6.2.1 Admission to Clinic

The office routines in chiropractic clinics were found to be similar in many respects to the office routines in allopathic clinics. Upon arrival, the new client goes to the reception desk, where he would be "warmly" greeted by the receptionist or whoever was present at the desk. He is asked for information regarding name, address and medical insurance number. A noticeable difference in admission routine from that of established allopathic clinics is that all chiropractic receptionists, secretaries or assistants with responsibility for admitting patients effusively greet new patients as well as take time to engage them in casual conversations which are sometimes unrelated to their health problems. For example, it was common for some receptionists to ask: "How warm is it out there?", or "Do you think it's going to rain? I hear it's getting kind of cloudy." This approach to admission, together with cheerful disposition exhibited by the receptionist, helped to relax nervous and apprehensive new clients. Most new clients, on first entering the waiting room, would surreptitiously survey the entire room, some would extend greetings to any patient who was waiting for treatment, and others would nervously walk directly to the reception desk. Only six new clients were observed to walk into the waiting room and wait to be invited to the reception desk.
In eleven clinics, upon entering the waiting room, regular patients signed-in their names on appointment registers at the reception desks. Very rarely did they escape some form of casual conversation initiated by the receptionist.

The new clients, upon entering the waiting room for the first time, were generally unprepared for what awaited them since there were no general or clear set of definitions or expectations concerning what chiropractic clinics looked like. As noted earlier, the first impression on the client would be the similarity of the clinic to that of the family doctor's office, and this tended to relieve anticipatory anxiety. Some waiting rooms would appear to some clients to be "tastefully" decorated with plants, carpets, "comfortable" chairs and wall pictures. The pleasant surroundings were a welcome sight to new clients who had been apprehensive about chiropractic.

Another common feature of the admission process was the waiting period itself, during which the client would take time to "settle" into the scene, notice the various wall pictures and contents of the notice boards, read some of the chiropractic leaflets within easy access of chairs, and, in some clinics, drink a cup of coffee. During the waiting period, the practitioner may or may not be genuinely busy. However, as Goffman (1963:51-52) has noted, newspapers and other reading materials in public places such as the chiropractic waiting room, offer actors a "minimal involvement" whenever the person "feels he ought to have an involvement but does not". Some new clients were observed to peruse four or six leaflets while waiting to see the chiropractor. At the same time, some new clients, were observed to walk up to the notice boards to read their contents. The majority of new clients looked around and presumably read the
various comments about chiropractic health care that hung on waiting room walls.

Although the waiting period was usually of some duration, lasting for approximately fifteen to forty-five minutes in the majority of cases, the receptionist, secretary or chiropractic assistant always tried to engage a new client in casual conversation. Often, the waiting period was seen as an opportunity to "convert" the new client regarding success of chiropractic in the treatment of a variety of health problems. The following cases provide some illustration.

Case 1

I telephoned Dr. C's office to change my scheduled appointment with him from 4 p.m. to 4:30 p.m. because I had a late seminar at the University. The receptionist, who is a trained chiropractic assistant, was not pleased with my proposed 30 minute change in schedule since it would have infringed on patients' time. I reminded her that the 4 p.m. appointment was suggested by Dr. C. because he expected to finish his daily patient schedule at that time. She indicated that some new patients had called after my discussion with Dr. C. and she worried that the patients she had scheduled at 4:30 p.m. would be unhappy. She indicated that it was not always possible to have new patients "phone in" since they did not have any new patients in the previous four days. She commented: "We mostly keep our regular patients", and she would be reluctant to lose any new patients. I detected a note of frustration because Dr. C. had agreed to participate in my study.
I kept my 4 p.m. appointment and showed up one hour early to observe the behaviour setting, electing to miss the university seminar. The receptionist was pleasant but concerned that I had come much earlier than 4 p.m.; however, she welcomed my presence.

At 3:50 p.m., a Mrs. T., probably in her fifties, walked in with a female acquaintance of about same age. Mrs. T., who is acquainted with the receptionist, Mrs. K., proceeded to the reception desk, loudly asking for an appointment:

Mrs. T.: Can Dr. C. see Martha? She's been complaining of back and hip problems for two weeks...you know how it is, the hassle, the weather and all of that s....

Mrs. K., the receptionist, took a few moments to consult the appointment book, which should have shown a vacancy for 4 p.m. because of my appointment.

Mrs. K.: Let me find out from Dr. C. He has been very busy these days.

Whereupon Mrs. K. went into her husband's office, came out in a minute and declared:

Mrs. K.: You are in luck. Dr. C. can see Martha at 4:10 p.m. Do you have insurance?

Martha: Yes (presenting her health insurance card).

A few minutes later, Mrs. C. offered me a cup of coffee, having obviously given away my time. At 4:30 p.m., I was again shifted down to 5 p.m. I had been told the previous day that the clinic was usually not busy after 1 p.m.
Mrs. K.: [To Mrs. T. and for the benefit of Martha] I used to get back problems. When you get on in years these things happen. I am OK now.

Mrs. T.: Yeah. I told Martha Dr. C. fixed me up. Whenever I get something funny going on in my knees and my back, I don't wait...I pop in to fix it up. This old geezer wants to keep going (laughter).

Mrs. K.: We always have people popping in. It's that time of year. Remember Mr. who used to hobble in here?

Mrs. T.: The guy who is always telling stories about them wars?

Mrs. K.: He is just about fixed up now. He doesn't hobble quite as much. Drops in sometimes just in case. You never know...you've got to take care of yourself to keep going.

I noted that there was no one in the waiting room when I arrived. Dr. C. was not busy seeing anyone, and no patient or client arrived during or after my initial interview session with Dr. C. Afterwards, Dr. C. indicated to me that he had been on the telephone. However, I had observed that all telephone calls passed through the reception desk and at no time did Mrs. C. transfer any call to Dr. C.

I have used this example to convey two observations. The first is that the impression of a busy schedule was conveyed to new clients regardless of "present realities". The second is that the receptionists, secretaries and chiropractic assistants performed the role of "socializing agents". They educated, informed, smoothed rough edges, and generally presented a positive, professional image of chiropractic whenever the opportunity arose.

The scenarios described above were repeated in different forms at various clinics. Secretaries and receptionists often structured personal encounters in order to socialize clients and patients. As noted above, through the dialogue
between Mrs. K. and Mrs. T., Martha was provided with information regarding her decision to visit Dr. C. because similar clients with identical health problems have benefitted from Dr. C., the chiropractor. Martha was also made aware of the need for a regular check-up as well as the view that at a certain age, one required periodic chiropractic care.

In the waiting rooms and during admission to the clinic, receptionists and secretaries often used questions relating to the well-being of clients, his family, his state of health and other personal matters to "draw" the individual into the behaviour setting. Often, conversation with regular patients was used to engage the attention of new patients.

Case 2

Mr. A. is a 37 year old new client I had interviewed and came to observe in clinical interaction with Dr. H., the chiropractor. Present in the waiting room were two regular patients, a male, Mr. Z., and a female, Ms. Y., of about 45 years and 30 years old respectively. Miss R., the receptionist, had dutifully registered Mr. A. and had tried unsuccessfully to engage him in casual conversation. Mr. A. had a serious look about him and it was possible to misread his countenance.

Miss R.: [To a regular male patient, Mr. Z.] It's been a while since you were here...remember seeing you all bent over, kind of like an old man. How're you doing?

Mr. Z.: Yeah, I am getting old. I hurt my back hustling around with the kids. My doctor [M.D.] says he can't find nothing...could have been crippled if I don't come here....O.K. now...(inaudible)...(my wife?) surprised how well I get around.
Miss R.: Don't quite know what it is...lots of people are hurting these days....Always good to do something about it before (inaudible)....[Looking at Ms. Y. and directing her comment to her]...Say, how're you doing...look pretty O.K.

Ms. Y.: I felt better last time but lately I've not been myself. [Did not disclose the nature of her health complaint.]

Miss R.: Happens all the time....specially with some people. Got to keep at it. Some people I know feel better and then forget to keep at it...Know what I mean?...ran into a friend of mine the other day who was here with knot in the neck...took a couple of treatments from Dr. H., then a couple of times a month...now she's O.K. [Directing her attention to Mr. A., the new client.]...Will be your turn to see Dr. H. Mr.____. Are you O.K.? You kind of look serious, Dr. H. will be with you in a minute.

Mr. A.: I have to get back to work pretty soon. I had an automobile accident 6 months ago resulting in occasional pain in my neck and back.

Miss R.: Poor baby....there are some crazy drivers out there. We've seen a lot of accident problems lately. Yep, I guess it's your turn now, (indicating to Mr. A. to proceed to Dr. H.'s office). Are you going in too? (Surprised that I wanted to observe the interaction)...Will be nice to know 'bout who you're with....I guess it's O.K., Dr. H. knows about it.

In this example, repeated regularly in chiropractic clinics in different ways, chiropractic receptionists or secretaries used the waiting period to initiate the client socialization process, this time through the experiences of regular clients. Mr. A., the new client, learned that he was not alone in his discomfort nor in seeking chiropractic help, especially for his particular health complaint. More importantly, through dialogue with regular patients, the receptionist was able to involve Mr. A. in ongoing interactive activities in the waiting room. I could not be sure whether all the "successful" examples of chiropractic treatments that were noted by receptionists were, indeed, accurate.
Nevertheless, the role of receptionists and secretaries as "waiting room catalysts" for clients' education, socialization and interaction was clearly part of the ongoing behaviour in the clinics. The chiropractic receptionist or secretary seemed to occupy what Goffman (1963:128-131) has termed an "opening position" in that she had the licence to approach those persons in the waiting room with whom she was not acquainted. In one sense, she is a host whose duties may be said to involve the first contact and "welcoming" of clients. Consequently, she has the "license" to structure interactions between new clients and regular patients, transforming the waiting room into a centre for focused and unfocused interactions. Occasionally, I saw receptionists involve other persons, who were accompanying new clients, in ongoing conversations. (Twelve new clients were accompanied to the clinics by either a relative or a close friend.)

The extent to which receptionists in the official allopathic [M.D.] behaviour setting fulfill similar roles is not clear. From my own experience, either as a patient or in the company of family members who were patients, the receptionist-patient relationship in allopathic waiting rooms appeared to be an end in itself. The relationship was business-like and often initiated mainly to secure specific information concerning the patient's medical background. In allopathic clinics, the receptionist would open a specific channel of communication through which the patient is expected to respond, such as age, name and address. In chiropractic clinics the receptionist would initiate and sustain the flow of communication by supplying a set of definitions concerning the nature of the behaviour setting, therefore, promoting less formal and less bureaucratic relationships.
During the process of this study, I made four visits to my family doctor and another two visits in the company of friends to two other family doctors. During these visits, I observed, much more deliberately how receptionists related to new and regular patients. During each of these visits, the waiting periods lasted from about fifteen to forty-five minutes. At no time were the receptionists engaged in casual conversations with patients beyond obtaining relevant statistical information upon the arrival of each patient. At no time did the receptionist in my family doctor's clinic engage me in casual conversation, although my family and I have been regular patrons of the clinic for six years. On the other hand, all chiropractic receptionists were observed to initiate casual conversations with anyone within conversational range as well as offer information, and sometimes coffee, to new and regular patients.

Frequently, experienced regular patients were used by chiropractic receptionists, secretaries, assistants to provide situational support in order to lend credence to claims concerning the promise and effectiveness of chiropractic, as well as to assure new clients of satisfactory results of chiropractic treatment.

Receptionist: [To a regular patient just coming in through the entrance] Hello...what are you doing here today...expecting you next month.

Regular Patient: Just brought my friend to see Dr. [chiropractor]. We're supposed to be going to the cottage...says his neck hurts after last night...sort of depends on what he's been doing (laughter).

Receptionist: You want him fixed up like you were...that explains it.. Remember to get us something nice from the trip.
6.2.2 The Treatment Area

Treatment or adjustment areas varied in dimensions and location within the building as well as in content. Some of the treatment rooms in solo clinical practices had direct access from waiting rooms. Although a few solo clinics had hallways leading from waiting rooms to treatment areas, it was generally in group clinical practices that one or two hallways led from waiting rooms to treatment rooms and washrooms. In all cases, treatment rooms had sufficient space to allow for easy mobility around "adjustment tables".

The majority of hallways were adorned with pictures, bulletin boards, and especially bold print chiropractic messages, some of which were found in the waiting rooms of other clinics. Some messages were simple while others were more detailed but noticeable by the bold lettering of the captions. Some of the captions and messages read as follows:

- Stay Healthy And Live Longer By Relying on Nature Instead of Drugs
- Look At Your Posture. Others Do.
- When You Are Sick, Injured, Or In Pain, Think Of Chiropractic First.
- Good Health Doesn't Cost, It Pays.
- Mould Your Future With Chiropractic
  (An Educational Advertisement for prospective students of Chiropractic).

These messages constantly reminded clients of the necessity to keep healthy, and emphasized the role of chiropractic in achieving this goal.

Chiropractic treatment rooms featured two or sometimes three large charts depicting the nervous system, the skeletal system and the muscular structures of the human body. These were often attached to the walls and given prominence in the room. The commercially produced charts usually had details of anatomical
structures, especially of the nervous system and the vertebral column. Also, at various corners of most treatment rooms hung replicas of the human skeleton, sometimes without the appendages. The skeletons sometimes faced the walls, exposing the spine. In some clinics, the skeletons had pieces of thin multi-coloured cords interwoven between the vertebra to demonstrate the major and minor nerves as they emerged from different parts of the skeleton and intervertebral spaces.

In addition to these visible, professionally appearing charts and devices, there were a few printed messages which were hung on various walls of treatment rooms. The number of signs varied between clinics but they were generally similar to those that are found in waiting rooms and hallways. One popular sign indicating a health "Resistance Chart", had the following messages:

<table>
<thead>
<tr>
<th>Resistance Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Health</td>
<td>100% life</td>
</tr>
<tr>
<td>Not Feeling Well</td>
<td>75% life</td>
</tr>
<tr>
<td>Sick</td>
<td>50% life</td>
</tr>
<tr>
<td>Very Sick</td>
<td>25% life</td>
</tr>
<tr>
<td>Dead</td>
<td>0% life</td>
</tr>
</tbody>
</table>

What is your Resistance?

Some treatment rooms also included various devices such as vibrators and one or two mechanical devices. One chiropractor commented that some of the devices were simply used to measure skin temperatures. Another chiropractor referred to something he called a "Tokki Machine" used to measure "energy flow", but claimed he has never used it. The machine has a blunt needle which is used to apply pressure but does not penetrate the skin. In some clinics, a stethoscope was sometimes casually placed on a sidetable or cupboard. Ostensibly, it is used to listen to the heart beat.
The most prominent fixture in all chiropractic treatment rooms were adjustment tables which occupied central locations. It is the adjustment table that provides the chiropractor with the chief professional intervention mechanism for treating patients.

It may be assumed that the chiropractor and his receptionist, secretary or chiropractic assistant constituted a "performance team"\(^1\) (Goffman, 1959:79) in that they cooperate in staging behavioural routines which serve to supply the new client with a specific and consistent set of definitions and expectations within the total configuration of the chiropractic behaviour setting.

Cooperative teamwork, which is usually not immediately or readily observed, varies somewhat within different clinics. Except in the most overt instances, however, cooperative teamwork is always routine, inconspicuous behaviour.

The following cases are used to illustrate the nature of cooperative teamwork between chiropractors and their assistants when confronted with problem patients.

Case 3

While I was being shown around the treatment room by Dr. V., his receptionist, Mrs. S., knocked on the door.

Dr. V.: Yes, come in.

Mrs. S.: I'm sorry to bother you Dr. V. I did not realize you haven't finished with Mr. Ini....did I say your name right?
   [I responded: Just about right. It is pronounced as in "Any".]

Dr. V.: I am almost done if it is okay with you, Mr. Ini.

Mrs. S.: Remember Mr. . He sent his friend to see you. He is kind of in a hurry...wants to see you. He says he's got a plane to catch. Em....didn't say much. Seems the way he carries on...dressed and all, he's an important guy.
Dr. V.: What's he wearing.

Mrs. S.: Three-piece, you know....rich. I don't know.

Dr. V.: What's wrong with him?

Mrs. S.: Didn't say....just his name....mentioned Mr. ____.

Dr. V.: Give me a few minutes. Say, Mr. Eni, do you mind waiting in my office?

Dr. V. accompanied me to his office whereupon he put on his white coat, straightened his tie and warmly welcomed the visitor, who turned out to be a sales representative promoting a special chair for back problems. The sales representative had been directed to Dr. V. by an "important" former patient.

Case 4

I visited another clinic to observe the treatment of a prospective client whom I had interviewed at home. The chiropractor, Dr. B., welcomed me in his office and we were discussing procedure for observing him in treatment when his receptionist came in and wanted to talk to Dr. B. before he saw his next patient. The receptionist seemed to want to talk privately with Dr. B., but he told her not to worry about my presence. Dr. B. said to Miss T., the receptionist: "Go on, that's O.K."

Miss T.: There is a patient who is complaining about time and wants to see you.

Dr. B.: Who is he?

Miss T.: Never been here before. He was asking around what's going to happen...Says to Mr. ____ (a regular patient) he is not sure if he's going to get help....Says something like meta [sic] something, and then arthritis.
Dr. B.: Get me his file. What did you notice...Is he in a hurry? [Miss T. brought in the registration file for the new patient, Mr. K.]

Dr. B.: [Perusing the file] OK, ask him if he's been to his family doctor...if he is on medication. I'll see him in 3 minutes.

Later, as Dr. B. was proceeding to the treatment room, I explained to him that I had come to observe Mr. K.'s treatment. I explained that I had interviewed Mr. K. prior to his visit and that I did not know much about his condition or what treatment he would receive. What I did not tell Dr. B. was that Mr. K. had told me he has been diagnosed as having some form of "metabolic disorder" which might be linked to his occasional joint pain or rheumatoid arthritis. Subsequent questioning by Dr. B. was aimed at finding out what Mr. K. thought he had and what his family doctor had told him.

These two cases are illustrative of the nature of cooperation aimed at gaining prior information about potential clients. Knowledge of prior information, therefore, enabled the chiropractor to structure his relationship, conversations, and general performance towards managing the impression of the client. In Case I, the chiropractor did not have sufficient prior information on which to structure his performance. His receptionist was unable to elicit much information to be transmitted to Dr. V. while the client was in the waiting room. The visitor's manner of dressing ("three-piece suit") gave the chiropractor the impression that the client was someone of importance to be impressed in a particular manner. By putting on his white coat and straightening his tie, Dr. V. was essentially structuring the impression he would like to present to the "patient". He was able to do so with the cooperation of Mrs. S., his
receptionist. Both the receptionist and Dr. V. were acting collectively in promoting a favourable image.

In Case 4, so little information was provided by Miss T. to Dr. B. that Dr. B. needed more information. Some questions, unavoidably arose: Was he in the process of encountering someone who had medical knowledge? Was he going to encounter a difficult client? What has the new client been told about his condition by the family doctor? What was the new client thinking? Again, the receptionist, Miss T., was instrumental, as a team member, in structuring the impression Dr. B. created for Mr. K. The performance team of Dr. B. and Miss T. tried to figure out what problem led Mr. K. to seek chiropractic. As we shall see in Chapter 7, individual chiropractors adopt different tactics in eliciting client beliefs about their health complaints and about ideas regarding the resolution of these complaints.

6.3 Summary

In this chapter, I have discussed constraints on chiropractic and the impressions people have about chiropractic from the point of view of potential chiropractic clients and chiropractors themselves. The majority of new clients get to know about chiropractic from present or former chiropractic patients, often without support and encouragement from friends and family members. Chiropractors do not have as much access to most official avenues for disseminating information as does allopathic medicine, hence, they must largely rely on satisfied patients for their clientele. Many chiropractors have difficulty "attracting" new clients while new clients generally do not know what chiropractors do. In particular, expectations regarding advice and treatment
differ between chiropractors and new clients, the latter varying considerably. The ability to provide personalized professional attention to new clients appears to be a major focus for chiropractors, usually as a way of improving public acceptance of chiropractic.

Chiropractors manage impressions of clients in different ways. Different parts of the "front", such as waiting rooms, treatment rooms and linkages with wider socio-political structures are given special attention aimed at convincing new clients that chiropractic is a safe, conservative and professional treatment.

New clients are persuaded through abundant chiropractic information leaflets, newspapers and "crisp" messages aimed at reminding and educating them about chiropractic. All areas of chiropractic behaviour settings are inundated with information about the role of chiropractic in health care. A strong professional image is conveyed and visual sketches and diagrams are used to simplify disease-health relationships. Perhaps, because of special constraints chiropractors face, there is almost "too much emphasis" in educating and socializing new clients. The anatomical charts, messages on notice boards, booklets, leaflets, newspapers, and pictures on walls all serve to "bombard" the visitor with chiropractic information.

An important link in the socialization, education and treatment of clients is the "performance team" composed of the chiropractor and his helpers. Close scrutiny of chiropractic clinics show that the 'team' attempts to gain information, social as well as medical, about clients prior to interaction with chiropractors. These attempts appear to be deliberately staged, indicating that "stage management" is an important feature of the behaviour setting of chiropractic in the study area.
1. Goffman (1959:79) has defined a performance team as referring to "any set of individuals who cooperate in staging a single routine".
7.0 MANAGING IMPRESSIONS AND NEGOTIATING EXPLANATORY MODELS

Impression and stage management are important features of the ongoing process of client socialization by chiropractic. It was indicated in Chapter 1 that chiropractic as a profession in British Columbia has faced legal, political, social and economic constraints which are more severe than the types of constraints that are faced by chiropractic in other Canadian provinces. Those persons who have sought help from chiropractors have done so because former chiropractic patients have suggested that they visit a chiropractor. New clients often lack consistent information regarding what chiropractic is, what chiropractors do, and how to go about obtaining chiropractic help for their health complaints. Very often, new clients do not have the support and encouragement of their friends and family, and more than half of the chiropractors have acknowledged that it has been difficult for them to recruit enough patients for their clinics. Although chiropractors have been trained in other treatment skills such as electrotherapy, they have been limited clinically to using only their hands in treatment.

Persons who have taken the first step towards visiting chiropractors for the first time often did not know enough about chiropractic to compare it with other healing groups in the province. Consequently, only 3% of new clients have rated chiropractic high as a profession. Generally, information about chiropractic that new clients have acquired before their first visits to chiropractors have been obtained from a variety of sources, often without encouragement from their family doctors. Consequently, new clients have been
apprehensive, doubtful, and generally uncertain about chiropractic because of the historic perception of chiropractic as a deviant or marginal occupational group compared to well-institutionalized "official" allopathic medicine. Chiropractors themselves, therefore, have felt that, in order to negate the effects of deviant perceptions, they should demonstrate a "professional appearance", have a "positive and directive attitude", work in "nice modern offices", and be "friendly", "relaxed" and "sincere" in order to gain the confidence of clients (Appendix XVI).

In part, the process of reorienting clients' perceptions and impressions about chiropractic has been via persuasive interaction structures and processes. While persuasive structures have related to the organization of clinical behaviour settings including wider sociopolitical linkages with the community, persuasive processes have focused on actions within behaviour settings that help manage the impressions of clients. Although it may be said that the collective duty of all chiropractors in British Columbia is to assist in improving the image of the profession, nevertheless, it has been the individual chiropractor who has carried out this function in his own clinic. Strategies for convincing new clients have been individually constructed since clinical realities differ somewhat with each new client.

I have argued that in order to deal satisfactorily with the different clinical realities presented by new clients, individual chiropractors must understand something about their beliefs and explanations regarding health, disease, treatment systems, and professional healers in order to negotiate common "platforms" for providing treatment. By querying new clients as well as chiropractors about their various beliefs, expectations, explanations for
illness problems, constraints on chiropractic and the impressions they have about chiropractic (Chapters 4 and 5), it became possible for me to examine congruencies and incongruencies between client and chiropractor explanatory models. Thus, chiropractors would have to negotiate any "discrepant perceptions" in order to retain new clients as chiropractic patients.

Through observations of individual chiropractic clinics it was found that chiropractors use particular "resocialization strategies" to modify perceptions of new clients (Chapter 6). The observation of clinical negotiations of explanatory models reveals that new clients also "resocialize" chiropractors to a certain extent. However, through the projection of a conservative, professional image, new clients are induced to modify any deviant perceptions of chiropractic that they may have entertained. Through abundant use of information booklets, leaflets and other materials, patients are given a chiropractic "education" in order to minimize the effects of the lack of information about chiropractic. Client education is further "buttressed" by the activities of chiropractic assistants, such as receptionists, who "coopt" the experiences of "satisfied" regular patients in educating new clients. Thus, the performance team of the chiropractor and his assistant cooperate in staging behavioural routines which supply the client with a specific and consistent set of definitions and expectations within the overall configurations of the chiropractic behaviour setting. In particular, the chiropractic assistant or receptionist, in many instances, not only obtains information relevant to a client's health and social needs, she also transmits such information to the chiropractor, thus alerting the latter, ahead of time, of possible difficulties which may arise during interaction for assessment and treatment. The
cooperative teamwork between some chiropractors and their receptionists or assistants is not easily observable, except in the most overt circumstances of their role performance.

