BOYS IN PLIGHT:
A CASE STUDY OF CHIROPRACTIC STUDENTS CONFRONTING A MEDICALLY-ORIENTED SOCIETY

by

David Sternberg

October, 1969

A dissertation in the Department of Sociology submitted to the faculty of the Graduate School of Arts and Science in partial fulfillment of the requirements for the degree of Doctor of Philosophy at New York University

Approved by:

Richard Quinney, Ph. D.
Dissertation Adviser

TABLE OF CONTENTS

LIST OF TABLES AND DIAGRAMS

PREFACE

If one had to pick out the major theme of this dissertation, it would be that chiropractic students are exposed to sustained suspicions and attacks from many groups in American society which surround them. Hence the title of the study: "Boys in Plight: A Case Study of Chiropractic Students Confronting a Medically-Oriented Society."

The use of the "sociological pun" on Howard S. Becker's Boys in White[1] in the title was designed to contrast the happy status situation of medical students with the gloomy status prospects of contemporary chiropractic students. This play on words follows a sociological tradition recently exemplified by Harry Cohen's "The Demonics of Bureaucracy"[2] (a "take-off" on Peter M. Blau's The Dynamics of Bureaucracy[3]), which showed the less functional

---

[1] Howard S. Becker, Blanche Geer, Everett C. Hughes, Anselm L. Strauss, Boys in White: Student Culture in Medical School, Chicago, University of Chicago Press, 1961.

[2] Harry Cohen, "The Demonics of Bur eaucracy," unpublished Ph. D. dissertation, University of Illinois, 1962.

[3] Peter M. Blau, The Dynamics of Bureaucracy: A Study of Interpersonal Relations in Two Government Agencies, Chicago: The University of Chicago Press, 1955.

aspects of informal arrangements in bureaucratic organizations; and Irving Peter Gellman's paradoxical title, The Sober Alcoholics,[1] a volume which portrays those prudent members of the alcoholic population who are attempting to cure themselves through participation in Alcoholics Anonymous.

Although I undertook the field work for this study in an open and objective frame of mind, certain themes emerged from my observations, interviews and questionnaires which the chiropractic profession and the students I studied will, no doubt, perceive as "unflattering," or "critical." I am thinking particularly of an important finding that chiropractic students tend to disassociate themselves from their professional colleagues-to-be to a markedly greater extent than medical and dental students, as well as the discussed implication that such disassociative or "atomistic" strains among current chiropractic recruits may spell its eventual demise as a distinct occupational group in this society.

From the start it was apparent that students, faculty and administrative personnel at the Columbia Institute of Chiropractic had defined a "role" and "function" for me which did not mesh with

---

[1] Irving Peter Gellman, The Sober Alcoholics: An Organizational Analysis of Alcoholics Anonymous, New Haven: College and University Press, 1964.

my objectives as a sociologist. Time and again I was told they hoped the study "helped the profession." My goals, on the other hand, were to, hopefully, add something to research on the processes of professionalization and adult socialization, and, because of chiropractic's rather unique occupational features, something to the social-psychological knowledge of stigmatized group members' reactions to stigma. To the extent that there exists what Peter Berger would call a "debunking motif" in this study, it comes, I believe as much from a conflict in perspective between myself and personnel at CIC as to what a sociologist does as from any other factor:

> The sociological frame of reference, with its built-in procedure of looking for levels of reality other than those given in the official interpretations of society, carries with it a logical imperative to unmask the pretensions and propaganda by which men cloak their actions with each other. This unmasking imperative is one of the characteristics of sociology particularly at home in the temper of the modern era.[1]

It should be stated at the beginning that this study is in no way an evaluation of the therapeutic efficacy of chiropractic;

---

[1]Peter L. Berger, Invitation to Sociology: A Humanistic Perspective, Garden City, New York: Doubleday and Company, Inc., 1963, p. 38.

as a sociologist-- as opposed to an anatomist, physiologist, or neurologist-- I am neither competent nor inclined to offer such an evaluation. It is no dark secret, however, that chiropractic is widely suspect in the United States, and it is most certainly squarely within the sociological province to inquire what effects wide-spread challenges to chiropractic's validity have on the subculture of its practitioners, teachers and recruits.

CHAPTER ONE: SOCIOLOGICAL ORIENTATION TO A STUDY OF CHIROPRACTIC STUDENTS

RECENT STUDIES OF HEALTH PROFESSIONAL SCHOOLS AND THE NEGLECT OF CHIROPRACTIC

Studies in Related Occupations

Adult socialization studies,[1] with particular emphasis on the training of recruits in professional schools, comprise a new major field in American sociology. In the area of the healing arts prominent studies have been carried out within the last ten or twelve years by, among others, Merton[2] and Becker[3] (medical students), Quarantelli[4] and Plasek[5] (dental students),

---

[1] Orville Brim's and Stanton Wheeler's Socialization After Childhood: Two Essays, New York: John Wiley and Sons, Inc., 1966, is a particularly good example of recent interest in the theoretical parameters of adult socialization in various settings.

[2] Robert K. Merton, George G. Reader, Patricia L. Kendall (eds.), The Student-Physician, Cambridge, Mass.: Harvard University Press, 1957.

[3] Howard S. Becker, Blanche Geer, Everett C. Hughes, Anselm L. Strauss, Boys in White: Student Culture in Medical School, Chicago: University of Chicago Press, 1961.

[4] Enrico L. Quarantelli, "The Dental Student: A Social Psychological Study," unpublished Ph. D. dissertation, University of Chicago, 1959.

[5] Wayne Plasek, "Interaction Patterns and Attitude Change: A Study of Professional Socialization," unpublished Ph. D. dissertation, University of California at Los Angeles, 1967.

Simpson[1] (student nurses), and New[2] (osteopathic students). Although the substance of these studies will not be discussed at this point, important sections of several of them are employed later in this dissertation.

These studies deal with one or more of three major phases in what Sherlock and Morris have recently termed "the evolution of a professional[3]:" (1) The decision to enter a particular type of professional school. (2) Training experiences during the resident school period. (3) Professional outcome, or orientation, of the student, sometimes already apparent during the years spent in professional school, other times contingent upon post-graduate situational experiences.

---

[1] Ida Harper Simpson, "Patterns of Socialization in Professions: The Case of Student Nurses," Sociological Inquiry, 37 (Winter, 1967), pp. 47-54.

[2] Peter New, "The Application of Reference Group Theory Shifts in Values: The Case of the Osteopathic Student," unpublished Ph. D. dissertation, University of Missouri, 1960.

[3] Basil J. Sherlock and Richard T. Morris, "The Evolution of the Professional: A Paradigm," Sociological Inquiry, 37 (Winter, 1967), pp. 27-46.

Morris and Sherlock comment that too seldom are the three phases of professional training studied together in the same research.[1] In the present research, which is a field study of chiropractic students at the Columbia Institute of Chiropractic (hereafter referred to as CIC) in New York City, an attempt is made to embrace some important elements of all three phases of Morris' and Sherlock's paradigm. Precisely how this is done is detailed in the next chapter on research objectives, plan of the study, and methods.

Overemphasis on High-Prestige Occuations

Everett Hughes, in particular, has noted an overemphasis on the study of students and practitioners in "high prestige" occupations.[2] Medicine, dentistry, and law seem to have received an especially disproportionate amount of sociological energy, if the ultimate aim of a sociology of professions is to achieve a balanced and full picture of the various types and stages of "professionalization" manifested in a large number of contemporary American

---

[1] Ibid., p. 28.

[2] Everett C. Hughes, Men and Their Work, Glencoe: The Free Press, 1958, pp. 44-49.

occupations.[1] Perhaps it would be more accurate to say that Hughes decries the underemphasis on many occupations rather than the overemphasis on some. That certain high-prestige occupations have been so heavily researched is certainly to sociology's benefit; let us replicate this intensive research interest in other occupations as well, urges Hughes.

Chiropractors: A Large Group of Health Practitioners with Low Prestige

Chiropractic is the second-largest "general" healing art in the United States, with some 23,000 licensed practitioners.[2] Chiropractors rank substantially lower than other types of health practitioner

---

[1] Sherlock and Morris comment: "Insufficient attention has been given in the past to socialization for the professions considered as a generic phenomenon . . . For example, the professions of greatest prestige or popular mystique seem to be the most frequently studied; medicine and law have received a disproprotionate share of attention." Sherlock and Morris, op. cit., p. 28.

[2] Walter I. Wardwell, "Limited, Marginal and Quasi-Practitioners," in Howard E. Freeman, Sol Levine, and Leo G. Reeder, (eds.), Handbook of Medical Sociology, Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1963, p. 216. Pages 216-217 contain a useful table comparing chiropractors with other types of health practitioner in the United States on a number of dimensions, including size of occupational group, number of years of training required, number of extant training colleges, and respective rankings on various prestige scales.

on occupational prestige scales.[1] Importantly too, chiropractic is the only major healing occupation in the United States which is actually stigmatized. Goffman uses the term "stigma" to refer to an attribute that is "deeply discrediting"[2] to its possessor in certain social relationships, and a full discussion of chiropractic's and chiropractor's stigmatized features in this respect follows later in this chapter, and in a number of subsequent chapters. Very little sociological work has been done on this occupational group; particularly scant attention has been given to chiropractic students, although fourteen chiropractic colleges[3] exist at present in the United States.

The term "general healing art" here means that its practitioners take the entire human body and its health problems as the legitimate scope of therapy. Medical doctors (about 236,000 American practitioners in 1960) and osteopaths (about 14,000

---

[1] Ibid., pp. 216-217.

[2] Erving Goffman, Stigma: Notes on the Management of Spoiled Identity, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963, p. 3.

[3] Thorp McClusky, Your Health and Chiropractic, New York: Pyramid Books, 1962, pp. 253-254.

American practitioners in 1960)[1] are the other major general healing arts occupations in America. Groups such as dentists and podiatrists are, on the other hand, defined as "limited" practioners, since they confine their therapeutic attentions to one particular part of the human body (teeth, feet), and make no claims to competence beyond these well defined anatomical limits.

Chiropractors and chiropractic students are extremely sensitive to this distinction between general and limited scopes of health practice. They constantly complain that the public, and even most of their patients, erroneously perceive them as limiting their attention to "back" problems, even though the goal of their spinal manipulations is to effect the entire organ system of the body.

A BRIEF HISTORY AND EXPLICATION OF CHIROPRACTIC

The reader must be provided with at least an outline of the development of chiropractic right at the start if he is to grasp some of the central problems that chiropractic students face in American society today, problems around which the research of this dissertation is built. I assume that the general sociologist knows little about chiropractic and its practitioners, just as I

---

[1] Both these figures come from Wardwell's compilations, ibid., p. 216.

knew little when I began this research project some eighteen months ago.

Although lucid and relatively objective accounts of chiropractic's development are not numerous, a few are available. Walter Wardwell's "Social Strain and Social Adjustment in the Marginal Role of the Chiropractor,"[1] and Julius Dintenfass' Chiropractic: A Modern Way to Health[2] are two rich sources that one can consult for a more detailed treatment than is offered below. The version in this chapter is a concentration and abbreviation from various sources which I consulted during the research; these sources[3]

---

[1] Walter I. Wardwell, "Social Strain and Social Adjustment in the Marginal Role of the Chiropractor," unpublished Ph. D. dissertation, Harvard University, 1951, Chapters 2 and 5.

[2] Julius Dintenfass, Chiropractic: A Modern Way to Health, New York: Pyramid Books, 1966.

[3] A detailed account of the various types of chiropractic materials consulted is found in the following chapter under the "Methods" section.

The Investigation Department of the AMA issues an annual packet of reprinted literature from various sources attacking chiropractic, and these materials were likewise intensively consulted.

For purposes of the following history, Wardwell's dissertation and articles were the basic sociological sources used. Parts of Chiropractic in California, Los Angeles: The Haynes Foundation, 1960, particularly Part I, "General Description of Chiropractic," pp. 11-30 were used.

It should be noted that the real bulk of my knowledge of chiropractic history, development and theory comes from my innumerable discussions with faculty and students at CIC, a rich source impossible to footnote in any more precise fashion.

included many conversations with chiropractors, chiropractic textbooks, chiropractic professional journals, pamphlets produced by chiropractic groups for the layman, publications from the American Medical Association on chiropractic, and two or three sociological researches.

Although what follows is mainly historical and explicative, some sociological themes are introduced, so that almost from the beginning the reader is attuned to certain major ideas in the dissertation.

The Discover of Chiropractic by D. D. Palmer in 1895

Chiropractic was discovered in 1895 by Daniel David Palmer, an Iowa grocer and magnetic healer. Much of the history of chiropractic has been accounted for by three generations of the Palmer family. Daniel Palmer is known as the "Founder of Chiropractic," his son, B. J. Palmer, is called the "Developer of Chiropractic," and B. J. Palmer's son, David D. Palmer, is the current president of the Palmer College of Chiropractic in Davenport, Iowa.

As the discovery story goes-- and it is impossible to know just how genuine or apocryphal the tale is-- Palmer cured

a Negro[1] janitor of deafness by "adjusting" certain vertebrae. The janitor had identified the onset of deafness-- seventeen years earlier-- with an accident resulting in constant back pain. Palmer manipulated

---

[1] An interesting sidenote: Very few chiropractors have been Negroes. The Chiropractic in California volume, for example, notes (at p. 4, ibid.) that all but three percent of California chiropractors are "Caucasians". At the time of my field work at CIC no full-time current students were black, although there had been two Negroes (out of 67 students) in the graduating class of 1967.

Although the chiropractic profession cannot be characterized as "liberal" or "progressive" on racial issues, I did notice stirrings in this direction among certain administrators and faculty at CIC. When I was doing my field work, the Presidents of many of the chiropractic colleges, including CIC, were considering a fellowship plan for a number of black students; the School closed on the date of Martin Luther King's burial, to the surprise of a number of students and myself who arrived to find the building locked.

One faculty member remarked to me that in a sense chiropractic had been intimately involved with Negroes in America from its inception, since its first successful cure had been a black man.

It may well be that the absence of black recruits to chiropractic is as much a function of reluctance on their parts to enter chiropractic as it is the result of refusal to admit them by the training schools: Already struggling with a stigmatized racial status, why take on the new burden of a stigmatized occupational one?

the backbone in the painful area, and the patient's ability to hear again came after one or two treatments. After this initial success, Palmer began to employ spinal manipulation in a wide variety of illnesses and conditions, claiming a high rate of improvement or cure with cases medicine and/or osteopathy (founded in 1874) had been unable to help.

The Theory Behind Chiropractic

Why did Palmer's janitor regain his hearing? Why were subsequent patients cured of ulcers, heart condition, headaches and other illnesses, through spinal adjustments? Palmer and his followers reasoned in the following way: The nervous system is the key, or coordinator system in the human body. The core of that system consists of the brain, encased by the skull, and its connected spinal cord, encased by twenty-four segmented and movable vertebrae. Nerves emitting from the spinal cord through small holes in the several vertebrae run to all organs of the body, sending and receiving neural impulses.

For chiropractors, "di-ease," as opposed to the non-hyphenated medical concept of disease, results from interference in neural communication between the spinal cord and any particular body organs. Such interference is caused, chiropractors believe,

most frequently by vertebrae impinging on spinal nerves as they emit through the foramae (small holes) in the separate vertebrae. When a particular vertebra, or group of vertebrae, is "pinching" emitting nerves-- thus interfering with full neural communication between the central system and parts of the body, chiropractors talk about a "subluxation," which is probably the most central theoretical and symbolic term in the entire chiropractic framework. In publications designed for the lay person the spinal cord is sometimes likened to a garden hose and a particular body organ to the attached sprinkler. If one were to pinch the hose, the activity of the sprinkler would be either diminished or entirely prevented, depending on how hard one pinched.

Chiropractic treatment consists in "adjusting"[1] the offending vertebra or vertebrae, which entails moving the vertebra(e) very slightly by a calculated thrust with the hands so that pressure on nerves is alleviated with a resultant restoration of neural communication and "health." From the time of Daniel Palmer a rather impressive

---

[1]Chiropractors are extremely sensitive about the term "adjusting" and take great pains to distinguish it from superficially similar ones, such as "manipulation" or "massage." Osteopaths manipulate and physiotherapists massage, but both of these techniques are not calculated to remove specific spinal subluxations. Chiropractors see them as either worthless, or crude attempts to adjust.

variety of spinal thrusts have been developed and handed down to new generations of chiropractors,[1] but the controlling concept behind the various techniques has always been in line with the theory indicated above.

Some chiropractors put a good deal of faith in neural charts purporting to indicate which nerves emanating from the

---

[1] During my research at CIC I came into contact with a number of very different adjusting approaches. Two important dimensions upon which these approaches might be ordered are (1) where you adjust, and (2) just how you go about adjusting. One can readily see that various combinations can result from the two dimensions.

Some chiropractors stress treatment of the cervical vertebrae, to the exclusion or underemphasis of vertebrae lower in the vertebral column. There are a number of techniques used in the cervical area, the best known of which is probably the "Toggle-recoil" which is a thrust of tremendous force to the side of the neck at the point of the Axis or Atlas vertebra.

Other chiropractors emphasize adjustment of the other end of the column, reasoning that "as the foundation (sacral and coccygeal vertebrae) goes, so goes the rest of the spine." A favored technique of this group is the "Logan contact" administered to the base of the vertebral column.

The present program at CIC in terms of adjusting approaches might be termed eclectic. There are specific courses stressing cervical and lower-spinal adjustments; but CIC also teaches "full-spine" adjustment as its central emphasis (that is adjustment of <u>any</u> part of the vertebral column when necessary) and fits special approaches into a more general view of the entire vertebral column.

What is most surprising is that the medical profession seems to have no idea of the range of techniques taught and debated in chiropractic colleges, nor the long hours of training necessary to perfect many of them. They may or may not be therapeutically effective, as chiropractors claim, but certainly medical criticism without knowledge of these approaches is very superficial.

several vertebrae control which body organs. Thus, if a patient appears with a stomach complaint, certain chiropractors are disposed to concentrate immediately on particular vertebrae, for example, the first and second thoracic, since chiropractic clinical evidence[1] has demonstrated a neural correlation between the stomach and that juncture of the spinal cord. Other chiropractors rely heavily on "palpation" (feeling with the hands) of the vertebrae and or "instrumentation" (often involving apparatuses, of debated efficacy, which work on the principle of detection of

---

[1] One hears all the time, from medical personnel especially, that chiropractors do no research. It is of course quite true that little research chiropractors do comes to wide-spread public attention, but this fact is probably as much a reflection of medical domination of the relevant journals as anything else. The fact is that in their own circles chiropractors circulate various types of clinical research that they have done with patients. Often these communications take the form of week-end seminars, where a chiropractor will come to a certain city and give a "course" in adjustive techniques, for example, to a group of colleagues (sometimes at the charge of a rather high entrance fee). At these seminars mimeographed materials dealing with clinical findings on patients are often distributed. Neural mappings of the relationship between various body tissues and sets of spinal nerves combined with tested adjustment approaches is a typical example of what colleagues are given. That this constitutes empirical research is beyond question.

Beyond research distributed in seminars, inspection of the chiropractic journals indicates that one or two research pieces can usually be found in each number.

The point is that there is some culture of research in the chiropractic profession, and that chiropractors expect and welcome exposure to it.

electrical-- here specifically neural-- impulses along the spine) for purposes of diagnosing subluxations in patients.

One wonders how people get "subluxated" in the first place, and chiropractors offer various reasons, all of which are ultimately related to trauma which the bones of the back may incur. An obvious case would be a blow to the vertebral column incurred by, for example, a fall. Certain vertebrae would be pushed out of line and impinge on spinal nerves. A constant factor contributing to potential subluxations is man's erect position, in defiance of the force of gravity, which puts under constant stress the several vertebrae, increasing the chances for subluxations and nerve interference. Chiropractors claim that animals (excepting perhaps nearly erect ape groups) are relatively free from subluxations because of their four-footed style of locomotion. Not entirely free, however, since there is a small group of chiropractors who "adjust" animals, giving veterinarians limited competition.

A social researcher, of course, is not competent to evaluate the efficacy of chiropractic treatment, or the soundness of its theoretical framework. On the other hand, that chiropractic's viewpoint is suspect for the majority of persons in this society

seems well-known. The effects of wide-scale societal suspicion of chiropractic's point of view on chiropractors and chiropractic students is certainly a legitimate area for sociological analysis. And a large part of this dissertation explores the problem of how chiropractic students deal with various "negative messages" coming their way from skeptical and suspicious groups in American society.

The "Straight"-"Mixer" Rift in Chiropractic

Over the years one particular division has manifested itself among chiropractors: the split between "straights" and "mixers." Straights confine themselves to adjustment of spinal subluxations, in the manner indicated above. Mixers use a variety of "adjunct" therapies, including massage of different body tissues throughout the body (beyond the spine), heat treatments, diet therapy, and mechanical devices for traction.

Straights are supposed to be keepers of the original chiropractic faith, mixers strayers from the true path toward medicine and/or osteopathy. But although the distinction might be logically (and emotionally)clear, my observations and interviews with many chiropractors and chiropractic students indicate that there are many "shades" of each large category, and that

individuals will occasionally shift sides due to particular cases or circumstances.

In a general way the trend in American chiropractic colleges, as well as among licensed chiropractors, is currently toward the mixer pole.[1] CIC, on the other hand, claims to be a straight chiropractic college[2] (along with Palmer and a few other colleges). But CIC students, and faculty, are not highly consistent in terms of adhering to the straight line of treatment.

The Continuing "Solo" Practice Tradition in Chiropractic

The fundamental logic of chiropractic has is that any one chiropractor can, by removing nerve interference originating in misplaced vertebrae, treat all human "dis-ease"; there is little

---

[1] See Chiropractic in California, op. cit., p. 25.

[2] The CIC Bulletin for 1966-1968 reads at page 2: "CIC . . . offers only one course - a course in Chiropractic. There is no intent to imply that enrollment as a student in this institute will result in anything but the preparation for entrance into the profession of Chiropractic. The school is not a school of medicine, nor does it hold itself out to be a school of medicine."

The Bulletin is telling the reader "We do not teach mixing, physiotherapy, medicine, etc." It will be shown later in the dissertation that these official protestations about "straightness" are not altogether true.

The Bulletin was useful on several occasions in allowing me to point up differences between the "ideal" and the "real" in the world of CIC.

or no need for specialties or referrals. Thus the basic practice unit of chiropractic continues to be chiropractor-patient, rather than the triadic unit of doctor-patient-colleague so prominent in contemporary medicine.[1]

Friedson has indicated the various "facilitative" reasons[2] for medical men organizing themselves. Chiropractors, on the other hand, appear to require organization into larger units primarily for "defensive" purposes. There is evidence, appearing later in the dissertation, that CIC students are "taught" that chiropractic's foundation is essentially the chiropractor-patient dyad, rather than more elaborate networks involving colleagues. Chiropractors have been peculiarly resistent to the bureaucratic forces that have drastically re-shaped the classical "solo" practice structures of professionals like physicians and lawyers in the direction of larger-scale organization. As we shall see, this resistance has not been a happy trend, since it has tended to further "squeeze" the

---

[1] See Eliot Freidson, "The Organization of Medical Practice," in Freeman, et al,, Handbook of Medical Sociology, op. cit., pp. 299-319, for an analysis of the ever-growing "cooperative" nature of American medicine.

[2] Ibid., pp. 302-313.

chiropractor in a society moving toward greater and greater collaborative structures in the health fields.

Quarreling and Ineffective Professional Associations

Chiropractors have never achieved the "horizontal" or "vertical" integration of their professional associations which are such prominent characteristics of other health professions in the United States, like medicine, dentistry, and optometry. Along the horizontal dimension, chiropractors have been split into two rival associations-- chiefly at the national level-- which represent the views of straight or mixer chiropractors. At present the straights are represented nationally by the International Chiropractors Association (ICA), the mixers by the American Chiropractic Association (ACA). Along the vertical dimension, national organizations have never integrated state and local community units into overall hierarchies. In their comparative evaluation of the differential organization of five health professions (dentistry, medicine, optometry, pharmacy and chiropractic) Akers and Quinney assign sole occupation of last place to chiropractic.[1] Although Akers and

---

[1] Ronald L. Akers and Richard Quinney, "Differential Organization of Health Professions: A Comparative Analysis," The American Sociological Review, 33 (February, 1968), pp. 104-121. Going beyond the particular substantive findings in this research, the paper was valuable to me in prompting me to collect some comparative data on medical and dental students as a way of supporting central findings in my research. See Chapter 6 on "Autistic Tendency" in this dissertation.

Quinney gauge the contemporary situation, other sources, such as Wardwell, indicate that weak organization has always been characteristic of chiropractors.

Differences between straights and mixers probably is one cause among a number for weak organizational bonds among chiropractors. As we have already suggested, the "solo" practice "set" of chiropractic would also tend to discourage cooperation. In any event, the unavailability of united professional associations is a fact of life which the contemporary chiropractic student must face as he moves toward graduation and practice.

Wide-Spread Early Licensure in the United States

Although their professional associations have been weak and feuding, chiropractors have managed to obtain licensure in 48 of the 50 American states.[1] In fact, 75% of the United States had licensed chiropractic nearly forty years ago. These blunt facts

---

[1] The two jurisdictions which do not license chiropractic are Louisiana and Mississippi. In those states chiropractors are liable to prosecution for "practicing medicine without a license." New York (1963) and Massachusetts (1966) have most recently licensed chiropractic, but chiropractors consider New York a "bad" state and Massachusetts a "good" one.

often come as a shock-- even today-- to individual members of the medical profession and to the public.

Scope of practice for chiropractors varies, however, drastically from one state statute to another,[1] so that what is legitimate chiropractic technique in one jurisdiction may be defined as "practicing medicine without a license" in another. Chiropractors view some statutes as "mixer" laws and others as "straight" laws. Depending upon one's basic position in this respect, particular scope of practice acts are perceived as "good" or "bad" for chiropractic.

A good deal of chiropractic associations' energy has been devoted to re-shaping certain states' chiropractic laws, with a striking lack of success. Much of the difficulty comes from various conflicting factions in a particular state who cannot agree among themselves as to the proper direction for change.

Among chiropractors in New York State there is a persistent story about how New York obtained its present chiropractic

---

[1] For comprehensive overviews of all states' statutory definitions of chiropractic, see "Scope of Chiropractic Practice in the United States," Department of Investigation, American Medical Association, 1966; or Chiropractic in California, op. cit., pp. 143-150.

law (1963) which pointedly illustrates the extent of intra conflicts. Governor Rockefeller is supposed to have issued a call to the New York State chiropractic community for advice and suggestions about the form and content of a chiropractic law. Irritated and confused by the bickering of straight and mixer elements, he dismissed all chiropractors' suggestions and had the final statute drafted by medical men, a statute universally condemned in New York and around the nation by chiropractors as "biased," "bad," "designed by medicine to destroy chiropractic," and so on.

Perhaps, however, the essential point to be made at this stage, is that wide-spread licensure leads to at least some elements of legitimacy and "respectibility," even if the substance of this licensure is conflicting from state to state. Then too, licensure has very frequently been one of the important correlates along the way to full prefessionalization for an occupation.[1] In the chiropractic case the "odd" situation is that, as we shall see, elements of legitimacy coexist with strong elements of stigma.

---

[1] See Harold L. Wilensky, "The Professionalization of Everyone?" The American Journal of Sociology, 70 (September, 1965), p. 145. Wilensky notes, that licensure of course as an isolated achievement is not always the mark of professionalization, as in the case, for example, of egg-graders, well-diggers, and horse-shoers.

Chiropractic Colleges

In the first decades of the twentieth century chiropractic colleges were apparently not much inferior to medical or osteopathic ones. All three health professions' training colleges were characterized by too short periods of instruction, poor teaching, inadequate facilities, and private ownership (often on a profit-making basis). At that time, too, we should remember, medicine's power position was much closer to chiropractic's than it is today.

In a large way, one can say that medicine (and to some extent osteopathy) has shot ahead in development of superior training colleges, whereas chiropractic has made much less progress. Today, as decades ago, chiropractic colleges continue to be in financial difficulties to the extent that particular schools actually fade out of existence with some frequency.[1] At CIC I heard constant rumors, for example, that the "Institute" (the Chiropractic Institute of New York, the other chiropractic college in New York City) had "folded." CIC students were exposed to a recurrent message about the unstable condition of chiropractic colleges, and, by inference, the shaky position of organized segments of their occupational group.

---

[1] See Chiropractic in California, op. cit., pp. 91-92, for a detailed account.

But it seems undeniable that chiropractic colleges have made some progress with the quality of their programs: The resident period of training is now often four years; the chiropractic techniques which are taught are more sophisticated; there is a better grounding in "basic sciences." It appears that these improvements have gone almost totally unrecognized by medical associations.

MEDICAL OPPOSITION TO CHIROPRACTIC

Why chiropractic has always been suspect in American society is difficult to ascertain. Certainly the continued and strenuous opposition of political elements in the medical profession has been a large factor. Actually this opposition has been a very central part of the history of chiropractic, so that the present section should be seen as linked with the previous one on historical elements.

But precisely why medical men have constantly deemed chiropractic beyond the pale of therapeutic respectibility is a complex problem. Since this dissertation takes chiropractic's suspect position as "given," and goes on from that point, we can only sketch in here a few elements in medicine's running battle with chiropractic.

Scientific Objections

From a purely scientific point of view, medical researchers have refused to accept chiropractic's central assertion that spinal subluxations are the basic cause of disease(s). They believe that chiropractors either exaggerate the causal power of neural interference or that subluxations just do not occur as chiropractors describe them. When the latter position is taken, the argument is that the anatomical relationship between spinal nerves and their foranae in the vertebrae precludes subluxations.

Social Class Factors

Wardwell suggests that social reasons have been as important as scientific ones in medicine's rejection of chiropractic.[1] Beginning with its founder, D. D. Palmer, chiropractors have generally come from relatively uneducated, "uncultured" working-class parts of the American population, groups to whom medical men, with a middle and even upper-class social tradition, have felt socially superior.

Wardwell believes that no small portion of medicine's relative acceptance of osteopathy-- as opposed to chiropractic--

---

[1] Wardwell, "Social Strain and Social Adjustment in the Marginal Role of the Chiropractor," op. cit., pp. 486-490.

comes from osteopathy's being founded by a medical doctor-- Andrew Still-- instead of a grocer, as in chiropractic's case. This argument is rather persuasive, since chiropractic's therapeutic approach is no more "outrageous" to orthodox medicine than traditional osteopathy's.[1] Indeed, for most of their histories, few beyond the practitioners of the respective disciplines seemed to have discerned the differences between chiropractic and osteopathy.

Economic Competition

A third element in medicine's opposition is economic. Recalling our earlier discussion, chiropractic is in direct competition with medicine for patients, since both disciplines hold themselves out as "general" practitioners ("general" used in the specific sense discussed previously).

---

[1] Very briefly, osteopathy taught that disease was a function of faulty blood circulation in the body, which could be alleviated by manipulation of offending parts of the body, including but not limited to the spinal area. Osteopathy and chiropractic shared, from the beginning, similar opposition to the use of drugs to cure persons, thus opposition to the central therapeutic of modern medicine. They also were unalterably opposed to medicine's alternative therapy: surgery. In both osteopathy and chiropractic the theme of the "wisdom of the body" is very strong combined with the corrolary that it does not require drastic forms (drugs, surgery) of help to take care of itself. Another common belief that osteopathy and chiropractic share is that the body is "sacred" and should not be subjected to undue intrusions. This latter point is very strong in the work of Stills, the founder of osteopathy.

It would indeed constitute an interesting dissertation in its own right to explore the historical forces shaping the very hostile relationship between medicine and chiropractic-- with osteopathy as a third party somewhere in between, but it does seem certain that the scientific, sociological and economic elements mentioned are central to the dispute in some overall way.

Most groups in American society presented with the choice between medicine and chiropractic have sided with medical authority, so that chiropractic has recurrently found itself in a state of seige over the last decades. One of the themes that emerges in this research is that the situation in this respect is deteriorating for chiropractors and chiropractic students. The irony is that chiropractic training standards have definitely improved, become more "professional," coincidentally as the very survival of chiropractors in American society as a distinct occupational group has become more problematic.

WHY HAVE SOCIOLOGISTS NEGLECTED CHIROPRACTORS?

We might pass from the question of why medicine has given so much attention to chiropractic to the question of why sociology has devoted so little attention to it. Certain traditional and prominent sociological preoccupations in this country would

have led one to expect chiropractors would have been of greater interest to sociologists.

Certainly the size of the group-- particularly when chiropractors, students, and patients are lumped together-- is substantial enough in American society to warrant greater attention on those grounds alone. One estimate states that thirty-five million calls are made annually to chiropractors (although the number of patients constituting these calls is not specified).[1]

A related point in their sociological favor is that chiropractors and chiropractic students most definitely have a distinct "subculture" to be studied. If one adds patients to the practitioners another and larger subculture is created.

Then again, one might have though that the "pariah" school in sociology, which has studied so many "outcast" groups from drug addicts, to mentally ill persons, to criminals, would have turned an interested eye toward chiropractors who unmistakably are stigmatized in important respects in American society.

---

[1] Gordon Leis, "The Transformation from a Healing Cult to a Profession: The Changing Place of Chiropractic Among the Healing Arts," a Ph. D. proposal in the Department of Sociology, State University of New York at Buffalo, March 1966 (Xerox), p. 2.

In 1964-65 there were 2,940 chiropractic students in the United States. This compares with 1,116 osteopathic students and 32,428 medical students. Henry G. Higley, "Chiropractic Licentiates in the United States," American Chiropractic Association (ACA) Journal of Chiropractic, 5 (January, 1968), p. 21.

Medical Sociologists Assume Medicine's Biases Toward Chiropractic

Freeman, Levine and Reeder note that there are certain medical sociologists "who become enmeshed in the specific problems of the prevention and treatment of illness and the maximal allocation of health resources, and whose identification with medicine far overshadows their commitment to sociology."[1] It is submitted here that in a larger, if less precise way, medical sociologists have excessively "bought" the assumptions of medicine, impressed or over-impressed as they have been by the authority and knowledge in the medical profession. Merton's The Student Physician, particularly Merton's introductory essay[2] in that volume, is a particularly good example of the sociologist's deference to medical authority. At least one sociologist has commented on the Columbia-Mertonian reverence of the medical profession and its training colleges.[3]

---

[1] Howard E. Freeman, Sol Levine, and Leo G. Reeder, "Present Status of Medical Sociology," in Freeman et al., Handbook of Medical Sociology, op. cit., p. 476.

[2] Robert K. Merton, "Some Preliminaries to a Sociology of Medical Education," in Merton et al., The Student-Physician, op. cit., pp. 3-79.

[3] Samuel W. Bloom, "The Sociology of Medical Education: Some Comments on the State of a Field," Milbank Memorial Fund Quarterly, 43 (April, 1965), pp. 143-184.

The vital point for our purposes is that medical sociologists, in terms of the sociological "division of labor" are those persons most likely to turn their research attention to various health fields, including chiropractic, but they have probably internalized medicine's aversion to chiropractic so that it goes unnoticed as a research area. Certainly other specialists in sociology outside the field of medical sociology might have legitimate interests in chiropractic: persons interested in professionalization, stigma and even religious phenomena (there is at least an argument that chiropractic is closer to a religious cult than a scientific discipline) come immediately to mind. Nevertheless the virtual elimination of medical sociologists greatly reduces the potential population of researchers into chiropractic.

Contradictory Sociological Features of the Chiropractic Case

Another reason that seems to have turned sociological researchers away from more extensive study of chiropractors and chiropractic students is the ambiguous image this group projects in terms of current theoretical foci in sociology. Chiropractors are "loaded" on both "professionalism/professionalization"[1]

[1] In the literature of this area these two terms are frequently used interchangeably, but in this dissertation they will

and "stigma," an odd combination in the list of American occupations and social statuses in general.[1] It is more assuring to study a group which falls more clearly into one of these two dimensions

---

have different meanings along the lines indicated by Vollmer and Mills: "We suggest . . . that the concept of 'professionalization' be used to refer to the dynamic process /authors' italics/ whereby many occupations can be observed to change certain crucial characteristics in the direction of a 'profession,' even though some of these may not move very far in that direction. It follows that these crucial characteristics constitute specifiable criteria of professionalization.

We would prefer to use 'professionalism' to refer to an ideology /authors' italics/ and associated activities that can be found in many and diverse occupational groups where members aspire to professional status. Professionalism as an ideology may induce members of many occupational groups to strive to become professional, but at the same time we can see that many occupational groups that express the ideology of professionalism in reality may not be very advanced in regard to professionalization. Professionalism may be a necessary constituent of professionalization, but professionalism is not a sufficient cause for the entire professional process." Howard M. Vollmer, Donald M. Mills, Professionalization, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1966, pp. vii-viii.

Chiropractic students, as we shall see, are exposed to certain features of both professionalization and professionalism.

[1] Actually very few American occupations are "stigmatized" if stigma is taken to mean a crucial fault in self as defined by Goffman in his Stigma, op. cit.

Of course, many occupations have low prestige, as various researches have demonstrated, but low prestige and stigma are two different dimensions. Stigma is not the polar opposite of high prestige. To rank low on the North-Hatt Scale, as a machinist, for example, does, is not to be stigmatized, because the American population does not perceive the status of machinist to carry a cloud or fundamental fault. Chiropractors, on the other hand, rank relatively high on occupational prestige scales, and yet are loaded on stigma which most of those occupational statuses lower on prestige scales lack.

The list of legitimate occupations that are actually stigmatized-- in that most others avoid members of these occupations, feel

or the other. Thus, we study medical students or law students and feel comfortable that we are solidly in the area of professions, or we study inmates in mental hospitals, in prisons or on reservations, and know that here is the "heart" of "stigma" or "outsider" data.

But with chiropractors we are in effect pulled in two directions: At the same time as the great majority of the American population continues to mistrust and disrespect them, they obstinately exhibit undeniable elements of professionalism and/or professionalization (as we have noted, they have obtained licensure in all but two American states, and their professional training has become increasingly rigorous). But stigma and professionalization (except in the case perhaps of the professional thief) are strange sociological bedfellows; the extant general theory in these two areas pass like ships in the night. A high loading on one variable is assumed to exclude a high loading on the other; certainly that simultaneous "loading" should be a stable condition through time, not tending toward resolution in one direction or the other, is sociologically unorthodox.

---

uncomfortable and embarrassed in their presence, and deeply distrust them-- could be counted on one's fingers. Besides chiropractors they probably include hangmen (executioners in general), mercenaries, embalmers, grave-diggers, and certain carnival personnel. Some might also, particularly currently, include the police.

It develops, as this dissertation is designed to demonstrate, that this odd sociological combination is precisely what makes an exploration of chiropractic students most valuable for sociology. The "bind" between these two dimensions creates a difficult situation for chiropractic students caught in the middle. The thesis will show that CIC students pick an individual, rather than a group, solution to their status problems, elevating their own personnel success as chiropractors far above their peers, and that "professionalization." of CIC students toward the individual pole is unique in major American healing arts.

A BRIEF REVIEW OF THE THREE MAJOR SOCIOLICAL STUDIES OF CHIROPRACTIC TO DATE

Chiropractors are not entirely a virgin field for sociologists, although no substantial research on chiropractic students-- to my knowledge-- has been undertaken prior to this present project.[1] It

---

[1] Mark J. Oromaner has published an article entitled "A Study of Students Entering a Marginal Profession," The Journal of Clinical Chiropractic, 1 (January, 1968), pp. 43-55, which is an interesting, if limited, study of certain variables connected with students choosing to enter CIC. That research was conducted in 1963. Interestingly, Oromaner's "entrance" problems four or five years ago with the CIC administration-- problems of which I was unaware until well into my field study-- came back to haunt me, and gave me some anxious moments with my sample. This situation will be discussed in the chapter on methods in research. At this point suffice it to say that Oromaner did not do observational or interview work with chiropractic students. His data comes from a short questionnaire that he administered.

should be noted at the outset that none of the studies to be discussed are part of the recent adult socialization trend discussed in the first pages of this chapter.

Wardwell's Study of Boston Chiropractors

The classic work (if the term "classic" can properly be used in an area where there are so few research studies) in the sociology of chiropractic is Walter Wardwell's Harvard dissertation in 1951, "Social Strain and Social Adjustment in the Marginal Role of the Chiropractor."[1] Subsequently Wardwell has published several articles on chiropractors,[2] but they are not further research since they derive in large part from his original dissertation. In this very extensive work can be found perhaps the best objective history of chiropractic written to date, as well as a good deal of descriptive material on the "subculture" of chiropractic. Interwoven with historical materials is primary data obtained from twenty-four chiropractors in the Boston area whom Wardwell interviewed

---

[1] Wardwell, "Social Strain and Social Adjustment in the Marginal Role of the Chiropractor," op. cit.

[2] Including Walter I. Wardwell, "A Marginal Professional Role: The Chiropractor," Social Forces, 30 (March, 1952), pp. 339-348; and "The Reduction of Strain in a Marginal Social Role," American Journal of Sociology, 61 (July, 1955), pp. 16-25.

repeatedly and intensively. Actually these twenty-four chiropractors composed the entire universe of full-time experienced chiropractors working in Boston at the time.

Wardwell's sample is extremely small, and generalizations from this group to chiropractors as a whole in America are quite dangerous. To some extent too, Wardwell's work of almost twenty years ago is outdated, although the degree to which this is true could be exaggerated, since one of the facts of chiropractic seems to be its relative constancy in so many ways.

At a number of places in the present dissertation, fruitful observations made by Wardwell will be discussed, but the present research departs from quite different theoretical bases than Wardwell's, so that this project cannot be viewed as a extension from Wardwell's starting point. To the extent that the earlier dissertation is theoretical, it is quite strictly within the Parsonian tradition of functionalism, with special emphasis on Parson's well-known pattern variables.[1] Essentially Wardwell's work is not hypothesis-testing research, since hypotheses set forth in advance to be tested are not forthcoming. Finally,

---

[1] Wardwell, "Social Strain and Social Adjustment in the Marginal Role of the Chiropractor," op. cit., pp. 8-42; 238-252; 356-358; 562-581.

Wardwell offers no data on chiropractic students experiencing the fundamental stages of the socialization process, and that data is the focus of the present research. Wardwell's dissertation is used more as a "handbook" or "encyclopedia" of facts than as a guiding theoretical framework, undeniably useful on its own terms.

The Stanford Research Institute Report on Chiropractic in California

A more recent sociological study of chiropractors and their patients, and to some limited extent chiropractic students, is the so-called (by chiropractors) "Stanford Report," actually entitled Chiropractic in California,[1] written by the Stanford Research Institute and published in 1960. I had heard of this study on no uncertain terms when I first began my negotiations for permission to study chiropractic students at CIC. For some weeks it became a major barrier for me to overcome, since faculty members at CIC universally condemned it as a "biased" and "negative" sociological report about chiropractic and chiropractors, certain to hurt the profession's image. What assurances did CIC have that my report would not be in a similar vein?

---

[1] Chiropractic in California, op. cit.

Since that time I have read the volume twice and find myself puzzled about chiropractors' reactions to it. At best it seems to be a relatively mild criticism of certain limited aspects of chiropractic, but certainly not the occasion for total condemnation. There is a great deal of descriptive material about various phases of chiropractic in California, including "Socioeconomic Characteristics and Ailments of People Treated by Chiropractors; Chiropractic Practices and Facilities; Selected Diagnostic and Therapeutic Electrical Apparatus Used by Chiropractors, and Chiropractic Educational Institutions."[1] There is a bewildering array of tables, both in the text and appendices which makes the volume exceedingly difficult to read. Another major characteristic of the report is its almost astonishing aversion to theory, in particular, sociological theory.[2]

In some of the chapters which follow in this dissertation--especially Chapter Three on characteristics of CIC, its faculty, and student body-- valuable findings from the "Stanford Report" are used

---

[1] Taken from the Table of Contents of Chiropractic in California, ibid., pp. vii-viii.

[2] The atheoretical character of the report is even more surprising in view of the fact that one of the principal investigators was Donald L. Mills, whose edited volume on Professionalization is acknowledged to be an excellent source of theoretical materials on the professions.

in some abundance for comparative purposes, but the study's uncanny avoidance of sociological theory in the area of professions and/or stigma makes it of limited use in the hypothesis-testing sections of the present research.

Leis' Current Study of Straights and Mixers in New York State

The third, and final, major piece of sociological work about chiropractors is Gordon Leis' unfinished doctoral dissertation at the State University of New York at Buffalo: "The transformation From a Healing Cult to a Profession: The Changing Place of Chiropractic Among the Healing Arts." Although I have only had the opportunity to read Leis' proposal,[1] it is clear that he is concerned with licensed chiropractors (in New York State), as opposed to students, and that his focus is upon chiropractic's increasing professionalization, omitting what my research has found to be the necessary counterpart, chiropractic's continued, and possibly intensified, stigmatization.

Leis' basic theme is that "mixer" chiropractors-- as opposed to more fanatical "straights"-- are becoming increasingly

---

[1] Gordon Leis, op. cit.

"professional" as time passes, and that the "mixers" may eventually effect a "rapprochement" with medical doctors, in a manner similar to osteopaths. But my research indicates no preference on the part of M. D. s for "mixers" as opposed to "straights." If anything M. D. s might be disposed to view "mixers" with more alarm than "straights" since the former group pursue therapeutic modalities possibly encroaching on medicine. In any event, official AMA publications about chiropractic lump all chiropractors together in one villainous group, and it is quite doubtful if the public is aware of the distinction(many chiropractic patients are not aware of th. distinction).

CHAPTER TWO: RESEARCH OBJECTIVES, PLAN OF THE STUDY, AND METHODS

RESEARCH OBJECTIVES AND PLAN OF THE STUDY

The two research objectives in this dissertation are: (1) an exploratory and descriptive study of (a) key features in CIC students' decision to enter the occupation of chiropractic and (b) important themes in the subculture of CIC, composed of faculty, administrators and students interacting among each other, which students confront during their training terms at the School; (2) an hypothesis-testing study about emerging "orientations" (or attitudinal "sets") on the part of these recruits toward fellow students, eventual chiropractic colleagues, and style of practice. The research covers, then, some elements of all three phases of Sherlock and Morris' paradigm for "the evolution of the professional."[1] In reference to chiropractic, all of these research areas are virtually uncharted. It should be noted at the start that the basic research case is CIC students, although a good deal of data on the School, its faculty

---

[1] Basil J. Sherlock and Richard T. Morris, "The Evolution of the Professional: A Paradigm," Sociological Inquiry, 37 (Winter, 1967), pp. 27-46.

and full-fledged chiropractors is necessarily involved as well in the analysis. (This point is expanded in a later section of this chapter on "The Nature of the Research Case".) It should also be stressed that the earlier descriptive materials (found primarily in Chapters 3, 4, and part of 5) have the dual function of providing an extensive and detailed picture of a little-known occupational group and building an empirical base from which a set of hypotheses can be reasonably generated.

A Descriptive Study of a Chiropractic College and Student-Chiropractors

The descriptive materials in this study are found primarily in the following two chapters, and are entitled, respectively, "The Columbia Institute of Chiropractic; The School, The Faculty, and the Student Body" (Chapter 3), and "Current and Prospective Liabilities of the Status of CIC Student" (Chapter 4). Chapter 3 offers a condensed history of CIC, an overview of its administrative organization, a review of its curriculum and an appraisal of its economic situation. Next the CIC faculty is discussed, both from the point of view of "background" characteristics (e.g., age, ethnicity, academic qualifications) and from the view of their salient interests or "preoccupations" (e.g., interest in teaching students

versus interest in building their own private practices).

The bulk of the chapter is devoted to the students, in keeping with the central focus of the research, and covers in some detail: general background characteristics, such as age, ethnicity, social class membership; key features of students' decision to study chiropractic, such as the degree of "occupational inheritance" involved, the extent of prior chiropractic care for self or family as a factor in choosing chiropractic, the time of decision to study chiropractic, occupational involvements prior to matriculation at CIC, stated motivations for studying chiropractic, and the degree of commitment to a chiropractic career upon entering CIC; students' and their families' and friends' early reactions to study at CIC. In this last area a distinctive social pattern associated with matriculation at CIC-- what Erving Goffman has called a "courtesy stigma"[1] pattern-- is documented.

Throughout the chapter, more than merely "bare" and isolated facts are presented:the reader obtains a picture of interactive patterns among faculty, administration and students, sometimes termed the "social climate"[2] of a group, as well as basic

---

[1]Erving Goffman, Stigma: Notes on the Management of Spoiled Identity, Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1963, p. 30.

[2]According to Wheeler, "the concept of social climate expresses something about the feelings generated by the total set

value tenets of the CIC and wider chiropractic subcultures. This picture is continued and elaborated in Chapter 4. Comparative materials from other health professions[1] are found in all sections of Chapter 3, most extensively in the discussion of CIC students. The basic sources of data for the chapter were: the CIC curriculum Bulletin for 1966-1968, the 1st Questionnaire (Appendix A) which I administered to CIC students in March 1968, and my field notes made over a period of some six months of observation and interaction with various personnel (students, faculty, administration) at the School. Supplementary and comparative sources consisted of: curriculum bulletins from other chiropractic colleges and medical colleges, data on California chiropractic colleges and students found in Chiropractic in California,[2] prior sociological studies of medical, dental and osteopathic students, and data which I collected from New York University medical and dental students.

---

of relations between staff and recruits. Relations may be warm, free, and easy, or harsh and hostile. Both within and between the major social categores there may be a feeling of trust or of suspicion and lack of confidence." Orville G. Brim, Jr. and Stanton Wheeler, Socialization After Childhood: Two Essays, New York: John Wiley and Sons, Inc., 1966, p. 82.

[1] These studies are fully cited as they appear in the discussion in Chapter 3.

[2] Chiropractic in California, A Report by Stanford Research Institute, Los Angeles: The Haynes Foundation, pp. 101-105, and pp. 226-228.

Chapter 4 constitutes an examination of (a) how the status of chiropractic student is defined by "outside" groups in American society which institutionally impinge on the status of chiropractor and, derivatively, the status of student-chiropractor, and (b) how these essentially "negative" or "disapproving" definitions and attitudes held by surrounding societal groups are "beamed" to and "received" by students, by way of CIC. It transpires that a large part of the subculture of CIC, or of the student culture, consists of and is oriented toward dealing with these "negative messages."

The most important sources for Chapter 4 included: The 1st and 2nd Questionnaires (the 2nd administered in May of 1968) given to CIC students, my field notes, state chiropractic laws, American Medical Association (hereafter called AMA) literature on chiropractic, limited prior sociological research on chiropractic, occupational prestige scales, such as the NORC Scale, and popular magazine articles about chiropractic.

An Hypothesis-Testing Study of Emergent Attitudes of Chiropractic Students

From the descriptive materials in earlier chapters emerged the central theoretical problem area in this disseration. That problem area can be stated by asking a number of questions which forcefully arise out of the descriptive study of CIC and the student body. Among the most crucial would be these:

"How do students handle the burden of stigmatic messages coming their way from so many groups?"

"Why in the face of these negative messages for both the present and the future do they continue on through CIC and into the chiropractic profession?"

"What counterbalancing advantages or rewards are they able to interject into a bleak situation?"

"How might the adaptations of CIC students be contrasted with emergent attitudes of health students in more prestigeful and highly respected professions, such as medicine and dentistry?"

"What can their style of adaptation tell us about the likely reactions of other stigmatized groups' (occupational or other) members to societal disapproval?"

In Chapter 5, entitled "Chiropractic Students' Answer to Stigma: The Elevation of Self Over Other," a sociological model of "identity-management"[1] is developed which hypothesizes that CIC students will insulate themselves from stigma by predicting a more successful coping on their own personal parts with the various problem sectors in their occupational environment than they predict for

---

[1] The term is from Goffman, op. cit., the sub-title of this volume being "Notes on the Management of Spoiled Identity," and embraces the techniques which stigmatized persons use to defend themselves intra and inter personally.

their student peers, or the "average chiropractic student," or "the average chiropractor." The reasons, connected with both the structure of the chiropractic "philosophy" and profession and with the specific organization of CIC itself, for expecting an "individualistic" rather than a "cooperative" solution to the stigma threats are indicated at this point.

The 2nd Questionnaire presented respondents with, inter alia, 14 self-other career success situations (thus 28 items) which reflected areas of potential difficulty with impinging groups and sectors in society (as these problem areas had been detailed in Chapter 4). Chapters 5-6 account the procedure, findings and implications of the self-other patterns yielded by these data. Chapter 7, finally, adds related findings on "solo practice" orientations among CIC students. In both Chapters 6 and 7 comparative data from the New York University medical and dental samples are introduced as additional evidence in support of the findings from the chiropractic student sample.

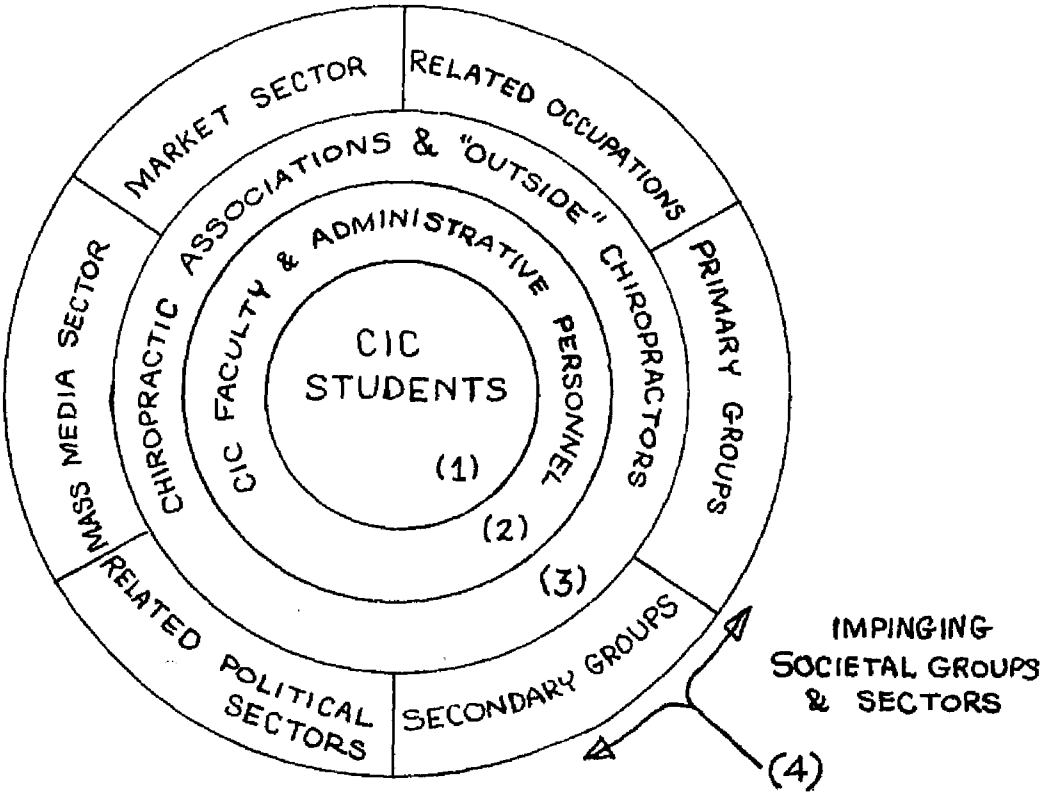
The Nature of the Research Case

In her "Paradigm: Some Alternatives of Sociological Research Design," Matilda Riley characterizes the specification of what the "research case"-- or central unit of analysis-- is to be

as a most crucial decision.[1] Since the present research contains aspects of both a descriptive and hypothesis-testing study, as well as a number of social groups involved in its analysis, a somewhat complex "research case" is involved, which merits a few paragraphs of explication.

Perhaps a diagram might clarify the nature of the "research case," or better said, the relationship in "social space" among various units embraced in this study:

Diagram 2-1: The Nature of the Research Case



1 Matilda White Riley, Sociological Research, vol. 1, New York: Harcourt, Brace and World Inc., 1963, p. 18

The innermost circle (1) includes data on the students' social backgrounds, their emergent attitudes, and the student subculture. Circles (1) and (2) together make up the world of CIC. Circles (1), (2) and (3) combined constitute in some large way what might be termed the "chiropractic subculture." Circle (4) is set off against the inner 3, surrounding them, and-- as we shall see-- quite alien to them. That impinging institutional sectors are pictured as surrounding the chiropractic world is a fortunate representation here, since chiropractic students and chiropractors do tend to feel surrounded by hostile groups in American society. The ultimate focus of the dissertation is on the relationship between (4) (the independent variables(s)) and (1) (the dependent variable) with (3) and especially (2) seen as links in between (intervening variable).

Representativeness of the Sample

In this research the question of "representativeness" is best broken down into two subquestions, in order of priority of research objectives: (1) How representative are CIC students of the universe of chiropractic students in the United States? (2) How representative is CIC of American chiropractic colleges? Although a detailed analysis of both CIC and its students is reserved for Chapter 3, we can certainly make some comments at this point,

necessarily alluding at times to materials and citations repeated in the next chapter, about the degree of representativeness.

