PHYSIOTHERAPY WISE

DAVID A. NICHOLLS
FOREWORD BY BARBARA GIBSON

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Physiotherapy Otherwise

David A. Nicholls

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For Irene Elizabeth Nicholls

The boundary lines have fallen for me in pleasant places; I have a goodly heritage (Psalm 16:6)

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Acknowledgements

Michael K. Bourdaghs made a very good point in the Acknowledgements to his latest book *A Fictional Commons* when he said that;

> *'Recent decades have brought an alarming bloat to the acknowledgement section of scholarly books: what used to be a tidy paragraph now often spills across several pages. And like the interminable end credits of recent Hollywood blockbusters, nobody actually reads through them anymore — except to scan to see if their own name is included. At least, that is what I do. I have a real fondness for older films that simple conclude, "The End," so I will keep things short and simple. More than likely, your name will not appear. Please do not interpret that as a sign of ingratitude: I am profoundly thankful to many, many colleagues, friends, and antagonists'.*

So, in that spirit, I will simply state that although many people have contributed to this book, I'd like to convey special thanks to Sarah Barradell, Wenche Bjorbækmo, Cath Conn, Tone Dahl Michelsen, Clair Hebron, Richard Horwood, Paul Lagerman, Matt Low, Filip Maric, Anna Rajala, Michael Rowe, Emma Stokes, Tobba Therkildsen Sudmann, Dave Walton, Joost van Wijchen, and Adriane Vieira, for their generosity, enthusiasm, and wisdom.

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But special mention needs to go to my wife Sue, my son Tom, my daughter Ali, my mom Irene, and brother Jon. These people have seen the travails of long-form writing at close quarters. I can't thank them enough for their love and support.

Notes on the cover image

'Group' by Melissa Schriek.

Melissa Schriek is a Dutch photographer, who graduated from the Royal Academy of Art in 2018. Her work explores the relationship between individuals and their environment through movement and gesture. The work is often created with a performative approach, aesthetically and conceptually exploring the border between staged and documentary photography.

The women in the cover photograph are part of a dance group that Melissa photographed for her latest project. The photo is made on a roof of a parking lot in the centre of Amsterdam. Melissa wanted the women's clothes to look the same so that it would be difficult to tell whose arms and legs belonged to whom; to look like they are in a knot. The women are becoming one by being so close that their own bodies are intertwined, but it is also clear that this is a struggle. They are not perfectly fitted and it they could be fighting for their own space. The image touches on the idea of the subject: what it is to be an individual, group dynamics, and the power of touch and movement.

www.melissaschriek.com

Foreword

It is an exciting time in the evolution of critical physiotherapy studies. Although physiotherapy is relatively late to the critical studies table, amongst the health professions it is, in many ways, leading the field. This is in a large degree due to the efforts of Dave Nicholls who, with the writing of this book, has once again challenged and invigorated physiotherapy by taking seriously the critical mantra of 'things could be otherwise'. I have had the privilege of collaborating with Dave on a number of projects over the last decade, including our first paper together, The Body and Physiotherapy (2010), and the 2018 edited collection Manipulating Practices: A Critical Physiotherapy Reader. Through this work, I have had a front row seat to observe how Dave combines an impressive command of diverse social theories to re-think and move physiotherapy in exciting new directions. Through both his scholarship and his leadership of the international Critical Physiotherapy Network, Dave has articulated a clear vision to work towards a more positive, inclusive, and critical future for physiotherapy and has done so by bringing together like-minded scholars and clinicians from around the globe. Ultimately it is those who seek out physiotherapy services who will benefit most from this innovative work. This latest book is no exception.

Physiotherapy Otherwise is a treasure trove of provocations designed to challenge and disrupt the philosophical moorings of physiotherapy and healthcare more broadly. As an invitation to think and do differently, the text extends an argument that Dave began in his previous book The End of Physiotherapy in which he provided a critical history of the physiotherapy profession and sketched a series of challenges facing contemporary practitioners. In Physiotherapy Otherwise, Dave addresses these challenges by extensively engaging with the sociology of the professions to make a case for a radical rethinking of the profession. The book is ground-breaking in its scope, providing an unprecedented deep dive into how physiotherapy emerged as a profession, its blind spots, and its future. I suspect the book will unnerve some readers, but this is to its credit. Dave seeks to radically challenge thinking as usual, and in this respect he more than succeeds. What struck me most in reading the text was the sheer depth and breadth of the different knowledges Dave deploys in order to delineate a contemporary crisis in the health professions and the implications for the future of physiotherapy. Extensively referenced, the text systematically engages with diverse theories to provide a rich and detailed accounting of this crisis and culminates with a manifesto for 're-enchanting physical therapy. This is unprecedented in our profession and is such a gift.

Arguably the role of critical work is problem-producing rather than problem-solving and Dave navigates this well. By conceptualizing the physiotherapy profession in unprecedented ways, he conjures new problems that can catalyze change. Without getting into the specifics, the future of physiotherapy that Dave proposes requires significant reform within and outside of the profession. My engagement with the text and agreement with the need for radical reforms raised a number of questions for me. Given that the future Dave envisions is unlikely to be realized in the short term, what can physiotherapists do today to begin addressing the problems he outlines? How can we begin the work of re-enchanting physiotherapy and the physical therapies? How can the neoliberal/managerialist straight-jacketing of healthcare that we find ourselves in be opened up? The text provides several points of departure for considering these questions and, as Dave says,

'intensifying the physical therapies, and re-enthusing our practice'. My own modest suggestion for starting this work is the adoption of an 'ethics of openness' in the doings of physiotherapy. The more narrowly physiotherapy is conceived the more limited and limiting it will continue to be. An ethics of openness is an invitation for creative experimentation in the doings of everyday work. What do we take for granted as good, right, and true in our teaching, research, or clinical care? How could things be otherwise? Even small acts of inspired tinkering can be revolutionary.

The radical changes that Dave advocates entail giving up all the acts of bordering that limit the profession and what it can do. For example, shifts are needed in all the ways physiotherapy works to normalize bodies to the exclusion of other ways of understanding disability. Such open-ended work requires a deep humility, comfort with discomfort, and understanding the unwitting harms and exclusions that might be perpetuated by thinking as usual. An affirmative embrace of radical reform resists closure in all its forms and continually questions not only what we do but the basic 'truths' underpinning of our work. To do so, physiotherapists must more directly engage with all the obvious and hidden forces, assumptions, and systematized inequalities that pervade contemporary healthcare. Our collective ethical task, that Dave so eloquently reminds us, is to 'secure the best possible physical therapies for people, even if this is at the detriment of the physiotherapy profession's own power and prestige'. This should be an exciting rather than disagreeable task, and for me is the crux of the tremendous affirmative message in Dave's astonishing book. Viva la Revolución!

Barbara E. Gibson
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1. Introduction

What this book sets out to do — Why we need more social theory in physiotherapy — A brief primer on the sociology of the professions — Sociology currently in physiotherapy — Closing words

Most people living in high-income countries are now so familiar with the idea of professions that it would be hard to imagine life without them. Imagine what life might be like without lawyers, doctors, architects, and plumbers. And yet, professions as we know them today are a relatively recent invention. They prosper mostly in affluent countries with large urban populations, but even here they are only one of a number of different ways of organising society. Given this, the professions have achieved extraordinary levels of privilege over the last 150 years, with medicine being the paradigm case. Physiotherapy[1] is not far behind though. With three quarters of a million practitioners worldwide, access to protective legislation, subsidised training and practice, physiotherapy is a model of a modern health profession.

The story of how physiotherapy arrived at this point in its history was the subject of *The End of Physiotherapy* (1), and this book focused on a critical history of the profession. But there is another story to be told about physiotherapy that is becoming pressingly important, and it draws on an entirely new body of literature known as the sociology of the professions. When I say *new*, I mean new to physiotherapists. Because, search as you might, you will find very few references to the material presented in this book in the physiotherapy literature, even though it explores subjects that are at the very heart of the profession's contemporary issues and challenges.

This book, then, is an analysis of physiotherapy through the lens of the sociology of the professions. It explores what the professions are, what they do in society, what's good about them, and what's bad. It applies these ideas to physiotherapy so that we can better understand the issues the profession is now facing. And the book concludes with some challenging and, some might say, heretical recommendations for where physiotherapy goes next, as we all adapt to the post-professional era.

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[1] I use the term physiotherapy throughout the book to refer to the discipline and professional body. I have done this to reserve the terms physical therapy for the action of performing the physical therapies. In this book, my argument is based on the principle that anyone can perform the physical therapies, but only recognised members of the profession enclosure can be physiotherapists. The physical therapies refer to those practices of therapeutic touch, mobilisation and manipulation; forms of movement and exercise used for health; as well as the use of various therapeutic agents like heat and cold, electromagnetism, water and light, that have been part of human civilisation since the dawn of humanity.

What this book sets out to do

Although I had a classical physiotherapy training in the applied sciences, patient assessment and treatment, I've been teaching, researching, and using sociological ideas for more than 30 years. Over that time, I've often been struck by how useful sociological theories can be for thinking through all sorts of physio-related issues. But I'm also frequently reminded how few physiotherapists know about concepts like the sick role, wage slavery, social capital, and the division of labour. I suspect that many of my colleagues would know much more about Rob McKenzie than Judith Butler. This is no slight on Rob McKenzie, but Butler and countless other social theorists of the last century have important things to tell physiotherapists too.

I believe physiotherapy's lack of interest in sociology derives both from the way our forebears set up the profession to focus on treating the body-as-machine, and from the social events that shaped physiotherapy in the last century. I unpacked these arguments at length in *The End of Physiotherapy* (forthwith, *EoP*). But to briefly summarise: the profession of physiotherapy was born from an attempt to legitimise touch, and most of the major events of the 20th century have helped it to bolster its claim to be an orthodox ally to the medical profession and the state. Nothing required physiotherapists to challenge their biomechanical principles until the economic crisis of the 1970s. But since then, the profession has been racing to keep up with the rapid pace of social change, widespread disruptions in our healthcare systems, changing public attitudes towards authority and control, changing lifestyles, globalisation, the information revolution, and free-market neoliberal competition[2].

And so, over the last half century, physiotherapists all over the world have been exploring ways to move beyond the body-as-machine, whilst not betraying the idea of what it means to be a physiotherapist. But we are trying to change our culture without cultural studies, and adapt to changing society without sociology. This book attempts to partially remedy this situation by bringing the sociology of the professions to our thinking about physiotherapy's future.

Physiotherapy is certainly not the first health profession to do this, but neither is it the last, and we can now draw on decades of work, especially from the sociologies of medicine and nursing. The field has become diverse, but also reasonably clearly divided into distinctive schools of thought. Which means we now have the luxury of being able to examine the different perspectives and see what they can tell us about physiotherapy theory and practice.

I have three main goals in writing this book, then. Firstly, like *EoP*, I want to continue the project of 'diagnosing' physiotherapy; to understand the conditions that make it possible as a unique and specific professional entity. Karl Marx said that sociology was secondary only to history in its ability to diagnose how ideas emerge and change. So, if *EoP* was historical, this should be sociological. Given that the profession has no founding mythology around a hero like Florence Nightingale or Robert Koch; that it relied on no invention to bring it to life (unlike radiography, for instance); and is based on techniques that have been performed in thousands of different ways, across all civilisations, for millennia, the book attempts to understand how physiotherapy has maintained its dominance as a discrete professional entity.

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[2] For a more comprehensive discussion of these changes and how they are influencing physiotherapy, read Chapter 5 of EoP.

Secondly, I have written the book as a way into the sociology of the professions for physiotherapists who have little or no experience of these ideas. Over the course of the next few chapters, I will discuss some of the main ways sociologists have understood the professions over the last 100 years. My hope is that this equips readers with some tools to undertake their own diagnostic work in the future.

And thirdly, I want to use the different theories in the book to suggest a way forward for the profession. So, even though social theories cannot tell us what to do, nor 'be applied mechanistically to generate 'an' answer' (2), they can still give us strong pointers to guide our thinking and practice. Because of my preference for postmodern thinking, I always prefer to hold on to what Diderot called an 'attitude of incredulity', and open space to alternative ideas, rather than suggest *a* way forward. The recommendations made throughout the book are responses to the different theories, and can be taken up according to the reader's own context.

The fundamental conclusions I arrive at will, no doubt, challenge some people. Which is why I have tried to construct the recommendations throughout the book with the utmost care. Sarah Barradell, writing recently about the concept of professional stewardship, said that 'being a caring professional is a different practice to that of caring for the profession' (3). Stewardship means having 'a critical understanding of the historical foundations of the discipline', acting 'in unconventional ways to create new knowledge and ideas', and having the will and the flexibility 'to act in unconventional ways to translate new ideas into new fields' (ibid). I have done my best to honour these principles here. Being a writer on one's profession means always having what Thomas Jefferson called 'vigilant and distrustful superintendence' (4).

And finally, a brief word about the style and language in the book. We are often told that physiotherapists are pragmatic people who trade in practical advice and workable solutions. If this is true, then Sarah Barradell is right when she warns that physiotherapists will often 'not appreciate the importance of thinking about their larger purpose and how they might participate in shaping the profession's future in the ways that globalised societies require' (3). But physiotherapists are also highly educated, intelligent, and thoughtful people, who use theories and ideas every day in their practice. So, I am confident that although the book might require slow, deliberate reading at times, and its themes and ideas may be new to many and provocative to most, its utility will soon become clear. In fact, the practical application of the ideas in the book may well prove to be the most challenging aspect of all. Because although there are many complex and difficult sociological ideas in here, it will almost certainly be the way they lead to my conclusions that will cause readers the most consternation. More on this shortly, though. Firstly, we should establish why physiotherapists need social theory at all.

Why do we need more social theory in physiotherapy?

Perhaps the first thing to establish is that the kinds of sociology this book deals with bears little resemblance to the kinds of 'social' questions physiotherapists ask in their patient assessments. We are not talking here about whether the patient is currently working, whether they live alone, or whether they have stairs at home. Nor are we talking about the kinds of social factors that are frequently confused for behaviours, cognitions, learning, or personal experiences. This is very common in the recent physiotherapy literature on the biopsychosocial model, for example, where

personal attitudes, beliefs, and emotions are called 'social' because they place abstract psychological concepts into the real world. But they are still fundamentally psychological constructs.

The kind of sociology we are dealing with here concerns a very different set of principles. Its interest is in social groups, and individuals within groups. It sees reality as constructed by groups. Health and illness are seen as social constructs, not as a biological reality or the expression of an individual mind. Sociologists are interested in the way language constructs reality, and the social structures and forces that shape who we are, what we can say and do. And, in the context of this book, they are interested in what makes institutions like the professions socially possible. Their focus is on professional power and boundaries; the role of professions in enhancing social order or acting as governmental arms of the state; concepts like work, encroachment, and wage slavery; and debates around the future of all professions in the new industrial revolution.

From a sociological perspective, then, the first reason why physiotherapists should have at least some understanding of social theory, is because physiotherapy is an entirely social construct. It is not a physical object like a pen or a cup. You cannot pick it up and put it in your pocket. It is an idea, created by people and 'performed' every day based on a set of loosely agreed social conventions. Physiotherapy is what Jason Turner called a 'folk institution' (5); a part of the apparatus of society, and one that is no more fixed and immutable than football or the weather. As with all professional practices, physiotherapy 'is a social phenomenon', and 'is inherently situated and temporally located in local settings, lifeworlds and systems' (6).

Because it is a social construct, it takes a lot of artifice, cunning, and hard work to corral a diffuse collection of concepts, strategies, practices, customs, beliefs, and objects about health and the body, medicine, disease and disability, movement and function, never mind people, and mould them into a coherent whole and call it a profession. Physiotherapy is a social construct in the same way that medicine, work, health, and gender are. And far from being a stable constant, the profession's identity is in perpetual motion, with the changing ways its supporting concepts deform and reform. It is different today to the way it was yesterday, and it is different here than it is over there.

The fluidity of the profession is only one dimension to be considered, though because there are also many different ways to understand the professions sociologically. There are schools of thought that see the professions as institutions bringing order to society (functionalism); as the product of industrial capitalism (Marxism), or entrenched gender relations (feminism); as the product of territorial disputes (neo-Weberianism), or as the positive result of circulating power relations (postmodernism). Symbolic interactionists see the professions as formed in the relationships between people in society, and critical realists aim to strike a balance between social structures and professional 'agency'[3]. Each of these has something interesting to say about physiotherapy, and we will look at them all shortly.

Social theories are particularly useful ways to understand the professions because they challenge some of the mythologies that the professions themselves have constructed. For instance, most professions promote the idea that their history has been one of gradual progress from struggle and strategic alliance, to maturity and autonomy. Over the last century, sociologists have shown that this is a fiction created by the professions themselves, as a necessary part of demonstrating that they are 'true' professions (more on this in Chapter 2). But few sociologists subscribe to this view any more.

[3] Agency in sociology refers to the ability of individuals or groups to act independently and make their own decisions. It is often contrasted with the idea of 'structure', which refers to conditions that shape what people can think and do. These ideas will be unpacked in much more detail later in the book.

Rather than the authors of their own professional destinies, sociologists see the professions as the outcome of social forces. Societies *make* the professions, not the other way around. This conceptual shift is important because it helps us think differently about the pressures now being faced by professions like physiotherapy. If professions are the 'effect' of social change, then their future will depend on their ability to understand the social forces that shape them. And it will be hard to do this without a reasonable understanding of social theory.

Sociology can be useful, for instance, in explaining why it was that the professions emerged in the first place. Because not only the health professions, but *all* of the professions are all quite recent social inventions. The health professions, as we know them today, have really only existed for just over a century. So, for the vast span of human history, societies have tended to people's health and illness, injury and rehabilitation, without any recourse to an expert, specialist, or regulated practitioner. Linda Jones puts it this way;

> *'In most of the Western world the healthcare system as we know it today — with its biomedical focus, its hierarchy of training health professionals and complex primary, secondary and tertiary facilities for cure and care — came fully into being only in the 20th century. In Britain some health occupations, such as health visiting, only came into existence after 1900, and the idea of a national, coordinated service to treat illness was a product of the 1940s. The notion of a single medical 'profession', with a virtual monopoly of medical practice, dates from the later 19th century in Britain; the USA monopoly status for doctors came much later. It was only in the 1880s that 'germ theory' began to be accepted, and it took another 30 years for it to become the orthodox way of thinking about disease among professional health workers in Europe. Finally, it was about 200 years ago in the West that people began to think about bodies as collections of discrete cells and membranes rather than mainly undifferentiated 'flesh' and organs. In other words, the ways of thinking about and organising healthcare that we take for granted are actually quite 'new' and distinctive* (7).

It follows then that if the professions are a relatively recent social construct, we should ask: why they came into existence at all, and why now? As Albert Schütz argued in 1946, 'Knowledge is socially distributed and the mechanism of this distribution can be made the subject matter of a sociological discipline' (8). What is more, the professions are only one of a number of ways of organising society and getting things done. People have organised things like healthcare, education, law and order, food production, labour, leisure, building, faith, finances, and government, in all sorts of ways around the world over the last 12,000 years, and only the smallest fraction of this work has involved professionals. So, we should ask how, of the thousands of different ways the physical therapies could have manifested over the last century or so, did we arrive at a point where a profession like physiotherapy has an effective monopoly over the orthodox provision of physical rehabilitation services in many high-income countries around the world? How is it possible that a group of practitioners, with relatively modest claims to therapeutic efficacy, can become the world's third-largest profession allied to medicine; have 650,000 registered practitioners; have its status entrenched in law, and receive substantial subsidies for training and practice; and have secured enormous social prestige?

The answers to questions like these have proven elusive not only to physiotherapists, but to most professionals in the past. Part of the problem is that our professions are often so familiar to us that we struggle to be objective. Katherine Shepard and her co-researchers found this in their 1999 paper *Describing expert practice in physical therapy* (9). The team undertook an enormous eight-year study into

the theoretical frameworks underpinning physiotherapy, but it took three non-physiotherapy 'consultants' to show them that they were taking some of the most obvious things for granted;

> *'… Because it was so obvious to us as physical therapists what the experts were actually doing with the patients, such as performing mobilisation techniques teaching functional activities, we simply forgot to record and speak to movement and task data. Because our consultants are from outside the field of physical therapy, what we saw the physical therapists doing with the patients on videotape was new and quite fascinating to them, and they immediately pointed out what we have missed'* (9).

Canadian physiotherapist and educator Dave Walton found something similar in his 2018 Canada-wide study of therapists' perceptions of the profession. Walton's data indicated that physiotherapists had been learning, practicing, and thinking in much the same way for decades, but had almost no understanding why (10). The physiotherapists in the study did not really know what physiotherapy *was*, which is strange because in *EoP* I argued that the profession is actually based upon some very straightforward principles. And quite obviously the principles that underpin physiotherapy must — at least on a tacit level — be understood by members of the profession because physiotherapy practice around the world shows remarkable internal consistency. So, there must be at least *some* understanding of what defines our physiotherapy-ness. What Dave Walton's work shows, then, echoes one of the key findings of *EoP*: that the true nature of the profession eludes physiotherapists because most practitioners are never given the tools to know how to make sense of it.

The absence of a firm appreciation for the way physiotherapy is socially constructed has led many to overstate the profession's distinctiveness, and has underpinned the drive for greater professional autonomy. In a recent article asking *What Is Physiotherapy, and Where Are We Heading?*, Tori Smedal and Bente Elisabeth Bassøe Gjelsvik suggest that; 'A person seeks the expertise of a physiotherapist because he/she has experienced a negative change in body function and thereby the ability to use his/her body as before, leading to functional challenges for movement control and activity' (11). Whilst this seems a reasonable explanation of contemporary physiotherapy, it does overstate the power of physiotherapists in determining how people act in society. It seems to suggest that "people come to me because I'm skilled and knowledgeable in certain things", which may be true on one level, but it also ignores the many *other* reasons why people engage a physiotherapist. Perhaps they were referred by a doctor or insurer, or because it was a physiotherapist that appeared at their bedside in hospital, or because they had the nicest website, were the nearest person to the patient's home, or were the only practitioner available this week? Thinking about healthcare from a profession-first perspective undermines our claims to be person-centred. It encourages physiotherapists to think that professional progress entails greater autonomy and separation, rather than collaboration and social activism. And it perpetuates a myth that the profession is in control of its own destiny. My contention is that a good understanding of social theory would make this kind of solipsistic thinking less likely.

This mythology encourages physiotherapists to believe their profession *should* have a singular, coherent, and uniform identity. But this can lead to frustration when we realise that, try as we might, we cannot put our finger on exactly what the profession *is*, and that it is much harder to capture than we first thought. We know physiotherapy is not fully evident in a lot of our research because much of that is devoted to testing discrete aspects of practice, rather than physiotherapy as a concept. And we know it is not in our textbooks because so often real practice defies simple explanation. It is not in the school curricula because we know that many people have to do a lot of work after they graduate to *become* deliberate and effective clinicians. And it is not in our scopes of practice or the definitions

offered by our professional bodies because these only speak about physiotherapy in the most generic terms. We might say it is in the hands and the stories of the therapists themselves, but very few personal accounts of physiotherapy have ever been written, and translating the non-verbal work of therapy is often impossibly hard. So, where is this 'physiotherapy' to be found?

The reality is that physiotherapy resides in all of these places, and more besides; too many perhaps to comprehend with the tools that physiotherapists are currently equipped with. What we need are approaches that are designed to help us understand physiotherapy as it is in real life; occupying multiple social settings, and constructed by myriad forces and individuals across many different locations, all at the same time. But while the kind of scholarship needed to develop this level of understanding has been lavished on medicine in the past, much less attention has been paid to the professions *allied* to medicine. As Jonathan Gabe suggested about nursing; 'there has been much less consensus among sociologists, and perhaps in society generally, about… the validity of nursing's claim to be a profession' (12). But even the literature on the sociology of nursing looks like a vast treasure trove by comparison with the handful of studies exploring the sociology of physiotherapy.

This would be less concerning, perhaps, if physiotherapists didn't at the same time claim a grand social mandate. But when organisations like the American Physical Therapy Association claims that their vision is for the profession to '*transform society*' (13), and play 'an important role in supporting, maintaining and enhancing the physical activity level for better health on individual, group *and societal levels*' (14), one would assume such claims were accompanied by a strong social theory. But this is not the case.

Historically, physiotherapists have been reluctant to think of their profession as a fundamentally social entity, anxious, perhaps, not to stray too far from a focus on the body of the person in front of them. Edgar Burns suggests this is common among other Anglo-American professionals, who have often sought 'to bracket out the statutory space created for them and within which they enjoy significant privileges' (15). Physiotherapists certainly aren't alone in being highly dependent on the patronage of powerful elites, like the medical profession and the state, whilst at the same time claiming to be autonomous. And physiotherapists are certainly not the only health professional claiming to be innately apolitical and asocial.

Given all the debates about the subordination of nursing knowledge and the gendering of caring, for instance, one could be forgiven for thinking that the nursing profession would be steeped in political rhetoric. But a number of authors have argued that the social dimensions of nursing rarely extend beyond the physical aspects of patient care and patient's home surroundings (16). In a study led by Iben Munksgaard Ravn into the visual representations of nursing in Norwegian and Danish journals, the authors showed that there was a 'tendency in the nursing and research literature to represent nursing as an unchanging phenomenon untouched by developments in society and politically decontextualised' (17). This sentiment echoes the work of other nursing sociologists who have argued that the majority of nursing theories have paid little attention to the political dimensions of practice (18–21). So, physiotherapy is by no means alone in bracketing out the political and the social dimensions of its work.

But physiotherapy certainly does appear to go to quite extraordinary lengths to maintain its indifference to sociology. In the course of writing this book, I spoke to dozens of physiotherapists from all over the world, and not one single person told me that they had had any exposure to social theory as part of their pre- or post-graduation training. Of course there are exceptions, but over the years I've come across physiotherapists who think that social theories have never really been part of

physiotherapy, and it is not really a 'political' profession anyway. Some argued that while they had no problem with the sociology, per se, physiotherapy was already too full, too complex, and too diverse to accommodate other perspectives, (as if they weren't already present anyway).

Michael Traynor has suggested that nurses have such a strong 'orientation towards 'usefulness" that this 'limits the role of theory to dealing with the status quo and denies its radical possibilities" (22). In physiotherapy, there appears to be a similar scepticism towards theory in general, underpinned by the profession's long-standing belief that physiotherapists are "practical people". This helps craft the image of the physiotherapist as a dynamic, go-getting practitioner, but it also hampers our ability to develop the profession in thoughtful, theoretically robust ways; to anticipate change; to prepare students for future practice; or to know how to adapt in any other way than by being simply reactive. Physiotherapy is awash with important social phenomena, but perhaps the way that physiotherapists construct their professional identity actively obstructs the 'demonstrable and latent capacity of social and sociological theory to guide, shape and inform research, education and practice' (20)?