In this chapter, negotiations of explanatory models [EM] between chiropractors and new clients are described. Also described are some characteristics of clinical communication in 6 chiropractic clinics covering 18 two-party exchanges. Although both new clients and chiropractors used mechanical analogies in conceptualizing the functions of human body, these conceptualizations were differently articulated. For new clients, it was blood in the circulatory system, "transportation mechanism" which was chiefly responsible for getting rid of poisons, expelling waste products and for keeping all body organs healthy and functional. For chiropractors, it was the central nervous system, through the self-equilibrating process of homeostasis, as well as energy balance, that was responsible for the well-ordered functioning of the human body. Chiropractors viewed the human body as self-regenerating, clients viewed it as requiring help because it could be "invaded" by germs and poisons. Thus, clients and chiropractors would need to negotiate not only "blood" versus "central nervous system" perspectives of human body functions, but also "invasion" versus "energy imbalance" as causes of illness and disease. The role of "mental energy" is especially important in the chiropractic perspective for health promotion.

Explaining how illness is caused and how it works in the body is important for chiropractors. For example, notions of "postural strain and tension", "muscular disrelationships" and especially "subluxation" warrant explanation. Clients who believe that hereditary factors or factors such as changes in climatic conditions cause illness, will have difficulties with chiropractic
explanations of causes of illness. In general, different rationalizations of illness production, causation and remedy will have to be negotiated by chiropractors to enable chiropractic treatment. Although allopathic physicians do not try to convince patients about cause before recommending treatment, new chiropractic clients in this study often believe that germs cause illness, and they express a preference for drugs and medication. Chiropractors, therefore, have to dissuade clients who begin treatment with a strong allopathic orientation.

New clients and chiropractors were interviewed after either their initial clinical encounter or after a few interactions between them to ascertain whether there were any changes in their pre-interaction beliefs and explanations about illness. Twenty regular chiropractic patients, randomly chosen from those in attendance at the clinics at various times, were interviewed to see whether their clinical experiences corresponded to the post-clinical interaction accounts of new clients. The results of these interviews are presented in Tables 16, 17 and 18 and discussed in this chapter, along with descriptions of chiropractor-client negotiations of health and explanatory models. The foci of the interviews are (a) whether or not chiropractors understand the health problems of new clients, and whether they have preconceived notions or "hidden" agendas about particular illness problems; (b) whether disagreements or areas of differences between new clients and chiropractors are completely resolved; (c) any changes in opinions about chiropractic and expectations about treatment from those that were held prior to interacting with chiropractic; (d) how treatment has been evaluated; (e) reasons for continuing or discontinuing treatment; (f) time spent in treatment; (g) changes in treatment methodologies; (h) comparing
chiropractic with other professions; and (i) further comments opposite to particular difficulties arising from the interaction or experience.

In this chapter, the results of the post-interaction interviews are discussed together with some descriptions of clinical interactions that I have observed. Some examples are provided from my observation regarding how chiropractors negotiated explanatory models. Although individual behaviour patterns and negotiation skills will be discussed in most instances, emphasis will be placed on aggregate behaviours that collectively characterize clinical negotiation. Also, the characteristics of clinical communication in six clinics will be described and compared with what is known about allopathic clinical communication. The purpose of such a comparison is to emphasize how the form of chiropractic clinical communication assists in the making of chiropractic clientele.

This research cannot fully address the questions of whether the negotiation process undertaken by chiropractors is, itself "staged" in order to lure the new client into a long-term commitment. Nor can this research conclusively establish whether new clients who became regular chiropractic patients did indeed acquire lasting beliefs and explanations about health and illness. Such questions could eventually be answered through a longitudinal study involving even closer observational scrutiny, as well as follow-up interviews. Some attempt will be made, however, to infer the degree of "sincerity" in the chiropractor-new client negotiations.
7.1 Chiropractic Self-Presentation

The framework that has been used in observing how chiropractors present themselves in clinical behaviour settings is offered in Goffman's (1959) seminal work, *The Presentation of Self in Everyday Life*. Goffman discusses interactive behaviours in terms of performance teams, discrepant roles, out-of-character communications, and the art of impression-management. Chiropractors, too, "give expressions" as well as "give off expressions", the former involving "verbal symbols or their substitutes" which are used "solely to convey the information" that are commonly known by their symbols, and the latter involving "a wide range of actions that others can treat as symptomatic of the actor, the expectation being that the action was performed for reasons other than the information conveyed in this way" (p.2). In the following discussion, both sets of expressions are examined, and provide some indication of the intentionality of the behaviour.

All twenty chiropractors preferred conservative clothes such as pants, shirts, jackets and ties which enabled them to project a clean professional image. A few of them wore white coats "as the occasion demanded". Those whose clinics were located in the more affluent parts of town tended to favour blue jackets and blue ties. As I will discuss later, the use of white coats by a few chiropractors seemed to depend on what impression needed to be conveyed and to which client. The expressions that were "given off" by chiropractors suggested behaviours that were consistent with scientific orientation, i.e. a clinical presence similar to that associated with official allopathic physicians. Similarly, by favouring blue coats and ties, some chiropractors whose clinics have been located in the wealthier "blue chip" parts of town seemed to "give
off" the expression that they, themselves, were also professional "blue chip" individuals.

Generally, the chiropractic assistant or receptionist would announce to a new client by name that it was his or her turn to be seen by the chiropractor and accordingly directed the client to the entrance of the treatment room. Most often, the new client was accompanied by the receptionist and subsequently introduced to the chiropractor. Typical introductory lines are as follows:

Receptionist I: Dr. _____, Mr.(Mrs.)(Miss) _____ here to see you. He(she) has been kind enough to wait as he(she) has to get back to work soon. I know you have been busy all afternoon.

Receptionist II: I am glad you are able to see Mrs.(Miss)_____. She has been in pain sitting for a while.

These "lines" of introduction seemed to indicate a process in which the receptionist conveyed some information about new clients to the chiropractor, especially information she had picked up in the waiting room but which she was unable to convey to the chiropractor during one of her many short trips to his office. Secondly, the chiropractor would be furnished an opening line or topic such as the new client who is anxious to return to work, or who has been sitting in pain in the waiting room.

Chiropractors met with new patients in a treatment or adjustment room as in their private offices for the preliminary interview. In whatever arena a new client was received, he or she was warmly welcomed, mostly with handshakes for men, an easy smile, and an indication to the client to "have a seat", "please sit down", "where would you like to sit", or "why don't we make ourselves
comfortable". On several occasions, the chiropractor offered "foam" or "pillow" support for clients with back pain, a rare gesture in allopathic settings.

In every instance, new clients were immediately engaged in casual conversation by the chiropractor, which was then sustained by some clients. Some opening statements probed non-medical areas of the client's world; for example:

Case 1

Dr. C.: I hear you're in a hurry to get back to work, what do you do?

Client: I am a school teacher - Grade 4.

Dr. C.: I wonder what is happening these days....Is it like the old days, learning and all?

Client: Quite a bit different....kids are more inquisitive, demanding and sometimes spoiled...puts some strain on teachers.

From such casual conversations, chiropractors not only became better acquainted with their new clients, but also they are provided with clues regarding what was likely to be of concern to the client, in this case "strain on teachers." As I will discuss later, the approach of individual chiropractors in eliciting clients' health beliefs vary considerably depending on how cooperative a new client proved to be in offering personal information or how engaging in casual conversation.

The chiropractor "gets off on the right foot" by presenting a cheerful appearance, by dressing in a professional manner, by wearing an easy smile, and by engaging new clients in "free flowing" casual conversations which are often unrelated to particular health complaints. These behaviours made it easier for
chiropractors to educate new clients on chiropractic philosophy and to negotiate treatment.

Sometimes, a difficult situation arises in which the chiropractor is unable to "get off on the right foot", thus necessitating "protective practices" or counter-reactions (Goffman, 1959:13).

Case 2

Mr. D. was a company executive with a serious countenance about him. He indicated to me during the initial interview that he is "very skeptical" of what a chiropractor can do for his neck pain. His wife had urged him to seek chiropractic help, having learned of such assistance from a friend. Mr. D.'s first encounter with Dr. B. was not typical of other encounters I had observed in this or other clinics before that time. Mr. D. did not wish to engage in casual conversation having walked to a chair past the smiling practitioner with outstretched hand.

Dr. B.: How are you feeling today?

Mr. D.: I wouldn't be here if I am feeling like a million dollars! What are you going to do about my neck...It has been causing me problems for a year now and I have had all kinds of medical tests both here and U.S. Some specialists have told me it will go away if given time...started on a squash court.

Dr. B.: Let me have a look [moving behind Mr. D. and about to palpate his neck].

Mr. D.: No problem bending my neck or turning it...only when I sit for a while...sort of gnawing pain...quite deep...here, let me show you (pressing his right index finger on his lower neck).

Dr. B.: What exercises do you do?

Mr. D.: Told you I play squash...been playing it over ten years.

Dr. B.: I may have to adjust your cervical vertebra.

Mr. D.: What's that...I mean adjust, I told you I have no problem bending or turning it.
Aggressive and skeptical responses from Mr. D. did not offer Dr. B. any avenues for "getting off on the right foot". His subsequent attempts at explaining chiropractic views of "musculoskeletal disrelationship" were met with "can you prove it?" Dr. B. then resorted to "protective mechanisms" as a way of dealing with philosophical disagreements. First, he blamed allopathic medicine for "disinformation" about chiropractic. Then he inferred that Mr. D. did not have an "open mind" and that the failure of other specialists in the U.S. and Canada called for him to have an "open mind" about other sources of help. Mr. D. turned out to be one of the seven new clients who discontinued chiropractic treatment for various reasons before completing the four visits.

Some chiropractors presented themselves by using opening statements which dealt with fundamental information contained in chiropractic leaflets or booklets which new clients had read or seen in waiting rooms. For example: "How can chiropractic help your body help itself?" Or, "Now let us do something about your back pain". The use of plural "us" or "we" was a common feature of opening and continuing sentences. The new client was often encouraged to believe that mutual cooperation was required for him to get well or that a cooperative effort between chiropractor and client was a necessary condition of ongoing care. One chiropractor commented to a patient as follows:

"You get good and beautiful music when all instruments harmonize and play together as the conductor wants them to... one player out of sync, you get a problem on your hands... the music doesn't synchronize anymore."

Nine of the twenty chiropractors observed in clinical interaction used quite different but indirect means for obtaining prior information about new
clients. These chiropractors then had much better access to health beliefs of new clients than their colleagues. During the first visits, new clients were asked by those chiropractors to fill out information forms about themselves. These forms contained questions about age, sex, occupation, health complaint, limits to activities, family relationships, descriptions of experience with health complaints, onset of illness, symptoms, previous treatments, general health history, particular health and dietary habits and reason for seeking help from chiropractic. Space was provided on the forms for elaboration of responses.

The forms were made available to chiropractors by receptionists prior to their encounter with clients. The chiropractors examined the forms in the privacy of their offices and evaluated the nature of problems they would come across. One chiropractor explained it this way.

"I get to know the patients by having them fill out own medical history, health complaints, degree of pain and so forth...It helps the patients psychologically by helping reduce anxiety and nervousness. I get the patient's profile, personal feelings, extent of pain, and what he is thinking about his problem before I see him or her...Saves time, don't you think?"

The requirement that new patients provide "full information" about themselves and their health problems before the initial interviews was a useful innovation. I noticed that chiropractors who adopted this practice appeared to have more and fuller information about the health beliefs of new clients. I also observed that new clients in these clinics appeared more relaxed and more willing to engage in casual conversations with receptionists and chiropractors.
Moreover, none of the new clients I observed in the clinics which used this process discontinued treatment.

During the initial encounters, new clients were encouraged to discuss their health problems and concerns as fully and as exhaustively as possible. The longest time in the encounter was spent during initial interviews when clients were given the impression chiropractors were attentive to their health complaints. These occasions were marked by frequent eye contact and concentrated attention on the part of chiropractors. Quite often, single words, phrases or short sentences were used to encourage clients to continue in their explanation of events and circumstances. Examples of such words and phrases are: "Then?", "Go on", "What happened", "And so?", "Is that right?", "With what?", and so on. This form of encouragement was used to minimize interruption of client's expressions of their feelings as well as to elicit more "usable information" with which to "structure" the negotiation of treatments. Careful attention was often paid to the immediate needs of new clients. For example, one chiropractor offered a distraught new client a glass of water during an emotional scene in which the client was relating unpleasant stories about her wayward husband.

72% of clients indicated at the beginning of study, prior to their first encounter with chiropractors, that it was very important for them to be able to talk easily to a healer, and 54% felt that it was also very important how they were treated in the offices of professional healers (Table 31). 70% of chiropractors agreed with new clients that it was very important for them to talk with new clients in an easy manner. 90% of chiropractors also agreed with new clients that it is very important the way clients are treated in clinics (Table
Table 31

Preferred Healer Characteristics: Views of New Clients and Chiropractors

Question: In your dealing with a healer, how important do you consider the following: [Clients n=60, Chiropractors n=20]

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Being easy to talk to</td>
<td>71.7</td>
<td>70.0</td>
<td>15.0</td>
<td>25.0</td>
</tr>
<tr>
<td>- Showing the same opinion about your illness</td>
<td>32.0</td>
<td>30.0</td>
<td>25.0</td>
<td>40.0</td>
</tr>
<tr>
<td>- How s/he treats you in the office during treatment</td>
<td>54.0</td>
<td>90.0</td>
<td>13.0</td>
<td>10.0</td>
</tr>
<tr>
<td>- How s/he presents himself or herself</td>
<td>42.0</td>
<td>60.0</td>
<td>42.0</td>
<td>20.0</td>
</tr>
<tr>
<td>- How her/his office looks</td>
<td>12.0</td>
<td>60.0</td>
<td>45.0</td>
<td>20.0</td>
</tr>
<tr>
<td>- What s/he uses in treating you</td>
<td>23.0</td>
<td>-</td>
<td>45.0</td>
<td>-</td>
</tr>
</tbody>
</table>

Percentage: %
When asked about their experiences after initial encounters with chiropractors, 93.3% and 85% respectively, said they found it easy to talk to chiropractors and that they were treated "just" the way they wanted to be treated in chiropractic offices during interviews (Table 32). In general, new clients felt that chiropractors were also able to share their own opinions about illness (70%) and present themselves in an acceptable way (97%). Before visiting chiropractors for the first time, new clients expected to be given the opportunity to explain themselves properly in order to convey their personal feelings about health problems in a relaxed and comfortable atmosphere. They also expected that professional healers would have the ability to relax them as well as listen sympathetically to their problems (Appendix XV). These were exactly the experiences chiropractors provided new clients. Before interacting with new clients, most chiropractors wanted to have "good rapport" with them. They also wanted to "relax" them because "good rapport", "good communication" and relaxation would help to "lessen the burden of illness" for clients. They wanted to bring out "hidden and relevant factors which related to" health complaints such as "Christian beliefs about divorce". They wanted to have mutual understanding with patients as "friends" and to show "respect" because most "people are put off by how others behave or by what they see around them". Most of all, they wanted to treat patients "just like" they wanted to be treated themselves (Appendix XVI).

Before encountering new clients, 90% of chiropractors had agreed that "it is very important how a practitioner relates to a patient" in the clinical setting, because it would result in high compliance with treatment if there is mutual respect (Appendix XVI).
Table 32

Impressions of New Clients about Chiropractors

<table>
<thead>
<tr>
<th>Question: Was the CHIROPRACTOR:</th>
<th>No. of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)  Easy to talk to?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>56</td>
</tr>
<tr>
<td>Somewhat</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>(b)  Able to share your own opinion about your illness?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42</td>
</tr>
<tr>
<td>Somewhat</td>
<td>11</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Don't Know</td>
<td>6</td>
</tr>
<tr>
<td>(c)  Able to treat you the way you wanted to be treated?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>51</td>
</tr>
<tr>
<td>Somewhat</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
</tr>
<tr>
<td>(d)  Able to present himself in a way acceptable to you?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>58</td>
</tr>
<tr>
<td>Somewhat</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
</tr>
</tbody>
</table>
During my numerous visits to chiropractic clinics to observe clinical interactions, by chance, I came across an undated document written by one Dr. Herb Vear, a chiropractor, entitled, "The Practice of Clinical Chiropractic". According to my host practitioner, the document is used in continuing chiropractic education of chiropractors in British Columbia. The 36 page document discusses several aspects of clinical practice which emphasize the importance of the chiropractor-patient relationship. Dr. Vear writes:

"The patient/doctor relationship is one of the highest callings in human intercourse. No single attribute is more difficult to acquire and more exacting to maintain than the bond between doctor and patient. Effective interpersonal skills do not just happen nor are they inherited; they are learned....Positive human relations with patients are enhanced by developing patient cooperation, by showing concern and consideration for patient distress and then attempting to relieve anxiety, tension and discomfort by listening, understanding and communicating." (p.7)

The document goes on to emphasize the importance of maintaining a relationship with clients beyond the first clinical encounter. It advises as follows:

"The establishment of a doctor/patient relationship is not the only outcome from the first meeting with the patient... the outcome from this interview will be:

a) establishment of a doctor/patient relationship with a continuing goal to build trust, communication and understanding.

b) an appreciation of the patients' chief complaint and the reasons for consulting with the chiropractor....

History-taking provides the chiropractor with a continuing opportunity to develop rapport with the patient through empathy, understanding and patience. At the same time, the chiropractor reaches a value judgement on appropriate examination procedures required to arrive at a clinical impression.... (pp.7-11)."
I have quoted extensively from this training document in order to demonstrate the importance chiropractors have attached to initial encounters with clients, especially regarding the retention of clients as patients through the establishment of positive relationships, trust and confidence. What I observed in various clinics was a concerted effort by chiropractors to show "concern and consideration" for clients' distress, and to elicit the "real reasons" why new clients would consult them, their particular views about pain and discomfort, and the limitations that their health problems have placed on social, occupational and related activities. Kleinman (1986) has used the terminology "Empathic Witnessing" to describe the sympathy a healer must have as he enters a patient's lifeworld. Chiropractors were observed to "empathize", in a convincing manner with "suffering" clients. Thus, new clients became more willing to share related experiences, social, as well as medical, with them. The mutual sharing of information, therefore, enabled chiropractors to gain better access to clinical realities as perceived by clients, how clients felt about treatment systems, and what their beliefs and experiences had been prior to seeking help from chiropractic.

All new clients who were observed during the first clinical interactions with chiropractors were given ample opportunity to ask questions, seek further clarification, and decide when the interview process had been exhausted. There was no rush on the part of chiropractors to conclude the interviews. One chiropractor commented:

"I am in no hurry to get rid of the patient...not at all. On the contrary, the more questions the patient asks, the
better the chance he will accept and continue treatment....
it's not psychological, it is how everyone feels...you got
to understand it to use it."

Some new clients commented as follows:

"He put his finger on it...Like I said, something is wrong
with my backbone, but my doctor [M.D.] couldn't tell from
so many x-rays." (Appendix XVII).

When new clients were asked, after their initial visits to clinics, whether
or not individual chiropractors understood their particular problems, 78% said
chiropractors understood their problems, 16% said maybe, and only 5% said their
problems were not understood (Table 34). Those who said their problems were
understood felt that individual chiropractors "listened", "relaxed" them, and
"took a bit of time to explain" the problems, because they were "patient" and
they showed they "really cared".

The views and experiences of regular chiropractic patients supported the
observation that chiropractors made sure they "got off on the right foot" in
order to create a favourable impression on new clients. All twenty regular
patients interviewed found it was easy to talk to chiropractors. 75% felt they
were treated in the manner in which they wanted to be treated, and 70% found
that the way chiropractors presented themselves was quite acceptable to them
(Table 33). However, 60% of regular patients were unable to recall whether or
not individual chiropractors understood their problems during their first visits
to clinics partly because it had been "such a long time". 25% were able to
indicate that chiropractors understood their problems and only 3 patients did
Table 33

Impressions of Regular Chiropractic Patients about Chiropractors

Question: During your first visit, was the Chiropractor

<table>
<thead>
<tr>
<th>Question</th>
<th>No. of Patients</th>
<th></th>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) easy to talk to?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>13</td>
<td>20</td>
<td>100%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>No</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>(b) able to share your opinion about your illness?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>12</td>
<td>18</td>
<td>90.0</td>
</tr>
<tr>
<td>Somewhat</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>No</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>(c) able to treat you the way you wanted to be treated?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>75.0</td>
</tr>
<tr>
<td>Somewhat</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>15.0</td>
</tr>
<tr>
<td>No</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>(d) able to present himself in a way acceptable to you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>11</td>
<td>14</td>
<td>70.0</td>
</tr>
<tr>
<td>Somewhat</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>30.0</td>
</tr>
<tr>
<td>No</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Table 34

Post-Interaction Views of New Clients and Chiropractors

Question: [Clients] Do you think the chiropractor understood your problem? [Chiropractor] Can you always tell from past experience what to do about a problem?

<table>
<thead>
<tr>
<th></th>
<th>New Clients</th>
<th>Chiropractors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>78.3%</td>
<td>60%</td>
</tr>
<tr>
<td>No</td>
<td>5.0%</td>
<td>-</td>
</tr>
<tr>
<td>Perhaps/Maybe</td>
<td>16.7%</td>
<td>-</td>
</tr>
<tr>
<td>Sometimes</td>
<td>-</td>
<td>40%</td>
</tr>
</tbody>
</table>

Question: [Clients] Did he make you feel comfortable or not? [Chiropractors] Did you know what to do about a problem?

<table>
<thead>
<tr>
<th></th>
<th>New Clients</th>
<th>Chiropractors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>96.6%</td>
<td>60.0%</td>
</tr>
<tr>
<td>No</td>
<td>1.7%</td>
<td>-</td>
</tr>
<tr>
<td>Not Sure</td>
<td>1.7%</td>
<td>-</td>
</tr>
<tr>
<td>Sometimes</td>
<td>-</td>
<td>40.0%</td>
</tr>
</tbody>
</table>

Question: [Chiropractors] Did you know what to do about a problem...

(a) When you first see a patient?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>60.0%</td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>40.0%</td>
</tr>
</tbody>
</table>

(b) After initial interview?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>80.0%</td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

(c) After interview and examination?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>100.0%</td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td></td>
</tr>
</tbody>
</table>
not think their problems were understood the first time they visited a chiropractor.

After new clients have interacted with chiropractors, 97% of them responded that chiropractors made them comfortable (Table 34). One new client commented:

"...funny, I almost fell asleep...that's how comfortable I was the first time. He's very nice."

Another client said that the chiropractor

"takes time to talk to you, understand how you feel... You just felt you can talk to him...this guy has got some experience...he knows from where you are coming."

Yet another client commented,

"He didn't think I was faking it...I can relate to him... I didn't know what to expect the first time with him, but he took care and really discussed the whole thing."

60% of chiropractors said that they knew what to do about a clients' problem when they saw the client for the first time. 40% of chiropractors said that sometimes they knew what to do about a new clients' problem during their first encounter (Table 34). However, 80% of chiropractors thought they knew what to do about a new clients' health problem after the initial interview. All of the chiropractors said that they definitely knew what to do about a potential patients' health problem after an interview and a physical examination (Table 34).

One chiropractor comments as follows:

"If you conduct an interview and assessment very carefully with understanding, you can generally get the picture of the problem... things that make it worse including stress, posture, and so on. The treatment becomes apparent..."
Another chiropractor comments:

"...I pay a lot of attention to what the patient tells me the first time. If I miss it, I've lost him. The examination is often to confirm what you have learned from the interview."

Another way in which chiropractors gained the trust and confidence of new clients during initial clinical visits was by relating illness problems to clients' life histories. This type of clinical behaviour has been termed "Retrospective Narrowtization" by Kleinman (1986). Nearly always, new clients were encouraged to provide information about their social worlds, living habits and health practices. The information thus obtained provided some reasonable profile of the lifestyles of clients. Quite often, short stories and anecdotes were used by chiropractors to relate "present" health complaints of clients to what had happened in their social worlds and lifestyle. More often, chiropractors often recalled the experiences of nameless previous patients they had successfully treated in the past. The skill with which these examples were related to clients varied among chiropractors. Some would say: "This reminds me of....", or "Just the other day I saw a patient who...." Others preferred to proceed with a discussion of some aspects of clients' lifeworld which had influenced their health. Clients often provided the clues on which anecdotes were constructed by chiropractors.

Case 3

Client: 

"....I feel worse when I get up in the morning...oh, the pain in my back. My doctor [M.D.] told me to sleep on the hard floor or slip a hard board under the mattress. I did that."

Chiropractor: Uh...huh...
Client: I still feel terrible. It went away for a while when I was going to a physiotherapist, but not completely.

Chiropractor: Yes, I understand...what else did you do?

Client: Nothing...just try to tolerate it...Been bothering me much lately, especially when I get back from work...(inaudible). I live in Richmond. Well, I got a new car a month ago...has bucket seats, nice...but I don't enjoy very much sitting in it.

Chiropractor: I see. You like the car, but you feel pain in it (laughter).

Client: Oh yeah....

Chiropractor: Happens all the time with bucket seats. It's not good for sitting posture...let me see...just about 3 months ago a nice young man came in here with same problem. Well, we did something about it...."

An effective way by which chiropractors gained the total attention of new clients and began to reorient or "remoralize" them (Kleinman, 1986) towards chiropractic was through the ritual of physical examination. The preliminary warm-up of that ritual had the chiropractor moving around the adjustment table, pleasantly helping the client settle into a comfortable lying position while making minor adjustments on parts of the adjustment table. Thus, the impression of relaxed and confident expertise was conveyed to the client. Rarely would the chiropractor expose parts of the client's body which were not directly affected by the health complaint or specifically targeted for physical examination. If patients volunteered to expose more of their bodies than had been requested, they would wear special gowns available in the treatment room.

The remainder of the examination process resembled what Goffman (1963: 75-79) has termed "occult involvement". First the chiropractor gently placed his hands on the affected area, usually the back and neck regions of the
vertebral column. He paused for a few seconds, then began to remark softly and absentmindedly to no one in particular with expressions such as, "Hmm...Oh yes!", "...tense, very tense...", or "I can feel it...tense, quite tense."