(1) Only a limited amount of available contemporary comparative data on chiropractic students in other colleges in other regions of the country exists. Chiropractic in California contains some information on the background characteristics of students at two chiropractic colleges, the Los Angeles College of Chiropractic (LACC) and Cleveland Chiropractic College (CCC), and a perusal of chiropractic journals and college catalogues yields bits and pieces of information.

Although the details are found in Chapter 3, it seems that the CIC student sample is not ethnically nor religiously typical of chiropractic students in the United States: CIC students are much more heavily Jewish and Italian than their peers in other chiropractic colleges, who tend to be, like contemporary licensed chiropractors, "Anglo-Saxon-Protestant."[1] The heavy Jewish and Italian

---

[1] The origins of chiropractic in America were in a white, Protestant, midwestern-rural group of persons. Although chiropractors increasingly lose their rural-born characteristic, paralleling a general trend in American society-at-large toward urbanization, the limited evidence that is available suggests the majority are still Anglo-Saxon-Protestant. See Walter I. Wardwell, "Social Strain and Social Adjustment in the Marginal Role of the Chiropractor," unpublished Ph. D. dissertation, Harvard University, 1951, p. 295. For some data on the Anglo-Saxon-Protestant character of the largest chiropractic student body, at Palmer College, Iowa, see Chapter 3.

concentration among both students and faculty is, however, consistent with the ethnic concentrations in the New York City metropolitan area (including northern New Jersey and southern Connecticut), from which most of the students come. The fact that the great majority of the CIC students come from either New York or New Jersey makes them a more "provincial" group of students in comparison to other chiropractic colleges for which data is available, where students came to a much greater degree from many regions of the country (see Chapter 3).

The CIC student sample may come from a somewhat higher socio-economic class level than contemporary chiropractic California students[1] -- although no data on this point is obtainable for other chiropractic colleges, so that the issue of CIC students' representativesness on social class membership is up in the air.

---

[1] The only direct allusion to the socio-economic status of chiropractic students appearing in Chiropractic in California, op. cit., is the following statement: "Most of the students come from families of modest financial resources." (Page 6) This suggests their family backgrounds are generally working-class. We shall see in Chapter 3 that CIC students' family backgrounds are generally middle-class.

CIC students were younger and better educated (see Chapter 3 for details) than students at LACC and CCC in California, but no comparative data is available for other major colleges such as Palmer, National Texas, Lincoln, and Logan.

In terms, then, of the usual background characteristics or status taken into account by the sociologist when he attempts to gauge the representativeness of a particular sample, it would be very risky to say that the CIC group either was or was not generally representative of the universe of chiropractic students, because of the dearth of available data.

But, even conceding the fact that CIC students are probably not representative of all chiropractic students in the United States on some of the above-mentioned variates, I would contend that the CIC sample <u>is</u> representative of the entire universe of chiropractic students in one most crucial way: although local conditions in the different chiropractic colleges undoubtedly create variations on the theme, both CIC students and their fellow chiropractic students across the nation receive essentially the same array of unwelcome messages (outlined in Chapter 4) from surrounding sectors in American society. After

all, the medical culture and the mass media culture are national systems and their values and communications reach into most areas of this nation. It is probable that differences in the background statuses of students from chiropractic college to college do not substantially affect some degree of universal exposure to stigma, because of the possession of the common status of chiropractic student; that the status chiropractic student is so salient that it dwarfs the representative importance of other statuses for our purposes.

That adaptation to negative messages may differ on the part of chiropractic students in various localities is possible, but I hope to show that the structure of the chiropractic profession in a generic way is such that one might reasonably predict a similar elevation of collegial self over collegial other in most areas of the country.

(2) Whether CIC is representative of American chiropractic colleges is obviously linked with the question of representativeness of its student body. But there are certain additional factors which can be treated as specific structural features of the

School in their own right, such as the administrative structure of the School, the nature of its faculty, its avowed policies and ideology, the nature of its training program and its physical location.

The School does appear to be representative, or typical, of chiropractic colleges in most major respects. Her organizational structure (administrative offices, various departments, and so on) is similar to Palmer College in Iowa, LACC and CCC in California, and CINY in New York City.[1] The facts that (a) the majority of the CIC faculty do not possess any non-chiropractic academic degrees, and that (b) many of the minority who do have such degrees possess them in areas not connected with science or chiropractic treatment seem characteristic of chiropractic college faculties.[2] The nature and length of CIC's four-year curriculum is

---

[1] CIC's organization plan is discussed in the next chapter. For comparative sources, see the Bulletin of the Palmer College of Chiropractic, Catalog Issue, 1967-1968, pp. 50-60, 85-117; Chiropractic in California, ibid., pp. 101 and 223; and the Bulletin of the Chiropractic Institute of New York, 1967-1968.

[2] See the faculty list for Palmer College (pp. 51-55 in the Bulletin) and data on LACC and CCC faculty in Chiropractic in California, op. cit., pp. 110-111. Even those California college faculty members who did have a non-chiropractic cegree did not usually possess it in "an area readily applicable to chiropractic education." (Page 111). Somewhat more than 50% of the faculty of the Chiropractic Institute of New York are presented as having a non-chiropractic degree, but in many instances it is not at all clear whether the degree has much relevance to teaching either basic science or chiropractic courses. CINY Bulletin, pp. 9-11. A

very similar to most of the other chiropractic training schools, running somewhat over 4400 classroom and clinic hours, and being a combination of a substantial "hard core" of chiropractic courses and an increasing number of basic science and "medical" courses.[1]

That CIC holds itself out as a "straight" rather than a "mixer" college puts her in the minority group of colleges in this respect,[2] but it is a substantial minority, including, most notably the largest chiropractic college, Palmer, and CCC and Logan College as well. The majority of currently operating chiropractic colleges are found within large cities[3] and CIC is typical in this

---

prominent chiropractor contends that "too many instructors (in chiropractic colleges) are teaching the basic sciences without having had any advanced or graduate training in these sciences. Too many instructors (are) not trained or qualified as teachers nor masters of their fields, resulting in a slavish devotion to textbook teaching and instruction considerably below the level of post-college professional education." Memorandum from Dewey Anderson, Ph. D., D. C., Director of Education, the American Chiropractic Association, 1963-1964, to Delegates. Officers, Committee Members, and Officials of the American Chiropractic Association, June 15, 1964, at page 3.

[1] A detailed analysis of CIC's and other chiropractic colleges' curricula is found in Chapter 3. Wardwell notes that most chiropractic colleges today are four-year ones, with a curriculum similar to CIC's. Walter I. Wardwell, Limited, Marginal, and Quasi-Practitioners," in Howard E. Freeman, Sol Levine, and Leo G. Reader (eds.), Handbook of Medical Sociology, Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1963, p. 226.

[2] See "Chiropractic Education in the United States" in Chiropractic in California, op. cit., pp. 92-93.

[3] The locations of all fourteen colleges currently operating

respect. Finally, CIC's limited physical facilities and equipment, and her rather shaky economic position seems characteristic of many, if not most, contemporary chiropractic colleges.[1]

MAJOR RESEARCH METHODS

Observation at CIC

First-hand observation of people "doing their thing" in a particular social system is one of the most time-honored methods employed by sociologists and anthropologists. In the study of students in health fields, Becker and his associates' study of Kansas University medical students comes directly to mind.[2] Another observational study (in part) of health students was carried out by Plasek[3] (dental students). Beyond the health situses per se numberous observational

---

in the United States, and one operating in Canada, are found, ibid., p. 92. Twelve of these colleges are located in very large or large cities, with only one (Palmer) residing in a small town (Davenport, Iowa).

[1] "While adequate for the purposes of some phases of the educational program offered, the buildings and equipment utilized by the /California chiropractic/ colleges suggest a general condition of financial hardship." Ibid., p. 7; "they /chiropractic students in the United States/ are educated in four-year colleges, which, while neither well-equipped nor known for scholarly research, prepare students to take state licensing examinations . . . " Walter I. Wardwell, "Limited, Marginal and Quasi-Practitioners," op. cit., p. 226.

[2] Howard S. Becker, Blanche Geer, Everett C. Hughes, and Anselm L. Strauss, Boys in White: Student Culture in Medical School, Chicago: The University of Chicago Press, 1961.

[3] Wayne Plasek, "Interaction Patterns and Attitude Change: A Study of Professional Socialization," unpublished Ph. D. dissertation, University of California at Berkeley, 1967.

studies of personnel in organizational structures are available in sociology. Peter Blau's study of a department of a state employment agency and a department of a federal enforcement agency;[1] Montagna's study of the operations of large accounting firms;[2] and Goffman's observational studies of the social climate in a mental institution are examples.[3]

In my particular case, the initial observation approach consisted in going to all lectures and technique classes with each of the three classes at CIC, spending two weeks with each class (September and October of 1967). On a normal day, this entailed a schedule from 8:45 A. M. to 2:30 P. M., with six class hours per day, five days a week. During my weeks with the seniors I also spent a good time in the out-patient adjusting clinic since seniors serve as externs three days a week, from 3:00-8:00 P. M. After the first six weeks of observation, I was careful to spend at least six classroom hours at the School every week (sometimes double this amount of time) for a period of some four additional months.

---

[1] Peter M. Blau, The Dynamics of Bureaucracy (Rev. Ed.), Chicago: University of Chicago Press, 1963.

[2] Paul D. Montagna, "Bureaucracy and Change in Large Professional Organizations: A Functional Analysis of Large Public Accounting Firms," unpublished Ph. D. dissertation, New York University, 1967, p. 35 and infra.

[3] Erving Goffman, Asylums, Garden City, New York: Doubleday and Co., Inc., 1961.

My procedure in terms of recording observations was always the same. I made it a point to type up my notes for any given day of observation that same evening, so that I ended up with a field note journal of some 130 single-space typewritten pages upon which to draw for illustrative materials and theoretical formulations. Included in these notes are occasional memoranda and summaries which I wrote from time to time. These notes also include a record of informal conversations I had with students and faculty.

The actual mechanics of note-taking during the school day created some initial difficulties. Blau recounts that his too-early note taking in the presence of his sample created problems with rapport and acceptance,[1] and I had his difficulties in mind when I first began to sit in on classes. But I found almost immediately that I could not remember much of the important happenings in classes and/or ideas that struck me during class if I waited until the evening to write anything down. I thus took a chance-- only a day or so after I began-- and started note-taking right alongside the students, hoping that their own preoccupation with taking notes on course materials would make my writing fairly inconspicuous. On the whole, this procedure did work out, although there were a number

---

[1] Blau, op. cit., pp. 279-280.

of jokes about my constant note taking during the 1st sessions with any class. Students would introduce me as "the guy who takes more notes than any of us" or as "getting a free chiropractic education down in his notebook." Blau appears to have been extremely worried about joking referrals to his note taking,[1] but I found this part of my interaction with students rather enjoyable. I didn't, of course, tell them what I was actually writing (although many of them asked, and one student once tried to grab my notes from a desk), and became adept at giving joking answers to that particular question.

During the first days of class observation I experimented with Becker's "perspective"[2] approach, looking for recurrent themes which pointed to anxieties or problems that students were concerned with. Although some of the material I gathered along these lines did eventually find itself into my main theoretical model, I abandoned systematic use of this technique very shortly because (1) being only one person (as opposed to Bekker's staff) I did not feel I was getting enough exposure to possible expression of perspectives and (2) too many of the classes, especially in the basic sciences yielded very

---

[1] Ibid., pp. 279-280.

[2] Becker et al., op. cit.; see Chapters 2 and 3 for the theory and methodology of the "perspective" approach.

little perspective material, being mainly cut and dry expositions on subjects such as histology, myology cardiology, or analysis of spinal x-rays. But even those sessions with so much "dross"[1] material from the sociologist's point of view turned out to be valuable in that students became convinced I was "really interested" in them and chiropractic and thus were more apt to confide in me as the study proceeded.

Although my observations were mainly restricted to the situs of the school, I did also attend a student dance, several "lay" meetings which students found popular and a major rite de passage, the seniors' graduation at a New York City hotel in June, 1968.

Apparently most sociological observers-- participant or not-- encounter certain crises in their field work. Blau,[2] Smigel,[3]

---

[1]The term is derived from Webb's discussion of the "dross-rate" defined in this manner: "In any given interview a part of the conversation is irrelevant to the topic at hand. This proportion is the dross-rate." Eugene J. Webb, Donald T. Campbell, Richard D. Schwartz, and Lee Sechrest, Unobtrusive Measures: Nonreactive Research in the Social Sciences, Chicago: Rand McNally and Company, 1966, p. 32.

[2]Blau, op. cit., pp. 279-286.

[3]Erwin O. Smigel, The Wall Street Lawyer: Professional Organization Man?, Glencoe: Free Press, 1964, pp. 17-21.

and Polsky[1], among others, all describe tense phases or episodes in their researches. I most certainly had my share of crises, and because they tell me something of the chiropractic subculture, they deserve some discussion.

My "entry" problem was rather severe. Chiropractors have not welcomed research in the past, as the Stanford Report's experience in California indicates.[2] It is most improbable that I would ever have gained admission if I had not been friendly with a young chiropractor who had recently been appointed Academic Dean, and who was highly regarded by the powers-that-be. In any case, he obtained a commitment from the President of CIC that I would have observational carte blanche at the School, and this commitment, except for a few unimportant small exceptions, was kept.

---

[1] Howard W. Polsky, Cottage Six, New York: The Russel Sage Foundation, 1962, pp. 109-121.

[2] See page 203 of Chiropractic in California, op. cit., where a letter from the Hollywood College of Chiropractic rejects admission of the Stanford Research Institute Survey to its students and premises. The Hollywood College letter states a sentiment that I have come across on other occasions about research into the chiropractic profession: that the profession itself is best qualified to do an objective job. For the same theme see "Self-Analysis Through a One-Way Mirror" in The Journal of Clinical Chiropractic, 1 (Spring, 1968), p. 10, which is a chiropractor's critique of Oromaner's study of influences responsible for choosing chiropractic as a career: "Mr. Oromaner would appear to give evidence of expertise by his 'form' of analysis, were it not for the

"Maintenance" problems were a much slower torture than entry ones. At a number of points I had reason to believe that my research days at CIC were numbered. Since these occasions preceded by months my completion of two extensive questionnaires which were absolutely necessary to the project, I had a number of bad nights.

It is difficult to be entirely precise about what prompted these research anxieties. There were, however, definite developments at CIC during my stay there which played a prominent part.[1]

---

fact that his Tables were arrived at by one who is not himself a student or graduate D. C. and hence can apprise student motivation ONLY as an outsider looking in. There is no mention of 'close collaboration' with a D. C. for truly objective study and analysis /my emphasis/, regardless of permissive findings."

[1] In "Some Psychological Techniques and Objectives in Anthropology," Morton H. Fried (ed.), Readings in Anthropology, vol. 2, New York: Thomas Y. Crowell Co., 1959, pp. 47-48, Cora DuBois discusses "personality factors of the field worker" as an important ingredient in resultant data. One of her main points is that the field worker (in anthropology and sociology) should have some idea of how his own particular problems, biases, preferences, might interact with the mood, values, etc., of the culture he is studying. During the course of my field work I had more than one occasion to wonder whether my anxieties about being "thrown out" of CIC were more a function of my own personality than the actual reality of the situation. Looking back, however, I have come to the conclusion that my field work anxiety syndrome was caused mostly by the fluctuating moods of the administrators at CIC, who perceived themselves as constantly in a crisis situation. The crisis mood of CIC is discussed in the next chapter.

Perhaps the most crucial development which threatened my research was CIC's bid for a "charter" from New York State. Apparently CIC has been attempting to get chartered by the State for quite some time, but only recently had she compiled the necessary minimum capital to make her eligible. To get a charter would yield several immediate rewards including a soar in prestige for the profession and state economic support (and derivatively HEW federal funds which all chartered New York State schools receive). While I was doing my field work it appeared as if things were coming to a head. There was constant talk about "The Charter" among students and faculty, rumors flew about the imminent visit of state inspectors, several special assemblies were called by the President to encourage morale. The worry from my side was that under these conditions my ubiquitous presence might be conceived as detrimental to CIC's chances, since I might, even unwittingly, convey information about CIC to state officials which was unfavorable to CIC's image.

My worries were exacerbated about this time by my finding out the fate of research begun by a fellow graduate student of the N. Y. U. Sociology department at CIC in 1963. He had gained permission to study CIC students and had gone to considerable difficulty in constructing a research plan and a questionnaire. At that time, New York State chiropractors were engaged in a fight to have

chiropractic licensed in New York. Eventually the student was peremptorily informed that his research project was cancelled in the "best interests of chiropractic" at that time. Since I had obtained much more "guilty knowledge" than my predecessor (who never really got started in the field) in my months of contact with students and faculty, I felt my position to be very dangerous. In any event, the crisis somehow blew over, and to my knowledge New York State has made no decision to this date (some twelve months later) on CIC's application.

It is my feeling that some students and faculty always secretly suspected me and my motives in some part of their chiropractic souls. This suspicion emerged on several occasions although always veiled with the disguise of humor. For example, in the 1968 version of the School Yearbook, The Columbian, there is a picture of me sitting in a classroom in my characteristic note-taking posture. The caption reads "The Spy From Harvard" (many of the students knew I had attended Harvard). Another day in a class with the Seniors, someone jokingly said "Don't say that while Dave's here. He's really a spy for the AMA." I jokingly responded with "That's right, I really am." To my astonishment this remark was met with absolute silence and stares in my direction. I recall that moment of the research as the one of absolute dead calm. Wardwell

writes about chiropractors as perceiving themselves as an "oppressed minority"[1] and observations like the above indicate that this culture pattern is at least part of the total picture.

On the other hand, a contradictory tendency toward openness and full revelation on the part of this group manifested itself. Involved here was the genuine friendliness that many of the students extended me, a friendliness that I reciprocated in many cases. I discuss the "open" quality of my respondents in the following section on informal interviews.

Informal Interviews at CIC

Whereas my "observation" procedure consisted in the main of watching CIC students and faculty interact among themselves, I also carried on numerous conversations with people at School, many of which I initiated. In many instances I asked questions about what I had seen or heard in classes or in informal discussions to which I had listened. My field notes are essentially a combination of watching and interviewing students and teachers.

Within a very short time after my entrance, I found that students were constantly taking me aside for a few minutes'

---

[1] Walter I. Wardwell, "Limited, Marginal and Quasi-Practitioners," in Freeman et al., Handbook of Medical Sociology, op. cit., p. 226.

conversation to "set me straight" or "show me the ropes" about CIC.[1] Like Wardwell,[2] I was very surprised at the frequency of critical remarks which students made about each other, the faculty and the School (the substance of some of these comments is discussed in Chapter 4). This internal vindictiveness was one of the first clues I had to the "individual" set in chiropractic.

I made it my business to "get around" to as many students as possible, using class period breaks, coffee breaks, after school lulls, and lunches to talk with student after student. Almost invariably I found that students would open up and be quite frank about the School and the profession if I could get them on a one-to-one (or even a bit larger) basis. The "secrecy and suspicion" atmosphere which I discussed in the preceding section seemed more

---

[1] Interestingly, several faculty members also took me aside to broach the subject of my faulty posture. According to their specially trained eyes and point of view I walked with a marked slouch. Could I not try to straighten up? -- such a change being beneficial for my own health (less tendency toward subluxations) and the image of the School! Thus, as Smigel changed his habit of going hatless to appease his lawyers, I changed by posture habits to appease my chiropractors. See Smigel, op. cit., p. 22.

[2] Walter I. Wardwell, "Social Strain and Social Adjustment in the Marginal Role of the Chiropractor, op. cit., p. 363.

characteristic of the School administration than the students. At times I had the distinct feeling that students were using or perceiving me as an ally against the administration for which most of them had a good deal of dislike and resentment. It was necessary to be quite discreet about how I responded to their often bitter attacks on CIC, since over-identification with the students would have put me in "hot water" with the faculty and administration.

With both my observation and interviewing approaches-- which of course ran together in many cases-- the problem of "guilty knowledge"[1] frequently appeared. That is, I was witness to considerable deviant behavior on the part of students, faculty and administrative personnel.[2] One problem was keeping my

---

[1] Hughes discusses the problem of "guilty knowledge" in a different context: the knowledge that the professional has about his client. Everett C. Hughes, Men and Their Work, Glencoe: The Free Press, 1958, pp. 80-82. The kind of "guilty knowledge" to which I became exposed as a field worker is discussed sensitively by Melville Dalton-- who confronted similar compartmentalization problems in his study of Men Who Manage; "Preconceptions and Methods in Men Who Manage," in Phillip E. Hammond (ed.), Sociologists at Work, New York: Basic Books, Inc., 1964, pp. 50-95.

[2] All of the deviant behavior I personally witnessed was deviant or illegitimate in terms of the rules of CIC, not in terms of the larger legal system. But there was a good deal of talk on the part of both students and some faculty which supported the violation of certain parts of the chiropractic law regulating the scope of practice in New York. Students were encouraged by some instructors to ignore parts of the chiropractic law which were "unfair" or "discriminatory." I did not have, then, the very urgent problem,

guilty knowledge in separate compartments-- not to reveal to the administration or faculty forbidden behavior on students' parts, and vice versa. For example, I knew that students adjusted each other in situations prohibited by official School rules, and that they used diagnostic techniques that were forbidden. I also was privy to slanderous attacks made by some students about certain faculty and administrators. On the other hand, I knew that the faculty and administration "played favorites" to some extent when evaluating transfer credits and marking make-up examinations. I knew in a general way that certain students were kept on well after they had failed more than the maximum number of courses, after which dismissal should have occurred. I also heard scandalous attacks by some faculty members on certain students. That students, faculty and administrators continued to confide in me about "confidential," or "touchy," or "personal" matters that were negative to the image of the School as a highly professional site and to break rules in my presence is some demonstration that I was successful on the whole in compartmentalizing my "guilty knowledge," and gaining their trust.

---

that some field researchers face, of being witness to illegal acts, crimes and so on which can entail forced choices about whether to report such behavior, etc.

Over a period of time at CIC I became in a sense what Goffman would describe one of "the wise." The wise are "persons who are "normal" but whose special situation has made them intimately privy to the secret life of the stigmatized individual and sympathetic with it, and who find themselves accorded a measure of acceptance, a measure of courtesy membership in the clan."[1]

The Two Questionnaires

From the time I began my field work I had planned to complement the "qualitative" data gathered by observation and informal interview with more systematic "quantitative" data about the students. In March of 1968 I administered the first of the two questionnaires to students (N=89). This first questionnaire was of an exploratory nature designed to get a history on each student up to the time of his entrance to CIC. The second questionnaire administered in May of 1968 (N=75) was designed inter alia to gather data that would test certain hypotheses about adaptation to stigma on the part of CIC students. Both questionnaires are produced in their entirety in the Appendices to this dissertation. (Appendices A and B)

---

[1] Goffman, Stigma, op. cit., p. 28. To put it in Polsky's terms, I became an "inside-outsider." Polsky, op. cit., p. 119.

The questionnaires were pre-tested to some degree, but the scope of this procedure was limitdd by the relatively small number of persons available as a total sample. I did pre-test both questionnaires with two or three students at the School, with two chiropractors on the CIC faculty, with three of my students at Queens College, and one sociologist colleague. To some extent the first questionnaire became a pre-test for the second one. I was able to modify question form and content in the second questionnaire in terms of the results yielded by the first instrument. For example, it became clear in the analysis of responses to certain items in the first questionnaire that many respondents were unable to make a distinction between the alternative choices of "slightly important" and "unimportant," so that the "slightly important" response alternative was eliminated in the second questionnaire.

The fact that I remained in close contact with most members of my sample well after they took both questionnaires[1] also diminished the degree of possible error usually connected with limited pre-testing. In a number of cases respondents

---

[1] Montagna, op. cit., p. 41, notes the value to his research project of having his accountant respondents gene: available to him during eighteen months of contact.

approached me at School or called me at home (both actions I encouraged) when they found a particular question ambiguous. With two or three items I cleared up for the whole School in assembly possible ambiguities. More important, after reading students' responses, I was usually able to clarify inconsistent or incomplete answers by personal interviews. With both questionnaires my procedure was to go through each questionnaire as quickly as possible, transfer all responses to abbreviated code sheets (to facilitate later tabulations), mark items which needed attention, and then arrange talks with students. In most cases I successfully cleared up trouble spots. I was not able to follow such a procedure in some cases where respondents had already left CIC (graduated), but in these latter situations I followed up the original questionnaires with a detailed letter concerning particular omissions,[1] and so on. In the majority of instances these respondents answered and clarified the indicated items.

It is necessary to indicate just who were in the questionnaire samples, particularly why the number of respondents in each sample is not the same.

---

[1] If the omissions and/or contradictions were extensive in certain parts of a questionnaire, I mailed a new copy of the problem pages to the respondent, marking with a phrase or sentence where I would like him to be clearer or more complete, etc.

When I began this research in the fall of 1967 I had intended to confine my attention to full-time regular students currently attending CIC. During the fall and spring terms of 1967-68, this total population varied from 48-44. There were in addition 27 so-called "specials" whose significance will become clear in a moment. What should first be emphasized is that enrollment had sunk drastically in recent years. In the graduating class of 1967 (the class which had finished at CIC in the summer of 1967) there were 67 members alone. Why the current freshman-sophomore, junior and senior classes were small fractions of the size of the preceding senior class is not a simple trend to explain. At this point we can note that CIC's abandonment of an evening program (which existed for persons through the 1967 graduating class) plus New York State's new requirement that all chiropractic licensure candidates must have two years of pre-professional college training (in effect for candidates after January of 1968) were two important elements in the shrinkage. These two reasons were repeatedly offered by key administrative personnel when I asked them about the attendance drop.

The 27 "specials" were "graduated"[1] seniors from the Class of 1967 who, for one reason or another had not completed the necessary credit hours for graduation. These students were humorously called "superseniors" by many of the "regulars." Some had failed courses and never made them up, some were

---

[1]Actually graduation takes place in June, some eight weeks before seniors have completed their final term at CIC; thus no one has really graduated at the earlier date, and it is already clear that some students will not have completed degree requirements by the end of the term, in August. It transpired that about 40 percent of the Class of 1967 had to return to CIC in the autumn of 1967 for additional work.

The School insists, moreover, as a degree-conferring condition, that all students in a particular senior class attend graduation exercises, regardless of their true academic condition at the time. Apparently the June commencement date is chosen to keep CIC's "image" in line with other types of professional school (medical, dental, law), which normally graduate classes in June.

This type of premature graduation seems very atypical of other health professions. The only similar procedure I recall is the practice of some high schools to give "placebo" diplomas to avoid embarrassment on the part of failures and their relatives. In the CIC case, however, it seemed to me that the giving of "diplomas" to students who were clearly not going to finish by the end of the summer term was primarily a face-saving device for CIC, rather than for these students and their families, to give the picture of a professional school putting out fully trained new members on a regularly scheduled and reliable basis.

making up penalty "hours" for infractions of rules,[1] some were making up clinic hours they lacked. In a few instances were students who had come into the 1967 cohort a term late, and had to wait until eight successive terms were completed before they could make up the first term of the course.[2] There were several cases where a number of the above reasons for extra attendance were present in the same person. The comings and goings of these special students were very vague, and in any case, I payed no systematic attention to them at first, since I had not contemplated them as part of the questionnaire sample. But in light of the small size of the "regular" three classes of students, I eventually included the entire 1967 graduate class (both those who had to return in September, 1967, after "graduation" for additional courses, hours or terms, and those who had really

---

[1] CIC's official rules and regulations can be found in its Bulletin for 1966-68, pp. 45-46. Rules for which one can receive penalty or make-up hours include those against obscene language, smoking on the premises, improper attire.

[2] The complete program at CIC is a 9-term course, running consecutively over three years (with no summer vacations), but providing the same number of hours as a 2-semester four year course. Essentially there are three classes then, each with three terms of instruction: Freshman-Sophomore, Junior and Senior. Each class begins anew in the fall of a given year. But usually only one term of each of the three classes is taught in any given semester. For example, if a person came to CIC in the winter of 1968 he would have to begin as a second-term Freshman. He would then continue for eight terms, and make up the first term he had missed at the end of his program-- an unhappy arrangement (both students and School agree), but one necessitated, claims the School, by lack of funds and insufficient numbers of students.

graduated in August, 1967 free of "encumbrances") in my target population for the 1st Questionnaire and part of the 1967 class in the target group for the 2nd Questionnaire.

Table 2-1 indicates how many respondents, by academic class[1], returned the two questionnaires:

Table 2-1. Extent of Response to Two Questionnaires, by Academic Class at CIC

	Number Returning 1st Questionnaire	Number Returning 2nd Questionnaire	Total Number in Target Population[a]
Sophomores[b]	20	16	20
Juniors	17	17	17
Seniors	11	11	11
1967 Graduates	41		67
1967 Graduates		31	35

[a]Target populations for Sophomores, Juniors and Seniors were (a) the same size and (b) the very same persons for both questionnaires. Why the target populations for the 1967 Graduates varied from the 1st to the 2nd Questionnaire is discussed below in the text.

[b]Throughout this study the terms "Sophomores," "Juniors," "Seniors" and "1967 Graduates" are capitalized when they are used in presentation or discussion of tables, or in quotations from specific class members.

[1]By the spring of 1968, when the questionnaires were administered, the freshmen who began in the fall of 1967 were already being termed "Sophomores," a convention which I adopted in all subsequent table references in this thesis to the Freshman-Sophomore class.

On the 1st Questionnaire the return rate for the "regulars" is 100% of the target population; 61% of the 1967 Graduates returned the 1st Questionnaire. That I should have had less success with the 1967 group is not surprising. First, unlike the situation with the regulars, where I knew almost every student rather well, I personally knew less than half of the 1967 Graduates (for the most part only the "specials" who had returned in the fall of 1967) so that the lever of personal appeal for questionnaire return was considerably reduced with this group. Second, I had to send the majority of the 1967 Graduates questionnaires by mail (with enclosed stamped and self-addressed envelopes), whereas I distributed and collected all questionnaires from the regulars on a face-to-face basis, and the lower rate of return on mailed questionnaires is well-known.[1] Follow-up letters were sent to all recipients of the 1st Questionnaire who did not return them within two weeks of their receipt. I also asked certain faculty members and regular students who knew various members of the Class of 1967 to call them and urge their cooperation. These follow-up procedures were moderately successful. In two or three cases the mailed questionnaires

---

[1] Although there is a good deal of variance among groups in percentage of returns, the more literate and the "professional" being better return risks. See Claire Selltiz, Marie Johoda, Morton Deutsch, and Stuart W. Cook, Research Methods in Social Relations (Rev. Ed.), New York: Holt, Rinehart and Winston, 1962, pp. 241-242.

returned unopened, stamped "Address Unknown," and CIC, which had provided me with an original address list of the graduates, was unable to locate them. Eighty-nine students, then, out of a total target population of 115, or 77%, returned the 1st Questionnaire.

For the 2nd Questionnaire, the return rate for Seniors and Juniors was once again 100%, it was 80% for the Sophomores, and 89% of the 1967 Graduates to whom the 2nd Questionnaire was sent responded. No 2nd Questionnaires were sent to members of the 1967 class who had not responded to the 1st one, since my plan of data analysis precluded the use of 2nd Questionnaires without the accompanying 1st ones. In addition, six persons who had returned the 1st Questionnaire were not recontacted for the 2nd one, since they had indicated in the 1st that they were already licensed and in practice, and the nature of the 2nd Questionnaire (with many key predictive items based on the assumption that respondents were not yet licensed or practicing) was such that these six 1967 Graduates were not appropriate. Eventually, then 31 of 35 1967 Graduates to whom the 2nd Questionnaire was mailed responded. Seventy-five students, then, out of a total target population of 83, or 90%, answered the 2nd Questionnaire.

Because of the crisis at CIC caused by its bid for a New York State Charter, I was forced to exercise a certain degree

of "self-censorship" with the 2nd Questionnaire. After showing the 1st Questionnaire to the Academic Dean, and gaining his approval, without changes, I had immediately distributed it to students, allocating a copy to the President and the "Front Office." A week before distribution of the 2nd Questionnaire I was told by the Academic Dean that the President had been "concerned" that he had not seen the 1st Questionnaire prior to distribution and would like to see the 2nd one before I proceeded with distribution. At the time the questionnaire contained questions about CIC's chances for getting the Charter as well as certain probes about the extent of rule-breaking behavior. I carefully went through the questionnaire and excised items which I felt might be very threatening to the administration. Given the unpredictable nature of the key administrative figures at CIC combined with the charter crisis, I did not care to take any chances with their suddenly suspecting my motives just on the verge of the completion of my data collection. Looking back, I believe my action in this respect was correct.[1] In any event the deletions had no ultimate effect on the hypothesis-testing.

---

[1] On the need for the researcher to be willing to modify his research demands when confronted with unexpected or "touchy" areas of resistance on the part of his sample, see Smigel, op. cit., pp. 21-22.

Interestingly, a number of students indicated (in a provided space for general comments about the research and the questionnaires) their displeasure that more chances to be critical of CIC were not included in the 2nd Questionnaire. These attitudes supported by feeling that students perceived me as an ally against an administration they disliked and feared.

Unobtrustive Measures

By "unobtrusive measures" Webb, Campbell, Schwartz and Sechrest mean "social science research data not obtained by interview or questionnaire."[1] Observation of the type I practiced at CIC would not be termed unobtrusive, since my observer role had at least some effect on the behavior of persons observed. Unobtrusive data about a social group under study is data obtained through no or very minimal direct contact with people in the group. Webb cites physical traces, archives and exterior physical signs as important examples of unobtrustive measures.[2]

I was able to employ certain "archive" records-- particularly publications put out by CIC, like its curriculum Bulletin Yearbook, Alumni Newsletter, and articles written about

---

[1] Webb et al., op. cit., p. 1.

[2] See ibid., Chapters 2, 3, and 4.

the School appearing in chiropractic journals to paint a picture of the discrepancy between "ideal" and "real" at the School.

My constant "hanging around" the School premises produced valuable unobtrusive data. For example, I discovered by "popping in" the library very frequently that practically no one used it; and by remaining some time after 2:30 day after day, it became apparent that very little after-school clique interaction took place. The unobtrusive data about the low-rate of library use provided a "real" indicant about the meaning of the library for students to set off against CIC articles in journals about the important role of the library in the students' daily round of events. The fact that the student population vanished in all directions immediately after the last bell provided an objective indicant of CIC's "low sequestration" feature,[1] a feature which was corroborated by "obtrusive" data from the 2nd Questionnaire given to students.

Contrary to the vast majority of the students I used the CIC library a good deal. In plentiful array were chiropractic journals, such as the American Chiropractic Association (ACA) Journal of Chiropractic, the International Chiropractors Association (ICA) Journal of Chiropractic, The Digest of Chiropractic Economics,

---

[1] The concept of degree of sequestration or isolation during a socialization experience is discussed fully in the beginning of Chapter 5.

and The Journal of Clinical Chiropractic; texts on chiropractic philosophy, notably the collected volumes of B. J. Palmer; up-to-date reports from the Council of State Chiropractic Examining Boards on various state licensure examinations, with detailed descriptions of the nature of the tests and composition of examining boards (chiropractic, medical, mixed).

Available as well were back issues of a CIC newspaper (no longer in existence), back issues of the Alumni Newsletter and many CIC yearbooks. These sources were helpful in getting some historical picture of the School. One point that struck me immediately as I perused the old yearbooks was how similar the central activities of the students seemed to be. The same pictures of students adjusting each other[1] -- with the exact same stance and

---

[1] Chiropractic students spend a good part of their total training hours stripped to the waist, first palpating and then, at a more advanced stage, adjusting each other for practice before they treat patients. Indeed the extent to which chiropractic students practice the main techniques of their therapeutic trade upon one another is peculiar to this group of health students in contrast with say, medical recruits. To be sure, medical students undoubtedly practice certain diagnostic tests and techniques (e.g., blood pressure, eye examination, blood tests) with fellow students as "patients," but in the nature of medicine, whose central therapeutics are drugs and surgery, the main techniques cannot be practiced arbitrarily on healthy persons.

An important difference between how chiropractic and medicine view disease comes out here: Chiropractic argues that everyone needs and can benefit from a spinal adjustment most of

table equipment-- peer out at one from ten or fifteen years ago as from the most recent yearbooks.

The CIC library also contained numerous numbers of publications designed for the layman and chiropractic patient. Very prominent among these were Voice for Health,[1] Abundant Living[2] and Healthways.[3] There were also numerous small pamphlets discussing the curative aspects of chiropractic for many sorts of disease. Most often, no author or publisher was identified on them. These latter kinds of publications are found very frequently in chiropractors' offices as well.

---

the time, while medicine confines its therapeutics to defined illnesses and disease syndromes.

Over a period of time CIC classmates get to know the problems of each others' vertebral columns, ultimately giving much more specific adjustments than the general ones they began with. When students first begin to adjust each other they sometimes create temporary illnesses, like stomach, back, or headache, due to incorrect adjustive thrusts to the spine. I heard them contend on a number of occasions that the emergence of such symptoms directly after incorrect adjustments was "proof" that chiropractic "worked."

[1]Voice for Health, Atlanta: National Health Education Society.

[2]Abundant Living, John H. Stoke, Editor, Roanoke, Va.

[3]Healthways, Des Moines, Iowa: The American Chiropractic Association.

Collection of Comparative Data from Other Health Students

Data was collected from NYU dental and medical students to strengthen the confidence in crucial findings about the separation of self from other in the area of economic success which the CIC students exhibited. This supplemental questionnaire data was gathered in the fall of 1968 (a copy of these questionnaires is found in Appendices C and D) and was expedited by the assistance of Professors Smigel and Quinney. Just how those data fit in with the hypotheses-testing in this dissertation (as well as details of these samples) is discussed in Chapter 6 on "Autistic Tendency." Data from these other health groups was also used in a comparative way in Chapter 7 on the continuing "solo practice" style in chiropractic.

CHAPTER THREE: THE COLUMBIA INSTITUTE OF CHIROPRACTIC: THE SCHOOL, THE FACULTY AND THE STUDENT BODY

THE SCHOOL

A Brief History

There is no really adequate written history of CIC available, although one can garner bits and pieces of its development by consulting old School Yearbooks or by talking with older members of the faculty and administration who have been connected with CIC for many years. The CIC Bulletin contains a "Brief History" of the School, and it, scanty as it is, provides perhaps the best historical summary:

> The Columbia Institute of Chiropractic, founded by Frank E. Dean, was established in 1919 and is the oldest accredited Chiropractic school in the East incorporated as a non-profit institution. The initial facilities were housed in a modest dwelling on 72nd Street in New York City from 1919 to 1921. The Board of Trustees of Columbia purchased one four-story building located at 261 West 71st Street in November, 1921 and established a new home for the Institute. In April, 1923 a second four-story structure was purchased (263 West 71st Street) to satisfy increased student enrollment. Continued progress prevailed throughout the years. Improved Faculty staff, revision of the curriculum and

departmentalization paralleled the standards and requirements of institutions of higher learning.

In June, 1954 the Columbia College of Chiropractic of Baltimore, Maryland, consolidated with Columbia Institute of Chiropractic of New York City. The younger of the two institutions was also dedicated to the highest standards of professional education.

On November 29, 1959, Ernest G. Napolitano was appointed by the Board of Trustees to the position of President. During the month of January, 1960 the Trustees approved an extensive renovation program. The modernization was completed in August, 1961. The library, laboratories, classrooms, executive offices, clinic, x-ray laboratories, student lounge and audio visual aid lab were all newly furnished.

On September 21, 1964, the Atlantic States Chiropractic Institute merged with the Columbia Institute of Chiropractic. Under the terms of the agreement, the surviving institution was identified as being the Columbia Institute of Chiropractic. The merger brought about a true blending of the two institutions and retained support of the Alumni of both schools.

For almost half a century, the Columbia Institute of Chiropractic has experienced many changes in the quality of faculty, curriculum and administration. The present staff meets the needs and requirements of an institution of higher learning. The depth of material offered in our curriculum adequately prepares our students to accept their responsibility as Chiropractors within their chosen community. Considering the total picture, Columbia has kept abreast of the social, cultural and academic developments. [1]

---

[1] The Columbia Institute of Chiropractic Bulletin (hereafter the CIC Bulletin) for the year 1966-68, page 10.

We see then that CIC is fifty years old, and that it has absorbed two other chiropractic colleges within the last fifteen years.

Physical Plant and Facilities

Again from the Bulletin:

> Columbia is the most modern Chiropractic school in the East. The facilities at the Institute have been recently modernized to include thoroughly equipped laboratories for Histology, Bacteriology, Chemistry, and Pathology.
>
> The library contains more than 3000 volumes which are available to students on a loan basis.
>
> There are eight spacious scientifically illuminated classrooms, student lounge and lunch room and three large technique rooms equipped with modern Chiropractic adjusting tables specially designed for the various techniques taught.
>
> The Institute is completely equipped with a spinographic laboratory (X-ray). Inasmuch as Spinography is so essential in Chiropractic analysis, this equipment has been specially designed for our purpose. [1]

The Bulletin's "Brief History" and section on "Facilities" are not totally free from error or exaggeration on all points. Indeed, CIC's Bulletin typifies much of the chiropractic literature I have read during my research: a combination of true and false assertions, where it is often difficult to unravel the two aspects. Nor

---

[1] Ibid., p. 11.

can one be sure that the false or misleading statements are made in a deliberate or calculating way; some defensive tendency to exaggerate or self-delude may well exist among chiropractors, particularly those delegated to represent their occupation and its training schools to both fellow chiropractors and the public.

Returning to the Bulletin, how is this blend of truth and falsehood manifested in the above-quoted sections? The statement, for example, that "Columbia is the most modern Chiropractic school in the East" loses some of its impressiveness when one knows that only two chiropractic colleges exist in the East, and that the second one (another school located in New York City) is rumored to be on the verge of closing its doors. The library-- at least during the year I spent at CIC-- contains no where near 3000 volumes. The student lounge and lunch room are non-existent. The classrooms are well illuminated, but most of them are oppressively small rather than spacious; in a number of classrooms the blackboards are in such poor condition that one can hardly write on them (a subject of constant complaint among teachers and students).

On the other hand, it is true that the school possesses three large and very adequate technique rooms equipped with modern adjusting tables, and it is true that its X-ray facilities

are extraordinarily good.

The overall ambience of the School is rather shabby and confining. As we shall see, students shared the observer's feelings in this respect.[1] During five-minute recesses between classes students take to the sidewalk in front of the building (if the weather is not too inclement), since the School has no other "campus." Much of my most valuable "inside" information was picked up standing around with various groups of students during class breaks. The fact that the mood of the premises is dreary and that one literally has no where to go outside of the classrooms per se contributes, along with other features to be discussed, to the almost complete dispersal of students as soon as the last bell rings at 2:40 P. M.

Who Runs CIC?

On paper CIC's structure of authority is lengthy and rather complex. Without listing their respective duties, we can

---

[1] See Table 3-8, infra, in this chapter on students' dissatisfaction with CIC's physical plant.

note that the Bulletin[1] names the following persons and committees in CIC's organizational chart: (1) a Board of Trustees, (2) a President, (3) an Administrative Dean, (4) a Dean of Faculty, (5) a Dean of Students, (6) an Educational Consultant, (7) a Registrar, (8) a Director of Education, (9) a Faculty Advisory Board, (10) Department Chairmen, (11) a Clinic Director, (12) an Executive Committee, (13) a Library Committee, and (14) an Executive Secretary. But again, the official picture is somewhat at odds with the real one.

The truth of the matter is that only six of these persons (none of the groups) play crucial roles in the day-to-day running of CIC's activities and policies: The President, the Administrative Dean, who is the President's assistant, the Registrar, the Director of Education, who schedules courses, the Clinic Director, in charge of the out-patient clinic which is open three days a week, and the Executive Secretary, who is the President's personal secretary. Some of the other positions are statuses without behavioral roles (e.g., the Dean of Faculty and the Educational Consultant) regardless of what ideal duties the official plan of organization might prescribe for them, while other positions

---

[1] CIC Bulletin, op. cit., "Plan of Organization," p. 9.

simply do not exist in terms of any person occupying them--for example, there is no librarian at CIC whom I was ever able to discover.

Even as among these six, opinion was divided among students, faculty and administration as to who really "runs things." Some maintained that the President was all powerful, others contended that he and the Clinic Director controlled the School. Still others felt that the "front office,"[1] consisting of the Administrative Dean, the Registrar and the Director of Education shaped School policy despite some appearances to the contrary, and that the President was blissfully unaware of the daily pressing crises and controversies that beset the School and its students. This lack of consensus about allocation of power and authority at CIC appears to parallel a lack of consensus about the structure of authority in the chiropractic profession at large, which Akers and Quinney[2] have demonstrated elsewhere.

---

[1] Although the CIC students constantly used this term to designate these administrative officers, it is my impression that "front office" much more frequently describes the administrative unit of a factory or plant than of a professional school.

[2] Ronald L. Akers and Richard Quinney, "Differential Organization of Health Professions: A Comparative Analysis," American Sociological Review, 33 (February, 1968), especially pp. 117-121.

Student Activities

The Bulletin[1] notes the presence of two fraternities at CIC, a Student Council which "meets weekly to discuss student problems with the Faculty Advisory Board," a Junior American Chiropractic Association Chapter, a Toastmasters Club, a Cultural Society and an athletic program "composed of students, faculty and alumni of the Institute under the direction of the Dean of Students. My observations were that the fraternities were virtually non-existent as far as membership and function went (not once during my time at CIC did I hear a discussion about a fraternity meeting, function, and so on). Nor did I come across a Toastmaster Club or a Cultural Society. The athletic program which the Bulletin describes existed a few years ago, but is now defunct. There is, in truth, a Student Council, but it meets irregularly and its influence (according to my discussions with its current President and other members) on School policy is minimal. In short, in terms of para-curricular and extra-curricular activities at CIC, few exist. CIC students appear to have little to do with each other outside the classroom situation (a point broadly documented in Chapter 5), a factor which cannot

[1] CIC Bulletin, op. cit., p. 13.

help but seriously hinder the formation of a student subculture capable of being mobilized for concerted group action.

The Course of Study

To receive a degree of Doctor of Chiropractic from CIC, students must attend nine semesters of classroom and clinical instruction, extending over a three year period. The total hours in such a course of instruction are 4,488, a figure somewhat lower than the academic hours spent in a four-year medical college.[1] Most chiropractic colleges, e.g., The Chiropractic Institute of New York and the Palmer College of Chiropractic, now require somewhere in the neighborhood of 4,400 hours of residential work for a degree (the equivalent of a four-year two semester professional school).[2] During his

---

[1] See, for example, College of Physicians and Surgeons (Columbia University) Bulletin for 1967-1968, pp. 28-29, where the "Summary of Studies" indicates 5,449 academic hours in the four-year program leading to the medical doctorate.

[2] The Chiropractic Institute of New York, Bulletin for 1967-1969, pp. 18-22; Palmer College of Chiropractic, Bulletin for 1967-1968, pp. 81-82.

According to Wardwell all current chiropractic colleges are four year colleges, although the work is often offered in a condensed tri-semester three year time period. Walter I. Wardell, "Limited, Marginal, and Quasi-Practitioners," in Howard E. Freeman, Sol Levine, and Leo G. Reeder, (eds.) Handbook of Medical Sociology, Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1963, p. 226.

nine semesters at CIC a student must take a total of 132 courses.[1] Even though there is, to be sure, a good deal of overlap and repetition among many of the courses, the students must take examinations in most of these courses, which places a very heavy psychological burden on their shoulders. The sheer number of examinations to negotiate combined with virtually no extended vacation period in which to recuperate for a length of three years is one of a number of unhappy elements in CIC students' lives.

The CIC courses[2] can be divided roughly into three basic areas of study: (1) courses directly concerned with chiropractic, including the theory of chiropractic as a healing art, manipulative techniques of chiropractic, and clinical instruction (most often with patients); (2) basic science courses dealing with subjects such as anatomy, physiology and chemistry; and (3) medically-related subjects, such as X-ray procedure and interpretation, physical diagnosis and pathology.

---

[1] The corresponding number of courses at The Chiropractic Institute of New York and Palmer College of Chiropractic (with essentially equal total required hours) are 84 and 53. The College of Medical Surgeons schedules 66 courses in its 5,449 hours.

[2] A listing and description of all CIC courses is found in the CIC Bulletin, pp. 22-44.

Of the 162 courses, 59 of them, or 45% of the total are specifically chiropractic courses, 38, or 29%, are basic science ones, and 35, or 27% are best characterized as medically related courses. Looking at the curriculum in terms of hours, 1688 hours, or 39% of the total required 4488 hours for a chiropractic degree, are specifically devoted to chiropractic. Another 1404 hours, or about 31% of the total, are devoted to basic science subjects, and 1296 hours are given to medically related subjects, these last hours constituting some 29% of the total CIC curriculum, hour-wise. Analyzed, then, either by number of courses or by classroom hours, we see that the chiropractic curriculum wins a plurality but not a majority of emphasis. These statistics are especially interesting in the light of CIC's assertion that "/CIC/ offers only one course-- a course in Chiropractic."[1]

Of course, one can argue with some conviction that the basic science courses, dealing as they do with the functioning of the human body, are vital to the education of any type of health practitioner. Even so, 30% of the curriculum remains which is medically-oriented, a statistic which does not set well with CIC's contention that "The school is not a school of medicine, nor does

---

[1] Ibid., p. 2.

it hold itself out to be a school of medicine."[1]

In truth, a good deal of tension exists at CIC because of the coexistence of chiropractic and non-chiropractic courses, especially with the medical courses, but even to some degree with basic science subjects. My discussions with administrative officers of the School, as well as perusal of earlier curriculum bulletins, indicates that basic science and medical courses have multiplied rapidly in recent years. These administrators are convinced that these courses have been added to help students prepare for state basic science licensing examinations (which they believe are medically oriented), rather than because a new awareness of the need for such subjects in a chiropractic education has suddenly emerged.

Discussion with many students and faculty members revealed the same pragmatic and quite cynical attitude toward the non-chiropractic courses: Although there was a solid minority[2] which steadfastly maintained that one should have an

---

[1] Ibid., p. 2.

[2] In response to the question "During or after your chiropractic education are you planning to complete a non-chiropractic degree?" (Question 49, 2nd Questionnaire, Appendix B) 28 students indicated "yes." 22 of these degrees were a B.S., indicating unmistakable respect for basic science. Another way to look at these statistics on plans for a non-chiropractic degree, however, is to take them as a sign that many students are not satisfied with the "Doctor of Chiropractic" degree, and perhaps want a more generally accredited, accepted, or "respected" degree as well.

extensive grasp of anatomy, pathology, diagnosis (in the medical sense of that term), and so on, to be a complete doctor of chiropractic, the majority contended that such courses were "garbage courses" (this expression uttered by both students and faculty referring to non-chiropractic materials appears in my field notes literally dozens of times) that had to be learned to pass the biased basic science boards, but which would have virtually no value in their ultimate day-to-day practice of chiropractic. This same majority maintained that the influx of non-chiropractic courses artificially "blew up" the length of a chiropractic education by at least one year.

In terms of its curriculum, then, one gets a picture of a school divided against itself. On the one hand, a substantial hard-core of material directly related to its espoused aim-- training chiropractors-- exists in a continuing and hardy tradition. On the other hand, the necessity of successfully preparing its students for negotiations of essentially non-chiropractic licensing examinations forces it to offer a great deal of non-chiropractic material; this leads to embarrassing ideological contradictions in view of CIC's emphatic claims about being a "straight" chiropractic college. Viewed in this light, CIC might be seen as two schools: one teaching recruits the trade which they enrolled to learn; the other

school a kind of three-year "cram course" teaching recruits materials they must, reluctantly, absorb (at least until the state boards are done) if they are to obtain licenses to practice their trade.

CIC's Financial Position

The money to operate CIC comes from tuition payments and gifts and bequests from Alumni of the School and friends. The School receives no state or federal aid because it is not a chartered degree-granting institution under New York's educational laws. Nor does it receive monies from foundations (large or small). A few small scholarships are available. Tuition is $285 for the first term and $275 for the other nine terms.[1] The School, then, receives $2485 from every student who takes nine terms of work (a few students contribute less, since they took some chiropractic credits at another college, and some contribute more, since they fail to complete all requirements in nine terms and must stay on for one or more additional ones).

In 1967 CIC instituted a fund-raising campaign to attain several objectives. Quotations from one of the campaign circulars

---

[1] CIC Bulletin, op. cit., p. 17. Actually at this writing the tuition has been increased slightly from these figures.

gives a good picture of its financial resources and outlook:

> The enactment of the New York State Chiropractic Law in 1963 established chiropractic as a regulated profession. The requirements for a chartered degree-granting institution under the educational laws of New York State include, among other things, resources of $500,000. Columbia, in a realistic manner, is close to achieving this appalachian. Our present assets, including the ownership of our real properties at 261-263 West 71st Street, New York City, are in excess of $300,000.
>
> However, we do need your help to ascend this first plateau. We feel certain that our colleagues, friends, and benefactors are well aware of the advantages and the importance of a chartered New York State chiropractic college if the profession is to survive and flourish.
>
> Our goal for this project...$200,000.
>
> THIS MUST BE MET BY MAY 30, 1967.
>
> The second phase is designed to meet the capital needs of CIC... To construct new buildings and to improve its present facilities.
>
> Many worthy and qualified students are often required to interrupt their studies due to their inability to pay tuition and living expenses. Aid in the form of scholarships and campus employment will see many of these fine young men and women complete their professional training.
>
> If CIC is to continue its rapid rate of expansion and improvement, our faculty must be (financially) assisted...
>
> A new library will be constructed (projected in Capital Improvements)...

> A new clinic facility will be constructed (projected in Capital Improvements)...[1]

The drive to raise $200,000 to meet the Charter requirement was successful, for we read in the Alumni Newsletter of CIC (February, 1968) that "as a result of an energetic fund raising program initiated less than six months ago, the net assets of C.I.C. are $578,837.96 (as of a certified accountant's report dated October 29, 1967)."[2]

But the great majority ($500,000) of CIC's assets are "frozen," since they must be maintained intact to meet the Charter financial requirement. No one knows when, or if, the Charter will be granted, and so in terms of day-to-day operating expenses (as well as planned expansions, such as a new library or new clinic facility) the margin is very slim. The front office's and students' continued haggling over due dates for tuition payments, and the fact that two of the seven requirements listed by the Bulletin for graduation deal with satisfactorily clearing "all financial obligations,"[3] attest to the crucial role tuition payments play in keeping CIC financially afloat.

---

[1]"A Program For Action," 6 pages, no date.

[2]Alumni Newsletter of CIC, vol. 1, no. 7, February, 1968, p. 1.

[3]CIC Bulletin, op. cit., p. 18.

Still the raising of $200,000 by a relatively small educational institution was no mean achievement, and CIC's financial condition, although by no means strong or secure, appears to be somewhat better than many chiropractic colleges in the United States. Whether it will achieve its "expansion" goals (new buildings, library, and so on) is difficult to predict. Much hangs on the outcome of the drive to be chartered. In the middle of 1968, when I was still doing field work at the School (six months after the State inspection teams had visited CIC two or three times to examine its financial position, facilities and curriculum) a "lull" in the Charter issue seemed to have developed; if asked, students and administrators were betting against the Charter.

THE FACULTY

During the two terms (September, 1967 - April, 1968) at CIC when I did my field work, a total of twenty faculty members taught courses to the three classes of students (freshmen-sophomores, juniors, and seniors), although many more faculty were listed in the Bulletin.[1] All but one of these persons were

---

[1] Actually, the faculty is not listed in the main Bulletin, but in a supplement to it, under separate cover, with no date. Many of the current instructors were not listed in this supplement, and many of those listed made no appearance during my three terms

chiropractors, the twentieth being an elderly M. D. from eastern Europe, who taught certain medically-oriented diagnostic courses in very heavily accented English. Sitting in on some of his classes, one gained the distinct impression that he believed he was teaching medical students-- for example, he would make frequent references to surgical techniques, cautioning students never to make certain kinds of surgical incisions in given conditions. His lectures were treated largely as a "joke" by the upperclassmen, who often prepared for other courses or examinations during their hours with him. When I pursued this behavior with them, they hastened to tell me that he had once been a famous M. D. in Poland and still retained vast amounts of knowledge if you took the trouble to really listen to him. No doubt, the prestige of having an M. D. on the faculty was the chief factor in his continued employment.

Eight of these 20 possessed another academic degree besides the doctorate in chiropractic, most of them being B. A. s

---

of field work at the School. In reference to these latter persons, students sometimes joked about the "phantom faculty." Whether this listing of persons who were not actually teaching was another aspect of CIC's "image-building," or the consequence of more normal academic conditions-- such as catalogues designed to cover three academic years inevitably making mistakes in terms of any particular year's faculty-- is difficult to determine.

or B. S. s. One faculty member had a Ph. D. in education from New York University, and one an M. A. in Fine Arts from Columbia University. The courses which teachers gave were not necessarily consistent with their extra-chiropractic training. Thus many of the basic science and medically related courses were taught by people who had no degree in basic science (B. S.). Training in basic science was bound to suffer because of this condition, as it has in other chiropractic colleges. It was my distinct impression after attending classes for two months that the non-chiropractic courses were generally (although there were exceptions) taught with less competence and enthusiasm than the chiropractic ones, paralleling the "set" students had for the non-chiropractic courses.