Physiotherapy needs social theories more than ever now because the social world around the profession is changing so fast. The professions in general are such a familiar part of our everyday lives that we assume they have always been here and will endure. But as I argued earlier, the professions are a recent invention, and there is growing evidence from around the world that attitudes towards expertise and orthodox authority are changing. Edgar Burns wrote recently that, 'The richer parts of the world have come to regard professions as indispensable to civic and general well-being and essential to how modern societies operate', but a 'rapidly globalising and connecting world society', and 'the digital technology revolution', are marking the urgent need 'to rethink the role and function of professions' (15). This echoes Daniel and Richard Susskind, who suggested that;

> *'Professionals play such a central role in our lives that we can barely imagine different ways of tackling the problems that they sort out for us. But the professions are not immutable. They are an artefact that we have built to meet a particular set of needs in a print-based industrial society as we progress into a technology-based Internet society, however, we claim that the professions in their current form will no longer be the best answer to those needs. To pick out a few of their shortcomings—we cannot afford them, they are often antiquated, the expertise of the best is enjoyed only by a few, and their workings are not transparent. For these and other reasons, we believe today's professions should and will be displaced by feasible alternatives'* (23).

The statement that 'we cannot afford them, they are often antiquated, the expertise of the best is enjoyed only by a few, and their workings are not transparent', bears repeating, because in various ways, over the course of this book, I will argue that this critique applies very much to contemporary physiotherapy. The seismic shifts now taking place in society are affecting 'how knowledge is generated, accessed, distributed, resisted, authorised, applied and mis-applied, more and more in real time—for both individuals and at population levels', and that these 'will change decision-making dramatically in the coming decades with all sorts of unexpected consequences' (15).

So, we need some help from social theories because, quite frankly, our professional leaders are struggling to know what to do. Gail Jensen's writing team wrote recently that;

> *'The lag in therapy education strategies that will prepare students for rapid change may be due in part to current leadership, including faculty and practitioners who are just catching up with the fact that*

> *apparently subtle societal changes have the power to dramatically affect physical therapy practice and are doing so at an accelerating rate'* (24).

We need social theories because it is becoming increasingly clear that the kinds of problems now facing the profession cannot be answered with more clinical trials and evidence-based practice. We have known for many decades that quantitative research has a poor track record of addressing the big, society-level health questions. This is because, 'quantitative researchers have largely relied on a kind of empiricism whereby their data is presented as a set of statistical correlations without any attempt to provide a detailed theoretical engagement with their topic' (25). But it would also be wrong to place too much faith in the kinds of humanistic, behavioural, phenomenological, and relational scholarship that have emerged within healthcare (and latterly physiotherapy) in recent years. The kinds of social questions now being thrown up by today's globalised, neoliberal, digitally mediated, precarious, and post-binary societies, cannot be addressed with the experiential, subjective, qualitative research, which all too often says little about the social conditions that shape what is possible for people to think and do. The questions now being asked of the profession are very different from the ones that once prompted the creation and organisation of the physiotherapy profession a century or more ago. It remains to be seen if physiotherapy still represents one of the answers.

If I were to summarise my argument thus far, it would be that an understanding of sociology will be vital in the coming years if we are going to better understanding the profession's past, present, and future. Physiotherapy is awash with sociological concepts and principles, but these are mostly hiding in plain sight because physiotherapists have never equipped themselves with the tools and the vocabulary to interrogate them well. Edgar Burns suggests that 'a 'more of the same' view of professions will not speak to present dilemmas and issues of performance. Even less will it prepare new thinking to face the future' (15), and I believe this is a message worth heeding. Mostly, I believe sociology can give us new and powerful tools to analyse who we are, what defines our work, who we serve, and why. But before we delve too deeply into these questions, we should know more about the tools we will be using. So, what is the sociology of the professions, where does it come from, and what does it have to say about the world of healthcare?

A brief primer on the sociology of the professions

There are many subdivisions within the broad field of sociology. There are sociologists interested in criminal justice, the environment, religion, and economics; there are sociologists of education, travel, food, and politics; as well as branches of sociology devoted to urban design, film, literature and the family. But perhaps one of the strongest and most fertile areas of sociology over the last century has been the branch of sociology devoted to health and, most especially, the health professions. But there are even subdivisions and specialties within this field, with scholars specialising in disability, work, health policy, aboriginal and Indigenous peoples' health, commodification, alienation, bodies and boundaries, bureaucracy, disease, ideas of progress, solidarity, lay/professional interactions, myths, authority, domination, power and oppression, social rituals, marginalisation, the division of labour, class conflict, status, intersubjectivity, labelling and stigma, social values, deviance, profanity and transgression, religious beliefs, economics, morality, the body, social order, globalisation, emancipation, health policy, surveillance, emotions, legitimacy, equality, social theories like feminism,

Marxism and postmodernism, science and progress, the self, technological knowledge, racism, societal norms, industrialisation, and language. Clearly, then, it is a vast field.

Notwithstanding its diversity, though, it would be no exaggeration to say that sociologists have been quite obsessed with healthcare. There are perhaps a number of important reasons for this. Health occupies many people's lives, it is very important in shaping our lived experiences and, therefore, our attitudes and beliefs about the world. Plus it is dominated, in the West at least, by a very particular and powerful approach to the body and health, so perhaps naturally, sociologists are interested in how this shapes society, the way people think, and behave. Health also consumes an enormous amount of a country's resources, not only in terms of its government budgets, but also time spent in organising, reorganising, and discussing how health could be better.

Perhaps it is not surprising, then, that sociologists have had an enduring interest in the nature and functions of the health professions. Jonathan Gabe has suggested that this work has focused on two complex and inter-related issues:

> *'First, what (if anything) distinguishes those occupations that are generally accepted as being professions from those that are not, given that many occupations would apparently like to be regarded as professions? Second, can we trust these professionals' claims to trustworthiness and their connected demands for autonomy (freedom from external monitoring), and what are the consequences of accepting (or, indeed, of refusing to accept) professionals' claims?'* (12).

Different authors have approached these questions in different ways. David Landy suggested that healthcare could be divided into its social and cultural aspects (26). The social being the domain of organisations, professional roles, and rules governing relationships, and the cultural being the domain of perceptions, beliefs, practices, and theories. Arthur Kleinman (27) suggested three different healthcare 'sectors': the popular sector of the non-professional, or the kinds of informal, non-expert, fee-free care and support that is usually the first place illness manifests; the folk sector of non-orthodox, Indigenous, sacred and secular healers, offering more holistic healing options; and the third professional sector, an organised, legally sanctioned space.

What these approaches point to is that the sociological study of the professions has largely remained 'a rather narrow field of research despite its vast literature' (28). This has meant that 'few other fields in sociology present such a linear development of the theoretical discussion', with each decade 'characterized by a dominant theoretical perspective that has first been gradually challenged and then superseded by alternative interpretations' (ibid). This relatively contained body of work is good for us because it makes it easier to explain the different perspectives. But there is also real depth lying behind these ideas, and to date very little of this has been applied directly to physiotherapy.

To begin with, sociologists only really began to be interested in the professions in the 1930s. But then the professions, as we know them today, only began to establish themselves towards the end of the 19th century. So, although the 'true' professions — medicine, law, and theology — had existed in some form for centuries, professions as a whole were neither organised, nationalised, nor theoretically and practically coherent before 1900. The reason the professions came to the attention of sociologists in the inter-war years was probably because sociology itself was becoming an established discipline. But professions like medicine were also acquiring significant social status, and so naturally prompted sociologists to ask how and why.

The first people to critique the rise of a new professional class came to be known as the *functionalists*. These sociologists theorised that the elite professions had achieved special prestige because they

possessed certain traits and characteristics that brought balance to society. Because all societies included people who were ill, criminal, immoral, and idle, functionalists theorised that certain elite professions had risen to prominence because they represented the best response to social disorder. Functionalists studied medicine extensively, and concluded that it was doctors' altruism and public service ethic, their specific expertise, shared moral code, and lengthy training, that set them apart, and justified their social privileges. This view dominated people's understanding of professions through to the 1960s, and still has echoes today. As you will see later in the book, one of the key arguments I make is that physiotherapists still think very much in functionalist terms, despite the fact that it is now largely discredited. But functionalism is where we have to begin if we want to understand the professions sociologically, and so it is the subject of Chapter 2.

One of the main problems with functionalism is that it says almost nothing about power. It assumes that professions are disinterested in their own social status, and work only for the betterment of the public. It assumes that lists of value-neutral traits and professional characteristics explain why some professions hold elite social positions and others don't. And it tells us nothing about how occupations managed to persuade society to grant them a privileged position in the first place. These limitations were starting to be unpacked in the early 1950s, but became a cacophony of criticism a decade later.

Functionalists belong to a group of sociological thinkers known as *consensus* theorists. Their belief is that social order 'flows from consensus — from the existence of shared norms and values' (29). But through the 1950s and 60s, consensus theories were progressively undermined and replaced by the work of prominent *conflict* theorists, who then held sway in social theory circles for much of the next three decades. Conflict theories are based on the idea that society is not self-balancing, but is an ongoing struggle for power. Many of the most prominent conflict theorists used the tools of sociological research to show that the social conditions people were born into and had to live with — despite their abilities and choices — shaped the life they led. Today's focus on the social determinants of health (poverty, access to services, discrimination, educational opportunity, employment, environmental degradation, etc.), is a direct legacy of this work (30–35).

The impetus behind much of the conflict theory work was a desire to give voice to people increasingly marginalised by the now elite mainstream professions: women, people from racialised ethnicities, disabled people, gender non-binary people, people in the LGBTQI+ community, … In fact, the majority of people who were not the white, heterosexual, affluent, non-disabled, straight, 'Northern' men, who had come to dominate the elite professions over the previous 60 years. Conflict theorists argued in a string of eviscerating critiques through the 1960s, 70s, 80s and 90s, that professions like medicine seemed happy to ignore the rich cultural contribution that under-represented people and groups made in society, and through their ignorance, perpetuate stigma and disadvantage (36–42). Beyond health itself, conflict theories were part of the broad sociological turn towards Marxist, feminist, post-colonial, and disability rights scholarship that dominated sociology in the second half of the twentieth century, and these are the subject of Chapters 4 and 5. But these ideas too began to be critiqued in the 1980s and 90s, just as functionalism had been decades before.

Conflict theories are powerful critiques of the professions, but sometimes they can imply that there are deep social forces shaping our lives that are hard to see and even harder to resist. There is little place for human agency in conflict theory. Some sociologists in the early 1980s, seeing society shifting subtly away from the radical activism of the 1960s and feeling the first blushes of neoliberalism, began to turn their focus away from conflict theories and concentrate, instead, on the sociology of inter-

personal relationships and the ways societies gave collective meaning to things. These came to be known as *symbolic interactionists* because they were interested in how societies created meaning through inter-personal dialogue and exchange. This gave birth to an enormous body of work looking at lay-professional relationships, and, in healthcare, the way physicians and patients co-constructed what it meant to be healthy and sick. This field drew heavily on phenomenology and contributed a large part to the birth of the new field of *qualitative research*, that began to have an impact on healthcare in the 1990s. It also underpinned what we now call person-centred care.

At the same time, a second group of sociologists departed from conflict theories, but retained an interest in professional power. These sociologists drew heavily on the work of Max Weber — one of the founding fathers of sociology — and so came to be known as the *neo-Weberians*. These scholars concentrated on professional boundaries and the ways occupations practiced 'social closure' and encroachment as part of their professional 'projects'. Inter-professional practice today is a beneficiary of this work, and much of the discussion about post-professional healthcare derives from them. Symbolic interactionism and neo-Weberianism are both unpacked in Chapter 6. But, as seems to happen in the sociology of the professions, both the symbolic interactionists and neo-Weberians accumulated more and more critique towards the end of the 20th century, and as we entered the new millennium, postmodernism came to prominence.

Postmodernists argued that there was no objective reality lying *behind* our experience of the world, and that it was the human hubris of the Enlightenment that had convinced us that science could discover some kind of universal truth. Postmodernists argued that all major beliefs, be they about science, religion, or even those pertaining to the professions themselves, were attempts to impose *some* ideas on to society at the expense of others. They argued that our task was not to pick a winner, but to expose the game being played and open doors to its alternatives. Postmodern approaches to the professions are explored in more depth in Chapter 7. Of course, postmodernism has not been immune from strong criticism in recent years either, and we are now beginning to see the emergence of even more diverse and interesting approaches to social institutions like expertise and the professions as a result of this critique.

Despite the seeming linearity of this very brief history of the sociology of the professions, the reality is that *all* the approaches mentioned above are alive and well, and operating very happily in a physiotherapy clinic, hospital ward, or online venue near you. Some of these approaches will resonate with readers more than others. That is fine. My goal with this book is not to try to sell you a particular perspective, but to try to use these tools to analyse physiotherapy and show how they can guide us to meet the challenges of 21st century healthcare. Whether you agree or not with my conclusions will depend, to some extent, on your own sociological orientation, and this will inform what you believe a profession is and can be. Before beginning this work in earnest, though, it would be useful to understand the role sociology has played in physiotherapy to date.

Sociology currently in physiotherapy

Any sociology of a profession like physiotherapy must try to understand the social forces and processes that shape how the profession operates, what this makes possible, and what it denies. It must ask why this, why now? But this is no simple task because in doing so, 'physiotherapists can

develop an increased sensitivity to the multiple hidden effects of practice and their unintended harms' (43), and these might be things it is reluctant to do.

But a sociological analysis of a profession is also a 'technically' complex task, in part because a profession is shaped and made, not like a chair, but as a living entity, that is performed every day, and in every moment, by the people who embody it. So asking why an abstract, socially constructed entity, which has real material effects in the world, is here, and how it relates to the myriad ways people engage in health and healthcare today, is beset with complexities. Here, for instance, are some of the questions we might pose in a sociological analysis of physiotherapy:

- If the questions that prompted the formation of the profession in the 19th century have changed, are the answers also different?
- How and why did the profession rise to social prominence, and whose work did it supersede?
- What is the relationship between the profession and powerful institutions like 'The State', biomedicine, and capitalism?
- In what ways do social forces like power, discrimination, stigma, and privilege, manifest over time and in everyday work?
- Whose interests does the profession serve, whose voices does it privilege, and whose does it marginalise?
- What is the profession vocal around, and what is it silent on?
- How does the division of labour function in physiotherapy, and how does it favour particular social groupings over others?
- Where in the world is the profession prominent and strong, and where is it absent or only now emerging? What do these locations tell us about the discourses shaping the profession?
- What are the customs, habits, routines, and everyday rituals particular to physiotherapy?
- What beliefs and values around concepts like health, disability, movement, and independence, are physiotherapists socialised to favour?
- What kinds of relationships and interactions are customary, and how do these construct meaning?
- What are the technologies that are archetypical and commonplace to practice?
- If the profession is proclaiming new ways of working (person-centred care, evidence-based practice, telemedicine, for example), what function do these new social forces serve, and why are they only coming to prominence now?
- And what influence do the profession's tools of social governance (laws, codes, guidelines, etc.), have in shaping social forces?

Reading through this list of questions and prompts, it may become clear why I mentioned in the second paragraph of this chapter that, 'you will find very few references to the material presented in this book in the physiotherapy literature'. This is not to say, of course, that sociological scholarship

is entirely missing from physiotherapy. There are some really important examples cited throughout this book of physiotherapists addressing questions exactly like these. But the overwhelming sense, from reading around the sociology of healthcare and the professions, is that physiotherapy is largely absent. Some people may argue that sociology is very much a part of physiotherapy these days, perhaps citing the enormous growth of interest in the biopsychosocial model, person-centred care, or qualitative research, as examples. But while these are excellent case studies of a broadening in physiotherapy scholarship, and a subtle expansion on the profession's historical biomechanism, there is very little about them that is really sociological.

The growth of interest in psycho-social aspects of physiotherapy practice, for instance, has been heavily underpinned by an increased interest in behavioural psychology. This is an approach that sits very comfortably within conventional biomedical notions of objective neuroscience, and measurable cause-effect responses to external stimuli, whilst also playing into neoliberal notions of personal responsibility for health and wellbeing (44–50)[4]. And although these studies often deploy the word 'social' as a way of shifting beyond the purely biomedical, the sociological dimensions of health are mostly portrayed as social 'factors' or polluting 'variables' (51).

This is particularly evident in the 'soft' behaviourism being promoted in the pain management literature; an approach which also works well to disrupt the profession's historical affinity with so-called 'passive' therapies (manipulation, massage, mobilisation, etc.). Pain is no longer about 'issues with the tissues', and has become much more about behaviour change, personal agency and resilience, lifestyle choices, and healthy conversations (52). But these are all psychological constructs, not sociological.

William Cockerham has suggested that social dimensions play only a 'distant supporting role in studies of health and disease', reflecting 'the pervasiveness of the biomedical model in conceptualising sickness' (53). This situation has not been improved by the turn towards behaviourism in physiotherapy, leaving sociocultural influences on health poorly recognised, and 'theoretically and empirically under-explored in comparison… to… biomedical aspects' (52). But;

> *'If we are all different individuals acting according to the dictates of unique psychological influences, why do different people in the same social circumstances behave similarly and in ways others can understand? Clearly there is a social dimension to human existence, which requires sociological theorising to explain it'* (29).

Fortunately, we are seeing some awareness of this in the physiotherapy literature (52, 54–58), suggesting that sociological concepts are now being used to critique the taken-for-granted obviousness of approaches like the biopsychosocial, which claims to be a more holistic model of practice, but effectively hides its bio-behavioural bias. The biopsychosocial approach cannot be considered a viable 'holistic' model of practice for physiotherapists if it cannot effectively account for sociological paradigms (52, 58). But perhaps the vigour with which it has been taken up by some sections of the physiotherapy community, says something, at least, about our appetite for alternatives to the body-as-machine, which, in itself, creates an opening for social theory, if its principles can be explained in a reasonably coherent way. If Arthur Frank is right, that the social sciences help us to understand what Max Weber called 'the fate of our times' (59), then we owe it to ourselves, to

[4] This is discussed much more in Chapters 8, 9, and 10.

physiotherapists to come, and to the people we serve, to learn something more about what they have to offer.

Closing words

This book works from the adage that if you want to see the future look in a telescope, but if you want to know what you're seeing, look *at* the telescope. It is early days in physiotherapy's sociological study of itself, so this book can be little more than a primer to what is now a vast field of scholarship. Naturally, there are many omissions and shortcuts. I often refer to physiotherapy as if it were a homogeneous entity, a singular thing, when clearly it is anything but. I hope you will see this as shorthand rather than laziness. The book is also a book of the sociology *of* physiotherapy, not sociology *in* physiotherapy. My focus is on ways of understanding the profession, not necessarily all the sociological fields to which physiotherapy applies. The book is also highly critical. Not in the nihilistic or pessimistic sense, but in the exact opposite postmodern sense, in which critical thinking opens up new spaces for a thousand possible alternatives. I hope it is what Rita Felski called a 'distinctively modern style of interpretation that circumvents obvious or self-evident meanings in order to draw out less visible and less flattering truths' (60).

The reader I am most anxious about is the person who wants to hold on to physiotherapy at all costs; who would preserve the good name of the profession even after it has run its course. I am anxious that there are many people within the profession who will try to hold on to physiotherapy's long-fought-for prestige for sentimental reasons, even if it had been shown that other ways would serve people better. As with my previous book, *Physiotherapy Otherwise* openly explores whether we are seeing the end of the profession. But as I argued in *EoP*, this is not because I see our knowledge and skills becoming obsolete; only the idea of a bounded *profession*, regulating, controlling, educating, and preserving physiotherapy in the mistaken assumption that, once established, it will endure forever. The jury is very much out on this question, and even after more than 30 years of researching physiotherapy as a social entity, I can tell you that I'm yet to find a definitive answer. What we do know, though, is that *all* of the professions are now under pressure, and physiotherapy may be no more immune to rapid and profound disruption than accountancy, manufacturing, and journalism.

One final qualification also needs to be stated. As a white, English-born, straight, non-disabled, professional, middle-class, cis-man, I am acutely aware of my privilege in being able to give voice to these ideas. Would it be possible for me to make the claims laid out in this book if I were a young black therapist trying to build a career, a female academic in an aggressively heteronormative culture, or someone not in a position of professional privilege? I believe strongly that it would not. So, I hope I have done justice to that privilege and used it to 'kick up', not 'kick down'. As Natalie Wynn from *Contrapoints* (https://www.youtube.com/user/ContraPoints) argues, it's all well and good proclaiming that the house is burning down when it's not your house. But it is my house, and being a critical insider feels important right now. Paul de Man once said that you can only deconstruct what you love, "because you are doing it from the inside, with real intimacy" (61). So, this book is underpinned by a deep 'curiosity about how to make sense of… what is going on in the world around us' (21), using well-developed and well-honed tools that have, up to this point, largely evaded physiotherapists.

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2. Balance and social order

A brief introduction to functionalism — Trait theory — The sick role — Medicine as an ideal-type profession — The Flexner Report — Types of professions — The body-as-machine and physiotherapy's reductionism — Taylorism, Fordism, and modern bureaucracy — Traits and the characteristics of professional physiotherapy — Neo-functionalism — Critiques of functionalism

The first concerted attempt to understand the professions sociologically began a century ago in the 1930s. Until then, the professions, as we know of them today, had not really existed. Medicine, for example, was considered one of the three 'true' professions, but medicine possessed 'little of the autonomy and self-control so characteristic of the medical profession today' until the enactment of the *1858 Medical Registration* Bill in Britain (1). At this point, medicine was still half a century away from discovering the placebo effect, and although germ theory had superseded belief in miasmas in the last decades of the previous century, insulin treatment had only just begun, sulphonamide drugs were entirely new, and antibiotic, widespread vaccinations, and mood-changing drugs would not become commonplace for another 20 years. So, these scientific and practice innovations cannot explain why medicine became so powerful, so quickly because medicine had achieved impressive social status long before it could demonstrate any therapeutic efficacy.

Sociologist Bryan Turner suggests that between 1875 and 1920 'the status of the general practitioner in the USA was transformed by a number of social developments' (2). He suggests that the market for medical services expanded because of economic growth, urbanisation, and the development of large-scale transport systems, 'licensing laws with the legal backing of the state' (ibid), and medicine's opposition to alternative forms of practice. Turner suggests it was *social* factors, rather than features intrinsic to medicine, that shaped the direction the profession took.

As with medicine, early sociological studies showed that the emergence of all of the professions owed more to societal influences than had previously been thought. The first group of sociologists to take a particular interest in the professions came to be known as the *functionalists*, for their analysis of the ways professions functioned as a balancing force in society. This chapter explores the enduring legacy of functionalism and the ideas that shaped early thoughts about the sociology of the professions. We start with functionalism partly because it was the first established 'school' of sociology concerned with the professions, but also because the ideas it promoted are still heavily influential in healthcare today, particularly in professions allied to medicine.

A brief introduction to functionalism

The first widely acknowledged sociological critique of the health professions came from the collaborative work of Emile Durkheim (1858-1917) and Talcott Parsons (1902-1979). Durkheim, considered to be one of the fathers of modern sociology, and Parsons, who did as much as anyone to bring scientific respectability to early sociology, defined an approach to the study of society that saw the professions as playing an important stabilising role in society. The professions, they argued, brought balance and order to society by offering services that addressed some of the 'negative' conditions prevalent in all developed nations. Where there was illness, we needed doctors and nurses, and we had police officers *because* there was crime; and so on. When professional groups brought social order, society functioned more effectively and people were happier. And because they claimed that people always preferred order to chaos, those professions that tuned into society's needs were rewarded most for their service.

Durkheim and Parsons made popular an idea that had been prevalent in Europe since at least the 17th century; that a 'social contract' existed between the people of a nation and its government, and that all developed societies possessed an innate collective desire to make living conditions better by improving social stability. Functionalists argued that this 'collective consciousness', as Thomas Hobbes (1588-1679) called it in his book *The Leviathan* in 1651, drove the creation and organisation of things like the healthcare system, the military, schooling, and the legal system, and made it necessary to create a professional class that could do the work of securing the health, wealth, and happiness of the people. The power of this ideal is one of the founding principles of functionalism, and it remains a seductive concept for many people today. Authors like Daniel and Richard Susskind, for instance, recently spoke about automation, digital technology, and the changing nature of globalised life-threatening the historical 'Grand Bargain' between the professions and society (3).

The functionalist sociologists of the 1930s suggested that the professions were a *response* to society's need for order and balance, and that the professions solved problems that lay members of society had neither the experience nor the expertise to address themselves. Durkheim believed that the professions enhanced social cohesion and 'were (or ought to be) an important integrative force in rapidly changing, industrializing societies' (4). Durkheim believed that laws governing social life operated in the same way as natural laws, like gravity, and that 'shared modern beliefs act as a social 'glue' and create a sense of harmony in a society' (5). He put forward the radical suggestion that social rules, laws, cultural beliefs, customs, and practices, or what Durkheim called 'social facts', were as real as the physical world that surrounded people, and that knowledge of these rules could promote good society. Key to this operation were the social institutions, especially the family, the workplace, religions, political systems, education, and healthcare. These institutions played a key role in establishing and maintaining social solidarity and stability.

Durkheim provided the template for the belief inherent to all functionalism that societies work better when people depend on each other, and his research promoted the idea that a 'sense of social solidarity' (5) exceeded the kinds of individualism that he thought was becoming increasingly pervasive in society. Social solidarity underpinned Durkheim's secular ethics, and he articulated this in a number of forms that related to the work of the professions. Durkheim defined a form of *mechanical* solidarity between people who share similar work, where there is little division of labour (in trans-disciplinary practice, for instance), as well as *organic* solidarity, when people performed distinctive roles. It is called 'organic' solidarity because Durkheim believed that this kind of division

of labour required people to work together to maintain a functioning society, and this kind of collaboration led organically to interdependence.

The idea of social solidarity was not Durkheim's alone, however. And nor was it a purely sociological idea. John Maynard Keynes (1883-1946), the economist responsible for designing the National Health Service in the UK and developing the principle of macroeconomics, believed that war and inequality, not scarcity and unlimited demand, were the major problems for economists. As a young man, Keynes had believed passionately in free trade and the role of the British Empire, which he saw as a powerful force for democracy and hope around the world. These beliefs were radically altered by World War I, however. Keynes was responsible for British war finance and negotiated the Treaty of Versailles, but he was also a pacifist that became appalled by the war itself, which he saw as being driven by naked self-interest and competition. Keynes argued for an economics that was essentially functionalist. He proposed economics driven and governed by the state as a vehicle of social solidarity. Like Durkheim, Keynes's ideas were shaped by the remarkable social progress of the late 19th and early 20th centuries, but also by the shocking realisation of what uncontrolled progress could be used for if anomie and inequality went unchecked.

Like Keynes, Durkheim believed that because modern societies had much more complex divisions of labour, and people occupied an enormous number of interconnected roles, social solidarity was much harder to achieve. He believed that humans were prone to antisocial and individualistic behaviour, and needed social norms in order to prevent anomie. Durkheim believed that anomie, meaning 'without law' or 'the lack of a sufficiently secure framework by which people are provided with a sense of moral regulation and social integration' (5), was the result of rampant individualism. And like Karl Marx before him, Durkheim believed that anomie was a major cause of individual and collective ill health.