After what he considered adequate preliminary "feeling" of the affected area, the chiropractor would suggest to the client to "relax...your hands are tense" or "you are tense all over...please ree-lax."

The client was further given the impression that the chiropractor was not only able to detect things throughout the body with his hands by carefully touching and probing the spinal column, but that he also was using his experience in doing something about it. He often assumed total control of the examination routine by asking the client to relax. None of the clients were observed to have objected to the suggestion. "Occult involvement" began when the chiropractor became engrossed in specific and minute examination and palpation of the spinal column, while at the same time exhibiting marked inattention to the social presence of the client. There was usually "a kind of awareness where the individual (chiropractor) gives others (clients) the impression...that he is not aware that he is away." (Goffman, 1963:76).

On many occasions, the chiropractor would ask the client "not to move" or to "remain still" so that both could concentrate on the examination of the spinal column, thus indicating to the client that he was, for the moment, "going away". After several moments, some patients would ask questions which may or may not have elicited a response from the chiropractor. An aura of mystery was usually enhanced when the chiropractor would suddenly ask if the client had experienced any stomach problems such as "indigestion", "gas" or "things like that" in the past few weeks. The inquiries varied from client to client and
from chiropractor to chiropractor but usually related to information that clients had provided during interviews about their health problems. Often clients would reply in the affirmative and would attempt to provide full descriptions of the relevant health habit, or when questioned further, their health beliefs. Sometimes the chiropractor would say to the client: "We will talk about it later", and then incorporate what he heard during the interview and physical examination in his explanation of what had gone wrong with the client's health.

Prior to each inquiry or observation during physical examination, some chiropractors made it clear they had found "something" which they had been looking for. These findings were conveyed to clients by a series of non-communicative utterances and exclamations such as "Hmm...Oh yes", "I see", or "Yep". If a question were asked such as, "Now tell me, has your knee recently given up or buckled?" or "Have you recently had a fall?", and the response was affirmative, an impression was conveyed that the practitioner had the ability to detect problems of the human body in a simple, straight-forward manner. This form of examination process appeared to have quite an impact on many clients. On those occasions when an x-ray picture was taken and processed in the clinic, it would be used to support statements made by the chiropractor about the general posture and health of the client. Other sources of support were anatomical diagrams of the nervous system and spinal column, and life-size models of the spinal column in prominent display in examination rooms. By taking the client to places where the anatomical diagrams hung on walls, or to the location of skeletal models, chiropractors were able to involve clients in elaborate explanations of chiropractic views of health and illness, especially chiropractic "adjustment". Various vertebrae would often be moved around to demonstrate
how they interfered by pressing on the nerves. The entire demonstration, even for someone such as myself with extensive clinical training and experience, was quite impressive and "convincing".

Case 4

Chiropractor: [Pointing to two adjacent vertebrae in the lower back region of model spinal column] This is where your problem comes from...a lot of weakness you've been having lately comes from here...this bone pressing on this one is cutting off nerve supply and possibly blood supply to your legs (demonstrating the process).

Client: But the pain down my leg comes and goes.

Chiropractor: It has to do that [taking the client to the x-ray film]. See how you are bent over some to this side. If you remember what I showed you, the top bone is pressing on the nerves on this side [indicating which side]. Now, when you bend over to this other side to scratch your back, the top bone opens up and does not press on the nerves, and you get relief.

Client: But the pain goes away sometimes for a while...

Chiropractor: It's because of energy stored in the nerves and released to the muscles. When this side opens up, energy goes to the muscles as it is supposed to...and stored there for a while. When it closes up again, some energy remains to keep away pain for a while.

Client: Makes sense.

Chiropractor: You see, everything that we do...breathe, sweat, jog, eat, think, depends on our nervous system...even...they tell our bladder when to get rid of urine, tell us when to eat, even when we are sleeping the heart is beating and we are breathing. Also, our nervous system breaks down...so we have problems with where they send messages.

Client: So to get my posture right, I shouldn't bend this way.

Chiropractor: That is part of it, not all of it. Say, do you want us to get to the bottom of it. In chiropractic we do not treat symptoms, we treat causes of problems."
This style of educating the client was a very convincing one, whether or not the scientific basis or rationalization was correct. As an observer, I was impressed with the sincerity and conviction with which chiropractors communicated their beliefs about the function of the human body. Very quickly, the client is instilled with chiropractic philosophy, how the human body functions and why "adjustment" is the preferred method for treating particular kinds of health problems.

7.2 NEGOTIATING EXPLANATORY MODELS

It was largely through the careful observation of many clinics that the elements of negotiation of explanatory models began to emerge. Very often, the context in which the labeling of a health complaint occurred did not allow for negotiation to occur. For example, clients who made up their minds about what was wrong with them often went along with chiropractic treatment "just to try it out". Some clients allowed themselves to temporarily accept chiropractic treatment without question, while other clients questioned the rationale behind the treatments that were proposed. For example, on a few occasions, a new client would accept the chiropractor's explanations without question, and agree to receive treatment without the "usual" search for clarifications that other new clients exhibited. Nevertheless, it became very clear during clinical interviews that negotiation of health beliefs normally does occur. Chiropractors often took the lead in seeking responses, while most clients cautiously rationed out their responses. The more responsive they were to questions, or the more explanation and detailed discussion new clients provided, the more
chiropractors were able to discern and select clues to clients' beliefs and experiences. These clues were first probed for consistency and later used as a basis for educating and convincing clients about chiropractic in a process which Kleinman (1986) has called "remoralization". This often led to incremental and gradual reorientation of clients towards chiropractic (see Section 7.4).

Although separate chiropractic-client negotiations had different characteristics and approaches, a few examples, out of many that were observed, are presented here to illustrate the negotiation of explanatory models. Again, individual chiropractors differed in their approaches. Some were more innovative than others, but the end result was always to attract, educate and retrain the client.

7.2.1 Negotiating Functions of the Human Body

Discrepant perceptions resulting from different views and beliefs held by new clients and chiropractors which were to be reconciled have been summarized in Chapter 5, Section 5.5. It was noted in Chapter 5 that differences exist between new clients and chiropractors in their beliefs regarding the human body and its functions. Although both chiropractors and new clients used mechanical analogies in conceptualizing body functions, new clients viewed the human body as capable of expelling "wastes", "germs" and "poisons" through the transportation mechanism of blood and the circulatory system. On the other hand, chiropractors believed the human body to be capable of curing itself through the central control of the nervous system.
Case 5:

A particularly argumentative 26 year old female student (Ms. M.), related her generalized body aches and pains to different national foods she ate during her recent travels abroad as well as to dramatic changes in climate. It was her first trip abroad. While in Japan, she had become mildly ill after her first "sushi" dinner. She again became ill in Hong Kong following ingestion of street-vendored appetizers. While at home in Canada, and prior to her trip abroad, she had been very "selective" about what she ate. Her family physician had found nothing wrong medically after blood tests and physical examinations. Between referrals to "specialists" she had been convinced by her roommate, another female student, to try chiropractic. The following dialogue was recorded during her initial visit and interview with Dr. S., chiropractor, and a partner in group practice.

Dr. S.: Sometimes what we eat affects how we feel, the energy we have, our thinking and even our studies...(laughter).

Ms. M.: I still think I haven't gotten rid of all of the stuff I pumped into my poor body...it was tempting...you know, on vacation you try everything.

Dr. S.: But you have had Japanese and Chinese foods before....(inaudible)..here in Vancouver.

Ms. M.: Yes, but not those kinds. Wow, was I ever sick...do I ever regret it.

Dr. S.: What kinds of things do you do besides travel and eat all these wonderful foods (laughter)...I mean, do you exercise, jog, walk around the block...?

Ms. M.: No. I haven't got time from assignments.

Dr. S.: Most people usually say so, but they weaken their muscles, their system...their resistance and nerves. I see them all the time, and they usually feel better of course with help...we can come up with some things for you.

Ms. M.: Well, I just don't have to eat what my body hates.

Dr. S.: Yes, but you still feel aches and pain, don't you?

Ms. M.: ...is still there, not all of it is out. What goes in must come out...
Dr. S.: Yes, we know that what makes it come out is the nervous system which controls all we do, ...our bowel movements, when and how we sweat ... we can even tell it what to control sometimes by how we feel.

Ms. M.: What are you going to do?

Dr. S.: First, we want to find out how fit you are ... apart from those foods (laughter) ... I mean some examination, then we do some adjustment of your system and tie it up with some dieting ... I mean the kinds of things you should eat and not feel too bad. I find also that vitamins help the system.

Temporarily, at least, Dr. S. has been able to "remoralize" Ms. M. from a strongly held belief about the effect of foreign foods on her health and the importance of getting rid of unwanted foods in her blood and circulatory system, towards considering the role of the nervous system and mental processes in illness causation. Dr. S. was able to achieve his objective by:

(a) agreeing, to some extent, that foreign foods do have adverse effects on some people and that human activities are affected by "what we eat",
(b) introducing and later educating the client on the role of nervous system in body functions,
(c) incorporating the belief of the client into his own belief as a compromise which will enable chiropractic treatment to occur, and
(d) buttressing his belief about chiropractic treatment by introducing an "enhancement factor", vitamins.

Dr. S. appeared to have modified his EM by agreeing, to some extent, that foreign foods may have adverse health effects on some individuals. Whether or not Dr. S.'s "limited" agreement with Ms. M. was simply a "tactical manoeuver", "
aimed as a temporary negotiation strategy, is unclear. However, the notion that a practitioner's EM can be modified is a departure from Kleinman's perspective (see Chapter 2, Section 2.2, p.89).

In another example, one chiropractor commented to a particularly skeptical new client: "The only way you get improvement in most things is by trying something different. Bell tried the telephone, Edison tried electric lights.... today the world is better off." The new client in this example chose to try chiropractic adjustment, and she remained in treatment throughout the course of this study. Another chiropractor who did not succeed in convincing a client to make a repeat visit after initial treatment commented to me privately: "I wonder why he bothered to come. Some people just want to peek into chiropractic...we are not magicians...it takes time to get results."

7.2.2 Negotiating Causes of Illness, Signs and Symptoms

Negotiations within the context of chiropractic behaviour settings, or any clinical setting invariably involves the issue of treatment. As I discussed in Case 1, negotiation for a compromise belief regarding the function of "food" in the human body led to a compromise on treatment. Similarly, during occasions when cause or, less often, signs and symptoms, have been at issue, compromises are also forged about treatment. Only on rare occasions did negotiations for specific beliefs occur independently. This observation is consistent with allopathic negotiation (Kleinman, 1980). Examples of cases that have been provided in this chapter have been extrapolated from full length interviews and are not really separate or isolated discussions. The context in which
chiropractic clinical interviews take place are complex as well as important aspects of the clinical realities of those situations.

Case 6:

A 59 year old woman, Mrs. N., had attributed both the onset and cause of her joint aches and pains to changes in weather conditions. During the interview with the chiropractor, Dr. F., she had provided extensive information relating the flaring-up of her pains with damp weather conditions, especially rainy weather to the extent she claimed to be able to predict when there will be rainfall. Over the previous 6 years, since the death of her husband, she has noticed that her painful joints began to swell, especially at the knees during damp weather conditions. She has been seeing a family doctor [M.D.] ever since, who prescribed pain killing drugs for occasional use. Mrs. N. now cares for the family "corner" store and she has lived alone since the death of her husband.

Dr. F.: [Trying to convince Mrs. N. that the cause of her joint pain may be something other than damp atmosphere]

"...but you also feel pain when you turn up the heater or light the fireplace..."

Mrs. N.: It doesn't go away for good, it's still there and getting harder to get up sometimes...

Dr. F.: Do you shower or fill up the tub with warm, hot or cold water?

Mrs. N.: Really warm, I mean almost hot water....you wouldn't sit in the kind of hot water I take my bath in....

Dr. F.: Do you feel less pain?

Mrs. N.: Yeah - I feel nice.

Dr. F.: You see, it is not the wet weather...something else is happening...just the other day, I helped [Dr. F. proceeded to provide an example of successful treatment of similar condition which had been attributed by the patient to damp weather]. Do you want us to do something about it?

Mrs. N.: I want you to do something....I still think going out too much doesn't help it. I used to get some pain in my back when my husband, God bless him, was around...He's dead now...been hard for me....He used to rub my back and it felt better....sort of massage...something like that.
Dr. F.: That will help. We need to treat the cause. Your body is telling you something...the nerves are reporting that they need help to get you going. If you want, I can look you over, check the joints, the back, and if we need it, fix up your backbone.

Mrs. N.: Whatever you want to do, so long as you do something. Been going on for some time now...seems only rubbing... helps before or after the weather gets bad.

Dr. F.: Let's go over there and look you over.
[After the physical examination, Dr. F. provided massage to her back and around her shoulder and knee joints after Mrs. N. expressed dissatisfaction with the quick adjustment she received as treatment].

Mrs. N. did not give up her belief regarding the cause of her joint pains even though she was willing to accept chiropractic adjustment. Her continuing belief in damp weather conditions as the cause of her health problems as well as her claim to be able to pick up signs of impending rainfall through associated joint pains, were re-emphasized in the follow-up interview. Dr. F. tried to re-define the problem by redirecting the focus on the cause of the patient's illness to his own perspective. He used what Goffman (1969:12) has termed "control moves" through his efforts to prove that different "wet" or "damp" weather conditions were not necessarily pain producing. Goffman has stated that a control move is used as an "intentional effort....to produce expressions that (a person) thinks will improve his situation..." Dr. F. was trying to improve his "bargaining" situation, but in the end, he was unable to shift Mrs. N. away from her personally held and "experience-based" beliefs; nevertheless, he succeeded in getting her to accept chiropractic adjustment by also offering what Mrs. N. wanted in the first place, massage. Mrs. N. has continued in treatment
and according to her, she continues to receive occasional massage as part of her adjustment.

How has Mrs. N. viewed the clinical reality of her situation? For Mrs. N., most of the realities of her health complaint were located partly in the physical environment and partly in the loss of her husband. Her needs included not only the amelioration of her generalized pain, but also the receipt of some kind of comfort through massage - something she always received from her husband. As a chiropractor in search of clients, Dr. F. felt obliged to respond to the needs of Mrs. N. in order to be successful in "making" her a regular patient. It is difficult to ascertain whether the decision by Dr. F. to provide massage as well as adjustment was motivated by his desire to keep Mrs. N. as a client. Regardless, the net effect was the "acquisition" of a regular client who, in the process, has continued to retain her original beliefs regarding the cause and signs of her health problem, while remaining a patient of chiropractic.

Case 7:

Dr. N. was having difficulty agreeing with Mr. E. regarding the "tingling" sensation Mr. E. sometimes felt in his ears while playing the game of rugby. Mr. E. came to the clinic because his legs "occasionally" gave out on him while actively playing rugby. However, during physical examination, Mr. E. recollected that on more than one occasion, "tingling" in his ears had been associated with his legs "giving way" or "weakening". Dr. N. commented that the "tingling sensation" was an obvious sign of impending neurological impairment, a signal to voluntary muscles of the body. Mr. E. disagreed, noting that he felt the sensation on occasions when he was not engaged in the game of rugby, "at home", and sometimes at work.

Dr. N: You use your muscles all the time you are awake, and some when you are sleeping. Nerves constantly discharge impulses to muscles. You get around at home and in the office...
and you use your muscles, but not as much as when you're playing rugby...therefore, your nerves send messages to muscles and one of the signs is the sensation you feel in your ears.

Mr. E.: I may be the only one who hears his muscles (laughter)...Em....it's funny the way it happens.

[Dr. N. decided to coopt my help as I was sitting in a corner of the adjustment room observing their interaction and jotting down notes.]

Dr. N.: Well, it's quite common. Every neurologist knows that muscles depend on impulses from nerves...it can be recorded and observed....Here,...Godwin sitting over there is a physiotherapist...am I right?...I bet you don't know I checked up on you (laughter)...[Pointing to me] You agree muscles receive impulses from nerves [At which time I responded that I am not a specialist in the area, besides that I have not been following up on new knowledge since I shifted my professional concerns to health services administration.]

This was one of three occasions in which individual chiropractors tried to obtain my cooperation in their clinical interaction with new clients. Dr. N. was having difficulty negotiating the signs of an illness. He had become conscious of possible failure in his attempt at socializing this particular client. To remedy the situation he chose to take advantage of my presence in an effort to convince Mr. E. that his assumptions were correct. As Goffman (1967:120-21) has noted about such encounters:

"A common source of interaction - consciousness is related to the special responsibility that an individual may have for ongoing interaction 'going well', ie. calling forth the proper kind of involvement from those present."

This may have been an unusual situation because chiropractors normally do not conduct their interviews and physical examinations in the presence of third
parties except on those occasions when clients have been accompanied by relatives. It was possible that Dr. N. wanted to avoid further disagreement by introducing a third party opinion in support of his opinion. It may also be that he simply had wanted to let me know that he had been aware of my training as a physiotherapist. Whatever the case, Mr. E. continued to receive chiropractic treatment beyond the fourth treatment when he was interviewed by me for the second time.

7.2.3 Negotiating Health Habits

There was general agreement between chiropractors and new clients regarding the kinds of behaviours that constituted good or bad habits (see Chapter 5, subsection 5.2.4). However, chiropractors identified a greater range of behaviours than did new clients, as well as a greater number of different explanations for considering certain behaviours good or bad.

There were not many opportunities during this study for observing chiropractor-client negotiation in this area. Clients appeared to accept suggestions relating to their health behaviours. Although some differences in explanations of "good" and "bad" habits had been noted during pre-interaction interviews, there were no vigorous attempts by either participants in the interaction to advance a particular explanation. Both the new clients and chiropractors often agreed on the categorization of particular behaviours but they often did not explore further reasons or personal reasons for categorizing those behaviours. A typical example is as follows:
Chiropractor: You shouldn't be smoking. Not good for you.

New client: I know, I know.

Chiropractor: You plan on quitting?

New client: Been working at it.

[End of discussion on habit formation]

Most of the chiropractors used personal examples in trying to influence new clients towards practicing good health habits such as daily exercises, "sensible eating", and less dependence on "pain killers" or analgesic drugs. Sometimes positive mental attitude was often incorporated in the examples.

Case 8

Dr. P.: I find that I feel better when I go for a walk, better when I jog around my block and best when I jog 3 to 5 miles after a very busy day...clears up my mind...you know, clears the head of all that pressure looking after people...makes me feel better, enjoy the family, get ready for the next day.

Mr. K.: I get home from work at about 6 to 6:30 p.m., sometimes because of traffic...It's sort of supper time and late for that sort of thing...

Dr. P.: How about early in the morning...before you go to work, during lunch time...you don't have to run 5 miles...start with 50 yards then beef it up as you go along...Besides, it helps your heart and everything.

It may be that chiropractors and new clients readily agree on good and bad habits, in spite of different explanations, because society at large has endorsed certain behaviours as "good" or "bad". There is considerable evidence in support of this view particularly through advertisements on television. Cigarette smoking is discouraged, drug addiction is a persistent social problem, there are health clubs for keeping fit, as well as dietary regimens for persons
who consider themselves overweight. In particular, the Canadian government has been promoting good physical health in all Canadian provinces through advertisements on television under the caption "Participation". More and more British Columbians than ever before participate in group exercises and fitness groups which promote dietary as well as physical well-being.

7.2.4 Negotiating Treatment

About 50% of new clients interviewed "most preferred" medication for their health problems, and 70% of them had been to allopathic physicians and probably received medication for their health complaints. By deciding to try chiropractic, these clients were admitting that medication had not solved their problems. It can be assumed that pain was one of the motivating forces which drove clients from family doctors to chiropractors. Family doctors [M.Ds], are generally known to treat pain with analgesics in order to achieve temporary relief (Tables 18, 19).

Chiropractors, on the other hand, "least preferred" surgery and medication as treatments; nevertheless, they were prepared to subject themselves to these forms of treatment if necessary (Table 19). Therefore, while some differences existed between the views of chiropractors and new clients, they were more philosophical rather than pragmatic. New clients preferred drugs because they are said to be "fast acting", and "quick", "can be taken at home", "fights and kills germs", and "relieves pain". Chiropractors "least preferred" drugs because they are "unnatural substances", have "side effects", and are said to be "addictive". On the one hand, the client perceived treatment as the "killing of germs", "fast acting" and "quick", and on the other hand, the chiropractor
favoured natural treatment, preferrably by hands; in particular, treatment by "adjustment" of the spinal column.

It was noted in Chapter 5, Section 5.5, that "subluxation" as an illness category was new to prospective clients of chiropractic. It was also noted that "adjustment" of the spinal column was the preferred treatment of chiropractors for most illness conditions. Two important observations affected the outcome of clinical negotiations regarding the linkage between "subluxation" and "adjustment". The first was that the labeling of health complaints were often minimized. Rather, chiropractors preferred to provide general descriptions of mechanisms by which a symptom was produced. For example:

Chiropractor: [Explaining to a client how displaced vertebrae affects the function of nerves].
Imagine shifting the gear from 1 to 2, the car moves as it is supposed to...but when it is shifted in between... not in 1, not in 2, then it stalls, moves slow, can't get going. The bones of your spine (pointing at the skeleton model of vertebral column) do the same thing. They have to be adjusted when that happens....

The explanation for the kinds of health complaints chiropractors treated in their clinics was often simple compared to the variety of diagnostic possibilities invoked by allopathic physicians. For example, in cases of low back pain, chiropractic explanation revolved around two factors, namely, "musculo-skeletal disrelationship", and "pressure on nerve roots" due to "subluxation" of two or more vertebrae. On the other hand, allopathic physicians would have a battery of reasons as to why pain might occur in the back region. These examples included nerve root pressure, displaced disc, displaced nucleus pulposus, metabolic diseases, malignancy, necrosis of spine,
narrowing of vertebral space, spinal degeneration, and formation of new bone or calcification, among others. It would, therefore, be easier for chiropractors to use relatively simple analogies in describing the course of a health complaint or its treatment than it would be for allopaths. Statements such as "Your nerve is like a string, when you pull it tight, it hurts", helped to define the situation for new clients.

Nearly always, the cause of a health complaint, for example, subluxation of the spine, was associated with its treatment during clinical negotiation; for example, treatment by adjustment of the spine. Rarely were health complaints labeled in specific ways, rather their courses were explained. The following example illustrates chiropractic negotiation of treatment with a new client.

Case 9

Mr. H. is a 66 year old recently retired salesman who complained of pain from the left hip joint to calf muscles. For a few years prior to his retirement, he received pain killing drugs from his family doctor and had been seen on two occasions by a neurologist and an orthopaedist. Medical specialists suggested increased rest periods and advised him of the cause of his pain, namely, spinal degeneration, for which surgical intervention was not contemplated. During the initial interview, Mr. H. provided me with details of his medical treatment and experience while responding to questions relating to his health beliefs. As a younger man, he had taken part in various activities such as horseriding and for a few years he was a policeman working long hours of street work. Mr. H. gave the impression of someone who had an "ear" for details. He wanted a full explanation for events with which he was unfamiliar and he had tried several home remedies in an effort to alleviate his "nagging" hip and leg pain.

Dr. R. is a 42 year old chiropractor who has been engaged in solo clinical practice for 14 years. He received his training in one of the oldest chiropractic colleges in the United States. He had a fairly busy practice judging by the regularity of half hourly appointments for new and regular patients. From casual conversation with regular patients in the waiting room, I learned that Dr. R. is well regarded by his patients. Perhaps his reputation as a thoughtful, competent practitioner has helped sustain his practice through social networks.
in the community. He gave the impression of someone who is congenial and willing to talk about chiropractic at the least opportunity. I had the opportunity to discuss chiropractic with Dr. R. in his private office on three occasions. I observed his interaction with new patients. There was an "air of confidence" about Dr. R. which he did not hesitate to convey verbally or symbolically through "self-carriage" and gestures.

On learning that Mr. H. had tried self-treatment with hot towels and patent medicines, and that allopathic treatments failed to substantially relieve his pain, Dr. R. immediately assured Mr. H. of his competence in dealing with the situation:

Dr. R.: [To Mr. H.] You've come to the right place. Only those who know and understand these kinds of problems are able to do something about it...that's what chiropractic is about...helping to relieve muscle and joint pains.

During the interview, Dr. R. tried to elicit how Mr. H. felt about his painful hip and leg:

Dr. R.: [Leaning forward, clasping his hands, and engaging in eye to eye contact] Tell me what you have been doing lately about the pain?

Mr. H.: Nothing unusual. Since my retirement, I have not been so busy, but I visit a lot...but I can't walk too far with this pain.

Dr. R.: Do you walk a lot before?

Mr. H.: Oh, yes.

Dr. R.: Every day?

Mr. H.: Yes...Em, no, not every day. I used to stand and walk a lot in the salesroom...about five hours every day...not to any particular place.

Dr. R.: Do you have any idea when your pain started...how long ago and why it started in the first place?

Mr. H.: [After a long history of his physical activities as a policeman] It must have been the fall I had...(inaudible) some crack in my hip which took oh...about two months to heal. I was in hospital...never been myself since...then the pain began, at first not so much, I can still do things, but then it got worse.
Dr. R.: What did your doctor tell you?

Mr. H.: Something about wear and tear of my spine...some degeneration...but they can't operate.

Dr. R.: Well...let's look at you.

Dr. R. proceeded to make Mr. H. comfortable by asking him if he needed help to get off the chair and on to the adjustment table. Mr. H. was first examined in a sitting position for knee, ankle and elbow reflexes, and then while lying on his back, and on his stomach. He was asked to raise each of his legs separately without bending his knees, and later, to do so while bending them.