Teaching loads were unevenly distributed among the 20 teachers. In the Fall term, for example, seven teachers (each teaching five or more classroom hours) accounted for nearly 60% of the total instructor hours. One instructor taught 15 hours, or 17% of the total (90 combined hours in any given week for all three academic classes).

Looking to teachers' ages, eight of the 20 were under thirty. Seven of the faculty had themselves graduated from CIC in 1966 or 1967.

This situation would occasionally create status conflict problems (teacher vs. friend status) for the young instructors when teaching upperclassmen with whom they had attended CIC. The administration attempted to mitigate this kind of difficulty by assigning recent graduates to freshmen-sophomore classes, but this was not always possible. In a medical school this problem would not, of course, arise, since medical graduates generally spend at least two years in internship programs before they are ready for teaching or private practice.

Eighty percent of the 20 teachers were either Italian or Jewish in ethnic background, with 55% being Italian and 25% Jewish. This is a larger percentage for these ethnic groups than in either of my student samples, where the Italian-Jewish percentage ranged from 60-65%. In addition, the Jewish subsample of students is larger than the Italian one. Why there should be such a heavy concentration of Italians among the "working" faculty is a question often posed at CIC by the students themselves. From the information I have been able to gather through conversations with faculty and administrative personnel plus limited access to early faculty records, Italian faculty membership has increased since the appointment a decade ago of an Italian President. In all probability,

friendship circles extending out from the President have brought more Italian chiropractors to CIC.

CIC constituted a full-time job for only one of the 20 faculty people, the Clinic director. The usual pattern was for an instructor to come in one day, or at most two days, a week for a few hours of instruction. Rather than being primarily devoted to a career in teaching, the main concern of the vast majority of these faculty members was their own private chiropractic practices, to which they gave most of their professional time. This was evident not only from their limited appearances at CIC, but in their frequent references to their practices in the School's classrooms. Students were constantly exposed to stories about situations "out in practice," a major element in their socialization to the occupation of chiropractic.

Eight of the 20 faculty members (most of these locating in New York) had not successfully negotiated all of their own state board examinations for licensure, so that students heard much about the problems of licensure as well as chiropractic practice.

From discussions with these teachers, I classified fully half of them as "preoccupied" with one or more of three personal career problems: (1) obtaining a license to practice, (2) building

a successful, i.e., large and profitable, practice and (3) the possibility of being drafted into the Armed Forces. A number of the younger teachers told me frankly that their major reason for teaching a course or two at CIC was to preserve (or create, if it was their first term of teaching) a college teacher military deferment.

A picture, then, of limited faculty-student contact at CIC emerges. At the same time, it was clear that many of the faculty were facing currently the very same crucial career problems that the students would themselves be confronting in two or three years, so that students paid rapt attention when faculty discussed their own crises; to this extent a bond was forged between part-time faculty members and students.

THE STUDENTS

The data in this chapter on CIC students comes from the larger, 1st Questionnaire sample of 89[1] respondents. In the later hypothesis-testing chapters, the key data is obtained from those 75 CIC students who answered both the 1st and 2nd Questionnaires. Whenever appropriate and possible, comparisons are made between characteristics of the CIC sample and California

---

[1]N will occasionally be 88 or 87 when a student failed to respond to a question.

chiropractic students at the Los Angeles College of Chiropractic (N=108) and Cleveland Chiropractic College (N=85) reported in research by the Stanford Research Institute. Apart from the present research, the California study is the only available source of statistical data on chiropractic students.

General Background Characteristics of the CIC Students

The median age of CIC respondents was 23.2 years, with 7% of the students under 21 and 11% 30 or older.[1] The CIC students are strikingly younger than chiropractic students in the California study, where 51% of both the Los Angeles College of Chiropractic (hereafter referred to as LACC) and and Cleveland Chiropractic College (hereafter called CCC) were 30 or over.[2] The CIC students are also substantially younger

---

[1] Of these, five were over 35, with one student being 53 when he graduated, one being 49, and one 45. The median ages for Becker's medical student sample and the present CIC sample are very close, but Becker notes that Kansas University Medical School ordinarily does not admit as freshmen persons over 30. The oldest persons in Becker's sample could not have been more than 31 or 32. See Howard S. Becker, Blanche Geer, Everett C. Hughes, and Anselm L. Strauss, Boys in White: Student Culture in Medical School, Chicago: University of Chicago Press, 1961, p. 59.

[2] Chiropractic in California, A Report by Stanford Research Institute, Los Angeles: The Haynes Foundation, 1960, p. 226.

than the osteopathic sample studied by New, where the average age (whether mean or median not specified) was about 27.[1]

All students in the CIC sample, excepting one, were males. There was one other woman student (a "special" student not enrolled on a full-time basis) at the School during my field work there, but she was not included in the sample. 88% of the LACC sample were males and 81% of the CCC sample were men.[2] CIC administrators informed me that over the years few women have attended the School.

In terms of nationality, all but three students (two Frenchmen and one Belgian) were United States citizens. Racially, all but two in the CIC sample would be classified as "Caucasian, with the other two being "Puerto Rican," or "Hispanic." Although there were two Negroes in my potential target sample (both in the 1967 Graduate class) neither of them responded to mailed questionnaires. The Stanford Research Institute gives no figures on nationality or race in California chiropractic students. Concerning chiropractors in California, it reports that 90% were

---

[1] Peter New, "The Application of Reference Group Theory to Shifts in Values: The Case of the Osteopathic Student," unpublished Ph. D. dissertation, University of Missouri, 1960, p. 89.

[2] Chiropractic in California, A Report by Stanford Research Institute, Los Angeles: The Haynes Foundation, 1960, p. 226.

born in the United States, and that all but three percent are Caucasian.[1]

Ethnically 34% (n=30) of the CIC student sample came from "Jewish" backgrounds; 28% (n=25) were "Italian"; 17% (n=15) were from "English-Irish" families; 10% (n=9) were "Slavic"; and 11% (n=10) could not logically be allocated to any of these ethnic groups. There is no other available data on ethnicity of chiropractic students, although a check of the Palmer College of Chiropractic catalogue's list of students yields few Jewish and Italian "sounding" names and a resounding majority of English-Irish-- Protestant ones.[2]

Sixty-three percent of the CIC sample (N=88) was single, 32% married,

---

[1] Ibid., p. 4.

[2] Palmer College of Chiropractic, Bulletin for 1967-1968, "Students at Palmer College of Chiropractic in 1966," pp. 125-143. I found about twenty "Italian-sounding" names, and about ten distinctly "Jewish-sounding" ones out of a total student body of approximately 930. The list abounds in names like Alexander, Jones, Miller and Smith.

In the end, I did not ask students about their religious background in the questionnaires, concentrating on ethnic backgrounds (e.g., Irish-Americans, Italian-Americans, Jewish-Americans) instead. Preliminary field work questioning of some students had indicated that a number were "touchy" about questions of religion-- as opposed to questions about national background-- and I cared to take no chances with alienating my sample. Consequently, I have some information derived incidentally from the ethnic question about respondents' religious affiliation: e.g., I know how many Jewish respondents there are in the sample, I assume that nearly all the Italian-American respondents are Catholics, but I have no total religious classification of the sample.

with the remaining 5% divorced or separated. 46% of the 1967 graduates were married, with about one-third of each of the other three academic classes married. The California data shows a complete reversal in civil statuses of chiropractic students, with 69% of the LACC sample and 62% of the CCC sample being married.[1]

The overwhelming number of CIC respondents (N=88) grew up on the northeastern seaboard (94%), with 60% reared in New York State, 24% in New Jersey, and 10% in Massachusetts, Connecticut, Pennsylvania, and Maryland. One student was raised in the southwest, one in Puerto Rico, two in France and one in Belgium. The California chiropractic students show a much greater geographic dispersion: Less than half of both LACC and CCC students were raised in the West (46% and 41%, respectively), with over 40% of both these colleges' student populations being reared in the northeast or north central United States.[2] Given these propinquity statistics on the present CIC

---

[1] Chiropractic in California, op. cit., p. 226.

[2] Ibid., p. 226. The Palmer College students also show a much greater geographical dispersion than the CIC group. Palmer College Bulletin for 1967-1968, pp. 125-143.

sample, one would certainly hesitate in calling CIC a "national" chiropractic college. Although I never inspected "home town" statistics on earlier classes at CIC, my conversations with faculty and front office personnel indicate that the School has always drawn the great majority of its students from New York and neighboring states.

The CIC sample is better educated than students from LACC or CCC. 28% of the CIC respondents had received a B.A. or B.S. degree, with one student possessing a Master's degree as well. Only 7% of the CCC group and 5% of the LACC students had received pre-professional college degrees. 54% of the CIC group had had some college, as contrasted with 51% of LACC students and 33% of CCC students.[1] 57 CIC students, or 64% of the total sample, had attended pre-professional college for at least two years.

Twelve percent (11 students) of the CIC sample had attended another chiropractic college before coming to CIC. One student had attended two other chiropractic colleges. Six of the students had previously enrolled at the Chiropractic Institute of New York also located in Manhattan. Three had gone to the Palmer College

---

[1] Chiropractic in California, op. cit., p. 226.

of Chiropractic in Iowa, and two to National College in Illinois. 14% of the LACC students and 19% of the CCC students in the California study were transfer students from another chiropractic college.[1]

What is the social class composition of the CIC sample? A key indicant of social class level conventionally employed in "objective approach" studies of social stratification is father's occupation, supplemented by father's educational level.[2] Tables 3-1 and 3-2 give the occupations and educations of students' fathers for both the larger sample, composed of all persons answering the 1st Questionnaire, and the smaller one, composed of those students who answered both questionnaires:

---

[1] Ibid., p. 227.

[2] For three, among many, examples of this usage see Becker et al., op. cit., pp. 60-61; Wayne Plasek, "Student Subculture and Professional Socialization: An Interaction Approach," unpublished doctoral dissertation, University of California, Los Angeles, 1967, pp. 63-64; Arthur Neiderhoffer, Behind the Shield: The Police in Urban Society, Garden City, New York: Doubleday and Company, Inc., 1967, pp. 36-37.

Table 3-1. Occupations of CIC Students' Fathers for N=88[a] and N=75

Occupational Category	N=88 Number	N=88 %	N=75 Number	N=75 %
1. Professionals, semi-professionals	20	23	19	25
2. Proprietors, self-employed businessmen	13	15	12	16
3. Managers, executives, office supervisors	15	17	12	16
4. Salesmen	4	5	4	5
----------[b]				
5. White-collar office workers	1	1	1	1
6. Factory and building foremen	4	5	3	4
7. Skilled workers	9	10	9	12
8. Semi-skilled workers and laborers	16	18	11	15
9. Service workers	6	6	4	5
Totals	88	100	75	99[c]

[a]N=88 instead of 89 because one student failed to answer the question on father's occupation.

[b]The broken line signifies a conventional sociological borderline between middle and working-class occupations. See particularly Kahl's discussion of Richard Center's classification scheme in Joseph Kahl, The American Class Structure, New York: Holt, Rinehart and Winston, 1962, pp. 80-81.

[c]The percentage total comes to 99 instead of 100 because of rounding in the summed %s.

Table 3-2. Educational Level of CIC Students' Fathers for N=87[a] and N=75

	N=87		N=75	
Educational Level	Number	%	Number	%
Grade School	22	25	17	23
Some High School	15	17	14	19
----------[b]				
High School Graduate	24	28	20	27
Some College	8	9	8	11
College Graduate	8	9	7	9
Professional Degree[c]	10	11	9	12
Totals	87	99[d]	75	101

[a]N=87 instead of 89 because two students failed to answer the question on father's education.

[b]The broken line signifies a conventional sociological borderline for indicating working-class or middle-class membership. See Howard S. Becker, Blanche Geer, Everett C. Hughes and Anselm L. Strauss, Boys in White, Chicago: The University of Chicago Press, 1961, pp. 60-61.

[c]Fathers who were both college graduates and holders of professional degrees were placed only in the Professional Degree Educational Level (Thus the Ns add to 87 and 75).

[d]The percentage totals come to 99 and 101 because of rounding in the summed %s.

About 60% (63% if one uses the sample of 75 instead of 88) of the CIC respondents can be classified as "middle-class," employing the data on fathers' occupations. Looking at the educational data, and employing high school diploma as the dividing line, a slightly lower portion of the CIC sample can be called "middle-class," but even here the middle-class percentage for both sample sizes is very close to 60%. Note that the use of one sample size or the other with either the occupational or education level data makes little difference in the resulting percentages of middle-class and working-class respondents.

As far as I have been able to ascertain there is no other data on social class composition of chiropractic student bodies with which the present research findings might be compared. The California study suggests vaguely that California chiropractic students might be somewhat more heavily working-class than the CIC group when it notes that "Most of the students come from families of modest financial resources,"[1] but there is no data offered on father's occupation, education, or income. Regarding chiropractors, rather than students, Wardwell notes that the medical profession believes them to come generally from the

---

[1] Chiropractic in California, op. cit., p. 6.

working or "lower class," but comes to his own conclusion that their socio-economic level is not as low as the medical literature would lead one to expect (again, little data is offered to support his position).[1] The California study's data on education of chiropractors' (not students') parents and occupations of fathers also suggests that they are more frequently middle-class persons than is generally believed.[2]

For want of intra-chiropractic comparative data on students, we might look briefly at research on social class features of professional students in other health fields. Using an occupation-of-father scheme rather similar (although not identical) to the present one, Becker classified 71% of his medical student sample as "middle-class," and the rest "working-class."[3]

---

[1] Walter I. Wardwell, "Social Strain and Social Adjustment in the Marginal Role of the Chiropractor," unpublished Ph. D. dissertation, Harvard University, 1950, p. 172.

[2] Chiropractic in California, op. cit., pp. 173-174. Education-wise, 54% of these chiropractors' fathers had a high school diploma or greater; occupation-wise 43% of their fathers had jobs which are gnerally classified as indicative of middle-class membership.

[3] Becker et al., op. cit., pp. 60-61.

Plasek's occupational classification of dental students' fathers (again quite similar to mine) used as an indicant of social class would label 77% of his sample "middle-class," with 23% working-class.[1] My own research on current medical and dental students at New York University (to be discussed fully in Chapter 7) showed that by occupation of father over 90% of the medical sample could be called "middle-class," and 78% of the dental sample were "middle-class." On the other hand, New's data on fathers' occupations for osteopathic students, although somewhat ambiguous and incomplete, shows osteopathic students to be more heavily "working-class" (about 45-50%) than the CIC sample.[2] One might conclude-- supporting Wardwell-- that although medical and dental students are more often recruited from middle-class families than are CIC students, the percentage differences, at least currently, are not as large as is often loosely indicated. A judgment on the comparative social class characteristics of chiropractic versus osteopathic students, on the other hand,would be very risky without more data.

---

[1] Plasek, op. cit., p. 63.

[2] New, op. cit., p. 90. His data here should be taken, for any comparative purposes, with caution since (a) only three occupational categories are given, and (b) no occupational data on father's occupation was obtained for almost one-fourth of his sample (24 out of 103).

ASPECTS OF STUDENTS' DECISION TO STUDY CHIROPRACTIC

Although the central concern of this dissertation is not with the determinants and patterns of CIC students' occupational choice (a dissertation topic in its own right)-- but rather with what happens to them, in terms of socialization, after they arrive at CIC, it seems incumbent upon the researcher in such a little-explored occupation to examine at least certain selected features of this particular recruitment and selection process, especially since the unusual status liabilities of the occupation of chiropractic lead one to the question "How does anybody get into such an occupation in the first place?"

A reasonably large amount of research has already been conducted into vocational choices in other health fields, such as medicine, dentistry, and osteopathy, and the reader will note that key themes from these studies dictate the departure points for much of the present discussion: comparative materials from these health occupations are utilized throughout this section.

Besides pointing up certain common aspects which students' selection of chiropractic have with more conventional professions in the health area, the discussion also points up some of the peculiarities in the pattern of choosing chiropractic as a career, peculiarities linked with chiropractic's suspect position in this society. To some extent, then, the theme of exposure to stigma, which runs so prominently through the following chapter, on students' status difficulties after matriculation, is anticipated in the materials on student's recruitment to and choice of chiropractic.

Occupational Inheritance in the CIC Sample

Students of vocational choice often focus attention on the degree of "occupational inheritance" in a given occupation. An examination of the relevant sociological literature on the professions indicates that (a) at least four types of situation are embraced by the concept of occupational inheritance, and (b) that various researchers use one or more of these four types with no particular attention to how fellow researchers are proceeding-- thus making overall comparisons between or among occupations on rates of occupational inheritance quite murky. What we shall do here is to list the four types of occupational inheritance present in the literature,[1] offer statistics for the CIC sample for all four types, and then present as much (comparable) comparative data with occupational inheritance among medical, dental and osteopathic students as is available.

The four types of "occupational inheritance" which appear most commonly in the sociological literature are:[2]

(1) An intergenerational process where the child assumes the same permanent occupation as his father. This type is the

---

[1] The relevant studies themselves are not cited at this point. They appear in the comparative discussion of occupational inheritance in chiropractic and other health fields.

[2] Much of the discussions on occupational inheritance will be presented in single-spaced style because of its rather complex nature.

most orthodox meaning of the concept of occupational inheritance. The following three are to varying extents all attentuations of this strict meaning.[1]

(2) An intergenerational process where the child assumes a permanent occupation which is related to, but not identical with his father's. In this type of occupational inheritance, researchers often say that father and son's occupations are in the same "situs." Our specific focus is the health situs occupations. These most usually include, medicine, pharmacy, dentistry, podiatry, optometry, osteopathy, chiropractic, veterinary medicine, and, recently, clinical psychology. Some researchers might not include optometry as a major health-related profession, while others might include nursing. A difficulty in a number of the studies is that the exact categories of occupations within the term "related health professions," or health situs professions" are not specified, hindering full-scale comparison between studies in this area.

(3) An intergenerational process where the recruit assumes a permanent occupation which is the same as a close relative's, not his father, most commonly an uncle or older first cousin.

(4) An intergenerational process where the recruit chooses a permanent occupation which is related to, but not identical with an older close relative's. Research-wise this type is open to all the terminological difficulties noted for type (2).

The current research collected data on all four types of occupational inheritance for the CIC sample:

(1) Three students, 3%, out of the N of 89 had fathers who were chiropractors.

(2) Five CIC students, 6%, had fathers in health occupations related

---

[1] The first two types of inheritance might be called "direct" since they involve parent and child; the third and fourth types might be conceptualized as "indirect" since the relationships between occupational legator and legatee involve the extended family.

to chiropractic (my definition of related health occupations consistently including optometry and excluding nursing [1]).

(3) Twelve students, 13%, had one or more close relatives, not fathers, who were chiropractors (usually uncles or cousins), two of these twelve being respondents whose fathers were also chiropractors.

(4) 32 of the students, 36% of the sample, had one or more close relatives in health professions related to chiropractic. None of the sons of chiropractors so indicated, although six of the ten students who had another relative in chiropractic also had one or more relatives in another major healing professions. 23 of the students mentioned an M. D. as the relative, 10 noted a dentist, and pharmacists, osteopaths and podiatrists were each mentioned a few times (the total adds to more than 32 b ause some students mentioned more than one category of related practitioner).

What comparative occupational inheritance statistics are available for other types of health student? The fullest range of data can be found for direct inheritance (1) of the same profession among medical, dental and osteopathic students:

> 18% of Rogoff's sample of 741 medical students indicated their fathers were medical doctors. 19% of Becker's 62 medical students had fathers who were medical doctors. 15% of my sample of 116 N. Y. U. medical students who answered the question on father's occupation said their fathers were medical doctors. [2]

---

[1] For the same definition of what constitute "major health-related professions, see Wardwell, "Limited, Marginal, and Quasi-Practitioners," op. cit., p. 216.

[2] Natalie Rogoff, "The Decision to Study Medicine," in Robert K. Merton, George C. Reader and Patricia L. Kendall (eds.), The Student-Physician, Cambridge: Harvard University Press, 1957, pp. 112.

Becker et al., op. cit., p. 61.

Regarding dental students, the only data on direct occupational inheritance seems to be my current survey of N. Y. U. dental students. Of the 329 students who answered the occupational question, 20 students, or 6%, had fathers who were dentists.

Finally, osteopathic students: The only available data comes from Peter New's study. Of the 79 students who answered the question on father's occupation four students, or 5%, had fathers who were osteopaths.[1]

We might conclude that direct inheritance of the same occupation is substantially more characteristic of medical students than any of the other three health groups, with the rates for dentistry and osteopathy being about the same, and the rate for chiropractic the lowest of the four. However, more studies seem needed of dental, osteopathic and chiropractic student groups to chart reliably the frequencies of direct vocational inheritance among these three health groups.

There is much more limited comparative data available for the other three types of occupational inheritance, although it is possible to somewhat increase the comparison of CIC data with other studies by combining certain inheritance categories used in the present study:

(2) My current study on CIC students and N. Y. U. medical and dental students seems to be the only material which offers statistics specifically on fathers of students who have related, but not identical, health occupations (other studies combine

---

[1]New, op. cit., p. 90.

fathers with other relatives, so that one cannot sort out the kinship statuses). 7% of both the medical and dental students had fathers who were in related, but not identical, health professions to their student sons. This percentage compares with 6% of the CIC sample. There is no data available on this point for osteopathic students.

If we combine occupational inheritance types (1) and (2) for CIC students and N. Y. U. medical and dental students, we see that 9% of the CIC sample, 25% of the medical sample, and 13% of the dental sample had fathers who were either in identical or related health occupations as their sons.

(3) Becker found that an additional 29% of his sample whose fathers were not physicians had other relatives who were, and Rogoff found an additional 27% of her sample in this category. 12% of the CIC sample whose fathers were not chiropractors had relatives who were.[1]

Thielens[2] cites a study where 50% of a group of medical students was found to have at least one relative in the medical profession, but the "relative" category combines father with many other relations. If, to compare his results with those cited by Thielens, we combine Becker's statistics on fathers plus additional relatives who are medical doctors, we find that 48% of his medical student sample had at least one relative in the medical profession. Making the same combination of categories, 45% of Rogoff's medical students had at least one relative in the medical professions. In a similar combination of two categories of CIC statistics, we find that 15% of the CIC students had at least one relative in the chiropractic profession. We see then that the 5-6 fold percentage advantage that medical students have over CIC students in direct inheritance of occupation is somewhat decreased when talking in terms of extended family inheritance. There is no

---

[1] Becker et al., op. cit., p. 71; Rogoff, op. cit., p. 112.

[2] Wagner Thielens, Jr., "Entrants to Medical and Law School," in Merton et al., op. cit., p. 134.

available data for occupational inheritance by dental and osteopathic recruits of professions identical to "other relatives."

(4) We saw that 36% of the CIC sample had one or more close relatives in a health profession other than chiropractic. I have found no comparable data on this kind of occupational inheritance for medical students or osteopathic students. Plasek states that about 53% of his dental student sample[1] of 62 respondents had one or more "relatives" in "health situs occupations," without specifying the categories these terms embrace. The most probable meaning of "relatives" in the context of his report is fathers plus other types of kin, and the most probable reading of "health situs occupations" would include dentistry itself. Because Plasek eliminates the two essential distinctions in the present scheme (father versus other relative inheritance; and identical versus related occupation), his statistics on occupational inheritance are not helpful to the present comparisons.

The overall conclusions that one might safely make from these limitedly comparable data are: (a) Looked at from either the standpoint of direct inheritance from father or extended family inheritance from other relatives, the mechanism of occupational inheritance definitely plays a much larger role for medical than for chiropractic students; (b) Direct inheritance is nearly as limited for dental and osteopathic students as it is for chiropractic students, but no data is available on indirect inheritance for these other groups; (c) 38% of the CIC student sample had close relatives (now including fathers) in a major non-chiropractic healing art, suggesting that one can by no means

---

[1] Plasek, op. cit., p. 52.

assert that this student group was totally "cut off" from exposure to accessible reference individuals who represented more "conventional," or "respectable" health professions.

Prior Chiropractic Care for Self and Family

Although researchers often ask medical and dental students about the number of physicians or dentists in their families, as an indicant of "anticipatory socialization" to these respective professions, it does not occur to them to use pre-professional school medical or dental care as a measure of prior knowledge of medicine or dentistry. Indeed, a question to these students such as "Before entering medical (or dental) school had you ever been under medical (or dental) care?" would be taken as more than slightly ridiculous, since medicine and dentistry are so ubiquitous and universally accepted as therapeutic modalities in the United States. Researchers assume that all medical and dental students have visited doctors and dentists at one time or another for particular health problems, or at least occasional "check ups" since early childhood; thus the measure of prior care would yield little, if any, useful variance among respondents in terms of gauging anticipatory socialization.

On the other hand, when one studies recruits to a minority (and even stigmatized)healing art, one useful measure of differentials in pre-matriculation knowledge about its values and institutions can be whether respondents have actually undergone chiropractic care before studying it. With a minority healing art the question of prior care is a more problematic one than with professions like medicine and dentistry, and we shall see that the CIC sample exhibits a number of distinct patterns in terms of prior care, ranging from virtually no personal therapeutic experience prior to CIC to many years' prior experience.

It emerges from the data that the CIC sample has had a much greater prior exposure to chiropractic in terms of care than in numbers of relatives who are chiropractors (see the preceding section on "Occupational Inheritance in the CIC Sample" for details). Whereas only 15% of the sample possessed one or more relatives who were chiropractors, 49% of the sample's members had either experienced/substantial prior chiropractic care themselves, or one or more of their immediate family of orientation (father, mother, siblings) had experienced such care.

Chiropractic care histories for respondents and

relatives were obtained from the "time lines" found in Questions 34 and 35 of the 1st Questionnaire, Appendix A. "Substantial chiropractic" care prior to CIC was partly a judgment on my part (a judgment which used as indicants supplementary to the "time lines" themselves other pertinent information about respondents garnered from reading through their questionnaires as a whole, as well as interview notes which I had taken on many of the students), but a consistent rule was that at least two straight years of such care was necessary to consider it prior and substantial.

Broken down by types, prior chiropractic care histories for CIC students and their immediate families look like this:

(a) 45 students, or 51% of the sample (N=89) indicate, by my operational definition, no substantial chiropractic care for either themselves or any member of their immediate family, prior to matriculation. A few of these students had had "one or two" adjustments over the years with no use of chiropractic treatment as a regular procedure (visiting M. D. s instead for any serious health problems); a number of them or their immediate family had received a series of chiropractic treatments within the year before they matriculated at CIC, but the large majority

of this 51% came to CIC "cold" in terms of adjustments for themselves or immediate family.

(b) 31 students, or 35% of the sample, indicated substantial pre-CIC chiropractic care for themselves and one or more member of their immediate families. Included in this group are about ten students who said they "grew up in chiropractic" (a phrase I heard rather frequently at CIC during my field work) which meant that they and most of their immediate family had experienced chiropractic care since childhood. With these persons, experience with medical care was either nonexistent, or exceedingly minimal.

(c) Seven additional students, or 9% of the sample, had experienced substantial prior chiropractic care for themselves, but no immediate family member had undergone such care.

(d) Finally, six students indicated that one or more immediate family members had undergone substantial chiropractic care prior to these students entering CIC, but that they had not personally received such care.

In summary, 51 students, or 57%, entered CIC without substantial earlier chiropractic care for themselves. 38 students, or 43% of the total sample, had undergone substantial earlier

chiropractic care. Approximately half of the CIC sample (49%) had experienced chiropractic care "personally" in a substantial way, either through being treated frequently and regularly themselves or through a close relative being so treated.

Using substantial prior chiropractic care as an indicant of anticipatory socialization, we see that the sample is split almost exactly in half, with 44 students exhibiting a high "loading" on prior experience, and 45 students a low "loading."

The great majority of respondents relating no prior chiropractic care for themselves or families do indicate regular medical care (the "time lines" in the 1st Questionnaire provided space for medical care as well as chiropractic care histories). Even the majority of students indicating substantial prior chiropractic treatment for self and/or family state that they also had regular or at least intermittent care from medical doctors. The point to stress is that only with perhaps 11% of the sample (those who "grew up in chiropractic") was a good deal of prior contact and exposure to medical and para-medical values and institutions lacking. In support of this point, remember that just under 40% of the CIC sample had one or more close relatives in the medical or para-medical professions. These indicants of access to and

knowledge about the "dominant" health institutions in American society become important later in this thesis when we discuss "shame" and/or "guilt" which CIC students may experience in their minority status as chiropractic students.

How Old Were Respondents When They First Heard About Chiropractic?

Again, a question to medical students in the vein of "How old were you when you first heard about medicine?" is never asked by researchers, and if it were asked would probably yield a median age around three years old, with a total range of one or two years. This question, however, asked to CIC students yields a large and meaningful spread: Twelve of the respondents had heard about chiropractic before they were ten years old (this is the group who "grew up in chiropractic"); another twenty students had heard about chiropractic by the time they were thirteen years old, and an additional twenty by the time they were sixteen. Still 31 of the students, over one-third of the sample, had not even heard of chiropractic before they were seventeen years old, and ten percent of the sample were ignorant of chiropractic beyond the age of twenty-two. The median age for first hearing about chiropractic was 14.5 years old.

Persons often first learn something about less-known occupations in high school through a vocational guidance program. CIC students were asked in the 1st Questionnaire "Was chiropractic an occupation that your high school guidance counsellor discussed as a possibility with students?" All but one respondent answered "No." An ordinarily prime source of information at a peak time for choosing an occupation is cut off in chiropractic's case. The failure of high school guidance counsellors, at least in the urban eastern seaboard high schools which CIC respondents attended, to discuss the possibilities of a career in chiropractic with students reflects larger societal views on chiropractic: the majority of people either know virtually nothing about chiropractic, or if they have some acquaintance with it, they do not deem it a "suitable," or "respectable," or "professional" occupation which young people should be actively encouraged to consider.

How Old Were CIC Students When They Considered and Decided Upon a Chiropractic Career?

Table 3-3 summarizes the sample's responses to questions about how old they were when they initially thought about becoming a chiropractor and when they definitely decided to study chiropractic.

Table 3-3. Ages at Which CIC Students First Considered, and Definitely Decided Upon a Chiropractic Career (N=89)

First Considered Chiropractic Career			Definitely Decided on Chiropractic Career		
Age	No.	%	Age	No.	%
Younger than 10	1	1	Younger than 10	1	1
10-13	5	6	10-13	3	3
14-16	7	8	14-16		
17-18	19	21	17-18	20	22
19-20	26	29	19-20	24	27
21-22	13	15	21-22	19	21
23-25	9	10	23-25	11	12
Older than 25	9	10	Older than 25	11	12
Totals	89	100		89	98[a]

[a]The total comes to 98 instead of 100 because of rounding of individual %s in the column.

The median age for the sample when chiropractic was first considered as a career is 19.5 years. The median age for

definitely deciding to study chiropractic is 20.6 years. The striking closeness in time of these two points in a career choice is underscored when we add the fact that 63 students, or 71% of the sample, checked the same interval of years for both first considering and definitely deciding upon a chiropractic career.

If we compare these statistics with the timing of vocational choice in a sample of medical students, large differences are immediately apparent. The median age for first considering a medical career in Rogoff's sample was 13.3 years old;[1] the median age for definitely deciding on medicine, 18 years old.[2] On the average, then, the medical students had definitely made up their minds about medicine before the CIC students even entertained a serious thought of studying chiropractic! Once the CIC students do entertain the idea, however, they are, on the average, a good deal speedier about making a final decision than the medical students: whereas a year's time is the usual gap between first thoughts and final commitment for the CIC students, nearly six years separate the medical recruits' first thoughts and eventual decision. Obviously much of this difference in the speed with

---

[1] I computed this median from Rogoff's data using the conventional formula for medians for grouped data.

[2] Rogoff, op. cit., p. 114.

which the two groups decide has to do with the fact that CIC students discover chiropractic so much later than medical students discover medicine, thus giving them, the CIC students, less time to ponder about a career, and increasing the pressures to make a fast decision. A startling fact of the data is that the average medical students had considered a career in medicine (13.3 years of age) more than a year before the average CIC recruit had ever heard about chiropractic (14.5 median age for first hearing about chiropractic).

That decision-making in a chiropractic career starts later than other health professions is also illustrated by a comparison with Plasek's data on dental students. One-half of his sample first thought about becoming a dentist during high school with the rest equally distributed in earlier and later years.[1] In total violation of Plasek's bell curve, 7% of the CIC sample first considered chiropractic before high school, 29% during high school, and 64% of the sample first considered a chiropractic career after high school.

Although New intimates in his dissertation that osteo-

---

[1] Plasek, op. cit., p. 52.

pathic students are also late deciders,[1] somewhat on a par with the CIC group, he offers no systematic data which would make a real comparison possible.

Students were also asked which persons they connected with their definitely deciding to study chiropractic. Although they wrote in a range of persons they associated with their decision, these persons could be grouped in the following categories: (a) various types of chiropractor, such as "our family chiropractor," or a "chiropractor I knew;" (b) one or both parents; (c) other family members; (d) CIC faculty members and/or students with whom they had been acquainted prior to matriculation; (e) fiancees, wives and in-laws; (f) friends; and finally (g) many students wrote in phrases such as "I made up my own mind," or "No one but myself," or "Me." We might code these responses as self-associations in the decision process, and will have something to say about the frequency of this response after presenting the full data in Table 3-4. Three students, even after probing, continued to maintain that no reference figure-- other or self-- came to mind as associated with the decision to study chiropractic.

---

[1] He says, for example, that for many persons in his sample osteopathy was not a "conscious goal" during their undergraduate days. New, op. cit., p. 94.

Table 3-4. Persons CIC Students Associated With a Definite Decision to Study Chiropractic, by Frequencies (N=89)

	No. of Students[a] Who Mentioned	Percentage of Total Sample
One or more chiropractors (family, acquaintance, etc.)	33	37%
One or both parents	26	30%
Self-association	23	26%
CIC faculty and/or students	9	10%
Fiancee, wife, in-laws	4	4%
Friends	2	2%
Other family members	1	1%

[a] N=89 in each row.

Table 3-4 shows that members of the chiropractic profession itself played the single most influential reference role in CIC students' occupational decisions, followed rather closely by parents (most often the father). It transpires, although this table does not so indicate, that none of the nine students associating

to "CIC faculty and/or CIC students" mentioned any other chiropractor, so that practising chiropractors, and CIC faculty and students are mentioned as important by 42 students or 47% of the total sample.

The picture the data give of chiropractors (and to a limited extent chiropractic students as well) as active recruiters for their occupation is not at all inconsistent with the picture they project as especially active recruiters of patients for their practices. These data, combined with earlier data (see Table 3-3) on the very short length of time between first thinking about studying chiropractic and actually making a firm decision, suggest a common model of decision making on the part of the potential recruit where one or more chiropractor acquaintances "sell" chiropractic to him quite forcefully, pressing for a fast decision, rather than a model where the recruit comes to an "independent" decision after long and careful deliberation.

Perhaps the most intriguing finding with these particular data is the relatively large percentage of the sample (26%) who stated (and usually not in conjunction with another association) they associated themselves with the decision to study chiropractic. Whether this answer stems from belligerence (as the tone of some of them seemed to indicate), from defensiveness, or from

firm ego-strength is impossible to determine at a questionnaire level of analysis, but certainly, whatever the psychic sources, these responses demonstrate a self-assertiveness (and unsolicited at that) and mesh with a central argument appearing later in this dissertation that CIC students have an especially strong tendency to elevate self over others in a given situation.

Paths to Chiropractic

New found in his study of osteopathic students that only 44 of the 103 persons in his sample, or 39%, went directly from undergraduate college to osteopathic college, with the remainder pursuing some substantial intervening activity (such as full-time employment, or attendance at a medical or para-medical college). He calls these detours "way stations" to osteopathy.[1] He also notes that the frequency of interrupted trips to the study of osteopathy is in marked opposition to careers in medicine where almost all students move directly to medical school from pre-professional college.[2]

---

[1]New, op. cit., p. 50.

[2]New, ibid., p. 88. New notes the one exception to this direct path is some medical students serving two years in the Armed Forces between college and medical school.

Since a substantial minority of the CIC students came to CIC by one "way station" or another, it seems appropriate to employ New's model, adapted to the way station categories of our sample, in the present examination.

Fifty-three of the CIC sample of 89, or 60%, came to CIC directly from undergraduate college or high school. Five students matriculated directly from high school with the other 48 coming directly from college, although the majority of these 48 did not come possessing baccalaureate degrees. This leaves 36 students for whose indirect paths to CIC we must account.

An examination of the pre-CIC materials available in the 1st Questionnaire indicates that the "way stations" of the 36 students fall into three categories: (1) substantial full-time employment (usually defined operationally here in terms of two or more years consecutive employment); (2) attendance at another chiropractic college before matriculating at CIC; (3) attendance at a medical or para-medical school (with our respondents usually pharmacy school). As far as the students go, there is a small "overlap" among the way stations (one student had spent time at all three of them, and five others had occupied two of them).

By far the most frequent way station to CIC was prior

substantial full-time employment. 27 of the students had been so involved. Although a number of these persons had held more than one full-time job prior to CIC, we shall report here only that job for each person which appeared to be the "major" one in their occupational histories. Although they held a variety of positions, the main categories were these: Seven worked as skilled, semi-skilled or unskilled laborers; five were salesmen (equipment, insurance, and one pharmaceutical salesman); four had been high school teachers; three were civil service workers (two policemen and one fireman); two were small business proprietors; two were office workers; one had been a pharmacist for many years, one a physiotherapist; one a department store manager; and one had been a draftsman. Few, then, had jobs related to the healing arts.

The next most frequent way station occupied by CIC students was prior attendance at other chiropractic colleges. Ten students had attended one other college, and one student two. Most of these attended either CIC's "rival" college, the Chiropractic Institute of New York (CINY), or the Palmer College of Chiropractic.

Five students, finally, had come indirectly to CIC after attending a medical or para-medical school for some time. Three of these people had been pharmacy students, one a medical student, and one attended physiotherapy school.

Chiropractic in California affords some comparative data on way stations occupied by students from the Los Angeles College of Chiropractic (LACC) and Cleveland Chiropractic College (CCC). The report states "Ninety percent of all chiropractic students (at these two colleges) were engaged in some type of full-time employment before entering school. Inasmuch as the average age of all chiropractic students is 32 years, and since 66 percent of their number are married, it is logical to expect that a high percentage of students would have some previous full-time work experience." Even though a more satisfying and accurate comparison between these chiropractic students and the CIC group would have been possible if the California study had specifically defined "full-time work experience" (How long a period of work was necessary to meet this definition?), it is obvious that the California sample is much more heavily characterized by the occupational way station biographical feature than the CIC students. We saw that very few CIC students who had had substantial full-time employment prior to CIC held "health-oriented" positions. Not so with the California students, where 29% had such employment.[1]

---

[1] All data references in this paragraph to the California students can be found in Chiropractic in California, op. cit., p. 105.

As we have seen already 12% of the CIC sample attended a prior chiropractic college, as opposed to 14% of the LACC students and 19% of the CCC students. It is in the previous full-time employment figures of the three groups of students, then, where the major frequency differences in occupation of a way station exist. The California report offers no data on our third way station, students who attended medical or para-medical school prior to chiropractic college.

A way station journey to professional school, then, is almost universal for the California chiropractic students, with it being the majority path for New's osteopathic sample (drawn from four colleges), and a frequent, if still minority, route for CIC students.

Motivations For Studying Chiropractic

We have just sketched CIC students' paths to CIC in terms of "official" objective career data. It is quite another thing to inquire about the subjective reasons the sample had for (a) choosing to study chiropractic and (b) specifically choosing to study it at CIC. In the 1st Questionnaire, students were given a check list of reasons for their deciding to study chiropractic. The alternatives

offered to the sample stemmed from (a) field work at the School--from listening to classroom discussions and talking informally about this issue with many of the students, and (b) from perusal of studies into vocational motivations of professional students in other health fields. The results from this question follow in Table 3-5:[1]

---

[1] It seemed too simplistic to conceptualize each student as having one prime motive-- rather, the combination of a number of motives brought students to the study of chiropractic. Thus a form of data-gathering and data analysis was employed which allowed the tabulation of multiple responses by students. Table 3-5 follows in spirit and form the mode of analysis used by More and Kohn in their study of factors influencing dental students' choice of dentistry. D. M. More and Nathan Kohn, Jr., "Some Motives for Entering Dentistry," in Howard M. Vollmer and Donald L. Mills (eds.), Professionalization, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1966, pp. 82-83.

In the California research on chiropractic students, respondents were assigned one central reason for choosing chiropractic as their profession, thus making comparisons on this point between these students groups and the CIC students difficult. See Chiropractic in California, op. cit., pp. 105-106, 109-110.

Table 3-5. Reasons Indicated by CIC Students for Their Choosing Chiropractic as a Career[a] (N=88)[b]

Reasons Indicated In Check List	No. in Sample Checking[c]	% in Sample Checking
1. Helped (or family member helped) personally by chiropractic	51	58
2. Dissatisfied with another job	10	11
3. Couldn't make medical or dental school	7	8
4. Wanted to get sick people well	77	88
5. Wanted the 2-S draft status	8	9
6. Grew up in chiropractic	10	11
7. Felt chiropractic would be a good profession financially	58	66
8. Drifted into chiropractic	17	19
9. Wanted to be a professional person	53	62
10. Wanted to buck the crowd	8	9
11. Were convinced chiropractic was right	58	66
12. Wanted to be own boss	59	67

[a]Respondents were asked to indicate whether a particular reason was "very" "quite" or "slightly" important in their decision. If a student answered "very" or "quite" he was coded, for purposes of Table 3-5, as checking a reason. "Slightly" checks are not included above, primarily because post-questionnaire discussions with students indicated that they had taken this phrase to mean "of little or no importance."

[b]N=88 because, due to a collation error, one student (to whom the 1st Questionnaire was mailed) did not receive the page on which the personal motivation question was found.

[c]Total N=88 in each row.

Six of the reasons were considered personally important by 58 or more percent of the CIC sample. "Wanting to get sick people well" was a litany-like phrase I had heard used countless times at CIC, by teachers and students alike. This specific phrase, and the set of associations it evokes, appears to be one of the cornerstones of the CIC culture. It was, then, perhaps unwise to quote the phrase verbatim in the check-list, since the "cuing" effect of just these words appears to be so strong. Some students hearing the familiar refrain no doubt checked this item "automatically," with no thoughtful reference to the motivations of their pre-CIC days.

But in spite of the above interpretative difficulties involved in the statistic, 88% of the sample checking this reason is an impressive number. The figure is provocative because it is nearly identical with the percentage of dental students in More's and Kohn's study checking a quite similar reason for their choice of dentistry.[1] This particular motivation-- or lack of it-- is, of course, one of the major issues seen in both medical and lay discussions of chiropractors and their values. Medical commentators would doubt the presence of strong "humanitarian" motives in nearly

---

[1] More and Kohn, ibid., p. 83. The reason in that study is "Desire to work for and with people."

90% of any sample of chiropractors or chiropractic students-- since they believe that perhaps the majority of chiropractors are cynical charlatans-- although they would concede that a substantial minority of chiropractors really do, in their "naive" way, want to "get sick people well." In any event, the findings from these data-- even blurred to some extent as they are by the unfortunate phrasing of the question-- indicate that most chiropractic students enter their occupation with a "sincere" humanitarian motive ("naive" or not) as one important reason for its selection.

Let us give some attention to the other reasons checked by a majority of the CIC sample. The reader will note that five reasons were checked as "very" or "quite" important by between 67 and 58% of the sample. 66% of the students indicate that monetary advantages of chiropractic played a role in their choice of occupation. That financial rewards should be one-- but only one-- of the strong motivations for choosing one's life work appears to be characteristic of contemporary professional students in health fields,[1] and in this respect the CIC student is not unlike medical or dental students. As important to the CIC students'

---

[1] Ibid., p. 83.

choice as monetary gain were reasons such as wanting to be "a professional person," or wanting to be one's "own boss."[1]

Although medical, dental and chiropractic students offer certain motives in common for choosing to study their respective health occupations, the themes of (a) wanting to be a chiropractor because one was "personally helped" by chiropractic (58% of the sample checked this reason[2]) and (b) deciding to be a chiropractor because one is "convinced chiropractic is right," (66% of the sample checked this motive) are found prominently only with chiropractic students, and suggest, respectively, the presences of two elements generally found in "mystic-cultist" subcultures,[3]

---

[1]These reasons for choosing dentistry were also important to a majority of More's and Kohn's sample. Ibid., p. 83.

[2]Note that this figure of 58% checking "personally helped" by chiropractic is 9% higher than my coded figure for students and/or their families receiving "substantial prior" chiropractic care before matriculating at CIC. The discrepancy most probably comes from the fact that some students who received less than the two years prior care, which was necessary to be coded as "receiving substantial prior care," experienced this shorter period of care in an intense enough way to attribute their vocational choice, in some measure, to that care.

Although the California data on students' motivation for choosing chiropractic is, as noted above, ordered on a different basis than the present research, the most important single motive for choosing chiropractic (on a one motive to a man basis) is "benefited by a chiropractor," with no specification as to whether respondent or his family was so benefited. Ibid., p. 109.

[3]Elements of cultist groups, including those discussed here, were treated extensively in Professor Joseph Bram's Sociology of Religion course, which I took at New York University (Graduate Sociology) in the Fall of 1963.

or found among cultist-prone individuals: the element of divine inspiration or conversion, and that of militant self-righteousness.

Being "personally helped" by chiropractic and then wanting to pursue it as an occupation, sounds very much like experiencing a personal and often mystical revelation of the Divine Being and then electing henceforth to serve Him. To be "convinced chiropractic is right" for these students contains a necessary added assertion (or assumption): that other methods of healing (especially medicine) are wrong. In this connection Wardwell found that the chiropractors in his sample likened medicine and its practitioners to "evil" or "the Devil" (particularly because they used destructive drug therapy) and themselves and their colleagues to agents of righteousness because they practiced the one true healing art.[1] Militancy is involved

---

[1]See Wardwell's general discussion of the cultist elements in chiropractic in his unpublished doctoral dissertation, op. cit., pp. 477-504. Among these elements he lists (a) the infallibility of the Palmers' doctrines, (b) deification of their personages, (c) a belief by chiropractors that they are an oppressed, but righteous, minority, (d) constant exhortations to keep the "faith," and support the "cause."

Although some of these elements seemed present at CIC-- particularly exhortations to keep the faith-- others-- e.g., the importance of the Palmers for chiropractic-- were not at all prominent. Students were asked in the 2nd Questionnaire "In your judgment, how important are the writings and teachings of D. D. and B. J. Palmer in the everyday curriculum at CIC?" (Question 103) 27% answered "very important," 52%

because a true believer must, naturally, combat the Devil.

Certain events I observed during my field work at the School enforce the suspicion that some cultist elements are present not only in many students' decision to study chiropractic but in CIC's culture, as enacted by faculty, students and administrators. On several occasions all classes were summarily and unexpectedly interrupted for an "assembly" in the auditorium. On these occasions the President would deliver to the collected student, faculty and administrative bodies what could best be

---

"somewhat important," and 21% "unimportant." These data do not give strong support to students believing in anything as strong as the "infallibility" of the founders of chiropractic. Pursuing the "founder" theme somewhat further-- since reaffirmation of the founder is so often stressed as one of the cornerstones of cultist groups-- the 2nd Questionnaire also asked students "In your judgment, how important are the traditions and teachings of CIC's founder, Frank E. Dean, in the everyday curriculum at CIC?" (Question 104) 53% answered "unimportant," 41% checked "somewhat important," and only 5% of the sample of 75 checked "very important." Clearly the founder theme of a cult-- whether we talk here about the founders of the entire faith, or the founder of the particular group within the faith-- is, if not entirely absent, very dim at CIC.

described as an empassioned "jeremiad"[1] urging them to keep to the path of straight chiropractic and warning of dark enemies (usually organized medicine) planning to destroy chiropractic (particularly in New York State). When I questioned students (and faculty) about their reactions to such meetings, I obtained mixed feelings. Some people were quite irritated by having the business of 2nd-term spanchnology or 4th-term adjustment technique rudely severed; others felt such meetings relieved the "boredom" of the everyday curriculum; a number of students told me that they "needed" periodically this kind of "pep talk" to avert the discouragement and depression they often felt about the state of the chiropractic profession. After one particular meeting which I attended a student said to me "It's just like a revival meeting. He (the President) really got worked up, didn't he? Did you notice (two Seniors)? I thought they were going to go up to the front and testify!"

---

[1] Perhaps the best descriptions of the jeremiads delivered by Puritan sect ministers to their congregations in the 17th and early 18th centuries can be found in the work of the American historian, Perry Miller. Although there are, of course, important differences, between the sermons of the 18th century minister Cotton Mather and the contemporary addresses of CIC's President, the common theme of doom being "just around the corner" is very apparent. See Perry Miller, The New England Mind: From Colony to Province, Boston: Beacon Press, 1961.

These remarks must not be construed as an attempt to portray either the CIC recruits or the CIC culture as totally cultist. Indeed, one of the most intriguing facets of CIC is the coexistence of strong elements of professionalization (e.g., 62% of the students indicated "wanting to be a professional person" as a reason for choosing chiropractic; CIC's training program has become longer and more rigorous than formerly) with some elements of cultism. Nor is there any convincing evidence that this coexistence is temporary or "unstable," although certain sociological observers, like Leis,[1] believe the occupation as a whole is becoming more professionalized and less cultist.

Of the other six reasons for choosing chiropractic found on the check-list, all of which were checked by less than twenty percent of the sample, "drifted into chiropractic" (19%) was most frequently indicated. That one-fifth of the sample

---

[1]Gordon Leis, "The Transformation from a Healing Cult to a Profession: The Changing Place of Chiropractic Among the Healing Arts," a doctoral dissertation proposal in the Dept. of Sociology, State University of New York at Buffalo, March 1966 (Xerox). Wardwell takes a more cautious view of the full-scale professionalization of chiropractic and elimination of all cultist elements. Wardwell, "Limited, Marginal and Quasi-Practitioners," op. cit., pp. 226-229.

should indicate their eventual arrival at chiropractic school to be at least partially the result of aimless wandering is no insubstantial statistic. It stems with a picture New paints of many osteopathic students and strongly conflicts with the image of premeditated, pre-medical students' deliberate and narrow path to professional school.

Seven students admitted that chiropractic school was a second or third choice to thwarted ambition for medical or dental school. My own coding of "2nd-Choice Syndromers,"[1] we shall see, indicated that over three times as many students as Table 3-5 indicates could be taken (after an examination of the background information in the 1st Questionnaire) to have made some serious effort to enter another preferred healing art. Part of the disparity comes from the fact that some students couldn't make a healing art school not indicated on the career choice question (like pharmacy or osteopathic school); part comes from the situation that some students were probably embarrassed to admit so baldly

---

[1] The use of the term "2nd-Choice Syndrome," in this research or "Runner-Up Syndrome" as it is sometimes called stems from a discussion by Sherlock and Morris on dental students who may have picked dentistry as an alternative to thwarted ambitions for medical school. See Basil J. Sherlock and Richard T. Morris, "The Evolution of the Professional: A Paradigm," in Sociological Inquiry, 37 (Winter, 1967), p. 31.

that they had failed in preferred career lines (With this latter category of person, the 2nd-Choice Syndrome could be "teased" out of other items in the 1st Questionnaire on prior educational history, and so on).

"Wanted to buck the crowd" was an exploratory item which drew fewer takers than I had anticipated. My field notes contained references to a certain "belligerence" on the part of some students which I believed might be reflected in their motives for studying chiropractic. Then too, it seemed logical, and sociological,[1] that a certain obstinacy of personality might play a part in choosing an occupation which went against the societal grain. It may be that "wanting to buck the crowd" was too bald a statement of social stubbornness to be openly admitted, and that some students found a more conventional equivalent to check in "wanted to be my own boss."

The small hard-core group of students exposed to many years of pre-CIC chiropractic care emerge here again in Table 3-5 as persons motivated to enter chiropractic by "growing

---

[1] That particular kinds of occupations do in fact select or attract certain kinds of personality types has been well demonstrated in sociologist Morris Rosenberg's Occupations and Values, Glencoe: The Free Press, 1957.

up" in it. A motive for vocational choice with which researchers may increasingly have to contend, because of internal and international politics, was openly indicated by eight students (although my informal talks with students indicates a higher figure): draft deferment. It is no secret, of course, that this motivation is currently playing a part in students' choices of many professional and graduate school programs. The draft status of a CIC student is, however, not clear-cut, and students, administrators and faculty frequently debate this point with each other. From my discussions with the "front office," particularly the Director of Education, who schedules programs for students, the situation appears to be this: The students most definitely do not possess a draft deferment reserved for professional health students. Medical, dental, and osteopathic students matriculated in full-time programs are entitled to such a deferment,[1] but the federal government does not (as we shall see later in more detail) consider chiropractic students as professional health students for purposes of military service exemptions or for purposes of military commissions. Apparently CIC is able to confer the same draft deferment status as any

---

1 "Selective Service officials said those fields allied to medicine and dentistry for which graduate deferments would still be granted are osteopathy, optometry and veterinary medicine." The New York Times, February 17, 1968. Chiropractic is (and was) visible by its absence from this list.

undergraduate college, a deferment which normally runs out after four years of full matriculation. Thus the "haven" it provides varies with the number of years of full-time college deferment a particular CIC student has "used up" before he came to CIC. Assuming that CIC can provide four years of draft shelter (Even though a CIC education runs through three years, its tri-semester credit hours define it, for draft purposes, as a four-year college), the majority of current students of most potential draft age (under 26) had had enough full-time undergraduate exemption at pre-professional colleges to place them in jeopardy some time during their three years at CIC. Those students under 26 who came to CIC possessing a B.A. or B.S. were vulnerable from the beginning of their training. Some who came directly from high school were protected for the entire nine terms of CIC. The irony here is that those perhaps best qualified for a professional education through prior educational experience are most vulnerable to having their CIC experience involuntarily interrupted.

Why CIC?

Students were not only asked why they decided to study chiropractic, but whey they chose specifically to study it at CIC. Again, a check list of possible reasons, compiled from field work notes, was provided the samples:

Table 3-6[a] Reasons Indicated by CIC Students for Their Specifically Choosing CIC[b] (N=89)

Reasons Indicated in Check List	No. in Sample Checking[c]	% in Sample Checking
1. Financial limitations	38	43
2. Rejected by other chiropractic colleges	0	0
3. Particularly wanted the specific curriculum CIC offers	26	29
4. Had friends currently studying at CIC	17	19
5. Had friends who were graduates of CIC	9	10
6. Had relatives who were graduates of CIC	2	2
7. Wanted to remain in the area where I was raised	52	58
8. Persuaded by D. C. s in CIC's front office or on its faculty	12	13
9. Heavily influenced by CIC's President	10	11
10. Didn't know much about other chiropractic colleges	40	45
11. Didn't want to go to a mixer school	20	22
12. Other reason[d]	14	16

[a]As with Table 3-5, the form and analytical approach of this Table follows the model of More and Kohn, op. cit., pp. 82-83.

[b]"slightly" important checks were not included, as per the procedure in Table 3-5.

[c]Total N=89 in each row.

[d]"Other reasons" included: Palmer College not accepted by the New Jersey Chiropractic Examination Board (3 students); miscellaneous personal reasons (3 students); CIC recommended by a chiropractor not connected with CIC (2 students); a desire to live specifically in New York City (2 foreign students); dissatisfied with a prior attended chiropractic

school; received a partial scholarship to CIC; came to CIC from Atlantic States Chiropractic Institute when the latter merged with the former; CIC's program allowed meeting a New York State deadline for licensure without two years of prior liberal arts college (each of these 1 student).

There were only three reasons for choosing CIC which a considerable portion of the students checked: (1) wanting to remain in the area where they were raised (58%); (2) not having information about other chiropractic colleges (45%); and (3) financial limitations, which presumably prevented attendance at chiropractic schools in other parts of the country (43%).

Students' lacking information about chiropractic colleges located in other areas tells one something about the limitations of the occupation's recruitment system: there appear to be no national sources or organs of information about the occupations of chiropractic and its training colleges which have had success in reaching potential recruits. In contrast to medical, or dental, or law students, the chiropractic student's acquaintance with his occupation is likely to come through "particularistic" channels (family, friends) rather than through "universalistic" channels (mass media, guidance counselling in high school). The key to communication networks within chiropractic is that they are <u>small-scale</u> and <u>local</u>.

The very limited application by CIC to other chiropractic

colleges matches the "provinciality" of Becker's Kansas University medical students in this respect. 56% of his sample had applied only to Kansas University,[1] while 61%, or 54 CIC students had applied only to CIC. Of the remaining 35 students, 29 had applied to only one other chiropractic college, which most often (75% of the cases) was CINY, CIC's "mixer" rival in New York. Palmer College, mentioned by seven students, was the only other prominent name.

Table 3-6 shows no student choosing CIC because of rejection by another chiropractic college, and an analysis of the data indicates that no student in the sample was rejected by another chiropractic school. Since eleven students had attended other chiropractic schools prior to CIC, it is possible that they "flunked out" of the other chiropractic college, coming to CIC on the rebound, but interviews with these students indicates this possibility in only one case. Usually students transferred because of sudden financial difficulties, illness in the family, or dissatisfaction with the first chiropractic college's program (this last reason for transfer seems

---

[1] Becker, et al., op. cit., p. 62.

the most probable in the case of the six students who had previously studied at CINY).