To counterbalance this, people needed structural forces operating in society to promote social cohesion and integration. People needed to submit to these forces as a condition of their liberation because, 'For man, freedom consists in the deliverance from blind, unthinking physical forces; this is achieved by posing against them the great and intelligent force which is society, under whose protection he shelters' (6). Durkheim believed that the nation state bore a key responsibility for diagnosing and maintaining social order, much in the way a doctor might diagnose and treat an illness in a patient. Governments established social agencies, like the professions, regulators, administrators, and judges, and these undertook the empirical work of monitoring and rehabilitating social ills. In this way, the health of the social 'organism' as a whole was maintained.

The idea of society as a 'body' with interconnected parts and systems was a popular analogy for functionalists. Herbert Spencer (1820-1903), one of the first functionalists, drew heavily on Darwinism to develop the idea that society could be understood like an organism, with discreet institutions performing specific functions and maintaining the health of society as a whole. Spencer believed that the malfunction of individual social institutions (like the breakdown of the nuclear family, for instance), led directly to social pathology[1]. So at its most fundamental level, functionalism operates on the basis that society has 'certain 'needs' that must be fulfilled to ensure its smooth operation' (7).

[1] We will come to some of the criticisms of functionalism shortly, but it is perhaps worth pointing out here that Spencer used his belief in social pathology to argue that some societies were more developed than others, and that a kind of social Darwinism was at play when societies prospered or declined. Spencer believed white, European cultural dominance was justified by its development of social institutions. These ideas have now been widely discredited and seen as racist and abhorrent.

Cockerham has suggested that social agents like the professions come to prominence as a result of social instability. In other words, 'when "dysfunctional" processes arise that create instability, like crime, society counterbalances the potential for disorder by creating restorative and/or punitive institutions like criminal justice systems' (8). This is significant because it is a reminder of one of the fundamental issues raised in Chapter 1, that sociologists largely believe that the professions are the *result* of social process, not the originators. Pip Jones and Liz Bradbury put it this way;

> *'The existence of a social institution, of a part of the social structure, is not the result of the members of society deciding to act or think this way. After all, people do not* decide *to have bowels or a liver or a pair of kidneys. These organs exist because the body needs them to perform necessary functions. In the same way, in functionalist theory, the institutional arrangements of the society take the shape they do not because of any choice on the part of its members, but because they are performing a necessary function for the social structure as a whole'* (5).

In functionalist theory then, society is much bigger than the individual, existing 'above and beyond the level of individuals' influencing or perhaps even determining their behaviour' (8). Durkheim's work argues that social forces can have a direct causal influence on people's health, and that disruption to organic social homeostasis *calls* for the creation of groups who can restore stability to society.

Trait theory

One of the questions that the idea of social solidarity created was why certain professions became elite and others did not. Why, for instance, had medicine and not, say, bone setting or homeopathy, become the dominant voice in healthcare and the primary mechanism through which societies sought to restore health and stability? The answer to this question lay in what functionalists called the *traits*, or characteristics, of different professions. By studying those professions who have succeeded in gaining social respectability, functionalists arrived at a set of traits that demarcated the elite professions from the more prosaic semi-professions and occupations. Talcott Parsons' work became particularly important here.

Parsons saw that contemporary medicine had successfully navigated the complex relationships that existed between the state and its people, and had helped to create the services, structures, and systems necessary for social order. Echoing Parsons' functionalism, Victoria Sparkes, writing about physiotherapy professionalisation suggested that, 'Society provides a demand for the services of a profession, which in turn maintains its elevated position in the social strata, chiefly because society is unable to realise the service for itself' (9). As Parsons saw it, the doctor's role was to identify disease, illness, and other forms of what the functionalists called 'social deviance', and to act as 'agents of social control' (4). Patients were expected to defer to the doctor's authority, and seek appropriate help when their lives fell out of balance as a result of illness or injury. As compensation for their work in nurturing social solidarity, doctors were given powers of self-regulation — the much sought after professional autonomy — and significant financial rewards, in part to reduce the temptation to financially exploit their patients. Other checks and balances were also drawn up to prevent doctors taking advantage of what had effectively become a healthcare monopoly. And so only those

professionals who could demonstrate the highest levels of probity and altruism were recognised by the state through professional registration and protective legislation.

A key feature of Parsons' functionalism was the belief that the patient's deference to medical authority, and their compliance with medical instructions, were necessary contributions to social order. In this way, the patient absolved themselves 'from the responsibility for the management of their illness' (10). Perhaps the best example of this was Parsons' now famous concept of the sick role.

The sick role

Arthur Frank has suggested that the sick role represents perhaps 'the root of social scientific consideration of the medical complex' (11), and its influence on the way we think about healthcare in Western societies cannot be understated. Parsons suggested that being sick represented a specific *role* that people fulfilled at times in their lives, and this role came with certain rights and obligations. The sick role was a position people adopted during bouts of short-term illness or injury. For a short period of time, the sick person was allowed to be exempted from their normal duties. They could take time off work or school, take to their bed, and avoid all commitments and responsibilities, if they could show that they were genuinely sick. They could hand over some of their responsibilities to others, who would pick up their burden for them. And they would receive the sympathy of their family and friends. In return, the sick person was expected to seek medical help, rest, accept help from those around them, and, crucially, work hard to get well again. Because after a few days, people's tolerance for the sick person would start to wear thin, and they would be expected to return to their 'normal' role and their period in the sick role comes to an end.

This model explains what is probably a familiar experience for most of us. For a few days, we become model docile patients, and society mobilises to make the impact of our illness as short-lived as possible. Parsons' model, though, says much more than this. It explains, for example, how healthcare is orientated towards acute, short-term conditions, in preference to long-term, chronic disorders. As a society, we are much less tolerant of people who either cannot take up 'normal' life roles, or become dependent on others for an extended period of time. The sick role was also one of the first models to show that health and illness could not be understood *only* as a pathological phenomenon, and that it was 'self-evident that the institutional shape of the illness-health-medicine complex can be understood only within more extensive conceptualisations of how society works' (11).

Parsons showed that being sick was 'a role granted by society to those who accept its core values' (7). Being sick could be seen as a sociological rather than a biological phenomenon which, in turn, provided some of the impetus to think about why we had health professions because it was clear to many of the early functionalists that the biological basis of health and illness could not explain why health professionals had appeared and risen to prominence only in the previous half century. To put this in physiotherapeutic terms, one might say that a person does not have physiotherapy because they have a pathology; people have had illnesses and injuries for ever, and for much of human history there have been no physiotherapists. Rather, they have physiotherapy because physiotherapists have shown their aptitude in restoring the delicate balance of society. As long as physiotherapists restore social order more effectively than others, they will continue to receive their mandate. So contrary to the ethos of person-centred care, in functionalism, society, not the individual, comes first.

Uta Gerhardt (12) has suggested that there are two distinctive approaches to illness at work in Parsons' sick role:

1. The first she calls the 'capacity' model. Here the person has failed to keep well and has become incapacitated by an illness that has overwhelmed their 'capacity' (an acute sport's injury or debilitating flu, for example). The illness is seen by society as a natural phenomenon and not the result of some failure of personal motivation. The person's recovery is often relatively uncomplicated, and rarely involves social judgement or punitive measures. Patients are given a window of time in which to recover and rehabilitate. Most then return to work or 'normal' life, without question or judgement;
2. The second model of illness Gerhardt calls the 'deviance' model. Here people are often believed to be layering personal, social, psychological, and cultural factors on to a biological process, manifesting what society sees as 'deviant behaviour'. They are subject to social judgements and accusations of malingering, fraud, over exaggeration, hypochondria, attention seeking, and so on, and experience social judgement and pressure to return to 'normal', socially-mandated roles. Numerous studies have shown how stigma and labelling function in this way as *social* rather than biological readings of illness (see more on this in Chapter 6).

Gerhardt's work reinforces functionalist beliefs that acute and chronic illnesses are first-and-foremost expressions of the things society finds intolerable, rather than purely medical pathologies. Given this, Parsons' sick role perhaps does a better job than biology in explaining why the boundaries have shifted around disease and illness concepts over the last century. Parsons' interest in developing the sick role was not, however, on illness in and of itself, but on understanding how practices like medicine *used* particular ways of thinking about illness for its own professionalisation project. Parsons was interested in how doctors became *key agents* in the management of what had been for centuries a very personal experience.

Parsons was enamoured with the success of medicine, and suggested that medical practice in the 1930s represented an ideal working example of a synthesis between the self-interest of capitalism and business, and the collective control of socialism (11). Indeed, Parsons saw the relationship between the medical profession, the state, and the population as a model for future democratic capitalism. Perhaps it is not surprising, therefore, that medicine came to be seen by many as an ideal-type profession.

Medicine as an ideal-type profession

Parsons' work effectively established a set of traits for an *ideal-type* profession. Doctors emphasised their detachment from their patients (what Parsons called their 'affective neutrality') as a way to emphasise their objectivity and clarity of decision-making. But, at the same time, doctors fostered a 'community of equals' (13), in promoting the idea of medicine as an elite cadre of like-minded specialists. Dating as far back as the 13th century, the medical profession established a strong code of conduct and a collective ethos, and drew on the specialised, shared language of diagnosis, taxonomy and treatment, to differentiate its training and practice from others (14). It emphasised professional achievement and promoted the idea of heroic medicine, and it increasingly took on

broad social interests beyond the narrow confines of internal medicine and surgery. Parsons argued that medicine represented the very model of an advanced profession because it achieved all of these things whilst also reasoning 'instrumentally', with reason and logic , rather than 'expressively', relying on human emotion and subjectivity. He argued that any profession wanting to be considered elite, needed to mirror the following traits:

1. A professional body with a large number of members;
2. Affective neutrality — or the degree to which the professional can remove emotion from their work;
3. Mastery of a specialised body of knowledge and skills learnt through a lengthy process of higher education, and an ongoing interest in developing one's professional craft;
4. Universalism — focusing on rules to guide decisions rather than the particularism and subjectivity that comes with treating each person as an individual;
5. Recognition of the exclusive competence of the profession in the domain to which its body of knowledge refers — or a monopoly over a defined area of social need;
6. A service ideal — that is, a commitment or ethical imperative to place the welfare of the public or of the individual client above the self-interest of the practitioner, even though the practitioner is earning a living through the exercise of the profession. Parsons argued that 'medical professionals rightly deserved the high status and high rewards they received because they act in the interests of the whole society rather than their own self-interest' (7);
7. Achievement — Parsons believed that status should derive from the profession's achievements, rather than being ascribed to the group by some accident of birth or other 'internal' attribute;
8. A recognised code of ethics emphasising the responsibilities of practitioners and defining a limited scope of practice;
9. Specificity, or the degree to which the profession focuses on a specific rather than a diffuse field;
10. And professional autonomy, or the definition of what constitutes the work of the profession, controlled by the profession itself, including who can legitimately do that work and how the work should be done (15–17).

It is perhaps remarkable to think that within just a few decades, medicine had arrived at the point where it could be called an ideal-type profession. It was only as little as a century ago, though, that medicine became the organised, coherent discipline it is today. Much of the responsibility for that consolidation derived from the work of Abraham Flexner (1866-1959) and the Hopkins Circle, and their reform of the American medical education system.

The Flexner Report

The 1910 *Flexner Report* is credited by many as responsible for putting in place a science-based foundation for medical training in the United States. Abraham Flexner was a former schoolteacher and student of educational philosophy, very heavily influenced by German approaches to medical education, that required physicians to be trained as laboratory scientists before entering the hospital and beginning their clinical training (18). Flexner studied educational methods throughout Europe and, on his return, was invited to survey the quality of medical education in America and Canada. Flexner used the well-established and highly successful Johns Hopkins University Medical School as his benchmark, and found that many of the schools across the country — especially those running courses for profit — were substandard. Flexner recommended the closure of one-third of all medical schools, and the radical reform of many others (19). He then secured enormous funds, mostly from the Rockefeller and Connie foundations, to rebuild almost the entire infrastructure of medical training. New medical schools were built, faculty members were freed up to concentrate on academic medicine, research, and teaching, and an emphasis was placed on the advancement of medical knowledge (above, even the welfare of patients and the education of students) (18).

Although Flexner's recommendations were widely accepted by the medical establishment — not least because of the boost to the profession's social standing that accompanied the enormous injection of funds — they also came in for some criticism. William Ostler suggested that the emphasis on laboratory work would reduce doctors' clinical skills and empathy, and that 'patients were primarily viewed as serving the academic purposes of the professor' (18). Flexner also betrayed some troublingly racist and anti-semitic views. His report led to the closure of 46 medical schools, mostly in rural locations, and including all but two African-American medical colleges (2). His view was that the poor health of African-Americans was a threat to white Americans, and that the education of African-American doctors was necessary, not least for the protection of the white American population.

The Flexner report shifted American medicine rapidly from being an exploitative, pastoral, cottage industry, into a coherent, rational, and objective professional discipline. But this came at some considerable cost. In Thomas Duffy's retrospective on the report in 2011, for example, Duffy argues that;

> *'Edmund Pellegrino's lament was proven true that doctors had become neutered technicians with patients in the service of science rather than science in the service of patients. How else to explain the seemingly unexplainable Tuskegee experiments, the Henrietta Lacks tissue culture tragedy, and many occurrences in which the physician scientist has taken precedence over the physician as healer'* (18).

Flexner's 'infatuation with the hyper-rational world of German medicine created an excellence in science that was not balanced by a comparable excellence in clinical caring. Flexner's corpus was all nerves without the lifeblood of caring' (ibid). This approach, though, seems not to have hurt the medical profession's social standing, and may have been a necessary step in securing its monopoly over healthcare. Bryan Turner has suggested that the report may have brought about a significant decline in competition from other healthcare providers, including homeopaths (2). He also suggests that the sudden decline in the number of doctors and medical educators that flowed from the closure of so many schools, significantly increased the status and pay of those who had achieved

accreditation, whilst, at the same time, establishing new accreditation frameworks that could be applied to other professions in future (ibid). What is clear, is that by the time Talcott Parsons at Harvard and Alexander Carr-Saunders at the London School of Economic were exploring what constituted an ideal-type profession, much had been learned about the tripartite relationship that now existed between medicine, the patient, and the state.

Types of professions

Parsons' trait theory established an ideal standard against which all occupations could be measured, with medicine being the paradigm case. Alexander Carr-Saunders used this to begin a debate that has run for decades now into whether disciplines like physiotherapy and nursing are true, or semi-professional (20). Carr-Saunders defined the distinction in this way:

1. Established professions (medicine, for example);
2. New professions — based on 'fundamental' studies (engineering and the social sciences);
3. Semi-professions — based on the acquisition of technical skill (nursing and social work);
4. Would-be professions — 'occupations which require neither theoretical study nor the acquisition of exact technical skills, but may require facility with modern practices in business administration — for example, hospital managers (21).

The argument against calling nursing or physiotherapy true professions stems from the functionalist claim that they lack 'sufficient theoretical knowledge or powers of self-regulation' (4), a point of contention within physiotherapy for more than half a century. In the 1961 Mary McMillan lecture to APTA members, for instance, Catherine Worthington argued that 'Physical therapy has generally been thought of as a therapeutic technique, not a source of new knowledge' (22), and so;

> *'To be specific and very blunt — if your objective is to* develop physical therapy into a profession *— you must give attention to the differences between technicians and professional persons. Historically, you are technicians. You aspire to professional status. You are sensitive to the lack of confidence of the medical profession in your professional competence and judgement and, as a result, are often defensive in your reactions. Many of you failed to realise that to call yourselves professional does not of itself entitles you to such a designation. To be professional, members of the group must possess a body of knowledge that is both identifiable and different from that of other professions. They must also assume responsibility for adding to that body of knowledge and for developing their own standards of education and practice'* (22).

Whether it be through moves away from vocational training to degree-level education, research, the pursuit of professional autonomy, legislative protection of title, or increasing clinical specialisation, physiotherapists have worked hard to be judged against the ideal-type functionalist definition of a profession. For physiotherapists, the task has been made somewhat easier by the profession's adoption of many of Parsons' professional traits. Physiotherapists' affective neutrality and

universalism, particularly, set them apart from other 'caring' professions. And from a purely functionalist point of view, this has historically been to their advantage.

Pamela Abbott and Liz Meerabeau suggest that nursing, midwifery, health visiting, and social work, have all made claims to be professions, but 'these occupational groups are still striving to demonstrate that caring is work, and to find ways of caring that do not make them subservient, but which demonstrate that they have professional expertise' (21). As early as 1933, Carr-Saunders and Wilson suggested that masseurs, biophysical assistants, and medical auxiliaries, could not be considered true professions because they worked in service of medicine (23). Eliot Freidson argued that 'those paramedical occupations which are arranged around the physician cannot fail to be subordinate in authority and responsibility' (24). William J. Goode argued that 'no other occupation in the medical sphere will achieve the full professional status of the doctor and dentist' (20). While physiotherapists like John Mercer, writing in his 1978 doctoral thesis, argued that clinical physiotherapy, 'cannot equal the professional attributes of the doctor because it is a segment of the medical profession without its overarching leadership function. It can no more become an 'ideal' type profession than the arm can become the whole body' (25).

The desire to be judged against ideal-type functionalist definitions of the 'true' professions remains strong, however. Professions Australia, for instance, defines a profession as;

> *'a disciplined group of individuals who adhere to* high ethical standards *and* uphold themselves *to, and are* accepted by, the public *as* possessing special knowledge and skills *in a widely recognised,* organised body of learning *derived from* education *and training at a high level, and who are prepared to exercise this knowledge and these skills* in the interest of others*'* (26).

Similarly, the latest NHS Allied Health report draws heavily on functionalist language when it argues that;

> *'Physiotherapists are* autonomous *practitioners, with* expertise *in the use of physical and psychosocial approaches to rehabilitation, optimising independence and quality of life. Physiotherapy is a* science-based *profession and takes an evidenced approach to 'whole person' health and wellbeing'* (27).

What these definitions illustrate is the enduring influence of functionalist ideas on all aspects of professional life. Functionalist motifs resonate through many aspects of healthcare, and almost every facet of physiotherapy, past, and present. And it seems this most often happens without the authors' and instigators' awareness that their ideas and practices can be understood as functionalist. Functionalism is clearly both a powerful and enduring tool for developing, explaining, and analysing professional practice and thinking.

To briefly summarise, the two main principles of functionalism are that parts of a system contribute to the stability of the whole, and that the different parts of a system can be differentiated by their traits or characteristics. How, then, does this relate specifically to physiotherapy?

The body-as-machine and physiotherapy's reductionism

In many ways, physiotherapy is an archetypical functionalist profession because it works to rehabilitate those who are ill or injured, and it is happy to be one 'arm' of the complex Western healthcare system, and operates alongside other 'organs' of state-sponsored healthcare (medicine, nursing, occupational therapy, patients, healthcare assistants, managers and administrators, etc.). The body analogy here is particularly relevant, partly because of physiotherapy's longstanding affinity with the body-as-machine (28), but also because functionalist thinkers have always drawn heavily on organic metaphors of bodies and parts, to explain how they thought society worked.

Reductionism is the practice of simplifying what would otherwise be a complex, holistic entity by dividing the whole into smaller parts, and is a fundamental principle of functionalism *and* Western healthcare. Reductionism became a necessary part of biomedicine as the complexity of the body in health and illness became clearer. Although forms of reductionism have operated in healthcare for centuries, it acquired real power in the 19th century, as medicine began to divide into specialties. By the early 20th century, healthcare services were being designed around these specialties, and every profession that aspired to imitate medicine's ideal-type traits, was required to follow suit.

Reductionism in physiotherapy manifests in a number of ways: at the bodily level, with physiotherapists emphasising body systems (musculoskeletal, cardiorespiratory, neurological), and structures (anatomy, physiology, pathology, biomechanics, kinesiology). But also in their corresponding specialisations. Reductionism is one of the main reasons physiotherapy has musculoskeletal, neurological, and cardiorespiratory specialities. But reductionism also relates to the way physiotherapists moulded the profession to treat not just the body, but also *society*, 'as-machine'.

It was not only physiotherapists that saw the body-as-machine, though. In fact, the profession adopted this approach, in part because it had been an important feature of Western thinking since the Industrial Revolution. The metaphor of the body-as-machine enabled nation states to govern their growing populations through the designation of different role identities for different people, including the creation of a class of professionals to act as one important cog in the harmoniously progressive machine of society. But reductionism also shaped modern methods of industrial production, and the capitalism to which physiotherapy has been so intimately tied.

Taylorism, Fordism, and modern bureaucracy

The idea of interdependent systems functioning harmoniously to produce an end product with maximum efficiency and predictability, may seem like a familiar and taken-for-granted concept today, but it was literally revolutionary only a few centuries ago. The mass production of goods and services only became thinkable with the Industrial Revolution. But it was not until the early 20th century that production line manufacturing created commodities in such quantities for today's culture of consumption to exist.

The transformation in what was essentially applied functionalism came to be known as Fordism (after the American car manufacturer, Henry Ford), and Taylorism (after engineer Frederick W Taylor). Both Ford and Taylor were heavily influenced by the work of Herbert Spencer, mentioned earlier, whose organic analogy explained how society could be understood as functioning reductively.

Spencer's work also heavily influenced Talcott Parsons, who contributed to the growing field of systems theory, and the belief that society could be understood as a series of inputs and outputs (think here of the way healthcare today is understood as admissions and discharges). But it was his influence on Ford and Taylor that has been most enduring.

Henry Ford revolutionised manufacturing in America in the early years of the 20th century, creating production lines that broke down the task of building cars in his Ford Motors plants, and gave each person a discrete responsibility. Raw materials entered at one end, and a car appeared at the other. Ford dispensed with the idea of skilled craftsmen who could build a car from scratch by hand, and replaced it with an army of low-paid, relatively unskilled workers, each with a highly efficient, predictable, and repeatable task. Production in Ford's factories never stopped and labour became entirely replaceable; at first by other unskilled labour, then by machines. At the same time, Frederick Taylor was applying his interest in mechanical engineering to the scientific management of work organisation, arguing that it was in the interests of both workers and management to increase productivity. Managers would increase profits, and workers would increase pay. Taylor argued that maximum efficiency could only be achieved where the 'physical movements in the workplace were meticulously timed and studied' (29), and pay was linked to productivity.

Nigel Malin has suggested that the work of Taylor and Ford embodied 'principles of work organisation, notably the transfer of all discretion from workers to management and the fragmentation and simplification of tasks, including managerial control over the pace of work' (30). You can see this in the emphasis we now place on efficiency and organisation in healthcare, for instance, in the 'production-line' mentality that drives a lot of decision-making around patients' admission, assessment, treatment, and discharge from care in publicly-funded healthcare; and in the emphasis on managerialism and streamlined 'customer-focused' services. But a version of Taylorism and Fordism has always resided within physiotherapy too, and this helps explain why the profession has remained an important agent of social progress in many (Western) healthcare systems.

Physiotherapy has always been oriented towards maximising the efficiency of function and movement. There is little place in physiotherapy for convalescence, relaxation, and rest (31), and the profession's focus has always been centred on the productive, working, active, able body. It has always seen itself as an important and distinguishable cog within the machine that is the orthodox healthcare system. And in recent years its professional educators, leaders, and researchers have wholly embraced the objectivity and scientific reductionism of quantitative research and evidence-based practice. All of these are classical traits of functionalism, and tie physiotherapy closely to the goals of industrial capitalism, medicine, and the modern state.

Traits and characteristics of professional physiotherapy

If reductionism is one of the most subtly influential forces shaping how physiotherapy is practiced, then trait theory is perhaps one of the most obvious. Every position description, definition of physiotherapy, guideline for best practice or ethical conduct; every patient assessment, evidence-based treatment plan, and clinical record, is underpinned, on some level, by functionalist thinking. With a few notable exceptions, almost all of the writing about what physiotherapy is, returns to the functionalist idea of the traits and characteristics, that define physiotherapy and differentiate it from other professions. Recall Catherine Worthington's argument in 1961 that 'if your objective is to

develop physical therapy into a profession — you must give attention to the differences between technicians and professional persons' (22).

One of the first attempts to define the profession theoretically came in Julius Sim's 1985 paper *Physiotherapy: A professional portrait* (32). This made reference to many of the key works in the sociology of the professions, but concentrated on functionalist questions of what the profession *is*, and whether it matters whether it calls itself a profession or not. Echoes of this can be seen in Katherine Shepard and colleagues' seminal 1999 paper *Describing expert practice in physical therapy* (33). In their comprehensive study designed to establish a theoretical framework that adequately mapped and accounted for the complexities and diversities of the profession, the authors focused initially on the 'characteristics and factors' inherent in practice. This was supplemented in 1991 with data that focused on the attributes that characterised 'expert' clinicians. These 'attribute dimensions' were strongly influenced by trait theory. Gradually, the study moved towards more performative and relational approaches, and finally reported in 1999 with the goal of understanding how expert clinicians 'sought knowledge of the patients as persons' (33). But perhaps one of the most telling findings from this study justifies Edgar Burns' argument that professionals will always justify their existence in classical functionalist terms (34). In this case, citing the importance of physiotherapists demonstrating personal responsibility for maintaining one's health, moral rectitude in practice, dedication, compassion, and modesty about the limits of one's knowledge (33).

Perhaps one of the people who have done most to excavate the meaning of physiotherapy, however, is Professor Joy Higgs. Over more than three decades, Higgs has written, amongst other things, about physiotherapy education (35, 36), and practice (37–40), the profession's approach to clinical reasoning and the development of practice expertise (41–44). Her 2001 paper, *Portrait of the physiotherapy profession*, written with Australian colleagues Kathryn Refshauge and Elizabeth Ellis, though, is particularly significant in the way it draws on functionalist motifs.

In the paper, the authors ask 'what is physiotherapy?' Pointing to published definitions by World Physiotherapy (formerly WCPT - the World Confederation for Physical Therapy) and others, they highlight the profession's autonomy and freedom to exercise professional judgement; its international professional associations; its distinctive roles and functions (being 'concerned with the promotion of health and well-being and with prevention, treatment or rehabilitation of disorders or dysfunction of human movement', for example (45)); its training in specific tasks ('motor skills, exercise therapy, joint mobilisation and manipulation' etc. (ibid, p. 82)), and its avoidance of approaches to health that 'belong' to others (invasive procedures and pharmaceutical remedies, for example). The profession's 'body of knowledge and approach to management of patients clearly distinguishes physiotherapy from the other health professions', they argue (45).

Whilst being distinguishable for their 'deep and broad understanding of normal movement and impaired function' (45), physiotherapists also maintain a direct connection between physiotherapy and medicine, through a shared appreciation for 'anatomy, pathology, biomechanics, medical sciences and psychology', as well as the adoption of standard Western medical approaches to the assessment, diagnosis, treatment planning, intervention, and evaluation of health and illness (45). The authors are confident enough in the maturity of the profession to argue that by 2001, physiotherapy had 'reached a stage of consolidation of its development as a profession' (45), in high-income countries at least, evidenced by 'high levels of status, qualification and recognition, of expansion of the discipline's knowledge base, critical self-evaluation or systems of self-regulation, advances in clinical practice and specialisation' (45). Perhaps the only aspect of professional status remaining in doubt, the authors

suggest, is physiotherapy's autonomy; 'Beyond peer regulation, the essence of professional practice in physiotherapy is professional autonomy and the responsibility for one's actions which is inherent in this autonomy' (45).