Dr. R.: [To Mr. H.] Do not lift your leg beyond when you start feeling pain...just to the point of pain.

Dr. R. explained every procedure before carrying them out. Mr. H. chose not to disrobe allowing only the exposure of body parts to be examined. Dr. R. took time to explain the procedures, results of examinations, and treatment. This is done in all chiropractic clinics, and a majority of chiropractors do not proceed with treatment until all of the client's questions have been satisfactorily answered.

Dr. R. advised Mr. H. that he would require an x-ray picture "to see what is going on". An x-ray of the lower back was taken and processed within ten minutes. Propping the film up on an x-ray display stand, Dr. R. commented as follows:

Dr. R.: Hm...(placing a measurement ruler along the length of the spine) Slight curvature...I can see the narrowing of space...here, look at this area (inviting Mr. H. to examine the x-ray with him). See this one is out of place here...pointing at a vertebra.
Mr. H.: What does this mean? I don't quite get it...

Dr. R.: There is slight rotation of L3 on L4 (pointing to a spot on the x-ray film)...also L4 is out of its usual place.

Mr. H.: Is that what they call degeneration? My doctor says something like that....

Dr. R.: There is degeneration all right, but that's only a part of it...the space here is not as wide as the space here (pointing to two spaces between vertebrae).

Mr. H.: I don't get it...that and then this, what did you say about L3....?

Dr. R.: That's subluxation...your L3 is not sitting right on L4, and L4 not sitting right on L5 (pointing again to the spots on the x-ray film).

Mr. H.: You mean there's something else wrong?

Dr. R.: Yes...I have been seeing these kinds of problems for a long time. Your family doctor did not see it because he isn't trained to look for it...he sent you to somebody else, didn't he? Here...let's just say it's not an unusual problem, lots of people have it, they come in and we do something about it.

Mr. H.: Like what?

Dr. R.: We call it adjustment...just putting those bones where they are supposed to be...return them to where nature wants them to be...all those falls and walking around over the years as a policeman and salesman (laughter). You must have been quite active....?

Mr. H.: Is it what's causing the pain?

Dr. R.: Of course...part of it.

Dr. R. proceeded to provide Mr. H. with a simple but complete explanation of how "rotation" and displacement of L3 and L4 affected the nerve roots that "are coming out", "in between them" to the legs. Using analogies, and plain words, Dr. R. explained how pain often radiates down the leg. He commented,
"You cannot feel any pain, unless your brain interprets it...think about it."

He further explained how adjustment would relieve the pain.

Mr. H.: How long does it take...?
Dr. R.: Oh, a few seconds, maybe a minute or so.
Mr. H.: That's all?
Dr. R.: For today, but we have to do it a couple of times, give you some exercises.
Mr. H.: That will get rid of this bloody pain?
Dr. R.: Why don't we give it a try.

Mr. H. was asked to lie down on his right side and gently bend his knees. Dr. R., facing him, bent over him and gently placed his right palm over the back of Mr. H.'s hip and the left hand under the upper body. With a quick and sudden motion, Dr. R. rotated the upper half of Mr. H.'s body away from him while, at the same time, sharply rotating the hip towards himself. There was a short cracking noise from Mr. H.'s back. Dr. R. had explained this would happen during the process of adjustment.

Contrary to expectation, Mr. H. did not feel immediate relief of pain.

Dr. R.: How is it? How do you feel now.
Mr. H.: I, eh...I still feel the pain...seems to be more than when we started.
Dr. R.: It takes time...one adjustment is not enough to undo what you've had for how many years now...?
Mr. H.: I got the feeling it will get worse afterwards.
Dr. R.: Of course you will be better. Most patients feel the way you are feeling right now, but they have a different story after a couple of sessions.
Mr. H. had difficulty sitting up. He had said he always had difficulty sitting up in bed at home. With assistance from Dr. R., he sat up but tried to straighten himself by sitting up straight. He had a worried look about him. Dr. R. made him lie down again, this time on his stomach. He began to palpate his lower back using the points of his fingers.

Dr. R.: How do you feel now?
Mr. H.: Same.

After more finger palpation, later explained to me by Dr. R. as a form of accupressure, Mr. H. expressed no relief from his pain, rather the pain was more in his left leg. At this time, Dr. R. began a series of further physical examination, measuring the circumference of the calf muscles as well as leg lengths.

Dr. R.: Do you know your left leg is one and half inches shorter than your right leg?
Mr. H.: No. What does that mean?
Dr. R.: That's why we could not help you with your pain the first time. Now I know the reason...you've got to correct your posture...when you sit or stand, you favour the right side ...am I right?...we have to do quite a bit more. That fall you had may have shortened the left leg, I don't know.

Mr. H. continued to receive weekly chiropractic adjustments for five weeks. The clinical interaction between Dr. R. and Mr. H. was remarkable in many ways. Allopathic medicine was unable to significantly relieve Mr. H.'s "nagging" pain. However, it provided him with a label for his health complaint, namely "spinal
degeneration" which was quite different from his view regarding the cause of his problem. For Mr. H., his problem was related to a fall, his duties as a policeman and long hours of standing and walking around as a salesman. His problem, in his view, began with the fall.

The chiropractor, Dr. R., was able to elicit Mr. H.'s beliefs regarding the cause of his problem, and to obtain the context in which Mr. H. had come to hold these beliefs. It was, therefore, a question of his reconciling chiropractic explanation of cause, for example, subluxation, with the clients' explanation of cause for "present" problem, in this case, a fall. This came later in the interaction when the chiropractor was not achieving the results he expected, namely, relief of pain.

Secondly, the chiropractor, Dr. R., presented a confident image regarding his ability and success with helping people with similar health complaints. He was quite popular, as a practitioner, within the local social scene. As Goffman (1967:9) put it, Dr. R. took "on a self-image expressed through face* that he will be expected to live up to". He had assured Mr. H. of his ability and competence in helping clients with similar health complaints. He used the "ritual" of physical examination, and the interpretation of x-ray to confirm his chiropractic beliefs, namely, subluxation as the cause of the problem and adjustment as the preferred treatment. Throughout the interaction, he did not disagree with the allopathic interpretation of the condition that was spinal degeneration, rather he included it as part of his findings and incorporated it in his explanation about cause(s). In this context, there was a higher probability that Mr. H. would accept subluxation as a label for his health complaint. The trade-off for Dr. R. was that he include "spinal degeneration"
as a label in his diagnosis in order to retain Mr. H. as a client. Physical examination and an x-ray were used to provide supportive evidence with which to "conconvince" Mr. H. of the chiropractic diagnosis of his health complaint.

Thirdly, the negotiation of explanatory models between Dr. R. and Mr. H. ran into a major problem: Mr. H. had indicated during the initial interview and prior to his first visit to Dr. R., that he originally felt that medication or surgery could help alleviate his "nagging pain". He now hoped that the "yet to be experienced chiropractic treatment" would help him since medical specialists eliminated surgery, and medication had not been of much help. Contrary to his expectation, he was not relieved of the pain. Moreover, Dr. R. had expressed confidence in his ability to relieve such pain. Sensing that his credibility and reputation were in jeopardy, Dr. R. embarked on a series of efforts to explain why he had failed the first time around. There was a second physical examination, a different treatment approach (accupressure), and further reasons were noted as to why chiropractic adjustment failed in relieving this particular pain. Goffman (1967:32) has observed:

"...it appears that once a person has gotten a reputation for good or bad play this reputation may become part of the face he must later play at maintaining."

It was, therefore, important for Dr. R. that he not fail in helping Mr. H. That Mr. H. continued in treatment for five weeks was evidence of success on the part of Dr. R. in persuading Mr. H. to become his patient.
7.3 From Client to Patient

89% or 53 of 60 new clients in the study continued to receive chiropractic treatment beyond the initial 4 visits. Of the 7 new clients who discontinued treatment, 4 discontinued voluntarily after four visits, 1 after three visits, 1 after one visit and 1 after two visits. Another client voluntarily terminated the relationship immediately after the initial interview and without undergoing treatment (Appendix XVIII).

At the beginning of the study, a successful socialization was said to be one which involved at least four treatments following the initial visit to the clinic. That the great majority of new clients remained in chiropractic treatment for at least four visits is a demonstration of the success of chiropractors in the making of their clientele.

Individual chiropractors observed within the study area had different ways of achieving the same objective, within general expectations and prevailing constraints. Certain commonalities were observed to exist between chiropractors in the course of achieving client socialization. These included: (a) "mirroring" the settings of allopathic clinics which are familiar to the general public; (b) ensuring a conservative appearance of behaviour settings in order to minimize expectations of "deviance" or whatever notions of uncertainties new clients may entertain towards chiropractic; (c) manifesting pleasant personal behaviours among members of the "performance teams"; (d) "ritualizing" the stage management of treatment procedures and displaying "occult involvement" during physical examinations; and (e) using abundant chiropractic literature, information and positive reviews about chiropractic to indoctrinate new clients from the moment they entered the waiting rooms through the time spent in interviews, assessments and treatment.
All chiropractors gave the impression of carrying out well-rehearsed routines which appeared to be similar in many respects. Some differences, such as whether or not a white coat was worn, or in the particular employment of language, were matters of individual style. However, it was the ability of individual chiropractors to manage impressions and elicit health beliefs and explanations for "present" illness that was critical in the successful socialization of new clients.

People in general do not usually make obvious to others the meanings particular illnesses have for them, their beliefs regarding what the causes are, what to do about them, how to explain them, or the treatment or remedy they feel they should receive. Rather, elements of health and explanatory models are stored in memory, in the unconscious mind to be recalled at critical moments. Thus, health beliefs and explanatory models are largely tacit and not always well-articulated (Kleinman, 1980). It is the ability of chiropractors to "tease" out elements of client beliefs and explanatory models that explains their success in making their clientele in spite of the unfavourable conditions in which they practice their "healing art" in the province of British Columbia.

Chiropractors do seem aware that, in practice, they elicit health and illness beliefs of clients during clinical encounters. This is a cultivated ability and has been an integral part of their training in their continuing effort to discover collective and individual strategies for negating the constraints on chiropractic. The chiropractors in this study certainly exploited clinical behaviours and practices aimed at finding out what a client thinks, believes, and has experienced about his illness, in order to negotiate treatment, partly by incorporating some of these beliefs and expectations into
their explanations of cause. It is, therefore, not certain whether some or all of the clinical negotiations in chiropractic clinics are "genuine" or "mock" negotiations.

Consequently, an important issue relating to the chiropractic-client negotiation process is the degree to which the negotiators are engaged in 'genuine' exchanges. To what extent was the chiropractor or the new client sincere in presenting his or her EM? To what extent is either of the partners in the negotiation manipulating the other in order to gain a certain advantage? If a chiropractor agreed with a client on the client's perception of his problem, does this necessarily imply a change in the chiropractor's EM, or is it only a temporary effort to ensure that the client remains in treatment?

Both the new client and the chiropractor may be "manipulating" one another. However, the chiropractor has a much greater desire to retain the client as a patient because of the constraints he faces in calling the attention of potential patients to his work. In the context of everyday relationships, Goffman (1959) views interaction as highly structured. People present a "face" and they work hard to retain it. That the chiropractor presents a face is evidenced in the numerous chiropractic leaflets and persuasive processes and presentational devices that have been used to uphold the client's interest in chiropractic. Therefore, the chiropractor has an interest in ensuring that the "face" is retained. One way of doing this may be to "lure" the new client into thinking that the chiropractor is in agreement with his EM when, in fact, it is a "strategic move" on the part of the chiropractor (Goffman, 1967:12). In this case, the clinical negotiation may not be a "genuine" negotiation.
Similarly, the new client may apply the same "strategic move" in order not to "displease" the chiropractor, or as a way of finding out more about chiropractic without really "trading-off" any part of his EM.

This brings to question of the role of "power" in the relationship. By compromising some aspects of his EM, the chiropractor may indeed have been negotiating from a disadvantaged "power" relationship vis-a-vis the new client. I have shown how some new clients do indeed get the chiropractor to do their bidding. The question is whether the chiropractor has been so constrained socially and politically, that he sees himself as having to "please" the clients. This is a reversal of roles compared to allopathic-patient relationships in which physicians demonstrate the power inherent in their profession.

In order to verify what was observed in chiropractic behaviour settings and during interactions, all new clients as well as chiropractors were interviewed after their clinical encounters. The purposes for the post-encounter interviews with new clients were to find out a) whether they thought chiropractors understood their individual problems, (b) their personal impressions about chiropractic behaviour settings, (c) opinions about their health problems and how any differences were resolved, (d) whether their opinions about chiropractic had changed, (e) whether or not they planned to continue in chiropractic treatment, (f) their views about treatment forms, (g) any further concerns they may have had about chiropractic, and (h) how they compared chiropractic with other professions.

The purposes of the post-interaction interviews with chiropractors were to find out (a) if chiropractors had any "hidden agendas" for interaction with new clients, (b) whether during the interactions they felt new clients had personal
notions about cause, course, and explanations for particular health problems [HMs and EMs], (c) any particular difficulties they may have had with new clients, (d) what they thought were the reasons why some new clients refused treatment or discontinued visits to clinics, (d) how any disagreements or differences of opinions were resolved, (f) whether or not they thought individual new clients would continue to receive chiropractic treatment in the future and the reasons for their thoughts, (g) how they accounted for any changes in opinions of new clients, (h) what they did to bring about any changes in the views of new clients, (i) whether they thought new clients now prefer chiropractic to other forms of treatment and would recommend chiropractic to friends, (j) if all or any remaining concerns of new clients were completely resolved, so that individual clients could now consider chiropractic a profession, (k) and whether they considered treatment outcomes successful or unsuccessful.

Some evidence that chiropractors were aware of the importance of clients' health beliefs in the negotiation of EM and treatment was discussed earlier in Section 7.1 as part of chiropractic self-presentation (see Tables 31, 32, 33 and 34, and Appendices XV and XVI). Chiropractors and new clients agreed on the "very important" characteristics of a healer which are conducive for "good" clinical relationships. New clients agreed with chiropractors that the latter understood their problems, made them comfortable and knew what to do during the initial visits (Table 34).

More importantly, 80% of chiropractors said that at "any time before or during the interview", they felt that the new client had some idea, or somehow had some idea about the cause of the client's problem. 82% of chiropractors
felt that clients knew how their health problem works in the body, and 73% how to explain it (Table 35). Also, 75% of chiropractors thought that the client better understood their explanations regarding cause of problem when they were not sure the client had some idea about cause (Table 35). Also, from past experience, 60% of chiropractors "knew" what to do about the cause of a problem, 40% sometimes knew what to do. 85% knew what treatment to give, 28% how the problem works in the body and 28%, its explanations.

Almost half of all new clients felt that the general appearance of chiropractic clinics either had an effect or somehow had an effect on the opinions they had of individual chiropractors (Appendix XXC). They found chiropractic clinics similar to those of their family doctors, "well decorated", with comfortable seating arrangements, "spacious", "simple" and "tasteful". Many of them did not find anything unusual about the clinics except for too many plants, and "too many wall pictures". Some clients were impressed with certain courtesies such as coffee in waiting rooms for the benefit of patients (see Appendix 5c for some of the comments).

In the words of two chiropractors:

"...once you get the patient relaxed and over her fears, and to trust you, you can find out a lot about how they see their condition...A woman once came to me complaining of backache...her real problem was painful sexual intercourse...she wants to get away from it..."

"...I am not a magician. I don't know of a chiropractor who is. I just let Mr.____ get it all out of his chest, tell me how he sees things, what he does and so on...kind of sympathetic..."
Table 35
Chiropractors' Views about the Explanatory Model of New Clients

Question: Did you feel, at any time, before or during your interview with Mr/Mrs/Ms., that s/he had some idea about:

<table>
<thead>
<tr>
<th>(a) The cause of his/her problem?</th>
<th>*No. of Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>31</td>
<td>51.7</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>20.0</td>
</tr>
<tr>
<td>Somehow</td>
<td>17</td>
<td>28.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(b) How the problem works in the body?</th>
<th>*No. of Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>49</td>
<td>81.7</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>6.6</td>
</tr>
<tr>
<td>Somehow</td>
<td>7</td>
<td>11.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(c) How to explain the problem?</th>
<th>*No. of Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>44</td>
<td>73.3</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>Somehow</td>
<td>9</td>
<td>15.0</td>
</tr>
</tbody>
</table>

Question: If not, did you think that Mr/Mrs/Ms., after the interview and/or treatment, better understood your explanations regarding:

| No. of Responses: % |
|----------------------|-------------------|-------------------|
| (a) The Cause?       | Yes 71.4 14.3 14.3|
| (b) How the problem works in the body? | No 28.6 14.3 57.1|
| (c) Its explanation? | Yes 28.6 14.3 57.1|

* There were 3 new clients per chiropractor and separate responses were sought for each new client including the 7 new clients who dropped out of the relationship (see Appendix XVI).
The chiropractors' awareness that new clients had "some idea" about the causes and explanations of their health problems, indicates that chiropractors are highly conscious of the probability that the way they relate to clients' beliefs would strongly influence whether or not clients become patients. Indeed, the belief of new clients and regular chiropractic patients that chiropractors understood their health problems indicates how successful chiropractors have been in negotiating explanatory models with new clients, despite the clients' fears and anxieties.

The extent to which chiropractors were able to successfully negotiate explanatory models with new clients in order to retain them as regular patients is further reflected in the higher percentage of new clients who changed their minds about chiropractic after encountering chiropractors. 83% of new clients changed their minds about chiropractic after they had been to chiropractic clinics (Table 36). 77% said they would continue in chiropractic treatment, although only 15% said they "now prefer" chiropractic to more conventional forms of medical treatment (Table 36). Similarly, most chiropractors were of the view that new clients would continue in treatment, especially if they had the same problems, and they thought that 65% of the new clients would recommend chiropractic to their friends or relatives (Table 36). However, only 20% of the chiropractors thought that the same new clients "now prefer" chiropractic to more conventional forms of treatment (Table 36) even though they believed that most new clients would recommend chiropractic to their friends and family.

It seems that although fewer new clients "most preferred" chiropractic to other forms of conventional treatments, even after encountering chiropractic, chiropractors were confident of their ability to retain more than 80% of new
Table 36
Post-Interaction Impressions of Chiropractic: Views of New Clients

<table>
<thead>
<tr>
<th>Question</th>
<th>*No. of Responses (n=12)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before your visit to the chiropractor, you said that.... Has your opinion changed since you first went there?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
<td>83.3</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>Have you decided whether you will continue or discontinue treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue</td>
<td>46</td>
<td>76.6</td>
</tr>
<tr>
<td>Discontinue</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>*Don't Know</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>At the time of the interview, all 7 clients were still receiving chiropractic treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on your experience, do you now prefer chiropractic treatment to more conventional forms of medical treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>15.0</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>In Some Ways</td>
<td>32</td>
<td>53.3</td>
</tr>
<tr>
<td>Don't Know</td>
<td>12</td>
<td>20.0</td>
</tr>
<tr>
<td>How would you compare your chiropractor to your regular family doctor?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Similar</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>About similar</td>
<td>20</td>
<td>33.3</td>
</tr>
<tr>
<td>Not similar</td>
<td>33</td>
<td>55.0</td>
</tr>
<tr>
<td>Did the appearance of the chiropractor's office have any effect on your opinion of the chiropractor?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23</td>
<td>38.3</td>
</tr>
<tr>
<td>No</td>
<td>25</td>
<td>41.7</td>
</tr>
<tr>
<td>Somehow</td>
<td>12</td>
<td>20.0</td>
</tr>
</tbody>
</table>
clients as regular patients. They were also confident that new clients had positive experiences in chiropractic which would be transmitted to friends and relatives, thus ensuring an extension of social networks and a continuing flow of new clients to chiropractic clinics. The best explanation for the high level of confidence and optimism shared by chiropractors regarding continued utilization of chiropractic by new clients is to be found in the nature of the relationships they promote and foster with new clients.

47% of new clients reported having disagreements or differences with individual chiropractors during their initial visits to clinics. 12% had "some" differences and 42% experienced no differences with chiropractors (Table 37). 68% of new clients were of the view that all differences or disagreements were resolved, and 18% felt that all differences were "not quite" fully resolved (Table 37). 48% of new clients said that they received the treatment they had expected and 20% received "just about" the treatment they had expected (Table 38). 52% thought the treatments they received were good and 62% thought them to be useful. 38% and 27% of new clients, respectively, did not know whether the treatments they received were good or bad, useful or not useful (Table 39).

On the other hand, a slightly higher percentage of chiropractors, 23%, compared to 15% of new clients, thought that there were some remaining client concerns and doubts about chiropractic yet to be resolved (Table 37). 88% of chiropractors compared to 67% of new clients, felt they were able to partially or completely resolve all disagreements. Asked how they were able to bring about changes in views of new clients, some chiropractors commented as follows:

"Nothing that I don't do for every patient...Listen, figure out their problem, what they've been doing to it, who they've seen...sort of what is important to them..."
Table 37

Differences of Opinion: New Clients and Chiropractors

Question: Did you have any disagreements or differences of opinion with the chiropractor about his/her diagnosis of your problem?

<table>
<thead>
<tr>
<th>No. of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Clients %</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Some</td>
</tr>
</tbody>
</table>

Question: [Clients] If so, were these disagreements resolved? [Chiropractors] Were any (and all) disagreements or differences of opinion between you and Mr/Mrs/Ms. ______ completely resolved regarding diagnosis and recommended treatment?

<table>
<thead>
<tr>
<th>No. of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Clients %</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Some</td>
</tr>
<tr>
<td>Partially</td>
</tr>
</tbody>
</table>
Table 38

Chiropractic Treatment: Views of New Clients

Question: Did you have any disagreements or differences of opinion about the treatment you received for your problem?

<table>
<thead>
<tr>
<th></th>
<th>No. of Clients (n=60)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>40</td>
<td>66.7</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>15.0</td>
</tr>
<tr>
<td>Some</td>
<td>11</td>
<td>18.3</td>
</tr>
</tbody>
</table>

Question: Is the treatment you received what you expected?

<table>
<thead>
<tr>
<th></th>
<th>No. of Clients (n=60)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>29</td>
<td>48.3</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>31.7</td>
</tr>
<tr>
<td>Somewhat</td>
<td>12</td>
<td>20.0</td>
</tr>
</tbody>
</table>

How many treatments have you received from the chiropractor?

<table>
<thead>
<tr>
<th>No. of Treatments</th>
<th>No. of Treatments</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5</td>
<td>21</td>
<td>35.0</td>
</tr>
<tr>
<td>6 - 10</td>
<td>18</td>
<td>30.0</td>
</tr>
<tr>
<td>11 - 15</td>
<td>14</td>
<td>23.3</td>
</tr>
<tr>
<td>Over 15</td>
<td>7</td>
<td>11.7</td>
</tr>
</tbody>
</table>

Question: How did you pay beyond 12 (or 15) visits?

<table>
<thead>
<tr>
<th>Payment Method</th>
<th>No. of Treatments (n=19)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal cheque/cash</td>
<td>12</td>
<td>60.0</td>
</tr>
<tr>
<td>Extended health insurance plan</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>Arranged installment payments</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>Has not yet paid</td>
<td>5</td>
<td>25.0</td>
</tr>
</tbody>
</table>

Table 39
Evaluation of Chiropractic Treatment: Views of New Clients

Question: What did you think of the treatment you received? (i.e. did you judge it to be):

<table>
<thead>
<tr>
<th></th>
<th>No. of Clients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=60)</td>
<td></td>
</tr>
<tr>
<td>(a) Good or bad?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>31</td>
<td>51.7</td>
</tr>
<tr>
<td>Bad</td>
<td>6</td>
<td>10.0</td>
</tr>
<tr>
<td>Don't Know</td>
<td>23</td>
<td>38.3</td>
</tr>
<tr>
<td>(b) Useful or not useful?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Useful</td>
<td>37</td>
<td>61.7</td>
</tr>
<tr>
<td>Not useful</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>Don't Know</td>
<td>16</td>
<td>26.6</td>
</tr>
</tbody>
</table>

Question: Have you sought other kinds of medical help while you were obtaining treatment from the chiropractor?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>37</td>
<td>61.7</td>
</tr>
<tr>
<td>No</td>
<td>23</td>
<td>38.3</td>
</tr>
</tbody>
</table>

Question: If so, from what kind of practitioner? (n=37)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Doctor [M.D.]</td>
<td>29</td>
<td>78.4</td>
</tr>
<tr>
<td>Accupuncturist</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td>Naturalist</td>
<td>5</td>
<td>13.5</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td>Faith Healer</td>
<td>1</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Question: Would you recommend chiropractic treatment to a friend or relative who had the same kind of problem you had? (n=60)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>38</td>
<td>63.3</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>Perhaps</td>
<td>15</td>
<td>25.0</td>
</tr>
</tbody>
</table>

Question: Based on your experience, do you think of chiropractic as a profession?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>50</td>
<td>83.3</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>Somewhat</td>
<td>8</td>
<td>13.4</td>
</tr>
</tbody>
</table>
"The patient is the boss, don't forget that."

"Mrs. ___ had a lot of problems at home. She is lonely... seems her husband was cheating on her (laugh). Well, she had problems with her joints, but I think these other worries kind of made it worse. She wants to talk to someone...you have to see the total person...give advice, something that works."

It is apparent from these responses that most chiropractors consider the "lifeworld" or social world of patients in their effort to understand the beliefs and feelings of clients. This provides them with materials with which to "empathize" with clients whose social worlds have become embedded in their health complaints. From this position of "personal intimate knowledge" of clients' social problems, chiropractors are able to eventually gain an advantageous position during negotiations for illness labels, treatment and ongoing management. New clients, therefore, may be considered "susceptible" to suggestions from someone who has knowledge of their personal, social problems as well as the skill to do something about the problems. With this kind of expertise in the application of social relationships to healing activities, there is little doubt why 73% of chiropractors in the study considered the outcome of the treatments they had provided to new clients successful or partially successful (Table 40).