In Delinquency and Opportunity, Cloward and Ohlin take Robert Merton's theory of the cause of criminal behavior to task for failing to recognize that illegal ladders to success are as crowded as legitimate ones.[1] Their point was that since the worlds of crime and deviance were as many-shaded as the legitimate world, in terms of competence and excellence, one could not lump all criminal behavior systems into one category. Assuming that chiropractic is a "deviant" therapeutic system, do we do it a Mertonian injustice by lumping the standards of all its centers of socialization-- the various chiropractic colleges-- into one common category? One important measure of differentials in quality between schools or groups is entrance standards. That the students themselves perceive the standards of chiropractic colleges to be uniformly low came out in a serendipitous fashion in their answers to another question. They were asked "What do you think you would have done, occupation-wise, if your application to study chiropractic had been turned down by CIC and other chiropractic colleges?" Although some

---

[1] Richard A. Cloward and Lloyd E. Ohlin, Delinquency and Opportunity, Glencoe: The Free Press, 1961, pp. 145-152.

students took the question seriously and on its own terms (as I had intended it), writing a sober sentence or two about possible alternative careers, fifteen of them wrote in comments like "Are you kidding," or "That's a laugh!" clearly indicating that the present-day possibility of being turned down by chiropractic schools was nil. One student made it plainer: "Nobody ever gets turned down by chiropractic schools."

Students' Commitment to a Chiropractic Career When They Entered CIC

Combining our objective data on students' "paths to chiropractic" with subjective information on their checked reasons for studying chiropractic, and adding a few specific questionnaire items on commitment to chiropractic,[1] it is possible to assign

---

[1] Unlike the analysis of reasons for deciding upon chiropractic as a career, it seemed possible to assign each individual in the sample to one particular category of commitment to chiropractic at the time he entered CIC.

As noted in the text, all of the items from the 1st Questionnaire (specifically cited at points when they were introduced into the discussion) used to determine paths to chiropractic and motivations for studying chiropractic were systematically examined for each respondent to obtain a commitment type Additional items employed to score commitment were Questions 20, which asked respondents "At the time you entered CIC, given the choice, were there other occupations you had seriously considered which you would have preferred to enter?" and Question 31: "What do you think you would have done, occupation-wise, if your application to study chiropractic had been turned down by CIC and other chiropractic colleges?" If a student indicated, on Question 57,

each student in our sample to a particular category of commitment (or lack of it) to a chiropractic career at the time of entrance to CIC. Table 3-7 gives the results:

---

that a very or quite important reason for his choosing chiropractic had been "drifted" into the field, he was never assigned a "high intensity" commitment for purposes of the typology in Table 3-7 (although he may have received a "medium" score, depending upon his other answers). Admittedly, the assignation of several students to low instead of medium commitment, or vice versa, was a question of my judgment given the total amount of information I had about people in the sample. These cases were certainly the exception, however, since for most respondents one could assign them to a particular category with a high level of confidence.

As far as the category "would have preferred another career" goes, mere having "thought about" another occupation, which is tapped in Question 18 of the 1st Questionnaire, was far from enough to type a respondent as would have preferred another career. His record had to give evidence that he had done something substantial about pursuing that career. For example, if a student was assigned to "would have preferred another health field," say medicine, there had to be evidence that he had taken a pre-medical course in college, or that he was still applying to medical schools while attending CIC. Even a declaration that he specifically would have preferred medicine (on Question 20) was not taken as sufficient evidence in itself.

Table 3-7. Commitment to a Chiropractic Career at the Time of Entering CIC (N=89)

Categories of Commitment	N	%
1. High Intensity	29	33
2. Medium Intensity	20	22
3. Low Intensity[a]	11	12
4. Would Have Preferred Another Career in:		
(a) A Related Health Field	25	28
(b) A Non-Health Occupation	4	4
Totals	89	99[b]

[a]None of the respondents in the first three categories had an alternative career preference. The intensity of commitment to chiropractic of the 29 persons in the fourth category could not, by definition, have been very high at the time of entering CIC, although the added possibility of conflicted commitment must be entertained for this fourth group, particularly the (a) subgroup.

[b]The percentage total comes to 99 instead of 100 because of rounding in the individual %s in the column.

From the Table, it is fair to say that 55% of the students (high plus medium intensity) entered CIC with a substantial degree of unconflicted commitment to a chiropractic career. Of the

remaining students 12% might best be termed "aimless" or "indifferent" regarding chiropractic upon entrance, while 32% (those preferring another line of work) might be called "frustrated" or even "hostile" in some measure to a chiropractic career when they first matriculated at CIC. We should note that 25 of the 29 persons who would have preferred another occupation, or 86%, wanted to be another type of health practitioner (a medical doctor, a dentist, an osteopath, a veterinarian, or a pharmacist). Of the other four, one wished to be an automotive engineer, one a professional athlete, one an entertainer, and one a lawyer.

During their freshman year in dental school 60% of Plasek's sample stated that they were convinced at that time that dentistry was the only career which interested them, with the remainder declaring that other careers might be equally interesting and satisfying.[1] Thus, for both the CIC sample and the Plasek dental sample there appear to be a considerable number of students who enter these professional schools with the intent of "trying on" chiropractic or dentistry. This trend contrasts sharply with Becker's medical students who appear to arrive at medical school

---

[1] Plasek, op. cit., p. 52.

already firmly committed to a medical career, almost to a man.[1]

STUDENTS' EARLY REACTIONS TO THE CIC EXPERIENCE

The sample was asked to "Recall your very first week or two at CIC. To what extent did you feel satisfied with its physical plant, the faculty, front office personnel, and other students?" Table 3-8 gives the results:

---

[1] "Although there may be one or two students in each class merely 'trying on' medicine, most of the freshmen arrive firmly committed to it as a career and expecting to go into practice." Becker, et al., p. 73.

Table 3-8. Initial Student Satisfaction With Various Aspects of CIC (N=89)

Aspect	Very Satisfied No.	%	Fairly Satisfied No.	%	Somewhat Dissatisfied No.	%	Very Dissatisfied No.	%	Totals No.	%[a]
Physical Plant	5	6	31	35	30	34	23	26	89	101
Faculty	13	15	50	56	21	24	5	6	89	101
Front Office Personnel	18	20	51	57	12	13	8	9	89	99
Fellow Students	22	25	45	51	14	16	8	9	89	101

[a]Percentage totals come to 101 or 99 because of rounding of individual %s in the rows.

A perusal of the Table indicates that students were not overly sanguine about what they confronted at CIC. They were particularly displeased with the physical plant, 60% of them being either "somewhat" or "very" dissatisfied, with only 6% being "very satisfied." With no aspect of CIC was a majority of the sample "very satisfied," but for three aspects of CIC (faculty, front office personnel, and fellow students) the modal percentage was "fairly satisfied." This relative initial coolness toward CIC hardened into indifference or even hostility toward the School as the terms passed for the majority of the students. Students were asked, on the 2nd Questionnaire, if they had become more or less enthused about CIC itself as they progressed through their training. 70% of the students answered "less enthused," 20% answered "stayed about the same," and only 10% answered "more enthused."

How Do Relatives and Friends React to Students Studying Chiropractic?

We shall demonstrate in the next chapter that in terms of attitudes close family and friends of CIC students are not happy about their relative's, or friend's, choice of career when he enters CIC.

Looking at behavior, however, students' primary groups demonstrate astonishing solidarity and support for the status of chiropractic student: Analysis of the data show that 67 students, or 75% of the sample (N=89), had one or more (usually more than one, often four or five) relatives and/or close friends who began chiropractic care for the first time in their lives within one year of their student-relative's or student-friend's matriculation at CIC.[1]

Goffman writes in Stigma about "courtesy stigma," which extends to the primary groups of the person actually possessing the stigmatized status:

> A second type of wise person is the individual who is related through the social structure to a stigmatized individual-- a relationship that leads the wider society to treat both individuals in some respect as one.... One response to this fate is to

---

[1] This trend is equally apparent among those students who (or whose close family) had received substantial chiropractic care prior to CIC and those who had not. About 75% of both of these groups have relatives or friends going under chiropractic care for the first time after students have matriculated at CIC. The rush to chiropractic care on the part of students' primary groups parallels students' own hasty decision making pattern, where we saw it usually takes about a year between first thinking about and firmly deciding to study chiropractic; it seems that students "sell" chiropractic to family and friends as it had been "sold" to them by chiropractors.

> embrace it, and to live within the world of one's stigmatized connection. [1]

To the extent that one accepts the contention that chiropractic student and chiropractor are stigmatized statuses (a contention systematically documented in the next chapter), one valid way of conceptualizing this wide-spread assumption of chiropractic care by family and friends after CIC students' matriculation is to construe it as an "embrace" (albeit reluctant) of the fate of "courtesy stigma."

---

[1] Erving Goffman, Stigma: Notes on the Management of Spoiled Identity, Englewood Cliffs, N. J.: Prentice-Hall Inc., 1963, p. 30.

CHAPTER FOUR: CURRENT AND PROSPECTIVE LIABILITIES OF THE STATUS OF CIC STUDENT

OCCUPATIONAL STATUS AS THE TARGET FOR COMMUNICATIONS FROM EXTERNAL GROUPS

Sociologically, a person is conceptualized as relating to various social groups and institutional sectors[1] by way of the major statuses which he occupies. As one moves through life,

---

[1] In this dissertation, an "institutional sector" contains both institutions and groups. Institutions in society are "ways of doing things" organized around important "functions" or needs of society. With every important institution (and its sub-institutions) we find certain social groups (often associations) designed to promote those institutions. MacIver, Bierstedt, and Inkeles, among others, define the relationship of group to institution in this way. R. M. MacIver and Charles H. Page, Society (Rev. Ed.), New York: Holt, Rinehart and Winston, 1949, p. 15; Robert Bierstedt, The Social Order (Rev. Ed.), New York: McGraw-Hill Book Co., Inc., 1963, p. 340 and following; Alex Inkeles, What Is Sociology?, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1964, pp. 67-68.

A perspective of the occupational status as linked to a network of other affected "sectors" is very central to the work of Theodore Caplow. In a general way the model which follows, of the CIC student receiving messages from surrounding institutional sectors is derived from Caplow. See especially his "Homelessness Project" at the Columbia Bureau of Applied Social Research (1964-67).

his "status-set" undergoes changes; as new major statuses are assumed, the "interests" of additional groups in a person's activities and attitudes are activated. Becoming an "eligible" or "relevant" target for information and "messages" from these concerned groups, the initiate must restructure, to a greater or lesser extent, his "life-space." Goffman writes of the confrontation which takes place when one assumes an important new social label and the "eligibility" status which goes with it:

> /A person/ must go through another process by which his new involvement finds its proper place, in space and time, relative to the other calls, demands and commitments that he has upon himself. At this point certain other persons suddenly begin to play an important part in the individual's story; they impinge upon him by virtue of the relationship they happen to have to the value /which in Goffman's context means status/ in which he has become involved. [1]

Sociologists have recognized that assumption of an occupational status by a person is particularly important in prompting "messages" and "directives" from new groups and sections of society. Friedmann and Havighurst, for example, characterize the importance of occupational status in this way:

---

[1] Erving Goffman, "On Cooling the Mark Out," in Arnold Rose (ed.), Human Behavior and Social Processes, Boston: Houghton-Mifflin Co., 1962, p. 486.

"It serves to maintain (a person) in his group, to regulate his life-activity, to fix his position in society, and to determine the pattern of his social participation and the nature of his life-experience, and is a source of many of his satisfactions and affective experience."[1]

With certain occupations-- most notably the professions and semi-professions-- assumption of occupational status proceeds in stages, where the recruit must move through initiatory and training phases (usually with a cohort group) before he is granted full membership. When students actually matriculate in a training course they (1) make themselves "eligible" to receive "messages" from external groups and (2) place themselves in a prime "reception zone"-- the school situs and culture-- for such messages. It is too seldom made explicit that students in professional schools receive to a large extent the same messages, "directives" and evaluations from surrounding groups as do the full-fledged members of their respective professions.

This research takes the most important groups and sectors impinging on the status of professional student to be: (1) the market sector (2) the political sector (3) the publicity

---

[1]Eugene A. Friedmann and Robert J. Havighurst, The Meaning of Work and Retirement, Chicago: University of Chicago Press, 1954, p. 3.

sector (4) primary and secondary groups (5) related occupations (6) own occupational associations. The detailed meanings of these terms will become clear as the discussion unfolds.

In most health professions in the United States, the messages, directives, and evaluations which are sent from the above-mentioned groups in society are "positive," indicating either current approval of the student status or future welcome for the graduate. Let us briefly sketch the case of the medical student vis a vis these groups, since his is perhaps the polar case for reception of positive messages.

In the United States today a medical student knows that his services as a physician will be much in demand and that he will earn, at the very least, a secure living (positive messages from the market sector of society). Upon licensure, he will have the broadest possible mandate from the state in terms of scope of practice. For certain health problems he will have an exclusive mandate. He knows too that if he must spend time in the Armed Forces after graduation, he will receive a commission as an officer (positive messages from various political sectors). The medical profession generally receives favorable coverage from the press, magazine articles, novels and television. Although

they are neither the sole nor the primary target audience for such mass media communications, medical doctors and students are certainly one group of "receivers," and they certainly get the message that the media positively evaluate their professional statuses (approving messages from the mass-media). Families and friends are generally very proud of the medical student. The prestige of both student and doctor is high in the community (approving messages from primary and secondary groups).

In medical school the student learns that the medical doctor is "king of the heap" vis a vis other health professions. Nurses grant him deference (both as student and graduate doctor); optometrists, podiatrists, osteopaths, chiropractors and dentists will all someday refer cases to him which they feel are beyond the bounds of their more limited therapeutic mandates (deferential and approving messages from related occupations). Finally, while he is a medical student one learns how close-knit and important is the collegial network of physicians in the United States, and how powerful and integrated are local, state-wide and national medical associations (favorable and supportive messages from own occupational associations).

THE "MORAL CAREER" OF THE CIC STUDENT

The CIC student is the polar case in the other direction. During his residence in chiropractic college he receives numerous messages that a much less hospitable welcome awaits him on many institutional fronts than most other types of health practitioners (most other health professions are allied with medicine in terms of a general theory of disease). As we shall see, he is socialized in a range of career uncertainties far wider than those described by Renee Fox in her "Training for Uncertainty,"[1] relative to medical students.

In recent years the concept of "moral career" has been used by sociologists mostly to describe adult socialization processes

---

[1] The major uncertainty for Fox's medical students is that they won't be able to accurately diagnose and/or effectively cure all illnesses which they confront due to definite limits of available medical knowledge and limitations of personal skill. Chiropractic students are "trained" in both these kinds of uncertainty; further, they are socialized to the uncertainties of their being able to practice in particular states, to the conflicting limits of their legitimate scope of practice in various jurisdictions, and to financial uncertainties in their professional careers. See Renee C. Fox, "Training for Uncertainty," in Robert K. Merton, George Reader, and Patricia L. Kendall (eds.), The Student-Physician, Cambridge: Harvard University Press, 1957, pp. 207-241.

which result in a stigmatization[1] of self. Initially employed in a vivid fashion by Goffman[2] to analyze the situations of mental patients and prison inmates, it has recently been extended by Blumberg[3] to cover the accused person in a criminal court system. Goffman's description of the concept of moral career is most succinct:

> The moral career of a person of a given social category involves a standard sequence of changes in his way of conceiving of selves, including, importantly, his own. . . .
>
> Each moral career, and behind this, each self, occurs within the confines of an institutional system, whether a social establishment such as a mental hospital or a complex of personal and professional relationships. The self, then, can be seen as something that resides in the arrangements prevailing in a social system for its members. The self in this sense is not

---

[1] Conceptually "moral career" could refer to any new development in self-concept. Nevertheless, most sociological research has in fact dealt with stigmatized developments. For a wider use of the concept see Julius Roth, Timetables: Structuring the Passage of Time in Hospital Treatment and Other Careers, Indianapolis: Bobbs-Merrill, 1963, where "moral career" is used to analyze the careers of airline pilots and business executives.

[2] Erving Goffman, Asylums, Garden City, New York: Anchor Books, Doubleday and Company, 1961, especially "The Moral Career of the Mental Patient," pp. 127-169.

[3] Abraham S. Blumberg, Criminal Justice, Chicago: Quadrangle Books, 1967, especially "The 'Moral Career' of An Accused Person," pp. 63-71.

> a property of the person to whom it is attributed, but dwells rather in the pattern of social control that is exerted in connection with the person by himself and those around him.[1]

There appears to be a "moral career" of the CIC student which is squarely within the more specialized definition of that concept as adult socialization which leads particularly to mortification of self. Blumberg's scheme, for example of "The Accused Vis a Vis His Agent Mediators,"[2] where the accused person is bombarded by "negative messages" from various impinging groups, such as news media, police, kin group and probation officer, is strikingly similar to the present model of the CIC student surrounded by hostile communications (although some of the groups and sectors are of a different nature).

As this thesis hopes to show in subsequent chapters a most significant development in the "moral career" of the CIC student is the particular manner in which his occupational or "professional" self-concept emerges: because of threat to self posed by the barrage of negative messages he receives, he tends to make a strong distinction between his self and the other selves involved in the chiropractic profession.

---

[1]Goffman, Asylums, op. cit., p. 168.

[2]Blumberg, op. cit., p. 70.

NEGATIVE MESSAGES BEAMED TO CIC STUDENTS: A DIAGRAM

It is useful to present at the beginning a schematic picture of negative messages metaphorically beamed to CIC students from the groups and societal sectors indicated above. Such a picture will be found in Figure 4-1, but the reader should keep in mind several points about the Figure, and the detailed discussion following it, before examining it.

The "messages" stemming from any particular source are often presented in an "abstracted" manner on the Diagram, since they are frequently the "sum" of independent or objective information directly from or about the external group combined with "interpretations" "amendments," and "additions" superimposed on this factual data by CIC students, faculty and administrative personnel. For example, Figure I indicates that one message from the political sector beamed to CIC students is that the scope of chiropractic practice laws are "limited and discriminatory." This "resultant" messages is a combination of objective statutory reality and attitudes held by chiropractors and students about medical domination of state legislatures, and so on.

Three orders of data are usually available in this research concerning any group's or institutional sector's message

to CIC students:

(1) Direct and independent information stemming from the group or sector concerning chiropractic and chiropractors, such as independent research estimates of chiropractors' incomes; the content of state laws regulating chiropractic, and judicial decisions affecting chiropractors; mass media literature about chiropractic; AMA literature attacking chiropractic; published materials, such as professional journals emanating from within the chiropractic profession, as well as a recent sociological study of chiropractic professional organization at the national level.

(2) Statements, remarks, rumors, and behavior, concerning the various groups and sectors impinging on chiropractors made or exhibited by various people at CIC, which I recorded in my field notes. For each of the sectors I have attempted to give a "representative sample" of prominent and repeated statements and situations. Toward the end of my field observations I stopped recording certain statements since they were already so prominent and recurrent in my notes. As Francis and Stone note "When certain patterns became manifest, when certain values were uniformly expressed, when the content of the interviews and observations became similar, a point of diminishing returns

was felt. . . ."[1]

Following Becker,[2] I was careful to maintain a balance between remarks made by students and other CIC personnel among themselves and those made by people directly to me. In all cases where direct quotations are used, the reader is told in what particular context they occurred. If too many of the quotations had been the specific result of my probing-- as opposed to spontaneous exchanges among the actors in the CIC culture-- I could not contend, as I do, that these particular "perspectives" on attitudes of various groups toward CIC students and chiropractors were "in the air" at CIC.

The quotations are only secondarily to be identified with particular persons. The assumption is that what is stated by one person or another is heard by others, bruited about as it were in the CIC subculture. With this order of data particular persons are conceptualized as "informers"-- in the anthropological field worker's sense of that term-- who give expression to more

---

[1]Roy G. Francis and Robert C. Stone, Service and Procedure in Bureaucracy, Minneapolis: University of Minnesota Press, 1956, p. 26.

[2]Howard S. Becker, Blanche Geer, Everett C. Hughes and Anselm L. Strauss, Boys in White: Student Culture in Medical School, Chicago: The University of Chicago Press, 1961, pp. 41-43.

widely shared cultural items or culture patterns.

(3) Finally, there is systematic data from the two questionnaires administered to the students concerning some of the negative messages which specifically demonstrate that a majority of the students have in fact "received" and "internalized" unfavorable communications about different aspects of their upcoming careers. At this level what is "in the air" at CIC as a cultural theme is "stepped down" to the individual students.

In a rough and partly metaphoric way, then, the data carries us through three phases of transmission and reception of messages. The messages are "sent" from the various sectors (1); picked up by a large "receiver"-- the CIC subculture (2); and finally "re-transmitted" to individual students (3).

Following the Figure, which gives an overview, each sector, or group, and its messages is discussed in detail with supporting data of the types note above. Although the messages are not exhaustive, it is believed that they represent the full range of serious current and future liabilities of which students are made aware. The role of CIC itself as a creator as well as conveyor of bad news is analyzed after the six sectors are covered in turn.

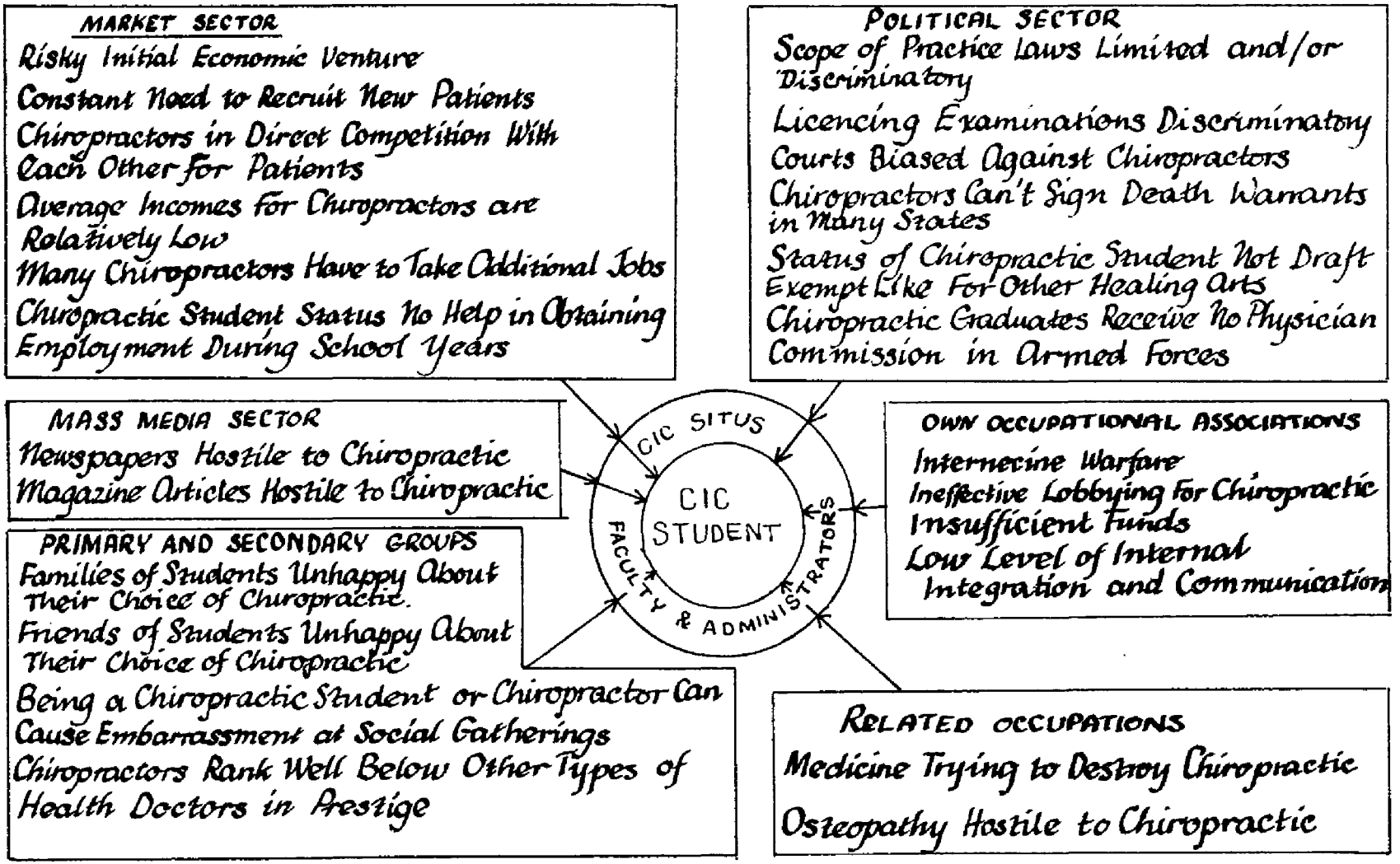
The major focus of this research is on the relationship

between any particular external group and chiropractic students. It is, of course, true that these various groups and sectors interact among each other in multiple ways, as well as with chiropractic students directly, and that a "total" analysis here would involve a simultaneous discussion of all six groups and sectors related to each other and chiropractic studen s. But the "compartmentalized" model employed in this research certainly has precedent in much contemporary sociological analysis.[1] Beyond the support of precedent, however, field work indicated that CIC students do in fact perceive negative messages as coming from specifically identifiable societal segments, as much as they experience a general rejection from "society-at-large." The sector model, then, seems to follow the contours of the data.

---

[1] Robert Merton's "reference group theory" is an important example of this type of analysis. See Robert K. Merton, Social Theory and Social Structure (Rev. Ed.), Glencoe: The Free Press, 1957, Chaps. 8 and 9, pp. 225-386.

Figure 4-1: Diagram of "Negative Messages" Beamed To CIC Students From Societal Sectors and Groups



THE MARKET SECTOR

One crucial sector or "domain" of society with which any occupation must reckon is the "market situation" in relation to its particular supply of goods and/or services. Weber defined "market situation," in broad terms, in the following way:

> By the "market situation" for any object of exchange is meant all the opportunities of exchanging it for money which are known by the participants in the market situation to be available to them and relevant in orienting their attitudes to prices and to competition. [1]

When chiropractors-to-be assess the "opportunities of exchange" in their market situation they focus on features which must include: possibility for full-time work; the relative attraction of chiropractic versus medicine and osteopathy for potential patients; "average income" figures for chiropractors already in practice; the degree of expense and difficulty in setting up a practice; the degree of competition among chiropractors for patients; and the extent to which the status of chiropractic student opens up special or favorable opportunities for pre-graduate employment.

(1) There is some independent or "objective" information on certain

---

[1] Max Weber, "The Market," in Talcott Parsons, Edward Shils, Kaspar D. Naegele, and Jesse R. Pitts (eds.), Theories of Society, Glencoe: The Free Press, 1961, vol. 1, p. 443.

of these market features that paints a relatively bleak market picture for prospective chiropractors in comparison to what medical graduates can expect.

United States Department of Labor statistics tell us that "although incomes of chiropractors vary widely, experienced chiropractors generally had average yearly incomes ranging from $11,000 to $16,000 in early 1967," and that "the net income of physicians in private practice was generally between $20,000 and $27,000 in 1966."[1] Note that novice physicians in private practice are presumably included in the $20,000 to $27,000 range, whereas beginning chiropractors (the inexperienced ones) presumably make less than $11,000 to $16,000; so that for purposes of comparing the outlook for new practitioners in these two health professions the advantage on the side of the physician is even greater than these government statistics indicate.

Chiropractic in California states:

> The median workweek for chiropractors is 39 hours as compared with 60 hours for medical doctors. While 40 percent of the chiropractors surveyed see fewer than 10 patients per day, the median number is 12. This compares with 25 patients seen daily by the

---

[1] United States Department of Labor, Bureau of Labor Statistics, Occupational Outlook Report Series, Bulletin No. 1550-17 (chiropractors) and Bulletin No. 1550-58 (medical doctors). Although it is not specifically stated that reported figures for chiropractors' incomes are net, this is most probably the case, since many other occupational incomes in this series (including medical doctors) are reported in net terms.

> average general practitioner in medicine. Among chiropractors surveyed, median monthly overhead office expenses are $252, and median monthly earnings are $539 before taxes. Comparable monthly earnings for medical doctors throughout the nation are $1,335.
>
> This information shows that about 50 percent of licensed chiropractors are in full-time practice as compared with 97 percent of all osteopaths and 91 percent of all medical doctors. [1]

Chiropractors, then (in California), see less than half the number of patients as an average M. D., and earn well less than half the M. D. 's income. Then too, only half of California's chiropractors practice full-time, as opposed to over 90 percent of both medical men and osteopaths.

The California report also found that chiropractors were "losing out" to M. D. s and osteopaths in competition for patients:

> Thus, practicing chiropractors, comprising 16 percent of all California doctors, attended 3.6 percent of all reported conditions; osteopaths, comprising 9 percent of all doctors attended 9.3 percent of all conditions; and medical doctors, comprising 75 percent of all doctors attended 87 percent of all conditions. Therefore, chiropractors were found to have the lowest rate of utilization among California doctors.
>
> Chiropractors, although comprising the second largest group of healers, serve less than one-thirtieth of the market for healing services. [2]

---

[1] Chiropractic in California, Los Angeles: The Haynes Foundation, 1960, pp. 4-5.

[2] Ibid., pp. 4 and 9.

Although the California report offers no direct data on the point, the limited patient pool available combined with a relatively large number of practitioners would lead one to predict a high degree of competition among chiropractors for patients. As we shall see, CIC students perception of the chiropractic market is that very strong competition prevails.

Chiropractic in California does not systematically study the kinds of employment held by chiropractic students while in chiropractic college, but its survey of their pre-chiro practice education work experience plus the following quotation indicates that chiropractic students are forced to take low-status and low-paying work:

> In many cases he /the chiropractic student in California/ has had little or no college education, and he comes to school with meager savings, a family to support, and tuition payments to meet. To achieve his objective he often must work a full day in a plant or a store /my italics/. . . .[1]

There is no comparable market data to Chiropractic in California for New York State. However, a rich collection of statements and behavior by students, faculty, and administrative personnel recorded at CIC indicates that the CIC subculture defines the market situation and its "messages" in a pessimistic fashion, quite similar to Chiropractic in California's portrayal.

---

[1] Ibid., p. 105.

(2) Comments, interpretations and "perspectives" voiced by persons at CIC on the important features of the chiropractor's market were generally very unfavorable, with limited exceptions. What follows is a sample of typical comments or situations selected from a larger number in my notes, and ordered along basic problems in the chiropractor's economic situation.

Initial "Starvation" Period -

> "X (who graduated from CIC in 1966) told me the other day that he's seeing close to 100 patients a week. But I heard from two other guys in his class that he's starving."
>
> - A Supersenior to other students

> "I'm going to get into an older guy's office if I can instead of starting out on my own-- it's much safer."
>
> - A Junior to classmates

> A representative from an x-ray equipment supply company gave a two-hour talk to the Seniors on the economics of setting up an office, with detailed cost estimates. The minimum initial expenditure figure turned out to be much higher than many of the class had thought. They seemed stunned by the cost, and after class wondered among each other where they would get "that kind of money," especially since opening a chiropractic office was such a risky business.

Generally Low Income For Chiropractors -

> "Most of these guys will starve when they get out of here-- and keep starving! You hear a lot of bullshit from some people around here that chiropractors make a lot of money, but most guys do poorly, and lots of them have to take other jobs to make ends meet. There are only a few rich chiropractors."
>
> - A Supersenior to me

"My parents are very worried about my becoming a chiropractor, because they are afraid I won't be able to make a living. That's why they wanted me to be a dentist."

- A Sophomore to me

Chiropractic as a Part-Time Profession -

"Y is lucky he was trained as an engineer before he became a chiropractor. He makes most of his money at that since his practice is so small."

- CIC faculty member to me

"I've got a real dilemma when I graduate. I already own a trucking company which is doing well. So I'll probably divide my time between that and practicing chiropractic."

- A Junior to classmates

"I hear that more chiropractic offices are closing up in New York City every day."

- CIC faculty member to Senior class

Limited Patient Pool and Heavy Competition Among Chiropractors -

"Chiropractic isn't like medicine, you know, where you just wait for the patients to come into your office. You've got to go out and hustle if you're going to make it as a chiropractor."

- A Pennsylvania D. C. to me during his two days at CIC, attendance required by Pennsylvania license statute to maintain one's license

"The trouble with chiropractors is that they can't get together with each other. As far as patients go, this is a dog-eat-dog business."

- A Supersenior to me and several students

Chiropractic Student Status a Liability
for Outside Employment -

> "If you're a chiropractic student and need money, there are no jobs for you related to your field. Medical students can work in a hospital or a lab, but we haven't got any of that. The job most students here end up getting is waiter, or truck driver, or sales clerk--something low-paid like that."
>
> - "Front office" personnel to me

> "I've been working part-time as an orderly in a hospital. I keep my mouth shut about being a chiropractic student, because I know that would finish me if they found out."
>
> - A Sophomore to me

(3) Questionnaire data from the 2nd Questionnaire (N=75) demonstrates that students have on the whole internalized the negative messages about the market situation that are recurrently "in the air" at CIC.

Initial Starvation Period -

In response to a question about the economic situation of the recent chiropractic graduate 8% of the sample indicated he "better be prepared to starve for the first couple of years," and 53% of the sample thought he "will probably just get by for the first couple of years." 39% felt that "even the recent graduate these days generally does well very soon after he opens an office."

Chiropractic as a Part-Time Profession -

In response to a question as to whether chiropractors who have just recently opened a practice ever take additional non-chiropractic employment 57% of the sample checked "occasionally" and 20% "frequently," with only 23% choosing "rarely or never."

Limited Patient Pool and Heavy Competition Among Chiropractors -

Students were asked to indicate some measure of agreement or disagreement with the statement: "Although it's not often said openly, many chiropractors feel that they are in direct competition with other D.C.s for patients." 19% of the sample "strongly agreed," 44% of the sample "agreed somewhat," 27% of the sample disagreed somewhat," and 11% "disagreed strongly."

Chiropractic Student Status a Liability for Outside Employment -

Students were asked how helpful mentioning they were chiropractic students was in getting a desirable outside job while finishing chiropractic college. 4% answered "very helpful," 29% answered "fairly helpful," 59% of the sample responded "of no help," and 8% responded "detrimental." While these figures do not fully support the contention that the status of chiropractic student

is seen as "detrimental" or a "liability" in getting employment, they certainly illustrated that the majority of students perceive the status as "of no help."

Limited Favorable Perspective in the Market Sector Area -

It would test credulity to assert that I noted no "positive" messages whatsoever bruited about CIC concerning features of the chiropractor's market. Students and faculty would sometimes talk about chiropractic as being a "good racket," or "providing security"; or they would tell stories about the occasional chiropractor who achieves very great financial success. But, although I kept no total record of "plus" or "minus" statements, as Becker and his associates did in Boys in White[1] concerning expressed "perspectives" of their medical students toward the limits of materials to be studied, and so on, my field notes convey the impression of an overwhelming majority of "negative" perspectives on the chiropractic market. With the questionnaire data as well,

---

[1] Becker et al., op. cit., Chp. 3, pp. 33-48. I did not follow Becker's approach for two reasons: (1) unlike Becker I worked alone and had no staff of researchers to systematically record all statements in many classes at the same time, and (2) following Francis and Stone, I accepted the prominence of a certain "perspective" or "message" concerning one institutional sector or another after I had heard it repeated frequently and rarely (if ever) contradicted by other people at CIC.

answers to most items bearing on this question correspond to the gloomy mood of statements "in the air" at CIC about chiropractors' prospects.[1]

THE POLITICAL SECTOR

"In any very complex society certain systems of cultural norms and social organization become sufficiently explicit and

---

[1] At really only one point in the questionnaire data is the trend reversed.

In response to the questions about how much the "average chiropractor" can expect to make after 10-15 years of practice and at the peak of his career, students estimate $28,400 and $37,100 (both medians) respectively. These prognoses are so out of line with "objective" estimations of chiropractors' incomes, as well as with the majority of negative perspectives voiced by students both in my notes and in the Questionnaire, that one immediately suspects them to be an "over-reaction in the opposite direction, prompted by the bombardment of negative information about the market reaching CIC students.

In any case, since a comparison between students' estimates of colleague's prospective incomes and their own incomes is a core section of the hypothesis-testing part of this thesis (beginning in the following chapter)-- a comparison which puts these high estimates of $28,400 and $37,100 in quite a different perspective-- let us merely note here that these particular data constitute a partial qualification, or even contradiction, to the assertion that CIC students are exposed to, and internalize, basically negative meassages about their market situation.

differentiated to be labeled as political. We then speak of government, the state, political parties, sovereignty."[1] In modern society all occupations are regulated by certain institutions and groups within the political sector to a greater or lesser extent. The professions and semi-professions particularly exhibit multi-bonded connections with the political sector. For CIC students looking to the future three areas of political connection and regulation are most prominent: (1) the nature of state licensing examinations and scope of practice legislation (2) the attitude (and action) of the judiciary toward chiropractors (3) the attitude of the Armed Forces toward chiropractors.

(1) A good deal of independent evidence emanating directly from legislative, judicial and military groups demonstrates that negative messages are being sent to chiropractors and chiropractic students from the political sector of American society.

Laws Regulating Chiropractic -

Although chiropractic is now legally regulated in all but two (Mississippi and Louisiana) United States jurisdictions, the several scope of practice acts vary widely. In many states chiro-

---

[1] Robin M. Williams, Jr., American Society (2nd Ed., Rev.), New York: Alfred A. Knopf, 1961, p. 215.

practic practice is severely limited-- it being specifically stated in the statute that such practice is not the practice of medicine, osteopathy, and so on. Missouri's law is quite typical in this respect:

> The practice of Chiropractic is hereby defined to be the science and art of palpating and adjusting by hand the movable articulations of the human spinal column, for the correction of the cause of abnormalities and deformities of the body. It shall not include the use of operative surgery, obstetrics, osteopathy, nor the administration is hereby declared not to be the practice of medicine and surgery or osteopathy....
>
> - Revised Chiropractic Law as passed by the 65th General Assembly of the State of Missouri, Section 331.010

The New York chiropractic law, passed in 1963, contains a typical qualification that possession of a license to practice chiropractic does not allow one "to practice obstetrics, psychiatry or any medical, surgical or paramedical specialty or sub-speciality." (Laws of New York, Chapter 780, Article 132, Section 6558, 3(a)) It also contains an unusual and particularly restrictive clause forbidding the chiropractor "to treat for any of the following conditions: any infectious diseases such as pneumonia, any communicable diseases listed in the sanitary code of the State of New York, any of the cardio-vascular-renal or cardio-pulmonary diseases, any surgical condition of the abdomen such as acute appendicitis, or

diabetes, or any benign or malignant neoplasms." (Laws of New York, Capter 780, Article 132, Section 6558, 3(c))

In a more general overview of the New York law, fully one half of its 14-pages is punitive in nature, detailing legal action which can be taken against a New York State chiropractor for a range of violations he may commit. (pp. 8-15 of Laws of New York, Chapter 780, Article 132)

The Courts and Chiropractic -

Recent state and federal court decisions have decided against chiropractors and chiropractic. In Gian-Cursio vs. State of Florida, 1965, two chiropractors were convicted on a charge of manslaughter for causing the death of a patient through culpable negligence in the treatment of his pulmonary tuberculosis.

In December, 1967, a California court convicted Dr. Marvin Phillips, a chiropractor, for the second time of second-degree murder in connection with the 1961 death of an 8-year old girl. In January of 1968 he was sentenced to five years to life in what the state called a case of "cancer quackery,"[1]

In 1966, the United States Supreme Court upheld a decision of the Federal District Court in New Orleans, which had held that the

---

[1] The New York Times, January 2, 1968.

State of Louisiana was within its rights to demand that chiropractors have a medical education to be licensed.

Chiropractic Students' and Chiropractors' Status With the Armed Forces -

We have already noted (in Chapter 3) that draft deferments for professional students in health-related fields do not cover chiropractic students-- although students in medical, dental, osteopathic, optometry and veterinary medicine programs are so covered. Nor are graduates of chiropractic colleges given officer commissions-- as are medical, dental and osteopathic graduates-- in the Armed Forces of the United States. In effect, the military does not recognize chiropractors as skilled, professional health practitioners.

(2) Typical comments heard at CIC interpreting attitudes of crucial political groups toward chiropractic "confirm" the unfavorable tone of pronouncements made directly by these groups. Again, what is presented here is only a sampling of a larger number of similar statements. As with the market sector, the great majority of relevant comments expressed the unfavorable tone of received "messages." The quotations are grouped in the three categories employed directly above: (1) Unfavorable information about state licensing exams and scope of practice laws (2) Unfavorable

information about judicial treatment of chiropractors and (3) Unfavorable information about Armed Forces' attitude toward the status of chiropractic student and graduate.

Discriminatory Examinations and Restrictive Scopes of Practice -

Students, faculty and administration at CIC universally condemn the present New York law, both in terms of its licensure qualifications-- which they feel are discriminatory (controlled by medicine) and its drastic restriction of just what a licensed chiropractor can do therapy-wise. Although there is no objective reliable information giving exact figures, it appears that less than 10 candidates who have graduated from chiropractic colleges since 1966, out of a total of over 300 taking the examinations, have succeeded in negotiating all five of the New York State basic science examinations.

> "New York State is out to destroy chiropractic under the guise of regulating it. There isn't going to be a new generation of chiropractors here because nobody will pass those tests."
>
> - CIC Clinic Director to all classes

> "I studied night and day for the exams (New York's basic science exams) this time and got the same marks in Pathology and Bacteriology as last time when I didn't open a book! I'm sure there messing around with our marks."
>
> - CIC Instructor to other Instructors

"I feel like my native state is kicking me out."

- A Senior living in New York
to classmates

"You read the New York law and you see you can't treat this and you can't treat that, and finally you say to yourself 'What the hell can I treat in this lousy state?'"

-CIC Instructor to Junior class

"In New York State, Dave, and some other states, we're not allowed to sign death warrants if a patient dies in the office or under your care. You have to go begging to an M. D. We all have nightmares about somebody dropping dead on the table."

- A CIC Instructor to me

Hostility of the Courts to Chiropractors -

"Did you hear what they did to Phillips in California? They sent him up for murder! And I thought California was a 'good' state!"

- A Sophomore to classmates

"In the old days in New York we used to go to jail for chiropractic when they closed us for practicing medicine and we wouldn't stop. With the law we have now it looks like some of you are going to have to go to jail for chiropractic-- that is if you want to practice in this state."

- Clinic Director to Senior class

No Preferential Treatment of Students and Chiropractors by Armed Forces -

"I went down to see my draft board about an exemption, seeing as I'm a professional student in chiropractic. They laughed in my face. I felt miserable."

- A Sophomore to other students

"The only good thing about being a chiropractor military-wise for me was that I was able to fool their dumb osteopath into thinking I had a bad back."

- A Supersenior to me

"If you're lucky being a chiropractor might get
you in as a medical corpsman-- that's if you're lucky!"

- Another Supersenior to me

It should perhaps be noted, before moving on to questionnaire evidence about reception of negative communications from political groups, that although CIC comments relative to the situation in New York State were particularly stressed, chiefly because CIC is situated in that state, a number of the remarks have application beyond the specific political institutions of New York.

(3) As with the Market Sector, responses to certain items in the 2nd Questionnaire support the argument that students on the whole have internalized the negative tone of messages sent to them from the political sector.

Discriminatory Licensing Examinations and Poor Performance by Chiropractic Candidates -

Students were asked whether any states require chiropractic candidates for licensure to take basic science examinations which are based on a medical education rather than a chiropractic one. 60% answered "many," 32% responded "some," 8% "one or two," and no students responded "none."

Respondents were also asked how well they believed chiropractic students succeeded on the basic science parts of state

licensing examinations the first time they tried them. 32% of the sample responded average students passed "all or most," 51% answered passed "about half," and 17% answered passed "less than half." Thus nearly relatively 70% were pessimistic about the average candidate's chances.

State Laws Hostile to Chiropractors -

To the question "Although generalizations are difficult, how would you best sum up the attitude of state licensing laws toward the chiropractic profession?" 41% of the sample answered "unfriendly," 48% responded "lukewarm," and only 11% answered "friendly."

Courts Hostile to Chiropractors -

To the question as to how malpractice suits against chiropractors turned out, 15% of the sample responded "favorable to chiropractors," 60% responded "about equally divided between favorable and unfavorable to chiropractors," and 25% answered "unfavorable to chiropractors."

Students were given an open-ended question "What aspects of being a chiropractor might you dislike?" Although not all students (N=75)[1] answered this question, the majority responded with one or

---

[1] The Ns of 75 or 89 will occasionally be stated in the test along with a quoted questionnaire item to remind the reader of the sample sizes for the 1st and 2nd Questionnaires.

more possible dislikes. One category of worries was political. A number of students were concerned about "limitations on my practice imposed by state laws." Others wrote about "not being able to pass the state boards in a state where I want to practice." One student expressed fear of "being sued by a patient for malpractice, since people know courts are against chiropractors." This data is not as systematic or complete as other questions discussed above, but its spontaneous character adds support to the contention that negative communications from the political sector are reaching, and disturbing, CIC students.

It should be noted that these questionnaire data are not specifically concerned with political messages to chiropractic students sent by New York State, but with the general tone of political messages from American society. Although CIC students' present location in New York State may make them peculiarly sensitive to and eligible for political liabilities from this particular state, the questionnaire responses indicate a wider sense of inequity, beyond the geographic bounds of any one state.

THE MASS MEDIA SECTOR

The most important individual media within the mass

media sector of our society are newspapers, books, magazines, radio, movie and television. Bensman and Rosenberg[1] note the powerful influence these media have on shaping public images of issues, persons, occupations, and so on. Novels, motion pictures and television have no doubt been very influential in building an aura of drama and mystique about professions such as law and medicine. The mass media have not only made certain professions appear valuable and attractive to the public, (or with some occupations, worthless and unattractive) but to recruits and practitioners in these professions as well.

(1) The negative attitude that the mass media exhibit vis a vis chiropractic and its practitioners manifests itself in two ways: Either there is an absence of information and comment about chiropractic in the several media, or limited coverage is distinctly unflattering and critical.

The Absence of the Chiropractor in the Mass Media -

As far as I have been able to ascertain, there has never been a novel, film, or television show (or series) featuring a chiropractor as hero or protagonist. Play-wise, there is one exception: William Inge's Come Back, Little Sheba portrays the life of "Doc," a chiropractor, and his wife. Significantly, the American concep-

[1] Joseph Bensman and Bernard Rosenberg, Mass, Class and Bureaucracy, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963, Chapter 11, pp. 323-349.

tion of chiropractic as a second-choice and unenviable occupation emerges in the play: the dreariness of "Doc's" life goes back to his having to leave costly medical school and become a chiropractor instead because he made his girlfriend pregnant and was forced to marry her.

The various mass media forms have ignored the status-role of chiropractor almost completely, refusing to see in that occupational nexus any noteworthy human drama, responsibilities or contributions to society. On the other hand, these aspects of the medical doctor's status-role have been portrayed by novels, films, radio and television too many times to require specific citations.

The occupation of chiropractor is generally not included in vocational guidance books and pamphlets designed for wide-spread popular consumption by American teen-agers on the verge of occupational choice. Information about a career as a chiropractor can generally only be obtained from sources within the chiropractic profession.

The Limited Coverage He Does Receive is Unfavorable-

When the mass media do comment on chiropractic they usually have something unfavorable to say. Newspapers stress

civil or criminal judicial proceedings for malpractice against chiropractors, or alleged excesses on chiropractors' parts in relation to insurance claims.[1] Novels occasionally portray him (in a minor supporting role) as quack or abortionist. Popular magazine articles take the orthodox medical point of view-- the tone and substance of their commentaries is usually to "expose" chiropractors. A May, 1967 article in Good Housekeeping entitled "The Medical Dispute About Treatment by Chiropractors," is rather typical of this approach. Although some facade of "objectivity" is maintained, chiropractic is painted in black terms with the usual AMA criticisms of chiropractic (inadequate schooling, quack theory of disease, excessive therapeutic claims, and so on) very evident. Ralph Lee Smith's The Health Hucksters is even more forthright in its damning "exposure" of chiropractors: "Too few realize that chiropractors reject the findings of modern medicine because these findings conflict with the ideas of a 19th century fish-peddler."[2]

---

[1] On January 25, 1968 the New York Times reported testimony before the Joint Legislative Committee on Public Health and Medicare which attacked chiropractors' excessive claims under the state medical insurance law, Medicaid (not to be confused with federal Medicare, from from which chiropractic is excluded) and recommended eliminating chiropractic from the program:

"The chiropractor frequently saw all the family members at the same time and gave them the same diagnosis and treatment, although their ages ranged from 7 months to 55 years. The diagnosis invariably was 'misplaced vertebrae,' the committee was told, and the treatment was spinal manipulation.

'I would strongly suggest that our legislative body reconsider

Further: "The most serious and dangerous thing about chiropractic remains the fact that its belief are sheer myth, and its methods of treatment have nothing whatever to do with the cause and cure of illness."[3]

(2) My field notes from CIC indicate that students, faculty and administrative officers perceive very acutely that the mass media either ignore chiropractic or condemn it.

> One day one of the men from the "front office" came into each of the classes (sophomores, etc.) and announced to students that a prominent New York chiropractor would be on the "Long John Nebel Show" very late one night that week. Two of the instructors in these classes made remarks to the students to the effect that M. D. s made sure Cs couldn't get on the air during the day by threatening the networks with withdrawal of commercials. The mechanisms of this pressure were not explained by the instructors.
>
> "One reason we chiropractors have to advertise (in newspapers, etc. when state law allows) openly is because we don't get any free publicity which the M. D. s get every day from the papers and TV. Just give us a

---

chiropractic participation in Medicaid.' Dr. Huddle told an enthusiastic audience at the Mark Twain Hotel."

[2]"Chiropractic: Science or Swindle?" Today's Health, May, 1965.

[3]Ibid.

Ben Casey or a Dr. Kildare and we can stop advertising."

- CIC Faculty Member to me

A Junior student repeatedly urged me to get hold of an article on chiropractic in Fortune a few years ago because, as he said, "It's the only favorable piece on chiropractic I've seen."

"Our biggest problem is public ignorance about chiropractic, and the chief reason for this is lack of publicity in the papers and on TV."

- Front Office official to me

"One reason we find it so hard to get students is because the high school guidance counsellors almost never tell students about chiropractic. This is partly because they never have any books or materials on chiropractic to show students-- or to learn themselves about it. I know this is true because I've been a high school teacher in the Jersey school system off and on for years."

-A CIC Instructor to both the Freshman and Senior class

"Sure we've got faults in our profession, but the damn newspapers always concentrate on them and ignore our good points."

- A Supersenior to me

(3) Questionnaire data which is available on the mass media sector support the other orders of data in confirming that CIC students define the mass media as either ignoring them or attacking them.

For example, in answer to the question "How important has the public's unfamiliarity with chiropractic been in explaining why chiropractic has not been as fully accepted in the United States

as it has wished?" 79% of the sample (N=75) answered "very important," and 21% responded "fairly important." Not one respondent chose the "unimportant" category. The unspoken assumption in these data is that the mass media are primarily responsible for not publicizing chiropractic. This particular finding is strikingly similar to data in Chiropractic in California where 43% of a sample of 517 chiropractors gave "an uninformed public" as their first choice to the question "Which factors account for the fact that chiropractors do not receive the respect they should?"[1]

In response to the question "Was chiropractic an occupation that your high school guidance counsellor discussed as a possibility with students?" 94% of my sample of 89 students answered "No," 2% responded "Yes," with 3% failing to answer this question and one student writing in that "my high school adviser advised me against it." Alongside the indicated choices three students wrote in "Are you kidding?" Students very clearly believe that chiropractic is not a profession publicized by the media or available to hand for guidance counsellors.

---

[1] Chiropractic in California, op. cit., p. 67.

I also asked students in the 2nd Questionnaire how they evaluated the messages which newspapers were sending out about chiropractic. No respondents (N=75) felt that "Newspapers support chiropractic by giving prominent coverage to items favorable to the profession," 44% felt that "Newspapers are neutral or lukewarm about chiropractic," and 56% felt that "Newspapers seem to enjoy giving an unfavorable slant to news concerning chiropractic, and play up its faults rather than its virtues."[1]

PRIMARY AND SECONDARY GROUP SECTOR

In this research "primary group" membership conveys the conventional sociological definition of Cooley and others, being "characterized by intimate face-to-face association and cooperation."[2] We are particularly concerned here with family and friendship primary groups of the chiropractic student, who transmit

---

[1] This question is adapted from Niederhoffer's questionnaire for police, another possibly stigmatized occupational group. His sample also felt that the newspapers were very hostile to police: 72% of his sample felt that "Newspapers seem to enjoy giving an unfavorable slant to news concerning the police," whereas only 10% of the sample thought that "Newspapers try to help police departments by giving prominent coverage to items favorable to police." See Arthur Niederhoffer, Behind the Shield, Garden City, New York: Doubleday and Company, 1967, p. 227.

[2] C. H. Cooley, Social Organization, New York: Scribner, 1915, p. 23.

evaluative messages to him in reference to his occupational choice of chiropractic.

Our definition of "secondary groups" is not so tidy. Bierstedt notes that secondary groups with which a person interacts are "a residual category that has no significance in and by itself."[1] Our definition of secondary groups eliminates several types which would be embraced in a general residual category, since a student's membership in them is dealt with in the discussion of other "sectors" impinging upon the status of chiropractic student. Thus a student's membership (student) in the American Chiropractic Association would be conceptualized as a relationship in "own professional associations," and his part-time job as participation in the "market sector"-- whereas in a most general way both of these "memberships" would be secondary group involvements.

By secondary groups the present scheme of analysis means (a) social groups with which a chiropractic student comes into casual, limited and irregular contact, e.g., parties and similar types of social gathering-- settings in which evaluations of chiropractors and/or chiropractic students might be aired. (b) numerous groups and persons (without being specific) which in a composite manner might be called "the community," and

---

[1] Bierstedt, op. cit., p. 306.

which in some sum way exhibit a general attitude about the worth of the occupational status of chiropractor, such attitudes being most concretely expressed in available occupational prestige scales. The CIC student is seen as "belonging" to the community, which in turn is here conceived as a secondary group of a kind.

(1) Independent evidence from "the community" indicates that the prestige of chiropractors is consistently below that of other health practitioners. In the 1963 ratings of the NORC, physician received an average score of 93, dentist an average score of 88, and chiropractor a score of 75. In Warren E. James' Ranking of Acceptance as a Profession (1957) medicine received a score of 97, dentistry 97, osteopathy 75 and chiropractic 56.[1]

(2) More substantial evidence of negative messages from primary and secondary groups comes from field note observations and questionnaire data. What follows here are "typical" statements heard from CIC personnel in reference to messages received from primary, casual and community groups about the worth of chiropractic.

> "It wasn't bad enough I married a shiksa. I'm going to be a chiropractor too! My parents will hardly talk to me."
>
> - A Jewish Junior to me

---

[1]For the NORC ratings, see Lee Taylor, Occupational Sociology, New York: Oxford University Press, 1968, p. 172. For James' scale, see Walter I. Wardwell, "Limited Marginal and Quasi-Practitioners," in Howard E. Freeman, Sol

"I suppose a lot of you are being asked at home about why in God's name you chose chiropractic."

- A Freshman Instructor to class early in their first term

"I come with him (a CIC Junior) to these meetings because he seems to believe in it (chiropractic). I think it's kind of weird myself."

- The girlfriend of a student to me at a "lay meeting."

"Don't ever be ashamed to tell people you're a chiropractic student. It's a great profession. Stand your ground and defend your position."

- Another CIC Instructor to Freshman class

"A lot of guys' parents are upset about their becoming chiropractors, but not mine."

- Junior, whose father is a chiropractor, to me.

"I went to a party last year with my girl. Somehow it came up I was studying to become a chiropractor and some guy started shouting and screaming at me--how we were all quacks and crazy. We almost had a fight. I was really shook when we left."

- A Senior to me

"When I graduate, I think I'll go overseas to practice. Maybe Australia. I hear they really respect chiropractors over there-- not like here. They even pay your fare over and help you set up (practice)."

-Sophomore student to classmates

Observation forces one to the conclusion that rejection and disapproval from primary and social groups is a problem near the top of the CIC cultural agenda. That instructors should,

---

Levine and Leo G. Reeder (eds.), Handbook of Medical Sociology, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963, p. 217.

without solicitation, bring up the issue in classes-- at the beginning of students' course of chiropractic study indicates that it is a prominent problem that students face (and which faculty members are still facing themselves in their own lives and practices). The theme of being "more appreciated" or "more respected" in another country came up rather often. Sometimes the "other country" would be Australia or New Zealand, sometimes it would be Germany and Switzerland. When the first two nations were mentioned the idea seemed to be that the "people" there respected and needed chiropractors; when the latter European nations were named, the central idea was that medical doctors respected chiropractors there.