Taken together, this is the model of a functionalist analysis of physiotherapy, touching on all of the ways in which the profession has come to define itself, how it functions alongside others, and restores balance in society. The traits it defines as the key features of physiotherapy (its professional body, affective neutrality, mastery and exclusive competency, universalism, service ideal, autonomy, and ethical comportment), are almost exactly the traits of elite professions identified by Parsons in the 1930s. A similar argument is made by Rob Jones in his edited collection *Management in Physiotherapy* (46). Here, Jones acknowledges a debt to the sociology of the professions, but focuses almost exclusively on the early functionalist thinkers (23, 47, 48). Jones argues that physiotherapy possesses now familiar traits, and, as a result, is progressing towards full professional autonomy (46).

The same approach to understanding physiotherapy can be seen in numerous other studies published in recent years: in Randy McCombie, Shelby O'Connor, and Sarah Schumacher's paper comparing the personality traits of occupational therapists and physiotherapists (49); in Emer McGowan and Emma Stokes' paper on leadership in physical therapy (50); and in Marlena Calo and colleagues' analysis of the grit and resilience needed by physiotherapy students (51). In Marianne Eliassen, Nils Henriksen, and Siri Moe's recent paper (52), you have characteristics of reablement practice, and in David Martínez-Pernía, Óscar González-Castán, and David Huepe's historical review of physical rehabilitation (53), functionalism is explicitly cited as a driving force in shaping practice.

In most cases, functionalism serves as an invisible influence on studies that look at what physiotherapy is and where it comes from. But only occasionally do authors acknowledge that their analyses are shaped this way. Rarer still are studies that actively use the work of functionalist authors as the philosophical basis for analysis. In recent years, though, there has been something of a resurgence of interest in new forms of functionalism — or *neo*-functionalism — especially in the work of Andrew Abbott (54–56) and Harold Wilensky (48).

Neo-functionalism

Abbott's work is particularly notable here because it broke with the classical functionalist belief in the need for social stability, and looked, instead, at inter-professional competition. Abbott was interested in the ways that disputes over local professional jurisdictions caused professions to develop in idiosyncratic ways, rather than as orderly progress. His work remained broadly functionalist because his interest lay in developing a generalisable 'system' for understanding the development of the professions, but he was much more interested in who was doing what to whom, and the internal conflicts that tended to disrupt social order, rather than secure it.

Abbott's work has featured in a number of physiotherapy studies in recent years (57–64). In Pauline Norris's article, *How 'we' are different from 'them'* (65), in particular, Abbott's thesis that 'professions form an interlocking system in which they compete for work' (ibid, p.25), plays a prominent role. Focusing on the contested field of musculoskeletal practice, Norris studied medical specialists, general practitioners, physiotherapists, chiropractors, osteopaths, massage therapists, and a range of other practitioners, both orthodox and alternative. Her findings reinforce Abbott's argument that it

is not claims to scientific knowledge that define professional identities in practice, but the relationships *between* competing professions.

What these studies point to, is the enduring power of functionalism as a way to make sense of what physiotherapy *is*. Functionalism has had a powerful influence on the sociology of *all* professions though, especially in healthcare, where it was the most important and widely cited approach shaping the aspirations of the new professions that emerged in the early part of the 20th century. In healthcare, functionalist research showed how a profession could aspire to be like medicine; how to build a relationship with the public and the state; how to operate for maximal efficiency, objectivity and productivity; and how to carve out a distinctive position in an increasingly competitive marketplace.

It would be fair to say that through the 1930s, 40s and 50s, functionalism was the most important ideology shaping the professions as social entities. But life for many people after WWII disrupted not only our beliefs about the professions, but about so many other things too: gender and sexuality, race relations, attitudes towards war, human rights, disability, ecology, music, drugs, technology and the media. Perhaps not surprisingly, the values and principles that had made functionalism seem so obvious in the 1930s began to be questioned in the 1960s, leading to revolutionary new ways to think about society and the ways it had been organised. So, what did critics claim was now wrong with functionalism?

Critiques of functionalism

The professions have historically enjoyed significant social standing and prestige, and to be a professional has always carried a degree of kudos. And although some have recently sought to undermine the value of professional expertise (see, for example, UK politician Michael Gove's recent announcement that "people in this country have had enough of experts" (66)), being a professional, particularly a healthcare professional, remains significant. Functionalism is responsible for a fair amount of this cultural capital because it solidified the professions within the establishment, at a time in the first half of the twentieth century when many people were looking for more order and stability. But since the heyday of functionalism in the first half of the 20th century, there has hardly been a sociologist who has not weighed in to functionalism's shortcomings.

Functionalism has largely been rejected for a number of important reasons. Firstly, critics argued that it says nothing about the kinds of power that the professions accumulated around themselves during the 20th century. Functionalism has no mechanism to account for the elite professions' 'enlightened paternalism' (67–70). This has been especially true for the medical profession, whose financial rewards, social privilege, and jurisdictional control over how people experience, think, and practice healthcare (4), has caused many critics to doubt Parsons' early claim that true professionals were altruistic and disinterested in personal or professional gain. Keith Macdonald suggested that the key question we should be asking the professions is how they managed to persuade society to grant them a privileged position in the first place (71). And Jonathan Gabe has even argued that this acquisition of enormous social capital, whilst claiming to be public-spirited and altruistic, represents 'something of a con trick' (4).

Functionalism says nothing about the 'self-interested practices of social closure, of professions seeking to maintain their occupational autonomy, their pursuit of high incomes, and the maintenance

of their social status' (72). The whole question of social closure is something I will return to at length later, but it critiques functionalist thinkers for taking the profession's claims to professionalism at face value. For example, functionalism does not question a profession's claim to be value free yet, at the same time, 'good' (73). Functionalism says nothing about the way that medicine has consistently treated people differently depending on their gender, ethnicity, race, social class, ability, and sexuality, or how it has functioned as 'a particular, institutionalized form of client control', with their professional status deriving from 'the assumed ignorance of the client' (21). Nor does it account for the 'greed, hubris, fragmentation, and insensitivity to patients' that proliferated in medicine in the second half of the last century (67). And it says little about the way medicine routinely makes 'moral judgements about the role patients play in causing their illnesses' (7), or the way the functionalist position 'typifies patients as compliant, passive and grateful, while doctors are represented as universally beneficent, competent and altruistic' (10).

Functionalist descriptions of professions suit the professions themselves because they 'mostly consider traits like expertise, ethicality, autonomy, care, to be self-evident features' (34). But these fail to explain the broader 'external', macroscopic, social structures, that make the professions possible in the first place. They ignore, for instance, the loss of much of the traditional cultural authority possessed by the elite professions, and the fact that many professions — including those allied to medicine — serve important functions in society, but often remain poorly paid and subordinate (74). Also, Abbott and Meerabeau have argued that functionalism provides the justification for professions to serve their own interests as much as those of others, and, because of this, 'the professions cannot necessarily be relied upon to police themselves effectively, nor to act in the public interest' (21). Because functionalism makes professions appear self-satisfied, Macdonald has suggested that some studies of the professions, by the professions themselves, have reached 'a level of uncriticality that is hard to credit' (71).

Building on Macdonald's criticism, Burns suggests that functionalism actively discourages critical questioning (34) because it only provides a description of what a profession *is*, not what a profession *does* (21). It has helped the elite 'true' professions develop a social brand that others might imitate (75), and it has explained why things are the way they are 'for a particular group or social class at a given point in history' (34), but says little about the external, social forces that shape professions, or the fluidity of social relations that see professions in a constant state of flux. It leads to what Burns calls an 'abstract universalism' (ibid), that promotes the idea that there is only one kind of profession, rather than the myriad local, context-specific variations. We see this in the way professions are defined in functionalist terms, implying that they are more stable and resolute than the reality of people's practice 'on the ground'. Functionalism tells us little about a profession's ability to maintain its cultural legitimacy in the face of prevalent social values and concerns (56, 76). We know, for instance, that people's trust in medicine is much more volatile than it once was, but functionalism has no mechanism to explain why this is, or how medicine has changed as a result. Functionalism judges all occupations against an ideal or archetypal model represented in healthcare by medicine. It suggests that professions like medicine and law represent the ideal standard against which we should judge all other professions. Trait theory offers no explanation for how and why an occupation became a profession in the first place, though. It says nothing about the economic and social rewards that flow to elite professions, nor criticises the ways in which these elite social bodies exercise their power, sometimes at the expense of those people they putatively claim to serve.

Critics argue that functionalism promotes the belief that society is innately stabilising and progressive, and that the professions serve as stabilising agents. But such 'consensus' theories were largely advanced during periods of the 20th century when there was more faith in authority figures, and people were more accepting of grand narratives like science and religion (77). Since the 1960s, conflict theories have been used much more to explain how professional projects have shifted and changed over time, and consensus theories have largely been jettisoned.

In the functionalist tradition, 'people disappear into social structures, become passive reactors to those structures and lack any ability to engage with the external world as their actions are deterministically structured by them' (78). This is true of individuals who make up the collective face of a profession, but it is also true of the clients, patients, consumers, and service users, as well as the myriad 'others' that the professionals work with [2]. Functionalism says nothing about the relational nature of healthcare practice, or the existential and subjective experience of being a professional. It assumes that all of the professionals of a particular stripe conform to the same traits and characteristics, and everyone is subject to the same social rules, which operate uniformly throughout the profession.

Finally, and perhaps most significantly for this book, functionalist ways of thinking may hamper a profession's own abilities to grow and change because they tend to see social institutions like the professions as 'simply and naturally, how things are' (34). But this assumed 'naturalness' is not supported by history. It also discourages critical interrogation of the profession's role and social context because its existence and purpose are seemingly explained by the profession's affinity with the traits of other elites. Burns goes as far as to say that functionalism is 'increasingly getting in the way of the important job of linking professions with the kinds of societal questions that they should be answering' (ibid).

Suffice to say, much of the literature in the sociology of the professions has, in recent years, 'taken a critical stance, challenging the motivation of professionals and suggesting that they control clients and are concerned primarily with their own status and economic rewards' (21). Worst of all, particularly for any project that tries to explain how a profession like physiotherapy becomes even thinkable and practicable, is that functionalism fails to answer some of the most pressing questions facing the professions: 'is the present configuration of this particular professional service best? Best for whom? Who pays? Who pays most? Who should pay most? Who benefits most? What implicit costs are there in this situation? How best to improve, remake a professional group or deliver a professional function?', and 'how might things be otherwise?' (34).

The lack of social theory in physiotherapy explains, in part, why functionalist thinking persists in the profession, long after it has been discredited. We see functionalism every day in the traits promoted by our professional bodies. But we also see functionalist motifs repeatedly used by profession leaders who claim that physiotherapists are well-meaning, altruistic, public-spirited, objective, rational, and dispassionate. But, of course, physiotherapy isn't alone in over-relying on functionalist ideas to explain what it is;

> *'Even today functionalism, though discredited in social theorising, remains the default mode of thinking about professions and professionalism for the majority of professionals, if they think about their*

[2] Different terms for patients, clients, consumers, and service-users are used throughout the book. I have attempted to use them in their particular context rather than offer one standardised term. Thus the idea of the consumer and service-user, in contrast to the 'passive' patient, become highly relevant when I discuss the neoliberal market economies now driving Western healthcare.

> *professions in a broader way at all. It reaffirms for themselves, and reasserts to others, the previously hegemonic conception of conjoined professional goodness and expertise"* (34).

Burns suggests that functionalism persists in at least four areas:

1. Within the professions themselves, in 'accounting for their social positioning';
2. Amongst politicians and policymakers;
3. With the lay public, 'which holds a conflicted mixture of 'doctor knows best', and the 'sense of being excluded from many decisions in many spheres';
4. And within the media, whose 'stereotypic positioning of professionals… mixes adulation, fascination and demand in frequently unsatisfactory ways, but which also at times breaks open covert, bad professional situations needing public examination' (ibid).

Clearly it is necessary to move beyond simply analysing how professions function in society, or the rudimentary categorising of what a profession is or does. And this is especially true in times of rapid and profound social change. And while there is no need to reject functionalism outright, we have definitely arrived at the point where we can move past it, and consider some other ways to think about how professions function within the complex matrix of possibilities and contingencies that is contemporary healthcare. To do this, we need to understand some of the ideas that have supplanted functionalism and open up to some other ways of thinking about physiotherapy. So, this is where we go next.

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3. Surplus labour

The origins of professions — Alienation — Wage slavery — How does capitalism dominate Western? — Controlling systems — Professional projects — The conquest of official privilege — Implications for physiotherapy — Are individual physiotherapists responsible? — Critiques of Marxian approaches to the professions

In the last chapter, we set the foundations for the sociological study of physiotherapy, focusing on functionalism, and its belief in the stabilising role professions played in society. Functionalism came at a time when Western societies were in upheaval, and it fed into peoples' hope that human society was ultimately progressing and becoming balanced, ordered, and peaceful. It also appealed greatly to the new professional middle-class of teachers, engineers, lawyers, scientists, journalists, architects, doctors, nurses, and physiotherapists, that had begun to emerge. It told them that their work was socially significant, and that they represented the best of us.

But functionalism had many critics too, and these became increasingly vocal after World War II. Critics argued that functionalism told us nothing about the reasons why power was so unevenly distributed in society. It said nothing about the professionals' practices of self-interested social closure. It viewed any critique as upsetting the balancing effect of professions in society. And it saw people as passive subjects of social order, rather than active agents shaping the world around them.

There have been dozens of social theorists offering alternatives to functionalism over the last century. But all of them, at some level, owe a debt to the ideas explored in this chapter. The chapter deals with the legacy of Karl Marx (1818-1883), and the Marxian critique of the professions that began in earnest in the 1950s. Marx's work, especially *The Communist Manifesto* (1) and *Das Kapital* (translated simply as *Capital*) (2), were produced together with Friedrich Engels (1820-1895) who, together, provided some of the most important works of social history ever produced.

Although Marx and Engels' writings came in the 19th century, before today's health professions had been conceived, their work provided the groundwork for much of the sociology of the professions that followed. In fact, it would be no exaggeration to say that it would be impossible to understand what the professions are today, without a reasonable understanding of Marxian theory. Marx and Engels gave birth to 'conflict theory' and the idea that societies were based on disputes and competition, rather than the consensus of functionalism. But their focus on the nature of work and labour also holds special significance for our analysis of physiotherapy, and so sets up much of what follows in the subsequent seven chapters.

As well as redefining the study of economics, Marx and Engels were consummate historians and sociologists. Their writings redefined how we understood the history of Western society; the relationships between social institutions like 'the state', and individual human agency; the psychology of modern life; and the role concepts like work and surplus value play in shaping capitalism and market economies. Perhaps we should begin, then, with the way Marxian theorists explain how professionals appeared in the first place.

The origins of the professions

A key principle in understanding the sociology of the professions is the realisation that the professions, as we know them today, are only a very recent invention. They have existed as social entities for only a few decades. And so, in the history of humanity, today's health professionals are only the most recent, and not necessarily the best, way to manage health and wellbeing.

We know that the professions were few and far between before the Industrial Revolution, which transformed society in Europe and North America during the seventeenth and nineteenth centuries (3). Clearly, work of all sorts had always been done by people, and human labour has been organised, in some form, for thousands of years. There is even evidence of the organisation of work around various craft guilds, trades unions, and worker's collectives, dating back to the Middle Ages (4, 5). But the *professions* are a very distinctive form of social organisation that has only really existed since the 19th century.

Originally, the professions were conceived of as a 'gentlemanly' pursuit, with the professions of medicine, law, and the clergy representing 'an idealised career trajectory for young men, conferring status, applying science and technology in new and interesting ways and assigning immense prestige on a much wider scale' (6). In the Western world, the roles of doctor, priest, and lawyer were largely held by independently wealthy men whose interests lay in establishing the prestige of their work, rather than ensuring a stable income and fair working conditions for their peers. Importantly, the work that was done, could not demean the aristocratic gentleman (7), and needed to be distinguishable from more ordinary trades.

This was possible because the early gentlemen professionals did not rely on their work for their living, so could afford to adopt a detached disinterest in its efficacy. If their experiments in professional practice failed, only their interests suffered. For less well-disposed sons of the aristocracy, the challenge was to find work that gave them an income and a way of life that allowed them to remain part of a social circle (8). But gentlemanly attitudes to work, and even the growth of scientific knowledge after the Enlightenment, cannot explain the sudden growth in the number and range of professions that emerged towards the end of the 19th century. For this, we need to understand the roles played by the Industrial Revolution and early capitalism.

For much of human history, people have lived in small, isolated communities, and their daily toil has been dominated by the need to find and produce food. It would often take all 30 people to produce enough food to feed 30 people. There was rarely any surplus. Everyone, young or old, was involved in the same cycle of seasonal work and there was very little division of labour. Because everything had to be carried by hand, crops, and animals were tended close to the settlement, and so villages often remained small and isolated. People lived precarious lives, often at the mercy of the seasons. Infant mortality was high, and a bad season could decimate the village. This was the pattern

of existence for people for thousands of years before the invention of agricultural machinery, and still remains true for billions of people living in low- and middle-income countries today.

The invention of agricultural machinery in the 17th and 18th centuries, however, changed the picture for many. Now, for the first time, people could grow food miles from the village because they had the machinery to sow, harvest, and transport their crops more easily. Villagers had more food than they could eat for the first time, giving them a surplus that could be stored, to see out a bad season, or be traded for goods and services that the village did not possess. Surplus meant there was less hunger. People rapidly became bigger, healthier, and stronger. Infant mortality rates declined and longevity increased dramatically, leading to a population explosion after 1800.

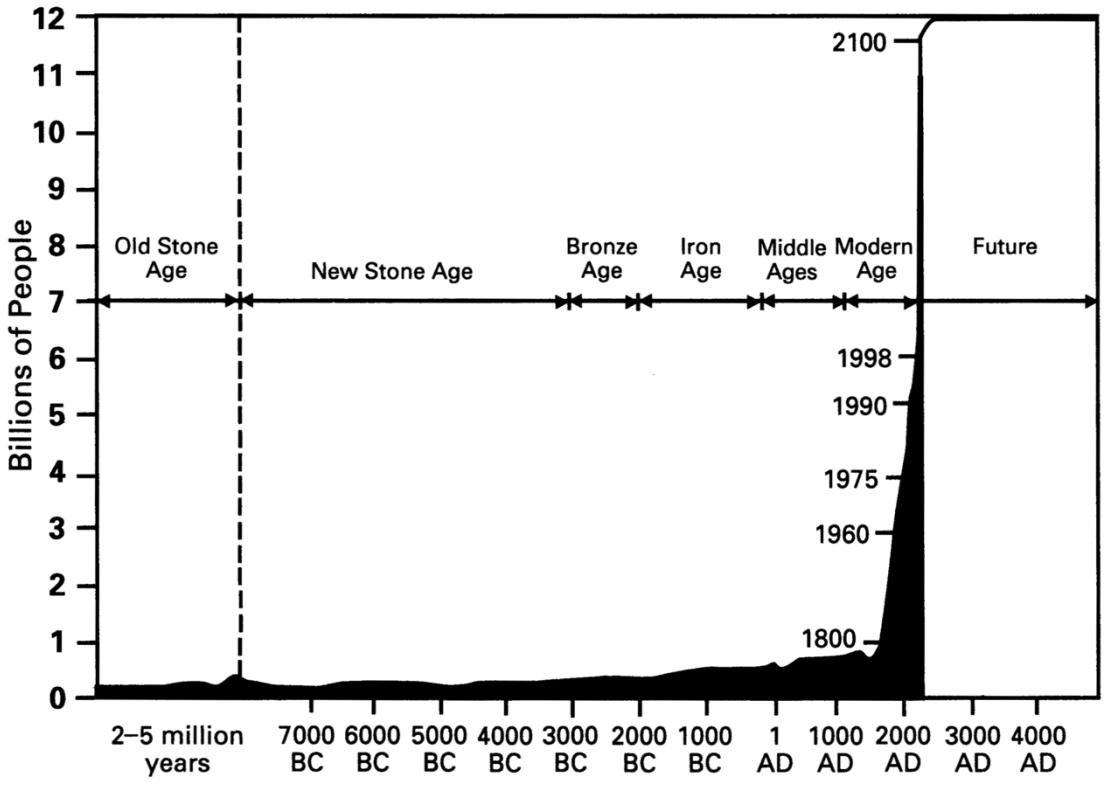

Figure 1. World population growth through history. From McFall Jr, J.A. Population Bulletin, 42(2), October 1991. Population Reference Bureau, Washington, D.C.

But the use of agricultural machinery also had another important effect. Villages now needed only one or two people to tend the machines that produced all of the food that had once occupied the whole village. With populations growing rapidly, whole swathes of the rural population now found themselves in need of work. Some took up new skills as blacksmiths, tailors, masons, carpenters, and milliners. But others simply abandoned the countryside in an enormous exodus to the cities.

The invention of the railways at least meant that people could trade their labour wherever they could find work. But there was no more guarantee of work in the rapidly overcrowding cities than in the countryside, and so, within a few decades, millions of people became destitute. The need for work forced some into small business and, although many speculative ventures failed, many succeeded.

But for the vast majority of the population, work was scarce and life precarious. And while this precarity was bad for workers and their families, it was a boon for the new industrialists.

The vast oversupply of human labour, and the relative scarcity of work, meant that workers competed for jobs. A business owner given a fixed fee for completing a job, for instance, could tender out parts of the job to workers who would negotiate their own rates of pay. In order to secure employment and feed their families, workers would undercut each other, taking less and less pay for the same work. This drove down the labour costs for the business owner, and increased profits[1]. I will return to this theme shortly, but, suffice to say, the availability of cheap, unskilled labour, drove the mills, foundries, and factories of the Industrial Revolution, and put enormous profits in the hands of a new class of industrialist. How, though, does this relate to the history of the professions?

As well as providing the impetus for early capitalism, the Industrial Revolution created a mass of angry, desperate, and politically active citizens. The revolutions that ensued in the 18th and 19th centuries reshaped societies, and gave birth to modern government. When populations are small, and a feudal system maintains strict divisions between people in society, it is possible to have sovereigns who rule by fear, and exercise what they believe to be God-given power through acts of symbolic violence. But guillotines and public beheadings are little threat to cities teeming with millions of starving, sick, and destitute slum dwellers.

New forms of government were needed that did more than simply suppress unrest. The population needed to be known and understood, and basic services needed to be provided, if people were to stop revolting and contribute, instead, to the prosperity of their country. Nascent governments began to ask who its people were and what they needed. Surveys, censuses, and statistics were used for the first time, and ideas of basic civic rights were mooted. New ideas of 'citizenship' and national identity began, tying each person to certain rights and responsibilities. And nation states increasingly saw it as their role to protect their borders, colonise new territory, expand trade, and use these strategies to enhance the health, wealth, and happiness of *all* of its people.

Clearly, the 'work' of these new forms of government could not be done by the handful of elected officials. People were needed to teach children how to be good citizens, heal the sick, maintain law and order, build houses, hospitals, and public works, and defend the country, on a grander scale than had ever been conceived before. And so, a new class of 'professional' was created. First, the gentlemanly doctors, lawyers, and priests, were given specific privileges and protections in return for their service to the state. Then, over time, others were added to the professional ranks, in the image of its progenitors. Gradually an infrastructure was built around the professions. In the case of medicine, funding was provided for training and employment, protective legislation was written, hospitals and clinics were built, medical schools established, and the ability to grant their own access rights and privileges was agreed (10–12).

Of course, this narrative vastly over-simplified the history of modernisation, and variations can be found in many countries around the world. That notwithstanding, though, the route that most societies have taken from subsistence to modern nation states, has been mirrored wherever the professions have become significant social entities. And Marx and Engels' work helped to establish the sociological principle that the professions cannot function in a vacuum and need social structures

[1] There is a beautiful semi-fictional account of this process at work in Robert Tressel's 1914 book *The ragged trousered philanthropists* (9), which tells the story of a painting and decorating firm on England's south coast at the turn of the century. The book has been called 'the reformist's bible' for the way it exposes the injustices faced by everyday workers after the Industrial Revolution.

to survive. The reverse has not always been true though, and history has shown us that many societies around the world have functioned perfectly well, for thousands of years, without professionals. The reasons why Western societies established an entire professional class, then, has been of interest to sociologists for decades. And Marx and Engels' work reminds us how deeply Western professionals are tied to the birth of industrial capitalism and the modern state. Marxian theory has also helped explain some of the unwanted consequences of 'progress' in Western societies, and some of these have direct relevance to physiotherapy today.

Alienation

Marx believed that what made humans unique was our capacity to shape the world to our advantage. He argued that our best work made the world better. Birds can build nests, but only humans can design hospitals and public healthcare systems. Human work was anything but haphazard and, like Durkheim, Marx believed it was organised around social relationships (which is why we can talk about Marx as a sociologist). Hannah Arendt picked up on this in her book *The human condition* (13), arguing that human activity could be divided into labour, work, and action. Where labour addressed only life's necessities (eating, toileting, reproducing, etc.), and work crafted the liveable world (building roads, writing novels, designing websites), action gave meaning to our lives. Where labour was predictable and mundane, and work was often skilled but repetitive, action was a spontaneous, inter-subjective activity, involving people speaking out to make the world better.

But Marx was also interested in the ways the benefits of social progress had been unequally distributed, and his iconoclastic analysis of life in 19th century Europe showed how this had been made possible. Marx argued that the Industrial Revolution had created an abundance of materials that people could use to their advantage: food, new technologies and scientific discoveries, raw materials for building, and new methods of transport blossomed in Europe after the 17th century. But the dividend of this surplus was not shared equally. In fact, European societies became significantly more unequal after the Industrial Revolution, as some people exploited the new collective wealth for individual purpose. The key, for Marx, lay with the ability to control the 'relations of production'.

Marx drew a distinction between those people who controlled the mills and mines (the bourgeoisie), and those who worked in them (the proletariat). Controlling this *relation* of production determined who owned the *means* of production (the factory, the machines, the worker's time and effort). Workers gave their labour to turn raw materials into goods and services, but the difference between what something cost to produce, and what it sold for, created a surplus that could be taken as profit by those who controlled the means of production. Thus, it was always in the interests of capitalism to keep wages low to maximise profits. But this was also the source of anger for workers, who saw the profits of their labour going to people who had not worked for it; 'This surplus value costs the capitalist nothing, and is a tangible symbol of the exploitation of wage-earners' labour power by employers' (14). Marx's revolutionary idea was that the whole basis of Western society had been built on this rift between the bosses and the workers. He saw the whole political system, with its laws and regulations, customs and structures, as underpinned by this fundamentally exploitative economic ideology.

Marx and Engels believed this had a profoundly alienating effect on people. Being forced to leave homes and communities to find work, and competing with others to produce goods and services that people had no affinity with, was, for Marx and Engels, the source of profound spiritual, mental, and physical ill health. Alienation expressed the estrangement and detachment that accompanies peoples' sense of the loss for the deeper meaning of our work. We should be working for our communities, helping those closest to us, not stitching footballs in a factory hundreds of miles from home, or filing in forms to ask an insurer to fund a few more treatment sessions. People's work had been turned into a commodity, whose surplus value went not back to them, but to others whose interests depended on continually demeaning the value of their 'species being' (14).