Most new and regular clients evaluated the treatment they received on the basis of relief of pain, cure of their health problems, whether or not they perceived they had received adequate treatment, and how the treatments they received compared to other forms of treatments they had previously, especially
Table 40

Evaluation of Chiropractic Treatment: Views of Chiropractors

<table>
<thead>
<tr>
<th>Question</th>
<th>Successful</th>
<th>Unsuccessful</th>
<th>Partially successful</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>34</td>
<td>11</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>56.7%</td>
<td>18.3%</td>
<td>16.7%</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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from their family doctors. Some patients evaluated the treatments they received against the expectations of individual chiropractors regarding outcome.

At the time of the final interview of new clients, 35% of them had received five treatments, 30% had received six to ten treatments, 23% had received eleven to fifteen treatments and 12% had received over fifteen treatments. 62% of new clients had sought other kinds of help while receiving chiropractic treatment. Of these, 78% sought help from allopathic physicians or family doctors, 3% from accupuncturists, 14% from naturalists, 3% from faith healers, and 3% from pharmacists (Table 39). Many of the new clients did not tell their family doctors they were receiving chiropractic treatments. Although 83% of all new clients thought chiropractic to be a profession after encountering it as compared to 3% before encountering it, only 12% thought chiropractic similar to medicine [M.D.], 3% similar to law, 32% similar to dentistry, and 3% similar to pharmacy (Table 36). So, although new clients rated chiropractic higher as a profession after they had encountered it, they were not yet ready to provide it with a status similar to that of allopathic medicine, dentistry or law. Only 12% of all new clients, for example, thought that chiropractors were similar to their family doctors (Table 36). However, they were willing to suscribe to chiropractic on the basis of the persuasive abilities of individual chiropractors.

When asked about what advice they would provide a younger colleague regarding how to interpret the behaviour of new clients, one chiropractor responded as follows:

"...hard to say...patients are different. With experience you can spot a nervous, scared or worried patient before he opens his mouth. They want you to do all the talking or something"
to confirm their fears. They don't open up quickly...you must relax them, get them to trust you, feel them out, see what they want, where they've been..."

Most chiropractors follow these instructions. "Feeling clients out", and seeing "what they want" are essentially probing into the minds of clients in order to elicit their beliefs, explanations and experiences regarding their health and possibly social problems. By using the information that has been gathered through the probing of clients' minds, chiropractors are able to successfully negotiate acceptable treatments. These treatments often incorporate some of the clients' expectations along with the favoured chiropractic technique of adjustment. By linking treatments to the social worlds of clients, chiropractors are able to "make" and "retain" their clients as patients.

7.3.1 Communication and Language in Chiropractic-New Client Clinical Negotiation

Goffman (1981:41) has noted that there is no reason to hypothesize that conversation is composed of pre-determined "utterance-types". Statements, questions, and responses might all provide reasonable building blocks for a form of talk in which turn-order, turn-size, and turn-content are all free to vary. However, physician-patient exchanges are not easily characterized by alternative analytical units because in this form of talk, talk is often organized as alternating questions and answers (West, 1983).
In examining the characteristics of chiropractor-new client clinical exchanges, therefore, I have assumed that the form of talk is organized in the alternative questions and answers format.

18 chiropractor-new client exchanges (6 chiropractors and 18 new clients) were observed and tape-recorded for analysis. Subsequently, seven criteria were used to analyse the conversations, namely, the number of questions asked by each partner in the conversation, the number of questions initiated, the number of interruptions, corrections, comments, back-channel comments, and overlaps (see Chapter 4, Section 3.4).

Shuy (1982) and Fisher (1983) have noted that medical interviews have an impact on patient's participation in and understanding of the interviewing and treatment processes. Others have argued that how information is exchanged has an impact on how it is understood (Cicourel, 1974, 1975). More importantly, how information is exchanged reveals something about the nature of power relationships between the conversationalists (Fisher, 1986). West (1981) has shown that patients enter allopathic interactions from a position of relative weakness. For example, a patient with an abnormal pap smear test result may feel threatened by the possibility of a cancer-related medical problem. Medical doctors, on the other hand, are in their "home court" in medical settings (p.142). They understand and have control over the making of the clinic. They also have the knowledge and skills that are usually mysterious to patients. On the other hand, patients are afraid of the unknown.

However, both the doctor and the patient have information [EM] that is necessary to the decision-making process of the other. To gain access to the
information, they exchange information (negotiate EMs) which are organized around topics by requesting and providing information.

Table 41 shows the result of 18 chiropractor-new client negotiative conversations. In the 18 exchanges, a total of 588 questions were observed. Of these, 390 or 66% were asked by chiropractors, 198 or 34% by new clients. 397 or 68% of the questions were initiated by chiropractors and 191 or 33% by new clients. As few as 8 and as many as 11 questions were initiated in a single exchange. Chiropractor-initiated questions account for a greater proportion of the variation (at the initial stages of the interview) while client-initiated questions accounted for the variation at the middle and later stages of the interview.

This finding is different from what has been found in allopathic-patient exchanges. West (1983) found that physicians initiated 91% of the questions and patients, 9%. In this study, new clients asked about one-third of the questions, indicating a greater degree of shared, reciprocal interests between chiropractors and new clients than between allopathic physicians and patients. Also, the greater portion of the interview was not dominated by chiropractors although they asked more questions. Rather, new clients dominated the latter parts of the interview by asking more questions. Shuy (1974) had found that physicians dominate patients by asking more questions throughout the interview.

New clients interrupted chiropractors for 61% of the total number of interruptions by both interactants in the interview (Table 41). Chiropractors interrupted for about a third of the time, and they were generally reluctant to interrupt a client in the midst of an explanation. It was found that clients were given the opportunity to "fully" explain, and in great detail, their
Table 41

Communication Characteristics in 18 Two-Party Chiropractor-Client Conversations

<table>
<thead>
<tr>
<th>Indicator</th>
<th>New Clients No.</th>
<th>New Clients %</th>
<th>Chiropractors No.</th>
<th>Chiropractors %</th>
<th>Total</th>
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<td>33.6</td>
<td>390</td>
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<td>588</td>
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<tr>
<td>Questions Initiated</td>
<td>197</td>
<td>32.5</td>
<td>397</td>
<td>67.5</td>
<td>588</td>
</tr>
<tr>
<td>Interruptions</td>
<td>38</td>
<td>61.3</td>
<td>24</td>
<td>38.7</td>
<td>62</td>
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<tr>
<td>Corrections</td>
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</table>
problems, how they perceive the problem and any associated views and conditions. Thus, the patient may be seen as being in a position of greater strength or "power" in the interaction. In allopathic interviews, it has been noted that the relatively greater power of physicians is indicated by the large number of interruptions they make during clinical interviews (Fisher, 1986; West, 1983).

Chiropractors and new clients correct each other about equally during clinical exchanges although the number of corrections is slightly in favour of chiropractors (table 41). Much of chiropractic interruptions were primarily for clarification of an "erroneous" perception by the client. Unlike allopathic conversations, in which physicians exhibit their domination of patients (Fisher, 1986), in chiropractic conversations, there is the appearance of "equality" in taking turns and in mutual correction.

On the other hand, chiropractors made more comments 81%, than new clients, 19%. Chiropractors' comments were primarily to ensure that clients were following and understanding what they were saying. They did not seem to be competing for control with clients, as in Fisher's (1986) observation of allopathic interviews in which patients tend to verbally compete with physicians for control.

Similarly, chiropractors used more back-channel comments, 71% (see Chapter 3, p.134) than clients, 29%. The "uhs" and "uhums" were used to let clients know that chiropractors were following their arguments or were encouraging clients to elaborate and to continue what they were saying (Table 41).
An unexpected finding is the number of overlaps (Chapter 3, p.134) in favour of clients. New clients used overlaps to seek more clarification rather than struggle for the floor. Of the 12 or 75% of the total number of overlaps by clients in the interview, 7 were used to change the topic (Table 41). This supports an earlier finding in this study that new clients of chiropractic were in relatively greater positions of power in clinical negotiations than chiropractors. The asymmetry of the chiropractic relationship appears to favour new clients.

7.4 Summary

Chiropractors dressed conservatively and they "gave off" non-verbal expressions which suggested behaviours that were consistent with the local environment in which the clinics were located. Chiropractic was presented to new clients in a manner that provided much information about chiropractic in a behaviour setting which was similar to that of allopathy. Thus, deviant perceptions of allopathy were minimized and reluctant new clients seemed to be reassured. Very often, new clients were engaged in casual conversations by the receptionist or the chiropractor which was then sustained by new clients. Through casual conversations, chiropractors became better acquainted with new clients and obtained clues regarding the likely "concerns" of new clients, whether in the medical or the social arena. The free-flowing, casual
conversations, the conservative appearances of the clinics, and the friendly and
easy smiles, helped to present a "chiropractic self, which enabled chiropractors
to "get off" on the right foot.

When difficult situations arose, "protective practices" were employed
primarily to minimize any damaging effects on the chiropractic face that was
being presented.

New clients were encouraged to discuss their health beliefs, health
problems and concerns as exhaustively as possible during the initial clinical
encounters. Some chiropractors gained access to clients' health beliefs, health
problems and concerns by having the clients fill out forms, which were examined
privately by chiropractors prior to the first encounter. During the initial
encounter, chiropractors were attentive and they used backchannel comments to
encourage clients to discuss their problems and beliefs as fully as possible.

Although chiropractors asked and initiated more questions during the
interviews, there was an atmosphere of balanced participation in asking and
answering questions between the interactants. However, new clients interrupted
chiropractors more than they were interrupted by chiropractors. They corrected
each other about equally and new clients "overlapped" or engaged in simultaneous
speeches" more often than chiropractors. Thus, the structure and the format of
chiropractic clinical conversation seemed to portray a rough equality in power
relationships between interactants, with some leverage enjoyed by the new
clients in the early encounters.

New clients were "remoralized" toward chiropractic through the ritual of
physical examinations, a process which Goffman (1963:75-79) would characterize
as "occult involvement". Through specific and minute physical examination of clients, the chiropractor conveys the impression that he is not aware that "he is away" (p.76) - a sort of ritual process aimed as conveying an impression of skilled professionalism.

The practice of occult involvement in chiropractic physical examinations, modifies Kleinman's (1980) explanatory model concept in that the process of clinical negotiation need not be verbally conducted. Part of the outcome of the negotiation depends on the interpretation that clients and chiropractors assign to each other's behaviours and symbolic actions.

Chiropractors negotiated explanatory models with clients by sometimes "agreeing" with clients that there was some relevance to the health beliefs clients had espoused, by incorporating some of the beliefs into their own practices to enable treatment to occur, and by gradually introducing and educating the client on the role of the nervous system in health and illness which is at the core of the Chiropractic explanatory model. Whether or not chiropractors were genuine in the negotiation of EMs as stated, cannot be determined from this study as designed. However, Kleinman (1980) viewed clinical negotiation as a genuine effort by patients and doctors to come to common understanding regarding treatment. Goffman (1959) has observed that people often contrive their performances in order to impress others. When placed in the context of Goffman, Kleinman's characterization of the genuine aspects of clinical negotiation appears somewhat dubious and certainly bears scrutiny.

The fundamental observation in this study was that chiropractors made concerted efforts to elicit the health and illness beliefs of new clients.
On the other hand, new clients also made attempts to assess and sometimes disagree with chiropractic health beliefs. The compromise of differences in clients' and chiropractors' EMs essentially involved "trade-offs" which, unlike allopathic interviews, were a two-party affair.

It was not always that chiropractors were successful in negotiating EMs. New clients who dropped off from the relationship did so very early (Appendix XVIII), especially during the first visit to the clinic or soon afterwards. It appeared that the longer clients stayed in the early going, the greater the possibility of their continuing to receive chiropractic treatment. Over 80% of new clients who did not discontinue their relationship with chiropractors after three visits remained in treatment for the duration of the study.

The success of chiropractors in "making their clientele" was further supported by the post-interaction views and impressions of new clients and chiropractors. New clients agreed that chiropractors addressed most of their "problems". New clients also felt that many of the differences they had with chiropractors were resolved. More importantly, clients changed their pre-encounter attitudes and impressions to the extent that the majority would recommend chiropractic to their friends (Appendix XIX-XXII). Chiropractors were confident in their ability to resolve differences with new clients and to provide positive experiences. However, chiropractors were not able to resolve all differences. Still, many of the new clients whose differences with chiropractors were not fully resolved, continued to receive chiropractic treatment. This suggests that some new clients were not convinced of the chiropractic model of care and had retained their own original model. Nevertheless, they continued in treatment, perhaps because of the chiropractor's
person-centred approach and the agreeable structure of chiropractic interviews and treatment. The use of "we" and "us" pronouns to engage the cooperation of clients and to frame the results of treatment as a joint venture, may have some effects on some clients who felt obligated to remain in treatment, in spite of their differences with chiropractors.

Although the majority of new clients evaluated the treatment they received favourably - "good" and "useful" - nevertheless, they also sought other kinds of help, especially from allopaths. This provided further support for the view that chiropractors may not have been as successful as they had thought in resolving all of the clients' problems.

It seemed that both the chiropractors and new clients behaved differently, in certain respects, from what Kleinman (1980) had proposed. In the management of impressions, there is the possibility of "contrived" performances which Goffman (1959) has used to describe the "dramaturgically prudent" behaviour which a person adopts in "his performance to the information conditions under which it must be staged". Relatedly, the extent to which clinical negotiations are genuine is unclear. Also, chiropractors appeared to have modified some of their EMs based on the information they received from individual clients. Again, such modifications may have been a temporary tactic to gain cooperation, but they did occur, although the permanence of negotiated and modified EMs was not ascertainable within the timeframe of this study. The continuing positive views of the smaller sample of 'regular' patients do suggest that chiropractors had not discarded their attitude of flexibility.
NOTES

1. Kleinman believes that the ability of a physician to show sympathy to a patient and to share information relating to the patient's pain and suffering are necessary conditions which make it possible for the physician to "enter the patient's life world". Kleinman uses the terminology "empathic witnessing" to describe this process in the physician-patient relationship. (Personal conversation with Arthur Kleinman)

2. Kleinman (1986) has described "retrospective narrowtization" as the ability of a practitioner to trace a patients' illness problem to what has happened sometimes in the past. By recalling and detailing a patient's life history, it will be possible to locate some pertinent aspects of the illness at a point in the life history. For example, a widow may have begun to experience "depression" from the time her husband died. Over time, the depression may become chronic or "triggered off" from time to time during moments when she feels the loss of her husband.

3. By "genuine negotiation" I mean a negotiation process in which one or both negotiating partners actually and sincerely believe in negotiating for an agreement satisfactory to both. The various positions are true positions without an ulterior motive to temporarily accommodate another's position only to change course as time goes on. When someone accommodates falsely, only to gain a temporary advantage, "mock negotiation" is said to have taken place. It is clear that some or all chiropractors engage in both forms of negotiation in order to gain the trust of new clients. This is an area of study that calls for even closer scrutiny and analysis than was possible to achieve within the ethical and circumstantial constraints of this study.
CHAPTER 8

8.0 CONCLUSION

From the outset, the purpose of the study was to describe how chiropractors in a particular political environment, "convince" new clients to become their patients. I argued that because of the relatively acute constraints on chiropractors in British Columbia, they, of necessity, develop "persuasive" strategies, individually or collectively, for socializing sick persons who come to them for help. I also argued that although client socialization often began prior to the actual contact in clinical settings, it was maximized during the clinical interaction between the chiropractor and the new client. It was during this encounter that treatment would be "negotiated" in order to encourage the continuing utilization of chiropractic by new clients. Continued utilization or the "success" of chiropractic was defined as not less than four visits to the chiropractor by a new client following the initial visit.

In particular, I argued, after Kleinman (1980), that the negotiation of explanatory models between clients and chiropractors was an important aspect of the socialization process, and that "success" is the result of the negotiation of a common explanatory model which would enable treatment to occur. According to Kleinman (1980), the patient-doctor relationship is a transaction between the patient's explanatory model [EMp] and the doctor's model [EMd], and that there are four possible outcomes or results, namely: (a) an outcome in which the doctor's EM is transferred to the patient who, therefore, holds both EMs [EMp + EMd], (b) the outcome in which the patient's EM "gains" from the doctor's EM
[EMp > EMd], (c) the outcome in which the patient retains either his original model or he has acquired the doctor's model [EMp or EMd], and (d) the situation in which the patient acquires a totally new EM based on a new source of information.

I argued in Chapter 2, Section 2.2, p.89, that there are two other possibilities, namely: (a) a situation in which the client's EM is transferred, in a certain proportion, to the chiropractor's or physician's EM. In other words, the practitioner's EM is modified by or gains from the patient's EM [EMd > EMp], and (b) an outcome in which the doctor's EM changes to the patient's EM or in which the practitioner retains both EMs [EMd + EMp].

What Kleinman said about the negotiation of EMs was examined in the context of Goffman's (1959, 1967, 1969) observations regarding everyday relationships.

8.1 Findings and Discussion

(a) It was found that because of the nature of the political, social and economic constraints upon chiropractic in British Columbia, chiropractors used persuasive interaction structures and processes to convince apprehensive and "somewhat reluctant" new clients towards favourable impressions of chiropractic as a health care system. The conservative appearances of chiropractic waiting rooms which "mirror" those of allopathic waiting rooms helped to reassure apprehensive new clients and to minimize any deviant perceptions they held prior to their first visits. The secretaries and receptionists often functioned as "socializing" agents by helping new clients to define the chiropractic situation. Regular patients were "coopted" to provide evidence of the
competencies of chiropractors by relating, through casual conversations, how satisfied they have been with the results and clinical experiences of their treatments.

The waiting rooms often functioned as "classrooms" in which the first lessons on chiropractic were learned by the new client. Wall posters, favourable newspaper reports, and leaflets were used to educate the client and to lessen his doubts and apprehensions as well as to prepare him for his interaction with the chiropractor. Both the receptionist and the chiropractor often function as "performance teams" (Goffman, 1959:79) for the exchange of information about clients and for structuring the waiting room situation in order to educate the client in chiropractic. They cooperated in "staging behavioural routines" which served to supply the new client with specific and consistent sets of definition and information.

Chiropractors managed the impression of new clients by presenting a "chiropractic front" which includes the structures and processes of admissions to the clinics, the elaborate use of stories of "successful encounters", and the "occult involvement" in ritualized examination processes (Goffman, 1963:75-79).

Chiropractors seemed to understand the feelings and expectations of new clients (see Appendices XV-XXII for some of the comments), although their health beliefs and explanatory models differed.

In negotiating explanatory models, chiropractors focused on the elicitation of clients' health beliefs and explanations for "present" health problems. New clients focused on making sure they understood what chiropractors intended to do about their health complaints, therefore, providing chiropractors with the
avenue for detailed explanations of chiropractic perspective on health and illness - the chiropractic explanatory model.

Both the new clients and chiropractors modified their explanatory models. An unexpected finding was that chiropractors incorporated aspects of patient EMs on many occasions, thus pointing to some limitation in the range of possible outcomes proposed by Kleinman (1980). The research undertaken thus far cannot clearly distinguish between genuine or contrived negotiations of patient EMs, although the need for expanding the clientele underscores the likelihood of contrived responses in at least some instances.

The chiropractor, who has been labelled as a marginally deviant individual when compared to the allopathic physician, becomes a labeler in the chiropractic behaviour setting. He is a volitional actor in the sense of having considerable command over the situation. The chiropractor may also be said to engage in some form of "psychological" activity. When a new client is engaged in some sort of behaviour which the chiropractor considers inappropriate or "deviant", the client is categorized, for example, as a potential problem client, therefore, enabling the chiropractor to develop various strategies or plans of action. Viewed in this way, the chiropractor has the ability to manipulate the behaviour setting for his clientele and to create for himself the most favourable environment for his interventions, which will enable him to influence the views of prospective patients about chiropractic. Most chiropractors in this study reported that after a few opening statements during initial interviews, they were able to "predict in some way" whether or not a new client would be problematic. They were, therefore, able to assess the overall expressions that are "given" or "given off" by the new clients towards them and towards
chiropractic in general (Goffman, 1959:2). The basis for how they arrive at their assessment is unclear, but they appear to interpret certain behaviours, interaction, symbols, or manner of communication as indicative of impending problems with the clinical negotiation of treatments.

Upon encountering new clients for the first time, chiropractors "give off" expressions that are meant to achieve three basic goals, namely: instill "favourable" personal impressions on the new client; get off on the right foot; and define the situation with respect to the particular new client. The process of seeing that these three goals are successfully attained make up the "presentation" of the chiropractic self.

Clients are warmly welcomed, often with handshakes for men, and always with an easy smile. They are comfortably seated, and those who are in some pain are appropriately seated before starting the interview. In almost every instance, clients are engaged in casual conversation, often unrelated to their health problems, but designed to relax the client and to establish mutual trust and confidence. Bits of information that have been provided by the receptionists, or which are gleaned from clinical notes, are included to capture the interest of the client.

Chiropractors, therefore, "get off on the right foot" by reducing the anxiety, fears, and apprehension of new clients and by giving the impression that they are warm, "human" and caring persons who may share similar interests, views and feelings with their clients.

The readiness with which new clients respond to the pleasant, welcoming disposition of chiropractors provide valuable clues for defining the situation. New clients who are more cautious in responding to overtures, or who respond
with clipped answers are considered potentially problematic. However, this does not prevent chiropractors from trying to "win" them over.

Sometimes, chiropractors fail to "get off on the right foot", because some clients are extremely skeptical. Here too, there is a patient effort to win over such problematic clients and to persuade them to keep an "open mind".

The first clinical interviews between clients and chiropractors are critical to the success of chiropractic since they usually determine whether or not clients remain in treatment. Successful interviews result in satisfactory negotiation of differing health beliefs and compromise solutions that enable treatment to occur. If clients are suitably "convinced", they become patients.

The goals of chiropractic interviews, as observed in this study, are to discover the clients' personally held beliefs about "present" illness and connected experiences in order to reconstruct the clients' problem from a chiropractic viewpoint, and to negotiate treatment to enable ongoing care. At all times, the overriding objective is to reduce clients' fears, anxieties, and apprehensions, and to build mutual trust and confidence.

Shrewd assessment of the personalities of new clients enables chiropractors to adapt to a wide variety of individuals and to achieve maximum cooperation. The initial interviews are the occasions when new clients and chiropractors "size up" one another. They are also the time when clinical realities must be given "human" consideration. Even regular clients can still recollect their initial interviews with chiropractors because of the impact of that first encounter.

In the negotiation of explanatory models, chiropractors "empathize" with the "suffering" of clients as they probe into the clients' lifeworld and life
histories while searching for clues about clients' beliefs and explanations for present health problems. Information that is gathered from this process is used during the course of the interview and physical examination to "remoralize" or reorient new clients toward chiropractic views of health care.

In evaluating health problems, chiropractors rely on what they have learned about specific problems from previous cases. For example, backache is a common health complaint which all chiropractors come across in large numbers. Therefore, certain features of the medical history of backache are recurrent. When the medical history is vague and non-specific, the chiropractor is likely to explore social factors in attempting to form an "objective" assessment.

Rarely does a chiropractor openly disagree with a client about the cause of an illness. Rather, the client is gradually channelled towards chiropractic explanations. Because health problems have personal meaning for sufferers, chiropractors avoid discrediting personal meanings of ill-health. Rather, these are accommodated and sometimes incorporated into chiropractic explanations of cause and treatment.

Chiropractors recognize the importance of the first interview in the negotiation of treatment. It is during the first interview that the chiropractor and the new client attempt to construct a bond. During the initial interview, chiropractors try to create an atmosphere which suggests to new clients that they are interested in them first as a human being, and second, as a patient. In doing this, they inquire into the client's comfort, explain their professional role, and show that they are not in a hurry to finish the interview. They speak to new clients in terms that are simple and understandable, and they use simple descriptions and analogies to illustrate their points.
They appear to listen very intently, and they attend to the "body language" of the client.

Most chiropractors use the plural "we" in questions and explanations in order to encourage new clients to believe that successful therapy is a cooperative venture. This model of "mutual cooperation" is not characteristic of allopathic medicine where the general assumption is that the doctor [M.D.] orders the patient to behave in certain ways.

An unexpected but not insensible finding is that few chiropractors make written notes during the interview process, apart from writing down dates, numbers and key words. Many chiropractors feel that it detracts from giving concentrated attention to the client. Chiropractors do not want new clients to think that they are interested only in cold empirical data, but rather that they are giving their full attention to the person before them, who is in pain or discomfort.

An important finding is the difference between the chiropractors and new clients' EMs. Both groups use mechanical analogies to describe their health beliefs. More importantly, while new clients believe that infection, poisons and foreign bodies are causes of illness and that medication is an appropriate treatment, chiropractors believe in the malfunctions of the central nervous system as the primary cause of illness and adjustment of spine as the preferred treatment. While new clients identify blood and the circulatory system as the prime sites of the transportation of food energy, and nourishment to promote healing, chiropractors identify the nervous system and its "homeostatic" control functions as the key to health and illness.
In spite of these differences, chiropractors and new clients were able to negotiate understandings that enable chiropractic treatments to be provided. Some of the reasons for the success of chiropractic in the negotiation of EMs are located in the type of relationships they have with the clients.