I have recorded very few really enthusiastic messages from students' families or friends vis a vis chiropractic as a profession. Positive evaluations seem, when they are forthcoming, to be of the "left-handed compliment" type. Either the student in question is the son of a chiropractor (and even he might admit that many other students' families are not happy with their occupational choice, or parents will say to the student: "We don't like chiropractors; but we love you, and if this is your choice, so be it." The latter attitude is very central, I think, to the "courtesy

stigma" phenomenon which I described at the end of Chapter 3. (3) In the first questionnaire students (N=89) were asked "Think back to when you first started here at CIC. How did each of the following persons (various close relatives and friends were listed) react to your studying chiropractic?" 60% of the sample indicated they had families and/or friends who were either "unhappy" or "lukewarm" about their studying chiropractic.

The 2nd Questionnaire inquired of respondents "Can an announcement at a social gathering that one is a chiropractic student ever cause a strong reaction (like anger or confusion)?" 9% of the sample answered that this "never happens," 77% answered it "happens occasionally," and 14% said it "happens often." These data support the claim that CIC students are aware of the negative messages potentially awaiting them at social gatherings.

Students were asked two questions about prestige messages coming to them from the "general community." First they were asked "How would you say the general community presently rates D.C.s in relation to other health practitioners, like dentists and M.D.s?" 15% of the sample felt that the community rates chiropractors "about the

same" as these other groups. 37% answered "a little below," and 48% responded "considerably below."

Students were also asked to compare the chiropractor's reputation here and in Europe. 57% of the sample said that his reputation was "higher (in Europe) than here," 16% answered "about the same as here," and 27% responded that they didn't know about the European situation.

A question at the end of the 2nd instrument asked "What aspects of being a chiropractor might you dislike?" Although there were several categories of answer, one group of responses focused on difficulties with attitudes of primary groups and more casual acquaintances toward chiropractic:

> /I will dislike/ "the constant striving for recognition and difficulties trying to indoctrinate friends and relatives to chiropractic philosophy."
>
> - A Sophomore

> /I will dislike/ "calling myself 'Doctor at a party and then waiting for people's reactions when they find out I'm a chiropractor."
>
> - A 1967 Graduate

> "I might lose friends!"
>
> - A Sophomore

"Not enough prestige; always having to be on the defensive and explaining; lack of acceptance."

- A Senior

"Confronting people who degrade you for practicing and preaching a form of healing which they know nothing about."

- A Sophomore

CHIROPRACTIC PROFESSIONAL ASSOCIATIONS

Caplow notes that one of the first steps on the road to professionalization taken by an occupational group is the establishment of a professional association.[1] Chiropractors in fact undertook rudimentary professional organization very soon after their emergence as a distinct occupation-- the first professional association, the Universal Chiropractors' Association, was founded in 1906 "as a protective association to provide legal assistance to chiropractors"-- but from that time to the present the associations have never been unified nor effective in promoting chiropractic's attempt to be politically, socially and economically accepted on a par with medicine and osteopathy.

(1) A continuing problem for unity has been the division of chiropractors into two groups of associations-- straight and mixer. Neither mixer nor straight national association has been able to

---

[1] Theodore Caplow, The Sociology of Work, New York: McGraw-Hill Book Co., 1964, p. 139.

control state or local chapters, so that the disunity in chiropractic has been "vertical" as well as "horizontal." Wardwell concluded that "organized chiropractic is a shaky structure." He noted that the chiropractor is not nearly as dependent on his state associations as the average M. D., and even less controlled by a national association.[1] In an up-to-date analysis of the structure of organized chiropractic, Akers and Quinney substantiate in detail Wardwell's early 1950's observations about the disunity and ineffectiveness of organized chiropractic at the national level.[2]

If one looks to the various professional journals published within chiropractic, recognition of the problem of disunity is acknowledged. There are constant exhortations about the need for unity and the formation of a "united front" in the face of common

---

[1] Walter I. Wardwell, "Social Strain and Social Adjustment in the Marginal Role of the Chiropractor," unpublished Ph. D. dissertation, Harvard University, 1951, p. 255, and 264-265.

[2] Ronald L. Akers and Richard Quinney, "Differential Organization of Health Professions: A Comparative Analysis, American Sociological Review, 33 (February, 1968), pp. 104-121. "Chiropractic is not only relatively disadvantaged and undeveloped in resources but it is also a relatively non-unified and non-integrated profession. (p. 119)"

enemies.[1] But the ideology of unity continues to be more real than its implementation among chiropractors.

(2) Stories and comments heard at CIC indicate that the ineffective and disunited state of chiropractic associations is very much "in the air" at the School.

> A number of instructors and people in the "front office" told me some version of the following story about how New York State got its present chiropractic law (in 1963): "Rockefeller called in some top chiropractors from around the state to give suggestions about how the law should read. The straights and the mixers (from the different associations) kept arguing among themselves about what they wanted in the law. Finally Rockefeller just got fed up with their bickering, tossed them and all their suggestions out, and got some of his M. D. friends to make up the law. And now we have the worst chiropractic law in the United States."

> "I don't know if I'll join any of the associations when I get out. They never get a damn thing done."
>
> - A Senior to me

> "Don't ever say a particular chiropractor isn't doing a good job. Everybody's doing a good job. If we kept up that line our associations would get some strength."
>
> - CIC Instructor to Seniors

> "What I don't like about the journals (chiropractic professional journals) is that there's so much bullshit

---

[1] "Now it's time for some blunt talk about racking issues that face our profession. This may not be pleasant, but it's always much healthier to view things clearly rather than through a haze that fogs our view of the facts. Our profession drifts in a sea of trouble with no shore in sight. Our profession is caught in a cross current of needless strife and suspicion."

"The two national organizations are at a stand-off, no closer than ever. Their divided efforts destroy our capacity for collective thought or effective action. I can see no indication of their

in them about how we're all working together and how everything's just fine. So many of the items about how effective our lobbies are and how improved our schools are just lies. This really turns me off."

- A Junior to me

"The only reason I'd join an association (a national one) is that they give you a fairly decent malpractice insurance policy as part of the membership."

- Another Junior to me

(3) Questionnaire data indicates that students have internalized a relatively bleak picture of what they can expect from their professional associations. One question asked the sample (N=75) to evaluate the "effectiveness of various professional chiropractic associations in promoting the profession." Since the respondents are students who have had little or no actual personal experience with the performance of the associations, one can assume that expressed attitudes reflect what students are "taught" about the associations while at CIC. No student in the sample chose "Their overall record would be a difficult one upon which to improve," the answer which would have expressed confidence in the associations. 71% indicated that "They are making some headway, although they

---

getting together to form a common front, especially needed now more than ever, in light of the very obviously stepped-up AMA attacks."

- Excerpts from Dr. David D. Palmer's Presidential Message at Palmer College's Homecoming, August 17-20, 1967, reprinted and discussed in The Digest of Chiropractic Economics, 10 (October, 1967), pp. 24-25.

could be much more effective," and 29% said "They have made relatively little headway." Even the intermediate response indicates a quite skeptical view of the associations' performance.

Students were also asked how important "the relative ineffectiveness of organized chiropractic groups (professional associations) in this country" has been in explaining "why chiropractic has so far not been as fully accepted in the United States as it has wished." 53% of the sample indicated "very important," 33% "fairly important," 12% "unimportant," and 2% (one student) didn't feel professional chiropractic associations were ineffective. Thus, 86% of the sample believed that ineffective professional organization is an important factor in chiropractic's continuing low-status position within the family of healing arts.

The question on what aspects of being a chiropractor students might dislike yielded valuable information on their perception of professional unity or lack of it. The following quotations certainly illustrate little faith in their professional associations. Beyond this, some of them illustrate a good deal of hostility or even disdain that students hold for other chiropractors seen as <u>individual practitioners</u>. It is important to note again that these attitudes have crystallized well before students have begun to practice.

"What might you dislike about being a chiropractor?"

"Contact with other chiropractors."[1]

-A Supersenior

"The necessity of living with other D. C. s"

- 1967 Graduate

"The unprofessional attitudes of most of my fellow D. C. s, their inability to communicate with each other, their negativity, and their pursuit of the almighty dollar as their primary objective."

- A Supersenior

"The disunity among chiropractors."

- 1967 Graduate

"Dealing with other D. C. s in the field."

-A Senior

"Some or most of my associates (jerks)."

-Another Senior

---

[1] Wardwell encountered similar vehemence and inclination to slander from some persons in his sample toward other chiropractors. Two examples:

"I got out of the state association because they are a bunch of wranglers. 90% are moronic."

"I don't get along with X... He tries to make a pass at every woman he has in his office.... He once told a woman whose husband was a patient of mine that I am drunk both in and out of the office, and that I try to rape my women patients..."

Wardwell, "Social Strain and Social Adjustment in the Marginal Role of the Chiropractor," op. cit., p. 263.

Compare the vituperative statements in Wardwell and the present research with Sykes' prisoner informant who says "The worst thing about prisons is that you have to live with other prisoners." Gresham Sykes, The Society of Captives, Princeton: Princeton University Press, 1958, Chapter 3, "The Pains of Imprisonment."

"Basically the dissension among certain unsuccessful D. C. s in the profession and those not working for the advancement of chiropractic."

- A Junior

"The constant bickering within the profession."

- Another Junior

"The lack of unity."

- A third Junior

"Chiropractic associations have so many different views that they hurt the profession more than help."

- A Sophomore

Students not only lack respect for chiropractors, but for their fellow students as well. A number of them expressed that sentiment in the question about upsetting experiences at CIC

One 1967 Graduate was upset by "the rude, crass and vulgar behavior of many of the students."

"Realizing what low-class slobs most CIC students are" distressed a Sophomore student.

Another Sophomore was upset by "becoming aware of the attitudes and I. Q. s of some of the current students."

It should be noted that this kind of critical commentary is especially important because it was not specifically solicited.[1] Students

---

[1] Selltiz observes "Even when a space is provided for "other" replies, most respondents limit their answers to the alternatives provided." In this case, however, respondents felt urgently enough to use the "other" category frequently. Claire Selltiz, Marie Jahoda, Morton Deutsch and Stuart W. Cook, Research Methods in Social Relations (Rev. Ed.), New York: Holt, Rinehart and Winston, 1959, p. 261.

writing in this type of comment presumably have very strong feelings about these matters.

The pattern of lack of respect that chiropractors and students exhibit toward each other as individuals is only secondarily relevant at this point. It will be re-discussed as the thesis unfolds. It certainly meshes with the "Elevation of Self Over Other," which is a major theme of this thesis.

RELATED OCCUPATIONS SECTOR

Chiropractic is one of a number of occupations in this society whose espoused goal is healing the sick. All of the other major healing arts in the United States-- principally medicine, dentistry, and now osteopathy as well-- stand together, sharing a common frame of reference in disease theory. As Wardwell notes "Since its beginnings in 1895, chiropractic has been beyond the medical pale,"[1] and the sharp segregation of medical and para-medical groups from chiropractors is still the rule today.

(1) Physicians have maintained a consistent stand on chiropractors for over half a century: They are untrained quacks and charlatans whose theory of illness is totally unscientific and whose therapy is totally ineffective. Literature distributed by medical men through

---

[1] Wardwell, "Limited, Marginal and Quasi-Practitioners," op. cit., p. 225.

five decades illustrate uncompromising attacks on chiropractors. Whether one looks to the diatribes against chiropractic made by Morris Fishbein[1] in the 1920's or current attachs from the AMA's Department of Investigation[2] the negative messages to chiropractors and the public about the evils of chiropractic is astonishingly constant. Medical men remain extremely ignorant about developments in chiropractic (new adjustive techniques, stiffer academic requirements, etc.), a point which Wardwell makes. Few M. D. s, for example, know that chiropractors are licensed in all but two American jurisdictions, and that in half of the United States they must pass the same "basic science" examinations as physicians, osteopaths and dentists. As Wardwell puts it, "These facts usually comes as a shock to most physicians."[3]

---

[1]Fishbein wrote a number of books attacking quacks of various sorts. Chiropractic is given extensive treatment in The Medical Follies, New York: Boni and Liveright, 1925.

[2]If one writes to the AMA's Department of Investigation for information on chiropractors, he receives a large packet of literature, some pieces reprints from various medical and popular journals, some pieces written by the AMA Department of Investigation. A particularly virulent attack of the latter category is found in "Chiropractic: The Unscientific Cult," The AMA Department of Investigation, Chicago, 1966, 23 pages.

[3]Wardwell, "Limited, Marginal and Quasi-Practitioners," op. cit., p. 226.

Medicine's sole intention vis a vis chiropractic is to destroy it. Repeated public statements to this effect can be found. Edward T. Wentworth, past president of the Medical Society of the State of New York has said, for example, "The only form of legislative control of chiropractic which makes sense is to prohibit its practice because it is a fraud."[1]

The attacks made by medical practitioners-- either as private individuals or as a professional association-- on chiropractors are often libelous (written literature) or slanderous (oral statements). A radio re-broadcast I heard on November 2, 1968 over WNYC-FM entitled "War on Medical Quackery" produced by the Northwestern Forum Reviewing Stand, is a particularly vivid example of medical slander of chiropractors. During that half hour program, in which two California M. D. s and an officer of the Better Business Bureau in Chicago participated, the physicians termed chiropractors-- among other things-- "the biggest quacks of all," "murderers," "paranoids who should be committed." These statements are surely actionable, especially in light of the fact that chiropractic is a legal and certified occupation in California, Illinois, and New York. That medical men should nevertheless slander chiropractors as a group in such a blatant fashion indicates an awareness on

---

[1] Quoted in Ralph Lee Smith, "Chiropractic: Science or Swindle?" op. cit.

medicine's part of the lack of power of chiropractic vis a vis medicine in any public forum, such as a judicial proceeding. Chiropractic is perhaps the best example in the United States of an occupation which is formally and legally legitimate and yet consistently stigmatized at the same time.

Osteopathy has likewise been opposed to chiropractic, but for historically different reasons. The basic quarrel which osteopathy originally had with chiropractic was its claim that the latter had stolen osteopathy's principles (osteopathy was founded some twenty years earlier than chiropractic by Dr. Andrew Taylor Still). At present, as Wardwell observes, osteopathy has for all intents and purposes merged with medicine,[1] so that its antipathy toward chiropractic is medicine's, seasoned with the special relish of the recently accepted member toward the pariah.

I know of no research testing attitudes of other health groups, like dentists, nurses and druggists, toward chiropractic, but it seems reasonable to assume that they would generally share medicine's antipathy (although there might be differences in degree from one group to another). Certainly, as we shall see, CIC students perceive all of the other major health groups as relatively

---

[1] Wardwell, "Limited, Marginal and Quasi-Practitioners," op. cit., pp. 224-225.

hostile to chiropractors.

(2) Field note data illustrate abundantly CIC's perception of other health fields'-- most particularly medicine's-- hostility to chiropractors. A prevalent theme is medicine's determined goal to destroy chiropractic and its practitioners:

> "They've planned to destroy us for decades, and this law (New York chiropractic law) may just do it."
>
> - CIC Clinic Director to classes

> "It's just like the Arabs with Israel. They say over and over again publicly that they won't be satisfied until Israel is destroyed. It's the same with the medics and chiropractors."
>
> - A Supersenior to me

Another theme is mutual avoidance:

> "I'm proud to say I have no friends who are M. D. s. I avoid them like the plague."
>
> -CIC Instructor to the Freshman class

> "They know we're around, and we know they're around, but we both go about our business pretending the other guys don't exist."
>
> - "Front Office" official to me

"Putting one over" on the physicians is a third hostile theme in this complex. I heard several similar versions of the following story at CIC:

> "One of my patients was laid up in the hospital. I went in to give him an adjustment. While I was doing it, a nurse came in, so I took up some rubbing alcohol and pretended I was massaging him."

Further:

> "If you want a discount on your textbooks just go over to X Bookstore and tell them you're a student at 'Columbia.' They'll think it's Physicians and Surgeons."[1]
>
> - CIC Instructor to Freshman class

The CIC culture also has it that medical men benefit from or employ chiropractic principles and techniques frequently, but refuse to give chiropractic credit:

> "A lot of them come to us themselves when they've got a health problem, but they wouldn't dare refer their patients to us."
>
> -CIC Clinic Director to me

> "They use our techniques all the time in what they call 'physical medicine,' but never give us any credit."
>
> - CIC Instructor to Junior class

Medicine's hostility to chiropractors was constantly discussed at CIC, with less attention devoted to the attitudes of other healing arts. Osteopaths, however, were occasionally the subject of comment:

> "They hate us almost as much as the medics do. We're their chief competitors."
>
> - CIC Instructor to me

---

[1]Consulting the 1968-69 Manhattan telephone Directory one finds a number of "Institutes" and "Schools" using the Columbia name which are not attached to Columbia University, e.g., The Columbia Institute of Languages, The Columbia Institute For Maternal Infant and Child Care, and the Columbia School of Broadcasting. No doubt, the name "Columbia" is too common in the language to allow Columbia University to legally prevent other organizations from using this title.

"Osteopathy? There isn't any such thing any more. Osteopaths are just 2nd-rate M. D. s now. They sold out."

- A Sophomore to classmates

(3) Students were asked in the 2nd Questionnaire how well average members of several other healing arts get along with the average chiropractor. Alternates provided ran (on a linear scale) from very friendly relations with chiropractors to very unfriendly relations. Table 4-1 gives the percentage distribution of responses for each healing art:

Table 4-1. CIC Students' Perceptions of Other Health Practitioners' Relations with Chiropractors (N=75)

	Very Friendly Relations With D. C. s		Friendly Relations With D. C. s		Lukewarm Relations With D. C. s		Unfriendly Relations With D. C. s		Very Unfriendly Relations With D. C. s		Totals[a]	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Average M. D. Has:	0	0	7	9	34	45	19	25	15	20	75	99
Average Dentist Has:	8	11	24	32	36	48	6	8	1	1	75	100
Average Osteopath Has:	8	11	25	33	30	40	6	8	6	8	75	100
Average Podiatrist Has:	13	17	22	29	33	44	6	8	1	1	75	99
Average Nurse Has:	9	12	18	24	34	45	9	12	5	7	75	100
Average Pharmacist Has:	7	9	4	5	34	45	19	25	11	15	75	99

[a]Percentage totals in three instances come to 99 because of rounding in individual cells.

For every related occupation at least 53% of the sample believes that relations vis à vis chiropractors are "lukewarm" or worse. The most extreme negative messages are perceived, as might well be expected, coming from physicians, where no students felt the average doctor has very friendly relations with chiropractors and only 10% of the sample felt he has friendly relations. Apart from the M. D. figures the percentage distributions for the other occupations are quite similar. They support, in the main, the argument that students do in fact view related healing occupations as either hostile or, at best, lukewarm toward chiropractors.

That students detect potent persecutory messages coming their way from the AMA is supported by their responses to a question asking them how important they felt organized medicine's opposition has been in impeding respect for chiropractic in the United States. 76% of the sample (N=75) answered "Very important," and the other 24% chose "fairly important."

The open-ended question on what students might dislike about being a chiropractor also yielded answers about negative messages coming from related healing arts:

/I will dislike/ "constant battle with...the powers that be (AMA, legislature) to gain complete acceptance of chiropractic."

- A Sophomore

/I will dislike/ "the disrespect I might encounter from the medical profession...."

- A Senior

/I will dislike/ "slanderous and false statements, both oral and written, made by the drug monopolies and medical monopolies, like the AMA...."

- Another Senior

/I will dislike/ "opposition from other health professions."

- A 1967 Graduate

/I will dislike/ "ridicule from the medical doctors."

- Another 1967 Graduate

CIC AS CONVEYOR AND CREATOR OF NEGATIVE MESSAGES TO STUDENTS

CIC might be conceptualized as both (a) the situs where negative messages from the "outside" are conveyed to students, by way of faculty, administrative personnel and other students and (b), through its own situation and problems, a reinforcer of external bad news and creator of additional unhappy tidings for students. It is the latter contribution which CIC makes to negative messages about the status of chiropractic student which particularly concerns us in this short section. One can look at some of the impinging sectors in terms of how they evaluate and affect CIC itself and then

proceed to students' inferring messages by way of the School.

CIC and The Market Sector

A central economic fact about CIC is its relatively shaky financial position. Its physical plant and facilities are rather inadequate and shabby. Frequent demands are made upon students to help raise money for the School; the "front office" is almost compulsively concerned with prompt tuition payments-- quite understandably since the major operating capital stems from tuition. Enrollment has decreased drastically in the last two or three years which has further limited operating capital. This collection of facts about his training college dramatizes for the CIC student from the start of his career the relatively poor position of chiropractic in the market.

That students are acutely aware of CIC's poor physical plant emerges in the following story, which is a close approximate of one told to me by several students:

> "When I came to CIC on my first day I went into the children's school next door (a large, modern building). I couldn't believe it when I found out this dump was CIC."

The reference to the School as being "a dump" is scattered throughout my field notes. The disposal-system metaphor is quite strong in the CIC culture since another frequent term in my

notes used by students and faculty is "garbage," which usually modified "course" or "material" and was employed to refer to courses, etc., which were judged irrelevant to the practice of chiropractic-- particularly certain basic science courses.

CIC and The Political Sector

While I was doing field work at CIC a burning political issue "in the air" was whether CIC would "get the Charter," that is would be chartered as part of the official educational system of New York State. (See the discussion on the Charter in Chapter 2). Through the late fall and early winter (1967-68) there were constant rumors about CIC's chances; at one point New York State inspectors arrived on the scene to "look over" the School and their visit was followed by new speculation. Although the President of CIC repeatedly told the assembled student body and faculty that a decision would be made "within weeks" by the Board of Education. Almost a year has elapsed since the inspectors' visits, and no word has been received. That CIC has so little prestige and/or power that the State can keep her "dangling" as long as it wishes surely impresses upon the student the political impotence of chiropractic.

CIC and Students' Primary Groups

Students are unhappy with CIC's physical layout, not only

for themselves but their relatives and friends. I had occasion to attend a program for Freshman students and their families in the fall of 1967. The general mood was one of a distinct lack of enthusiasm for the School grounds. In responding to the question about "upsetting experiences at CIC" several students mentioned "showing the School and its facilities to relatives" as a source of trauma. One student who had gone to a campus college in Kansas told me that he was very embarrassed to show CIC to "dates," especially since it was such a let-down from his college days.

CIC and Chiropractic Associations

Students appear uneasy and upset about CIC's not "belonging" to a larger structure of chiropractic education. True, the School is formally a member of one of the two major chiropractic educational groups (ACA), but the students sense little concrete anchorage with other chiropractic schools from this fact. They know that curricula are not standard from one training school to another-- sometimes this point becomes very vivid when a transfer student appears at CIC and much haggling about transfer credits for courses takes place. Although no specific research was done on this point, I have the impression from discussions and interviews with students that part of the blame is definitely put on the ineffective

professional associations which have been unable to standardize the curricula. Thus the associations' impotence to regulate CIC's program leads to a conclusion on students' parts that they are also relatively powerless to regulate and aid individual chiropractors.

THE "BESIEGED" STATUS OF CIC STUDENT

The purpose of this chapter has been, using a number of levels of data for documentation, to convey to the reader the picture of chiropractic students surrounded or besieged by hostile groups and forces. Taking the point of view of a CIC student's perception of the social landscape surrounding him, no one particular negative message from any specific sector should be stressed as much as the cumulative and consistent resistance, hostility and even stigma he faces in whatever direction he turns. The majority of the messages received are about the future-- his future-- so that the student is warned of continued-- and intensified-- unpleasantness on many fronts in his chiropractic career.

The image then is of a threatened self-- torn between its own relatively positive and worthwhile view of the status of chiropractic student and the negative view of most of society. The self is torn because, as this chapter has tried to demonstrate, it is so

intensely aware of the "bad" evaluation of chiropractic, chiropractors and chiropractic students made by most people.

At this point an important sociological problem, which can be delineated by posing several questions (many of which were first mentioned in Chapter 2) emerges about the CIC students. How do students who continue on at CIC reconcile their own and others' images of the value of chiropractic and chiropractor? What "counterweights" are available to them to offset the heavy burden of hostility and stigma heaped upon them? Are "solutions" to their status problems generally "individual" or "communal?" Does the burden of stigma lend a peculiar twist to the professionalization process of chiropractic recruits?

Beginning with the next chapter, a series of three chapters attempts to answer these questions.

CHAPTER FIVE: CHIROPRACTIC STUDENTS' ANSWER TO STIGMA: THE ELEVATION OF SELF OVER OTHER

GROUP AND INDIVIDUAL RESPONSES TO STATUS PROBLEMS

When persons sharing a common status face a common problem, because of that status, their response or adaptation to that "status problem" can, sociologically, be either "communal" or "individual." Either they can band together to meet a challenge or each can strike out on his own. One important variable in predicting which direction the response is most likely to take is the degree of "sequestration" or isolation imposed upon the persons in question.

Morris and Sherlock,[1] and Wheeler and Brim,[2] define sequestration as a process where persons are ecologically and temporally isolated from other groups so that the force of a socialization experience will be more effective and perdurable. Sequestration can occur with, among other, mental patients, prison inmates, and professional students. Sociological research has indicated that the greater the

---

[1] Basil J. Sherlock and Richard T. Morris, "The Evolution of the Professional: A Paradigm," Sociological Inquiry, 37 (Winter, 1967), pp. 34-35.

[2] Orville G. Brim, Jr., and Stanton Wheeler, Socialization After Childhood, New York: John Wiley and Sons, Inc., 1966, pp. 79-81.

sequestration or isolation of persons sharing a common status problem (and the status involved can be a "high" one, such as medical student, or a "low one" such as convict) the higher the tendency for the adaptation to difficulties to be communal.

Thus, Korn and McKorkle, and Sykes have shown that prison inmates participate in a common inmate social code of attitudes and behavior to "reject their rejectors,"[1] Goffman has described a similar group response of mental patient inmates to ward off stigma imposed by warders;[2] and Becker has demonstrated how medical students in a sequestered environment evolve a shared understanding of what to study (and what not to study) in the face of heavy-- and sometimes ambiguous-- demands of their professors.[3]

On the other hand, low sequestration and a common status problem are most often linked to an individual solution. The Ph. D.

---

[1] Richard R. Korn and Lloyd W. McCorkle, Criminology and Penology, New York: Holt, Rinehart and Winston, 1960, Chapter 22, "The World of Inmates," pp. 512-552.

Gresham M. Sykes, The Society of Captives, Princeton: Princeton University Press, 1958, pp. 78-83.

[2] Erving Goffman, Asylums, Garden City, New York: Doubleday and Company, 1961, especially "The Underlife of a Public Institution," pp. 171-320.

[3] Howard S. Becker, Blanche Geer, Everett C. Hughes, and Anselm L. Strauss, Boys in White, Chicago: The University of Chicago Press, 1961, Chapter 10, "The Final Perspective," pp. 158-184.

matriculant in a non-cohort graduate program, research suggests, finds his own solutions to the uncertainties and pressures of graduate school.[1] "Outcast" groups adrift in the community, such as drug addicts[2] or hobos, infrequently unite with each other to face common societal enemies. Caplow and his associates have remarked on the striking indifference which hobos and bums show for each other.[3]

The three variables we have been discussing, i.e., prestige, sequestration, and modality of problem solving, can be combined in a typology of problem solving, a typology which allows us to introduce CIC's situation as one concrete case:

---

[1] Elbridge Sibley, The Education of Sociologists in the United States, New York: Russell Sage Foundation, 1963, Chapter 7, "Initiation Into the Profession," pp. 103-111.

Bernard C. Rosen and Alan P. Bates, "The Structure of Socialization in Graduate School," Sociological Inquiry, op. cit., especially p. 77.

[2] See Richard A. Cloward and Lloyd E. Ohlin's discussion of "retreatist" drug addicts in their Delinquency and Opportunity, Glencoe: The Free Press, 1961, pp. 178-186.

[3] Staff Meeting, "Homelessness Project," Columbia University Bureau of Applied Social Research, February, 1965 (ditto), p. 5. See also Theodore Caplow, Howard M. Bahr, and David Sternberg, (2nd Ed.), "Homelessness," in The International Encyclopedia of the Social Sciences, The Macmillan Company and the Free Press, 1968: "The homeless in great cities... stand and watch their companions assaulted by strangers without offering to interfere...," p. 495.

Diagram 5-1. A Typology of Problem-Solving

	High Prestige	Low Prestige (and/or Stigma)	
High Sequestration	(1) Medical students in some medical schools Recruits in monasteries and seminaries Cadets at West Point	(2) Prison inmates Mental hospital inmates	COMMUNAL SOLUTIONS (1) and (2)
Low Sequestration	(3) Matriculants in Ph. D. programs	(4) Hobos Drug addicts CIC students	INDIVIDUAL SOLUTIONS (3) and (4)

The concrete cases in the four cells are obviously nowhere near exhaustive; they are offered as examples, with the added virtue that some sociological attention has been devoted to nearly all of them.[1] CIC is a problematic case. The argument of this disseration is that CIC students do in fact share a common status which leads to a common stigma (see the preceding chapter for full documentation), and that the low sequestration of their socialization experience leads one to expect a modal adaptation falling within Cell (4). Along with low sequestration at CIC, certain fundamental assumptions of chiropractic, to be discussed below, also lead to a prediction that students will tend to opt for individualistic solutions to stigma.

LOW SEQUESTRATION AT CIC

When one inquires how sequestered or isolated a group of students is from other social systems and influences, the following questions come to mind: Do members of the group find their intimate friends among each other, or in "outside" groups? Do members of the group live with each other? How much total time do group members spend with each other, as opposed to spending time in other

---

[1] Throughout Asylums, op. cit., Goffman gives some attention to seminary and military students' shared norms for meeting problems of their recruit status-- albeit in an unsystematic manner.

groups? Do students study with each other to a significant extent? Do students pursue a substantial activity (job) in addition to studying chiropractic?

Two types of data bearing on these and related questions support the assertion that CIC rates low (as compared, for example, to Becker's medical school or Plasek's dental school) on sequestration of its students: (1) "unobtrusive measures" on sequestration that I gathered during my field work, and (2) data from the 2nd Questionnaire which I administered to students.

(1) Chapter 5 of Webb's Unobtrusive Measures accounts a range of ways in which social scientists have used "simple observation" of people to infer the structure of their social arrangements. Aggregations or dispersions of persons are taken as measures of social cohesion, or lack of it.[1]

Time after time at CIC, when the school day ended at 2:30, I witnessed an almost total dispersion of students. By 2:40 every day the school grounds were practically deserted (with the exception of the 11 seniors who stayed on Monday, Wednesday, and Friday for their clinic hours). Many of the students were off to their jobs, which began shortly after the end of the school day; others were off to their

---

[1] Eugene J. Webb, Donald T. Campbell, Richard D. Schwartz and Lee Sechrest, Unobtrusive Measures: Nonreactive Research in the Social Sciences, Chicago: Rand McNally, 1966, pp. 112-141.

separate residences to study. In any event, it was strikingly clear that CIC's after-school hold on the students was nearly non-existent; sequestration of the student body was definitely limited to the five and one-half hours per day of classroom instruction.

(2) A group of items in the 2nd Questionnaire were designed to test how sequestered CIC students were in terms of several areas of social behavior.[1]

Low Intra-Friendship Rates Among CIC Students -

The 2nd Questionnaire asked students how many of their closest friends were current CIC students. 11% of the sample (n=75) replied "a majority," 17% answered "about half," 51% said "less than half," and 21% replied "none." Thus over 70% of the CIC sample found the majority of their intimate friendships outside of CIC.

CIC Students Spend Little Time
With Each Other Outside CIC -

To the question "during the past semester, how often did

---

[1] 1967 Graduates who had really graduated in the summer of 1967, and to whom questionnaires were mailed, were asked to answer the following set of questions in terms of their "last few terms at CIC."

you participate in social activities with at least one other CIC student who was not your roommate?" the sample responded in the following way: 40% said "never," 36% answered "1 or 2 times," 13% said "3-5 times," and 11% said "6 or more times."

CIC Students Do Not Room With Each Other -

To the question about their current living arrangements, three students answered that they lived with "1 CIC student," and six responded that they roomed "with 2 or more CIC students." Thus, only 13% of the sample of 72[1] roomed with other CIC students. 51% lived with their parents, 30% with wives (and children), with the other 6% indicating "other living arrangements."

CIC Students Do Not Study With Each Other -

Students were asked how much of their total studying time was spent with other CIC students. 83% of the sample of 75 answered "little or no time," 13% responded "a moderate amount," and only 4% said "a good deal."

---

[1] Three respondents failed to answer this question, so the usual sample size of 75 for the 2nd Questionnaire was reduced here to 72.

A Majority of CIC Students Work -

In response to a question about "current employment,"[1] 22 students indicated they worked from ten up to 20 hours a week, and 24 students indicated they worked more than 20 hours a week. Thus 61% of the sample pursued a substantial non-chiropractic activity, although six students did have jobs in the health field, such as hospital orderly, laboratory technician, or physical therapist. Four students indicated they worked with each other, although their jobs were not in the health field. "Outside" employment, then, is an important "splintering" factor, militating against a high degree of sequestration in the CIC socialization experience.

The picture of CIC students which emerges from these data is strikingly "atomistic." Contrast the multi-faceted isolation of CIC students from each other with Plasek's dental students, who very frequently live and study with each other in fraternity settings,[2] and

---

[1] In the case of those 1967 Graduates who had not returned to CIC after graduation in the summer of 1967, "current employment" meant employment during their last terms at CIC, and a supplementary direction on this point was enclosed in their particular 2nd Questionnaires.

[2] Wayne Plasek, "Interaction Patterns and Attitude Change: A Study of Professional Socialization," unpublished Ph. D. dissertation, Dept. of Sociology, University of California, Los Angeles, 1967. The CIC data on low sequestration of students, relatively low interclass interaction and very small class sizes would make research based on Plasek's clique model unrealistic in the present case.

Becker's medical students, who spend a large amount of their study time in groups.[1] In addition, in both of these latter cases the classroom and laboratory time which students share is a good deal lengthier than at CIC, probably between 10 and 15 hours longer per week.[2]

---

[1] A substantial number of Becker's medical students and Plasek's dental class lived together with each other in fraternities and made it a habit to study with each other. Although a student fraternity formally exists at CIC-- Beta Omega Chi-- I saw no evidence of its functioning or membership during my field work. There were eight members of the fraternity pictured in the 1967 CIC Yearbook, and the total seems to have decreased since then. The fraternity does not provide residential facilities for its members, nor do members study as a group (as far as I could learn by interviewing several of them).

[2] In general, beyond the specific cases of Becker's and Plasek's samples, medical and dental schools demand more time from their students than does CIC. Besides requiring more time during each day of the week, these schools often schedule classes on Saturdays (which CIC does not).

CIC Seniors are required to staff the Outpatient Clinic as externs for clinical experience with patients. The clinic is open from 3:00 P. M. to 8:00 P. M. three days a week. Compare this with the experience of Becker's Junior and Senior medical students:

> "The reader will have noted that the student in the clinical years, like the freshman, devotes most of his time to school. The student spends a minimum of five full days of most weeks in the hospital. These days ordinarily begin at eight in the morning (or earlier) and do not end until four-thirty or five in the afternoon. He spends Saturdays, from eight till one, in lectures and classes. Other activities oblige him to spend still more time on the premises. Various services require him to take occasional night call, which means that he does not leave the hospital for more than twenty-four hours. Many other services require him to return to the hospital to work-up patients assigned him at whatever time they are admitted to the hospital; this cuts into many of his evenings and nights." Becker et al., op. cit., p. 218.

CIC students experience no hospital activities because the School has no hospital.

One can say with some assurance that CIC ranks low on sequestration of its student body on an absolute scale, or in comparison with professional schools in other healing disciplines.

Just why sequestration is low at CIC is a complicated question. Undoubtedly CIC's weak power and prestige position in the New York community plays an important role. Having limited resources, the School has been unable to set up dormitory and fellowship programs which would keep students in greater contact with both School and other students. From the other end of the equation, many students are forced to take full or part-time employment unconnected with chiropractic because of shaky financial situations. But beyond the role of what the German historian Otto Hintze would term "real interests" (political and economic interests)[1] in limiting CIC's ability to sequestrate its students, certain "ideal interests" (ideology) which are fundamental to chiropractic "philosophy" militate against high sequestration of chiropractic students and the resulting communal response to problems which goes with high sequestration. There has always been an individualistic bias in the model of the practicing

---

Note that sequestration of medical students is greater than for CIC students throughout the training experience, whether we look at the pre-clinical or clinical years.

[1]Hintze's analysis of "ideal" and "real" interests are quoted in Reinhard Bendix, Max Weber: An Intellectual Portrait, Garden City, New York: Doubleday and Company, Inc., 1962, pp. 46-47.

chiropractor, and to that we now turn our brief attention.

THE INDIVIDUALISTIC BIAS IN CHIROPRACTIC PHILOSOPHY AND PRACTICE

On the very first day of school a freshman student asked in osteology class what determines how much chiropractors are respected. The instructor told the class "It depends entirely on the individual chiropractor."[1] In the months to follow I encountered many statements and opinions at CIC depicting the contemporary chiropractor as striking out on his own and building a successful (large) practice with little or no dependence on chiropractic colleagues.

Data from two questions in the 2nd Questionnaire confirm the individualistic "set" held by CIC students. I asked the sample "What elements determine how much any particular chiropractor is respected in his community these days?" 84% of the sample (N=75) responded "It depends primarily on the individual doctor and the impression he makes." 12% responded "The chiropractor's own skill and personality, on the one hand, and his membership in the chiropractic profession on the other, play about equal parts."

---

[1] At the time the remark was made-- September, 1967-- I merely wrote it into my notes, sensing in a vague way that it might say something important about career "sets" of chiropractors. It was only later, when I heard repeated versions of this individualistic point of view, that the serendipitous value of that initial remark became apparent.

The other 4% said "Regardless of a particular chiropractor's skill and personality, the degree to which he's respected in his community is mostly determined by how people feel about the chiropractic profession in general." As we shall see in a later chapter (Chapter 7) the overwhelming choice by these CIC students for the most individualistic response is in striking contrast to New York University medical and dental students' relative preference for prestige derived from membership in their professions.

Students also were asked whether they agreed or disagreed with the following statement: "Since you have to be an individualistic type of person in the first place to become a chiropractor, attempts to organize chiropractors beyond a point are bound to fail." Nearly half of the sample (48%) were in some measure (agreed "strongly" or "somewhat") of agreement about chiropractors being persons unamenable to elaborate occupational organization.

The individualistic set which CIC students internalize is undoubtedly linked to central assumptions in chiropractic philosophy and practice which reach the students through faculty members and administrative personnel. From its beginnings, the fundamental logic of chiropractic has been that any <u>one</u> chiropractor can, by removing nerve interference caused by subluxations, treat <u>all</u> human diseases; no specialties are required. Development over half a century has

seen perhaps some slight reduction in chiropractors' claims along these lines, but most chiropractors (be they straight or mixers) still espouse a general therapeutic competence.

Chiropractors' continued adherence to the "general practitioner" model is directly opposed to the development in medicine in recent decades, where speciality practices have become more and more prevalent.[1] Whereas physicians are increasingly linked to each other through intricate referral systems based largely on specialities and hospital affiliations, individual chiropractors continue to go their own way with relatively scant attention to their colleagues.

This continued "solo practice" tradition in chiropractic is treated in greater depth in Chapter 7-- along with an examination of its implications for American chiropractors' futures in an increasingly centralized and bureaucratized set of health institutions. At this point we are merely interested in stressing that the logic of chiropractic itself would lead one to predict an individualistic set on the part of students. Combined with this ideological predilection are certain situational features of the CIC situs itself-- discussed above--

---

[1] See Eliot Freidson's comprehensive essay, "The Organization of Medical Practice," in Howard E. Freeman, Sol Levine and George G. Reeder (eds.) Handbook of Medical Sociology, Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1963, pp. 299-319.

which also militate against the emergence of shared solutions to problems.

CIC STUDENTS' RESPONSE TO STIGMATIC MESSAGES: ELEVATION OF SELF OVER OTHER

We are now in a position to construct a model of how CIC students manage the stigmatic messages coming to them from the societal sectors discussed in the last chapter, and to generate testable hypotheses to verify that model.

In any given sector area our model will be this: the CIC student receives negative messages about what happens to the typical chiropractor-- or chiropractic student. He responds by accepting that unhappy fate for chiropractors as a group, but rejects it for himself, thereby assigning himself a higher chance for "success," "accommodation," or "rapprochement" in the several sector areas than he gives his colleagues. This tendency to elevate self over other in any particular problem or stigma area is theorized to be the product of (a) occupying a stigmatized status (in an "outcast" group), combined with (b) certain norms of the chiropractic profession ("make it on your own," "solo practice") and (c) certain features of the CIC situs, e.g., low sequestration, both of these latter factors lending to a tendency for individual, rather than communal, solution

to status problems. It is further theorized that this separation of self from other is necessary to keep most CIC students enrolled in the training program[1] -- to act as a counterweight to the otherwise overwhelming force of negative messages directed to the statuses of chiropractic student and chiropractor.

As we have seen, many of the unwelcome messages concern CIC students' future situations as full-fledged chiropractors. In those areas one cannot observe self-other behavior, but one can probe for attitudes and expectations vis a vis future coping with career problems. Other negative messages, however, concern the here and now for CIC students, such as angry outbursts against chiropractic students at social gatherings, and in such cases a researcher can tap actual rather than expected experiences.

Out of my field notes from CIC I "distilled" a series of situations which pinpointed central problems from various impinging

---

[1] An even more individualistic solution to the status problems of being a chiropractic student is to disavow the status by terminating one's course of study. Presumably students who dropped out of CIC were most hard hit and discouraged by incoming negative messages.

I was not able to obtain any official records pertaining to the number of drop-outs, but comments made by students, faculty, and administrative personnel plus perusal of consecutive student yearbooks (where the names of all students in each class are listed) indicates the rate is substantial (perhaps 20-30% at present).

In any event, we are considering solutions to stigma available to persons who have decided to "stick it out" at CIC.

institutional sectors. One or more negative messages from each of five external sectors[1] (excluding chiropractic professional associations which is not really an external sector) detailed in Figure 4-1, Chapter 4, were translated into a problem situation and presented to respondents in the 2nd Questionnaire. In each situation the expectation was that students would tend to predict higher "success"

---

[1]Specifically, the negative messages involved in the following hypotheses are:

(1) Market Sector	- Average incomes for chiropractors are low. Many chiropractors have to take additional jobs. Chiropractic is an initially risky economic venture.
(2) Political Sector	- Licensing examinations for chiropractic candidates are discriminatory.
(3) Mass Media Sector	- The mass media are hostile to chiropractic and give it a bad image in the public's eyes.
(4) Primary and Secondary Group Sector	- Families and friends of chiropractic students are unhappy about their occupational choice. Being a chiropractic student or chiropractor can cause embarrassment, or worse, at social gatherings.
(5) Related Occupations Sector	- Medicine is trying to destroy chiropractic. Osteopathy is hostile to chiropractic. Related health occupations won't open their facilities to chiropractors.

4

for themselves than for other chiropractic students or chiropractors.

The set of hypotheses which follow, then, are essentially a series of probability statements, based on a sociological model of how respondents should score their personal chances versus their peers' chances in several crucial problem areas for chiropractors if the underlying theory in the research is to be confirmed. Each hypothesis is tested by a corresponding pair of situational questions concerning one sector or another. One question in the pair asks the student to evaluate the chances for the typical chiropractor or student, the other question (usually identically worded) asks him to evaluate his own prospects. The 14 other-self hypotheses are listed immediately below, by sector, along with citations to the full text of the corresponding situational questions found in Appendix B.

THE HYPOTHESES

Sector	Hypothesis
Market	1. Respondents will predict higher incomes after 10-15 years of practice for themselves than for the average chiropractor. (Questions 2 and 3, Appendix B)
Market	2. Respondents will predict higher incomes at the peak of a chiropractic career for themselves than for the average chiropractor. (Questions 58 and 59, Appendix B)

Sector	Hypothesis	
Market	3.	Respondents will predict a greater likelihood for other chiropractors to take non-chiropractic employment when they begin to practice than for themselves to do so. (Questions 4 and 5, Appendix B)
Market	4.	Respondents will predict greater initial economic success in practice for themselves than for other starting chiropractors. (Questions 68 and 69, Appendix B)
Political	5.	Respondents will predict greater success for themselves on the chiropractic sections of state licensing examinations than for fellow candidates. (Questions 17 and 18, Appendix B)
Political	6.	Respondents will predict greater success for themselves on the basic science sections of state licensing examinations than for fellow candidates. (Questions 62 and 63, Appendix B)
Mass Media	7.	Respondents will predict that a publicized court decision against a chiropractor in their locality for malpractice would cause more harm to the practices of their fellow D.C.s than to their own practices. (Questions 27 and 28, Appendix B)
Mass Media	8.	Respondents will predict that negative newspaper publicity about chiropractors in general would have more harmful effect on their fellow chiropractors' practices than on their own. (Questions 53 and 54, Appendix B)
Primary Group	9.	Respondents will indicate that their own families and friends have more fully accepted their decision to become a chiropractor than have the families and friends of other students at CIC. (Questions 39 and 40, Appendix B)

Sector	Hypothesis	
Secondary Group	10.	Respondents will indicate that they have been less subject to unpleasant social confrontations because of their status as a chiropractic student than their fellow students. (Questions 29 and 30, Appendix B)
Related Occupations	11.	Respondents will predict friendlier relations with M. D. s for themselves than for other chiropractors. (Questions 55 and 57, Appendix B)
Related Occupations	12.	Respondents will predict friendlier relations with osteopaths for themselves than for other chiropractors. (Questions 65 and 67, Appendix B)
Related Occupations	13.	Respondents will predict a better chance for themselves becoming members of interprofessional clinics than for other chiropractors. (Questions 71 and 72, Appendix B)
Related Occupations	14.	Respondents will predict a better chance for themselves becoming members of hospital (non-chiropractic hospital) staffs than for other chiropractors. (Questions 77 and 78, Appendix B)

HOW THE HYPOTHESES WERE TESTED

The Format in the Questionnaire

Respondents were presented with the 14 pairs of situational questions, scattered throughout the 2nd Questionnaire. For the most part, pairs were isolated from each other-- separated by different types of questions-- but in every case the two questions comprising the test for a particular hypothesis came directly together. All of the questions offered students alternatives on an ordinal continuum of optimism-pessimism, or success-failure. Except for the four questions testing the first two hypotheses on amount of predicted income, each of which contained seven check-alternatives, all questions were three-point scales.

The Use of the Sign Test

The corresponding null hypothesis for each of the research hypotheses is that:

> CIC students perceive their own career success to be the same as the typical chiropractor or chiropractic student.

In more specific statistical terms, the null hypothesis states that for any pair of self-other questions CIC students will choose the same amount of success for themselves and others, i.e., tied scores on any pair of questions, except for some error which is assumed to be random. Random error here means that students are as likely to pick other over self as self over other. For each of the fourteen hypotheses the sign test[1] was used to ascertain whether the null hypothesis should be rejected.

THE EVIDENCE FOR THE HYPOTHESES

Table 5-1 provides us with an overview as to how the sample distributed their self and other prognoses in all fourteen hypotheses:

---

[1] The statistical rationale and mechanics for the sign test are clearly presented in Sidney Siegel, Nonparametric Statistics: For the Behavioral Sciences, New York: McGraw-Hill Book Co., Inc., 1956, pp. 68-75.

The other test for statistical significance which might have been used with this form of ordering the self-other data is the McNemar Test For the Significance of Change. This is a cumbersome procedure, however, and not entirely suited to the present data. In any event, it yields about the same results of statistical significance as the more easily calculated sign test. See Siegel, ibid., pp. 63-67.

Table 5-1. Students' Self-Other Choices For 14 Career Problems (N=75)

Hypothesis	Sector	Problem Content	Number of Students Choosing: Self Over Other	Tie	Other Over Self	Totals
1	Market	Income after 10-15 years	52	21	2	75
2	Market	Income at peak of career	44	28	3	75
3	Market	Necessity of taking additional non-chiropractic employment at start of practice	41	27	7	75
4	Market	Initial economic situation in practice	33	42	0	75
5	Political	Negotiation of chiropractic boards	23	52	0	75
6	Political	Negotiation of basic science boards	39	35	1	75
7	Mass Media	Coping with effect of a publicized malpractice decision against a chiropractor	6	69	0	75
8	Mass Media	Coping with effect of negative publicity in general about chiropractic	17	58	0	75
9	Primary Group	Success in winning over primary groups to decision to become a chiropractor	49	25	1	75
10	Secondary Groups	Success in regulating frequency of unpleasant social confrontations in secondary groups	7	58	10	75
11	Related Occupations	Cordiality of relations with local M. D. s	48	27	0	75
12	Related Occupations	Cordiality of relations with local osteopaths	35	36	4	75
13	Related Occupations	Membership in interprofessional clinics	17	35	23	75
14	Related Occupations	Membership in non-chiropractic hospitals	21	49	5	75

And Table 5-2 gives us the sign test values for the fourteen self-other distributions in the first Table:

Table 5-2. Sign Test Values For Distributions in 14 Hypotheses

Hypotheses[a]	z Value[b]	Probability[c]
+ 1	6.668	$p < .001$
+ 2	5.835	$p < .001$
+ 3	4.763	$p < .001$
+ 4	5.570	$p < .001$
+ 5	4.592	$p < .001$
+ 6	5.849	$p < .001$
+ 7	-	$p < .02$
+ 8	-	$p < .001$
+ 9	6.647	$p < .001$
10	-	$p < .40$
+ 11	6.784	$p < .001$
+ 12	4.804	$p < .001$
13	.794	$p < .30$
+ 14	2.942	$p < .01$

[a] +s indicate research hypotheses which the sign test values support at a statistically significant level of probability.

[b] When N was 20 or less (three instances) the z formula for the sign test was not used: A binomial distribution table was consulted directly.

[c] For all hypotheses a one-tailed test of statistical significance was used, since for each hypothesis a specific prediction that non-tie cases would occur more often in the direction of self over other was offered. See Solomon Diamond, Information and Error, New York: Basic Books, Inc., 1959, pp. 114-116. However, use of a two-tailed test with these particular hypotheses would not have importantly altered the levels of statistical significance.

The sign test supports to a statistically significant value all the research hypotheses but Numbers 10 (on secondary group confrontations) and 13 (on chances for chiropractors participating in interprofessional clinics). At the same time, inspection of Table 5-1 indicates that the strength of the self-over-other tendency varies widely from one hypothesis, or sector, to another. Table 5-3 summarizes the strengths of the tendency by giving the percentage of students elevating self over other, tying self with other, and elevating other over self for all the hypotheses:

Table 5-3. Percentage of Students Elevating Self Over Other, Tying Self With Other, and Elevating Other Over Self, for 14 Hypotheses[a] (N=75)

Hypotheses	% Elevating Self Over Other	% Tying Self With Other	% Elevating Other Over Self	Totals[b]
1	69	28	3	100
2	59	37	4	100
3	55	36	9	100
4	44	56	0	100
5	31	69	0	100
6	52	47	1	100
7	8	92	0	100
8	23	77	0	100
9	65	33	1	99
10	9	77	13	99
11	64	36	0	100
12	47	48	5	100
13	23	47	31	101
14	28	65	7	100

[a] %s calculated from data in Table 5-1.

[b] Totals sometimes come to 99 or 101% because of rounding in individual cells.

From Table 5-3 it is immediately apparent, using the % Elevating Self Over Other standard, that the tendency is very strong in some hypotheses, e.g., 1, 2, 3, and 11, moderate in others, e.g., 5 and 8, and non-existent in Hypotheses 10 and 13, where the % Elevating Other Over Self actually slightly exceeds the % Elevating Self Over Other. Upon inspection of the range of self-over-other percentages in these hypotheses confirmed by the sign test (i.e., all hypotheses but 10 and 13), we might, somewhat arbitrarily to be sure, agree that those exhibiting a percentage of 40 or more show a relatively high order of self-over-other tendency in the sample, while those falling below this magnitude show a relatively low order.[1] Eight hypotheses, then, fall in the high-order category, four in the low-order category, and two exhibit no tendency toward self-over-other. Just why the tendency should vary in intensity among the hypotheses is the

---

[1] "Statistically significant results do not necessarily indicate that an association is substantively important. Statistical significance is only a necessary but not sufficient criterion of importance. An assessment of the magnitude of the association must still be made in some terms other than that of a statistical test of significance." David Gold, "Statistical Tests and Substantive Significance," The American Sociologist, 4 (February, 1969), p. 44.

central issue in the following Discussion section.[1]

DISCUSSION AND INTERPRETATION OF SELF-OVER-OTHER FINDINGS

Any analysis of the pattern in the findings from the fourteen hypotheses indicated a parsimonious interpretive principle to account for the percentage variation in self-over other in most of the hypotheses:

> Assuming the situations posed in the hypotheses are really perceived by CIC students as serious career-status problems, the strength of the self-over-other tendency varies roughly with the degree of openness to individual control and manipulation present in the structure of the several problem situations.

Here we define degree of openness to individual control in terms of (a) subcultural themes current at CIC and (b) the objective

---

[1] As part of the analysis of the self-other findings from the hypotheses-testing questions, the sample of 75 was broken down into various subgroups along lines which might be termed "characteristics of the population" (most of which were outlined in Chapter 3)-- including academic class at CIC, ethnicity, social class, age, intended location of practice, amount of chiropractic care prior to entering CIC, and priority of chiropractic as an occupational choice upon matriculation at CIC. Although numerous tables were run along these lines, the general upshot was that these other statuses played a minor, and sometimes inconsistent, role in affecting the strength of the self-over-other tendency in the hypotheses. In the great majority of instances subgrouping of this kind maintained for all the subgroups about the same discrepancy between self and other as reported for the sample as a whole. Although interesting points about one subgroup or another's personal degree of optimism in various problem situations emerged-- for example, Italian students predicted somewhat higher incomes for themselves than other ethnic group members, and students planning to locate in New York State were somewhat less optimistic about the early economic success of their practices than those planning to practice in other states-- little significant material bearing on the self-over-other hypotheses was evident. Hence, these internal analysis materials were not included in the final report.

social structure of the various external societal sectors, as they relate to career problems for chiropractors. For some hypotheses-situations, the extent of openness (or the lack of it), in terms of available evidence, is more prominently defined by the CIC culture, in others by the structure of an impinging societal sector. It should be noted that this explanatory or interpretative principle was formulated after the testing of the hypotheses-- the idea of self-over-other tendency varying with the degree of individual freedom allowed by the problem situation coming to me long after the hypotheses were formulated and the data tabulated-- so that its validity must be construed on the order of plausibility, rather than conclusive evidence. In future research along this line, one would have rigorously to define in advance problem situations with high, moderate, and low degrees of structural amenability to individual control in one's hypotheses. In any event, the fact that the above-stated interpretative principle, post factum or otherwise, appears to consistently account for the self-over-other variation in the majority of hypotheses makes it worthy of rather detailed examination.

In paradigm form, Chart 5-1 relates the findings in the hypotheses to the explanatory principle. The Chart summarizes key points in the discussion of self-other patterns for the sectors and hypotheses, which follows immediately below in the text:

Chart 5-1. A Paradigm For Interpreting the Self-Over-Other Variation in Fourteen Hypotheses

Hypothesis	Problem Content	Degree Problem Open to Individual Manipulation	Strength of Self-Over-Other Tendency	Comments:
1	Income after 10-15 years	High	High	Practice is domain of individual, entrepreneurial capitalism. CIC culture inculcates the possibility and importance of achieving the American Economic Dream.
2	Income at peak of career	High	High	Same.
3	Necessity of taking additional non-chiropractic employment at start of practice	High	High	Same.
4	Initial economic situation in practice	High	High	Same.
+ 5	Negotiation of chiropractic boards	-	Moderate	Poor career problem choice. Not enough evidence that CIC students perceive these exams as a real hurdle or discriminatory.
6	Negotiation of basic science boards	High	High	Individual student perceives himself as brighter and more capable than average chiropractic candidate in passing discriminatory examinations.

Hypothesis	Problem Content	Degree Problem Open to Individual Manipulation	Strength of Self-Over-Other Tendency	Comments:
7	Coping with effect of a publicized malpractice decision against a chiropractor	Moderate	Moderate	Mass media publicity a "social force" to some extent beyond control of any particular individual. But students believe they have some power in their individual practices to persuade own patients that negative comments about chiropractic do not apply to them personally.
8	Coping with effect of negative publicity in general about chiropractic	Moderate	Moderate	Same.
9	Success in winning over primary groups to decision to become a chiropractor	High	High	Domain for prolonged and repeated personal persuasion exercised in small, intimate groups.
10	Success in regulating frequency of unpleasant and social confrontations in secondary groups	Low	None	Impossible to control nature of transitory social contacts.
11	Cordiality of relations with local M. D. s	High	High	Domain for personal charm and persuasion, exercised with M. D. s in own community on one-to-one basis.

Hypothesis	Problem Content	Degree Problem Open to Individual Manipulation	Strength of Self-Over-Other Tendency	Comments:
12	Cordiality of relations with local osteopaths	High	High	Domain for personal charm and persuasion, exercised with osteopaths in own community on one-to-one basis.
13	Membership in inter-professional clinics	Low	None	Opposition to chiropractors' participation highly institutionalized in larger-scale medical and paramedical organization.
+ 14	Membership in non-chiropractic hospitals	Low	Moderate	Rationale for low degree of individual manipulation same as in interprofessional clinic situation. Finding of moderate (instead of no) self-over-other tendency inconsistent with major interpretative principle. Negative case.