Both Marx and Durkheim believed that people who lived and worked in their communities felt that their labour contributed directly to their wellbeing and the wellbeing of the people close to them. When people had to work on production lines, mines, prisons and hospitals, and labour for large, remote, multinational corporations, courier firms, and off-shore call centres, they are removed from their communities and lose a sense that their work really matters. Their work becomes a tradable, expendable, replaceable commodity over which they have no direct control. It becomes alien to the person's humanity and is inherently dehumanising (15).

Michael Thompson suggests that 'alienation can be understood as a particular kind of atrophy of moral concepts and moral thinking that affect the ways individuals cognize and legitimate the social world and their place within it' (16). Alienation is, at its heart, disempowering and dehumanising, or as David Foster Wallace suggested "the idea of giving yourself away entirely to the idea of working in order to achieve some sort of brass ring that usually involves people feeling some way about you — I mean, people wonder why we walk around feeling alienated and lonely and stressed out" (17).

Work, for Marx, was a 'sensuous and embodied practice through which human beings transform(ed) the world around them, in accordance with plans, projects and aesthetic sentiments' (18), and it reflects 'our humanity and individuality back to us' (ibid, p.5). And 'to live in accordance with our species-being is to live collectively, mutually recognizing one another as specifically human beings and thereby being able to recognize ourselves in this way' (ibid, p.6). But Marx believed capitalism had 'perverted the nature of work and prevented people from gaining fulfilment from it' (19).

Alienation clearly has important implications for physiotherapists, partly because physiotherapy *exists* to help manage the ill health that accompanies the alienation of human labour under capitalism. But also because we are, ourselves, workers. Physiotherapists, like all health workers, know the importance of demonstrating enthusiasm, commitment, and reflexive professionalism for their work, and they know to mask their 'true anxieties and hostilities' (20). But physiotherapists willingly contribute to their own alienation, by holding on to a professional identity that depends on practitioners' ability to distance their work from the physical therapies that have been practiced for centuries in communities all over the world. The ability of physiotherapists to claim a right to work *depends* on alienating themselves from communities and individual lay people. And physiotherapists are also complicit with the other Western, orthodox, biomedical professions in the process of *reification*; the Marxian term for the way the real harms of alienation are masked behind abstractions or 'phantom objectivity' (21)[2].

[2] Reification occurs when people stop seeing human beings as the cause of hurt and harm, racism and sexism, for instance, and see 'racism' and 'sexism' as things in themselves. In a similar way, Marxists argue

When physiotherapists emphasise outcome measures, objectify people as commodities, and attempt to provide universalised, evidence-based rationales for their care; when we claim our work reduces waiting times, increases choice and control, improves standards, and is more person-centred; when we increasingly talk of customers, consumers, personal care plans, personal health budgets, and health system evaluations; and when we talk of empowering consumers with greater choice, but limit that choice to a 'predetermined menu of services' (15), we are acting every day to revivify the alienation that lies at the heart of capitalism (22, 23).

Wage slavery

Given how debilitating alienation is for workers, one might ask why it is that capitalism has not been overthrown. Part of the reason for this is simply that people feel they have no choice but to work within 'the system' in order to live. Capitalism had created the conditions in which almost all of us need to work to survive, rather than working to fulfil our creative potential. And so, we are all, in Marxian terms, wage slaves.

Wage slavery derives from the fact that;

> *'most people spend most of their day under somebody else's supervision and control — namely at work. Every day, they sell not only their labour power but also their autonomy for a certain number of hours. Thus, they lose freedom, which in turn means a loss of self-determination. The power that the capitalists exert over workers doesn't benefit workers, it benefits the enterprise, which often enough turns against the workers. If you depend on someone else for your survival for the rest of your life, you are constantly forced to ensure that you remain competitive, i.e., cheaper and more productive than others. Your entire social environment is influenced and shaped by this competition, which extends into leisure time too'* (24).

And there are some important implications of being a wage slave for health professionals. Firstly, capitalism distinguishes meaningful work (that which maximises the use of people's time and labour, surplus value, and profit), from 'indulgent' work (intellectual development, aesthetic pleasure, fun and games, or what Hannah Arendt called 'action'). Secondly, it rewards those who help the system to prosper. Physiotherapy's longstanding focus on treating the body-as-machine, returning people to work, emphasising fitness and purposeful movement, focusing on restoring activities of daily living, and so on, suggest a bias inherent in the profession towards capitalism (25–27).

The focus on pathogens and germ theory as the basis of all illness, and today's more recent interest in personal responsibility, self-care, and 'active' rather than 'passive' therapies, also divert attention away from the social determinants that are known to give rise to disease in the first place. Marxist thinkers in healthcare believe that we are wrong to see illness and disease as residing within the body of individuals. Rather, today's maladies 'are located in the economic, political and social arrangements of capitalism, not within individual biology or lifestyle' (28).

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that when people's genuine healthcare needs are reframed as demand for standardised care packages; when basic human needs are reconceived as personal choices; or when services are reconstituted as commodities, the original force and effect of the person's needs are conveniently lost (15).

Of course, the state's endorsement of biomedical knowledge through public funding of research and legal protection of medicine's occupational territory, only reinforces the sense that capitalism is a powerful system into which all orthodox professions, including physiotherapy, are enmeshed. As Alan Petersen suggests;

> *'Doctors maintain their high status and incomes insofar as they control public expenditure in the health area; on the other hand, the state maintains its legitimacy as a 'caring' state insofar as it is seen to manage ill-health effectively and to deliver medical services which the population has come to regard as an essential component of good health'* (28).

Capitalism, therefore, creates a major dilemma for health professionals like physiotherapists. Many would love to spend longer with their client/patients, but they are told the economic constraints of the system will not allow it. They know there are times when they should advocate for their patients, but they know they risk their own security in doing so. And many would love to be able to be more compassionate and caring in their therapy, but the profession places little value on knowledge that cannot be externally verified, objectively measured, or based on quantitative evidence.

A recent Canadian study by Jennifer Bessette, Mélissa Généreux, Aliki Thomas, and Chantal Camden has shown just how conflicted physiotherapy is around its dual role as a patient advocate *and* as a profession that depends on its special status to provide work for its members. In the study, the authors argue that physiotherapists should play a vital role in helping to 'address national health concerns, such as the aging population and the opioid crisis', and that 'physiotherapists need to be educated to become competent advocates (29). The authors cite evidence that physiotherapy students are taught to 'speak out on health issues identified by clients', 'empower clients to speak on their own behalf', and to work collaboratively to 'optimize client care'.

But the authors also found that educators found advocacy difficult to teach and assess 'in a fair, clinically relevant, and time-effective manner' (ibid, p.309). The study found that some students were 'not naturally inclined to defend their patients' interests', and that others were 'often unwilling to engage in advocacy' (ibid). There were issues finding time in the curriculum to teach advocacy, and limited exposure clinically, unless students were placed in 'settings with a strong focus on patient-centred care, located in under-resourced areas, or in which students interacted with vulnerable patients offered more opportunities to practise advocacy' (ibid, p.310).

Crucially, the authors found no evidence that the fundamental ethical contradictions inherent in advocacy had been explored with the students. Often in health curricula, advocacy is seen as a skill or competency to be learned and applied in the way one might undertake a Thomas Test or a Timed Up-and-Go. The therapist here is seen as an objective agent of change, who can apply a set of skills and learned competencies to a situation and 'treat' the person's social situation much as they might treat an unstable shoulder. A Marxist reading of advocacy though would say that advocacy is fundamentally about power, in which an oppressed member of society reaches out for help. The therapist here is not the last link in the chain, but is, themselves, subject to the same system of oppression that envelopes their patient. If they speak out against the injustice affecting their client or their community, they may suffer as a result. They may lose their job, or be rebuked by their peers. The root of the problem of advocacy, then, is that it feels like 'an abstract concept' that the students 'just don't understand'. It is an ethical principle that should fit in to the schema of all practitioners, but feels, in the end, as if it is 'just "not physio." (Supervisor 8)' (29).

No matter how many ethical codes govern what people are *supposed* to do, if a person has the choice between speaking out and risking their livelihood, and staying quiet, they will most often choose the latter. A recent study by Phillippa Malpas, Warwick Bagg, Jill Yielder, and Alan Merry showed that doctors routinely practiced 'sensitive examinations (of female breasts and pelvis, female and male rectums and male genitalia)' on anaesthetised patients without consent (30). And;

> *'Students are not alone in acknowledging a conflict in speaking up. When medical oncologist, Ranjana Srivastava asked colleagues to reflect on her experience of not speaking up to a senior colleague about her concerns for a patient's safety, "each recalls sometimes harbouring misgivings about another doctor's treatment of a patient but feeling unable or reluctant to comment, even when a patient's life might be threatened"'* (30).

Marxian scholars say that the impulses that lie behind such actions cannot be reduced to individual choice, or understood simply as the actions of an individual corrupting what is otherwise an ethically robust system. These practices are too widespread to be about the individual's failure to follow an ethical code. In many cases, they are part of a systemic problem that Marxians believe underpins capitalism, and the systemic exploitation that forces people to make choices between advocating for their patients or losing their job. Marxist scholar Antonio Gramsci (1891-1937) argued that we are limited in our ways of thinking about things like advocacy and biomedicine because these ideas are *hegemonic*, an important concept that also applies directly to physiotherapists.

How does capitalism dominate Western healthcare?

Part of Antonio Gramsci's work, along with Theodor Adorno, Herbert Marcuse, and Max Horkheimer, looked at dominant, taken-for-granted, or 'hegemonic' ways of thinking, and asked what made them seem natural, compelling, sensible, and obvious to us? He asked why it requires a deliberate and sustained effort to convince people of the existence of hegemonic ideas like capitalism? And why was it so hard to overturn them? Marx believed that one of the victims of hegemony was *praxis*, or our capacity to act against oppressive material or social circumstances. People simply accepted the truth of hegemonic ideas, and so, like alienation, hegemonies reduced the 'unique capacity of humans to collectively create and transform their material and social relationships' (14). Gramsci argued that part of the reason societies were often slow to break with their current ways of thinking, was because this required people to challenge the things that they had long taken-for-granted. There had to be a strong reason for people to break with what felt comfortable and familiar to them; a process that, for Gramsci, demanded a deliberate act of 'counter-socialisation'.

Biomedicine, for instance, is so deeply grounded as a hegemonic discourse in Western healthcare, that people often naturally accept its very specific and particular way of thinking and practicing without question. Marx also believed that the classical liberal idea of the autonomous, sovereign individual at the heart of contemporary Western healthcare was a powerful and dangerous hegemonic idea because; 'This abstract individual comes into the world needing no one and relies exclusively on her own wits and abilities to pursue her self-interest' (31). Over the last half-century, a number of sociologists have considered how capitalism affects Western healthcare and the professions that work within it. Two of the most prominent here has been Harry Braverman and Magali Larson.

Controlling systems

Harry Braverman's studies centred on the *deskilling* of modern work in America (32). Long before the neoliberal economic reforms of the 1980s and 90s, Braverman began asking why Marx's critique of capitalism had not brought greater equity and respect for the true value of work to Americans. Braverman could not reconcile why people had simply accepted capitalism as inevitable, even when their society seemed to be drifting towards ever greater alienation and consumer fetishism.

At the heart of the problem faced by American workers was the capitalist desire to control their work. In order for business owners to obtain the 'full usefulness' of their employees labour power offered by people in society, it had become 'imperative to exert control over the labour process in order to maximise the productive potential of labour and therefore profits' (33). Unlike the work of a machine or horsepower, human labour was 'intelligent and purposeful' (ibid, p.56), and so capable of being harnessed for almost unlimited gain. Thus, what the capitalist business owner is buying is not tangible labour power, per se, but 'potential'.

One way to harness this potential, and maximise surplus value (profits for the business owner) had been pioneered by Frederick Taylor, founder of the 'scientific management' movement, and the *Taylorism* mentioned in Chapter 2. Taylor believed in 'gathering together… all the traditional knowledge which in the past had been possessed by the workmen and then classifying, tabulating and reducing this knowledge to rules' (34). Armed with this knowledge, business owners could employ 'large central bureaucracies' to collate, organise, and study the data, and advise managers on the best course of action. Critically, a new management class could take away from the workers the knowledge that had once defined their craft, giving the managers a 'monopoly over knowledge to control each step of the labour process and its mode of execution' (34).

Central to the process of 'scientific management' of work, then, was the transfer of all mental labour from the worker to management, and the subsequent creation of transferable, reproducible, and standardised programmes of work that could be easily quantified — a process that has been highly prevalent in Western healthcare, and physiotherapy practice specifically, in recent decades. Braverman saw this as an act of 'deskilling', designed to maximise the efficiency of the worker, whilst standardising their tasks to the point where their labour becomes entirely replaceable. In this way, the bourgeois business owner could reap all of the benefits of maximising the surplus value derived from people's labour, without having to invest in social programmes that took care of those who experience a drop in competitive performance, through illness and injury, for instance. The worker becomes a mere vassal in service of profit making, and the social welfare system provides the means to ensure that there were enough fit and active workers to fuel the machinery of capitalist production. What capitalism encourages, then, is the idea that people can be viewed as objects and things, stripped of their humanity, and as means to an (economic) end. Humans become 'instruments' in what Gramsci, Adorno, Marcuse, Horkheimer and other members of The Frankfurt School called the 'instrumental reason' of capitalism.

Professional projects

The ideology that is capitalism does not instrumentalise people and turn subjects into objects. Capitalism does not make business owners treat their workers as commodities. Capitalism is a way of thinking and acting, albeit a hegemonic one. For capitalism to work, it needs individuals and groups to put its principles into practice. And a range of Neo-Marxian sociologists, over the last 50 years, have looked at the role the professions play in enacting it. Magali Larson, Anne Witz, and Terry Johnson are perhaps some of the best known Neo-Marxists writing in the latter half of the twentieth century. Larson's work, particularly, focuses on the idea of 'professional projects'.

Professional projects are the 'more or less self-conscious efforts of members of an occupation to work collectively to improve their status and their economic prospects' (35), and, in so doing, promoting the values and beliefs of the culture that nurtures them. For Western professionals, that culture is capitalistic.

Larson was interested in the ways the professions defended, maintained, and improved their market position, by tying their identity with a distinctive 'commodity' (36, 37). Larson as interested in the way this commodity was inextricably 'bound to the person and the personality of the producer' (38). The goal in doing this, Larson argued, was to create a distinctive service that demanded 'the prior training, socialization and public establishment of a recognizable producer' (37).

Crucial in this process was the ability of the profession to standardise the commodity, and attribute to it a stable set of criteria that established what constituted expertise in the field. Larson thought commodity standardisation was important because it helped to eliminate alternative criteria for evaluation, and through this, 'professionals may impede the rise of new professions… to protect their monopoly power' (39).

Commodification also fed directly into a capitalist mentality because it supplied the market with one more 'product for sale' (40). The idea that fields like healthcare can become marketplaces for commodities now penetrates so deeply into people's psyche that health professionals now actively sell services; market therapies; compete to offer lifestyle advice, exercise regimes, and mindfulness courses; and price their own time and labour in a way that is indistinguishable from other forms of industrial process and capitalist production[3].

John Owens has suggested that the new language of personal choice, convenience, and independence — such a touchstone for physiotherapy in recent years — has introduced to healthcare 'a transactional set of norms more typically found in commercial activities into the consultation and care process which subjects patients and professionals to a form of commodification' (43). Or as Lindy Edwards puts it;

> *'Whether people are seeking help in the welfare, health or education sectors, they have become customers and clients rather than patients, students and people in need. The market-based reforms have replaced*

[3] Writing on Jürgen Marschukat's new book *The Age of Fitness*, Lola Seaton recently wrote that 'Part of what seems awry with contemporary fitness culture is its artifice, symptomatic of the wrongness of modernity, prior to which, one imagines, real life was excessively challenging and exercise blissfully inadvertent. Condemned to an "active" lifestyle, pre-modern humans would surely never have dreamed of inventing excuses to expend extra energy for the sake of it. Like the ubiquitous food products that advertise how little calorific sustenance they supply, confecting occasions for physical exertion seems to symbolise our alienation from a more natural, integrated, rational way of living' (41, 42).

relationships bound by trust, loyalty and reciprocity with 'client service'. Our innate obligations to our fellow human beings have been usurped by commercial obligations' (44).

Because healthcare is such an important tool with which to distribute resources in society, it is vulnerable to the kinds of economic exploitation and class oppression that are the hallmarks of capitalism (45). It has been customary to think of public welfare institutions like the National Health Service in the UK as bulwarks against such concerns. But the NHS has played an enormous role in consolidating the power of biomedicine, and created a 'closed shop' in which hegemonic medicine could control the way people are encouraged to think about the possibilities and limits of orthodox healthcare. The NHS helped Western medicine commodify health as something that can be linked to personal choice and behaviour, and entrenched inequalities in healthcare provision 'not just (as) an unfortunate bi-product of health work but an integral part of the logic of provision' (40).

Professions play a crucial role in perpetuating hegemonies, then. And from a Marxian perspective, professionals sit alongside consumer culture, mass media, the education system, and traditional notions of the nuclear family, in inducing a slow cultural fragmentation, and increasingly passive, psychological dependence in people (14). They reinforce our compliance in the face of aggressive monopoly capitalism, with the inevitable result being our growing sense of alienation, anxiety, and disconnection from our 'species being'.

Rather than resisting hegemonic discourses, Gramsci concluded that 'on some level people consent to subservience, even take it for granted, when the order in which they live comes to seem like common sense' (46). For the professions at least, a critical part of that consent stems from the promise of prestige and social capital that flow from being the ones to standardise the commodities that relate to their work. To be able to be the principle, state-supported, and legally sanctioned 'face' of physical rehabilitation, for instance, may be enough for a profession to conform to a hegemonic view of health and illness.

The conquest of official privilege

Magali Larson was particularly interested in this 'conquest of official privilege' (38), that had been used by the orthodox professions in the 19th century and after, as a way of establishing their 'monopoly of credibility' (ibid). Ian Kessler, Paul Heron, and Sue Dopson suggest that Larson viewed 'professional projects as the competitive and power-driven pursuit of labour market status and reward by self-interested occupations' (47).

Larson showed that part of the reason for medicine's success in establishing its social position in the 19th century was due to its ability to use 'educational credentials to affect social closure, to restrict entry to the occupation to those able to obtain formal training' (35), and to deliberately enhance it's 'claims to offer valued services, through espousing a scientific basis to medical knowledge' (ibid). Social closure allows the profession to establish the rules and principles upon which any future contest over ideology takes place. Having control over what is reasonable and unreasonable makes it much more difficult for others to compete because to do so may require the profession to abandon the principles it was built upon, weakening its claims in the face of a hegemonic, controlling competitor. This is why Marxist scholars argue that one of the major concerns with the capitalist system in healthcare lies in the way it reinforces occupational control as a strategy of medical power.

Gabe suggests that another critical factor in the growth of medicine's social capital came from 'the expansion of a middle-class able to purchase medical services in 19th-century Britain or the United States' (ibid). The ability of the increasingly professionalised middle-class to influence state policy and bolster its own interests resulted in the 'involvement of the state in supporting, at least partially, medicine's bid for monopoly control of healthcare provision' (ibid).

Larson's work here built on earlier Marxian scholarship that had argued that capitalism had enabled the creation of a new class of *petit bourgeois* professionals; a 'nouveau riche' class of middle-class workers that had managed to attract enormous wealth, power, and privilege to itself. In a recent study of the highest paying jobs in America, based on Bureau of Labor Statistics data, for instance, health professionals made up 11 of the 13 highest annual wage earners, and nine of the top 10 (48).

Larson suggests that state intervention to support the professions has historically favoured the bourgeoisie, 'Indeed, reliance upon the state was not merely a pattern borrowed by the 19th-century professions from the medieval guilds, but also the means by which the ascending bourgeoisie had advanced towards a self-regulating market' (38).

Neo-Marxian scholars like Larson, then, see the question of professional autonomy very differently to functionalists. Where functionalists argue that the ability to self-regulate is one of the rewards for a profession's help in resolving social problems, Larson and others (26, 49, 50), argue that autonomy had little to do with the profession's social contract, or its technical expertise, but was, part and parcel of 'the processes of class and state formation' (37). As Edgar Burns has suggested, professionalisation is 'a substantially intentional and effortful occupational activity, not a historically autonomous or reified process' (6).

Far from a profession seeking to act autonomously, Neo-Marxian scholars showed how vital it was that professionals were intimately connected to the processes of class and state formation;

> *'The medical profession is, for Marxists, part of the ideological state apparatus. As Waitzkin* (51) *puts it, 'medicine fosters an ideology that helps maintain and reproduce class structure and social domination.' The profession, along with educators, lawyers and other elements of the middle-class, plays a key role in legitimating the capitalist state and the search for profit and capital accumulation upon which the economic and social system relies. By presenting illness and disease as an individual, rather than a social issue, physicians contribute to legitimating the social conditions which create illness as well as profit. However, on the other hand, Marxists are not suggesting that capitalism thrives on a sick population — only that when there is an excess of labourers over employment (as there has been at most times since the nineteenth century), sickness like unemployment can be not only tolerated but approved, since its costs are predominantly borne by either individuals or the state'* (45).

The professions are key to the process of class and state formation because it is, perversely, in their competitive interest to see the illnesses and suffering caused by alienation and social inequality persist, especially if those illnesses further their claims to commodity control and special expertise. For instance, many of the diseases, injuries, and illnesses that have given the Western medical professions their power and prestige were directly created by living and working conditions engineered under capitalism. As John Swain, physiotherapist Sally French, and Colin Cameron suggest, the professions are 'parasites' in this regard (52).

Capitalism has also rewarded those who fuelled the engine of productivity and profit with protective legislation, subsidised training, and privileged access to the ill and injured. And established

a system of social reward and validation that encouraged elite and privileged health providers to perpetuate the system and entrench it as a hegemonic way of thinking in society.

Western medicine's focus on seeing health and illness in individualistic terms has also detracted attention from the deeper social determinants of health that might encourage people to critique the system that perpetuates them. A focus on personal prevention emphasises the importance of people taking individual responsibility for their own health and wellbeing, and rewards people who remain productive, independent, autonomous members of society. This perpetuates the Marxian view that healthcare practitioners have historically blamed the victim 'rather than recognising that the major causes of social problems were outside the control of the individual', and they have 'acted as agents of social control on behalf of a capitalist state by individualizing social problems' (53).

Implications for physiotherapy

Marxian analyses ask a number of searching questions of the professions:

- How reliant is the profession on capitalism? Is it a victim of it, a passive beneficiary, or a willing partner?
- How much agency do individual professionals have in the face of a hegemonic capitalistic system, or does the responsibility for action fall on the collective?
- How would the profession look had it not operated under capitalism? Would it even exist?

Perhaps the most fundamental question we can ask about physiotherapy, from a Marxian perspective, though, is whether the profession itself is capitalistic? Clearly, any institution that prospers, as physiotherapy has, within a Western capitalist system, must have some affinity with it. Identifying these affinities are not difficult. Physiotherapy, for instance, depends on its ability to commodify, standardise, and control concepts like the body, movement, function, touch, manipulation, mobilisation, exercise, posture, and rehabilitation, and regulate how these concepts are understood, taught, thought, and practiced. Many of the physical therapies have been practiced by all civilisations for thousands of years, but physiotherapy as a profession can only exist when aspects of them are colonised and turned to the profession's market advantage. Instead of continuing to share these openly and freely, physiotherapy has turned the physical therapies into marketable commodities that need to be purchased either directly or through people's taxation.

Physiotherapists are directly involved in servicing capitalism by rehabilitating people so that they can return to their place within the machinery of industry. This is as true of working age adults as it is of children, the elderly, and unemployed, who must ensure that they continue to lead independent, productive, active lives, in order to contribute to their own personal and collective (economic) prosperity, and not be a drain on social resources.

The profession also embraces objective performance measurement, outcome measures, and task specificity, that provide confidence that the profession understands the instrumental logic behind industrial capitalism (32). Physiotherapists have been subject to the kinds of deskilling imperatives of scientific management, as much as any of the health professions (i.e., the replacing of independent clinical decision-making with standardised assessments and treatment plans; clinical audit;

standardised care plans; universal evidence-based treatment regimens; and so on). But they have also contributed to the scientific management of client/patient time and labour, emphasising the importance of maximising people's functional capacity, movement efficiency, and physical potential as much, if not more than, most other health professionals.

Arseli Dokumacı has recently taken up Braverman's Marxist critique of scientific management to argue that physiotherapy's focus on functional limitation has played an important role in 'defining disability in relation to the capacity to work' (54). Indeed, Dokumacı reminds us of David Mitchell and Sharon Snyder's recent evidence that the term disability was originally used in the mid-nineteenth century for those incapable of work due to injury (55).

In effect, capitalism helped to *create* the idea of the disabled individual by designating human labour as a labour market concern, and in doing so, created the conditions necessary for a new 'medical' labour force to maximise the work capacity of those deemed disabled (56). Following Braverman's deskilling thesis, the work of rehabilitation specialists like physiotherapists could not be left un-managed, and needed to be brought within the system concerned with controlling labour supply (57). And a key part of this control required physiotherapists, occupational therapists, and others to refine ever more sophisticated assessments of functional limitation as a crucial tool in determining 'whether and to what extent a person is worthy of public assistance' (54).

> *'Capitalism demands individual economic productivity and this enshrines the notion of biophysical fitness, and its fulfilment as a key element in the quest for fashionable self-identity. Scientific medicine provides the means for measuring 'fitness' and identifying deviations from its statistical norm. Consequently, the hegemonic notion of the disabled body constructed in terms of corporeal or intellectual 'deficit'. To overcome this deficit, the disabled body requires the services of scientific medicine and rehabilitation'* (58).

Physiotherapists also work to remedy some of the ill effects of capitalism (injury, chronic illness, social isolation, pain, loss of function, etc.), but has little tangible investment in remedying the social causes of illness, injury, and disability. Action on social determinants like unemployment, poor quality housing, pollution, poor standards of education, and workplace safety hardly feature in the physiotherapy literature (see more on this in Chapter 4). Physiotherapy is quiet on most forms of social action, concerned, perhaps, that it be seen to critique the system that it draws its prestige and power from.

An example of this is the profession's lack of action against collision sports that are known to cause high levels of serious injury (concussions, traumatic brain injury, extensive musculoskeletal injuries, etc.). To date, there have been no calls from within physiotherapy to ban these sports. Preferring to fall back on capitalistic discourses of personal choice and responsibility, physiotherapists have been happy to take up the rewards of being lead rehabilitation providers when people do become injured. Perhaps practitioners are worried that criticising these sports might lead to others claiming their commodity control? This illustrates Gramsci's argument about the power of hegemonic discourses like capitalism to influence people's decisions and actions.

Are individual physiotherapists responsible?

So, to what extent are individual physiotherapists complicit in perpetuating capitalism in healthcare, and in society at large? Because Marxian theory is heavily structural, meaning that it looks at the social conditions that make it possible for people to act, rather than individual agency, it does not apportion much responsibility to individual social actors. As Keith Macdonald suggests, 'what happens to the profession', is an 'outcome of the workings of a society based on capitalist relations of production' (36).