Unlike allopathic interviews, where questions and answers are not organized in a two-way fashion (West, 1983), chiropractic interviews offered more of a two-way dialogue between new clients and chiropractors. Chiropractic clients ask more questions than allopathic patients, and they also initiate more of the questioning. Although chiropractors ask the majority of questions, many of these questions are asked early in the interview and most are intended to encourage clients to continue providing their responses and explanations. In chiropractic exchanges, client-initiated questions are not "dispreferred". West (1983:99) has noted that patient-initiated questions in allopathic exchanges are "dispreferred", therefore, resulting in an asymmetrical pattern of conversation in favour of the doctor.

The opportunity to ask questions and to explain own beliefs may in part, be one of the reasons why new clients in this study are satisfied with chiropractic interviews. Also, chiropractors do not "chain" their questions so that answers could not be provided to some of the questions. West (1986) finds that "doctor talk" is characterized by the chaining of questions thus providing it with a unique "utterance-type" characteristic (p.99). This constrains patients from having the opportunity to answer the questions (Goffman, 1981). Chiropractors, on the other hand, not only prefer clients' questions, they also use the plural "we" to encourage the full participation of clients in the
interviews. Unlike allopathic interviews wherein some of the patients' questions are ignored, given vague answers, or met with changes of subject by physicians (Korsch et al., 1968), chiropractors tend to answer all questions and encourage clients to continue to ask questions until they have understood the explanations.

An important finding is the recognition by chiropractors that clients have own beliefs and ideas about their illness - a recognition which is often lacking in allopathic interviews, hence the universal concept of "doctors' orders" which has characterized allopathic care over the years.

In relation to the client, the chiropractor is equal to or less "powerful" than the new clients during the initial interview. The situation may well change as the client continues in chiropractic treatment. In this study, clients and chiropractors corrected each other about equally, although clients used more "overlaps" to change the topics during conversation - a process which Fisher (1986) has shown to be one of the ways in which allopathic physicians manifest greater power and control in clinical interviews.

The few new clients who discontinued treatment did not do so because of the nature of the clinical interviews or inability to obtain full explanations from chiropractors. Many discontinued either because they "felt better" or because they had been advised by friends and family physicians to discontinue chiropractic treatment. Some of the clients who remained in treatment did not have all of their fears and concerns allayed, yet, they were satisfied with their relationships with chiropractors.

One question which has emerged from this study is the degree of "sincerity" with which both clients and chiropractors negotiate in the clinical setting. In
terms of Goffman (1959), one of the aspects of impression management is the ability to give the client the impression that the chiropractors are "shifting" their EMs while, in fact, they are not doing so. Kleinman (1980), Katon and Kleinman (1981), have envisaged a "shift" in EMs which is "genuine" and usually from doctor to patient. But if chiropractors are indeed managing the impressions of clients, then it is possible that some of the "shifts" in EMs may be contrived (Goffman, 1959). Similarly, because many of the new clients appear to have retained their original EMs since they continue to receive allopathic care while in chiropractic treatment, they, too, may have "contrived" a shift in their EMs in order to take advantage of the good clinical relationships they have with chiropractors. This "two-way" modification of EMs has not been considered in Kleinman's perspective. Is it, therefore, possible that Kleinman's negotiation model is applicable only to the allopathic model of clinical care where the physician expects the patient to make all the "shifts" in EM? In this case, it is the power of the profession of allopathic medicine that seems to have influenced the direction of "shifts" in Kleinman's model. In an equal power or reversed power relationship, that model is inadequate in explaining the ostensible shifts in practitioner EMs as well as the influence of everyday relationships on clinical negotiations. Thus, a serious limitation in Kleinman's model becomes transparent in the context of the more fluid impression-management character of the chiropractor-client relationship.

8.2 Implications of Study for Health Care

It is clear that limiting chiropractors in British Columbia to use of hands only in treatment of diseases has not deterred them from "making their
clientele". The "human touch" or the manifest laying of hands appears to increase patients' confidence in their health and treatment systems. Allopathy has become very detached from the human aspect of health care. In contrast, chiropractic re-directs health care towards "the human touch".

Furthermore, illnesses are conducive to the activation of latent beliefs in magic. These beliefs "tend to cluster about situations where there is an important uncertainty factor and where there are strong emotional interests in the success of action" (Parsons, 1951:468). Thus, the highly ritualistic aspects of chiropractic health care, especially the treatment by adjustment of the spinal column, may satisfy a person's need to be a focus of ceremonial attention. The performance of ritual, in itself, may function to alleviate anxiety.

There is no doubt that some patients may have a need to be held, touched and cared for. Some musculo-skeletal ailments may, therefore, be psychological in origin. The tactile stimulation received at the hands of a chiropractor, with the person lying on a couch in a dependent state, could be a legitimate face-saving means of gratifying repressed needs.

As well, chiropractor patient interviews are less structured than the standard allopathic physician-patient interviews. Conversation is not always focused on physical symptoms. Clients discover that they have an "open forum" to discuss any problems. The client is given more interview time and treated more cordially, and there is wider latitude in the definition of what is relevant to illness and its treatment. Most importantly, the chiropractor never suggests that there is nothing "wrong" or that the client should consult a psychiatrist. Instead, the chiropractor allows his client to maintain his
integrity and accepts the client's presentation of self and symptoms at face value.

The success that chiropractors seem to enjoy with their patients should tell us that the chiropractic method of clinical care has important lessons for health care in general. Kudushin (1962:526) has noted that a physician who diagnoses "nothing wrong" or merely prescribes medicine, but goes no further, does the patient an injustice and merely perpetuates "shopping" from one physician to another. This could raise the cost of health care under a state-sponsored health care system, even though clients are still not "cured".

The very existence of the diagnostic category "psychological illness" could well be a reflection of the arrogance of modern, scientific medicine, for it assumes that because no organic causes for a particular illness are known, therefore, there are none. Friedson (1961:176) has noted that "in every age there are likely to be diseases unrecognized by contemporary diagnostic categories - as typhoid and syphilis were once confused, and as mental diseases are no doubt being confused today". Therefore, the very act of defining illness is to some extent arbitrary and valuational. Chiropractors avoid making any overt judgements about how clients view their illness problems or the beliefs they hold in coming to these views. Allopathic physicians, by not recognizing the beliefs of patients about health and illness, are issuing a denial of the reality of patients' perceptions of their illness, and by logical extension, a denial of the reality of relief through conventional, "non-stigmatizing" medical means. In seeking to escape the uncertainty of their medical situation, allopathic "rejects" may affiliate themselves with another reference group, in this case, regular chiropractic patients. As Friedson notes (1961:171), "When
the doctor's diagnosis contradicts the patient's and his lay consultant's conception of illness and treatment, he seeks out other services."

Chiropractors fill this void partly by giving clients their full attention and by encouraging them to express their feelings and opinions. They use simple, everyday language in explanations rather than complicated medical terminologies. In every instance, they strive to establish rapport, trust and confidence with clients. Above all, they seek to understand the beliefs and feelings of clients about health, illness and treatment in general. In this way, they retain clients whether or not health problems are actually "cured". Indeed, most chiropractor patients assert that they feel much better after they have experienced chiropractic even though they continue to tout the virtues of allopathic medicine.

The relationship between chiropractors and clients is, therefore, a personalized relationship, enhanced by the high degree of physical contact. By empathizing with the suffering of clients, chiropractors add a human dimension to health care. It seems that the modern orthodox allopathic practitioner fulfills his "scientific-medical" role but no longer meets the layman's expectations of his social role (Mechanic, 1968:177). Although some patients may be able to accept a more narrow, technical definition of the physician's role, chiropractic provides a much-needed alternative for dissatisfied patients of orthodox medical practitioners.

At about the time of the conclusion of this study, the Government of British Columbia imposed a five dollar "user's charge" on chiropractic care and other non-allopathic health care groups such as naturopathy and physiotherapy. This places further constraint on chiropractic in that new clients will be
required to pay for a service of which they do not have adequate information. Chiropractors will have to refine their strategies further, or develop new strategies for calling the attention of new clients to chiropractic and for keeping them once they have made contact. Fewer new clients will be inclined towards chiropractic and the competition for patients among allopaths and alternative practitioners will be skewed in favour of allopathic physicians. Some chiropractic patients may return to their family doctors rather than receive medical and chiropractic services simultaneously. This will raise the cost of allopathic services which is already at the highest level since the introduction of universal health insurance services.

The introduction of the user's fee by the government demonstrates again, the political power of the allopathic medical group. Not long ago, the government prevented allopathic physicians from extra-billing patients. Now, more funds are being made available to allopathy by the restriction of services to alternative health care provider groups through the introduction of user's fees. More patients will go to allopathic doctors, therefore shifting the health insurance payments from alternative practitioner groups to allopathy. One alternative health care provider comments in the Vancouver Sun of March 23, 1987 as follows:

"It (the user's fee) is a disincentive to using a low cost, effective, conservative approach in treating a variety of conditions and disabilities."

The President of the Provincial Association of Chiropractors comments in the Vancouver Sun of March 24, 1987:
"We want the public to know there is money for some groups but not for others."

The findings of this study suggest that the chiropractic client will now enjoy more leverage in the power relationship with the chiropractor than was so before the introduction of user's fees. However, this also means that the quality of the clinical relationship is likely to become even more person-centred than it had been prior to the introduction of user's charges by the provincial government.

8.3 Suggestions for Future Studies and for the Sociology of Health Care

Much of what took place in the twenty clinics between chiropractors and their patients deviated from what one would normally expect in an established allopathic practitioner's office.

Utilizing the interactionist stance, coupled with the sensitizing concepts of behaviour settings, and employing the methodologies of interviews, observation, and record analysis, this study has sought to provide a body of descriptive data reliant upon actors' definitions of the situation in order to specify interactional patterns that lead to the making of chiropractic clientele.

As a descriptive and, to some extent, an ethnographic account, this study has not had as its purpose the support or rejection of any particular theory. Its contributions are to the sociological enterprise in the area of interactional studies in general, and to the study of chiropractic in particular. Although chiropractic as a profession has received some attention by sociologists, no
work has been done on the clinical behaviour and relationships of chiropractors in particular social and political environments in order to explain their success in attracting and maintaining clientele. There has been no research to date which identifies the health and illness beliefs of chiropractors and potential patients as a matter of considerable significance in explaining the success of chiropractic, including description of how these different beliefs are reconciled in clinical interaction, enabling clients to become patients. Yet, as the second largest health care profession in British Columbia and, indeed, in North America, chiropractic certainly warrants close study. This study was restricted to only twenty chiropractic clinics and sixty clients, but there is reason to believe that these clinics are not unlike other clinics, especially those operating in the province of British Columbia, because they all face the same kind of constraints.

This study has also furnished quite sensitive data on interactive behaviours through observation of ongoing situations and through structured interviews.

A third contribution of the research is the contrast drawn between chiropractic and allopathic health care. Increased awareness of their respective interactional styles may lead to improvements in clinical relationships between healers and patients. Future studies might examine the extent to which practitioner-client interactions in other "marginal" healing groups such as naturopathy are similar to or different from those of chiropractic.

Studies employing a Goffmanesque orientation might also be applied to allopathic medicine in order to describe its theatrical aspects. Perhaps, in
allopathy, we have a theatre of cold, condescending scientism, which appeals to certain kinds of individuals and disappoints or frightens others.

A fourth contribution of the research is that it documents the methodical efforts on the part of chiropractors to influence situational properties in order to impress new clients. This is consistent with the interactionist position that social actors possess the capability to modify their courses of action relative to changing definitions of the situation. Along the same lines, the research documents the "manipulative power" of chiropractors to stage the social audience, or more specifically, to redefine clinical realities in order to re-orient skeptical patients towards chiropractic, and eventually to persuade them to become chiropractic patients regardless of personally held beliefs.

Collaterally, this study contributes to an understanding of the relationship between the health beliefs of clients and practitioners. It has been suggested that only like-minded persons subscribe to chiropractic in that they believe in holistic care (McCorkle, 1961). This study has shown that clients of chiropractic do not necessarily enter treatment sharing chiropractors' beliefs about illness. Indeed most new clients have quite dissimilar beliefs about health and disease. Both clients and practitioners employ health and explanatory models in order to make sense of their illness problems, thus, the clinical process turns into an essentially negotiative activity involving the explanatory models of patients and practitioners, one in which the client's explanatory model is sometimes assimilated within the negotiative process, to the chiropractor's own explanatory model, thus enabling chiropractic treatment to occur. The chiropractor's success in "subduing" the client's potentially antagonistic explanatory model depends upon the impressive "fronts" that he can
mount and the skills at his command in "manoeuvering" the negotiations so that the client adopts the chiropractor's definitions of the situation. When this happens, whether by explicit acknowledgement or by tacit agreement, the client has been transformed into a chiropractic patient and the chiropractor has succeeded in "making the clientele".

Similarly, the client may structure the clinical situation by "contriving" agreement to the chiropractor's definition of the situation, especially if the client is experiencing discomfort or pain and is in need of the experience of chiropractic treatment. However, the client is not obligated to remain in treatment beyond the initial visit unless the experience is helpful and the clinical relationship is satisfactory.

This study contributes to our understanding of the wider implications of medical care as a socially constructed activity by examining specific socio-legal context. Chiropractors in British Columbia face a quite different set of constraints compared to their counterparts in other Canadian provinces. These constraints have influenced their approach to clinical relationships in that the denial of access to some of the treatment methods, which are ordinarily employed by chiropractors elsewhere, appear to have necessitated a more intensive focus on the improvement of clinical relationships with patients. This study, therefore, is generally supportive of Kleinman's (1980) sociocultural approach to the study of health care.

Going beyond Kleinman's discussion regarding the clinical negotiation of explanatory models is the finding that there are other possibilities in addition to the range of outcomes he proposed. Kleinman's negotiative approach provides primarily for the compliance of patients to suggestions by physicians, thus
suggesting a biomedically-centred model of negotiation. In other words, the doctor does not change or modify his explanatory model, only the patient does. In this study, it was discovered that chiropractors "shift" and modify their explanatory models, thus denoting outcomes unspecified in Kleinman's schema. The implication of this finding is that chiropractic patients appear to have considerably more leverage in their clinical interactions with chiropractors which is very different from what is known about allopathic-patient relationships (West, 1983; Mishler, 1984; Fisher, 1986).

Perhaps most importantly, this study points to the necessity of interpreting the entire negotiative process within the context of actors' pre-defined agendas, latent purposes, and contrived performances. Observation of the clinical interaction setting shows that it is unrealistic to try to account for negotiations over explanatory models solely on the basis of actors' manifest and stated objectives. The Kleinman model which focuses on surface negotiations, needs to be conceptually integrated with the Goffman perspective on "background", "front", "impression management" and intentional strategies, in ways that have been only pointed to and exemplified in this research. In addition, and along these same lines, it would be important to conduct longitudinal studies for the purpose of examining whether chiropractors attempt to reassert the primacy of their own explanatory models and their own favoured treatment procedures once their patients have become regular users of chiropractic.

A question worth considering that emanates from this study is whether chiropractors would continue to employ these same interactional strategies
should their services be included and remunerated in the government medical plan, in the same way that the plan now applies to allopathic physicians.

It is likely that the need for special "persuasion" strategies would continue, so long as allopoly is generally endorsed as the dominant medical belief-system, although the removal of the monetary constraint would certainly render the dominance of allopoly more vulnerable. Chiropractors would, no doubt, be willing to confront this changed situation.
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APPENDIX I

LETTER TO THE EXECUTIVE DIRECTOR AND PRESIDENT,
BRITISH COLUMBIA CHIROPRACTIC ASSOCIATION

Department of
Anthropology and Sociology

July 10, 1985

Dr. Don Nixdorf, D.C.
Executive Director and President
B.C. Chiropractic Association

Dear Dr. Nixdorf,

Re: Godwin Eni: Graduate Student (Ph.D.), Medical Sociology

I am the chairman of Mr. Eni's thesis committee with responsibility for
guiding his research. He tells me that he has discussed the details of his
study with you, and he is looking forward to beginning the field work as soon as
possible. His thesis prospectus has now been approved by his full supervisory
committee at U.B.C.

I would be grateful for any assistance that you and your membership are
able to give him, especially regarding the observation of clinics and the
interviewing of practitioners and new patients.

Mr. Eni is most appreciative of the assistance that you have already given
him. He hopes to commence the study in August and conclude it within two or
three months.

Sincerely,

R.S. Ratner, Ph.D.
Associate Professor
Sociology
APPENDIX II

LETTER OF INTRODUCTION

Vancouver, B.C.
August, 1985

To: Dr.

My name is Godwin Eni. I am a graduate student at U.B.C. with interest in the sociology of health care and health professions. My study is about Chiropractic and you can help me to understand more by providing me with some general information about your practice and about patients who come to you for treatment.

The research I am undertaking will not make judgements about any treatment system. Its purpose is to provide an understanding of a particular treatment system, in this case, Chiropractic. Dr. Nixdorf, President of your Association, has probably been in touch with you regarding my study.

Your name and those of your patients will not be used in any identifiable way. All confidential matters will be respected and will not be linked to identifiable individuals or to locations of practice.

This interview will take about 45 minutes and I am very grateful for your spending this time with me. As Dr. Nixdorf has indicated in his letter, I probably will want to talk with you briefly after each observation of your clinic. A final interview with you will probably take place in six to eight weeks.

Thank you for your help.

Sincerely,

GODWIN ENI
APPENDIX III

*INTERVIEW QUESTIONS: LEADERS OF CHIROPRACTIC

Thank you for agreeing to answer my questions about CHIROPRACTIC. Your answers will help me understand more about CHIROPRACTIC in my study of the profession. Nothing that you have to say will be identified with you, by name, in this study.

The following officials of CHIROPRACTIC were interviewed:

National President, Canadian Chiropractic Association
President, British Columbia Chiropractic Association - 1984/85
Executive Director, British Columbia Chiropractic Association - 1985/86:
President, Canadian Memorial Chiropractic College:

CONSTRAINTS ON CHIROPRACTIC

1. What constraints, if any, do you think your organization is faced with in functioning as a health profession in Canada? In the province of British Columbia? (Probe)

2. Why do you think these constraints exist?

3. Does the profession face these kinds of problems in other countries, for example, U.S., Great Britain? Why?

4. What is the Canadian (or British Columbia) Chiropractic Association doing at the present time about these constraints? (Probe)

5. Which constraint(s) do you think more directly affects the CHIROPRACTOR in his/her office practice or in his/her role as a healer? Explain.

6. What government policies relate to the practice of CHIROPRACTIC in Canada or in British Columbia? How do these policies affect CHIROPRACTIC?

7. What is the Canadian or British Columbia Association of Chiropractic doing or have done to change or modify policies considered not favourable to CHIROPRACTIC?
GENERAL

1. Do all CHIROPRACTORS in Canada or British Columbia belong to the Canadian or B.C. Association? Explain.
   What are the benefits of membership?
   Why should each individual CHIROPRACTOR feel s/he should belong to CCA or BCCA as a collective?
2. What have you been able to do for CHIROPRACTIC?
3. How do you think CHIROPRACTIC is generally regarded relative to medicine or law?
4. Any change in public perception of CHIROPRACTIC within the last 15 years? Since you assumed your present office? Explain. (Probe)
5. What kinds of things have gone on in the CHIROPRACTOR-client interaction that can be considered unethical or could jeopardize the status of the profession?
6. What are the earmarks of a profession?
7. How can CHIROPRACTORS best overcome the "ignorance" or resistance most people have about CHIROPRACTIC? What can the individual CHIROPRACTOR do?
8. What kinds of people are now going into CHIROPRACTIC?
   Any different with past students, regarding education, age, and any other characteristics you can think of?
9. Has the training of CHIROPRACTORS changed to accommodate new kinds of interests?
10. (Specific question to the president of the Chiropractic College regarding the education of student CHIROPRACTORS)
    How does the education of CHIROPRACTIC students differ from those of medical students? Student Physiotherapists? Osteopaths?
    What is the entry level of education of students in the CHIROPRACTIC college?
    What subjects do you consider most important for their survival as CHIROPRACTORS in the community? Explain.

Thank you.

* All interviews were tape recorded.
APPENDIX IV

*INTERVIEW QUESTIONS:
ASSISTANT DEPUTY MINISTER OF HEALTH
PROVINCE OF BRITISH COLUMBIA

Thank you for agreeing to answer my questions about government policies regarding CHIROPRACTIC in British Columbia. I am a graduate student (Ph.D.) at the University of British Columbia. Your answers will help me to complete my study about CHIROPRACTIC in the City of Vancouver. Nothing that you have to say will be reported to the CHIROPRACTORS, nor will any of your comments be identified with you, by name, in my study.

1. What provisions in the CHIROPRACTIC Act of British Columbia place limitations on CHIROPRACTIC. Explain.

2. What are the limitations on CHIROPRACTIC clinical practice?

3. What major changes or revisions have been made in the Act since the last 15 years?

4. What is the Ministry of Health's policy regarding hospital privileges for health care professionals?

5. Why are CHIROPRACTORS denied hospital privileges?

6. Are there CHIROPRACTORS in Government Medical Regulatory Committees, such as Medical Advisory Committee, Workers' Compensation Board? Explain.

7. How many treatments from a CHIROPRACTOR can a patient have for which the medical insurance plan pays?

8. Why is there limitation to the number of visits that can be paid for CHIROPRACTIC services from public funds?

9. What kind of relationship do the leaders of CHIROPRACTIC have with the Ministry of Health?

10. What is your personal view about CHIROPRACTIC as a treatment system?

11. As a profession?

12. What other linkages do CHIROPRACTORS have with the Ministry of Health?

13. How do they make their views known about an issue?
14. How successful have they been in negotiating with Ministry officials about issues of concern to them?

15. What aspect of CHIROPRACTIC treatment does the Ministry regard as not suitable for payment, under the public health insurance plan?

16. What percentage of health expenditure under the public health insurance plan is attributable to CHIROPRACTIC?

17. What is the total expenditure on CHIROPRACTIC services for the 1984/85 year?

* The Assistant Deputy Minister did not want a tape recording of his responses.
Hello. My name is Godwin Eni. I am a graduate student at U.B.C. I wish to learn something about what people believe about their health and how to care for it. You can help me by telling me about your own beliefs regarding health care.

I hope you don't mind if I make some notes of our conversation.

**BELIEFS ABOUT THE HUMAN BODY AND ITS FUNCTIONS**

Let me ask you some questions about how you think the human body functions.

1. What habits are good for bodily health and what habits are not good?
2. In your view, how does your own body keep healthy?
3. Why do you think that?
4. So, what needs to be done to keep it well?
5. Why do you think that?
6. Do you follow these habits? If not, why not?
7. Let's take the good habits you mentioned first. Please explain why they are good habits. And the bad habits?
8. Do you feel that the body is able to care for itself? For example, that if you get a cold you will naturally get well?
9. If yes, how and why? If no, why not?
10. Is there anything else you feel can affect the body, how it works or how long it survives?

**BELIEFS ABOUT ILLNESS AND DISEASE**

Can you tell me a little about what causes illness and how you can detect it?
CAUSE OF ILLNESS

1. In your opinion, is there one or more causes of illnesses, such as a cold, headache, heart disease? Explain.

2. How does this cause (or causes) affect the body?

3. How can one avoid being ill?

SIGNS AND SYMPTOMS

1. How do you know whether you are about to become ill?

2. Can you always tell you are about to become ill?

3. Are there some things that you suddenly cannot do which tell you that you are ill, or about to be ill?

BELIEF(S) ABOUT TREATMENT SYSTEMS AND PROFESSIONAL HEALERS

1. Can you tell me what type of treatment you generally prefer when you are ill?

2. Which of the following types of treatment do you most prefer: (a) use of drugs? (b) using natural herbs or things that grow naturally? (c) opening the body and removing whatever is thought to cause the problem? (d) using hands to fix the body? (e) other? Why?

3. Have you ever been treated by any of these healers? (a) medical doctor (b) faith healer (c) native doctor (d) Other Specify. Have you been treated by any of these healers within the past 5 years?

4. In your dealing with a healer, how important do you consider the following:

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Why is ___ the most important factor to you?

Why is ___ the least important factor?
5. Are there other things you want to tell me about people who help people with illnesses?

**HEALTH HABITS**

1. Are there things you do every day to keep healthy? Do you exercise? Take pills? Diet? Other?

2. Why do you do these things?

3. When did you start taking care of yourself in this way?

4. What do you think will happen if you do not continue to do these things over a long time?

**B: EXPLANATORY MODEL: NEW CLIENTS**

**PRESENT HEALTH PROBLEM**

1. What is the problem for which you want to see a chiropractor?

2. What do you think has caused your problem? Why do you think _____ is the cause?

3. Why do you think it started when it did?

4. What effect do you think your illness has within your body?

5. How do you think your illness works in your body? Why do you think it works in that way?

6. How severe is your sickness?

7. Do you think it will have a short or long course? How long, do you think?

8. What kind of treatment do you think you should receive?

9. What are the most important results you hope to receive from this treatment?

10. What kind of concerns do you have, if any, about undergoing chiropractic treatment?

11. What have you done by yourself about the problem before now?

12. Have you sought help from other people? If yes, from whom? Why did you seek help?
CONSTRAINTS ON CHIROPRACTIC

1. When did you first learn about chiropractic as a treatment system? How?
   What do you know about chiropractic?
   What do you know about chiropractic treatment?
   What does your family/friends think?
   Does your doctor know you are seeing a chiropractor?

2. How easy or difficult was it for you to come to see a chiropractor? Explain.

3. What kind of advice and treatment do you expect to receive from the chiropractor?

4. How would you pay for the treatment you receive?
   And if the government does not pay for all of your treatments?

IMPRESSIONS ABOUT CHIROPRACTIC

1. What is your impression of the standing of chiropractors amongst other health professions in the province?
   What do other people think? (your family, your friends)
   How do you rate them as a group? (a) high (b) above average (c) average or (d) low, amongst professions in this province?