+ Indicates findings not embraced by or compatible with explanatory principle of degree of individual control.

The Market Sector

The sample manifests a high-order self-over-other attitude in the market sector problems at early (Hypotheses 3 and 4), middle (Hypothesis 1), and peak (Hypothesis 2) stages of a chiropractic career. Ample evidence in Chapter 4 (and later in Chapter 7) exists strongly to suggest that CIC students are taught at the School to perceive the economics of a chiropractic practice as a "dog-eat-dog," highly competitive arrangement, with few restraints imposed by professional associations, where individual initiative, drive and "personality" play the large roles in determining one's success in a "wide-open" chiropractic market where "the sky's the limit."

The "American Dream" value pattern described by Merton,[1] linked to the model of an open market seems very dominant in CIC's subcultural definition of the practice of chiropractic. It is consistent, then, that students should very frequently predict greater initial economic success and greater eventual occupational incomes for themselves than for their chiropractic peers.

It was my strong impression from sustained field work at the School that students' wide-spread conviction that they would personally "make it big" financially in chiropractic-- regardless of the dimmer

[1] Robert K. Merton, Social Theory and Social Structure (Rev. Ed.), Glencoe: The Free Press, 1957, pp. 136-139.

performance of most other chiropractors in this respect-- was the largest single counterbalance to the array of foreboding messages which Chapter 4 depicts them receiving as chiropractic students in a medically-oriented society. Students seem to be constantly sending themselves the positive message of a personally great economic reward to ward off the negative messages communicated to them from external societal sectors.

Just how much distance CIC students put between themselves and other chiropractors on predicted career incomes can be seen from the median projected incomes[1] for self and other at 10-15 years and peak of career: At the earlier point in time respondents predicted a median income of $52,500 for themselves and $28,400 for the

---

[1] All reported self and other average income estimates in this and the following chapter (where medical and dental students' estimated incomes are introduced) are median averages, computed in accordance with standard procedure for finding medians from grouped data indicated by Guilford. J. P. Guilford, Fundamental Statistics in Education and Psychology, New York: McGraw-Hill Book Co., Inc., 1956, pp. 55-57. Medians were used because (a) it is conventional in sociology and economics to use medians when discussing income averages, see e.g., David Caplovitz, The Poor Pay More: Consumer Practices of Low Income Families, Glencoe: The Free Press, 1963, and (b) whenever the type of objective income average with which students' estimates are compared in Chapters 6 and 7 was actually specified, it was a median. Mean averages were also computed, but not included in this report, yielding essentially the same self-other discrepancies in favor of self, although all predictions (self and other) tended to be somewhat higher.

average chiropractor; at peak of career they predicted an average of $59,600 in personal income and $37,100 for the average practitioner. Predicted self incomes, then, exceeded predicted other incomes at the two time periods by 185% and 161% respectively.

How realistic are these predicted incomes in terms of available statistical data on how much chiropractors earn? The 1968-69 Occupational Outlook Handbook, published by the U. S. Department of Labor, states: "Though incomes of chiropractors vary widely, experienced chiropractors generally had average yearly incomes ranging from $11,000 to $16,000 in early 1967, according to the limited data available."[1] The federal government "average" estimate, then, for 1967 would be $13,500. Wilfred E. Belleau, in Chiropractic as a Career, writing as of 1966, states: "A recent study indicates that the average net income of chiropractors in practice for two or more years is approximately $10,500 a year."[2] Averaging these two net income estimates, we get an income figure of $12,000.

But there are strong reasons to believe that the great majority of respondents made their income predictions on the

---

[1] U. S. Department of Labor, Bureau of Labor Statistics, Occupation Outlook Report Series, Bulletin No. 1550-17, from the 1968-69 Occupational Outlook Handbook.

[2] Wilfred E. Belleau, Chiropractic as a Career (Rev. Ed.) Milwaukee: Park Publishing House, 1966, p. 16.

Questionnaire in terms of gross income.[1] If we are to compare their projections with the limited objective statistics available we must roughly, at least, convert the objective net averages-- i.e., "take-home" income-- into gross averages. It is difficult to move in any precise fashion from net to gross magnitudes of income. The two major factors involved in the translation when one is dealing with an occupation like chiropractic are income taxes and various office expenses (treatment equipment, office rentals, X-ray developing facilities, office personnel, and so on). After discussion with a number of experienced chiropractors, I set a 35% increase from net income as a reasonable percent to approximate average gross income based on objective statistics. This percentage increase yields a gross income figure of $16,200 (135% times $12,000) with which we can more fairly compare CIC students' various income predictions for themselves and others.

---

[1] In general when people discuss income or salaries they refer to total income before taxes and expenses, and there is no reason to assume these respondents proceeded on a different basis than ordinary usage when they answered income questions in this questionnaire. Further, subsequent questioning of many of the respondents yielded unfailingly the answer that they had assumed the questionnaire meant gross income.

Sociological questionnaires do not often make a point of the distinction between gross and net income, but the implication is that gross is being asked for. For an example, see Robert K. Merton, George G. Reader and Patricia L. Kendall's questionnaire for medical students in The Student-Physician, Cambridge: Harvard University Press, 1957, pp. 340 and 345.

It should be noted that for our analytical purposes of comparing self versus other income predictions, the fact that a few students

Comparing now our objective gross income figure of $16,200 with respondents' income estimates, we find that CIC students' income predictions for the average chiropractor at 10-15 years of practice and at the peak of his career are respectively 173% and 230% of the objective gross income for experienced chiropractors; and that students' predictions about their own income at the two time periods are respectively 321% and 378% of our approximate estimation of the objective gross income for experienced chiropractors.

Part of the disparity between respondents' projected income estimates and current government figures might conceivably be due to respondents incorporating the factor of probable future inflation (in the next two decades) into their predictions. It was my impression, however, from discussions with many students after they handed in the questionnaires that they based their calculations on the present economy and the value of the dollar. In fact, most of them were suprised when I asked whether they had considered an inflation factor in their estimates.

It is scarcely believable that the inflation element could explain the major part of the sample's enormous disagreement with present official and quasi-official figures on how much chiropractors earn.

---

might have preceded on a net basis rather than the usual gross one is unimportant, for presumably those students would use the net basis for both self and other, creating a constant which would allow discrepancies between self and other to emerge.

That students "overreact" to gloomy market messages coming their way by predicting inordinately large career incomes both for themselves and other chiropractors (although to different degrees) is a much more probable explanation. Even if students were systematically taking future inflation into account in their predictions, so that one might argue their projections were somewhat more realistic than they appear to be, the most important fact in the data still stands: Students predict much larger future incomes for themselves than for their fellow chiropractors.

The Political Sector

Although Hypothesis 6, concerning anticipated success on basic science parts of state licensing examinations yielded a high-order self-over-other tendency, the findings from Hypothesis 5 on self and other anticipated success with chiropractic sections of state boards showed a moderate tendency.

Reexamination of my field notes, interviews with students, and discussion of chiropractic examinations in chiropractic journals forces the conclusion that although one marks occasional grumbling that even chiropractic sections of chiropractic examinations were unfair or discriminatory in the sense that (in some states) they were made up by and/or graded by medical rather than chiropractic

examiners, most students and occupational literature did not consider the negotiation of chiropractic state examination a serious career problem akin to most of the others in the list of hypotheses (the seriousness of the great majority of problems in the hypotheses was detailed in Chapter 4). To the extent that it was perceived as a problem, the consensus seemed to be that it was a "routine" and justifiable career hurdle-- testing students' competence in areas intimately related to the competent practice of chiropractic-- rather than-- as in the case of perhaps all the other hypotheses-problems-- a function of peculiar societal suspicion and stigmatization of chiropractic and its practitioners. Viewed in this light, Hypothesis 5 falls outside the purview of the predicted self-over-other mechanism, since that mechanism is founded on an assumption of special threat attached to the status of chiropractic student. It is difficult, then, to interpret the moderate self-over-other tendency present in the findings in terms of the theory relevant to this research.

Certainly however, field note and questionnaire evidence from Chapter 4 tells us that CIC students, faculty, and administrators define many states' basic science examinations as "discriminatory" or "medically-dominated," and creating a serious and biased hurdle to their careers. Do they perceive the negotiation of such examinations

as open to control through personal skill? Although the evidence could be more complete, we did see in Chapter 4 an inclination on the part of many students to deprecate the abilities of fellow chiropractic students. It is certainly then not unreasonable to suggest here a model where individuals conceive of themselves as performing better on difficult and even biased examinations than average chiropractic candidates, whose intellectual capacities they define as inferior to their own. This model is consistent with the high self-over-other tendency manifested by students on Hypothesis 6.

The Mass Media Sector

First we might point that Hypothesis 7, concerning the effect of a court decision of malpractice against a chiropractor on other chiropractors in the same area is included within the mass media sector (rather than in, for example, the political sector) of career problems, because the situational model here is one where rumor and mass media publicity about a court finding of malpractice against a local chiropractor may well become a "social force" with which chiropractors in the court region become confronted by their patients.

The moderate self-over-other tendency in the two mass media-publicity problems appears to be the product of forces pulling

students' evaluations in two opposed directions. On the one hand there is a realistic perception by respondents that they have no control over the spread of unfavorable publicity by large newspapers and magazines. To this extent, students may regard unfavorable newspaper publicity, to take a common instance, as an inexorable social current sweeping across a city or community creating at least a measure of suspicion or doubt in most who read it, chiropractic patients included. On the other hand, CIC students, pursuing their concept of "solo practice," with all the stress on individual ability and relative inattention to collegial bonds it implies (see Chapter 7 for detail and documentation) and possessing a mild disdain for the abilities of many of their occupational peers, may feel that they can offset at least some of the negative effects of such general publicity in their personal practices by successfully treating (getting "sick people well") their own patients. There are, then, perhaps perceived degrees of freedom in persuading patients "I'm not like the fellow you read about, and the proof of the pudding is that I'm getting you better." Thus a moderate tendency to believe that one is personally more capable than others in coping with a practice problem which has some elements of inflexibility might be expected.

The Primary and Secondary Group Sectors

The primary group hypothesis (9) shows a high-order tendency among CIC students in favor of self-success in winning over recalcitrant family and friends to accepting their decision to become chiropractors, relative to other CIC students' sucess in this sensitive status problem area. However, the hypothesis concerning the self-other frequency of unpleasant confrontations due to one's chiropractic student status (Hypothesis 10) shows no tendency of self-over-other.

Again, in a manner somewhat parallel to the conditions prevailing in the mass media situations, it would appear that a near complete lack of control over the unfolding of events at parties and other transient secondary group gatherings accounts for students making virtually no distinction between self and other vulnerability to attack.

On the other hand, 65% of the students indicated greater success for themselves in coping with disapproving primary groups than for others. Unlike the capricious and uncontrollable social currents of newspaper attacks or cocktail confrontations, students no doubt feel that here is a status problem which they can personally affect and solve because of the opportunity for repeated and long-term persuading sessions with intimate friends and family members.

The Related Occupations Sector

Table 5-3 shows that respondents demonstrate a high-order self-over-other prognosis for friendly relations with both local M. D. s and osteopaths (Hypotheses 11 and 12), but a low-order tendency for predicted membership on the staff of a non-chiropractic hospital (Hypothesis 14), and no tendency for anticipated participation in an interprofessional clinic with practitioners from related healing arts, such as medicine, dentistry and osteopathy (Hypothesis 13).

It would appear that relations with local M. D. s and osteopaths is another area of career success, similar to successfully reconciling dissatisfied relatives and friends to one's choice of chiropractic, where students believe they can control the situation at the local-personal level with particular medical and osteopathic practitioners on a small-scale (usually one-to-one) basis. In the 2nd Questionnaire respondents were asked to distinguish between the attitudes of organized medicine (AMA) and individual M. D. s toward chiropractors. Responses to that question indicated that (a) students make a sharp distinction between the attitudes of the "political" representatives of medicine and individual doctors, and (b) feel that individual M. D. s in particular communities are more receptive and favorably inclined to chiropractors than the national, state or even local medical

associations.[1] Wardwell found in his dissertation that chiropractors' feelings of cordiality with medical men varied inversely with the size and complexity of contact.[2] They were most comfortable with individual physicians in smaller (rural and semi-rural) communities, and relations worsened with larger, more highly organized (urban) medical units.

Whereas Hypotheses 11 and 12 conceptualized chiropractors essentially pursuing their own practices and intermittently or occasionally coming into contact with M. D. s or osteopaths (with perhaps a referral sometimes involved)-- also pursuing their own disciplines-- the latter pair of related occupations hypotheses posited situations where chiropractors would deal with other types of practitioners on a larger-scale, more institutionalized and regularly collaborative basis. It seems very clear from, for example, countless statements by medical societies at the community level, that chiropractors are not wanted as colleagues in group health arrangements, be they interprofessional clinics or hospitals. In such arrangements where the degree of "visibility" is high, one would expect a close adherence

---

[1] 81% of the sample (N=75) felt that individual M. D. s were more favorable to chiropractors than organized (AMA) medicine. This trend is somewhat reminiscent of the often-heard folk theme that the peoples of different nations are not hostile to each other, only their organized governments.

[2] Walter I. Wardwell, "Social Strain and Social Adjustment in the Marginal Role of the Chiropractor," unpublished Ph. D. dissertation, Harvard University, 1951, pp. 279-287.

by physicians, dentists, and osteopaths to official professional group norms, in this case a strict ban on chiropractors. In terms of the present discussion, both the interprofessional clinic and hospital situations would have to be categorized as structurally "off limits" for chiropractors, unbending to the efforts of individual chiropractors to break down these barriers.

Hypothesis 11, concerning interprofessional clinic participation, follows the explanatory principle we have developed and shows no self-over-other tendency at all. The moderate self-over-other tendency evinced by the sample in Hypothesis 12, however, is inconsistent with the interpretative frame of reference that degree of individual control and strength of self-over-other tendency are positively correlated. One would have anticipated that there would be no self-over-other tendency in respondents' prognosis for hospital membership. Indeed, a stronger argument could be made in the hospital situation than the interprofessional one for absence of individual chance to alter the established bias against chiropractors' participation, because the hospital is a larger, more visible, more centrally controlled medical institution than the interprofessional clinic.[1]

---

[1] Chiropractors are not allowed to practice in any hospital accredited by the Joint Commission on Accreditation of Hospitals: "Membership upon the medical staff /of any accredited hospital/ is restricted to physicians and surgeons who are (a) legally licenced to practice medicine and surgery in their respective states..." Model Medical Staff By-Laws Rules and Regulations, Joint Commission on Accreditation of Hospitals, January, 1964.

In summary, the interpretive principle that subculturally perceived and/or structural degrees of freedom to shape the outcome of a chiropractic career problem and strength of self-over-other tendency are positively related was able to explain the findings quite satisfactorily and consistently in twelve of the fourteen hypotheses in the research. One hypothesis (5), and the situation it described, failed to fall within the scope of the principle since the problem involved did not embody the stigmatized features characteristic of the other thirteen. The findings from the final hypothesis were inconsistent with the logic of the principle.

CHAPTER SIX: WHAT PART DOES THE "AUTISTIC TENDENCY" PLAY IN CHIROPRACTIC STUDENTS' ELEVATION OF SELF OVER OTHER? AN EVALUATION THROUGH A COMPARISON OF CHIROPRACTIC, DENTAL AND MEDICAL STUDENTS

The controlling idea behind the research in Chapter 5 was that chiropractic students, confronted with a barrage of negative and unwelcome news from various societal sectors, have a strong tendency to separate themselves as individuals-- in any given career problem area-- from their occupational group, in the direction of favoring self. And Chapter 5 did indeed demonstrate that this tendency was evident, often very pronounced, in most of the career areas under examination.

THE AUTISTIC TENDENCY IN THE PSYCHOLOGICAL LITERATURE

There are, however, psychological, and even sociological, studies which suggest that in general persons tend to elevate themselves over others in testing situations. George Lehner, for example, gave 80 subjects the California Test of Personality and asked them to (1) take the test themselves and (2) answer the test as they believed the "average person" would answer it. Nearly all of both male and female subjects had adjustment scores for self considerably higher than scores assigned to the "average

person."[1] In another study Raven and Fishbein state: "Investigations of a person's self-evaluation in a test situation show that level of aspiration is a function of, among other things (a) an autistic factor manifesting itself in a distortion of one's self perception so as to overestimate one's performance.... In this study a general tendency among subjects to overestimate their test scores was found."[2] In a social-psychological research Herman Turk found that students consistently assigned to themselves much more time to make a point in a classroom discussion than they assigned to their fellow classmates.[3] On a more general level than testing situations, Dennis Wrong has remarked, in a theoretical piece, on a Freudian tendency in men to assert their selves in the face of social norms and conventions.[4]

---

[1]George F. J. Lehner, "Some Relationships Between Scores For Self and Projected 'Average' Scores On a Personality Test," The American Psychologist, 4 (September, 1949), p. 390. See also his "Personal Adjustment Scores and Assigned Average Scores," Journal of Psychology, 42 (October, 1956), pp. 227-236.

[2]Bertram Raven and Martin Fishbein, "Social Referents and Self-Evaluation in Examinations," Journal of Social Psychology, 65 (February, 1965), pp. 88-99.

Raven and Fishbein use the term "autistic factor" instead of "autistic tendency."

[3]Herman Turk, "An Inquiry Into the Undersocialized Conception of Man," Social Forces, 43 (May, 1967), pp. 518-521.

[4]Dennis H. Wrong, "The Oversocialized Conception of Man in Modern Sociology," American Sociological Review, 26 (April, 1961), pp. 187-193. The implication of Wrong's theme for our purposes is that in "the game of life" one might expect some exercise of self at the expense of others.

Gordon Allport has remarked on the tendency to exaggerate self-ratings, and suggested that it is peculiarly marked in American culture: "The method (he is discussing self-rating of personality) has one persistent source of error. Most people are self-flattering; they overestimate those qualities they consider desirable and underestimate those they consider undesirable. At least this tendency is marked for most self-ratings in the American culture where self-confidence is encouraged."[1] Hendin's research in Scandinavia and America also suggests that the autistic tendency is relatively stronger in our culture: "When asked if she were a good nurse, not one of 12 Norwegian curses would say yes.... Of 12 American nurses, all but one state that they considered themselves good nurses.... The American girls reflected the attitude that if you did not project a feeling of belief in your own competence, certainly no one else would believe in it (Hendin hastens to add that there were no objective reasons for concluding that the American nurses were, in fact, any more competent than the Norwegian ones)."[2]

Although the autistic tendency is by no means well-documented enough to talk about a "general law" in psychology, or

---

[1]Gordon W. Allport, Pattern and Growth in Personality, New York: Holt, Rinehart and Winston, 1961, p. 411.

[2]Herbert Hendin, Suicide and Scandinavia, New York: Grune and Stratton, Inc., 1964, p. 2.

social psychology, there is enough research to suggest that it exists to a stronger or weaker degree, (to a relatively stronger degree in American culture), and that it manifests itself in testing situations which include comparative self-other evaluations of behavior, personality, attitudes, and so on. This being the case, the research findings of Chapter 5 must pay some attention to the possible criticism that elevation of self over other being a general tendency among American subjects in testing situations, all the present research has achieved is to document that tendency, rather than to show its special presence in the case of chiropractic students.

COLLECTION OF COMPARATIVE SELF-OTHER DATA FROM MEDICAL AND DENTAL STUDENTS

To meet this objection head-on, a limited, but hopefully strategic, amount of comparative self-other data was collected from two other groups of healing arts students, dental students and medical students. The expectation was that these groups of students would show markedly less elevation of self over other than the CIC students in career prognosis areas, although some elevation of self over other was expected here as well, due to the "autistic constant." The expectation of substantially decreased elevation of self was based on the assumption that students in the highly respected professions of medicine and dentistry receive

virtually none of the negative messages which reach chiropractic students about their occupation; medical and dental students would, in contrast to the CIC sample, have every reason to identify with their professional groups and very few reasons to disavow membership. If the comparative data in fact showed a substantially decreased elevation of self over other on the part of both medical and dental students over and against the chiropractic students, then we would be justified in asserting that much more was at work in the chiropractic case than a general autistic tendency found in most persons in this culture: Over and beyond an autistic tendency, persons occupying a disadvantaged or stigmatized social (in this case occupational) status are forced into making a more extreme distinction between themselves and others sharing that status, as a "survival technique."

Sophomore, junior and senior students[1] at the New York University Dental and Medical Schools were asked questions identical with those asked CIC students for the first four items (income prognosis for self and other at two periods in a professional career) in the self-other battery for the chiropractic sample (See Chapter 6). Comparative self-other data was limited to

---

[1]Since no data was collected from a freshman class at CIC, no freshman data was collected for dental or medical school samples. Re the CIC sample, see Chapter 2.

income prognoses because of at least three reasons:

1. The self-over-other tendency had proven to be strongest with the CIC students in the predicted income area, and would be a strategic one for comparison with other types of health student.

2. Most of the problem situations which CIC students were confronting simply had no analogue with dental or medical school student career problems (e.g., licensing, primary and secondary group relations, problematic relations with related occupational groups) since these latter professions were highly prestigeful and respected. [1]

3. Although the Deans of both the Dental and Medical Schools cooperated, it was clear that only limited access to the students in both schools in terms of time was to be made available, so that the questionnaire had to be very short, and thus as strategic as possible.

I collected data in the fall of 1968 from both groups of students. Although the two-page questionnaires were identifical for

---

[1] Thus a problem remains: How can one be sure that the self-over-other tendency manifested by CIC students in self-other problems not also presented to dental and medical students is not merely the result of an autistic tendency (assuming the following pages of comparative research in this chapter refute the autistic argument for the income self-other situations)? Although no air-tight answer is available, the facts that (a) the degree of self-over-other tendency varied considerably from hypothesis to hypothesis, or from societal sector to sector, and (b) that this variation could reasonably be related to career determinants and possibilities in one problematic career situation or another, tend to cast strong doubt on autistic tendency playing the central role in CIC's students elevating self over other.

both the dental and medical groups (see Appendices C and D), the administering procedure varied in the two schools, because of differences in the training programs of the two schools, a difference which was to affect the number of responses I obtained. In the N. Y. U. Dental School it was possible to get all of the members of any given upper class together in the same lecture. In the N. Y. U. Medical School this was possible only with the sophomores, since the juniors and seniors are split up among various clinical programs scattered throughout New York City, and never meet as an entire class.

Thus with the Dental School I was able to pass out the ten-minute questionnaires at the beginning or end of a lecture, and re-collect them immediately. With the Medical School I was only able to obtain this "captive audience" for the sophomore class. I sent questionnaires to the juniors and seniors through the Medical School mail system, requesting them to return them to the Dean's Office, but the return was poor[1] (no doubt due to the Questionnaire seeming relatively trivial in the lives of very busy and harrassed clinical students). Under these varied circumstances I was able

---

[1] The Dean's secretary at the Medical School told me that rates of return on mailed requests to students from that office are generally very low.

to obtain data from 89% (N=358) of all sophomores, juniors and seniors currently studying in the N. Y. U. Dental School, and 35% (N=126) of the medical student upperclassmen handed in questionnaires. 73% of the sophomore medical class responded (in this instance a representative of the student council handed out questionnaires to the class and collected them on departure--some students were absent from the lecture and some did not hand questionnaires back), but only 15% of the combined junior and senior students responded. There does not appear, however, reason to believe that junior and senior medical students who did or did not return their mail questionnaires would differ from each other in terms of a self-over-other tendency on income prognosis (even though they might differ in terms of variables not relevant to the research, such as willingness to fill in questionnaires, or willingness to cooperate with the Dean's Office), so that the 15% who answered might still be considered fairly "representative" of junior and senior medical students on the particular issue of self versus other.

THE COMPARATIVE FINDINGS

The number of dental and medical students assigning to self a higher income category than to other at the 10-15 years and

peak of career stages was calculated, as it had been done for the CIC sample in Chapter 5. The comparative results for the three groups follow in Table 6-1:

Table 6-1. Number and Percentage of Those Choosing Self Over Other on Income Prediction at Two Time Periods in Career, For Three Groups of Health Students

Time	CIC Students (N=75) No.	%	N. Y. U. Dental Students (N=358) No.	%	N. Y. U. Medical Students (N=126) No.	%
10-15 Years	52	69	184	51	41	33
Peak of Career	44	59	141	39	30	24

To determine whether the percentages of those choosing self over other in the three groups at the two time periods were different to a statistically significant degree, a series of X^2 tests were carried out, dichotomizing students into those choosing self over other and those not doing so. Tables 6-2 and 6-3 give the overall observed frequencies for the three groups at 10-15 years and peak of career. Internal X^2 findings (between chiropractic students and dental students, dental students and medical students,

and so on) are then given and discussed.

Table 6-2. Distribution of Self-Over-Other Income Predictions at 10-15 Years For Three Groups of Health Students (Observed Frequencies)

	CIC Students No.	N. Y. U. Dental Students No.	N. Y. U. Medical Students No.	Total No.
Picked Self Over Other	52	184	41	277
Didn't Pick Self Over Other	23	174	85	282
Total	75	358	126	559

(df=2) $X^2 = 26.778$ $P < .001$

Table 6-3. Distribution of Self-Over-Other Income Predictions at Peak of Career For Three Groups of Health Students (Observed Frequencies)

	CIC Students No.	N. Y. U. Dental Students No.	N. Y. U. Medical Students No.	Total No.
Picked Self Over Other	44	141	30	215
Didn't Pick Self Over Other	31	217	96	344
Totals	75	358	126	559

(df=2) $X^2 = 24.626$ $P < .001$

Tables 6-2 and 6-3 show statistically significant X^2 values in an overall way for the differential frequencies of self-over-other predictions among the three groups of health students. Combining this information with Table 6-1 we see that CIC students exhibit the largest percentages of self-over-other income prediction, with dental students trailing considerably behind, and medical students very far behind. Finally, we must obtain internal X^2 values for comparisons between groups within the overall tables. These appear in Table 6-4:

Table 6-4. X^2 Values For Six Internal Comparisons Among Three Groups of Health Students On Self-Over-Other Tendency

Comparison	X^2 Value	P
CIC Students Versus N. Y. U. Dental Students, 10-15 Years	8.217	$< .01$
CIC Students Versus N. Y. U. Dental Students, Peak of Career	8.976	$< .01$
CIC Students Versus N. Y. U. Medical Students, 10-15 Years	25.500	$< .001$
CIC Students Versus N. Y. U. Medical Students, Peak of Career	24.820	$< .001$
N. Y. U. Dental Versus N. Y. U. Medical Students, 10-15 Years	13.620	$< .001$
N. Y. U. Dental Versus N. Y. U. Medical Students, Peak of Career	9.673	$< .01$

The findings from Tables 6-1 - 6-4 are in line with the expectations with which we began this chapter: Although dental and medical students both manifest some tendency to elevate self over other, it is considerably weaker than the CIC students (see Table 6-1). Further, the tendency is smaller to a statistically significant degree when CIC students are compared with either the dental or medical student group (see Table 6-4). These findings support our contention that the self-over-other tendency found in so many of the problem situations in Chapter 5 is most probably much more than manifestation of an autistic tendency on the part of respondents; a factor at least equal in importance is the stigmatized features of the status of chiropractic student, combined with students' reactions to these features.

An additional way to look at the comparative strength of the self-over-other tendency in the three student groups is to see how many income intervals or income categories students who chose self over other put between themselves and the average practitioner. It emerges that just as the CIC students elevate self over other more frequently than students in the dental and medical samples, so those in the chiropractic sample who do elevate self over other in income prediction put more distance between themselves and others than do the dental and medical students who elevate self over other.

Tables 6-5 and 6-6 support the idea of a "structural effects" mechanism[1] at work here, where the individuals in the three samples manifesting a self-over-other tendency to begin with are seen to manifest it in differential magnitude because of the varied sociological features in the chiropractic, dental and medical school cultures, which either "elicit" or "inhibit" such a tendency. From the following data we see clearly that medical school culture is the most restrictive toward an expression of this tendency, and chiropractic school culture most permissive or encouraging in this respect, with dental school somewhere between.

Table 6-5. Number of Income Intervals Between Self and Other Indicated By Those Choosing Self Over Other in Three Groups of Health Students, at 10-15 Years

	CIC Students (N=52)		N. Y. U. Dental Students (N=184)		N. Y. U. Medical Students (N=41)	
Number of Intervals	No.	%	No.	%	No.	%
1	22	42	96	52	31	76
2	12	23	43	23	7	17
3	11	21	42	23	1	22
4	6	12	3	22	2	55
5	1	22				
6						
Totals	52	100	184	100	41	100

[1] Peter Blau's research on structural effects is as well known as any. He found in a study of bureaucratic agencies, for example, that "pro-client individuals are not as likely to furnish extensive service to clients when they work in anti-client as when they work in pro-client

Table 6-6. Number of Income Intervals Between Self and Other Indicated By Those Choosing Self Over Other in Three Groups of Health Students, at Peak of Career

	CIC Students (N=44)		N. Y. U. Dental Students (N=141)		N. Y. U. Medical Students (N=30)	
Number of Intervals	No.	%	No.	%	No.	%
1	13	30	102	72	26	87
2	20	45	37	26	3	10
3	6	14	1	1		
4	3	7	1	1	1	3
5	2	5				
6						
Totals	44	100	141	100	30	100

It is interesting, although not central to our research goals, that there exist strong differences between dental and medical students at both time periods in regard to the extent of a self-over-other tendency, whether one discusses the frequency of the tendency (see Table 6-4) or the magnitude of the tendency (See Tables 6-5 and 6-6). At both time periods dental students exhibit a more frequent and stronger self-over-other tendency than medical students (although this research had not predicted either a dental-over-medical or medical-over-dental trend, being primarily concerned with the tendency in both these groups as set off against the chiropractic sample). A possible explanation: the tendency to elevate self

groups." Peter M. Blau, The Dynamics of Bureaucracy (Rev. Ed.), Chicago: University of Chicago Press, 1963, p. 76.

over other in an occupation may be inversely related to the prestige attached to an occupation. With the present three occupations, scales of occupational prestige, such as the NORC scale, rank medicine highest, dentistry next, and chiropractic last;[1] and the sizes of the self-over-other tendencies expressed by the three groups of students are inversely related to the prestige rankings of their respective occupations.

The degree of elevation of self over colleague is also no doubt related to perceptions of independence or dependence on the part of members of a given occupational group. That is, the more one feels himself dependent upon colleagues for the day-to-day conducting of his own practice, the less he may feel inclined to distinguish himself from his collegial group. Looking specifically at the institutions of modern dentistry and medicine, group control of day-to-day affairs is greater for medicine (principally because of the hospital system in medicine which has no real counterpart in dentistry), and the differential findings in self-over-other tendency (here operationalized in economic terms) between the two groups may in some large way reflect differentials in anticipated independence in the two healing arts. From a slightly different

---

[1]See Robert W. Hodge, Paul M. Siegel, and Peter H. Rossi, "Occupational Prestige in the United States, 1925-1963," American Journal of Sociology, 70 (November, 1964), pp. 290-292.

perspective, More and Kohn[1] contend that independence or "autonomy" is one of the prime motivations for persons choosing dentistry (choose own hours, freedom from evening work), and that, further, some of them have chosen dentistry instead of medicine because the practice of medicine put into jeopardy just this kind of valued independence. The need for autonomy, then, which may be present to a greater degree in recruits to dentistry than to medicine, is perhaps expressed to some degree in the differential self-over-other tendencies seen in this research.

Average Income Estimates For the Three Groups of Students

Average income estimates for self and other were calculated for the dental student and medical student groups just as they had been done for the CIC students in the previous chapter. The average income estimates for all three groups follow in Table 6-7:

---

[1] D. N. More and Nathan Kohn, Jr., "Some Motives for Entering Dentistry," The American Journal of Sociology, 66 (November, 1964), pp. 290-292.

Table 6-7. Median Other and Self Predicted Incomes (to nearest hundred dollars) For Three Groups of Health Students at Two Career Stages

	CIC Students (N=75)		N. Y. U. Dental Students (N=358)		N. Y. U. Medical Students (N=126)	
Time	Other	Self	Other	Self	Other	Self
10-15 Years	$28,400	$52,500	$34,100	$41,700	$34,000	$34,600
Peak of Career	$37,100	$59,600	$42,800	$52,300	$45,400	$44,600

One immediately marks the reduction in the self-over-other tendency moving from chiropractic student income estimates to dental students, and then to medical students. For the chiropractic sample the discrepancy is $24,100 and $22,500 in favor of self at the two time periods; for the dental sample the elevation in favor of self is $7,600 and $9,500 at the two career states; for the medical sample the discrepancy in favor of self is a mere $600 at the 10-15 year period, while at peak of career there is a slight tendency ($800) in favor of other's income. The average income data, then, go in "lockstep" with the percentage data on how many students elevate self over other in the three samples, again supporting the contention of the research that the strength of a tendency to elevate self over other is crucially linked to the relative statuses of occupations.

Just as we looked at CIC students' income predictions for self and other in light of objective statistics available on how much chiropractors earn, it is interesting to compare dental and medical students' estimates with available objective measures on how much average dentists and M.D.s earn. It will be recalled from Chapter 5 that CIC students' predictions were tremendously out of line with objective estimations of chiropractors' incomes,

particularly with self-estimates where their figures were well over 300% of the objective estimates. At that time we noted that these extra-hopeful estimates were most likely a reaction (or "over-reaction") to the gloomy negative messages students were receiving, most particularly here about the economic aspects of a chiropractic career, but more generally about most unhappy facets of this occupation. One would have reason to expect, then, that dental and medical school students' other and self income estimates would be closer to the objective statistics since, presumably, the distorting reaction-to-threat mechanism would not be operative in these more highly esteemed and orthodox occupations.

Net income data was obtained for all self-employed dentists in 1966 and physicians in private practice in 1966 from the 1968-69 Occupational Outlook Handbook. The dental income figure was about $21,000 a year[1] and the medical income figure $23,500.[2] Since, just as with the CIC sample, there is every reason to believe dental and medical respondents were operating on gross income assumptions when they filled in their questionnaires, we must convert the net income figures to approximate

---

[1] U. S. Dept. of Labor, Bureau of Labor Statistics, Occupational Outlook Report Series, Bulletin No. 1550-24, from the 1968-69 Occupational Outlook Handbook.

[2] Ibid., Bulletin No. 1550-66.

gross ones before comparing these students' estimates with the objective data. Now using a 40% increase[1] to move from net to gross, we obtain a dental income figure of $29,400 and a medical income figure of $32,900. Table 6-8 gives the results of comparing the three groups of students' self and other predictions with the approximate gross income statistics available from objective sources:

Table 6-8. Extent of Exaggeration of Predicted Income Over Objective Income Statistics For Three Groups of Health Students at Two Career Stages

	CIC Students (N=75)		N. Y. U. Dental Students (N=358)		N. Y. U. Medical Students (N=126)	
	% of Objective Statistics For		% of Objective Statistics For		% of Objective Statistics For	
Time	Other	Self	Other	Self	Other	Self
10-15 Years	173	321	116	142	103	105
Peak of Career	230	378	146	178	138	136

[1] It will be recalled that the objective income statistics on chiropractors' net earnings were multiplied by 35%. Since the objective statistics on how much dentists and M. D. s net give a considerably higher figure, the multiplier was raised 5% to take into account a higher tax bite. Since the net statistics for dentists and M. D. s are about the same, the 40% multiplier was used for both. It should be noted again that this transformation from net to gross income for all three health occupations is at best a rough approximation since the expense and tax variables involved are very difficult to specify.

Both dental and medical students, over against CIC students, are strikingly more "realistic" about incomes for other and self than the chiropractic respondents. Although dental students exaggerate more than medical students, even the dental sample's exaggerations are less than one half of the chiropractic sample's for self.

THE COMPARATIVE DATA CONTROLLED FOR SOCIAL CLASS AND ETHNICITY

The questionnaires administered to dental and medical students included items on father's occupation and students' ethnic backgrounds. Using father's occupation as an indicant of social class membership, 259 students, or 79% of the entire dental sample (N=329),[1] were classified as middle-class, and 70 students or 21% of the entire dental sample, as working-class.[2] 107 medical

---

[1] 29 dental students who handed in a questionnaire did not give a classifiable answer on the question of father's occupation.

[2] In Plasek's study of dental students, fathers' occupations were very similar to those in the present research. Translating Plasek's occupational data on students' fathers into social class membership, 77% of his sample (N=63) were from middle-class backgrounds, and 23% from working-class backgrounds. See Wayne Plasek, "Interaction Patterns and Attitude Change: A Study of Professional Socialization," unpublished Ph. D. dissertation, U. C. L. A., Dept. of Sociology, 1967, p. 63.

students, or 92% of the entire sample (N=116)[1] were characterized as middle-class, and nine students, or 8% of the medical sample, classified as working class.[2] An identical occupational coding of the CIC respondents indicated 47 of them, or 63% of the sample (N=75) to be from middle-class backgrounds, while 28 respondents, or 37% of the sample came from working-class backgrounds (See Chapter 3 for details).

Two hundred sixty-nine dental students out of a sample of 346[3] answered that they came from Jewish ethnic backgrounds, 78% of the sample. 88 medical students, or 75% of the entire sample of 117[4] answered

---

[1] 10 medical students who handed in a questionnaire did not give a classifiable answer on father's occupation.

[2] The present sample of medical school students, when classified by father's occupation, have a higher middle-class concentration than, for example, Becker's medical student sample (N=62) at the University of Kansas, where, father's occupation-wise, 66% of the students came from middle-class backgrounds, and the other 34% from working-class families. See Howard S. Becker, Blanche Geer, Everett C. Hughes and Anselm L. Strauss, Boys in White, Chicago: The University of Chicago Press, 1961, p. 61.

[3] 12 dental students who handed in a questionnaire failed to give a classifiable answer on ethnicity.

[4] 9 medical students who handed in a questionnaire failed to give a classifiable answer on ethnicity.

that they came from Jewish ethnic backgrounds.[1] 29 CIC students, or 39% of the CIC sample of 75 had indicated a Jewish background.

Since the social class differences among the three student samples are not insubstantial, and since the percentage of Jewish students in the dental and medical samples doubles that in the CIC sample, we might inquire how much effect these intergroup differences in social class and ethnicity are having-- as opposed to our favored explanatory variable of student status in one health profession or another-- on the differentials in the self-over-other tendency manifested in the three groups of students.

Accordingly, student self-other data was controlled for both social class and Jewishness-Non-Jewishness. In the latter case, for example, this meant comparing Jewish chiropractic, Jewish dental and Jewish medical students in terms of what percentage of students in each of these Jewish subgroups chose self over other. If Jewishness rather than differential status and prestige of the health professions was important as an explanatory variable in the self-over-other tendency, one would expect that the percentage of Jews choosing self over other would be about the same in the three health groups. Conversely, to the extent

---

[1] In Plasek's sample, op. cit., only 10% of the dental students were Jewish, and in Becker's study, ibid., one student in the 62 medical student sample was a Jew. In terms of ethnicity, then, the present dental and medical samples are radically different from at least certain other prominent researches that have been carried out with these kinds of professional students.

that membership in one health subculture or another was vital in determining the extent of the self-over-other tendency, one would anticipate the three Jewish samples would differ substantially in percent choosing self over other, and that their percentage figures and trend would mirror the self-over-other percentages and trends already found for their total respective student groups (see Table 6-1). Tables 6-9 and 6-10 restate the self-other data for the three groups of students when first social class and then Jewishness-Non-Jewishness are held constant.

Table 6-9. Percentage of Students in Three Health Occupations Choosing Self Over Other on Income Prediction at Two Career Stages, by Social Class

	10-15 Years					
	CIC Students (m-class n=47) (w-class n=28)		N. Y. U. Dental Students (m-class n=259) (w-class n= 70)		N. Y. U. Medical Students (m-class n=107) (w-class n= 9)	
Social Class	No.	%	No.	%	No.	%
Middle	33	70	139	52	34	32
Working	19	68	38	54	3	33

	Peak of Career					
	CIC Students		N. Y. U. Dental Students		N. Y. U. Medical Students	
Social Class	No.	%	No.	%	No.	%
Middle	29	62	109	42	28	26
Working	15	54	27	39	2	22

Table 6-10. Percentage of Students in Three Health Occupations Choosing Self Over Other on Income Prediction at Two Career Stages, by Jewish or Non-Jewish Ethnic Identification

10-15 Years

Ethnicity	CIC Students (Jewish n=29) (N-Jewish n=46) No.	%	N. Y. U. Dental Students (Jewish n=269) (N-Jewish n=77) No.	%	N. Y. U. Medical Students (Jewish n=88) (N-Jewish n=29) No.	%
Jewish	21	72	142	53	32	36
N-Jewish	31	67	39	51	7	24

Peak of Career

Ethnicity	CIC Students No.	%	N. Y. U. Dental Students No.	%	N. Y. U. Medical Students No.	%
Jewish	20	69	114	42	25	28
N-Jewish	24	52	25	33	3	10

The data in Tables 6-9 and 6-10 demonstrate very clearly that it is membership in one health occupation or another rather than social class or ethnicity which shapes the size of the self-over-other tendency in these groups of students. In Table 6-9 we see that the percentages of both middle-class and working-class students choosing self over other vary sharply, but systematically, from one health occupation to another. We also note that for both the middle-class and working-class samples (at both time periods) there is a perfectly parallel decline in percentage of persons choosing self over other as one moves from CIC students to dental, to medical students.

An interpretation of Table 6-10 repeats the same theme, this time in regard to ethnicity. Being Jewish or non-Jewish appears to have little relation to the self-over-other differentials among the three groups of students, since the percentage of Jewish (or non-Jewish) students elevating self over other varies drastically, in the expected direction, (i.e., highest frequency in CIC group, next highest in dental group, and lowest in medical group) among the three healing occupations.

CHAPTER SEVEN: THE INTERNALIZATION BY CONTEMPORARY RECRUITS OF THE CONTINUING "SOLO PRACTICE" TRADITION OF CHIROPRACTIC

Chapters 5 and 6 demonstrated an unmistakable "set" on the part of CIC students to elevate themselves over fellow students and colleagues-to-be when confronted with problematic career situations. We found this tendency-- in the important market area where it was tested-- much diminished on the part of two other kinds of health students, medical and dental, in comparison to the CIC sample (Chapter 6).

This final chapter attempts to show the internalization by CIC students of a "set" related to the self-over-other tendency: a perception of the practice of chiropractic as essentially "solo" and "individualistic," rather than "group" and "cooperative." Whereas Chapters 5 and 6 viewed chiropractic students in terms of ranking self versus others, the focus of this chapter is on any particular chiropractic student striking out on his own, without much attention to colleagues, in his imminent (or near-imminent) practice.

We begin with a brief review of the historical and contemporary situations of medicine and chiropractic in terms of "solo" and "group" practice of these healing disciplines. Throughout the chapter, medicine is contrasted with chiropractic, because it is the principal "general" healing art with which chiropractic must deal and compete in the United States. We then proceed to an examination of CIC students' attitudes toward individual and group styles of practice and their evaluations of the relative importance of collegial and patient groups in the success of their upcoming practices. Limited comparative data from N.Y.U. medical and dental students on a key point about extent of identification with one's occupational group is then introduced. Finally an attempt is made to assess some of the implications for the survival of chiropractic in America of a continued solo practice tradition in the face of growing large-scale practice within the dominant medical profession.

CHIROPRACTIC'S CONTINUED SOLO TRADITION VERSUS MEDICINE'S SHIFT TOWARD GROUP PRACTICE

In the first decades of this century, the modal form of practice for both medicine and chiropractic was "solo," which involved a man working by himself in an office which he secures and equips with his own capital and with patients who have freely

chosen him as their personal physician and for whom he assumes responsibility. Stereotypically he lacks any formal connection with colleagues."[1] In this type of practice style colleague control is at a minimum, and patient control much more important to the individual doctor's success. A key value in this arrangement is "professional autonomy."

Freidson and others have shown how short-lived was the true solo practice of medicine in the United States: "The nostalgic and sentimental image of the old-fashioned family doctor who was all things to all men is based upon the fleeting period in history (early years of the 20th century) when folk practice had declined but medical specialization was still in an incipient stage."[2] With the reform of medical education, the widespread growth of the hospital system, and the advent of medical specialties emerged various types of cooperative arrangements among physicians, including informal colleague networks, simple formal arrangements, such as the "association" and the partnership, and more complex formal arrangements, such as "group

---

[1] Eliot Freidson, "The Organization of Medical Practice," in Howard E. Freeman, Sol Levine, Leo G. Reeder (eds.), Handbook of Medical Sociology, Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1963, p. 302. The discussion of medical practice organization in this chapter relies heavily on Freidson's article, pp. 299-319.

[2] Ibid., p. 300.

practice." Regarding the latter arrangement, Freidson notes: "Large-scale, bureaucratic practice is not widespread in the United States, but it is becoming more common and its potential impact is great."[1] He sees the growth of bureaucratic practice as stemming from two sources: (1) adaptation of successful business techniques of consolidation to the practice of medicine, and (2) increasing provision of medical care to Americans by various "third party" agencies (public and private).

Although the idea of "solo practice" is still an ideological "sacred cow" in the United States, it seems clear that today most physicians are heavily dependent upon their colleagues in one or more ways. Quoting Freidson again: "Dependence on colleagues in one way or another is the rule in the United States, for consultations, hospitals and capital equipment are essential to modern practice. In short, present practice is not really solo: it embraces a large variety of organized relationships, most of which currently emphasize colleague rather than client controls."[2]

Unlike medicine, neither the hospital system nor specialties have developed in chiropractic. As we have previously noted,

---

[1] Ibid., p. 308.

[2] Ibid., p. 303.

the lack of development of specialties is at least partially due to the continuing tradition in chiropractic that one competent chiropractor can treat all the ills of the body. Without hospital centers and specialization, the need for regulation of practices and practitioners is diminished, and it is not surprising that chiropractic professional associations have remained relatively weak and ineffective. Thus, all the main factors which would tend to undermine the viability of continued "solo practice" arrangements are still either weak or non-existent within chiropractic. In 1963, the ACA Journal of Chiropractic conducted a survey of types of practice within the profession. Styles of practice were reported for 6517 chiropractors. These data, reproduced in Table 7-1, confirm the continued solo practice pattern among contemporary chiropractors:[1]

---

[1] "The Chiropractor-A Study in Depth," The ACA Journal of Chiropractic, 4 (March, 1967), p. 11.

Table 7-1. Types of Practice for Chiropractors in the United States (N=6517)

Type of Practice	No.	%
Alone as an individual	5481	84.1
As an individual with DC employees	221	3.4
As a member of a partnership	328	5.0
As a corporation	7	0.1
On a joint basis with other DCs sharing expenses and facilities (but not as partners or employers of one another)	353	5.4
As an employee of an individual or group of DCs	62	1.0
As a company DC doctor	0	0.0
As an employee of a chiropractic hospital	7	0.1
No answer	58	.9
Total	6517	100.0

Fully 84% of the sample engages in what can be legitimately be termed true "solo practice" because of the relative absence of collegial control within chiropractic. Of the 10.5% reporting that they operate under a partnership, corporation or joint venture, 80%, the ACA report notes, practice with just one other chiropractor;[1] so that even the limited amount of cooperative practice is essentially confined to the correspondingly simplest kinds of cooperative arrangements in medicine, the two-man informal "association," or more formal "partnership." Now it remains for us to inquire to what extent the "solo practice," patient-oriented traditions within contemporary chiropractic are internalized by current recruits to the occupation at CIC.

THE INDIVIDUALISTIC TRADITION AT CIC

Field Note Observations

The following quotations and situations from my field work at CIC illustrate that the individualistic and solo practice tradition of chiropractic is "in the air" at CIC. The observations which follow have been selected out of a larger pool of similar observations in my field notes:

---

[1] Ibid., p. 11.

"You know the practice of chiropractic isn't like medicine, where you can just sit back and wait for the patients and money to come in. To have a successful chiropractic practice you have to work at it all the time, every day, every week. The reason a lot of chiropractors don't do well is because they don't have the individual drive, the go-go power."

- a Pennsylvania chiropractor to Freshmen students

A Senior student was reprimanded in class by the Clinic Director for using unauthorized diagnostic techniques with patients in the School clinic. The student argued that only through experimentation with new techniques does one learn, but the Clinic Director was adamant, asserting that further use of one particular diagnostic instrument would result in penalties for the student. After class, when the Director had left, a heated discussion ensued among five or six of the seniors. Most of them told the reprimanded to "keep your cool," so as not to antagonize the power Clinic Director. He said finally "I'll take what I have to to graduate from here; then I'm going out on my own and not give a damm about other chiropractors-- you guys included."

A successful young graduate of CIC gave a guest lecture to the Senior class. One of his remarks: "It lies within the power of each individual to be a successful chiropractor if he knows what he wants and doesn't try to copy another chiropractor's approach."

"You know, chiropractors are pretty individualistic type people. Hell, you have to be quite an individualist to get into a controversial profession like chiropractic in the first place."

- CIC front office administrator to me

On the first day of the School term a Freshman student asked in osteology class what determines how much chiropractors are respected. The young instructor answered "It depends entirely on the individual chiropractor." (This observation was quoted first in Chapter 5.)

Questionnaire Data on Intended Style of Practice and Specialties

The 2nd Questionnaire asked students "At this point, do you plan to practice by yourself or with other chiropractors?" 64% of the sample (N=75) answered "probably by myself," 33% answered "with one other chiropractor," and 3% answered "with two or more other chiropractors." Although these answers are somewhat more group-practice oriented than the ACA report on types of practice, the percentage of persons expecting to practice "solo" increases in the CIC sample as one moves from the Sophomores through the 1967 Graduates (about 50% of the Sophomores expected at that point to practice alone, 55% of the Juniors, 72% of the Seniors and 77% of the 1967 Graduates), so that the 1967 Graduates' expectations of solo practice is nearly equal to the solo practice frequency in the ACA report on current chiropractors. It appears, then that the internalization of an individualistic practice orientation is escalated as people move through the nine-term CIC socialization experience.[1]

[1] Very significantly, a survey of medical students found just the opposite trend in preferred practice styles: Fewer seniors than freshmen preferred solo practice. Continued socialization in medical school leads to an increasingly stronger "set" among upper classmen for group practice of one kind or another. See Don Cahalan, Patricia Collette, and Norman Hilmar, "Career Interest and Expectations of U. S. Medical Students," Journal of Medical Education, 32 (August, 1957), pp. 255-274.

We know that in medicine the move away from "solo practice" was importantly related to the development of specialties within that discipline. Currently, about 80% of all American medical practitioners are specialists of one type or another.[1] Data from Chiropractic in California on specialization indicates, on the other hand, an almost complete reversal in figures: Nearly 80% of the questioned chiropractors indicated no specialty.[2] CIC students were asked in the 2nd Questionnaire if they contemplated a specialty either when they began practice or some years later. Seventy students, or 93% of the sample of 75, answered either "no" or "uncertain" (with

---

[1] The New York Times, February 11, 1969. In an article entitled "Family Medicine is Made a Specialty," we learn that the American Medical Association has created the first new specialty, family medicine, created since 1948, in an attempt to stem the overwhelming tide toward specialization now evident among graduates of United States medical colleges.

[2] Chiropractic in California, A Report by the Stanford Research Institute, Los Angeles: The Haynes Foundation, 1960, pp. 63-64. Twenty-three percent of the California chiropractic sample indicated as a "specialty" they practiced "Chiropractic adjustment, manipulation, body mechanics, philosophy." Eliminating "philosophy," the other activities here are "straight" Chiropractic, and can hardly be classified as a "specialty" as can areas like gynecology, pediatrics and dermatology (all of which are listed by very small percentages of the chiropractors).

the great majority of these stating "no"). Here there were no substantial differences in response among the four academic classes. It appears that almost from the start of their CIC experience students are inculcated with a "set" against specialty practices.

Questionnaire Data on Important Elements in a Successful Practice

The 2nd Questionnaire gave respondents a 2-page check-list and asked them "In your opinion, how important is each of the following elements likely to be to a chiropractor in building a large and financially successful practice?" Seventeen of the activities, skills and elements on the check-list were coded into one of the following three categories: (1) oriented toward colleagues and/or chiropractic professional associations; (2) oriented toward patients or lay groups within the community; (3) oriented toward individual abilities (inner direction). Table 7-2 shows the percentage of the sample checking each of these seventeen items as either "very important," or "fairly important" in building a successful chiropractic practice:

Table 7-2. Elements Important in Building a Large and Financially Successful Chiropractic Practice (N= 75)

Elements Indicated in Check List	No. Checking[a]	% Checking
Colleague and Professional Association Oriented:[b]		
Aid from professional chiropractic associations at various levels (national, state, local)	54	72
Participation in professional chiropractic associations	55	73
Referral of patients from chiropractic colleagues	53	71
Membership in the alumni association of the chiropractic college from which one graduates	27	36
Holding a teaching position in a chiropractic college	11	15
An excellent reputation as a chiropractor among one's chiropractic colleagues	60	80
Carrying out research in chiropractic	42	56
Patient and Lay Groups Oriented:[c]		
Sponsorship from important lay members of his community	65	87
Frequent speaking engagements on the topic of chiropractic to various lay groups (YMCA, lodges, etc.)	67	89
Lay meetings for patients	69	92
An excellent reputation as a chiropractor in the eyes of of one's patients	75	100
Membership in various civic and community groups	64	85

Elements Indicated in Check List	No. Checking[a]	% Checking
Self-Oriented:[d]		
Hard work and constant dedication to one's own practice	74	99
A winning personality	75	100
Expert adjusting abilities	75	100
A good head for business	72	96
A strong faith in one's ability to succeed as a chiropractor despite obstacles	75	100

[a] Total N= 75 in each row.

[b] The mean percentage checked for these seven items was 58%.

[c] The mean percentage checked for these five items was 91%.

[d] The mean percentage checked for these five items was 99%.

The most important points from Table 7-2: (1) Every one of the self-oriented and patient or lay groups oriented items were checked by more of the sample than any one of the colleague and professional association oriented items. (2) Although every respondent checked the importance of an excellent reputation in the eyes of one's patients as important in building a successful practice, 20% of the sample failed to check the importance of an excellent reputation in the eyes of one's chiropractic colleagues in building a practice. (3) From the standpoint of reference group theory, self and patient-lay groups are perceived

by budding practitioners as relatively far more important than colleagues in creating a successful practice. (See the mean checked percentages for each of these three orientations at the bottom of Table 7-2.) From these data a model emerges of CIC students perceiving the individual chiropractor going his own way, relatively unattuned to or uncontrolled by collegial affairs, and using personal skills and attributes plus contacts in the lay community to shape a successful practice.

Further Questionnaire Data on Students' Perceptions of Patient Versus Colleague Control

Students were presented with a series of "statements" (some of which I had heard made in toto by persons at CIC during my field work, others which were a "composite" of ideas expressed at the School) designed to tap attitudes about the relative importance of collegial and patient groups in the pursuance of day-to-day practice. To some extent (as the reader will see) the themes in these statements overlap with or repeat ideas contained in the check-list on important activities in practice building. To the extent that the sample responds in a consistent way for both measures, a degree of validation has been achieved. Students were asked to indicate whether they "strongly" or "somewhat" agreed or disagreed with each statement (a scheme of questioning adapted from "authoritarian personality" scales[1]).

[1] In these scales, the researchers used three shades of agreement (agree slightly, moderately, strongly) and disagreement. See T. W.

In Table 7-3 the data are organized along the lines of "Colleague Control" and "Patient Control" statements.[1]

The data in Table 7-3 avow the importance of patient controls and patient-directed activities at the expense of colleague controls and colleague-directed relationships. Responses to only one of the six colleague control statements contradict this pattern: 82% of the CIC students feel that "something very essential" is missed by the chiropractors who did not attend professional association meetings. But a majority of the students disagree that close collegial relations are necessary to a successful practice; agree that direct competition, rather than collegial cooperation, is the rule among chiropractors; agree that there exists an excess of professional organization (too many professional meetings, and so on); disagree that collegial referral has increased rapidly in recent years. Finally, almost half of the sample (48%) believe that collegial organization of chiropractors beyond a certain point is headed for failure.

On the contrary, the large majority of the sample emphasize the power of the patient group in shaping a chiropractic practice.

Adorno, Else Frenkel-Brunswik, Daniel J. Levinson, and R. Nevitt Sanford, The Authoritarian Personality, New York: Harpers and Brothers, 1950. I have already noted a strong tendency on the part of the CIC respondents to interpret "slightly" as of no importance, so that a "slightly" category of agreement or disagreement was omitted from this set of "statements."

[1] Table 7-3 is found on the following page.