And it would be hard to believe that when physiotherapists apply reductive, biomechanical approaches to their assessments and treatments, they are deliberately attempting to diminish their clients' subjectivity because they are driven by malign, capitalistic intent. It would be more reasonable to argue that they operate in this way because an objectivist biomedical hegemony dominates the profession. And Marxian theory would be much more likely to focus attention on the physiotherapy profession as a whole. In their 2008 article, *Physiotherapy as a profession: Where are we now?* (59), for example, Clair Kell and Gwyn Owen used Magali Larson's work to suggest focus on the physiotherapy profession, not its individual practitioners. In the paper, Kell and Owen argued that a profession needs to be able to draw on three related assets in order to gain recognition:

- Economic: Building and capital assets and resources
- Organisational: A credentialing body that controls access to the profession and serves its members interests directly
- Cultural: Shared values, understanding and beliefs (59).

These three 'assets' (note the language), are necessary, Kell and Owen argue, to build trust. Keith Macdonald made a similar point when he suggested that professional projects are always pursued within the social *and* economic sphere. In other words, a profession cannot survive or gain the trust of funders, governments, and the public, unless it responds to both social *and* economic imperatives. The economic sphere is important because it is where the profession establishes 'legal monopolies of knowledge-based services' (36), or commodity control, in Magali Larson's terms. Crucially, it is only when both projects are successfully pursued — especially in the case of medicine — an effective monopoly on knowledge combines with public trust and the profession can effectively assert 'social closure' (ibid). So, how much of this can realistically be achieved by individual practitioners? Clearly very little. It is perhaps ironic, then, that physiotherapists place so much emphasis on personal responsibility in their therapy. If they had real faith in the power of individual action, they might fight against the injustices that cause so much illness and injury in the first place. The fact that they do not do this to any great degree, suggests that physiotherapists do not have real faith in individual agency, or they are happy to support the capitalistic hegemony that has seen their individual and collective professional projects prosper.

The fact that physiotherapists colonised certain forms of knowledge and skills, and used these to establish allies and status within mainstream Western society, is a pattern that has been replicated throughout the professional sphere. Marxian scholars might argue that the prestige acquired from doing valuable work, and being an ally to biomedicine, coupled with the state sponsorship and protective legislation that flowed from being recognised as a legitimate, orthodox profession, may

well have been more than enough compensation for the need to perpetuate capitalistic attitudes to health and illness. And so, physiotherapy, like medicine, became a 'class instrument', focused on '*curative, individualistic* and *technical* solutions rather than social and political ones involving a fundamental restructuring of capitalist economic and social arrangements' (28). It was what Daniel and Richard Susskind called the professions *grand bargain* (60).

Critiques of Marxian approaches to the professions

Assuming that most of the readers of this book are physiotherapists or other health professionals, the first critique one might level at Marxian approaches is that they seem to have little good to say about the professions. Unlike functionalism, which gave us the idea of the professions as altruistic, public-spirited experts, deserving of our respect, Marxian ideas appear to portray the professions as a cadre of elite, power-hungry, and mean-spirited, petit bourgeoisie. And while this is a very reasonable reflection, we should remember that Marxian analysis arrived at a very particular time in our recent history, and that its application to the sociology of the professions was only one dimension of its broader analysis of capitalism. Marxist sociologists see a clear distinction between those who have power and those who don't. So in Western healthcare it is perhaps understandable that they would take aim at the elite professions, particularly medicine, and advocate for those who are often disenfranchised and powerless. This often means that Marxian thinkers view the professions' attempts to bolster their professional power, protect their boundaries, and promote their truths, in a rather dim light.

A second critique from physiotherapy readers might be about the uptake of Marxian ideas in the literature. With only one or two exceptions, very little of the material presented in this chapter appears in the physiotherapy literature. But I suspect this is not because physiotherapists have thoroughly appraised Marx's ideas and found them wanting. In my experience, physiotherapists have almost no exposure to these ideas, and if they do, it is not because of their training or practice. And so, I believe that the limited uptake of these ideas, relates more to our ignorance of their value than any judgement of their utility.

Some sociologists have criticised Marxian ideas for being too heavily 'structural', and thereby resembling functionalism. Both Marxian sociologies and functionalism are concerned with the way social systems can be designed to manage and maintain social order. And so, even though Marxist sociologists regard capitalism as 'an unjust and ultimately unstable' system (35), they both still take the central role that medicine plays 'in safeguarding the health of the labour force, present and future, and in controlling workers access to the privileges of the sick role' (ibid), as the basis for their analysis.

Others have suggested that the claim, particularly in Larson's work, that the professions are always working to secure a hegemonic monopoly over their territory, belies the fact that, empirically, professionals actually spend very little time in the pursuit of monopoly. Indeed, Halliday (61) has suggested that the professions are far from self-serving, and;

> *'while there is no need to revert to the functionalist view, which takes professions entirely at their own evaluation, these occupations are providing the services that they claim to provide in relation to the life, health, property and other matters of crucial importance to their clientele. It is, after all, essential that they do so, because they cannot keep afloat on ideology alone. Some of their actions may be mere self-*

> *enhancement, economic or social, but by far the greater part of the actions of members of professions are providing a service for their patients or clients'* (36).

Notwithstanding the work of more recent advocates of Marxism like Theador Adorno, Louis Althusser, Etienne Balibar, Terry Eagleton, Max Horkheimer, Henri Lefebvre, and Georg Lukács, it is also important to note that there have been few strongly Marxian studies that have focused explicitly on medicine and healthcare. With the exception of Vincenzo Navarro (25, 62), Howard Waitzkin (51, 63), Terry Johnson (27, 64, 65), and Magali Larson (38), there have been few Marxism studies of health professional practice, and none, to date, explicitly considering physiotherapy or rehabilitation.

Some of the reason for this lies in the broad social rejection of Marxian scholarship in mainstream academic circles, particularly in the United States after the neoliberal economic reforms of the 1980s. As William Cockerham pointed out;

> *'Political events sank Marxist theory in the universities. First, French scholars turned their backs on Marxism as a "theory of domination" in response to Soviet labour camps, the Cold War, Soviet military interventions against revolt in the former Czechoslovakia in 1968, and the Polish government's suppression of the Labour union Solidarity in 1981, that was followed by similar reactions elsewhere in Europe and Latin America, such that by 'the beginning of the 1990s, under the impact of post-modernism and the collapse of 'existing socialism' in Eastern Europe and the Soviet Union, Marx was a dead dog for most intellectuals there as well'* (66).

Cockerham's epitaph to Marx may well be a little premature, though, if Yoram Hazony's recent suggestion of a resurgence of interest in Marxism reflects current social and political realities: 'Marxism is back', suggests Hazony, 'and making an astonishingly successful bid to seize control of the most important American media companies, universities and schools, major corporations and philanthropic organizations, and even the courts, the government bureaucracy, and some churches' (67).

Perhaps the two most important criticisms of Marxism are substantive, however, and need to be given careful consideration. The first is that Marx's theories see power in quite a hierarchical, binary, and linear way. Society, for Marx, is made up of oppressors and the oppressed, and assumes that all societies are fundamentally exploitative. Because of this, Marx believes that all societies are in some ways revolutionary, and that the education of the oppressed will, in time, lead to the overthrow of the dominant class. In healthcare, this might mean that the patients take back the healthcare system from the health professionals and the managers. It assumes that less powerful members of society are frustrated by their position and are agitating for change. But this is often not the case. Many professions, including physiotherapists, appear quite content with their subordination by medicine, and many patients are often quite happy to defer to experts in the wake of illness or injury. So Marxian theory often fails to address whether system-wide revolution is always necessary or productive.

The second major critique is that Marxian social theory always defaults to what is known as 'economic determinism', or the belief that 'all social, political and intellectual development is caused by economic changes and even that all human action is economically motivated' (68). While this makes Marx's analysis distinctive, it fails to address a number of other ways to critique health and healthcare. It fails, for instance, to address the critically important relational dimension of healthcare. It has little to say about the gendered and racial nature of medicine, or the discursive way knowledge

and power operate in society. It sees the biological basis of Western healthcare as a tool in the class struggle, rather than a biological reality in its own right, and it offers little when it comes to understanding the lived experience of illness and injury.

So to understand health professionals and professionalisation projects more thoroughly, we need to move beyond Marx. But perhaps not too far to begin with, because Marxian methods and ideas form the backbone of some of the most fertile and penetrating analyses of the professions ever to emerge. As the distinct threads of class, race, gender and disability scholarship slowly came together during the second half of the twentieth century, a new field of critical theory emerged around healthcare and the health professions, sweeping away much of what had gone before, and laying the foundations for much of our thinking today. And so, it is to these people and the ideas of critical theory that we now turn.

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4. Critical identities

Key principles of critical theory — The conditions that made the health professions possible — The healthcare professions as gendered — Colonisation and healthcare — Healthcare and disability — Taking action — Critical theory and physiotherapy — Critiques of critical theory

Although Marx casts a long shadow over social theory in the 20th century, functionalism and ideas of social order dominated sociology until 1950. Things changed after World War II, however, with the emergence of a counter-culture movement created by a generation of young people who turned away from the conservative values of their parents. Feminism, civil rights, disability activism, gay liberation, anti-war protests, drug culture, investigative journalism, the contraceptive pill, university education, television, and rock and roll, instigated a radical and ground-breaking rupture in the social order of the rapidly advancing economies of Europe and North America. At the heart of this rupture was the rise of critical theory and its focus on questions of power. Critical theory brought to the surface the kinds of unequal 'distribution of advantage' that had blighted societies for generations (1). It argued that structural power was rife in modern society, and that the advantages that some people in the West enjoyed perpetuated the exploitation of others.

In sociology, advocates of critical theory rejected the idea inherited from functionalism that social rules and values operated equally for everyone. Rather, critical theorists saw functionalism as mistakenly promoting the 'moral integrity' of the Enlightenment (2), and being 'built on the gains of colonial conquest', involving 'violence and exploitation which utterly contradict and undermine Enlightenment ideals of rational progress towards greater prosperity' (1).

Critical theorists asked how it could be that societies as supposedly sophisticated and enlightened as those in the West, could invent devices of mass destruction like the atomic bomb; could build modern empires that forced nearly half of the world's population into servitude; could treat one entire gender as handmaidens and sex objects; and define anyone who was not an English-speaking, heterosexual, non-disabled, white man, as 'other'.

The impact of this work on people's consciousness of the world around them cannot be overstated. Over three decades after WWII, the world that had been the fantasy of empire-builders and social engineers, was shaken loose by a generation of activists and radicals that not only challenged every convention, but invented a whole new set of tools for analysis and critique.

There are many arms to critical theory, and many of these focus on the unique identities and voices of specific marginalised groups. There have also been many targets for critical theorists' ire, not least the military, capitalists, the church, the police, the education system, industrial farmers, government,

and the family. But the health professions have also come in for unprecedented critical scrutiny. Between 1960 and 1990, the health professions, and most especially medicine, was subject to a barrage of negative critical scrutiny that feels, in hindsight, like an insurgency or revolution. For the first time in its storied history, medicine was the object of withering critique, including claims of self-interest and abuse, anti-professional rhetoric and malpractice, cynicism towards its privilege and prestige, and the rejections of its claims to objectivity, detachment and value-neutrality.

This chapter unpacks some of this critique because many of the arguments made by critical theorists about medicine translate to physiotherapy. This is not surprising, perhaps because physiotherapy has always sought to reflect the language, culture, and practices of Western medicine. But there are some subtle and specific differences with physiotherapy too, and these need to be worked through if we are to make sense of critical theory and the lessons we can learn from it.

Before beginning, though, it is worth pointing out that, as with the last chapter, there is very little celebration of the beauty and splendour of physiotherapy here. Sometimes it is hard to read critical theory and see one's profession subject to such antipathy. But ultimately, the spirit of critical theory is deeply positive because it is based on the idea of liberation: liberation from oppression, liberation from domination, and liberation from tyranny. In their recent paper on nursing, Kylie Smith and Thomas Foth remind us of Jean-Luc Nancy's belief that "'a crisis is a period where something is revealed," symptoms appear and reveal something about us, and it is this "moment of revelation that allows us to judge and to heal'" (3). To arrive at liberation, though, we have to understand how oppression, domination, and tyranny came to be part of health professional practice in the first place, and then what critical theorists argue we should do about it.

Key principles of critical theory

If functionalism is a theory of consensus, then critical theory is about conflict, or *dissensus*, as Jacques Rancière called it (4). Rather than society being about the slow, progressive, drive towards harmony and order, critical theorists argue that it is about power and the often invisible social structures that privilege some at the expense of others. These beliefs stem from the upheavals and disillusionments of the first half of the twentieth century, but the influence of Marxian ideas has also been strong. People genuinely wanted to believe in a fairer society, where the divide between the 'haves' and the 'have-nots' was not so great. But this is not how Western societies have progressed.

Critical theory emerged across many disciplines and took many forms after WWII, but its many iterations hold six principles in common. Critical theorists argue that:

1. That power is structural, meaning that it is more concerned with the way society shapes people's experiences, than the agency, actions, or behaviours of any one individual or group (5, 6). Critical theorists believe that although people's actions are important — after all, it is a real person that uses sexist language or directs a water canon — these actions come as a *result* of social structures: they *follow on* from systems and organising principles that are built deep into the way society works;

2. These structures are often invisible to us. The way society operates often feels natural and obvious. Cars drive on this side of the road, people say "please" when they ask for things, and children go to school. Often the most powerful (and perhaps the most dangerous) structures,

then, are those that shape the world and feel most natural to us because, critical theorists argue, it is the ability of a social structure to become intuitively obvious that is its most potent weapon in the process of social ordering;

3. Social structures are human constructs, or ways of organising the world, that have been built by people to achieve certain ends. Sometimes those ends are about making the world safe. Sometimes they are about making things work more efficiently. But sometimes they are also about preserving a certain set of privileges for one group at the expense of another;

4. Social theory and social change should focus on some of the real inequities in society, most especially the unremittingly demeaning treatment of women, racialised people, the LGBTQ+ community, disabled people, immigrants, and the working classes;

5. We need to recognise that, for inequities to persist, the work of maintaining privilege and advantage must be ongoing. People often come to accept that certain kinds of disadvantage are unavoidable conditions of existence, and so become unwitting architects of their own fate (1). So, the work of critical theory has been exposing these entrenched structures of power and privilege, and helping to mobilise, emancipate, and give voice to those who have experienced oppression and often had to suffer in silence (1, 7, 8). Thomas Foth has suggested, for instance, that critical theorists confront the 'strangeness of existing reality', making 'blindspots visible and open[ing] systems to change' (9);

6. Critical theory is ultimately about action, resistance, opposition, emancipation and advocacy for everyone who is the victim of oppression, bigotry, hatred, stigma, and prejudice. Elizabeth McGibbon said that critical theory is more than a set of tools designed to assess and diagnose power in society, it is also about the 'many forms of cultural and political resistance', struggle, and emancipation needed to change the world for the better (6). Critical theory is also, therefore, a form of social treatment and therapy, directed at systems of injustice, marginalisation, abuses of power and prestige. Dave Holmes, Bernard Roy and Amélie Perron put it this way;

> *Research that aims to be critical seeks, as its purpose of inquiry, a confrontation of the injustices in society as well as a questioning of the status quo, while giving a voice to vulnerable persons (including marginal/ized discourses). Critical researchers believe that the knowledge developed in their research may serve as a first step toward addressing such injustices. As a consequence, the research aims for a transformative outcome, and therefore, is not interested in knowledge for knowledge's sake. In fact, some critical researchers argue that such a "neutral" stance toward research can too easily play into the conservative agendas of those who would rather preserve than challenge the status quo'* (10).

The medical profession was recognised early on as a prominent and powerful vehicle for the articulation and expression of white, male, Western values, and so quickly became the subject of a torrent of critical theory work. From Robert Merton's study *The student physician (11)* and Howard Becker's 1961 work *Boys in white (12),* through Eliot Freidson's ground-breaking work on medical power (13, 14), Ivan Illich's *Disabling professions (15)*, and Anne Witz's *Professions and patriarchy* (16), on through the work of Donald Light, Mike Saks, Deborah Lupton, Bryan Turner, Elianne Riska, and others (17–21); 'the institution of medicine' has been repeatedly critiqued for 'reinforcing class, gender, and ethnic inequalities' (5).

Critical theorists argue that Western medicine, and the professions that subscribe to it, including physiotherapists, have been remarkably effective in locating illness within an individual's body, and hiding the social causes of ill health; training professionals to objectify people and treat bodies as machines; claiming to be public-spirited and altruistic, whilst amassing enormous economic and political power for themselves; using practices of 'othering' and normalisation to create a demand that only professional allies could address; demonising non-Western understandings of health and marginalising traditional healing practices; and promoting independence and productivity in service of industrial capitalism. Why do the health professions, 'mainly serve the interests of a (middle-class, white, English-speaking) minority? What is it about our science, our practice and our education that allows for us to be complicit in creating inequities and in reproducing its effects over generations' (22)?

To begin thinking through this question, we should consider how critical theorists explain the origins of the health professionals, and how professions like physiotherapy have managed to build social structures that afford them the privileges and economic capital that they now enjoy.

The conditions that made the health professions possible

In simple terms, then, the critical theories of the latter half of the twentieth century were studies in the way society had been structured by historical conflicts for power, that created benefits for some at the expense of others. And many of these focused on social institutions like the family, criminal justice, and healthcare, as sites where some of the most significant contests had taken place. Consider this summary from Raewyn Connell, for example;

> *'From its early stages in mercantile and agricultural capitalism, the new economic order depended on the regulation and destruction of bodies. This became notorious in the 'industrial revolution' of the 18th and 19th centuries. Engels' Condition of the Working Class in England in 1844 is the most famous in a long series of reports that documented exhausting but tightly controlled labour in steam-powered factories, the coal mines that fuelled them, the cramped housing and polluted industrial cities that surrounded them. The process of extracting profit from other people's labour, institutionalised on a grand scale in capitalism, was also a form of social embodiment. It was significantly gender-structured. Working-class men's bodies were consumed—stressed, injured or worn out—in a process that constructs hegemonic masculinity in the working-class community and simultaneously creates profit for the employer. Colonialism created labour forces, in mines and plantations, in which such processes were at their most ferocious: Atlantic slavery, indentured migrant labour and forced Indigenous labour. The scale of death and impairment in a colonial enterprise like the silver mines of Potosí in the Andes, a main source of Spanish royal wealth, was worse than in any of Engels' factories'* (23).

Note how Connell argues that the control and exploitation of the people's work, the gendered division of labour, and the conquest of resources, can all be linked back to the Industrial Revolution and the birth of Western capitalism. But also, how Connell links capitalism to modern work, the creation of illness and injury, and the need to sustain a healthy workforce — all features that ought to be of particularly interest to physiotherapists. Shortly, I will look at three of the main fields of

critical theory relevant to physiotherapy: gender, colonisation, and disability, but before this, I will briefly summarise a critical theory analysis of how the health professions came about.

In Chapter 3 I unpacked how the Industrial Revolution in 17th and 18th century Europe had transformed society, created the modern ideas of work, capitalism, and government. In the chapter, I also looked at the Marxian view that capitalism was the cause of a great deal of ill health. These ideas were already well understood by the critical theorists in the 1960s, but what they did was to uncover in much more detail *how* these systems and structures had worked.

The rapid industrialisation of food production, transportation, and communications, for example, put huge pressure on domestic supplies of land and human labour, and fed an insatiable demand for goods and services in the Global North. This led a new class of Europe's avaricious industrialists to look overseas for ways to secure high-value foods, textiles, luxury goods, and cheap human labour. The race for resources, or 'earth hunger' (24), that this provoked, led to the colonial era, in which countries like Britain, Belgium, France, Germany, Japan, Portugal, Russia, and Spain, fought over entire countries, and forcibly enslaved whole populations in order to grow in wealth, and prestige.

Critical theorists have suggested that such naked acts of capitalist exploitation were welcomed by many, but also proved problematic for those in the emerging empires, who attempted to uphold the spirit of liberalism that had arrived with the Enlightenment. Liberalism argued that the 'fate of every individual should be determined through their own efforts rather than by birth or heredity' (25); that all 'men' were created equal. But this clearly could not be true for those who lived in India, Brazil, or Sudan, whose bodies and land were seen as resources, available to whomever could colonise them. The answer came in the way the natural sciences were mobilised to explain the claimed superiority of the colonists.

The study of biology, ethnology, and zoology had become fascinations for explorers, who could now use the overseas trade to access worlds previously unknown to them. The colonial fascination with naming and categorising 'exotic' animals, plants and peoples (taxonomy), for example, spawned attempts to place all things in some form of natural order (Linnaeus's eighteenth century 'nested hierarchies', for example). Because this hierarchical ordering was based on the emerging principles of reason and logic that increasingly underpinned the natural sciences, the knowledge gained could be used to explain why some species appeared to be superior to others: humans ranked higher than animals, animals higher than plants, and plants higher than all other things.

But what was also increasingly clear to the new class of European colonists - or so it seemed - was that there were subdivisions within each of these classes, and that empirical evidence clearly indicated that because it was white, European, heterosexual, non-disabled men who were succeeding in their empire building, they must clearly represent the highest, and therefore most worthy, of all beings (26, 27).

But while the new sciences could be mobilised to resolve the problem of the rights of all 'men', by providing empirical and theoretical 'proof' that some were more biologically and culturally superior to others, it could not fully address the moral problem of how to justify colonising another's land and enslaving its people. And so, the colonists turned to the second major social discourse of the Enlightenment era — religion — for moral justifications for global expansion.

Most settler's wanted peaceful acquiescence from the people they colonised, mainly because peaceful trade cost less, it was easier to maintain, and it fed the myth of the colonists' natural racial superiority (28). But no people can expect to practice land theft and slavery and expect it to be untroubled. And so while the might of European colonial power has been exercised with shocking

frequency over the last four centuries, with war, internment, forced labour, rape, and torture all used as 'deliberate and calculated' methods to demean, discourage, demonise, 'displace and distance people from their land and resources' (29), such actions were both expensive and morally problematic; not least because they suggested that white, European men were not as naturally superior as they had claimed to be.

One of the most powerful approaches taken drew directly from Western Enlightenment belief in the hierarchical ordering of species, however, and involved the deliberate construction of colonised people as different from, or 'other' than the European settlers. Sometimes, 'others' were given 'positive' terms (in the way the people of the Pacific were perceived to inhabit an unspoiled, Arcadian paradise on earth, for instance). But more often, others were seen as primitive, savage, uneducated, foreign, and godless (30). Edward Said famously called this process 'orientalisation' (31), to describe the way dominant 'occidental' cultures developed cultural stereotypes of people, sometimes based on physical appearance (race) and sometimes on culture and custom (ethnicity), in order to justify claiming power over them.

One of the most important functions of 'othering' — to use Gayatri Spivak's term (32) — was to create the image of an Indigenous culture needing to be saved: saved from its own primitive nature; saved from worshiping false idols; and even saved from a colonial culture that was so potent, that it might lead to their annihilation. Settlers argued that it would be in the interests of colonised peoples to join their colonisers rather than be trampled by them (33, 34). Missionary work became an important tool here, then because if colonised people could be brought into the flock, not only would their souls be saved, but their culture too. Matthew Fitzpatrick and Susie Protschky memorably called colonial missionary work a 'ruthless benevolence' (35), designed to support 'hard' colonisation with treaties and education, scientific evidence, bribery, new language, schooling and legal systems, training, manners and customs, inducements and promises, redesigned government, policing and surveillance; all designed with increasing sophistication by colonial powers as a way to support their economic interests (23).

Through these forms of 'soft' colonisation, colonial countries like Britain really 'sought to have it all — an empire with key components founded on the mass dispossession of other people's on the one hand, and a clean conscience on the other' (36). 'Saving' native races from the genocide that settlement inflicted on Indigenous peoples around the world, came to be seen as a charitable act conveying the manifest benefits of (Western) civilisation (26, 27).

The work of colonisation takes enormous human labour, however; not only the kinds of manual labour needed to build roads and railways, buildings and bridges, but also to administer, count, prosecute, train, and maintain the new colony so that it will be efficient and profitable. Soldiers, missionaries, and scientists can only do so much of this work, and so the work of transposing the cultural capital of the mother country onto the new colony fell to a newly 'enabling class' of accountants and lawyers, planners and administrators, builders and engineers, doctors and nurses, who were often uncritically complicit in practices of soft colonisation.

At the heart of this enterprise was a two-way process of exchange, between the lessons learned after the early Industrial Revolution that could be taken to the colonies, and the lessons learnt from colonisation that could be brought back home. Practices of 'othering' so crucial for the orientalising project of colonisation (37), drew on the gendered division of labour that came with early capitalism. The biological sciences had long been mobilised to define women as less resilient and powerful than men, and their role in procreation, childbirth, and nurturing became increasingly demarcated, to the

point that even by the late 18th century, early feminists like Mary Wolstencraft were arguing discrimination on the basis of gender was a breach of women's basic human rights (38). Wolstencraft argued that if natural scientists and liberal reformers were able to claim that our ability to reason set the human species apart from all other species, and all humans were capable of reason, denying women the right to education and work constituted an act of wilful discrimination (1).

Similarly, the hierarchical ordering of people along racial and gendered lines was supplemented by sciences that defined people by their ability, with those who were uneducated, illiterate, ill and injured, 'simple' or 'handicapped', being afforded the same 'ruthless benevolence' as Indigenous peoples. Darwinian concepts of natural selection, fed Francis Galton's work on eugenics and statistics, and these, in turn, were fuelled by growing anxieties about racial weakness and declining male potency. Key here were the practices of normalisation that drew on the growing use of surveys, censuses, and epidemiological statistics as tools of European and North American governments (39). The emerging class of enabling professions, particularly in the nineteenth century, drew heavily on statistical norms to distinguish those considered in need of diagnosis and treatment, arguing that the professional's specialised knowledge justified them taking a leading role in 'managing' the population both at home and overseas.

Here we have, then, a template, drawn from critical theory principles, for how the healthcare professions became necessary as a response to the Industrial Revolution and the European capitalist expansion that ensued. Science provided the hierarchical ordering that justified the claims of superiority for white, European, male colonists. Its detached objectivity armed those in the Global North with the ability to strip people of their history and culture. Capitalism allowed people to be seen as cogs in a great machine, and bodies as modes of capital accumulation. Othering and orientalisation, when combined with epidemiological statistics, allowed for the new professional gaze of the dominant culture to fall on those who needed 'treatment' to bring them back to the fold (most especially women, Indigenous, and disabled people). Faith and enlightened liberalism provided all of the 'soft' powers of education, bureaucracy, therapy, and rehabilitation necessary to ensure people's peaceful acquiescence. And the growing market for the trappings of affluence in the West created a demand for new forms of law and governance, buildings and infrastructure, trade and transportation, manufacturing and luxury goods, healthcare and education, that only the new professionals could provide.