2. What are your attitudes and conceptions about chiropractic in general? (probe on conceptions)

3. Do you always feel this way?
   What induced or led you to feel this way?

4. Do you view chiropractic as the only way to help your problem?
   If yes, explain.
   If no, explain.
   If no, what other ways?

5. Do you mind if the chiropractor refers you to another kind of healer?
   If yes, explain.
   If no, explain.

6. Do you think that blood tests can help in finding out about your problem? Explain.

7. Do you think chiropractors will be able to diagnose your problems by using blood tests?
8. Do you think that X-Rays would help in finding out about your problems? Explain.

9. Do you think your chiropractor will be able to diagnose your problem by using X-Ray?

10. Do you have any expectations about a chiropractor on meeting him/her for the first time? Explain.

11. Do you expect to have to make an appointment in advance to see the chiropractor? Explain your reason.

12. Did you make an appointment in advance for your forthcoming visit to the chiropractor? Explain.

O.K. That does it. I want to thank you for participating in this study. It's been very instructive, and I hope you've enjoyed doing it.

Do you have any questions/comments about the interview? 

Now, Dr. ____'s secretary may have already informed you that I will want to speak to you once more, probably in a few week's time, whether or not you continue to be a patient of Dr. ____.

Thank you.
C: HEALTH MODEL: CHIROPRACTOR

BELIEFS ABOUT THE HUMAN BODY

Let me ask you some questions about how you think the human body functions.

1. What habits are good for bodily health and what habits are not good?
2. In your view, how does your own body keep healthy?
3. Why do you think that?
4. So, what needs to be done to keep it well?
5. Why do you think that?
6. Do you follow these habits? If not, why not?
7. Let's take the good habits you mentioned first. Please explain why they are good habits. And the bad habits?
8. Do you feel that the body is able to care for itself? For example, that if you get a cold you will naturally get well?
9. If yes, how and why? If no, why not?
10. Is there anything else you feel can affect the body, how it works or how long it survives?

BELIEFS ABOUT ILLNESS AND DISEASE

1. Can you tell me a little about what causes illness and how you can detect it?
2. In your opinion, is there one or more causes of illnesses, such as a cold, headache, heart disease? Explain.
3. How does this cause (or causes) affect the body?
4. How can one avoid being ill?
CAUSES OF ILLNESS

1. In your opinion, is there one or more causes of illnesses, such as a cold, headache, heart disease? Explain.

2. How does this cause (or causes) affect the body?

3. How can one avoid being ill?

SIGNS AND SYMPTOMS

1. How do you know whether you are about to become ill?

2. Can you always tell you are about to become ill?

3. Are there some things that you suddenly cannot do which tell you that you are ill, or about to be ill?

BELIEF(S) ABOUT TREATMENT SYSTEMS AND PROFESSIONAL HEALERS

1. Can you tell me what type of treatment you generally prefer when you are ill?

2. Which of the following types of treatment do you most prefer: (a) use of drugs? (b) using natural herbs or things that grow naturally? (c) opening the body and removing whatever is thought to cause the problem? (d) using hands to fix the body? (e) other?
   Why?
   Which do you least prefer?
   Why?

3. Have you ever been treated by any of these healers? (a) medical doctor (b) faith healer (c) native doctor (d) Other Specify.
   Have you been treated by any of these healers within the past 5 years?

4. In your dealing with a healer, how important do you consider the following:

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   a) being easy to talk to?    
   b) sharing the same opinion about your illness? 
   c) how s/he treats you in the office or during treatment? 
   d) how s/he presents him/herself? 
   e) how his/her office looks? 
   f) what s/he uses in treating you?

   Why is ____ the most important factor to you?
   Why is ____ the least important factor?
5. Are there other things you want to tell me about people who help people with illnesses?

**HEALTH HABITS**

1. Are there things you do every day to keep healthy?  
   Do you exercise? Take pills? Diet? Other?

2. Why do you do these things?

3. When did you start taking care of yourself in this way?

4. What do you think will happen if you do not continue to do these things over a long time?

**D: EXPLANATORY MODEL: CHIROPRACTORS**

1. What is the cause or causes of illness(es) you see most often in your practice?  
   Why do you think the illness(es) that you see begin when they do?

2. Describe your reasons.

3. What effect do you think this illness or these illnesses have within the body?

4. How do you think it, or they, work in that way?

5. How severe are the illnesses you see in your practice?

6. Do they, or does it, have a long or short course?  
   How long or how short a course?

7. What kind of treatment(s) do you give for this, or these illness(es)?

8. With what expected result(s)?

9. What are your concerns, if any, about the administration of this or these kinds of treatment(s)?

10. What will you suggest patients with this or these kinds of problems do about this problem(s), before going to see a professional healer?

11. Do you think they should seek other kinds of help?

12. If yes, what other kinds and from whom?  
   Why do you not think so?
CONSTRAINTS/STRATEGIES ON CHIROPRACTIC

1. How do you make people become aware of Chiropractic?

2. Is it easy or difficult to have enough patients in your practice? Please explain.

3. How do your patients pay for their treatment(s)?
   Especially beyond the allowed 12 visits per year, per patient?
   Do you have any difficulty getting paid by patients beyond the 12 visits?
   Please explain (if yes or no) and what kind of difficulty.
   How do you deal with difficult to obtain payments? Please explain.

4. What kinds of advice, other than treatment, do you give your patients about their health?
   Why do you give the advice? Please explain.

5. What are your clients' perceptions and attitudes about chiropractic?
   (Probe on conceptions)
   Does that pose any problems for your practice?
   If so, how do you try to resolve them?

6. Do your clients or most of them always feel this way?
   If so, what do you think induced or led them to feel that way?

7. How do you think your profession of Chiropractic is regarded within the society at large, or in general?
   How do you think your clients regard Chiropractic compared to other health professions?
   Do your clients tend to compare you with medical doctors (allopathic doctors)?
   Does that pose any problem(s)?
   If so, what kind of problem(s)?
   How do you resolve them?
   How do you rate Chiropractic compared with other professions in general in this province? (a) high (b) above average (c) average (d) low

IMPRESSIONS ABOUT CHIROPRACTIC

1. Is spinal adjustment the only way to treat most illnesses or the kinds of illnesses you see most often in your practice?
   If yes, please explain.
   If no, please explain.
   If no, what other ways?

2. Do you refer patients to other kinds of health care practitioners?
   If yes, to what other kinds? and why?
   If no, please explain your reasons.
   Do you accept referrals from other kinds of health care practitioners?
   If no, please explain your reasons.
3. Do you use blood tests to help diagnosis?
   Why?
   Why not?
   Please explain your reason(s).

4. Do you think it is possible to know enough of patient illness problems through blood tests?
   Please explain your answer.
   By using X-Rays?
   Please explain.

5. What do you regard as the appropriate way to present yourself, regarding general appearance or manner, to your clients?

6. Do you think that it is important that patients be required to make appointments in advance of their coming to see you?
   If so, please explain.
   If not, please explain.

O.K., that does it. I want to thank you for your time. It has been very instructive and I hope you've enjoyed doing it.

Do you have any questions or comments about the interview?

I shall be seeing you again for a couple of sessions to learn more about chiropractic treatment.

Thank you.
APPENDIX VI

POST INTERACTION INTERVIEW QUESTIONS:

A: NEW CLIENTS

Thank you for helping my study by answering questions regarding your health beliefs and habits, and about your expectations and treatment. Now that you have undergone some treatment, I would like to complete my study by asking you a number of questions about your experience, and whether or not you intend to continue with CHIROPRACTIC treatment now or in the future, and your reasons for your decision. I'm sure you understand that my study will be of no value unless you are perfectly frank with me in stating your opinions. I can assure you that nothing you have to say will be reported to the CHIROPRACTOR, nor will any of your comments be identified with you, by name, in my study.

1. Do you think the CHIROPRACTOR understood your problem? Yes. No. Explain.

2. What did he do or say during your first visit to convince you that he did (or did not) understand your problem?

3. What did he do or say during your other visits to convince you that he did (or did not) understand your problem?

4. Did he make you feel comfortable, or not? Yes. No. How did he do that?

5. Was the CHIROPRACTOR

   (a) easy to talk to?
   (b) able to share your own opinion about your illness?
   (c) able to treat you the way you wanted to be treated?
   (d) able to present himself in a way acceptable to you?


7. Did you have any disagreements, or differences of opinion with the CHIROPRACTOR about his/her diagnosis of your problem? Yes. No. Explain. If so, were these disagreements resolved? Yes. No. How?

8. Did you have any disagreements or differences of opinion about the treatment you received for your problem? Yes. No. Explain. If so, how were these differences resolved?
9. Is the treatment that you received what you expected?

10. What did you think of the treatment you received (i.e. did you judge it to be (a) good or bad? Explain. (b) useful or not useful? Explain. (c) How did you arrive at the evaluation of the treatment you received?

11. How many treatments have you received from the CHIROPRACTOR? (If beyond 12 Medicare limit, or beyond 15 Medicare limit for senior citizens, probe as follows): (a) Why did you continue beyond 12 (or 15) visits? (b) How did you pay for your first 12 (or 15) visits? (c) How did you pay beyond the 12 (or 15) visits?

12. Before your visit to the CHIROPRACTOR you said that "....." Has that opinion changed since you first went there? Yes. No. Explain.

13. Have you decided on whether you will continue, or discontinue treatment? Yes. No. If not, why not? If so, what have you decided? Explain.

14. Based on your experience, do you now prefer CHIROPRACTIC treatment to more conventional forms of medical treatment? Yes. No. Explain.

15. What concerns, doubts or reservations, if any, do you now have about CHIROPRACTIC? Have you sought other kinds of medical help while you were obtaining treatment from the CHIROPRACTOR? Yes. No. If so, from what kind of practitioner? Why?

16. Would you recommend CHIROPRACTIC treatment to a friend or relative who had the same kind of problem you had? Yes. No. If so, why? If not, why not?


18. How would you compare CHIROPRACTIC to other professions such as:

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<td>(d) Pharmacy</td>
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19. How would you compare your CHIROPRACTOR to your regular or family doctor? Similar ___ About Similar ___ Not Similar ___ Explain.

20. Is there anything else you would like to tell me about your experience with Dr. _____, your CHIROPRACTOR?

I want to thank you again for your time and for helping my study by answering these questions. Your answers will contribute in the understanding of CHIROPRACTIC by helping to describe the feelings and expectations people have when seeking help for their problems and what actually happens when help is given.

Now, do you have any questions regarding the study?

Thank you again.
B: CHIROPRACtors

Thank you for helping my study by answering questions regarding your health beliefs and health habits and about your practice.

I would like to complete my study by asking you a number of questions regarding my observations in your practice, the treatments that your clients received, and some of the matters we talked about during the first interview.

I am sure you understand that my study will be of no value unless you are perfectly frank with me in stating your opinions. I can assure you that nothing you have to say will be reported back to your patients, nor will any of your comments be identified with you by name in my study.

   (a) Its cause? Explain.
   (b) The treatment to give? Explain.

2. Did you know what to do about a problem
   (a) when you first see a patient? Explain.
   (b) after initial interview? Explain.
   (c) after interview and examination? Explain.

3. Are there other types of treatment you feel you can give a patient but are unable to because of other reasons? Explain. What other reasons? Explain. Do you have these treatment types available to you, just in case? Explain.

4. Did you feel, at any time before or during your interview with Ms./Mrs./Mr. _____, that s/he had some idea about
   (a) the cause of his/her problem?
   (b) how the problem works in his/her body?
   (c) how to explain the problem?
   If not, did you think that Ms./Mrs./Mr. _____, after the interview and/or treatment, better understood your explanations regarding
   (a) the cause?
   (b) how the problem works in the body?
   (c) its explanation?
   Explain your reasons.
   (Repeat Question 4, for all 3 patients)

5. (If applicable) Why did you spend more time during the interview (and/or treatment) with Ms./Mrs./Mr. _____ than with Ms./Mrs./Mr. _____, although both patients seem to have identical problems?

6. (If applicable) What particular difficulty did you have with Ms./Mrs./Mr. _____? (Ask about all 3 patients)
7. (If applicable) Why did you recommend vitamins for Ms./Mrs./Mr. but not for Ms./Mrs./Mr., although both patients seem to have complained of tiredness and backache, or constant headache and tiredness?

8. Can you tell me in a little more detail how you deal with patients who are unable to pay, especially beyond 12 or 15 visits? (If applicable) During our first interview, you said that: (specific to CHIROPRACTOR) "_________________________" Explain.

9. What have you done within the last 5 years to increase the number of patients you see now in your clinic?

10. (If applicable) Why do you refer patients to other treatment systems, such as M.D.s, Naturopaths, Physiotherapists?

11. What did you think was the reason Ms./Mrs./Mr. refused treatment? (or stopped coming for treatment?)

12. Can you tell me in more detail how illness or disease works in the body?

13. Were any (and all) disagreements or differences of opinion between you and completely resolved, regarding diagnosis of problem and recommended treatment? Explain.

14. Has discontinued Chiropractic treatment? If so, why?

15. If has finished or is still under treatment, do you think that h/she will continue Chiropractic treatment, or make use of it again in future? Explain.

16. What do you think now thinks of Chiropractic? How does this compare with what thought at the start of his/her treatment? How do you account for the change?
   (a)
   (b)
   (c)

17. What were the most important things that you did to bring about that change? (if applicable)

18. Do you think that would now recommend Chiropractic to a friend or relative? How do you know?

19. Do you think that now prefers Chiropractic to more conventional forms of treatment? How do you know?

20. Do you think that has any remaining concerns, doubts, or reservations about Chiropractic? If so, what are they?
21. Do you think that now regards Chiropractic as a profession? (If yes) As a profession comparable in standing to other established professions such as law, medicine, dentistry, etc.? If not, why not?

22. Would you consider the outcome of the treatment that you provided to successful or unsuccessful (to this point)? Explain.

23. If you were providing instruction to a younger colleague, how would you tell him to discern how a person/client will behave?

Thank you for answering my questions. Your answers will further my understanding of how CHIROPRACTORS help and relate to their patients.

Thank you.
APPENDIX VII

INTERVIEW QUESTIONS: REGULAR CHIROPRACTIC PATIENTS

My name is Godwin Eni. I am a graduate student at the University of British Columbia. I am studying CHIROPRACTIC, especially how CHIROPRACTORS relate to their patients, what they use in treating their patients, and how they carry out their responsibilities.

Dr. _____ has agreed that I can talk to any of his/her patients who may be visiting the clinic today. If you agree, I would like to ask you a few questions about your experiences during your treatment. Your answers will help me to understand how CHIROPRACTORS help people who are ill.

Thank you.

1. Can you tell me why you are seeing Dr. _____?

2. How long have you been receiving treatment? How many times a month?

3. What did you do by yourself about your problem before coming to Dr. _____? (a) Did you see another kind of healer for treatment, before coming to see Dr. _____? What kind of healer? (b) Are you receiving another kind of treatment while you are seeing Dr. _____ (CHIROPRACTORS)? (c) What kind of treatment and from whom? (d) What concerns, if any, did you have with the treatment you were receiving before coming to see the CHIROPRACTORS? Explain.

4. How did you become aware of CHIROPRACTIC treatment? What concerns did you have, if any, about CHIROPRACTIC, during your first visit?

5. During your first visit, was the CHIROPRACTORS
   
<table>
<thead>
<tr>
<th>Yes</th>
<th>Somewhat</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) easy to talk to?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) able to share your opinion about your illness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) able to treat you the way you wanted to be treated?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) able to present himself in a way acceptable to you?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Did s/he do or say anything during your first visit to convince you that s/he did (or did not) understand your problem?
7. What kind of treatment did you receive during your first visit? Has there been a change in the treatment you have been receiving since your initial visit? Explain. How did the change(s) in treatment, if any, come about? What were the reason(s)?

8. How did you arrive at the evaluation of the treatment you received?

9. Is there anything else you would like to tell me about your experience with Dr. _____, your CHIROPRACTOR?

Thank you for answering my questions.
Question: Is it easy or difficult to have enough patients in your practice? (n=20)

<table>
<thead>
<tr>
<th></th>
<th>No. of Chiropractors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy</td>
<td>5</td>
<td>25.0</td>
</tr>
<tr>
<td>Difficult</td>
<td>11</td>
<td>55.0</td>
</tr>
<tr>
<td>Both</td>
<td>4</td>
<td>20.0</td>
</tr>
</tbody>
</table>

(Some explanations)

Easy

"Have well established caseload and patients." "just about right for my practice," "----was rough when I began soon after college ---has taken me good hard twelve years to get to where I am now."

Difficult

"---Lots of people out there need help but don't know where to get it," --in some cases, a lot of time is wasted for treatment at the doctor's office "(meaning M.D.)," "---got to prove myself, get people to know me, get around before I can get going."---(new graduate, recently established in practice.) "----some people want miracles," "---it's all the negative vibes from these allopats, "they've got the government and the market cornered," "have you read what they say about us?"

Both

"----Sometimes it's O.K. sometimes not," "get's better in Summer----lots of recreation and sports."
APPENDIX IX

Deciding to Visit a Chiropractor

Question: How easy or difficult was it for you to come to see a Chiropractor?

<table>
<thead>
<tr>
<th></th>
<th>No. of Clients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy</td>
<td>19</td>
<td>32</td>
</tr>
<tr>
<td>Difficult</td>
<td>36</td>
<td>60</td>
</tr>
<tr>
<td>Some difficulty</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Cannot say</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Explanations [Some examples]

Difficulty seeing a Chiropractor

"Don't know about the therapy." "Been told they are quacks - say a lot but don't do nothing." "My friend was worried for me....because he thinks chiropractors are unscientific."

"My sister, who is married to a regular doctor, says I will get hurt. She says her husband told her that chiropractors claim they can cure a lot - say diabetes, headache, cancer - but it is all phoney. Regular doctors end up correcting their mistakes."

"My doctor told me I am better off treating myself than going to a chiropractor. He says nobody knows what they do, and they cannot prove that they do help anybody."

"Scared of what I don't know."

"It can hurt a lot...I mean manipulating, bending and twisting your back. I already have a lot of pain in my back."

"Worried about their training."

"Just to try it, see if it will help. Don't know much about chiropractic."

(19 clients have no problem getting to see a chiropractor)
APPENDIX X

Payment for Chiropractic Services

Question: How do your patients pay for treatments? Especially beyond 12 visits per year? (n=20)

<table>
<thead>
<tr>
<th>No. of Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st 12 visits/yr</td>
<td></td>
</tr>
<tr>
<td>Medical Services Plan (MSP)</td>
<td>20</td>
</tr>
</tbody>
</table>

*Over 12 visits/yr.

<table>
<thead>
<tr>
<th>No. of Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash/personal cheque</td>
<td>20</td>
</tr>
<tr>
<td>Receptionist arranges payment</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Some patients refuse to pay (about 5%)</td>
<td>1</td>
</tr>
<tr>
<td>I take a &quot;rain-check&quot;</td>
<td>9</td>
</tr>
<tr>
<td>Some people pay even after a year</td>
<td>6</td>
</tr>
<tr>
<td>Write off debts</td>
<td>20</td>
</tr>
<tr>
<td>Incremented payment</td>
<td>15</td>
</tr>
</tbody>
</table>

*In general, there is no attempt to enforce payment or collect debt. Some respondents see it as a positive sign of understanding. "The idea is not to stop anyone from seeking or receiving chiropractic." 14 respondents or 70% of chiropractors interviewed have experienced varying difficulties with payment. None of them has used collection agencies for outstanding debts.
APPENDIX XI

Mechanisms for the Maintenance of "Own" Healthy Body: New Clients

<table>
<thead>
<tr>
<th>Explanation</th>
<th>No. of Clients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisons, germs, waste products and foreign bodies are not the same materials as human body, and must be gotten rid of.</td>
<td>23</td>
<td>41.1</td>
</tr>
<tr>
<td>New blood is made to replace old &quot;worn out&quot; blood with more energy to attack and kill germs.</td>
<td>4</td>
<td>7.1</td>
</tr>
<tr>
<td>Blood must carry enough &quot;good&quot; food to all parts of the body &quot;to get them all working together&quot;.</td>
<td>12</td>
<td>21.4</td>
</tr>
<tr>
<td>Body requires food and &quot;oxygen&quot; to survive and to repair itself.</td>
<td>5</td>
<td>8.9</td>
</tr>
<tr>
<td>Too much use of the body or parts of it wears it down, damages cells, and causes fatigue.</td>
<td>3</td>
<td>5.4</td>
</tr>
<tr>
<td>Right foods allow the body to function at its maximum.</td>
<td>7</td>
<td>12.5</td>
</tr>
<tr>
<td>Bad weather causes internal and external changes in the body.</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Rest allows body to recover from previous activity and so remain healthy.</td>
<td>1</td>
<td>1.8</td>
</tr>
</tbody>
</table>
### APPENDIX XII

Explanations Relating to "the workings" of a Healthy Body: New Clients

<table>
<thead>
<tr>
<th>Reason</th>
<th>No. of Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercises and &quot;good food&quot; Nourishes body cells and organs &quot;as it is supposed to be&quot;. &quot;Gives energy to body&quot;.</td>
<td>13</td>
<td>14.9</td>
</tr>
<tr>
<td>Overindulgence in alcohol &quot;limits&quot; body function and ability to protect itself. Smoking causes cancer and other diseases. Also cause damage to the &quot;natural&quot; cells and organs leading to illness.</td>
<td>7</td>
<td>8.0</td>
</tr>
<tr>
<td>Mind controls the body and both &quot;must work together to prevent illness&quot;. Rest helps the mind and body to work better &quot;next time&quot;.</td>
<td>6</td>
<td>6.9</td>
</tr>
<tr>
<td>Accumulation of waste products cause impaired body function and disease. &quot;Water helps wash them out&quot;.</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Drugs and poisons alter the composition of the blood thus &quot;contaminating food in blood&quot;, &quot;damage cells&quot;, &quot;reduce available energy&quot;, and cause illness.</td>
<td>5</td>
<td>5.7</td>
</tr>
<tr>
<td>Exercises circulate blood to body and helps keep muscles, nerves, organs healthy and working well.</td>
<td>14</td>
<td>16.1</td>
</tr>
<tr>
<td>Dieting prevents excess fat which causes sickness, eg. heart attacks.</td>
<td>21</td>
<td>24.1</td>
</tr>
<tr>
<td>Excess heat and cold dries up the body and damages cells.</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Enough sleep every day rests the body and prevents it from &quot;getting fatigue&quot; or &quot;wearing out too fast&quot; or &quot;getting sick&quot;.</td>
<td>9</td>
<td>10.4</td>
</tr>
<tr>
<td>The Doctor (M.D.) can detect when something is about to go wrong so that it can be corrected. &quot;Helps you keep healthy&quot;.</td>
<td>10</td>
<td>11.5</td>
</tr>
</tbody>
</table>
APPENDIX XIII

Explanations Relating to "the workings" of a Healthy Body: Chiropractors

<table>
<thead>
<tr>
<th>Chiropractors No. of Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regular Chiropractic Adjustment</strong>: Maintains the nervous system in good functional order, therefore body cells and organs in proper working conditions. Body more able to take care of and to defend itself.</td>
<td>11</td>
</tr>
<tr>
<td><strong>&quot;Stress-free&quot;, Healthy Mind</strong>: &quot;No pressure on nervous system, therefore on body organs and muscles. Improves body alertness and readiness to defend itself.&quot;</td>
<td>9</td>
</tr>
<tr>
<td><strong>Sensible Lifestyle</strong>: &quot;Overuse of body leads to tiredness and less available energy source&quot;. &quot;Poisonous substances&quot; and &quot;drugs&quot; limit the capacity of cells to &quot;rejuvenate&quot; or &quot;defend&quot; themselves.</td>
<td>12</td>
</tr>
<tr>
<td><strong>Natural, &quot;Non-processed&quot; Foods</strong>: Keeps body cells on natural nutrients as &quot;intended by nature&quot;. Also keeps away &quot;additives and poisons&quot;.</td>
<td>14</td>
</tr>
<tr>
<td><strong>Proper Dietary Habits</strong>: Reduce risk of illness such as heart attack from excess fat. Maintains optimum level of energy for normal functions of cells and organs. &quot;Keeps organs and intestine on regular time-frame&quot;. Improves mental energy. Junk food is limited in energy supply.</td>
<td>12</td>
</tr>
<tr>
<td><strong>Adequate Rest and Sleep</strong>: Body able and ready to defend itself &quot;by resting all systems&quot;. Elevates energy levels.</td>
<td>17</td>
</tr>
<tr>
<td><strong>Daily or Periodic Exercises</strong>: &quot;Eliminates waste&quot;, &quot;improves supply of nutrients from blood&quot;, &quot;tones muscles&quot;, &quot;raises energy levels&quot;, &quot;improves food assimilation&quot;.</td>
<td>18</td>
</tr>
<tr>
<td><strong>Daily Vitamins</strong>: &quot;Restoration of energy&quot;. &quot;Support for cell function&quot;.</td>
<td>6</td>
</tr>
</tbody>
</table>
APPENDIX XIV

Referrals to other Healers by Chiropractors

Question: Do you refer patients to other kinds of practitioners? If yes, what other kinds of health care professionals? (n=20)

<table>
<thead>
<tr>
<th>No. of Referrals</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allopath (M.D.)</td>
<td>9</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>10</td>
</tr>
<tr>
<td>Accupuncturist</td>
<td>1</td>
</tr>
<tr>
<td>Dietitian</td>
<td>1</td>
</tr>
<tr>
<td>Naturopath</td>
<td>4</td>
</tr>
<tr>
<td>Any two or more of the above (excluding M.D.s)</td>
<td>8</td>
</tr>
</tbody>
</table>

Why?