Table 7-3. CIC Students' Perceptions of the Relative Strengths of Colleague and Patient Controls in Practice (N= 75)

	No. and % Who:									
	Agree Strongly		Agree Somewhat		Disagree Somewhat		Disagree Strongly		Totals[a]	
	No.	%	No.	%	No.	%	No.	%	No.	%
Colleague Control Statements:										
"A chiropractor who doesn't maintain close relations with his fellow practitioners is not going to have a large practice."	7	9	29	39	34	45	5	7	75	100
"Although it's not often said openly, many chiropractors feel they are in direct competition with other D.C.s for patients."	14	19	33	44	20	27	8	11	75	101
"Chiropractors who are devoted to their own practices but who don't find time to go to professional chiropractic meetings are missing something very essential."	17	23	44	59	9	12	5	7	75	101
"Nowadays there are too many meetings, regulations and laws about chiropractic, all of which tend to obscure the point that the chiropractor's main job is to get sick people well."	30	40	27	36	13	17	5	7	75	100

	Agree Strongly		Agree Somewhat		Disagree Somewhat		Disagree Strongly		Totals[a]	
	No.	%	No.	%	No.	%	No.	%	No.	%
Colleague Control Statements (Cont.)										
"Patient referral from one D. C. to another has increased rapidly in recent years."	4	5	31	41	35	47	5	7	75	100
"Since you have to be an individualistic type of person in the first place to become a chiropractor, attempts to organize chiropractors beyond a certain point are bound to fail."	12	16	24	32	25	33	14	19	75	100
Patient Control Statements:										
"When you get down to essentials, the individual chiropractor's own patients are the most important group in determining whether he'll be a success."	53	71	16	21	3	4	3	4	75	100
"There are certain patients who can be tremendously helpful in building up a D. C.s practice."	71	95	4	5	-	-	-	-	75	100
"Lay meetings called by the chiropractor for his patients are just as important to a man's practice as his attendance at professional chiropractic meetings."	29	39	29	39	13	17	4	5	75	100
"Generally the chiropractor's main obligation is to his patients - so long as he remains true to the art, science and philosophy of chiropractic."	53	71	13	17	5	7	4	5	75	100

[a] Two percentage totals come to 101 because of rounding in individual % cells.

Response to the "Patient Control Statements" in Table 7-3 show quite definitely clients rather than colleagues are perceived to be the more vital reference group. No less than 78% of the students agree in some measure to each of the statements which attest to the importance of the patient reference group. Thus, the model of students perceiving the chiropractor as necessarily more attuned to patients than colleagues which came out of the data on important elements in a successful chiropractic practice (Table 7-2) is reinforced by the responses to the statements in Table 7-3.

DIFFERENTIAL ANTICIPATORY IDENTIFICATION WITH ONE'S PROFESSIONAL GROUP AMONG THREE GROUPS OF HEALTH STUDENTS

The data in this chapter (as well as the findings from Chapters 5 and 6) strongly suggests that CIC students do not strongly identify (a) with their student peers or (b) with full-fledged members of the occupation which they will soon enter. Put another way, colleague control norms appear to be peculiarly weak. Some comparative data is available to substantiate the relative weakness of anticipatory identification with one's professional group on the part of CIC students.

CIC students, N.Y.U. dental and N.Y.U. medical students were all asked an identical question tapping their perceptions of the relationship between the individual practitioner and his occupational

group. Specifically, the question asked the three groups of students to what extent individual practitioners derived prestige from indentification with their respective professional groups, as opposed to deriving respect from their individual attributes. From what we have already seen of the CIC student "set" on these matters, and from what we know about the strength of colleague controls in both medicine and dentistry,[1] we might anticipate stronger identification with their groups on the part of these two latter groups of students and less identification with the chiropractic profession as a source of prestige on the part of the CIC group.

Students were asked "What elements determine how much any particular chiropractor (or dentist, or medical doctor) is respected in his community these days?" The alternative responses were (a) "It depends primarily on the individual doctor and the impression he makes;" (b) The chiropractor's (dentist's, medical doctor's) own skill and personality, on the one hand, and his membership in the chiropractic (dental, medical) profession on the other, play about equal parts;" (c) Regardless of a particular chiropractor's (dentist's, medical doctor's) skill and personality, the degree to which he's respected in his community is mostly determined by how people feel about the chiropractic (dental, medical) profession in general." The comparative results, X^2 testing, and discussion of the findings follow below:

---

[1] For medicine, see Freidson, op. cit.; and Ronald L. Akers

Table 7-4. Opinions as to What Elements Determine Respect for a Practitioner, for Three Groups of Health Students (Observed Frequencies and Percentages)

Respect Depends:	CIC Students (N=75)		N.Y.U. Dental Students (N=358)		N.Y.U. Medical Students (N=126)	
	No.	%	No.	%	No.	%
Primarily on Individual Practitioner	63	84	192	54	44	35
Equally Upon Individual Practitioner and Membership in His Profession	9	12	136	38	67	53
Primarily on Membership in His Profession	3	4	30	8	15	12
Totals	75	100	358	100	126	100

(df= 4) $X^2 = 45.84$ $p < .001$

Internal X^2 calculations for CIC students versus the dental student sample ($X^2 = 24.05$ with df= 2) and CIC students versus the medical student sample ($X^2 = 45.71$ with df = 2) show a statistically significant difference in response distributions at the .001 level. There is also a statistically significant difference between the response distribution of dental and medical students at the .01 level ($X^2 = 12.79$ with df = 2). The significance findings

---

and Richard Quinney, "Differential Organization of Health Professions: A Comparative Analysis," American Sociological Review, 33 (February, 1968), pp. 104-121. For the strong collegial bonds in dentistry see the Akers and Quinney article.

here have a striking parallel with those in Chapter 6, where the three groups were compared on the self-over-other tendency.

Just as chiropractic students had a pronounced inclination to elevate self over other, over and against a much diminished inclination on the part of both dental and medical students, so here CIC students manifest a nearly overwhelming tendency to locate the source of prestige in the individual as compared with the dental and medical samples who see professional prestige more dually derived from personal attributes and membership in a profession. The fact that medical students attribute a greater role to the group than the dental students parallels the greater identification of medical student self with other, which we saw in Chapter 6, and also meshes with some sociological evidence, discussed in the last chapter, that dental students may place a somewhat higher value on autonomy than medical students.[1]

Looking to the percentage of persons identifying prestige primarily with membership in a profession, none of the three groups is highly represented here in an absolute sense of numbers. But in a relative manner we can note that three times as many medical students and twice as many dental students picked this alternative as did CIC students.

---

[1] See again D. M. More and Nathan Kohn, Jr., "Some Motives for Entering Dentistry," American Journal of Sociology, 66 (July, 1960), pp. 48-53.

THE TWILIGHT OF CHIROPRACTIC IN THE UNITED STATES?

In the last few decades the dominant health institutions in the United States have moved increasingly in the direction of large-scale, specialized and bureaucratized ways of helping the ill. This trend is also found in other major institutional sectors of American society, such as business and industry, and education. Indeed, sociologists have suggested that the shift toward and reliance upon bureaucratic procedures is one of the key themes of the second half of the twentieth century.[1]

The creation of a complex system of health care has been effected by four main groups, or sectors, within this society:

(1) medical doctors and their "auxiliary" personnel (e.g., nurses, laboratory technicians, hospital administrators, and so on), and limited para-medical practitioners (chiefly dentists, pharmacists and optometrists).

(2) various types of private insurers, which include:

> insurance companies, Blue Cross and other hospital service prepayment plans, Blue Shield and Medical

---

[1] Bensman and Rosenberg, for example, state: "Today, bureaucracy is a characteristic institution. It colors our age not just in government and in the army, but also in large-scale business, industry, trade, unionism, the church, education, and every other contemporary institution." Joseph Bensman and Bernard Rosenberg, Mass, Class, and Bureaucracy: The Evolution of Contemporary Society, Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1963, p. 262.

> Society approved plans, dental service corporations, group medical practice plans operating on a prepayment basis, community plans, vision care plans, industrial plans, plans self-administered by employers or labor unions, prepaid prescription drug plans, fraternal societies, college health plans, and rural and consumer health cooperatives.[1]

(3) the federal and many state governments which have undertaken to pay for the health services of some of its citizens. The federal Medicare program which underwrites health expenses for the elderly and the New York State Medicaid program , which covers the medical costs of low-income and welfare-roll families within the State, are two prominent examples of public medical care.

(4) Finally, one must not forget the patients, or clients, in this system who are served by these health practitioners and private or public health insurers.

As Freidson has shown, these groups are constantly interacting among each other[2]-- as well as developing separately themselves-- to escalate the size and complexity of health care institutions, and to reinforce a "set" on the part of practitioners, patients and insurers toward the suitability and desirability of large-scale and bureaucratic procedures in treating infirmed persons.

---

[1] J. F. Follmann, Jr., Medical Care and Health Insurance, Homewood, Illinois: Richard D. Irwin, Inc., 1963, pp. 116-117.

[2] Freidson, op. cit.

From the patient point of view, this extended health system now embraces, in one way or another, the large majority of American citizens. Looking at the private insurance sector, "One hundred and sixty-three million Americans were protected by some form of private health insurance as the new year /1968/ began, according to estimates released by the Health Insurance Institute. It . . . meant that four out of every five persons in the nation are protected by private insurance for health care costs."[1] Although the predominant type of coverage is for hospital expenses, the percentage of persons protected for surgical and regular medical expense in relation to those covered for hospital expenses has been growing rapidly.[2] The recent public health insurance programs have no doubt pushed the proportion of Americans insured to some extent for medical expenses beyond the 80 percent covered by the private insurance domain.

Throughout the expansion of this health care system in the United States, there has been a "boundary maintenance" process which has tended to exclude the participation of chiropractors. Although statistics are difficult to obtain, it seems that little more than half of the insurance companies which write one type or

---

[1] Insurance, 69 (January 6, 1968), p. 48.

[2] Sourcebook of Health Insurance Data, New York: Health Insurance Institute, 1965, p. 1 and infra; Follmann, op. cit., p. 128.

another of health insurance contract honor chiropractic claims stemming out of treatment for a particular injury, or the services of chiropractors on a "regular care" basis, and chiropractors are completely excluded from insurance programs covering hospital and surgical expenses.[1] In the public secto the exclusion of the chiropractor is evident: the Federal Medicaire program does not provide for his

---

[1] As of 1964, about 1000 private insurance companies wrote health insurance contracts. See Sourcebook of Health Insurance Data, ibid., p. 50. Available sources indicate that between 50 and 60 percent of these companies include chiropractic as a covered health service. See Chiropractic in California, op. cit., p. 16; and Mortimer Levine, "The Scope of Chiropractic Practice," The ACA Journal of Chiropractic, 2 (February, 1965), p. 53.

Insurance companies write five different types of health insurance: (1) hospital expenses, (2) surgical expenses, (3) regular medical expenses, (4) major medical expenses, (5) loss of income. Sourcebook of Health Insurance Data, ibid. At present, the first two types of insurance-- from which chiropractors are completely absent-- are much more frequently written than the last three, so that the actual number of health insurance policies actually written which cover chiropractic care is not large. Thus, the fact that about half of the insurance companies are officially willing to underwrite some kind of chiropractic care insurance, is very misleading if taken to mean that about half the actual health insurance contracts written provide for, among other services, chiropractic care. See Follmann, ibid., p. 128.

services; of the 43 United States jurisdictions where Medicaid programs now exist (as of January, 1969), only fifteen (35%) provide for chiropractic care.[1]

What appears to be happening is that the potential patient pool for chiropractors is diminishing with the passage of time. Either formerly receptive patients are enrolling in private insurance plans, which often as not exclude chiropractic care, or they are choosing health care from public health programs, the majority of which exclude chiropractic services. Data from Chiropractic in California suggests that relatively lower-income people visit chiropractors than visit physicians.[2] One might surmise that this group of chiropractic patients would be especially tempted to change "allegiances" to the publically-financed, medically-oriented, health programs.

Solomon H. Friend clearly states the "squeeze" in which contemporary chiropractors find themselves:

> The next decade will see vast and profound changes not only in the manner which health care is dispensed, but the manner by which it is financed. Clinics, hospitals,

---

[1] United States Department of Health, Education, and Welfare, "Table 2: Services Provided Under Title 19 of the Social Security Act to the Categorically Needy and Categorically Related Medically Needy, As of October 1," in Title 19 - Activities of the 54 Jurisdictions to Put Into Effect the New Medical Assistance Program, as of January 31, 1969. (Xerox)

[2] Chiropractic in California, op. cit., p. 39.

> nursing homes and other governmentally supported health care facilities will undoubtedly consume the major portion of the public's expenditures for medical treatment. Unless the chiropractors' efforts succeed in gaining them recognition as equal participants with medical doctors in these facilities, the chiropractic profession will become a page out of yesterday's newspaper.[1]

As we have seen, in the face of enormous cooperative developments in the medical and paramedical professions, chiropractors and chiropractic students still pursue both the antediluvian ideology and practice of "solo practice," which implies a relative absence of collegial controls and cooperation. As their patient pool shrinks, due to enormous expansions in public medical welfare and private health insurance, probably the only thing which could reverse the trend is very strong professional organization, which could bring to bear powerful enough pressures on both public and private insurers to gain wide-spread admission of chiropractic services to their programs.

But as the last three chapters of this study-- particularly the present one-- have taken pains to point out, the individualistic,

---

[1] Solomon H. Friend, "Economics of Government Control and the Healing Arts," The Digest of Chiropractic Economics, 10 (September-October, 1967), p. 30. That chiropractors are acutely aware of the fate that hangs over them is demonstrated by the "doomsday" articles frequently appearing in their own journals. Another premonitory article is entitled "Should Chiropractic Die?" written by P. J. Seufert, D.C., originally published in various newspapers owned by Herrschaft Publications, Brooklyn, and reprinted and circulated at CIC (no date).

autonomous mood-- inattentive, or outright opposed, to the concerns of group identification and mobilization-- is very strong among chiropractors and current student recruits alike, making it unlikely that such effective professional organization is forthcoming.

Comfortable with, and accustomed to, small-scale and "personalized" collegial and patient relationships, chiropractors have failed to gain for themselves, or teach their new recruits, as medical doctors have, experience and expertise in larger-scale and bureaucratic treatment institutions. Today, their relative naivete and "backwardness" in the ways of bureaucratic health procedures may play as large a part in public and private insurance plans' reluctance to admit them as the historical and enduring opposition of the medical profession.

There is little doubt that the student-chiropractor of the 1960's is technically better trained than chiropractors of earlier generations; hence an argument for his survival in the health field. But he is socialized to an outmoded style and scope of practice which flies in the face of dominant American health institutions, a situation which seems likely to decrease the size of new generations of chiropractors, or even eventually destroy chiropractors as a distinct occupational group.

APPENDIX A

1st Questionnaire Administered to CIC Students

DIRECTIONS TO CIC STUDENTS

Dear CIC Student:

This questionnaire is the first of two major ones which I ask your cooperation in filling out in connection with my study of CIC students, a project which you all know about.

Much of this first questionnaire is concerned with your pre-CIC experiences, your background and general interests. The other one will focus on your experiences at CIC and your chiropractic plans for the future.

There are a few points which you should bear in mind while filling out the questionnaire:

1. First of all, it's much shorter than it looks! Although there are a lot of pages, the majority of questions only require your checking alternatives. There are some questions where you are asked to write a phrase, or at most a sentence or two, but the entire questionnaire shouldn't take you more than an hour -- an hour and a half. When a written response is requested, please write clearly.

2. The questionnaire is not a "test" -- there is no "grade" or other mark. The only "right" answers to the questions are those which best express your feelings, your opinions, and your experiences.

3. Your individual identity will not be revealed and your personal answers will be kept confidential. The information provided by CIC students will be tabulated exclusively by me and made available to the faculty or front office of CIC only in the form of statistical summaries.

4. Read every question or statement carefully before answering. Please answer every question which is applicable to you in accordance with the directions.

5. If you find any of the questions confusing or ambiguous, get in touch with me. I can be found at CIC or called at 663-1372 in Manhattan.

I think the majority of you will enjoy answering this and the following questionnaire. It should be stressed that everybody's participation is vital if the study is to serve its purpose of giving a full and accurate picture of CIC, especially of the student body.

Please fill out the questionnaire and bring it in to School by NEXT WEDNESDAY (March 21), when I'll be around all day to get them directly from you.

Thank you for your continuing cooperation in this study. I'm sure most of you will be interested in reading it when it's completed.

Very truly,

DAVID STERNBERG

March 1968

Dear 1967 CIC Graduate:

If you have been around CIC during the Fall of 1967, or the early months of 1968, you already know that I am doing an in-depth study of chiropractic students at CIC as my doctoral dissertation in Sociology at New York University. If not, this letter will serve to introduce myself and the project.

Although the study is focused primarily on the current student body, you are a recent enough graduate to make certain information about your experiences and background extremely valuable to the research.

Accordingly, I send you the enclosed questionnaire, which I kindly ask you to answer and send back to me (in the self-addressed, stamped, envelope) within a week.

Most of those who have already answered the questionnaire have found it an enjoyable experience. It should be stressed that everybody's participation is vital if the study is to serve its purpose of giving a full and accurate picture of CIC students.

There are a few points which you might bear in mind while filling out the questionnaire:

1. First of all, it's much shorter than it looks! Although there are a lot of pages, the majority of questions only require your checking alternatives. There are some questions where you are asked to write a phrase -- or at most a sentence or two -- but the entire questionnaire shouldn't take you more than an hour -- an hour and a half. When a written response is requested, please write clearly.

2. The questionnaire is not a "test" -- there is no "grade" or other mark. The only "right" answers to the questions are those which best express your feelings, your opinions, and your experiences.

3. Your individual identity will not be revealed and your personal answers will be kept confidential. The information provided by CIC graduates will be tabulated exclusively by me and made available to the faculty or front office of CIC only in the form of statistical summaries.

4. Read every question or statement carefully before answering. Please answer every question which is applicable to you in accordance with the directions.

5. If you find any of the questions confusing or ambiguous, get in touch with me. I can be found at CIC or called at 663-1372 in Manhattan.

Thank you for your cooperation in this study. I'm sure many of you will be interested in reading it when it's completed.

Very truly,

DAVID STERNBERG

Your Name _____ Today's Date _____

1. When were you born? Month _____ Day _____ Year _____

2. What is your present marital status? (please check one)

_____ single

_____ married

_____ engaged

_____ divorced, separated, widowed

If you are engaged: When do you plan to marry? _____

If married: How long have you been married? _____

How many children do you have? _____ children

3. Where were you born? (please give city or town, and state)

_____

City or Town State

4. Where didyyou grow up? (city and state)

_____

City or Town State

What is your present local address? (for current students this would be where you are living weekdays while studying at CIC)

_____

Number and Street City State

5. What is your father's present age? _____ years old

(If he is deceased, when was he born? _____)

6. Here are a few questions about your father's work (If he is deceased, please answer in terms of his principal work when he was living):

Title or name of his present job (if he is a salesman, please state what type of salesman, for example, insurance salesman; if he is an engineer what type of engineer, for instance, electrical or design engineer, etc.):

(a) Name of job _____

If the duties of his position aren't self-evident from the name of his job, please give in a sentence or two the specific activities of his job.

(b) Specific activities _____

_____

(c) Is your father self-employed, or is he employed by a company, plant, or firm? (check one)

_____ self-employed

_____ employed by a company, plant or firm

(d) How long has he been in his present line of work (not necessarily with the same company, but doing the same type of work)? (check one)

_____ less than 3 years

_____ 3-5 years

_____ 5-10 years

_____ 10-15 years

_____ 15-20 years

_____ over 20 years

(e) Did your father have any other kinds of full-time occupation before his present type of work?

Yes _____ No _____

If "yes", please list the names or titles of those occupations.

Occupation immediately prior to his present one _____

Even earlier occupations (if any) _____

_____

7. Is your mother employed (outside the home)?

Yes _____ No _____

If "yes", in what job? _____

8. What is the extent of your father's formal education? (check as many as apply)

_____ grammar school, but no high school

_____ some high school, but didn't graduate

_____ high school graduate

_____ other training, like technical school or business course not connected with high school
(Which type? _____)

_____ some college, but didn't graduate

_____ college graduate

_____ professional school or graduate school
(Which field? _____)

9. What is the extent of your mother's formal education? (Check as many as apply)

_____ grammar school, but no high school

_____ some high school, but didn't graduate

_____ high school graduate

_____ secretarial or business school training not connected with high school

_____ some college, but didn't graduate

_____ college graduate

_____ professional school or graduate school (Which field? _____)

10. Do you have any brothers? Yes _____ No _____

If "yes", how old are they?

1st brother _____ Age 2nd brother _____ Age 3rd brother _____ Age

11. Do you have any sisters? Yes _____ No _____

If "yes", how old are they?

1st sister _____ Age 2nd sister _____ Age 3rd sister _____ Age

12. For each of your brothers, please give the extent of his formal education completed at present, and his current major activity.

1st BROTHER

(a) How much formal education completed? _____

(b) Current major activity (nature of job he has today, or military service he is currently doing, or some type of current student status)

_____

2nd BROTHER
(a) How much formal education completed? _____

(b) Current major activity _____

3rd BROTHER
(a) How much formal education completed? _____

(b) Current major activity _____

13. For each of your sisters, please give the extent of her formal education completed at present and her current major activity.

1st SISTER
(a) How much formal education completed? _____

(b) Current major activity _____

2nd SISTER
(a) How much formal education completed? _____

(b) Current major activity _____

3rd SISTER
(a) How much formal education completed? _____

(b) Current major activity _____

14. (a) How old were you when you first learned about chiropractic?

_____ under the age of 10

_____ between 10 and 13 years of age

_____ between 14 and 16 years of age

_____ 17 or 18 years of age

_____ 19 or 20 years of age

_____ 21 or 22 years of age

_____ older (what age? _____ years old)

(b) Which persons (for example, father, mother, brother, uncle, family chiropractor) do you connect with your first learning about chiropractic?

Persons connected _____

_____

15. (a) How old were you when you first thought of actually becoming a chiropractor? (check one)

_____ under the age of 10

_____ between 10 and 13 years of age

_____ between 14 and 16 years of age

_____ 17 or 18 years of age

_____ 19 or 20 years of age

_____ 21 or 22 years of age

_____ older (What age? _____ years old)

(b) Which persons do you connect with your first thinking about actually becoming a chiropractor?

Persons connected _____

_____

(No. 16 on next page)

16. (a) How old were you when you <u>definitely decided to study</u> chiropractic?

(check one)

_____ under the age of 10

_____ between 10 and 13 years of age

_____ between 14 and 16 years of age

_____ 17 or 18 years of age

_____ 19 or 20 years of age

_____ 21 or 22 years of age

_____ older (What age? _____ years old)

(b) Which persons do you connect with your definitely deciding to study chiropractic?

_____

_____ _____

17. This question attempts to find out what your general feelings were about chiropractic since the time you knew about it. Please check the appropriate blanks.

	Did you know about chiropractic? (check if you did)	Attitude at each age when you knew (check for <u>each</u> age)		
<u>Age</u>		Negative	Neutral-lukewarm	Positive
grade school	_____	_____	_____	_____
your early teens	_____	_____	_____	_____
middle teens	_____	_____	_____	_____
upper teens	_____	_____	_____	_____

18. Before deciding on chiropractic, did you seriously consider taking up any of the following jobs, occupations, or professions?
(check as many as apply)

_____ elementary or high school teacher

_____ male nurse

_____ engineer

_____ pharmacist

_____ veterinarian

_____ osteopath

_____ medical doctor

_____ dentist

_____ actor -- singer

_____ draftsman

_____ skilled worker (for example, machinist, electrician, plumber, foreman, carpenter, printer, baker)

(Which? _____)

_____ lawyer

_____ contractor (building, plumbing, etc.)

_____ store manager (What type of store? _____)

_____ store owner (What type of store? _____)

_____ salesman (What kind of salesman? _____)

_____ trucker

_____ civil servant (policeman, fireman, postman)

_____ musician

_____ mortician

_____ accountant

_____ technician (X-ray, laboratory, etc.)

_____ professional athlete

_____ other occupations or jobs (Which? _____

_____

19. Did you actually hold any full-time jobs before beginning your studies at Columbia Institute of Chiropractic*? (Please do not include summer vacation jobs.)

Yes _____ No _____

If "yes", what were they?

1. Your earliest full-time job (describe briefly) _____

_____

How long did you hold this job? _____

2. Next earliest full-time job (describe briefly) _____

_____

How long did you hold this job? _____

3. Other full-time job(s) (describe briefly including length of time held) _____

_____

20. At the time you entered CIC, given the choice, were there other occupations you had seriously considered which you would have preferred to enter?

(check one)

_____ definitely not

_____ probably not

_____ uncertain

_____ probably would have preferred another occupation at the time (Which? _____)

_____ definitely would have preferred another occupation at the time (Which? _____)

* hereafter referred to as CIC

21. Have you attended college (pre-professional school)?

Yes _____ No _____

If "yes", please give the following information about your college training:

College(s) Attended (names)	No. years attended	Degree (Which?)	Major subject
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

22. Have you had other kinds (non-college) of after-high school training, like technical school, retailing, travel agent courses, life insurance or real estate courses?

Yes _____ No _____

If "yes", which ones?	How long was course of instruction?
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

(No. 23 on next page)

23. (a) Did you apply to any other kinds of professional school besides chiropractic college?

Yes _____ No _____

If "yes", which types? (check below)	If "yes", how did things turn out? (check below)		
	Accepted by most	Accepted by some	Rejected by most
_____ law school	_____	_____	_____
_____ vet school	_____	_____	_____
_____ pharmacy school	_____	_____	_____
_____ osteopathic school	_____	_____	_____
_____ medical school	_____	_____	_____
_____ graduate business school	_____	_____	_____
_____ graduate engineering school	_____	_____	_____
_____ dental school	_____	_____	_____
_____ podiatry school	_____	_____	_____
_____ graduate nursing school	_____	_____	_____
_____ other professional school	_____	_____	_____

(Which? _____)

(b) Have you <u>in fact</u> attended any other type of professional school besides a chiropractic college?

Yes _____ No _____

If "yes", which type? _____

Before or after you began chiropractic college? (check one)

_____ before

_____ after

_____ both before starting CIC and afterwards

24. (a) Did any of your high school friends think seriously about being chiropractors?

Yes _____ No _____

If "yes", how many? (check one)

_____ 1 friend

_____ 2 friends

_____ 3 or more friends

(b) What jobs do your 2 best friends from high school hold today (or what are they studying to be)?

1st friend _____

2nd friend _____

(c) Was chiropractic an occupation that your high school guidance counsellor discussed as a possibility with students?

Yes _____ No _____

25. (a) Did any of your college friends think seriously about being chiropractors?

Yes _____ No _____

If "yes", how many? (check one)

_____ 1 friend

_____ 2 friends

_____ 3 or more friends

(b) What jobs do your 2 best friends from college hold today (or what are they studying to be)?

1st friend _____

2nd friend _____

26. To which other chiropractic colleges beside CIC did you apply?
(check as many as apply)

	Accepted?	Rejected?
_____ Chiropractic Institute of New York	_____	_____
_____ Palmer	_____	_____
_____ Logan	_____	_____
_____ Cleveland	_____	_____
_____ Northwestern	_____	_____
_____ National	_____	_____
_____ Los Angeles	_____	_____
_____ Texas	_____	_____
_____ Lincoln	_____	_____
_____ other chiropractic college	_____	_____

(Which? _____)

27. Before you began studying at CIC, where did CIC rank in the list of chiropractic colleges you preferred to attend?
(check one)

_____ my very first preference

_____ one of 2 or 3 I wanted most to attend

_____ CIC was not at the time one of my top preferences.

28. How old were you when you began studying at CIC? _____ years old

When did you begin to study at CIC? _____
Month Year

(No. 29 on next page)

29. Had you attended <u>other</u> chiropractic colleges <u>before</u> you first came to CIC?

Yes _____ No _____

If "yes", which ones, and for how many terms?

1._____ How many terms? _____ terms

2._____ How mahy terms? _____ terms

30. Have you attended any <u>other</u> chiropractic colleges <u>since</u> you first entered CIC?

Yes _____ No _____

If "yes", which ones, and for how many terms?

1._____ How many terms? _____ terms

2._____ How many terms? _____ terms

31. What do you think you would have done, occupation-wise, if your application to study chiropractic had been turned down by CIC and other chiropractic colleges?

(Please answer in a sentence or two)

_____

_____

_____

_____

32. In which states had you considered practicing when your first entered CIC?

States or areas you considered (Check as many as apply)

_____ New York

_____ New Jersey

_____ Massachusetts

_____ Pennsylvania

_____ Florida

_____ California

_____ Puerto Rico

_____ abroad (Where? _____)

_____ other state or area (Where? _____)

_____ I had no idea where I wanted to set up practice when I first entered CIC.

NOW PLEASE PUT A "1" IMMEDIATELY AFTER YOUR 1st CHOICE AND A "2" AFTER YOUR 2ND CHOICE (OF THOSE YOU CHECKED).

33. What states -- or countries -- in which to open up a practice are you seriously considering at the present time?

1st choice _____

2nd choice _____

3rd choice _____

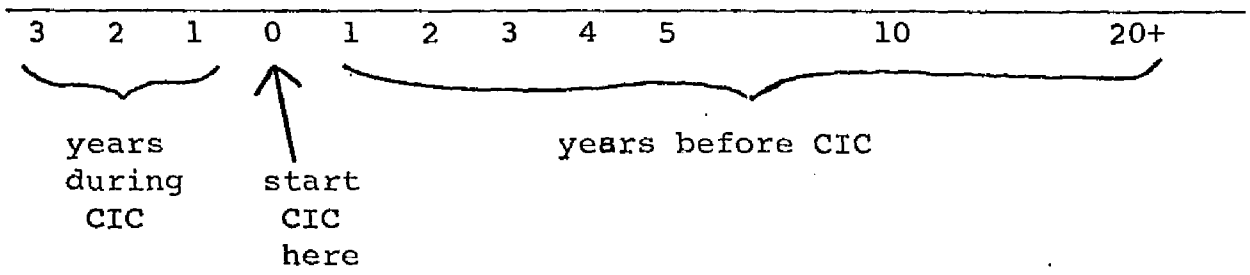
If you as yet have no real idea about where you might open up a practice, check here:

_____

34. This question and the one following it are perhaps a bit complicated at first glance, so please read the directions and examples with care before you draw in the appropriate lines.

It's actually very simple once you get the idea.

Below you will find a time line representing the 3 years of CIC education and the years extending back from the time you first entered CIC. The line looks like this:



On that line please indicate BY DRAWING YOUR OWN LINES ABOVE OR BELOW IT:

(a) Every time period -- LONG OR SHORT -- when you received some chiropractic care -- both before and after entering CIC
(ABOVE THE TIME LINE)

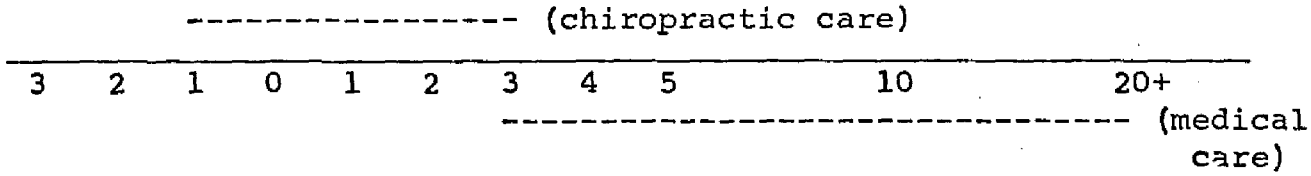
and

(b) Every time period when you received some medical care for various health needs* -- both before and after entering CIC
(BELOW THE TIME LINE)

For example: If you'd received your 1st adjustment(s) about 3 years before coming to CIC, and had continued chiropractic treatment uninterruptedly all the way through your 1st year at CIC

and

you'd received medical care when you had a health problem almost continuously from childhood up until the time you'd received your first adjustment -- at which time you'd stopped going to M.D.'s -- your lines would look like this:

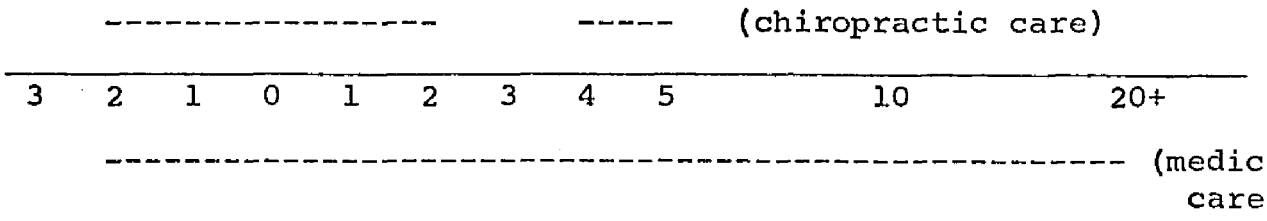


* In this questionnaire, "receiving medical care" during a certain time period means being in the habit of visiting an M.D. for health problems that might come up. The visits need not have been repeated nor the illness serious to qualify as medical care.

Another example: If you received your first adjustment 5 years before starting CIC and continued to receive chiropractic care for 1 year thereafter, and then stopped chiropractic care until beginning again 2 years before you started CIC -- from which time you continued through to the end of your junior year at CIC

and

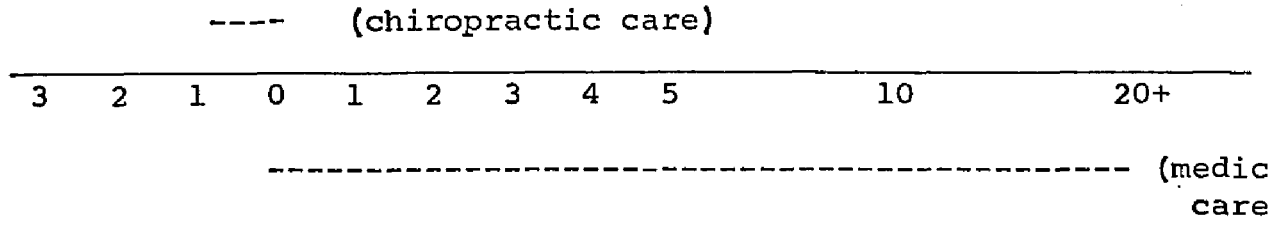
you'd received some medical care from the time you were young right through your CIC years, your lines would look like this:



A final example: If you'd never received an adjustment until after you entered CIC, getting your first ones shortly after beginning your studies and continuing with adjustments for the 2 terms of your 1st year

and

you'd received at least occasional medical care throughout most of your life, but stopped when you entered CIC, your lines would look like this:



On the line provided directly below please indicate by drawing with lines your periods of chiropractic and medical care, INDICATING CHIROPRACTIC CARE ABOVE THE TIME LINE and MEDICAL CARE BELOW THE TIME LINE. Remember "0" on the time line represents when you entered CIC.

3 2 1 0 1 2 3 4 5 10 20+

85. Here's the only other question where you have to do any work!

I'd like to find out about your family's experience with chiropractic care both before and after you yourself started attending CIC.

Below you'll find a separate line for each of a list of relatives. Each line represents the years before and during your CIC training.

The procedure for marking the time lines for your relatives is IDENTICAL TO THE OPERATION INDICATED IN THE PRECEDING QUESTION about your own history of chiropractic and medical care.

DRAW A LINE ABOVE THE TIME LINE TO INDICATE PERIODS OF CHIROPRACTIC CARE AND A LINE BELOW TO INDICATE PERIODS OF MEDICAL CARE.

Merely skip over the time lines of any relatives who have never received chiropractic care and relatives you don't have or don't know about.

FATHER

3 2 1 0 1 2 3 4 5 10 20 30+

MOTHER

3 2 1 0 1 2 3 4 5 10 20 30+

1st BROTHER

3	2	1	0	1	2	3	4	5	10	20	30+

2nd BROTHER

3	2	1	0	1	2	3	4	5	10	20	30+

3rd BROTHER

3	2	1	0	1	2	3	4	5	10	20	30+

1st SISTER

3	2	1	0	1	2	3	4	5	10	20	30+

2nd SISTER

3	2	1	0	1	2	3	4	5	10	20	30+

3rd SISTER

3	2	1	0	1	2	3	4	5	10	20	30+

ONE GRANDPARENT

3	2	1	0	1	2	3	4	5	10	20	30+

ANOTHER GRANDPARENT

3	2	1	0	1	2	3	4	5	10	20	30+

ONE UNCLE

3	2	1	0	1	2	3	4	5	10	20	30+

ANOTHER UNCLE

3	2	1	0	1	2	3	4	5	10	20	30+

ONE AUNT

3	2	1	0	1	2	3	4	5	10	20	30+

ANOTHER AUNT

3	2	1	0	1	2	3	4	5	10	20	30+

ONE COUSIN

3	2	1	0	1	2	3	4	5	10	20	30+

ANOTHER COUSIN

3	2	1	0	1	2	3	4	5	10	20	30+

YOUR WIFE

3	2	1	0	1	2	3	4	5	10	20	30+

YOUR 1st CHILD

3	2	1	0	1	2	3	4	5	10	20	30+

YOUR 2nd CHILD

3	2	1	0	1	2	3	4	5	10	20	30+

YOUR 3rd CHILD

3	2	1	0	1	2	3	4	5	10	20	30+

36. While you were in <u>grade</u> school, did you have school friends who to your knowledge were under chiropractic care?

Yes _____ No _____

If "yes", how many friends? (check one)

_____ 1 or 2

_____ 3 or 4

_____ more than 4

(No. 37 on next page)

37. While you were in high school, did you have school friends who to your knowledge were under chiropractic care?
(include female friends!)

Yes _____ No _____

If "yes", how many friends? (check one)

_____ 1 or 2

_____ 3 or 4

_____ more than 4

38. Were any of your college friends (include females again) to your knowledge under chiropractic care?

Yes _____ No _____

If "yes", how many friends? (check one)

_____ 1 or 2

_____ 3 or 4

_____ more than 4

39. (a) Please indicate with checks the chiropractic care histories of the following people:

	This person received chiropractic care before and after I entered CIC	This person received chiropractic care only after I entered CIC	This person has never received Chiropractic care
Your fiance	_____	_____	_____
Your present steady girl	_____	_____	_____
A current semipsteady girl	_____	_____	_____
Your best friend outside the chiropractic profession	_____	_____	_____
Your second best friend outside the chiropractic profession	_____	_____	_____

(b) Now -- for the same people -- please indicate with checks how long you have known them, and general information about their post-chiropractic medical care.

	When did you meet this person?		If this person has also received medical care after starting chiropractic care, check below:
	Before I entered CIC	After I entered CIC	
Your fiance	_____	_____	_____
Your present steady girl	_____	_____	_____
A current semi-steady girl	_____	_____	_____
Your best friend outside the chiropractic profession	_____	_____	_____
Your second best friend outsidd the chiropractic profession	_____	_____	_____

40. Are any (or were any) of the following members of your family chiropractors?

(check as many as apply)

_____ father

_____ mother

_____ brother(s) (How many? _____)

_____ sister(s) (How many? _____)

_____ uncle(s) (How many? _____)

_____ aunt(s) (How many? _____)

_____ cousin(s) (How many? _____)

_____ grandparents (How many? _____)

_____ your wife

_____ godparent

_____ other member of family (Which? _____)

41. If you do have family members who are chiropractors, have any of them treated you personally?

Yes _____ No _____

If "yes", would you please write in which members (father, uncle, etc.)

1. _____

2. _____

42. How important in your judgment was the influence of each of the following persons in your decision to enter the chiropractic profession? (answer for each)

	Very Important	Fairly Important	Of little or no importance
1. mother	_____	_____	_____
2. father	_____	_____	_____
3. wife	_____	_____	_____
4. own children	_____	_____	_____
5. brother(s)	_____	_____	_____
6. sister(s)	_____	_____	_____
7. uncle(s)	_____	_____	_____
8. aunt(s)	_____	_____	_____
9. cousin(s)	_____	_____	_____
10. chiropractors who you knew personally	_____	_____	_____
11. chiropractors you heard or read about	_____	_____	_____
12. chiropractic students who you knew	_____	_____	_____

(No. 42 continued on next page)

13

	Very Important	Fairly Important	Of little or no importance
13. friends who were not chiropractic students or chiropractors	_____	_____	_____
14. girl friend or fiance	_____	_____	_____
15. other persons	_____	_____	_____

(Which? _____)

Which <u>two</u> of those above were most important in your decision to study chiropractic?

No. _____ and No. _____

43. Do you have any close relatives (uncles, aunts, first cousins, grandparents) <u>not</u> including your father, mother, brothers or sisters) who are -- or were -- in any of the following professions?

	Yes	No	How many relatives?
M.D.s?	_____	_____	_____
D.O.s?	_____	_____	_____
Dentists?	_____	_____	_____
Lawyers?	_____	_____	_____
Podiatrists?	_____	_____	_____
Nurses?	_____	_____	_____
Clergy?	_____	_____	_____
Engineers?	_____	_____	_____
Accountants?	_____	_____	_____
Pharmacists?	_____	_____	_____
Other professionals?	_____	_____	_____

(What? _____)

44. Compared to what you know today, how much would you say you knew about the philosophy, science, and art of chiropractic on the day you first walked into CIC?

(check the alternative which comes closest to what you knew)

_____ I knew very little.

_____ I had a very general idea, but knew little specifics.

_____ I already had moderate knowledge about the specifics of philosophy, art and science.

_____ Even then I knew a great deal about the philosophy, art and science.

45. Recall your very first week or two at CIC. To what extent did you feel satisfied with its physical plant, the faculty, front office personnel, and other students?

(answer for each)

	Very satisfied	Fairly satisfied	Somewhat dissatisfied	Very dissatisfied
Physical plant	_____	_____	_____	_____
Faculty	_____	_____	_____	_____
Front office personnel	_____	_____	_____	_____
Other students	_____	_____	_____	_____

46. How did your first experiences with CIC (again during the first weeks) match up with what you'd expected before you actually started attending classes?

(answer for each)

	Better than I had expected	About what I'd expected	Worse than I'd expected
Physical plant	_____	_____	_____
Faculty	_____	_____	_____
Front office personnel	_____	_____	_____
Other students	_____	_____	_____

47. Think back to <u>when you first started here at CIC</u>. How did each of the following persons react to your studying chiropractic? (answer for each)

	Approved	Neutral-Lukewarm	Disapproved	Expressed no opinion at all
1. mother	_____	_____	_____	_____
2. father	_____	_____	_____	_____
3. brothers	_____	_____	_____	_____
4. sisters	_____	_____	_____	_____
5. other relatives	_____	_____	_____	_____
6. friends	_____	_____	_____	_____
7. girlfriend	_____	_____	_____	_____
8. wife	_____	_____	_____	_____

48. Which of the following adjectives describe your mood and feelings about the study of chiropractic <u>in the weeks just before</u> you started at CIC? (check as many as apply)

_____ expectant

_____ excited

_____ skeptical

_____ somewhat apprehensive

_____ depressed

_____ resigned

_____ indifferent

_____ curious

_____ wait and see

_____ nervous

_____ other (What? _____)

49. When you first entered CIC how many superseniors were there in classes as compared to most recent terms?
(check one)

_____ less than in the most recent terms

_____ about the same number as in recent terms

_____ more superseniors when I entered than in recent terms

_____ This question not applicable to me because I am only a first-year student.

50. How does the present standard of faculty instruction compare with when you first came to CIC?

_____ better now than when I entered

_____ about the same at present as when I entered

_____ poorer at present than when I entered

_____ question not applicable because I am only a first-year student

51. How much travelling have you done? Please check those places which you've visited.

_____ states neighboring your own state

_____ most of northern seaboard USA

_____ western USA

_____ southern USA

_____ southwestern USA

_____ midwestern USA

_____ Canada

_____ Mexico

_____ Caribbean

_____ Europe

_____ South America

_____ other areas (Which? _____)

52. In which of the following sports did you actively participate, either in high school or college?
(check as many as apply)

_____ football

_____ weightlifting

_____ baseball

_____ wrestling

_____ boxing

_____ tennis

_____ golf

_____ basketball

_____ track

_____ hockey

_____ swimming

_____ other (Which? _____)

53. Have you served in the Armed Forces?

Yes _____ No _____

If "yes", were you an <u>enlisted</u> man or an <u>officer</u>?

Enlisted man _____ Officer _____

54. In which of the following kinds of <u>leisure activity</u> do you quite <u>regularly</u> participate?
(check as many as apply)

_____ amateur photography

_____ stamp collecting

_____ ham radio operator

_____ carpentry -- home shop work

(No. 54 continued on next page)

_____ auto mechanics

_____ general do-it-yourself work around your house or apartment

_____ reading fiction

_____ reading non-fiction books outside the field of chiropractic

_____ sculpting

_____ listening to classical music

_____ listening to popular music

_____ listening to rock or jazz music

_____ gardening

_____ camping

_____ hunting

_____ hiking

_____ playing a musical instrument

_____ weight-lifting -- body-building

_____ visiting museums

_____ attending concerts, operas, ballets

_____ going to films

_____ watching TV

_____ attending sports events

_____ playing sports (Which? _____)

_____ building or repairing radios, TVs or other electrical equipment

_____ social dancing

_____ other regular leisure activity

(Which? _____)

55. Do you currently belong -- or have you belonged in the past -- to any of the following groups? For each group with which you check some affiliation, please also indicate in the spaces provided the time of your membership.

	When?			
If you are -- or were -- a member, check in this column	Joined before CIC and am currently a member	Joined before CIC and am not currently a member	Joined after CIC and am currently a member	Joined after CIC and am not currently a member
_____ Moral Rearmament	_____	_____	_____	_____
_____ Christian Scientists	_____	_____	_____	_____
_____ Y.M.C.A.	_____	_____	_____	_____
_____ a local political club	_____	_____	_____	_____
_____ Y.M.H.A.	_____	_____	_____	_____
_____ a health club	_____	_____	_____	_____
_____ Elks	_____	_____	_____	_____
_____ a rifle club or association	_____	_____	_____	_____
_____ Rotary Club	_____	_____	_____	_____
_____ Sons of Italy	_____	_____	_____	_____
_____ B'nai B'rith	_____	_____	_____	_____
_____ Knights of Columbus	_____	_____	_____	_____
_____ Mankind United	_____	_____	_____	_____
_____ a yoga group	_____	_____	_____	_____
_____ a karate club q	_____	_____	_____	_____

(No. 55 continued on next page)

If you are -- or were -- a member, check in this column	Joined before CIC and am currently a member	Joined before CIC and am not currently a member	Joined after CIC and am currently a member	Joined after CIC and am not currently a member
_____ Rosicrucians	_____	_____	_____	_____
_____ volunteer firemen	_____	_____	_____	_____
_____ Holy Name Society	_____	_____	_____	_____
_____ 7th Day Adventists	_____	_____	_____	_____
_____ Ethical Culture Society	_____	_____	_____	_____
_____ Jehovah's Witnesses	_____	_____	_____	_____
_____ Junior Chamber of Commerce	_____	_____	_____	_____
_____ others	_____	_____	_____	_____

(Which? _____)

(No. 56 on next page)

56. Different people have different reasons for attending a given type of professional school. In fact, most people have more than one reason that has played a part in their decision of what to study.

(a) Below is a list of reasons for deciding to study chiropractic. To what number of current CIC students do you feel each of the following reasons applies? (answer for each)

(1967 GRADUATES: Include all students who were at CIC during your terms there in your evaluation.)	Applies to: Majority of CIC student body	Somewhere near one half of CIC student body	A substantial number, but less than half	Very few or none
1. helped (or family member helped) personally by chiropractic	_____	_____	_____	_____
2. dissatisfied with another job	_____	_____	_____	_____
3. couldn't make medical or dental school	_____	_____	_____	_____
4. wanted to get sick people well	_____	_____	_____	_____
5. wanted the 2-S draft status	_____	_____	_____	_____
6. grew up in chiropractic	_____	_____	_____	_____
7. felt chiropractic would be a good profession financially	_____	_____	_____	_____
8. drifted into chiropractic	_____	_____	_____	_____
9. wanted to be a professional person	_____	_____	_____	_____

(No. 56 continued on next page)

	Applies to: Majority of CIC student body	Somewhere near one half of CIC student body	A substantial number, but less than half	Very few or none
10. wanted to buck the crowd	_____	_____	_____	_____
11. were convinced chiropractic was right	_____	_____	_____	_____
12. wanted to be own boss	_____	_____	_____	_____

(b) If you were to pick the 3 or 4 reasons from the above list which were the <u>most important ones</u> for your fellow students' decision to study chiropractic, which would they be?

the most important reasons: No. _____ No. _____ No._____

No. _____

(No. 57 on next page)

57. Which of the reasons in the above list played some role in your <u>own decision</u> to study chiropractic?

(For each reason you check, please indicate in the appropriate spaces how important it was for you.)

	(check those which apply)	How Important? Very	Quite	Slightly
_____ 1.	helped (or family member helped) personally by chiropractic	_____	_____	_____
_____ 2.	dissatisfied with another job	_____	_____	_____
_____ 3.	couldn't make medical or dental school	_____	_____	_____
_____ 4.	wanted to get sick people well	_____	_____	_____
_____ 5.	wanted the 2-S draft status	_____	_____	_____
_____ 6.	grew up in chiropractic	_____	_____	_____
_____ 7.	felt chiropractic would be a good profession financially	_____	_____	_____
_____ 8.	drifted into chiropractic	_____	_____	_____
_____ 9.	wanted to be a professional person	_____	_____	_____
_____10.	wanted to buck the crowd	_____	_____	_____
_____11.	were convinced chiropractic was right	_____	_____	_____
_____12.	wanted to be own boss	_____	_____	_____

(No. 58 on next page)

58. Below is a list of reasons that students might have had for SPECIFICALLY ENTERING CIC, rather than entering another chiropractic college.

(a) To what number of current CIC students do you feel each of the following reasons for SPECIFICALLY choosing CIC applies?

(answer for each) (1967 GRADUATES: Again include all students who were at CIC during your terms there.)	Applies to: Majority of CIC student body	Somewhere near half	A substantial number	Very few or none
1. financial limitations				
2. rejected by other chiropractic colleges				
3. particularly wanted the specific curriculum CIC offers				
4. had friends currently studying at CIC				
5. had friends who were graduates of CIC				
6. had relatives who were graduates of CIC				
7. wanted to remain in the area where they were raised				
8. persuaded by D.C.s in CIC's front office or on its faculty				
9. heavily influenced by CIC's President				
10. didn't know much about other chiropractic colleges				
11. didn't want to go to a mixer school				
12. other reason				

(Which? _____)

(No. 58 continued on next page)

(b) If you were to pick the 3 or 4 reasons from the above list which were the most important ones for your fellow students' decision to enter CIC, which would they be?

the most important reasons: No. _____ No. _____ No. _____

No. _____

59. Which of the reasons in the list played some role in your <u>own decision</u> to enter CIC?

(For each reason you check, indicate in the appropriate spaces how important it was for you.)

(check those which apply)	How Important? Very	Quite	Slightly
_____ 1. financial limitations	_____	_____	_____
_____ 2. rejected by other chiropractic colleges	_____	_____	_____
_____ 3. particularly wanted the specific curriculum CIC offers	_____	_____	_____
_____ 4. had friends currently studying at CIC	_____	_____	_____
_____ 5. had friends who were graduates of CIC	_____	_____	_____
_____ 6. had relatives who were graduates of CIC	_____	_____	_____
_____ 7. wanted to remain in the area where they were raised	_____	_____	_____
_____ 8. persuaded by D.C.s in CIC's front office or on its faculty	_____	_____	_____
_____ 9. heavily influenced by CIC's President	_____	_____	_____
_____10. didn't know much about other chiropractic colleges	_____	_____	_____
_____11. didn't want to go to a mixer school	_____	_____	_____
_____12. other reason	_____	_____	_____

(Which? _____)

60. Since graduating from CIC, have you taken any state board examinations?

Yes _____ No _____

If "yes", in which states? If "yes", how did things turn out? (check below)

	Passed Completely	Passed Partially	Didn't Pass
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

61. Since graduating from CIC, have you been <u>licensed</u> in any states?

Yes _____ No _____

If "yes", which states?

1. _____

2. _____

3. _____

62. Have you set up practice anywhere?

Yes _____ No _____

If "yes", where?

_____

City or town State

63. Since graduating from CIC, have you held any part or full-time non-chiropractic job?

Yes _____ No _____

If "yes", what type of work?

(describe briefly)	Full-time?	Part-time?
1. _____		
_____	_____	_____
2. _____		
_____	_____	_____

64. (a) Was your father born in the United States? Yes___ No___

If "No" where was he born? (country) _____

(b) Was your mother born in the United Sta tes? Yes___ No___

If "No" where was she born? (cou ntry) _____

(c) Were you born in the United States? Yes___ No___

If "No" where were you born? (country) _____

APPENDIX B

2nd Questionnaire Administered to CIC Students

May, 1968

DIRECTIONS TO CIC STUDENTS

Dear CIC Student:

This 2nd questionnaire deals with your experiences at CIC, your future professional plans, and your feelings (including predictions) about chirepractic and the chiropractic profession.

Please go through it carefully. Usually all you have to do is check one alternative or another. The entire questionnaire shouldn't take you more than an hour - an hour and a half to complete.

I recognize that many of the questions deal with complex issues, and that the check-list alternatives do not always express the subtleties of your opinions. But the purpose of a questionnaire like this is to obttain an overall picture of the attitudes held by CIC students. Other procedures - like my informal talks with almost all of you - have been used to explore more detailed opinions.

I also recognise that some of the questions ask you to speculate about the future. In those cases, using your judgment (which I value), merely indicate how things are most likely to turn out.

As with the 1st questionnaire, your individual identity will not be revealed and your personal answers will be kept confidential. Information provided by CIC students will be made available to the front office or faculty of CIC only in the form of statistical summaries.

Every current CIC student (minus one) answered the 1st questionnaire, and I hope to get the same response with the 2nd one.

If you have any questions, please call me at 663-1372 in Manhattan.

Please fill out your questionnaire - most preferably <u>not</u> in consultation with fellow students! - and bring it in to School by THIS FRIDAY (May 24), when I'll be around all day to get it directly from you.

Again, thank you for your fine and continuing cooperation in the study.

Very truly,

DAVID STERNBERG

YOUR NAME _____

1. In your opinion, how important is <u>each</u> of the following elements likely to be to a chiropractor in building <u>a large and financially successful</u> practice?

(Please check one alternative for each element)

	How Important?		
	Very Important	Fairly Important	Unimportant
1. Sponsorship from important lay members of his community	____	____	____
2. Aid from professional chiropractic associations at various levels (national, state, local)	____	____	____
3. Participation in professional chiropractic associations	____	____	____
4. Hard work and constant dedication to his own practice	____	____	____
5. Referral of patients from chiropractic colleagues	____	____	____
6. A winning personality	____	____	____
7. Frequent speaking engagements on the topic of chiropractic to various lay groups (YMCA, lodges, etc.)	____	____	____
8. Lay meetings for patients	____	____	____
9. Expert adjusting abilities	____	____	____
10. A good head for business	____	____	____
11. Membership in the alumni association of the chiropractic college from which he graduated	____	____	____
12. A strong faith in his own ability to succeed as a chiropractor despite obstacles	____	____	____
13. Holding a teaching position in a chiropractic college	____	____	____
14. An excellent reputation as a chiropractor in the eyes of his patients	____	____	____

(No. 1 continued on next page)

	How Important?		
	Very Important	Fairly Important	Unimportant
15. Ability to make friends with some local M.D.s	____	____	____
16. Taking frequent post-graduate course in new chiropractic techniques	____	____	____
17. An excellent reputation as a chiropractor among his chiropractic colleagues	____	____	____
18. Carrying out research in chiropractic	____	____	____
19. Some real element of luck or fate	____	____	____
20. A deep understanding of the philosophy of chiropractic	____	____	____
21. Following closely the Palmers' views of chiropractic, and how it should be practiced	____	____	____
22. A broad knowledge of the basic sciences, in fields like anatomy, physiology and histology	____	____	____
23. Possession of a pre-professional degree, like a B.S. or a B.A.	____	____	____
24. Competence in one or more chiropractic specialities, like pediatrics or low-back problems	____	____	____
25. Strong religious convictions	____	____	____
26. Membership in various civic and community groups	____	____	____
27. Other element (Which?_____	____	____	____

_____

_____)

MAKE SURE YOU CHECKED ONE ALTERNATIVE FOR EACH ELEMENT!

2. How much would you say the average chiropractor starting out today can expect to be earning per year 10-15 years from now?

(check one)

a.____ under $10,000

b.____ $10,000 up to $15,000

c.____ $15,000 up to $20,000

d.____ $20,000 up to $30,000

e.____ $30,000 up to $40,000

f.____ $40,000 up to $60,000

g.____ $60,000 up to $100,000

3. How much do you estimate that you yourself will be earning per year as a chiropractor when you've been out in practice 10-15 years?

(check one)

a.____ under $10,000

b.____ $10,000 up to $15,000

c.____ $15,000 up to $20,000

d.____ $20,000 up to $30,000

e.____ $30,000 up to $40,000

f.____ $40,000 up to $60,000

g.____ $60,000 up to $100,000

4. To your knowledge do D.C.s who have just recently opened a practice ever take non-chiropractic (part-time or full-time) jobs in addition to their chiropractic practices?

(check one)

a.____ rarely or never

b.____ occasionally

c.____ frequently

5. Do you personally contemplate some non-chiropractic employment in addition to your practice when you first open up?

(check one)

a.____ little or no chance of this

b.____ some chance of this

c.____ a good chance of this

6. Which of the following statements comes closest to your present evaluation of the chiropractic adjustment?

(check one)

a._____It's far and away the most important element in a chiropractor's treatment of his patients.

b._____It's one important skill among a number (including diagnostic ability, knowledge of vitamin therapy, etc.), all of which are vital to modern chiropractic practice.

c.____The adjustment is becoming less important in the chiropractor's total treatment procedure every year.