Pillay and Kathard have written that the prestige and privilege of Western health professions 'bear(s) testimony of our professions as products of a long history of slavery, colonisation and corporate capitalism' (22)', a sentiment echoed by Elizabeth McGibbon writing about Western nursing which, like physiotherapy, was 'grounded in Western biomedical hegemony and its philosophical premises in positivism… as if families, communities or nations exist in these discrete, apolitical forms' (6). McGibbon suggests that the 'facts and truths' that underpin Western healthcare 'are filtered through the lens of imperialist colonialism', which sustains 'conditions of social domination, limits autonomy and responsibility, and oppresses individuals and groups' (ibid).

Perhaps it is not difficult to see, then, how the work of critical theorists could be used to critique physiotherapy and the historical and material conditions that have underpinned its development. There are perhaps three discrete areas within the massive body of critical theory work that emerged in the second half of the twentieth century, that pertain directly to physiotherapy: gender, colonisation, and disability. There are others besides, and this chapter will deal only with what have been called first- and second-wave critical theories, meaning those that concentrated on the identity

politics that emerged around the struggles of women, racialised, Indigenous, and disabled people particularly between 1960 and 1990. The intersectional 'turn' that brought many of these discrete fields together will be looked at in Chapter 6. To begin with, then, we will consider how critical theorists came to see the health professions as gendered projects.

The healthcare professions as gendered

Across the entire field of the sociology of the professions, the subject of gender has perhaps drawn the greatest critical interest of physiotherapists. From Anne Parry's early paper, *Ginger Rogers Did Everything Fred Astaire Did Backwards and in High Heels* (40), and Ruby Heap's research into the gendering of women's physiotherapy training in Canada (41), we have seen over the last 25 years a smattering of studies looking at gendered power (42–44), the gendered division of labour (45, 45–49), studies of the gendered history of the profession (50–52), gendered role identities (53–55), the gendering of bodies (56–58), clinical implications of gender theory (44), gendered aspects of touch (59, 60), the role of gender in professional prestige (61), and gendered aspects of practice learning (62–66). But this represents only a tiny percentage of the research done in physiotherapy, and pales into insignificance when compared with the attention given to gender in medicine and nursing (16, 67–73).

The radical, or second wave, feminism that emerged after the 1950s took a different view of gender politics to the liberal first wave of Mary Wolstencraft and the suffragette movement. Where first wave liberal feminism fought to overthrow laws that 'denied women the right to work, to own property, to vote, to divorce, to receive higher education, and professional training and to make their own decisions about sexual and reproductive practices' (1), second wave feminists fought the ways society had been structured to oppress and disadvantage women, to make them victims of sexist exploitation, and to regulate the distribution of global resources so that women consistently fall below the levels achieved by men (74, 75). It asked what kinds of social structures consistently resulted in women doing 'two thirds of the world's work for 1/10 of the world's income', owning 'less than 1 per cent of the world's property', as well as making up 'two thirds of the world's illiterate', and being 'only 16% of the world's parliamentarians' (1).

As Pip Jones and Liz Bradbury argued, the women's liberation movement challenged 'the formal and informal structures, practices and normative values of male authority that defined and regulated both the public and private spheres' (1). Jones and Bradbury asked rhetorically; should a woman's ability to bear children dictate her entire life, rule her ambitions, determine that she should always be paid less, or confine her to socially mandated roles (like stay-at-home mom, or virtuous nurse) (1)?

Feminists argued that the organisation of social systems in capitalist societies did not merely perpetuate the subordination of women, but actually *depended* upon it (76). Women provide vastly more unpaid domestic service and low-paid professional labour than men, thereby bringing down the economic cost of work, and, like the *Ragged Trousered Philanthropists* in Chapter 3, extracting surplus profits for the men that control the means of production (1, 77–79).

Anne Oakley's detailed study of the distinction between housework and professional labour is a particularly powerful example of this (80). Oakley argued that housework reflected women's unpaid and uncelebrated labour that emerged following the Industrial Revolution, when domestic and gender roles became attenuated by the need to perform some work at the lowest possible cost to capital. As

Oakley reminds us with the well-known aphorism; "if you watch Cinderella backwards it's about a woman who learns her place" (ibid). Similarly, Elizabeth Grosz argued that medical knowledge saw women's bodies as inferior to men; as troublesome, and in need of greater care and attention (81). Women were frequently portrayed as weaker, passive, irrational and illogical, manipulative, subjective, intuitive, emotional, and unreliable (25).

Feminist scholars argued that masculine approaches to healthcare embodied 'phallocentric' traits of domination, control, power, and objectivity, that resulted in overly invasive interventions designed to reflect well on men's heroism, and emphasise women's caring support for this work (81, 82). Patriarchal attitudes also flow through every facet of healthcare, from the extent that male doctors have traditionally specialised in 'heroic' disciplines like orthopaedics and intensive care (83, 84), to the role that nurses, physiotherapists, and other female-dominated health professionals play as 'vassals' of medicine (10).

In healthcare, gender asymmetries are not only perpetuated through the work of nurses and other female-dominated professions (85–88), including the allied health professions too (20, 89–91), where the perpetuation of lower pay and low status for female-dominated professions allows the accumulation of prestige and economic capital by the largely male-dominated elite medical professions (89, 90, 92).

Often the skills associated with 'women's work' are less valued; 'caring tasks are something that women simply 'do' rather than skills that both women and men might need to acquire' (93). Because caring, relationship building, empathy, and other 'soft' skills (note the gendered language here), are assumed to be women's 'natural tendencies', they are assumed to be hard to instrumentalise and learn, and so rarely feature in medical training in the same way as other technical skills. This gendered division of labour mimics capitalist patriarchal society, propagating the belief that caring attitudes are less accessible to men, or are, at least, harder to learn for those not naturally predisposed towards caring (25, 94, 95). They are also assumed to be natural dispositions that women should offer without recognition or reward. At the same time, by claiming objectivity, detachment, and value-neutrality as masculine traits that can be accessed only through rigorous scientific study, elite male practitioners have argued that these traits are justifications for high social status and financial reward (16, 72, 86).

Western medicine, argued Malika Sharma, has for too long operated 'under the notion that it is value neutral, an occurrence that has been referred to as the "culture of no culture"' (74). 'By failing to interrogate its own culture', Sharma suggests, 'this so-called view from nowhere can reinforce societal, patriarchal, or cultural norms in medical education' (ibid). Western medicine exemplifies patriarchal attitudes to health, being based on 'a particular kind of logic that embraces heroism, rationalism, certainty, the intellect, distance, objectification, and explanation before appreciation' (96).

And yet, if medicine is as value-neutral, objective, disinterested, and based on factual knowledge as it claims, how can it manage to perpetuate the subordination of women even while claiming not to (81)? This proved, as Evelyn Keller suggested, that 'in characterising scientific and objective thought as masculine, the very activity by which the knower can acquire knowledge is gendered' (97).

Celia Davies took this argument further, to show that even the concept of professional autonomy was 'a masculine one, rooted in a vision of rationality and technological mastery as the appropriate ways of organising the most efficient form of authority in complex society' (72). Davies suggested that the gendered nature of autonomy explained why some female-dominated professions struggled to follow the same path to professionalisation as medicine. Fundamentally, women have what Witz called 'differential access' to the kinds of resources that would allow for equality of opportunity (16),

and so they repeatedly encounter structural barriers (social attitudes, pay differentials, lack of mentors, etc.), that prevent them from advancing professionally (98).

Colonisation and healthcare

The second potent area of sociology to draw on critical theory after the 1960s was racialised and Indigenous scholarship. Like feminism and disability activism, these drew heavily on the effects of injustice and oppression on people, their bodies, their land and culture, so it is perhaps surprising that so little of this has influenced the physiotherapy literature (99). Over the last decade, there have been smatterings of work done looking at physiotherapy's relationship with colonisation, race and ethnicity, including discussions of racism and ethnic diversity in physiotherapy (100–103) and physiotherapy training (64, 104–111), trans-cultural meaning making (112, 113), experiences of racism (103), professional attitudes towards culture (102, 114–117), the impact of ethnicity on employment equity (118, 119), work on cultural humility, competence, allyship, responsiveness and safety (102, 120–127), culturally-informed care (128–130), and the influence of ethnicity on treatment efficacy (131–133), but these are very marginal subjects in the profession as a whole.

For many racialised and Indigenous scholars, this is not that surprising, and only reinforces how deeply socialised white, middle-class cultures are in most Western health professions (134, 135). Because biomedicine places great stall on its supposed objectivity and value-neutrality, it assumes its position is 'colour-blind' when it comes to issues of ethnicity, race, and culture. But, as is true with gender blindness, Western medicine has largely ignored the fact that it is deeply embedded in dominant 'Northern' culture. As Zadie Smith wrote recently; 'White people belong in the world. It's theirs, they own it, and they don't even appreciate it. But they do get defensive when you point it out' (136).

What Smith points to here is the taken-for-granted, uncritical 'givenness' that comes with being part of a dominant white culture (23, 137). Part of this givenness relies on the idea of White European culture as the stable referent (read, 'norm') against which myriad others are judged (138). Critical race and postcolonial theorists argued that dominant cultures actively suppress and marginalise the 'other', even while claiming not to do so (139–141). Edward Said's *Orientalism* (31), Guyatri Spivak's *Can the subaltern speak*(32), Frantz Fanon's *The wretched of the earth* (142), Nancy Chodorow's *The reproduction of mothering* (143), and Paulo Freire's *Pedagogy of the oppressed* (144), are perhaps the seminal examples of this.

Racialised and Indigenous critical theorists have been drawing on these works since the 1980s, arguing that the evidence for this can be seen throughout society, including within the healthcare system. Racialised people 'have endured (and continue to endure) a long history of trauma and loss as a result of colonisation, racism, and discrimination, all of which have fragmented their family and kinship structures' (102). This has resulted in generations of people working in lower-paid jobs; being more likely to be employed in low-skilled, manual work; and being more likely to occupy the lower ranks in every professional scope and work in the less favoured specialities (145). Their labour is often used to 'prop up' the healthcare systems of past colonial countries, particularly during times of workforce shortage or rapid expansion, effectively creating labour shortages in their own home countries, with some of the brightest minds leaving their home to pursue work overseas. The British welfare state has drawn heavily on migrant doctors to overcome shortages in the NHS, as have

healthcare systems in Australia, Canada, and many of the advanced European economies. Unfortunately, many of the migrant workers are still seen as inferior to their colonial counterparts (145–148). Christopher Kyriakides and Satnam Virdee have suggested that this functions to perpetuate the dominance of empire, long after colonised countries have reclaimed their independence (149).

'In their ruthless pursuit of wealth and profit around the world', Colin Samson argues, Europeans wreaked havoc upon native societies, inflicting violence and spreading disease' (150). And the health effects of colonisation are now well known. First Nations researcher Raven Sinclair has argued that 'almost every contemporary social pathology or health issue in Aboriginal communities' is the direct result of colonisation (29). The WHO supports this, showing that Indigenous populations experience significantly higher rates of illness, disability and premature death but are much less likely to receive adequate care, or to *want* to engage in services that they perceive to be, at times, judgemental, incomprehensible, and antagonistic to their core beliefs (151, 152).

Psychiatrist, philosopher and activist, Frantz Fanon, argued that colonisation systematically robbed people of their humanity, but also the material resources people needed to thrive. Indigenous populations become overwhelmed and then forcibly dependent on handouts for survival (142). Fanon suggested that being a colonial subject creates a sense of 'estrangement' — that the person does not know who they are (142), which leads, in time, to poor multi-factorial health, the criminality of desperation, internalised violence, and post-traumatic stress (ibid). This multiplies the alienating effects of rapid industrialisation and resource exploitation that are often brought into colonised countries in the name of economic 'advancement'.

One of the most powerful critical arguments for the systematic nature of racism in Western societies has recently come from Isabel Wilkerson. In her book *Caste* (153), Wilkerson argues that socialised white European and American people have taken up positions at the pinnacle of a racial hierarchy, and used this power to define the metrics against which ideas of normality, truth, legitimacy, and people's beliefs and values are judged (as with commodity control in medicine seen in Chapter 3). This normalising hierarchy, which puts white people above all others, is a proxy for what is essentially a caste system based on entirely socially constructed ideas, into which we all, and perhaps especially health professionals, become socialised[1]. Indeed, Mershen Pillay and Harsha Kathard suggest that orthodox (Western) health professionals are entirely dependent on such practices of what they call 'dis-othering', for their legitimacy (22).

Because European culture has historically been 'presumed both to represent the highest stage of societal evolution and to have a duty to export its institutional framework to the rest of the world' (1). Western approaches to health 'repeatedly dismiss traditional knowledges as evidence of ignorance, or valued only as an exotic addenda to 'conventional' therapies (140, 155, 156). But even where efforts are made to make healthcare more inclusive, the underlying structures, language, ways of thinking and practicing perpetuate white Eurocentric interests (156–159).

Saleem Razack has suggested that this stems from the West's colonial past, when it was necessary for nations to create a myth of national coherence and solidarity, and to defend itself against threats from 'outsiders'. Implicit in this logic is the belief that there is a 'imagined homogeneous citizenry'

[1] It is perhaps worth echoing Lennard Davis's reminder that the concept of normalisation is a social construct, particular to modern (Western) societies: 'A common assumption would be that some concept of the norm must have always existed. After all, people seem to have an inherent desire to compare themselves to others. But the idea of a norm is less a condition of human nature than it is a feature of a certain kind of society' (154).

(160) that must be protected, by embedding (white) Western values throughout curricula and scopes of practice, and regulating the entry of 'interlopers' (ibid). As Timothy Mickleborough argued recently; 'Race thinking is a system of power that maintains the homogeneity of white society through eviction and containment of the 'Other" (161), often undertaken on the basis that 'it is our moral obligation to correct, discipline, and keep (the other) in line and to defend ourselves against their irrational excesses' (160).

Some scholars have argued that developing cultural competence, responsiveness, and humility within Western healthcare professionals, may help to improve inclusivity (102, 120, 162, 163). But a number of authors have found that these approaches are hard to embed in health curricula; they are often poorly resourced; and they are frequently undermined by intransigence or outright hostility from practitioners who perceive them as a threat to their own beliefs about health and healthcare (120, 152). Cultural competence training can too easily be seen as something that can be achieved once and ticked off, rather than instituting meaningful change. They can also place the emphasis on the individual rather than the systems that perpetuate racism within society. Cultural 'competence' has largely been replaced by terms like institutional racism and structural violence should be standardised, so that the systematic nature of this prejudice can be recognised and tackled (164–168).

Healthcare and disability

It would not be unreasonable to think, given physiotherapy's long-held interest in disability, that Critical Disability Studies (CDS) would occupy a prominent place in professional literature, thinking, training, and practice. But CDS plays almost no part in the profession's scholarship. There are many studies looking at the physical dimensions of disability from a biomedical perspective, and in recent years, attention has turned to the International Classification of Functioning, Disability and Health (ICF) as a way to assess, measure and categorise individual and population health and disability. But there is little *critical* research here. There is little here that looks at the relationships of power that shape physiotherapeutic practices around disability, or the asymmetrical relationships between therapists and service users (169). CDS plays a significant role in *rehabilitation* studies, and a number of physiotherapists are prominent in this space (58, 170–181), but much of this work skirts around the question of physiotherapy's role as a discipline. And so, as with critical gender and race studies, we are left wondering how structural power has shaped physiotherapy and disability.

Given how much disability is socially produced (through war, poor public infrastructure, dangerous workplaces, etc.), it is perhaps surprising that sociologists only began, in the 1980s, to give serious attention to the role health professionals have played in shaping the idea of disability as a social construct. Paul Abberley's study of disability caused by industrial workplaces (182), paved the way for a radically different understanding of disability, that spoke directly to the unquestioned power of medicine.

The medical model of disability had monopolised how health professionals had been trained to think about disability for decades before Mike Oliver, and a range of Marxian-inspired critical disability activists and researchers, developed the social model (183–186). The medical approach to disability — long promoted by Western medical professions like physiotherapy — 'sited disability as a personal tragedy, biological deficiency, and psychical trauma (187). Disability represented a 'lack'. Orthodox health professionals used statistics and standards to argue disability was a break from the

norm, using this as a justification for their therapeutic interventions. They labelled disabled people as pathological, deviant and aberrant, and as bioeconomic 'loss' (188), and in doing so, created a binary framework which made all disabled people 'other' (189, 190). The medical model saw health and disability as the responsibility of the individual, and bypassed serious consideration of the cultural, economic, political, and social worlds that people lived within (191, 192). Therapies were directed at individual behaviour change strategies, efforts to re-align people's perceptions of disability, or strategies of 'mainstreaming' disability (193).

At the heart of the social model was a critique of the 'medicalisation' of disability by doctors and nurses, occupational therapists, and physiotherapists (15, 194–196). It argued that it was not the presence of an impairment that caused disability, but the existence of disabling environments, attitudes, and social structures that *created* disability. Disability was a function of people's discrimination and the creation of social barriers. It was not a 'lack', but an expression of human diversity and something to be embraced; a form of resilience and resourcefulness to be celebrated.

The social model 'unearthed the structural foundations of oppression faced by disabled people' (187, 197), and was a powerful response to a long history of stigmatising labelling, enforced institutionalisation, rehabilitation, medical and surgical procedures, and the enormous social pressure to fit in and be 'normal', experienced by 'anomalously embodied' people (198–200). It 'sever(ed) the causal link between the body and disability' and 'relocated disability to social, cultural, economic and political registers' (187). Advocates sought to address the myriad disabling social forces faced by disabled people, including the complicity of health professionals like physiotherapists, in working to meet the demands of industrial capitalism for 'fit' workers (201).

But what the social model also showed was that disability represented more than just a form of anomalous embodiment. Rather, it was a proxy for kinds of bodies and people that we had come to believe should not exist, were 'unlike' us, or needed assimilation back into the majoritarian norm (197). Disability has been socially constructed as something that societies perceive to be frightening, monstrous, disturbing, out of control, disorderly, incomplete or disruptive (198, 202). Disability then cannot be seen as a fixed (in)capacity of the body or mind, but rather as a constantly moving screen onto which society projects its fears and anxieties (203). And because of this, '(t)he dominant ableist self is ready and willing to bring disabled people back into the norm (re/habilitate, educate) or banish them (cure, segregate) from its ghostly centre' (187).

Susannah Mintz suggested that these practices were not about identifying people's needs so that therapy and rehabilitation could make disabled people's lives better, 'but rather about a need to guarantee the privileged status' of the non-disabled, 'that, in its turn, emerges from fears about the fragility and unpredictability of embodied identities' (204). The work of physiotherapists and other rehabilitation specialists is therefore akin to the struggle with *abjection*, explored by Julia Kristeva (205), and the emotional labour of 'body work' (206), in which a profession helps to resolve some of our social anxieties around that which is alien and strange. Physiotherapists and others help to mask the 'huge problem' we have in society with disabled people who disrupt our image of people who, we believe, should always be in control of their bodies (187). Rehabilitating bodies is about integrating the disabled person into society without, at the same time, normalising the idea of disability itself (197).

This act of existential 'othering' feeds, and is fed by, Western attitudes to economics. Raewyn Connell, for example, ties rehabilitation closely to capitalism, arguing that there are two real categories of bodies operating in the West: 'those whose labour generates profit, and those whose labour does

not' (23). People's ability to contribute to the labour market is *the* principle determinant of their 'normality', and enabling 'labour market participation becomes a key form of treatment or rehabilitation' (ibid). And Deborah Lupton has suggested that, 'the institution of medicine exists to attempt to ensure that the population remains healthy enough to contribute to the economic system as workers and consumers' (21).

What is critically *absent* from this approach, though, is the 'meaningful integration of difference' (192), that would see different bodies, ways of moving, functions and capabilities *as* the norm. So, for example, Mitchell and Snyder have highlighted how approaches to accessibility — seemingly so benign as a way to adopt empowering attitudes and practices towards disability — should be viewed more critically. Kerbs suitable for wheelchairs, audible signs at pedestrian crossings, and lighting-based signalling systems in homes, may be seen as enabling, but these do not fundamentally change society's demeaning attitude towards anomalous embodiment. Rather, they allow us to integrate disability into our 'normative frameworks', without 'significantly upset[ing] or disrupt[ing] environments already suited to a narrow range of abilities' (ibid).

CDS scholars have worked to call our attitude towards disability 'disablism', to give it equivalence with heterosexism and racism. Carol Thomas defined disablism as a form 'of social oppression involving the social imposition of restrictions of activity on people with impairments and the socially engendered undermining of their psycho-emotional well being' (207). Critical disability activists have shown that disablism can take many forms, some of which appear on the surface to promote positive messages about disability. Displays of disabled people using 'lavish prosthetic enhancement(s)' (192), or films like the X-Men series, showing 'superpower overcompensation' (ibid) point to a neoliberal, transhuman future, when people can supposedly make informed choices about their preferred level of (dis)ability; 'Such systems enshrine bodies that are different yet enabled enough to ask nothing of their crumbling, obstruction-ridden infrastructure, continually naturalised as environments made for most but (unfortunately) not all bodies' (192). And grand concepts like 'movement' become critically important here because they can all-too-easily flatten out the 'affective, aesthetic and functional experiences' of disabled people, losing any rights disabled people have to fight against the material conditions of their oppression (192).

Taking action

If critical theory is fundamentally about the way power operates in society to the benefit of some and to the detriment of others, then the response to this is not passivity and acquiescence, but action. As mentioned earlier, fighting to highlight the ways people marginalise, oppress, and silence others' voices, and working to overturn asymmetrical power relations in society, lies at the heart of the critical theory project. And action has historically taken many forms, including street marches, academic social research, strikes and sit-ins, political lobbying, zines and posters, guerrilla activism, protest songs, visual arts, lectures and talks, courses and consciousness raising.

Consciousness raising is akin to Paulo Freire's concept of 'conscientization' (208), in which education can free people from 'the constraints of cultural silence' (209). Freedom comes with awakening of consciousness, by looking anew at the seemingly common sense and taken-for-granted realities of one's life, and identifying how these are structured to perpetuate advantage for only a few. 'Health activism', Heather Came argues, 'takes an overt political focus using both research and

creative, unconventional methods to challenge the status quo' (210). And when this is applied to medical education and education research, it 'can be a powerful means of changing how medicine is taught and whose voices are heard' (74).

This activism not only targets the structural violence of sexism, racism and disablism, but also the people who have knowingly or unknowingly benefitted from perpetuating them. In critical disability studies, for instance, people's use of stigmatising language in the media, the demeaning policies of politicians, and the lack of thought to good design by architects and town planners, have been particular targets. But by far the greatest level of condemnation has been directed at the health professionals, who have derived enormous social privilege and economic gain from practices of hierarchical ordering, normalisation, and othering, the design and use of stigmatising diagnostic labels, humiliating assessments, and painful treatments (199, 211–214). Liris Smith and colleagues recently expressed it this way;

> *'Standardisation of medical practice emerged as the dominant biomedical approach to healthcare which also dissociated the human body from the reality of peoples' lives and lived experience… the binaries of "normal"/"not normal", and "well"/"not well" silenced diversity, including the social, cultural, and political factors that influence health'* (102).

There is a striking disjunction here, then, between the claims of health professionals to be working *for* disabled people, and the views of disabled people themselves. Critical disability activists have argued that through their medicalisation of all forms of 'deviance', and their work to return people to narrow, socially-mandated forms of 'normal', health professionals have worked hand-in-hand with the interests of industrial capitalism. Their alliances have been with the state and other orthodox professions, and not with disabled people. It is notable, for instance, as Ron Iphofen and Fiona Poland point out, that health professionals have traditionally sought to assert their professional principles through the pursuit of more professional autonomy and strengthening claims to reductive medical specialties, than by withdrawing their labour and campaigning seriously in support of the rights of their clients and patients (215).

In recent times, health professionals have been 'called out' for their self-interest and failure to speak up in the face of injustice. Tracy Blake writing in the British Journal of Sports Medicine (BJSM), for example, recently argued that those who have gained so much from working in sports and exercise medicine, including physiotherapists (216), have chosen to remain silent in the face of racism, colonialism and white supremacy, and this silence 'speaks volumes' about the professions' real concerns when it comes to athlete health, safety and well-being (216). Writing in response to the killing of George Floyd and the #blacklivesmatter campaign, she argued that the 'The apathetic response from the BJSM to the laundry list of examples of institutionalised and interpersonal racism experienced by Indigenous and racialised people within sport around the globe has not gone unnoticed' (ibid). Critically, Blake argues that this lack of response doesn't 'just happen', but that, 'They are predisposed to occur when there is a pattern of bias towards whiteness as the default', and '(t)his is the foundational tenet of white supremacy', that results from the 'persistent dominance of older, White, cisgender male voices' in the journal (ibid). 'Racism will not fade into obscurity and irrelevance simply by people not being racist; it must be addressed through intentionally antiracist actions' (168).

Throughout its history, physiotherapy has almost entirely ignored the social determinants of health and has no particular view on social justice, unlike professions like occupational therapy, nursing,

midwifery, and psychology (for comparison, see the *Psychologists for Social Change Manifesto* here: http://www.psychchange.org/psc-manifesto-2019.html). It has done little, until recently, to formally acknowledge 'racism, misogyny, homophobia, transphobia, ableism, ageism, classism, or religious bigotry' (216). And, perhaps most tellingly, it has never thought to articulate *why* it has ignored these for so long. Its strong belief in a person's responsibility and a Protestant work ethic (see Chapter 5), appear to be tacit rejections of social, structural conditions that underpin people's choices, which, perhaps, explains why physiotherapists have historically ignored critical theories? But such choices — if indeed they are deliberately 'chosen', are particularly problematic because, as Keith Tuffin has argued, they promote the belief that seemingly intractable, deeply structural, societal issues, are 'individually surmountable' (26);

> *'Our dominant model of personal, individualised services is wrong if it does not get to people living in São Paulo's favelas, Bombay's slums, Beijing's underground cities, and Khayelitsha's shanty towns, or to those surviving on Rosstat's minimum consumer shopping baskets. It is in these spaces that most of the world's one billion people with disabilities go about their lives'* (22).

Perhaps the Western health professions have simply argued that whilst they don't deny that structural issues define many health problems, their focus is on the illness and injury that resides within the body, and their responsibility to return people back to 'normal'. But if this is the case, professions like medicine and physiotherapy have been indoctrinated with what Robert Merton has called 'an ethical sense of limited responsibility' (217), and for more than a century extracted enormous capital from society for doing so.

And yet, Margrit Shildrick has argued that it is the non-disabled 'who have the weightiest responsibility in the matter, not to speak on behalf of, or to pre-empt the experience of, others unlike themselves, but to interrogate precisely their own cultural and psychosocial location' (218). Jaris Swidrovich has recently called for the pharmacy profession to engage in 'decolonization and indigenation' (140). Elizabeth McGibbon and her co-authors have described nursing as 'ethically inadequate' to 'thinking about health and illness in the context of colonialism, globalization, pan-capitalism and environmental degradation' (6). Audiologist Mershen Pillay and Harsha Kathard have called for greater attention to the 'underserved' (22), while Kristen Abrahams has suggested speech-language pathology professionals need to give much more attention to social justice (219), a view echoed by Michelle Pentecost and Sadi Seyama in arguing for decolonised education (220, 221). Blythe Bell has recently described nursing education as an 'oppressive educational climate for non-white identifying people, a curriculum that does not attend to the social construction of difference, and a nursing culture that is not consciously situated in a broader sociopolitical context' (222). Cory Ellen Gatrall has gone further, suggesting that 'since its inception, organized nursing has not only tolerated racism but also actively practiced it' (223). And so, 'the operative word' for critical theorists is 'action' (6). So, what relevance does critical theory have for physiotherapists?