Some Comments

"Possibility of more serious ill-health such as cancer"
"----to receive electrotherapy which we are now allowed to provide in this province unlike elsewhere"
"----to get full benefit of all available help"
"----sometimes the patient suggests the referral"
"----to someone I think can help the patient in other ways"
APPENDIX XV

Comments on Characteristics of Healers: New Clients

Question: Why is ___ the most important factor to you? (Male and Female)

[Some Comments]

(a) Being Easy to Talk to?

(i) To explain self properly
(ii) Mutual understanding
(iii) Good communication
(iv) Adequately convey feelings, especially about illness problem
(v) "Able to relax and tell my story"
(vi) "Makes me comfortable"
(vii) "Share ideas"

(b) Sharing same opinion about illness?

(i) Promotes same understanding
(ii) Removes uncertainty
(iii) Healer "knows where I am coming from"
(iv) "Understands how I feel"

(c) How s/he treats you in the office during treatment?

(i) Makes me feel "comfortable", "less stressed"
(ii) Gives the feeling he is "nice", "will listen to me"

(d) How s/he presents himself or herself?

(i) "Could give me confidence in him"
(ii) "Does he know what he is doing?" "Sense of professionalism"
(iii) Helps get a feel what kind of person he is" - "he may well be on drugs" or "a homo", "or a good and nice person"
(iv) "Whether to trust him"
(v) "If I like him"
(vi) "What kind of person is he likely to be?"

(e) How his/her office looks?

(i) "Kind of tells you what to expect", "about the man", "how he sees things"
(ii) Gives you "first impression", "what kind of doctor he is"
(iii) "Whether the guy is a kook"
(iv) "Something about his profession", or "what he does"
(v) Gives some "respect"

(f) What s/he uses in treating you?

(i) "Helps me make up my mind whether to accept treatment"
(ii) "Could be dangerous not knowing", "can hurt yourself"
(iii) "Can't take it if I don't agree"
APPENDIX XVI

Comments on Characteristics of Healers: Chiropractors

Question: Why is ______________ the most important factor to you?

(some comments)

Being Easy to Talk To

"For comfort and confidence about ability," "good rapport," "good communication," "relaxes people," lessens the burden of illness," "help bring out other hidden and relevant factors which relate to the complaint, for example Christian belief, divorce, and so on," "does not threaten people," "so we can understand each other as friends."

Sharing same opinion about illness

"Makes it easier to give treatment," "so we can work together."

How she/he treats you in the office during treatment

"Good to show some kind of respect for the other person," "some people are put off by how others behave or what they see around them," "just like you want to be treated yourself", always keep that in mind. I try to. "high compliance with reciprocal respect."

How he/she presents himself or herself.

"How can somebody trust you when you don't work proper?" "Lots of people are afraid of chiropractors and dentists," "-----people don't know about chiropractors or what a chiropractor works with," "to give confidence," "first impressions lead to better communications."

How he/she office looks

"Good impression doesn't hurt, does it?" "What will you do if people don't know you?" People who have not been to a chiropractor's office don't know what to expect. At least it, should be no different from the family Doctor's office.

What he/she uses in treating you

"As long as he tells me first and we agree about it?" "Shouldn't be that much a problem as long as the job is done."
Question: *Why is ______________________ the least important factor to you?*

(some comments)

Sharing the same opinion

"The patient may be wrong in opinion. There is a need to educate him" "patient not a professional," only the chiropractor has chiropractor knowledge.

How she/he treats you in the office

"Some people are prejudiced anyway, so it doesn't matter what you do," "people are sometimes difficult to get along with even if you say the right thing."

How she/he presents himself or herself

"It is a matter of individual opinion," "one view may be quite different from the other, "would be wasting a lot of time on some people."

How his/her office looks

"Has nothing to do with the problem except for some people who expect something else," "one can overdo it, the result of your work is the important thing."

What he/she uses in treating you

"A trained professional should know what he is doing the patient may not know," "it's a matter of ethics."

*Although these factors are considered important, in varying degrees, however some respondents offer to these comments during extended discussions.*
APPENDIX XVI (Cont'd.)

Question: Are there other things you want to tell me about people who help people with their illness(es)?

(Chiropractors)

(some comments)

(a) Healer "must have general compassion," "willingness to learn anything that may benefit the patient."

(b) "----should come up with some game plan," "share the patients concerns, interest and love," "genuine interest in the wellbeing of the patient," "warmth."

(c) "Provide full information about problem, what the procedure and tests are for," "explain the therapy," "describe the complications."

(d) "----should keep up to date with recent developments socially, politically and professionally," "keep an open mind," "must have general compassion for the patient."

(e) "----make sure you understand the patient. Hang on every word----could be telling you something----be prepared to give a little here and there if only to make him happy," "----won't come back if he's not happy with you," "some people like to test you first."
APPENDIX XVII

Understanding of Problem by Chiropractor: Views of Regular Patients

Question: Did s/he do or say anything during your first visit to convince you that s/he did (or did not) understand your problem?

(n=20: 7 males, 13 females)

<table>
<thead>
<tr>
<th></th>
<th>No. of Patients</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5</td>
<td>25.0</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Can't remember</td>
<td>12</td>
<td>60.0</td>
</tr>
</tbody>
</table>

Some of the Comments

"He put his finger on it ... like I said, something is wrong with my backbone, but my doctor (M.D.) couldn't tell from so many x-rays."
"It's been quite some time. If he did, I can't remember .... I'm glad I stayed, it's the best treatment I've had .... he must have said something".
"....didn't agree with operation .... just good old-fashioned massage, manipulation, exercises .... with his hands."
APPENDIX XVIII

Reasons for Discontinuing Treatment: Views of Chiropractors

Question:  *Has ____ discontinued treatment? If so, why?  
(n=7)

*A total of 7 clients (6 male and 1 female) or 11.7% of all new clients discontinued treatment at various stages of interaction with Chiropractic.  

4 clients discontinued treatment after the fourth visit.  
1 client after the initial interview and did not receive treatment.  
1 client after the second visit and treatment.  
1 client after three visits and treatments.  

53 patients were continuing to receive treatment at the time of final interview and addendum to final interview, or four months after initial interview. The number of treatments received by the remaining 53 patients range from 4 to 11, staggered at different intervals - daily, weekly or monthly.

Some explanations

"feeling better...can manage with his home instructions now..."  
"...maybe expecting something different...never really tried to understand Chiropractic."  
"...I think his family doctor (M.D.) told him something or found out...I'm not sure..."  
"It's the negative attitude that we have faced as Chiropractors...but it is not always this way in my practice."  
"I don't know...why don't you ask him...I'd like to know."
APPENDIX XIX

Attitudes and Conceptions: Pre-Interaction Comments of New Clients

Question: What are your attitudes and conceptions about Chiropractic in general?

Some Comments on Attitude

(a) "Don't know enough" or "anything" about Chiropractic.

(b) "Are they licenced by Government?"...."Then they must be O.K." "Government can't allow anything to hurt people without testing it." "I hear they are some kind of back doctors."

(c) "They must be doing something right if a lot of people keep telling me they are O.K."

(d) "I don't care as long as they get rid of this bloody pain in my neck. Been going on for quite a while and my doctor keeps telling me to rest. How can I when I've got no money. Got to work to feed the kids."

(e) "It's O.K." "I have nothing against them."

(f) "I don't hear too much about Chiropractic. I am told the Medical Profession is against them and tries to keep people away from them." "I have read a bit about the controversy. The bottom line is money. Who wants professional competition. Sure the medical profession does not." (An Economics graduate employed in a processing industry)

Some Comments on Conceptions

(a) "Some kind of back specialist."

(b) Holistic. "Don't believe in drugs and operations."

(c) "Another group of borderline health care group. Same as physiotherapists, except they are not permitted to work in hospitals."

(d) "Nothing to conceptualize. Must get to know one first."
APPENDIX XX

Post-Interaction Comments: New Clients

Appendix XXa

Question: What did he do or say during your first visit to convince you that he did (or did not) understand your problem?

Some Explanations

Understood the Problem

"Says he's helped quite a few like me with same problem."
"Listened" "Didn't say it's in my head"
"Got to work on the right spot." "Didn't waste time or take long."
"Took a bit of time to explain the problem."
"I have always known I've got bad nerves. He sort of ties it all together...know what I mean...how it all went wrong cause you aren't fit."
"The way I sit in the office, the bucket car seat..."
"Relaxes you." "Shows he cares." "Not too many tests."
"Felt o.k. right away after he's done."
"...can sense it." "Just know."

Did not Understand the Problem

"Wants me to see another doctor...something about not being sure of what I have gotten."
"More x-rays. I have had my share of x-rays."
"Vitamins...I have been taking vitamins all my life...didn't stop my condition."

Maybe or Perhaps he Understood the Problem

"...all these questions about what my doctor says...has done."
"Seems to be all style and psychology. My brother is a medical doctor...says it's unscientific...but I feel much better after treatments."
"Does not know how long it will take to get rid of the damn pain. Should know."
"Just don't know...gut feeling."
Appendix XXb

Some clients' reasons for views that the Chiropractor did or did not understand problem

Question: What did he do or say during your other visits to convince you that he did (or did not) understand your problem?

Understood the Problem

"...seems to know how I've been getting on."
"Gave me some pamphlets to read about my condition...what to do...how chiropractic helps...I've been doing much better since."
"I am much better now, thank you."
"...saw some video with other patients...about how to care for our health and chiropractic."
"...been sort of lazy, he knows it, but I'm trying."
"The pressure at work and the kids...wants me to ease off and relax...that's the problem."
"I cannot say I agree with him...however, I have gotten much better with his manipulation."
"...does not pressure you...always patient with me...he really cares."

Did not Understand the Problem

"I can't say I'm better now than when I began chiropractic."
"It's a question of psychology...yours or mine."
"The explanation is too far-fetched, but he is getting good results."
Appendix XXc

Some comments of new clients regarding their impressions of clinics and chiropractors

Question: What did you think of his office?

Some Responses

"Like my doctor's office...has more plants."
"Quite nice...always have coffee when waiting for him."
"Can't complain." "Well decorated." "Too many wall pictures."
"Nice to have sofa...spacious...my doctor has these iron hotel chairs." "Simple" "...tasteful."

Its Appearance?

"Nothing unusual...just a regular appearance...I mean any doctor's office."
"I like the decoration...the atmosphere...a lot of plants...I like plants though, you can see I have lots of them in the living room."
"...don't know what you mean...if you mean do I like his office...the way it looks, yes I do. It's neat, carpeted, has room and businesslike."

Did that have any effect on your opinion of the CHIROPRACTOR?

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Some Explanations

"...I wasn't thinking about the office."
"I felt I was in a regular doctor's office...you know like my family doctor."
"I was surprised at first, 'cause I expected ropes and things I guess...don't know about Chiropractors...now I know."
"Didn't notice at first."
Evaluation of treatment received: New Clients

Question: How did you arrive at the evaluation of the treatment you received?

Some Responses

Whether there is relief of pain.
Cure of presenting health problem.
Consistency with perception of adequacy of treatment.
Degree of improvement - functional and social.
In comparison with other treatment forms including self-treatment and allopathy.
Against the Chiropractor's expectations.

Clients' concerns or reservations about Chiropractic: Some comments

Question: What concerns, doubts or reservations, if any, do you now have about Chiropractic?

Some Concerns

"....not an answer to everything. I got a problem with kidney stone on top of my arthritis...."
"....can really get hurt if he (the chiropractor) makes a mistake...all that walking and bending....I guess he is well trained."
"....what will happen if my doctor finds out I am seeing a chiropractor? I asked him once and he doesn't like them."
"I suppose....say I have something in my blood, but they say it's in my back?"
"not worried anymore about chiropractic....not as bad as I thought."
APPENDIX XXI

Post-Interaction Comments: Regular Chiropractic Patients

Appendix XXIa

Some comments regarding changes in type of chiropractic treatment as reported by regular chiropractic patients

Question: How did the change(s) in treatment, if any, come about? What were the reason(s)?

Some of the responses

"... don't particularly know."
"Always told him how I'm feeling ....where I am at ... he takes it from there. He always asks me."
"I was not improving at all. He tried a couple of things ....how I sleep at home, lift ..... before we found that swimming helped me. I swim a lot now .....used to swim at UBC".

Some comments regarding how regular chiropractic patients evaluated the treatments they received

Question: How did you arrive at the evaluation of the treatment you received?

Some of the responses

"Am I getting better or not, how else?"
"I had quite a bit of treatment from my doctor (M.D.) and I know whether chiropractic is helping. I wouldn't continue if it is not helping ... is that what you mean?"
"... he tells me what I'm doing wrong, so I correct it and see what happens..... sometimes, I can't help what I'm doing ... it's not his fault ...
"I can fool myself and say I will be 100% with chiropractic. At least I should be able to do a few things with chiropractic. So far, so good".
Appendix XXIa (Cont'd.)

Comments regarding the experiences of regular chiropractic patients with chiropractors

Question: Is there anything else you would like to tell me about your experience with Dr., your Chiropractor?

Some additional comments

".....they have been put down a lot. Some of friends think I am nuts, seeing a chiropractor. They think I should have been healed up by now." "Dr. _______ says it will be nice to come and see me in the hospital. I had an accident shortly after seeing Dr. _______ and was put in the hospital. I can't wait to get out .... would have been a cripple now." "Some of what my chiropractor does is psychological and common sense. Who says common sense is common?"

"I couldn't relate to my family doctor. He put me on pain killers and physiotherapy for one year, then sent me to Dr. _______ (orthopedic surgeon). The first thing you know, he wants more tests and operation ...."

"Always said my back has something to do with all the garbage I used to eat ... and I used to drink quite a bit, 'especially when my wife took off with the kids ....'

"A buddy of mine says I see this guy (the chiropractor) who fixed up his headache (migraine). First, I say, what's that got to do with my back? .... Look at me now, it's almost all fixed up..... I feel better.

"Dr. _______ (chiropractor) understands .... quite a nice guy .... does not do things to you, you don't want".
APPENDIX XXII

Post-Interaction Comments of Chiropractors

Appendix XXIIa

Particular difficulties experienced by chiropractors while treating new clients: Some responses

Question: (Only if applicable) What particular difficulty did you have with Ms/Mrs/Mr.____? (n=60)

Summary of some responses

Apprehension, trust, confidence, expectation regarding outcome and treatment, image of chiropractic, education about chiropractic, resistance to treatment, preconceived notions about chiropractic, influence of family physician, acceptable treatment, number of treatments, type of treatment equipment used, concurrent medical and other treatments, health habits and lifestyle, work habits, emotionalism and stress, drug addiction (pain killers).

Some explanations from chiropractors regarding different types of treatment given for identical health problems

Question: (Only if applicable) Why did you spend more time during the interview (and/or treatment) than usual with Ms/Mrs/Mr.____ than with Ms/Mrs/Mr.____, although both patients seem to have identical problems? (n=19)

Some responses

"you can see she's confused."
"This is rather an unusual case. You see, I know the man who referred her to me. He was my patient (sprained ankle) a year ago...gave him contrast baths....I have to be certain I help Ms.____."
"This guy comes in very hostile. He didn't need to say it. He wanted quick fix and sort of doubtful of everything. You can see he has been educated by somebody, usually his doctor (M.D.) or his relative is a doctor (M.D.) It is an opportunity to correct some of these impressions. This does not always happen this way...once in a while you face this type of situation."
"I know Mr.____ has been to an allopath. They mostly do...I saw the surgical scar on his left knee as he sat down. I have to know all that he has experienced. Sometimes I am the last hope after shopping around. It's tremendous responsibility."
"....she must trust you and have confidence in you...."
Appendix XXIIb

Question: Why did you recommend vitamins for Ms/Mrs/Mr.____ but not for Mr/Mrs/Mr.____ although both patients seem to have complained of the same problem (such as backache, tiredness, constant ache and pains)?

(n=6)

Some responses

"...obvious deficiency in nutritional habits."
"To reactivate energy threshold, sort of a catalyst and replacement of lost vitamins."
"...has been taking pain killers for a long time...needs to get off it, especially if she is depending so much on it and it is not too helpful over the long run...rather take vitamins which is a natural body component than poison it constantly with drugs."
"I think there is a lot of differences between Mr.____ and Mrs.____. For starters, Mr.____ is much younger and athletic looking, Mrs.____ has had some previous vitamin prescription from her doctor (M.D.). That must have been of some help but these other pills cancel out the benefit...Let's try vitamins without these other pills..."
"I always recommend vitamins in such cases. I take vitamins myself..."

Some reasons why chiropractors refer patients to other treatment systems

Question: (If applicable) Why do you refer patients to other treatment systems, such as M.D.s, naturopaths, physiotherapists?

Some responses

"I am not allowed to use electrotherapy in my practice although I trained for it...so I send them to Mrs.____, a private practice physiotherapist."
"I can be dealing with cancer of soft tissue or bone at early stages. Tests are required to find out and I am not allowed to do blood tests. It will be easier if some of this information can be shared with medical doctors and hospitals...even x-rays...sometimes the x-ray doesn't tell you all."
"...for things I am not legally permitted to carry out..."
"When I am not sure of what's happening. I once had a patient who came to me from another chiropractor. I didn't know because she is from Saskatchewan. When I found out I said to myself maybe she is a hypochondriac, so I told her to see a medical doctor...no, not a psychiatrist, I just said go and see your family doctor."
Some views of chiropractors why new clients refuse or discontinue treatment

Question: (If applicable) What did you think was the reason Ms/Mrs/Mr. refused treatment (or stopped coming for treatment)?

Some reasons

"bias"
"wrong information about chiropractic"
"...maybe we didn't understand each other. You saw the guy...how he was carrying on with a chip on his shoulder...feels he knows everything about chiropractic. That's why you can't be too careful."
"He is probably scared. A lot of new patients are that way until you relax them, they trust you. Well, if he is in real pain, he will try anything...makes me wonder why he came. Do you know him from before?"
"I guess he thinks he wasn't getting better. Sometimes after a couple of treatments some patients feel better and they stop coming. They forget preventive measures."
"I don't know. What do you think. I don't worry myself about somebody who says he doesn't want treatment...just respect it."
"...oh yes, Mr. has completed his treatment. He only needed a couple of visits...he is much improved now...Have you seen him lately? (After consultation with receptionist) "...Oh yes, he will be coming for check-up once a month."

Some explanations by chiropractors why they think particular new clients will continue treatment

Question: If has finished or is still undergoing treatment, do you think that h/she will continue Chiropractic treatment, or make use of it again in future? Explain.

Some Explanations

"It depends on a lot of things, for example, Mrs. may have a condition which is outside the scope of my practice...legally, don't forget I am restricted in what I can do...generally, I think she will continue treatment or come to see me in future if she has some problem."
"I can't tell...people have different reasons for continuing or not continuing treatment...pay, job, other concerns...I have a few patients dropping out of treatment and coming back later...or stopping treatment completely. Mrs. may continue...I think Mr. will continue, he has a lot of problems now...but, I am not sure of Mr. he has missed two appointments already, but came back the other day...says he was busy."
"I hope he comes back or recommends someone...I just try to do a good job and not worry about these things."
Appendix XXId

Changes in perceptions of chiropractic by new clients: Views of chiropractors

Question: What do you think Ms/Mrs/Mr. _____ now thinks of Chiropractic, how does this compare with what Ms/Mrs/Mr. _____ thought at the start of his/her treatment? How do you account for the change?

Some Responses

"Well, he is more relaxed now, can't you tell...when last did you see him...he knows what the treatment is about and quite happy with it."

"...was really uptight and scared...said something about being given the run around...all I did was to explain what I am doing and how it's all linked up...she trusts me and the treatment is good for her....still has to have a few more and lose some weight."

"I had a patient in about 3 weeks ago who was sent to me by Mrs.____. There is your example of how she feels about Chiropractic...wasn't it what you were asking a moment ago?...She's happy."

"You can never always tell, some people are funny, but on the whole, my patients are happy with me and what I do...sometimes somebody feels different...I think both Mr._____ and Mr.____ will continue. Mr._____ is on maintenance care now."

Specific actions by chiropractors to bring about changes in clients' perceptions of chiropractic

Question: What were the most important things that you did to bring about that change? (If applicable)

Some Responses

"Nothing that I don't do for every patient...listen, figure out their problem, what they've been doing to it, who they've seen...sort of what is important to them. You were here when Mr.____ was testing me out...he wanted to show he knows about Chiropractic...usually you listen and correct them."

"...the patient is the boss, don't forget that."

"Mrs.____ had a lot of problems at home. She is lonely...seems her husband was cheating on her (laugh). Well, she had problems with her joints but I think these other worries kind of made it worse. She wants to talk to someone...you have to see the total person...give advice, something that works. I hope what I am saying is not going back to her. Are you finished with her? You sort of fit in...every patient is different."

"...it's not going to hurt as much as he thinks. He's educated but wants to know certain things...so, I explained it...let him take time to think about it."

"I went along with Mr.____ until we discussed all his problems...then we work around them."
Appendix XXIIe

Activities undertaken by chiropractors in the preceding 5 years to increase clientele

Question: What have you done within the last 5 years to increase the number of patients you see now in your clinic?

Some responses

"participate in various educational programmes."
"appear on radio and television to talk about preventive care and chiropractic."
"...encourage mothers to bring in their children for preventive care and posture education."
"part of the Association's (professional) task force and a committee member."
"...it's the patients who really do something. When you have provided good quality care, the word gets around and you are known for that."
"...make myself available for consultation and advice."
"...belong to a number of sporting groups and clubs...I see quite a lot of sports injuries."
"nothing really. I have had a good practice for a number of years."
"It was quite difficult when I graduated from CMCC (Canadian Memorial Chiropractic College) 2 years ago. I had to depend on friends and Dr.____ (a senior partner)...Well, I printed my business card, distributed it and made sure I give good care. It's not bad now...you remember Mrs.____ (a new client)...she was referred by another patient."

Instructing younger colleagues about client behaviour: Some comments from chiropractors

Question: If you were providing instruction to a younger colleague, how would you tell him to discern how a person/client will behave?

Some Comments

"I am 28 and graduated 2 years ago. My experience is limited, but I will, in general, say 'don't rush it', listen carefully until you can communicate with the patient."
"...hard to say...patients are different. With experience you can spot a nervous, scared or worried patient before he opens his mouth. They want you to do all the talking or something to confirm their fears. They don't open up quickly...you must relax them, get them to trust you, feel them out, see what they want, where they've been..."
"...some look around in the office, try to size things up...I follow their eyes and explain what they are looking at."
"It varies. Some scared patients tend to ask a lot of questions, the ones in great pain don't, but want you to do something quickly..."
"...you can always tell when a family doctor does not approve chiropractic...the patient wants to know if he (the M.D.) will see your report...especially the compensation ones."
"...cross his legs, put his hand under the chin and look at you as if to say 'I don't know what's going on' or 'I know too much.'"
Dealing with patients who are unable to pay for services: Some comments from chiropractors

Question: Can you tell me in a little more detail how you deal with patients who are unable to pay, especially beyond 12 or 15 visits?

Some responses (See First Interview: Chiropractors - Question #41)

"It is a personal thing, especially for the patient who cannot afford to pay. My principle is never to let a patient's inability to pay beyond insured coverage prevent his treatment. Yes, I occasionally absorb some losses, but I don't think it is worthwhile spending a lot of money on it...don't need the bad publicity."

"I wrote it off...tell the patient he can pay me whenever he is able to do so."

"You asked this question a while ago if I remember. What's your interest...like I told you I have instalment payment plan...just tell me how much you can afford...if you can't I will still give you the right treatment."
Appendix XXIIg

More comments from chiropractors regarding how illness or disease works in the body

Question: Can you tell me in more detail how illness or disease works in the body?

Some responses (See First Interview of Chiropractors - Questions #3 and 4)

"...an imbalance in energy forces. I have a book on it by Dr. Shafer on CHIROPRACTIC DIAGNOSIS...you can borrow it...O.K. if you mean what I believe...I can tell you that, yes, there are many causes to illness and illness works in different ways depending on the cause. Germs cause illness by destroying the organs and blood function and by acting as poison or foreign body. Well I believe that it is the nervous system that controls what happens in the body...it also reports illness and fixes it."

"There is the emotional component to illness...I am not too concerned with the physical component...that can be objectified and measured through tests, but emotional and psychological recovery are key to getting well...One person's emotion may be more telling on the working of his illness than for another person...I have already told you about the physiological basis..."

"There are primary, secondary, predisposing, exciting, internal, external and specific causes of disease. The primary cause of disease is always interference with the transmission of impulses from the brain to the tissues. This lowers vitality and resistance, therefore disturbing function which in itself is disease. Infection may be a result of lowered tissue resistance...the lowering may be achieved by mechanical, chemical, thermal or electrical stimuli. Subluxation is a source of mechanical lowering...also pressure on nerves or altered innervation cause tension and interference with transmission and expression of nerve energy in the tissues...I believe that interference with nerve conduction be it mechanical, chemical, thermal or electrical, is the primary cause of infectious diseases while infection is the secondary cause...it is known that the presence of germs in the body does not cause disease...we have germs all over us...inside and out."

"...Chiropractic view of the working of disease is complex...but they all relate to the nervous system. There are 9 hypotheses about the working of disease...some of them are nerve compression, proprioceptive insult, somatosympathetic reflex, viscerosomatic reflex, somatopsychic, psychogenic and so on...let me see, neurodystrophic...Articular alterations can cause irritation of nerve endings...joint pain, or pressure on a nerve root can cause leg pain."