7. Although you can't know for sure until you begin to practice, how straight a chiropractor do you think you'll be?

(check one)

a._____The only treatment I'll give will be adjustment of spinal vertebrae.

b._____My basic treatment will be adjustments, supplemented to a limited extent with vitamin therapy and certain pain killing techniques.

c._____I expect to use physiotherapy, vitamin therapy, ultra sound, etc. right alongside adjustments.

8. Although it's understood that the chiropractor's main concern is to clear out nerve interference, rather than treat any specific symptoms, how effective - in your judgment - is the chiropractic adjustment in treating a "typical" case of each of the following conditions?

	How Effective?			
	Very Effective	Somewhat Effective	Ineffective	I'm Uncertain
1. simple headache	_____	_____	_____	_____
2. migraine headache	_____	_____	_____	_____
3. "slipped" disc	_____	_____	_____	_____
4. lower back pain	_____	_____	_____	_____
5. ulcer	_____	_____	_____	_____
6. constipation	_____	_____	_____	_____
7. heart condition	_____	_____	_____	_____
8. diabetes	_____	_____	_____	_____
9. menstrual pain	_____	_____	_____	_____
10. generalized pain down the limbs	_____	_____	_____	_____

MAKE SURE YOU CHECKED ONE ALTERNATIVE FOR EACH CONDITION!

9. Here are a number of situations where you may be called upon – or perhaps already have been – to give somebody a chiropractic adjustment. Please indicate whether you would or wouldn't adjust in each case.

Situation	Would You Adjust? Definitely Would	Probably Would	Probably Wouldn't	Definitely Wouldn't
1. The person is a member of your immediate family.	____	____	____	____
2. You've no spinal X-rays of the patient.	____	____	____	____
3. You haven't thoroughly diagnosed the person's illness.	____	____	____	____
4. You know the person is already under another chiropractor's care.	____	____	____	____
5. The person is a close personal friend.	____	____	____	____
6. The person is also receiving medical care for the same condition he wants you to treat.	____	____	____	____
7. The person won't be able to pay your fee.	____	____	____	____
8. The person is under the age of 3.	____	____	____	____
9. The person is quite skeptical about chiropractic.	____	____	____	____

MAKE SURE YOU CHECKED ONE ALTERNATIVE FOR EACH SITUATION!

10. There is a good deal of discussion among students and faculty at CIC about the effectiveness of the chiropractic adjustment for different kinds of health problems. Which of the following statments is closest to your present evaluation?

(check one)

a.____I think the adjustment is at least somewhat effective in treating almost all types of sickness.

b.____Although adjustments are effective for many types of sickness, they are ineffective or inappropriate for other kinds.

c.____I honestly have my doubts at this point in my training as to whether adjustments really work.

11. (a) Do you plan to join a national chiropractic association when you graduate?

(check one)

a._____I'll probably join.

b._____I'll probably not join.

c._____I'm uncertain.

(b) If you checked "I'll probably join" in (a), how actively do you think you'll participate?

(check one)

a._____very actively

b._____moderately

c._____relatively inactive

12. (a) Do you plan to join a state chiropractic association when you graduate?

(check one)

a._____I'll probably join.

b._____I'll probably not join.

c._____I'm uncertain.

(b) If you checked "probably will" in (a), how actively do you plan to participate?

(check one)

a._____very actively

b._____moderately

c._____relatively inactive

13. (a) Do you plan to join a local chiropractic association or group when you graduate?

(check one)

a._____probably

b._____probably not

c._____I'm uncertain.

(b) If you checked "probably" in (a), how actively will you participate?

(check one)

a._____very active

b._____moderately

c._____relatively inactive

14. (a) Do you plan to join the CIC Alumni Association when you graduate?

(check one)

a._____probably

b._____probably not

c._____I'm uncertain.

(b) If you checked "probably" in (a) how actively will you participate?

(check one)

a._____very actively

b._____moderately

c._____relatively inactive

15. Is the <u>scope of practice</u> (what the D.C. is permitted to treat and not permitted to treat; and what treatment means he is allowed to use) under state chiropractic laws about the <u>same</u> from state to state, or is there considerable <u>variation</u>?

(check one)

a._____about the same

b._____considerable variation

c._____I'm uncertain.

16. Do any states require chiropractic candidates for licensure to take basic science examinations which are based on a medical education rather than a chiropractic one?

(check one)

a._____many

b._____some

c._____1 or 2

d._____none

17. How many of the <u>chiropractic parts</u> on state boards do chiropractic graduates usually pass these days <u>the first time around</u>?

(check one)

a._____all or most

b._____about half

c._____less than half

18. How many of the chiropractic parts on the state boards you intend to take do you expect to pass the first time around?

(check one)

a._____all or most

b._____about half

c._____less than half

19. Professional chiropractic associations in the United States have a number of activities. How important to chiropractic, in your opinion, is each of the following activities?

(Please check one alternative for each activity)

	How Important?		
	Very Important	Fairly Important	Unimportant
1. Policing the profession (ethics, control of advertising, etc.)	____	____	____
2. Counteracting negative propaganda of the AMA	____	____	____
3. Working for more favorable chiropractic legislation in state and federal governments	____	____	____
4. Spreading new scientific information about chiropractic to chiropractors	____	____	____
5. Spreading information about chiropractic to laymen	____	____	____
6. Providing chiropractors with malpractice insurance	____	____	____
7. Working for the inclusion of chiropractic care in public and private insurance plans	____	____	____
8. Standardizing the admissions requirements of all chiropractic colleges	____	____	____
9. Standardising the curriculum of all chiropractic colleges	____	____	____

MAKE SURE YOU CHECKED ONE ALTERNATIVE FOR EACH ACTIVITY!

20. If you had to choose, which level of organized chiropractic do you feel is most effective in supporting and promoting the profession?

(check one)

a._____national organizations

b._____state organizations

c._____local (community) associations or groups

d._____chiropractic colleges

21. If you had to choose, which level of organized chiropractic do you feel is least effective in supporting and promoting the profession?

(check one)

a._____national

b._____state

c._____local

d._____chiropractic colleges

22. Which of the following statements comes closest to your feeling about the present effectiveness of various professional chiropractic associations in promoting the profession?

(check one)

a._____Their overall record wou ld be a difficult one upon which to improve.

b._____They are making some headway, although they could be much more effective.

c._____They have made relatively little headway.

23. How effective, in your opinion, are chiropractic organisations of various kinds going to be in promoting the profession in the years to come?

(check one)

a._____very effective

b._____somewhat effective

c._____ineffective

24. How do malpractice suits against chiropractors these days generally turn out?

(check one)

a._____favorable to chiropractors

b._____about equally divided between favorable and unfavorable to chiropractors

c._____unfavorable to chiropractors

25. How do you think malpractice suits against chiropractors will turn out for them in the years to come?

(check one)

a._____generally favorable to chiropractors

b._____about equally divided between favorable and unfavorable to chiropractors

c._____unfavorable to chiropractors

26. Which of the following statements comes closest to your feeling about the value of professional chiropractic organizations of various types to individual chiropractors?

(check one)

a._____If chiropractors don't rally behind their organizations very soon, the survival of their profession in this country is going to be threatened.

b._____The organizations may be important to individual chiropractors, but not as essential as some persons in the profession make them seem.

c._____When it's all said and done, each chiropractor is more or less on his own anyway.

27. In your opinion, what effect would a court decision against a chiropractor in your locality for malpractice have on the practices of your fellow D.C.s in the area?

(check one)

a._____no harmful effect

b._____some harmful effect

c._____considerable harmful effect

28. In your opinion, what effect would a court decision against a chiropractor in your locality for malpractice have on your own practice?

(check one)

a._____no harmful effect

b._____some harmful effect

c._____considerable harmful effect

29. Can an announcement at a social gathering that one is a chiropractic student ever cause a strong reaction (like anger or confusion)?

(check one)

a._____It never happens.

b._____It's been known to happen.

c._____It happens quite often.

30. Have you personally ever confronted a strong reaction from people at a social gathering when you told them you were a chiropractic student?

(check one)

a._____It's never happened to me.

b._____It's happened once or twice.

c._____It's happened frequently.

31. As students progress through their terms of training at CIC, do you feel their enthusiasm for chiropractic increases, stays at about the same level, or decreases?

(check one)

a._____increases

b._____stays about the same

c._____decreases

32. As you personally progress through your terms of training at CIC, does your enthusiasm for chiropractic increase, remain at about the same level, or decrease?

(check one)

a._____increases

b._____stays about the same

c._____decreases

33. Among the three alternatives that follow, please check the one which comes closest to your feelings about newspaper coverage of chiropractic.

(check one)

a._____Newspapers support chiropractic by giving prominent coverage to items favorable to the profession.

b._____Newspapers are neutral or lukewarm about chiropractic.

c._____Newspapers seem to enjoy giving an unfavorable slant to news concerning chiropractic, and play up its faults rather than its virtues.

34. Are chiropractors generally more respected, in your judgment, in city or in rural areas?

(check one)

a._____more respected in cities

b._____more respected in rural areas

c._____about equally respected in both

35. How important do you feel <u>individual chiropractors</u> are to each other in each of the following activities?

	How Important?		
	Very Important	Fairly Important	Unimportant
1. Referral of patients from one D.C. to another	____	____	____
2. A common front against medicine	____	____	____
3. Exchange of new chiropractic information	____	____	____
4. Practicing with each other in partnerships	____	____	____
5. Help in setting up a new practice	____	____	____
6. Help in practice building	____	____	____
7. Regulating each others' professional conduct	____	____	____
8. Keeping chiropractic alive	____	____	____
9. Research collaboration	____	____	____
10. Providing personal friendships	____	____	____

MAKE SURE YOU CHECKED ONE ALTERNATIVE FOR EACH ACTIVITY!

36. Do <u>individual M.D.s</u> generally feel more or less favorable to chiropractors than organized (AMA) medicine?

(check one)

a.____more favorable than organized medicine

b.____about the same

c.____less favorable than organized medicine

37. At this point, how would you rate your adjustive skills (including spinal analysis and adjustive thrust) relative to other students <u>in your own class</u>?

(check one)

a.____better

b.____same

c.____not as good

38. From what you know, or have heard, how would you rate the competence of D.C.s who are presently practicing?

(check one)

a._____The large majority are competent.

b._____The majority are competent, with a substantial minority of questionable competence.

c._____The division between competents and incompetents is about 50-50.

d._____The majority are of questionable competence, with a substantial minority who are competent.

e._____The large majority are of questionable competence.

39. Are there students at CIC whose families or friends have not fully accepted their decision to become chiropractors?

(check one)

a._____ none

b._____a few

c._____many

40. How have most of <u>your own family and friends</u> accepted your becoming a D.C.?

(check one)

a._____accepted my decision

b._____lukewarm about it

c._____unhappy about it

41. What's your opinion about chiropractic's <u>future reputation</u> in the community?

(check one)

a._____I think chiropractic's reputation will improve.

b._____I think chiropractic's reputation will remain about the same.

c._____I think chiropractic's reputation may get worse.

42. Sizing up your own capabilities, how much success do you expect to have in the community where you locate?

(check one)

a._____more success than the average chiropractor

b._____about the same success as the average chiropractor anywhere

c._____less success than the average chiropractor

43. What elements determine how much any particular chiropractor is respected in his community these days?

(Check the statement which comes closest to your feelings)

a._____It depends primarily on the individual doctor and the impression he makes.

b._____The chiropractor's own skill and personality, on the one hand, and his membership in the chiropractic profession on the other, play about equal parts.

c._____Regardless of a particular chiropractor's skill and personality, the degree to which he's respected in his community is mostly determined by how people feel about the chiropractic profession in general.

44. In your opinion, will the number of chiropractors pursuing <u>speciality practices</u> (obstetrics, lower back, pediatrics, etc.) increase substantially in the <u>next 5-10 years</u>?

(check one)

a._____yes

b._____no

c._____I'm uncertain.

45. (a) Do <u>you yourself</u> contemplate a speciality practice <u>when you start to practice</u>?

Yes_____ No_____ I'm uncertain_____

If "Yes" what type?_____

(b) Do you contemplate a speciality practice <u>some years after you open up?</u>

Yes_____ No_____ I'm uncertain_____

If "Yes" what type?_____

46. How would you say the general community <u>presently</u> rates D.C.s in relation to other health practitioners, like dentists and M.D.s?

(check one)

a._____rates chiropractors above these other groups of practitioners

b._____rates chiropractors about the same

c._____rates chiropractors a little below

d._____rates chiropractors considerably below these other groups

47. What's the chiropractor's reputation in Europe?

(check one)

a._____higher than the chiropractor's reputation here

b._____about the same as here

c._____lower than here

d._____I don't know.

48. This question asks your judgment on how well average members of several other healing arts get along with the average doctor of chiropractic.

All you have to do is check that point on each of the following lines which indicates where dentists, osteopaths, etc. stand in relation to D.C.s

An example: If you feel that <u>podiatrists</u> generally have <u>quite friendly</u> relations with D.C.s, you check the podiatrist-chiropractor line like this:

YOUR CHECK HERE

X

Very Friendly With Chiropractors	← Lukewarm Neutral →	Very Unfriendly With Chiropractors

Now please check on each of the following 6 lines.

1. <u>M.D.s</u> and D.C.s

Very Friendly With Chiropractors	← Lukewarm Neutral →	Very Unfriendly With Chiropractors

2. <u>Dentists</u> and D.C.s

Very Friendly With Chiropractors	← Lukewarm Neutral →	Very Unfriendly With Chiropractors

3. <u>Osteopaths</u> and D.C.s

Very Friendly With Chiropractors	← Lukewarm Neutral →	Very Unfriendly With Chiropractors

4. <u>Podiatrists</u> and D.C.s

Very Friendly With Chiropractors	← Lukewarm Neutral →	Very Unfriendly With Chiropractors

(No. 48 continued on next page)

48. (contd.) 5. Nurses and D.C.s

Very Friendly With Chiropractors	←	Lukewarm Neutral	→	Very Unfriendly With Chiropractors

6. Pharmacists and D.C.s

Very Friendly With Chiropractors	←	Lukewarm Neutral	→	Very Unfriendly With Chiropractors

49. During or after your chiropractic education are you planning to complete any of the following academic degrees?

(Check any which are applicable)

a.____A.A.

b.____B.S. (Which major?_____)

c.____B.A. (Which major?_____)

d.____M.S. (Which major?_____)

e.____M.A. (Which major?_____)

f.____Other degree (Which?_____)

50. What does the future hold, in your judgment, for chiropractic's inclusion in various types of private and public health insurance plans?

(check one)

a.____Chiropractic's inclusion in these plans will increase.

b.____Extent of chiropractic's inclusion will not change very much from today's situation

c.____Chiropractic's inclusion will probably decrease in future years.

51. From which of the following sources have you received substantial information about the economic situation of D.C.s?

(check as many as apply)

a.____other CIC students

b.____younger faculty at CIC

c.____older faculty at CIC

d.____CIC front office

e.____President of CIC

f.____D.C.s not connected with CIC

g.____chiropractic journals and books

h.____Other sources

(If Other sources, which?_____)

52. In your opinion, what effect would each of the following factors have on the growth and development of chiropractic in the United States?

(Check one alternative for each factor)	What Effect? A Positive Effect	A Negative Effect	No Effect
1. Increasing the amount of pre-professional training required for entry into chiropractic college	____	____	____
2. Placing more emphasis on "medical science" courses in the chiropractic curriculum	____	____	____
3. Standardizing the curriculum in all chiropractic colleges	____	____	____
4. Requiring practitioners to attend at least one advanced program of training every 5 years in order to maintain "good standing" within the profession	____	____	____
5. Bringing all chiropractic colleges under the control of the profession itself, rather than allowing some colleges to be run by private persons	____	____	____
6. Standardizing admission and graduation requirements in all chiropractic colleges	____	____	____
7. Establishing a mandatory annual contribution for all practitioners for subsidizing chiropractic colleges	____	____	____
8. Establishing formal organizational contacts between units of the chiropractic and medical profession	____	____	____
9. Granting of public funds to subsidize the operation of chiropractic colleges	____	____	____
10. Standardizing of licensing requirements in all states	____	____	____
11. Requiring membership in chiropractic professional association in order to stay in practice	____	____	____
12. Increasing the control of national chiropractic associations over state and local ones	____	____	____
13. Establishing a more rigid code of ethics	____	____	____
14. Lengthing the period of training within chiropractic colleges	____	____	____
15. Requiring an original piece of research from students as a requirement for the D.C. diploma	____	____	____

MAKE SURE YOU CHECKED ONE ALTERNATIVE FOR EACH FACTOR!

53. What effect, in your judgment, would negative newspaper publicity about chiropractic in general have on the <u>average chiropractor's practice</u>?

(check one)

a.____considerable harmful effect

b.____some harmful effect

c.____no harmful effect

54. What effect, in your judgment, would negative newspaper publicity about chiropractic in general have on <u>your own practice</u>?

(check one)

a.____considerable harmful effect

b.____some harmful effect

c.____no harmful effect

55. What kind of relations do chiropractors generally have with <u>M.D.s</u>?

(check one)

a.____friendly

b.____lukewarm

c.____unfriendly

56. What does the <u>future</u> hold for relations between D.C.s and M.D.s?

(check one)

a.____friendly

b.____lukewarm

c.____unfriendly

57. What kind of relations do <u>you</u> expect to have with local M.D.s in the community where you locate?

(check one)

a.____friendly

b.____unfriendly c.____lukewarm

58. How much would you say the <u>average chiropractor starting out today</u> can expect to earn per year <u>at the peak of his professional career</u>?

(check one)

a.____under $10,000

b.____$10,000 up to $15,000

c.____$15,000 up to $20,000

d.____20,000 up to $30,000

e.____$30,000 up to $40,000

f.____$40,000 up to $60,000

g.____$60,000 up to $100,000

59. How much do you yourself expect to earn at the peak of your professional chiropractic career?

(check one)

a.____ under $10,000

b.____ $10,000 up to $15,000

c.____ $15,000 up to $20,000

d.____ $20,000 up to $30,000

e.____ $30,000 up to $40,000

f.____ $40,000 up to $60,000

g.____ $60,000 up to $100,000

60. This question attempts to find out what your general feelings were about chiropractic since the time you first heard anything at all about chiropractic.

Age	Had You Heard About Chiropractic? (Start checking at earliest age you'd heard about chiropractic and continue through later ages)	Attitude At Each Age From the Time You'd First Heard (Start checking at earliest age you'd heard about chiropractic and continue through later ages)		
		Positive	Neutral Lukewarm	Negative
Under 10	____	____	____	____
10-13	____	____	____	____
14-16	____	____	____	____
17-18	____	____	____	____
18-20	____	____	____	____
21-22	____	____	____	____
23-25	____	____	____	____
26-30	____	____	____	____
Older (What age?_____)	____	____	____	____

No. 61 on following page

61. (a) Now, how old were you when you first learned <u>something substantial</u> (beyond vague talk or hearsay) about chiropractic?

(check one)

a._____under 10

b._____10-13

c._____14-16

d._____17-18

e._____19-20

f._____21-22

g._____23-25

h._____26-30

i._____older (What age?_____)

(b) Which persons do you associate with your first learning something substantial about chiropractic?

---

62. On state boards which have both chiropractic and various basic science parts, how many of the <u>basic science parts</u> do chiropractic candidates for licensure usually pass these days <u>the first time around</u>?

(check one)

a._____all or most

b._____about half

c._____less than half

63. How many of the <u>basic science parts</u> on a state board with both basic science and chiropractic tests which you might take would <u>you</u> expect to pass <u>the</u> first time around?

(check one)

a._____all or most

b._____about half

c._____less than half

64. How do M.D.s and D.C.s get along with each other in <u>Europe</u>?

(check one)

a._____better relations than in the U.S.

b._____about the same as here

c._____worse than in U.S.

d._____I don't know.

65. What kind of relations do chiropractors generally have with <u>osteopaths</u>?

(check one)

a._____friendly

b._____lukewarm

c._____unfriendly

66. What does the future hold for relations between D.C.s and osteopaths?

(check one)

a._____friendly relations

b._____lukewarm relations

c._____unfriendly relations

67. What kind of relations do <u>you personally</u> expect to have with local osteopaths in your own practice?

(check one)

a._____friendly

b._____lukewarm

c._____unfriendly

68. Which of the following statements best describes your feeling about the economic situation of the <u>recent chiropractic college graduate</u> these days?

(check one)

a._____Even the recent graduate these days generally does well very soon after he opens an office.

b._____The recent graduate will probably get by for the first couple of years.

c._____The recent graduate better be prepared to starve for the first couple of years.

69. How do you feel things are going to go financially for <u>you personally</u> when you <u>first open an office</u>?

(check one)

a._____I expect to do well almost from the beginning.

b._____I'll just get by for the first couple of years.

c._____I expect to have to starve for the first couple of years.

70. Please indicate the extent to which you agree or disagree with each of the following statements

(Check one alternative for each statement)

	Agree Strongly	Agree Somewhat	Disagree Somewhat	Disagree Strongly
1. "A chiropractor who doesn't maintain close relations with his fellow practitioners is not going to have a large practice."	____	____	____	____
2. "When you get down to essentials, the individual chiropractor's patients are the most important group in determining whether he'll be a success."	____	____	____	____
3. "Most chiropractors would consider a D.C. who had a relatively small private practice, but who did research in chiropractic a big success."	____	____	____	____
4. "There are certain patients who can be tremendously helpful in building up a D.C.'s practice."	____	____	____	____
5. "Although it's not often said openly, many chiropractors feel that they are in direct competition with other D.C.s for patients."	____	____	____	____
6. "Lay meetings called by the chiropractor for his patients are just as important to a man's practice as his attendance at professional chiropractic meetings."	____	____	____	____
7. "Generally the chiropractor's main obligation is accomodating his patients - so long as he remains true to the art, science, and philosophy of chiropractic."	____	____	____	____
8. "Chiropractors who are devoted to their own practices but who don't find time to go to professional chiropractic meetings are missing something very essential."	____	____	____	____
9. "Nowadays there are too many meetings, regulations and laws about chiropractic, all of which tend to obscure the point that the chiropractor's main job is to get sick people well."	____	____	____	____

(No. 70 continued on next page)

70. (contd.)

	Agree Strongly	Agree Somewhat	Disagree Somewhat	Disagree Strongly
10. "Patient referral from one D.C. to another has increased rapidly in recent years."	____	____	____	____
11. "Since you have to be an individualistic type of person in the first place to become a chiropractor, attempts to organize chiropractors beyond a certain point are bound to fail."	____	____	____	____
12. "Only chiropractors with large private practices are really successful."	____	____	____	____

MAKE SURE YOU CHECKED ONE ALTERNATIVE FOR EACH STATEMENT!

71. Some chiropractors talk about inter-professional clinics, with, for example, an M.D., a dentist, an optometrist and a D.C. all sharing the same laboratory facilities. In your view, what are the chances of chiropractors being frequently included in these clinics in the <u>next 5-10 years</u>?

(check one)

a.____chances are high

b.____chances about 50-50

c.____chances are slim

72. Do <u>you personally</u> expect to participate someday in an inter-professional clinic with specialists from other healing arts?

(check one)

a.____chances are high

b.____chances about 50-50

c.____chances are slim

73. Although generalizations are difficult, how would you best sum up the attitude of state licensing laws toward the chiropractic profession?

(check one)

a.____friendly

b.____neutral-lukewarm

c.____unfriendly

74. What attitude do you think state licensing laws will take toward chiropractic in the future?
(check one)

a.____friendly b.____lukewarm c.____unfriendly

75. Various reasons have been offered from time to time to explain why chiropractic has so far not been as fully accepted in the United States as it has wished. Which of the following reasons do you feel have been important in this respect?

Note that you have an opportunity in the choices to disagree that any particular condition exists (or existed) in chiropractic.

	How Important			
	Very Important	Fairly Important	Unimportant	I don't think this condition exists in Chiropractic
1. The opposition from the AMA over the years	____	____	____	____
2. The public's unfamiliarity with chiropractic	____	____	____	____
3. The excesses of a few incompetent or non-professional chiropractors which have been over-publicised	____	____	____	____
4. The incompetence of a a substantial number of chiropractors over the years	____	____	____	____
5. The relative ineffectiveness of organized chiropractic groups in this country	____	____	____	____
6. The uneven quality of chiropractic colleges	____	____	____	____
7. An overly commercialistic viewpoint on the part of some chiropractors	____	____	____	____
8. Other reason	____	____	____	____

(Which?_____

_____

MAKE SURE YOU CHECKED ONE ALTERNATIVE FOR EACH REASON!

76. Do you personally worry about the fact that some states are not overly friendly toward chiropractic?

(check one)

a._____I rarely or never worry about it.

b._____I worry about it occasionally.

c._____I worry about it a good deal.

77. Are D.C.s members of hospital staffs (exoluding chiropractic hospitals)?

(check one)

a._____frequently

b._____occasionally

c._____rarely or never

78. Do <u>you</u> expect to become a member of a hospital staff (non-chiropractic) at some time during your practice?

(check one)

a._____probably yes

b._____50-50 chance

c._____probably not

79. Where do you probably intend to locate your practice?

(check one)

a._____a large metropolitan center

b._____a suburb near a large metropolitan area

c._____a smaller city

d._____a town, village, or rural area

80. Do students become more or less enthused about <u>CIC itself</u> as they progress through their 3 years of training?

(check one)

a._____more enthused

b._____stay about the same

c._____less enthused

81. Have you personally become more or less enthused about <u>CIC itself</u> as you progress through your training?

(check one)

a._____more enthused

b._____stayed about the same

c._____less enthused

82. How many of your closest friends at present are chiropractic students or chiropractors?

(check one)

a._____most b._____about half c._____less than half

83. At this point, do you plan to practice by yourself or with other D.C.s?

(check one)

a._____probably by myself

b._____with one other D.C.

c._____with 2 or more other D.C.s

84. How much of your total studying time is spent with other CIC students?

(check one)

a._____a great deal

b._____a moderate amount

c._____little or none

85. What are you living arrangements at present?

(check one)

a._____live at home with my parents

b._____live with my wife (and children)

c._____live alone

d._____live with 1 other CIC student

e._____live with 2 or more other CIC students

f._____live with non-relatives who are not CIC students

86. During the past semester how often did you participate in social activities (parties, sports, dances, evening out) with at least 1 other CIC student who was not your roommate?

(check one)

a._____never

b._____1 or 2 times

c._____3-5 times

d._____6 or more times

87. How many of your closest friends are current CIC students?

(check one)

a._____a majority

b._____about half

c._____less than half

d._____none

88. With how many CIC students outside of your classmates do you spend any substantial amount of time (a couple of hours or more) during a given week?

a._____none

b._____1 or 2 students

c._____3-5 students

d._____more than 5 students

89. (a) Are you employed at present? Yes_____ No_____

(b) If "Yes" how many hours per week? _____hours

(c) If "Yes" do you work in your job with other CIC students? Yes_____ No_____

(d) If "Yes" please give (1) the name of your job and (2) the specific activities connected with the job.

(1) Name of job_____

(2) Specific activities_____

90. Please list and briefly describe any jobs previous to your present one which you held while a student at CIC, and whether they were full-time or part-time.

Job	Full-time?	Part-time?
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

91. On the average, how helpful is being able to say one is a chiropractic student in getting a desirable outside job while finishing chiropractic college?

(check one)

a._____very helpful

b._____fairly helpful

c._____of no help

d._____detrimental

92. What percentage of the CIC student body would you estimate works 20 or more hours per week at an outside job?

(check one)

a._____10% or less

b._____10-25%

c._____25-40%

d._____40-60%

e._____over 60%

93. How many students at CIC outside your own class would you say you knew by name?

(check one)

a._____most of them

b._____about half

c._____quite a few, but less than half

d._____not very many

e._____none

94. How many of your current CIC instructors call you by your first name, in or out of class?

(check one)

a._____none

b._____1 or 2

c._____3 or 4

d._____5 or more

95. How many of your current CIC instructors do you call by their first names, in or out of class?

(check one)

a._____none

b._____1 or 2

c._____3 or 4

d._____5 or more

96. How important in your estimation, is each of the following in making a good instructor at CIC?

(Check one alternative for each)	How Important? Very Important	Fairly Important	Unimportant
1. Instructor has a large practice of his own	____	____	____
2. Instructor has a pre-chiropractic degree, like a B.S. or B.A.	____	____	____
3. Instructor works hard for the profession, by fighting for better chiropractic laws, recognition, etc.	____	____	____
4. Instructor keeps up with the latest chiropractic research	____	____	____
5. Instructor has published research in chiropractic journals	____	____	____
6. Instructor deals with students on a personal basis, knows their individual problems, first names, etc.	____	____	____
7. Instructor knows a good deal about related health fields, like medicine	____	____	____
8. Instructor weaves chiropractic into the course, no matter what its official title is	____	____	____
9. Instructor gives students advice about how and where to practice when they graduate	____	____	____
10. Instructor constantly emphasizes that chiropractic is a separate and distinct healing art	____	____	____
11. Instructor is well-groomed and wears tasteful clothing	____	____	____
12. Instructor went to CIC himself	____	____	____
13. Instructor has passed his own state boards	____	____	____
14. Instructor has a good knowledge of the chiropractic laws of different states	____	____	____

MAKE SURE YOU CHECKED ONE ALTERNATIVE FOR EACH!

97. What do you think the future holds in respect to the size of the CIC student body?

(check one)

a._____same size as today

b._____increase in size

c._____decrease in size

98. What's your feeling about the level of morale among students at CIC?

(check one)

a._____high among the majority of students

b._____uneven, with some students having a positive attitude and others having a negative one

c._____low among the majority of students

99. Which of the following statements comes closest to your feelings about your upcoming career as a chiropractor?

(check one)

a._____It's the best of all professions.

b._____It's one of a number I'd have been happy in.

c._____I can think of others I'd have been happier in.

d._____I think I may be unhappy as a chiropractor.

100. If you had a son old enough to choose a p manent profession, would you advise him to study chiropractic?

(check one)

a._____yes

b._____I'd take a neutral position.

c._____no

101. Since you've been in attendance at CIC have you ever seriously thought about transferring to another chiropractic college?

(check one)

a._____never

b._____at least once

c._____several times

102. Since you've been in attendance at CIC, have you ever thought seriously about abandoning your chiropractic education altogether?

(check one)

a._____never

b._____at least once

c._____several times

103. In your judgment, how important are the writings and teachings of D.D. and B.J. Palmer in the everyday curriculum at CIC?

(check one)

a._____very important

b._____somewhat important

c._____unimportant

104. In your judgment, how important are the traditions and teachings of Columbia's founder, Frank E. Dean, in the everyday curriculum at CIC?

(check one)

a._____very important

b._____somewhat important

c._____unimportant

105. How accurate a picture of what a day-to-day chiropractic practice is going to be like do you feel your CIC training is giving you?

(check one)

a._____a very accurate picture of what day-to-day practice is going to be like

b._____a fairly accurate picture

c._____a somewhat inaccurate picture

d._____a very inaccurate picture

106. How difficult, in your opinion, is CIC in comparison to medical school - in terms of study time required, complexity of the material, and difficulty of examinations?

(check one)

a._____even tougher than medical school

b._____about the same level of overall difficulty

c._____somewhat easier than medical school

d._____much easier than medical school

107. Up to this point in your chiropractic education, how important has each of the following been in helping you to become a skilled doctor of chiropractic?

(Check one alternative for each)	How Important: Very Important	Fairly Important	Unimportant
1. Overall presentation of the material by the majority of your instructors	____	____	____
2. Contacts, both in and out of class, with certain instructors	____	____	____
3. The President of CIC	____	____	____
4. The front office personnel	____	____	____
5. Reading the books of B.J. and D.D. Palmer	____	____	____
6. General independent reading in the field of chiropractic	____	____	____
7. Discussions with chiropractors not connected with CIC	____	____	____
8. Discussion and study with other CIC students	____	____	____

MAKE SURE YOU CHECKED ONE ALTERNATIVE FOR EACH!

108. Students in various kinds of professional schools often confront situations which, quite normally, upset or unsettle them. Here are experiences which some students at CIC have indicated to be more or less trying for them. Please indicate which, if any, of them were at all upsetting to you.

(Check as many as apply)

Which Were Upsetting?

a.____Taking my first set of major exams at CIC

b.____Receiving my first adjustment(s) from a clinician in the clinic

c.____Receiving my first adjustment(s) from fellow students in class

d.____Living through my first weeks at CIC when I didn't know what to expect

e.____Taking the National Boards

f.____Giving my first adjustment(s) to fellow students

g.____Giving my first adjustment(s) to patients in the clinic

h.____Explaining chiropractic to family and/or friends

i.____Other experience(s) (Which?_____)

109. Although you are not yet a chiropractor officially, many people probably think of you as one.

(a) How do you feel about <u>yourself</u> in this respect?

(check one alternative for each)

	Have Thought of Yourself: More as a chiropractor than a student	Have Thought of Yourself: More as a student than a chiropractor
1. In the most recent dealings you have had with patients, how have you tended to think of yourself?	____	____
2. When you have talked with your classmates recently?	____	____
3. When you have had contact with your instructors in recent weeks?	____	____
4. When you had contact recently with D.C.s not connected with CIC?	____	____
5. When you spent time recently with your family and friends?	____	____

(b) In your opinion, how have these different people <u>thought of you</u> recently in this respect?

(check on alternative for each)

	You Have Been Thought Of: More as a chiropractor than a student	You Have Been Thought Of: More as a student than a chiropractor
1. Patients?	____	____
2. Classmates?	____	____
3. CIC instructors?	____	____
4. D.C.s outside of CIC?	____	____
5. Family and friends?	____	____

110. How do your CIC classmates rate in <u>scholastic ability</u> in comparison to your pre-professional school classmates?

(check one)

a._____better at CIC

b._____worse at CIC

c._____about the same as in pre-professional school

d._____I didn't attend pre-professional school.

111. How do your CIC classmates rate in <u>motivation</u> (desire to learn course material, enthusiasm) in comparison to your pre-professional school classmates?

(check one)

a._____better at CIC

b._____worse at CIC

c._____about the same as in pre-professional school

d._____I didn't attend pre-professional school.

112. What things do you think you will like most about being a chiropractor?

_____

_____

_____

113. What aspects of being a chiropractor might you dislike?

_____

_____

_____

114. The last question is open-ended- and <u>optional</u>. Here feel free to mention what you thought of the questionnaires; additional topics which you think might or should have been included; and any further general comments about the project as a whole. If you have a lot to say, continue on the extra sheet. Your points will be appreciated, and held, of course, in the same confidence as the rest of the data.

_____

_____

_____

_____

APPENDIX C

Questionnaire Administered to N.Y.U. Dental Students

1. What is your father's occupation? Please give (a) the title of his occupation and (b) a brief description of the specific activities of his job, if they are not self-evident from the title.

(a) Title of father's occupation_____

(b) Specific activities_____

_____

2. What is your national background? (for example, German-American, Italian-American, Jewish, Irish-American, etc.)

National background_____

3. What elements determine how much any particular dentist is respected in his community these days?

(Please check the statement which comes closest to your feelings)

a._____It depends primarily on the individual dentist and the impression he makes.

b._____The dentist's own skill and personality, on the one hand, and his membership in the dental profession on the other, play about equal parts.

c._____Regardless of a particular dentist's skill and personality, the degree to which he's respected in his community is mostly determined by how people feel about the dental profession in general.

4. How much would you say the average dentist starting out today can expect to be earning per year 10-15 years from now?

(check one)

a._____under $10,000

b._____$10,000 up to $15,000

c._____$15,000 up to $20,000

d._____$20,000 up to $30,000

e._____$30,000 up to $40,000

f._____$40,000 up to $60,000

g._____$60,000 up to $100,000

5. How much would you estimate that you yourself will be earning per year as a dentist when you've been out in practice 10-15 years?

(check one)

a._____under $10,000

b._____$10,000 up to $15,000

c._____$15,000 up to $20,000

d._____$20,000 up to $30,000

e._____$30,000 up to $40,000

f._____$40,000 up to $60,000

g._____$60,000 up to $100,000

(continued on next page)

6. How much would you say the average dentist starting out today can expect to earn per year at the peak of his professional career? *

(check one)

a.____ under $10,000

b.____ $10,000 up to $15,000

c.____ $15,000 up to $20,000

d.____ $20,000 up to $30,000

e.____ $30,000 up to $40,000

f.____ $40,000 up to $60,000

g.____ $60,000 up to $100,000

7. How much do you yourself expect to earn at the peak of your professional dental career?

(check one)

a.____ under $10,000

b.____ $10,000 up to $15,000

c.____ $15,000 up to $20,000

d.____ $20,000 up to $30,000

e.____ $30,000 up to $40,000

f.____ $40,000 up to $60,000

g.____ $60,000 up to $100,000

* It may be that you feel "peak of career" and "10-15 years of practice" are the same time point.

In that case, merely check the same income categories for these last two questions as you did for the 10-15 year income questions, above.

APPENDIX D

Questionnaire Administered to N.Y.U. Medical Students

November, 1968

Dear N.Y.U. Medical Student:

The enclosed very short questionnaire is being given to all upperclassmen at the N.Y.U. Medical College. It has been seen and approved by both the Student Council of the Medical College and the Dean's Office (Dr. J.L. Potter, Associate Dean).

Your responses are part of a study of professional school students which I am conducting for my Ph.D. dissertation in Sociology at N.Y.U. I hope you will take the ten minutes to fill in this anonymous questionnaire.

Please drop it off as soon as possible at the Dean's Office, Room 164, of the Medical Science Building.

Thank you for your cooperation,

David Sternberg
Graduate Department of Sociology
New York University

1. What is your <u>father's occupation</u>? Please give (a) the title of his occupation and (b) a brief description of the specific activities of his job, if they are not self-evident from the title.

(a) Title of father's occupation _____

(b) Specific activities _____

_____

2. What is your national background? (for example, German-American, Italian-American, Jewish, Irish-American, etc.)

National background _____

3. How much would you say the <u>average physician starting out today</u> can expect to be earning per year <u>10-15 years from now</u>? *

(check one)

a. ____ under $10,000
b. ____ $10,000 up to $15,000
c. ____ $15,000 up to $20,000
d. ____ $20,000 up to $30,000
e. ____ $30,000 up to $40,000
f. ____ $40,000 up to $60,000
g. ____ $60,000 up to $100,000

4. How much would you estimate that <u>you yourself</u> will be earning per year as a physician when you've been out in practice <u>10-15 years</u>?

(check one)

a. ____ under $10,000
b. ____ $10,000 up to $15,000
c. ____ $15,000 up to $20,000
d. ____ $20,000 up to $30,000
e. ____ $30,000 up to $40,000
f. ____ $40,000 up to $60,000
g. ____ $60,000 up to $100,000

* Nowadays <u>speciality</u> practices are so common that you would certainly be justified, if you wanted to, in including speciality practitioners in your concept of the "average physician."

(continued on next page)

5. How much would you say the average physician starting out today can expect to earn per year at the peak of his professional career? *

(check one)

a.____under $10,000

b.____$10,000 up to $15,000

c.____$15,000 up to $20,000

d.____$20,000 up to $30,000

e.____$30,000 up to $40,000

f.____$40,000 up to $60,000

g.____$60,000 up to $100,000

6. How much do you yourself expect to earn at the peak of your professional medical career?

(check one)

a.____under $10,000

b.____$10,000 up to $15,000

c.____$15,000 up to $20,000

d.____$20,000 up to $30,000

e.____$30,000 up to $40,000

f.____$40,000 up to $60,000

g.____$60,000 up to $100,000

7. What elements determine how much any particular physician is respected in his community these days?

(Please check the statement which comes closest to your feelings)

a.____It depends primarily on the individual physician and the impression he makes.

b.____The physician's own skill and personality, on the one hand, and his membership in the medical profession on the other, play about equal parts.

c.____Regardless of a particular physician's skill and personality, the degree to which he's respected in his community is mostly determined by how people feel about the medical profession in general.

* It may be that you feel "peak of career" and "10-15 years of practice" are the same time point.

In that case, merely chekc the same income categories for these last two income questions as you did for the 10-15 year income questions, above.

BIBLIOGRAPHY

Abundant Living, Roanoke, Virginia, John H. Stokes, Editor.

The ACA Journal of Chiropractic, Des Moines, Iowa.

Adorno, T. W., Else Frenkel-Brunswik, Daniel J. Levinson, R. Nevitt Sanford, The Authoritarian Personality, New York: Harper and Brothers, 1950.

Akers, Ronald L., and Richard Quinney, "Differential Organization of Health Professions," American Sociological Review, 33 (February, 1968), pp. 104-121.

Allport, Gordon W., Pattern and Growth in Personality, New York: Holt, Rinehart and Winston, 1961.

Anderson, Dewey, The Present Day Doctor of Chiropractic, Washington: Public Affairs Institute, 1956.

Becker, Howard S., Blanche Geer, Everett C. Hughes, Anselm L. Strauss, Boys in White: Student Culture in Medical School, Chicago: The University of Chicago Press, 1961.

Becker, Howard S. and Blanche Geer, "Latent Culture: A Note on the Theory of Latent Social Roles," Administrative Science Quarterly, 5 (September, 1960), pp. 304-313.

Belleau, Wilfred E., Chiropractic as a Career, Milwaukee: Park Publishing House, 1966.

Bendix, Reinhard, Max Weber: An Intellectual Portrait, Garden City, New York: Doubleday and Co., Inc., Anchor Books Edition, 1962.

Bensman, Joseph, and Bernard Rosenberg, Mass, Class, and Bureaucracy, Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1963.

Berger, Peter L., Invitation to Sociology: A Humanistic Perspective; Garden City, New York: Doubleday and Company, Inc., 1963.

Bierstedt, Robert, The Social Order: An Introduction to Sociology (2nd Ed.), New York: McGraw-Hill Book Co., Inc., 1963.

Blau, Peter M., The Dynamics of Bureaucracy: A Study of Interpersonal Relations in Two Government Agencies (Rev. Ed.), Chicago: The University of Chicago Press, 1963.

Bloom, Samuel W., "The Sociology of Medical Education: Some Comments on the State of a Field," Milbank Memorial Fund Quarterly, 43 (April, 1965), pp. 143-184.

Blumberg, Abraham S., Criminal Justice, Chicago: Quadrangle Books, 1967.

Brim, Orville G., Jr., and Stanton Wheeler, Socialization After Childhood: Two Essays, New York: John Wiley and Sons, Inc., 1966.

Cahalan, Don, Patricia Collette, and Norman Hilmar, "Career Interest and Expectations of U. S. Medical Students," Journal of Medical Education, 32 (August, 1957), pp. 557-563.

Caplow, Theodore, Howard M. Bahr, and David Sternberg, "Homelessness," The International Encyclopedia of the Social Sciences (2nd Ed.), The Macmillan Company and The Free Press, 1968, pp. 494-499.

Caplow, Theodore, The Sociology of Work, New York: McGraw-Hill Book Co., 1964.

Chiropractic in California, Los Angeles: The Haynes Foundation, 1960.

The Chiropractic Institute of New York Bulletin, 1967-1969, published by the Chiropractic Institute of New York, New York City.

Cloward, Richard A. and Lloyd E. Ohlin, Delinquency and Opportunity, Glencoe: The Free Press, 1961.

Cohen, Harry, "The Demonics of Bureaucracy," unpublished Ph. D. dissertation, University of Illinois, 1962.

Columbia Institute of Chiropractic Alumni Newslatter, published by the Columbia Institute of Chiropractic, New York City.

The Columbia Institute of Chiropractic Bulletin, 1966-1968, published by the Columbia Institute of Chiropractic, New York City.

Columbia University Bureau of Applied Social Research, Staff Meeting, "Homelessness Project," February, 1967 (ditto).

Columbia University, College of Physicians and Surgeons Bulletin, 1967-1968, published by Columbia University, New York City.

The Columbian, 1967, published by Columbia Institute of Chiropractic, New York City.

Cooley, C. H., Social Organization, New York; Scribner, 1915.

Dalton, Melville, "Preconceptions and Methods in Men Who Manage," in Phillip E. Hammond (ed.), Sociologists at Work, New York: Basic Books, Inc., 1964.

Diamond, Solomon, Information and Error: An Introduction to Statistical Analysis, New York: Basic Books, Inc., 1959.

Dickerson, O. D., Health Insurance (Rev. Ed.), Homewood, Ill.: Richard D. Irwin, Inc., 1963.

The Digest of Chiropractic Economics, Detroit: Chiropractic News Publishing Co.

Dintenfass, Julius, Chiropractic: A Modern Way to Health, New York: Pyramid Books, 1966.

DuBois, Cora, "Some Psychological Techniques and Objectives in Anthropology," in Morton H. Fried (ed.), Readings in Anthropology, vol. 2, New York: Thomas Y. Crowell Co., 1959, pp. 45-58.

Faulkner, Edwin J., Health Insurance, New York: McGraw-Hill Book Company, Inc., 1960.

Fishbein, Morris, The Medical Follies, New York: Boni and Liveright, 1925.

Follman, J. F., Jr., Medical Care and Health Insurance, Homewood, Ill.: Richard D. Irwin, Inc., 1963.

Fox, Renee C., "Training For Uncertainty," in Robert K. Merton, George Reader, and Patricia L. Kendall (eds.), The Student-Physician: Introductory Studies in the Sociology of Medical Education, Cambridge: Harvard University Press, 1957, pp. 207-241.

Francis, Roy G., and Robert C. Stone, Service and Procedure in Bureaucracy, Minneapolis: University of Minnesota Press, 1956.

Freeman, Howard E., Sol Levine, and Leo G. Reeder, "Present Status of Medical Sociology," in Howard E. Freeman, Sol Levine, and Leo G. Reeder (eds.), Handbook of Medical Sociology, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963, pp. 473-491.

Freidson, Eliot, "The Organization of Medical Practice," in Howard E. Freeman, Sol Levine, and Leo G. Reeder (eds.), Handbook of Medical Sociology, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963, pp. 299-319.

Friedmann, Eugene A., and Robert J. Havinghurst, The Meaning of Work and Retirement, Chicago: University of Chicago Press, 1954.

Friend, Solomon H., "Economics of Government Control and the Healing Arts," The Digest of Chiropractic Economics, 10 (September-October, 1967), pp. 26-30.

Gellman, Irving Peter, The Sober Alcoholics: An Organizational Analysis of Alcoholics Anonymous, New Haven: College and University Press, 1964.

Goffman, Erving, Asylums: Essays on the Social Situations of Mental Patients and Other Inmates, Garden City, New York: Doubleday and Company, Inc., 1961.

_____, "On Cooling the Mark Out," in Arnold Rose (ed.), Human Behavior and Social Processes, Boston: Houghton-Mifflin Co., 1962, pp. 482-505.

Goffman, Erving, Stigma: Notes on the Management of Spoiled Identity, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963.

Gold, David, "Statistical Tests and Substantive Significance," The American Sociologist, 4 (February, 1969), pp. 42-46.

Guilford, J. P., Fundamental Statistics in Psychology and Education (3rd Ed.), New York: McGraw-Hill Book Company, 1956.

Healthways, Des Moines, Iowa: The American Chiropractic Association.

Hendin, Herbert, Suicide and Scandinavia, New York: Grune and Stratton, Inc., 1964.

Higley, Henry G., "Chiropractic Licentiates in the United States, American Chiropractic Association (ACA) Journal of Chiropractic, 5 (January, 1968), pp. 20-22.

Hodge, Robert W., Paul M. Siegel, and Peter H. Rossi, "Occupational Prestige in the United States, 1925-1963," American Journal of Sociology, 70 (November, 1964), pp. 290-292.

Hughes, Everett C., Men and Their Work, Glencoe: The Free Press, 1958.

Inkeles, Alex, What is Sociology?, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1964.

International Review of Chiropractic, Davenport, Iowa: International Chiropractors Association.

Irwin, John, and Donald R. Cressey, "Thieves, Convicts and the Inmate Culture," Social Problems, 10 (Fall, 1962), pp. 142-155.

Kahl, Joseph A., The American Class Structure, New York: Holt, Rinehart and Winston, 1957.

Korn, Richard R., and Lloyd W. McCorkle, Criminology and Penology, New York: Holt, Rinehart and Winston, 1960.

Laws of New York, Chapter 780, Article 132 (chiropractic law of New York State).

Lehner, George F. J., "Personal Adjustment Scores and Assigned Average Scores," Journal of Psychology, 42 (October, 1956), pp. 227-236.

_____, "Some Relationships Between Scores For Self and Projected 'Average' Scores on a Personality Test," The American Psychologist, 4 (September, 1949), p. 390.

Leis, Gordon, "The Transformation From a Healing Cult to a Profession: The Changing Place of Chiropractic Among the Healing Arts," a doctoral dissertation proposal in the Department of Sociology, State University of New York at Buffalo, March, 1966 (Xerox).

Levine, Mortimer, "The Scope of Chiropractic Practice," The ACA Journal of Chiropractic, 2 (February, 1965), pp. 24 and infra.

MacIver, Robert M., and Charles H. Page, Society: An Introductory Analysis, New York: Holt, Rinehart and Winston, 1961.

McClusky, Thorp, Your Health and Chiropractic, New York: Pyramid Books, 1962.

McNemar, Quinn, Psychological Statistics (3rd Ed.), New York: John Wiley and Sons, Inc., 1962.

Merton, Robert K., Social Theory and Social Structure (Rev. Ed.), Glencoe: The Free Press, 1957.

_____, "Some Preliminaries to a Sociology of Medical Education," in Robert K. Merton, George Reader, and Patricia L. Kendall (eds.), The Student-Physician: Introductory Studies in the Sociology of Medical Education, Cambridge: Harvard University Press, 1957, pp. 3-79.

Miller, Perry, The New England Mind: From Colony to Province, Boston: Beacon Press, 1961.

Montagna, Paul D., "Bureaucracy and Change in Large Professional Organizations: A Functional Analysis of Large Public Accounting Firms," unpublished Ph. D. dissertation, New York University, 1967.

More, D. M., Nathan Kohn, Jr., "Some Motives For Entering Dentistry," in Howard M. Vollmer and Donald L. Mills (eds.), Professionalization, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1966, pp. 81-87.

New, Peter, "The Application of Reference Group Theory Shifts in Values; The Case of the Osteopathic Student," unpublished Ph. D. dissertation, University of Missouri, 1960.

New York Medical College Bulletin, 1967-1968, published by New York Medical College, New York City.

Niederhoffer, Arthur, Behind the Shield: The Police in Urban Society, Garden City, New York: Doubleday and Company, Inc., 1967.

Oppenheim, A. N., Questionnaire Design and Attitude Measurement, New York: Basic Books, Inc., 1966.

Oromaner, Mark J., "A Study of Students Entering a Marginal Profession," The Journal of Clinical Chiropractic, 1 (January, 1968), pp. 43-55.

Palmer, D. D., The Chiropractor's Adjuster: A Textbook of the Science, Art, and Philosophy of Chiropractic for Students and Practitioners, 1910. Republished by the National Chiropractic Association, 1949.

The Palmer College of Chiropractic Bulletin, 1967-1968, published by the Palmer College of Chiropractic, Davenport, Iowa.

Plasek, Wayne, "Interaction Patterns and Attitudes Change: A Study of Professional Socialization," unpublished Ph. D. dissertation, University of California at Los Angeles, 1967.

Polsky, Howard W., Cottage Six: The Social System of Delinquent Boys in Residential Treatment, New York: Russel Sage Foundation, 1962.

Quarantelli, Enrico L., "The Dental Student: A Social Psychological Study," unpublished Ph. D. dissertation, University of Chicago, 1959.

Raven, Bertram, and Martin Fishbein, "Social Referents and Self-Evaluation in Examinations," Journal of Social Psychology, 65 (February, 1965), pp. 88-99.

Riley, Matilda White, Sociological Research: A Case Approach, vol. 1, New York: Harcourt, Brace and World, Inc., 1963.

Rogoff, Natalie, "The Decision to Study Medicine," in Robert K. Merton, George Reader, and Patricia L. Kendall (eds.), The Student-Physician: Introductory Studies in the Sociology of Medical Education, Cambridge: Harvard University Press, 1957, pp. 109-129.

Rosen, Bernard C., and Alan P. Bates, "The Structure of Socialization in Graduate School," Sociological Inquiry, 37 (Winter, 1967), pp. 71-84.

Rosenberg, Morris, Occupations and Values, Glencoe: The Free Press, 1957.

Roth, Julius, Timetables: Structuring the Passage of Time in Hospital Treatment and Other Careers, Indianapolis: Bobbs-Merrill, 1963.

"Scope of Chiropractic Practice in the United States," Department of Investigation, The American Medical Association, 1966.

Selltiz, Claire, Marie Jahoda, Morton Deutsch, and Stuart W. Cook, Research Methods in Social Relations (Rev. Ed.), New York: Holt, Rinehart and Winston, 1962.

Seufert, P. J., "Should Chiropractic Die?", Herrschaft Publications, Brooklyn, no date.

Sherlock, Basil J., and Richard T. Morris, "The Evolution of the Professional: A Paradigm," Sociological Inquiry, 37 (Winter, 1967), pp. 27-46.

Sibley, Elbridge, The Education of Sociologists in the United States, New York: Russel Sage Foundation, 1963.

Siegel, Sidney, Nonparametric Statistics: For the Behavioral Sciences, New York: McGraw-Hill Book Company, 1956.

Simmons, J. L., "On Maintaining Deviant Belief Systems: A Case Study," Social Problems, 11 (Winter, 1964), pp. 250-256.

Simpson, Ida Harper, "Patterns of Socialization in Professions: The Case of Student Nurses," Sociological Inquiry, 37 (Winter, 1967), pp. 47-54.

Sklare, Marshall (ed.), The Jews: Social Patterns of An American Group, Glencoe: The Free Press, 1958.

Smigel, Erwin O., The Wall Street Lawyer: Professional Organization Man?, Glencoe: The Free Press, 1964.

Smith, Ralph Lee, "Chiropractic: Science or Swindle?", Today's Health, May, 1965.

Sourcebook of Health Insurance Data, New York: Health Insurance Institute, 1965.

Sykes, Gresham, The Society of Captives, Princeton: Princeton University Press, 1958.

Taylor, Lee, Occupational Sociology, New York: Oxford University Press, 1968.

"The Chiropractor - A Study in Depth," The ACA Journal of Chiropractic, 4 (March, 1967), pp. 10-11.

Thielens, Wagner, Jr., "Some Comparisons of Entrants to Medical and Law School," in Robert K. Merton, George Reader, and Patricia L. Kendall (eds.), The Student-Physician: Introductory Studies in the Sociology of Medical Education, Cambridge: Harvard University Press, 1957, pp. 131-152.

_____, "The Socialization of Law Students: A Case Study in Three Parts," unpublished Ph. D. dissertation, Columbia University, 1965.

Turk, Herman, "An Inquiry Into the Undersocialized Conception of Man," Social Forces, 43 (May, 1967), pp. 518-521.

United States Department of Health, Education, and Welfare, Title 19 - Activities of the 54 Jurisdictions to Put Into Effect the New Medical Assistance Program, as of January 31, 1969 (Xerox).

United States Department of Labor, Occupational Outlook Report Series, 1968-1969, Bulletin No. 1550-17, Employment Outlook for Chiropractors.

_____, Bulletin No. 1550-66, Employment Outlook for Physicians.

_____, Bulletin No. 1550-24, Employment Outlook for Dentists.

Voice for Health, Atlanta: National Health Education Society.

Vollmer, Howard M., and Donald L. Mills (eds.), Professionalization, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1966.

Wardwell, Walter I., "A Marginal Professional Role: The Chiropractor," Social Forces, 30 (March, 1952), pp. 339-348.

_____, "Limited, Marginal, and Quasi-Practitioners," in Howard E. Freeman, Sol Levine, and Leo G. Reeder (eds.), Handbook of Medical Sociology, Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963, pp. 213-239.

_____," Social Strain and Social Adjustment in the Marginal Role of the Chiropractor," unpublished Ph. D. dissertation, Harvard University, 1951.

_____, "The Reduction of Strain in a Marginal Social Role," American Journal of Sociology, 61 (July, 1955), pp. 16-25.

Webb, Eugene J., Donald T. Campbell, Richard D. Schwartz, and Lee Sechrest, Unobtrusive Measures: Nonreactive Research in the Social Sciences, Chicago: Rand McNally and Company, 1966.

Weber, Max, "The Market," in Talcott Parsons, Edward Shils, Kaspar D. Naegele, and Jesse R. Pitts (eds.), Theories of Society, Glencoe: The Free Press, 1961, vol. 1, p. 443.

Wilensky, Harold L., "The Professionalization of Everyone?", American Journal of Sociology, 70 (September, 1965), pp. 137-158.

Williams, Robin M., Jr., American Society: A Sociological Interpretation (2nd Ed., Rev.), Alfred A. Knopf, 1961.

Wrong, Dennis H., "The Oversocialized Conception of Man in Modern Sociology," American Sociological Review, 26 (April, 1961), pp. 187-193.