Critical theory and physiotherapy

As has been mentioned already, there has been little critical theory applied to the physiotherapy profession over the past half century, be it by physiotherapists themselves, or by sociologists

interested in the health professions. Medicine and nursing have provided such rich material for anyone interested in the asymmetrical exercise of power that sociologists may have felt they can glean all that can be said critically about healthcare from these professions? And because the physiotherapy profession itself has never expressed any real interest in critical theory as a tool for self-analysis, it may have been simply ignored. But as I hope I have shown in this chapter, there is no shortage of material that physiotherapists and sociologists *might* sink their teeth into, if they are so inclined.

To take just a few examples: how could we better understand the reasons for the 'whiteness' of the Western physiotherapy profession? From a short perspective, piece on *Life as a black physiotherapist* for the Chartered Society of Physiotherapy's *Frontline* magazine recently, Warren Caffrey wrote that 'as I mature within my career I realise I've had to work incredibly hard to fit into a predominantly white middle-class profession' (224). This is not the first time that the profession has been described this way. Gillian Yeowell said something similar in 2013 (100), while commenting on the lack of diversity and pace of change within the profession. Although 32.4% of the American population self-identify as African American, Hispanic, or Latino, only 1.2% of American Physical Therapy Association members are African American, and 2.4% Hispanic or Latino. 91.7% of APTA members, however, are white (225). Proportions of racialised people in other professional bodies in the Global North are not that dissimilar.

We might also ask why it is that a female-dominated profession has always employed supposedly 'male' virtues of detachment, individuality, objectivity, reductionism, technical mastery, autonomy, domination, and value-neutrality, and eschewed historically 'female' approaches to care like empathy, relationships, mutuality, community, and subjectivity? Celia Davies has argued that masculine approaches to healthcare would be simply incompatible with nursing (72). So, what role does the gender of the physiotherapy profession play in shaping its philosophy of practice? Is it, as Arlie Hochschild suggested in 1983, simply that the supposedly masculine virtues of cognition, intellect and reason were consistently valued above feelings and emotions; perhaps because they appear an impediment to 'getting things done' (226)? Or is it that the profession's founding mothers wanted to offer women a different image of healthcare than their 'angelic' caring sisters? Julius Sim, writing in 1985, saw physiotherapists as sitting 'between the archetypal elite male role of the doctor and the female role of the nurse', being both 'curative and caring'. For Sim, this 'sex-role duality' may 'give rise to a feeling of conflict among female physiotherapists' (but not, it seems, the male physiotherapists) (45). If physiotherapists are now looking to move away from their historical affinity with the body-as-machine, will the decision to embrace greater care also mean embracing lower social capital, or does the profession see virtue in fighting the stigmatising social structures that constantly undervalue 'women's' work? And, does it follow that holding supposedly 'feminine' virtues automatically sacrifices 'masculine' values and beliefs?

One of the casualties of physiotherapy's historically reductive approach to the body has been its relationship with those we are supposed to serve. Historically, physiotherapists have objectified bodies by focusing not on the person but on the faulty body part, and they have deliberately analysed movement and function dispassionately so as to detach the person from their context (173). But in doing this, they replicate the kinds of objectifying gaze that women have fought so hard against for years. As White suggests, 'By locating illness within the woman's biological body, medicine helps perpetuate a sleight of hand which effectively ignores the social reasons for women's ongoing oppression' (25). We might ask whether physiotherapists are happy being on the side of the oppressor? This is a question that has been raised within the disability community before (169), and

in more recent times in the context of the social determinants, that physiotherapists are so dependent upon for work, but apparently have no interest in engaging with critically.

Many of the impairments and disabilities that provide work for physiotherapists, for instance, are created through dangerous working conditions, sporting injuries, and by the violence and wars that have been 'constantly provoked by the North, either directly or indirectly, in the struggle over the control of minerals, oil and other economic resources' (227). The ability to ignore these determinants, and situate therapy within the body of the individual patient is an almost unique power available only to a very elite group of 'Northern' specialists (5, 228, 229). Neville Chiavaroli, Julia Blitz, and Jennifer Cleland have recently suggested that it is only majority groups, like doctors, nurses, and physiotherapists, that have the ability to eliminate 'difficult causes' from their scope of interest (230). They can do this because they exist, and uphold, a society that has sufficient power and economic resources to determine '(w)hat gets considered under diversity' (ibid).

We might ask why it is that so few disabled students graduate from physiotherapy programmes. Alfiya Battalova's research team recently argued that the orthodox, patriarchal professions encourage their practitioners to be fit and strong, non-disabled and free from significant disability, despite that fact that this is the population that it putatively serves (231). Nurses, midwives, and social workers, purposefully look for caring attitudes in their students, and many of the mental health disciplines expect their practitioners to be actively engaging with their own psychic development. How might physiotherapy be different if the profession did not expect its students to represent non-disabled norms, but instead actively engaged in 'dissecting their own power and privilege' (74)? Or by expecting its students and practitioners to have some first-hand experience of significant injury, illness, or disability as a desirable attribute of training and practice?

In Hazel Horobin's doctoral study of Indian physiotherapists studying a master's degree at an English university (232), Horobin suggested that physiotherapists have historically used their clinical reasoning and professional judgement to bring 'authority and prowess' to the profession (232). And the heavy reliance on biomedicine has worked well for practitioners because it has enabled physiotherapists 'to wield power' over clients (ibid). But her study showed that Western-trained physiotherapists all too easily see 'other cultures as lesser', and label 'other practices as 'deficient'' (ibid). Tellingly, perhaps, the tutors 'that most need to alter their perspectives appear(ed) the most resistant to do so' (ibid). Crucially, 'even whilst the programme (was) apparently benign, cultural oppression (was) present, unrecognised by participants and staff alike' (ibid). Here, then, we have the crux of a critical theory perspective on contemporary physiotherapy: it is not that physiotherapy cannot see minorities, after all, it is entirely *dependent* on the construction of some people as 'others'. Rather, the problem physiotherapy currently faces is that it cannot see itself. And its practices are deeply rooted in occidental privilege and prestige.

The American writer and art critic Rebecca Solnit, once joked that museums love artists the way that taxidermists love deer (233) because 'something of that desire to secure, to stabilize, to render certain and definite the open-ended, nebulous, and adventurous work of artists is present in many who work in that confinement sometimes called the art world' (ibid). We could perhaps draw a similar comparison with physiotherapy, which loves to stabilise and render certainty from clinical situations, in which there is often very little. Critical theory has been very dubious of functionalist claims by the health professionals themselves that they are altruistic and public-spirited. Instead, they see practices like hierarchical ordering, normalisation, and othering, as endlessly inventive ways for elite professionals, like physiotherapists, to benefit from identifying people as 'other', under the cloak of

objectivist science (169, 234). As Merata Mita argued, 'The ones doing the looking are (always) giving themselves the power to define' (235). But as Kylie Smith and Thomas Foth recently argued, to do this is 'to get one's epoch wrong' (236).

Gender, colonisation, and disability are but three of the many axes through which professions like physiotherapy assert and maintain their social privilege. Critical theorists have argued for more than 50 years that the elite professions have been able to do this because they have grounded their work in hegemonic Western values. As Ludwig Fleck reflected in 1935; 'science reduces the complexities of cultural influences… to produce scientific facts' (237). Whether professions like physiotherapy will be allowed to continue this practice into the 21st century, remains to be seen.

Critiques of critical theory

In some ways, talk of critical theory as a homogenous field of sociological inquiry is misleading because although many of the marginalised groups share much in common about their opposition to patriarchal, elite, and occidental power, there are many variations within each field. In black political philosophy, for instance, there are advocates for afropessimism, African liberalism, black feminism, conservatism, culturalism, socialism, and many other smaller fields (https://tinyurl.com/yat8y5w3). Feminism, critical disability studies, queer theory, and other approaches are the same. That said, there are coherent principles underpinning critical theory that have been unpacked in this chapter, and have been the source of some significant criticism over the last half century.

The first major critique of critical theory was that it oversimplified power relations, often framing them as a binary between those that 'held' power and those who did not. The problem with seeing power in this binary fashion is that it tends to 'essentialise' and bunch people together in relatively unrefined categories, labelling them based on their degree of shared, often unearned, privilege. Under this scheme, all men can be characterised as misogynists, and all colonial settlers as perpetrators of historical trauma. Critics have argued that critical theorists are often quick to use abstract pronouns to describe those in power ('the medical profession', 'bodies', and 'the state', for example), whilst individualising the victims of oppression (67).

Paradoxically, some argue, critical theory also depends upon the existence of marginalised others for its very existence, so can sometimes appear to engage in oppression fetishism when highlighting peoples' plight. Robyn Autry has suggested, critical theory 'is, after all, deeply invested in its Others; racial others, gendered others, economic others, indeed every other other, is at the focal point of the discipline' (238). And yet, often, 'too narrow a lens is applied when studying some of these social others', and so it disappoints, 'because it doesn't know it's others very well' (ibid).

William Cockerham has suggested that critical theories bring some powerful tools of analysis, but often fail to explain *why* power persistently creates 'haves' and 'have-nots' (1), and how people facilitate the process (239). Cockerham has also argued that critical theory can be unrealistic and utopian, in calling for a world without power asymmetries, but that critical theorists rarely engage with how that world would work in practice. It is often said that critical theorists are good at diagnosing the structures of oppression in society, but have the greatest difficulty imagining a world where power asymmetries have been eliminated.

Terence Halliday believed that critical theorists had been so caustic in their criticism of the health professions over the last 50 years, that it has 'led to a totally cynical sociological view of the

professions' (240). In a similar vein, Deborah Lupton has suggested that critical theory has a reputation for its 'unrelenting nihilism', and a failure;

> *'to recognise that advances in health status and increase life expectancy which have occurred over the past century, associated with improvements in the human diet, reforms in sanitation and the supply of clean water, a rise of standards of housing, better contraceptive technologies and progress in medical treatment and drug therapies, are intrinsically linked to the requirements and demands of the capitalist economic system'* (21).

So, although critical theory occupied, and still occupies, a powerful place within the sociology of the professions, critical theory fell out of fashion, somewhat, in the 1990s. The rejection of Marxism and socialism as grand political philosophies and the rise of neoliberalism, combined with the growing influence of poststructuralism, and the sense that critical theory explained little about the inter-personal, relational, and agential nature of healthcare practice, led to new branches of the sociology of the health professions that we will explore over the remaining chapters of the book.

In some ways, this evolution was brought about by a realisation that the activism of the 1960s and 70s had been led by white, relatively privileged, men and women in the Global North. McGibbon et al. have argued that this can be seen in healthcare in the reforms in nursing and midwifery, which were largely led by elite white female professional leaders, and continued 'to create fertile ground for oppression of marginalized and racialized peoples' (6). What emerged from this was the field of intersectionality, a subject we will return to later. But before we can do this, we need to look at some of the schools of thought that critiqued critical theory and offered alternative ways to view the work of the health professions. Starting with the work of Max Weber.

Over the last decade, new forms of critical theory have emerged, and we have seen a resurgence of concern for forms of racialised violence, oppression based on gender and sexuality, social division, and ableism that were the subject of heated debates for activists in the 1960s and 70. The legacy of the identity politics that was the hallmark of radical activism, has resonated strongly in the Black Lives Matter and #metoo movements over the last few years. But critical theorists have also shifted to embrace the idea that many marginalised groups share common struggles with patriarchal culture.

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5. Boundary work

Weber, the Protestant work ethic, and social closure — Boundary work and social closure — Encroachment — Symbolic interactionism — Socialisation, or becoming a health professional — Ethnomethodology — Lay-professional interactions and social distance — Social action and physiotherapy — Critiques of social action

Beginning in the 1960s, somewhat in the shadow of the bellicose identity politics of critical theory, a new and very different way of understanding society began to emerge that would transform our understanding of the way health professions worked. At the same time as second wave feminists and the civil rights activists were threatening upheaval, social action perspectives were inciting a quieter, but no less influential, revolution. Like critical theory, social action perspectives also represented a cluster of sometimes quite diverse philosophical approaches, but they all share one important thing in common: a belief in the importance of human agency.

All of the approaches we have looked at so far have been fundamentally *structural*. Functionalism, Marxism, and critical theory, all share in common a belief that society is made up of structures that *precede* us as individuals, and that these structures shape what is possible for us to do in the world. Physiotherapy looks the way it does, for instance because specific conventions of language, power, gender relations, capitalism, and so on, exist, and operate invisibly in the background, making certain ways of thinking and practicing possible, whilst denying others. Medicine has power in society, functionalists argued, because it helps to bring order and balance to the world, and society has rewarded it accordingly. Women, racialised people, and disabled people are constantly marginalised, critical theorists argue because every level of society has been subtly designed to favour patriarchy and the Global North.

Social action argues instead that while social structures are certainly present, and have a powerful influence on who we are and what we do, they have tended to neglect the individual and the way that human relations shape the world. It is people's individual and collective actions, advocates argue, that defines social reality. As these approaches gained popularity in the 1980s and 90s, they began to open up entirely new ways of understanding people and the society, including healthcare.

The importance of the 'turn to agency' that social action instigated cannot be understated. Amongst other things, it gave birth to what we now think of as qualitative research; it shaped our understanding of professional boundaries, professional socialisation, and professional prestige; it developed our understanding of lay-professional relationships, and the idea of professionalism as performativity; it turned health professionals' attention towards patient narratives and subjective explanations for health and wellbeing; and it provided new insights into the sociology of identity and the self that had

previously been dominated by psychology. Perhaps the person most responsible for initiating this turn was the sociologist Max Weber, so we will begin the chapter with him.

Weber, the Protestant work ethic, and social closure

Max Weber (1864-1920) is, along with Marx and Durkheim, considered one of the founding fathers of modern sociology, despite the fact that he only wrote one major work, *The Protestant Ethic and the Spirit of Capitalism*, in 1905. Weber, like Marx, was a historian and a fierce critic of capitalism, which he described as a child that had grown into a monster. But he disagreed with Marx on one key point that has particular significance for physiotherapy. Where Marx believed that capitalism was fundamentally an economic phenomenon, Weber believed that economics alone could not explain why society operated the way it did. Weber believed that people's actions, rather than the social systems that Marx believed in, were what shaped society (1).

From Weber's work, we can glean six important ideas that have implications for the professions. These are that;

1. Society is underpinned by individuals who, through the pursuit of their own personal interests, organise groups with like-minded people, which generate the ideas inherent to the group and legitimise its interests;
2. Groups are always in competition with others for collective social mobility (2), often engaging in the social closure 'of social and economic opportunities to outsiders' (3);
3. Groups achieve 'social stratification' in three ways: economic, social, and through power or prestige (4, 5);
4. A group does not derive its social mobility and market control from any inherent skills, knowledge, expertise, or standards, but from the outcomes of a continuous professional project to secure its social advantage;
5. Conflict is, therefore, an inherent feature of society. For example, society cannot accommodate an unlimited number of social elites, and so the pursuit of professional prestige pitches all professions into competition for scarce resources. With the consolidation of Western healthcare around a small number of powerful orthodox professions, the boundaries around the entire healthcare system, for those in a position of advantage, are as protected as those around the professions themselves;
6. Human history is not progressive. In other words, people were not learning from the past and becoming smarter. Decisions are always contingent and based on the 'interplay of various social structures and social actions motivated by beliefs, ideas and values and carried out within particular cultural contexts' (6).

Weber believed that people's actions were just as important as class structures, and that sociologists should study why people do what they do to achieve the ends they desire. In his doctoral thesis, Weber studied the history of trading companies in the Middle Ages, and in it, he found numerous examples of people acting out of personal interest, even though these actions might have made them

worse off. Weber studied 'bonded labourers' who would endure 'extreme privations', and become 'heavily indebted to usurers' (7), in order to obtain a modicum of independence. This attempt to gain some personal freedom was often disadvantageous to people economically, but they did it anyway.

Weber was particularly interested in the reasons for the sudden entrepreneurial 'spirit' that emerged in Europe in the 17th century. He saw that modern capitalism could only have happened with a change in the way religious authorities viewed wealth, and the rapid accumulation and consolidation of vast quantities of money in the hands of a few industrialists and social reformers. Enormous amounts of capital, known as *primary accumulation* (see Chapter 4), were needed to build the vast network of factories, mills, and mines that fuelled the Industrial Revolution. But the Protestant church had previously seen wealth as a sin. The answer, Weber believed, lay in a revision to Biblical teaching ushered in by Calvinism.

Many Calvinists believed that God had reserved only a limited number of places for people in heaven, and so acts of contrition and repentance were meaningless. Because man[1] could not know God's will, what one needed were indications in life that one was one of the chosen few. Calvinists allowed that material wealth could be a sign of God's favour. And so if one worked as hard as possible, and profited from one's labour, this could now constitute 'good work' in God's eyes. But one's newfound wealth could not be used for idle luxuries and indulgence because this was a sure sign of man's fall from grace. All money earned that was not needed for basic necessities, therefore, needed to be turned back into making one's industry as efficient as possible in the pursuit of even greater profit.

Weber argued this shift provided the entrepreneurial spirit that gave birth to the Industrial Revolution, and fuelled empire building and colonisation. But it also created a new culture around work, efficiency, and the rejection of luxury. Work became a *duty* and a 'disciplined obligation' for Calvinists (7), whose life became suffused with 'salvation anxiety' (1). They believed people should work as hard as possible, and their time should be used to the maximum efficiency. Leisure, relaxation, and indulgence were all discouraged, as were workers' holidays, labour unions, and any form of external oversight. Calvinism, therefore, provided the perfect rationale — and the emotional and religious justification — for capitalism because 'Without a population dedicated to worldly work for its own sake, prepared to eschew as sinful any sign of extravagance, capitalism could not have got off the ground (1).

Calvinism shifted work from something that one did only out of necessity, to something one did as a moral obligation. Work became something that defined a person, and a lack of ability or willingness to work became a sign of indolence and laziness. Working to 'make money and then use the money to make more money and to carry on working' (8), became a goal in itself, creating new social systems around the definition of children (too young to work) and elderly (too old); creating the need for social welfare and support for those unfit or unable to work; and generating industries, like healthcare and rehabilitation, designed to keep people in work and foster enthusiasm for industriousness (6).

Alice Kwizera identified seven critical dimensions of what Weber called the *Protestant Work Ethic*: self-reliance, foregoing leisure, hard work, the centrality of work in life, not wasting time, delaying gratification, and work as a form of morality (9), to this we might add 'diligence, efficiency and rational, goal-directed behaviour' (10). Kenneth Hudson and Andrea Coukos have shown how the

[1] I use the term 'man' here in the sense that it was used at the time, which is to say that 'man' was taken to refer to all humankind.

protestant work ethic shaped attitudes towards 'need' amongst people in society over the last century, (11). Calvinist puritanism, they suggest, has strongly driven arguments *against* welfare reforms, and towards individual responsibility, the importance of work, and independence; an emphasis on 'doing one's duty'.

Weber's analysis of capitalism was of profound interest to Talcott Parsons, one of the founders of functionalism, who was a student of Weber and translated *The Protestant work ethic and the spirit of capitalism* into English in 1930 (12). It also provided the impetus for a raft of post-war sociologists to explore alternatives to functionalist and Marxian explanations for the workings of the health professions. The new, or neo-Weberian scholars, began to explore how individuals formed 'collectively conscious groups' (4), like professional guilds and societies, trades unions and worker's collectives, to speak for their particular interests and pursue social prestige (13–17).

Contrary to Marx's view that society could be understood as a class struggle, Weber believed that social prestige also played an important role in shaping society. Prestige helped explain why being a doctor or a judge came with economically rewards *and* high social status, while others of a similar 'economic' class (politicians, stock market traders, etc.), had much less prestige and a much lower standing in society. In a similar way, there were some that Marxist scholars might call 'working class', who had just as much social prestige as social elites, but received much less remuneration for being so (the new 'essential workers' after COVID-19, for instance: nurses, healthcare assistants, police officers, teachers, and bus drivers).

The idea of prestige as a key feature of social stratification was picked up by Terry Johnson, one of the most prominent neo-Weberian scholars (16, 18, 19). Johnson's work centred on the professions as a particular struggle for people in the middle-classes. Johnson argued that social prestige, risk and security, hard work, independence, comfortable affluence, and educational achievement, were much more significant concerns than issues like wage slavery and alienation for people in the middle-classes.

Neo-Weberians like Johnson realised that at some point in the 20th century, becoming a respected profession had become one of the most assured ways that someone might achieve middle-class respectability, to the point that the 'professional hierarchy has replaced class as the chief matrix of the new society' (20).

Social stratification, as Weber called it, became less about relatively fixed structural aspects of society, and more about the link between one's qualifications and expertise, and the opportunities for higher incomes and greater levels of social capital. Magali Larson, spoke about the 'novel possibility of gaining status through work' (17), that were created in developed economies after WWII. 'In an open society' Simon Weil argued, 'professionalism has the power to confer upon its practitioners some of that same elevated prestige that might elsewhere be obtained only by the accumulation of wealth or through aristocratic birth' (21). Larson tellingly argued that professionalism amounted to the ability to turn one scarce resource — special knowledge and skills — into another — social and economic rewards (17). But to do this, the professions had to engage in two key Weberian ideas; boundary work and social closure.

Boundary work and social closure

Boundary work is one of the most studied concepts in the sociology of the professions over the last 50 years. Keith Macdonald called it 'One of the most important means by which the professional project is pursued' (4). It draws on the agricultural metaphor of an open field that has been divided up into separate enclosures. Each enclosure represents a parcel or share of the field's resources. The field could represent anything from the world's stores of petroleum to the football teams in a particular division. Here, the field is healthcare, and the crops in the field are the patients, their body systems and parts.

The idea that, at some point in the past, healthcare was organised into disciplinary enclosures seems obvious to us today. But it reminds us that for much of human history, healthcare was an open field. It also raises some important questions about who designed the enclosures? Why were they distributed in this way and not other ways? Why, in the West, were the enclosures distributed to suit the medical profession? And why do we need boundaries at all? The walls around the enclosures are each profession's scopes of practice, and they define what students learn, how people work, and the need for authorities to police the boundaries.

Social closure is the mechanism used by different groups in society to colonise and claim exclusive access to certain resources within the field. These may be particular kinds of knowledge, patient groups, or kinds of skill or aptitude. And the ways groups secure closed access are many and varied, including:

- The implementation of systems of registration or examinations to restrict access to the group;
- The creation of scarcity by limiting the number of training places, monopolising supply, or controlling access to certain desirable resources;
- Creating a sense of occupational homogeneity and a closed 'club' culture of solidarity;
- Setting complex or lengthy skill standards for training or discrediting competitors (22);
- Claiming high levels of indeterminacy (see later) making entry into the profession complex and external comprehension difficult;
- Promoting kinds of work that are claimed to supersede consumers' desires (i.e., 'the doctor knows best').

All of these are all strategies used by professions to secure their enclosure. The process of training and registration of professionals for neo-Weberians is, therefore, much more than just the way in which someone acquires additional knowledge for practice. It is about how an individual supports a professional project directed at securing progressively higher levels of social advantage.

Magali Larson showed a different way social closure had been deployed. She argued that the kinds of upward social mobility pursued by medicine and the other emerging professional elites after 1850 relied entirely on the division of labour, and the incorporation of 'pre-industrial ideals of gentility (disinterestedness, manifesting in objectivity, value-neutrality, and detached experimentation, as well as noblesse oblige)' (17). Larson argued that these were used by professions like medicine, law and the clergy, to obtain prestige. Eliot Freidson echoed this in *The theory of professions*, arguing that we should be less concerned with professional 'traits', and more with the way that certain groups in

society have 'achieved' professional prestige, and the role that 'supportive social elites' (like legislators and funders) play in sponsoring these actions (23). Traits, Larson argued, don't tell us what a profession is, how it got there, or how it functions in each different social moment. What traits tell us is what a profession '*pretends* to be' (17).

Anne Witz's classic study *Professions and patriarchy* (24), examined how the division of labour had been constructed around gendered lines. But as well as arguing for structured relations of power (see Chapter 4), Witz showed that both men and women had actively pursued professionalisation projects in the 19th and 20th centuries. The key difference in outcomes, though, was the unequal access to resources available to male- and female-dominated professions. Male-dominated professions like medicine were able to claim characteristics of elite professions (objectivity, detachment, and a strong affinity with scientific principles), while the female-dominated professions like nursing and midwifery took over roles which carried much less social capital (25–27). From a social action perspective, Witz showed that not only were women professions engaged in all manner of different boundary tensions, but that women were active in all aspects of the process (28).

Valerie Fournier talked of the 'labour of division' that professions go through to create and maintain their professional boundaries (29). Fournier argued that there was no 'natural' basis to the hierarchy of elite professions in society. Rather, it is a dynamic, interactive, and contested process that requires constant attention and performative work. Olivia King and colleagues have called this process 'an act of creation and not revealing. In other words', they suggest, 'the field does not reflect a naturally occurring phenomenon but rather one that is created by the profession itself and expanded over time' (30).

For neo-Weberians like Fournier, professions create the fields in which they practice, and the field is continually shaped by their actions. The field does not pre-exist, waiting to be discovered. Western medicine, for example, defined how people should think about the body (anatomically, pathologically), and has shaped what constituted normal practice (studying 'cases', diagnosing and testing), and how services should be structured (reductively around body systems) (31). Sarah Nettleton has argued much the same about the way dentists constructed the mouth as a problem worthy of special professional interest, creating a dental profession as a response to a problem of their own creation (32, 33).

The value of a profession does not, therefore, lie in 'the inherent socially valued skills or expertise' the profession possesses (25), but in the 'production and maintenance of the body of eccentric knowledge' (ibid, p.132), that allows the profession to shape its field of interest and distinguish itself from others. Similarly, access to a particular client group is not based on the profession's access to any particular truth about health and illness, per se, since we know that medicine came to prominence long before it could prove its therapeutic efficacy. Rather, access to clients depends on a profession's ability to control certain socially mandated forms of knowledge and maintain a particular 'market situation' (ibid, p.131). Eliot Freidson stated that this was how medicine won the support of political, social, and economic elites (34), and achieved its 'organized autonomy' (ibid, p.71). But by placing so much emphasis on objectivity and technical knowledge, inter-personal aspects of practice had atrophied (34, 35). As a consequence, medicine had become reliant on the control of institutional structures, like the control of referral processes and clinical decisions, and 'the reduction of the client to an object' (4), as a way to secure market shelter (36).

In Andrew Abbott's book *The system of professions* (37), he argues that professions constantly compete over existing, empty, and emerging areas of expertise, and are always looking to exert their economic,

legal, training, research, and political advantage over the competition. Indeed, professions cannot be understood in isolation, but 'only in the sense to which they constitute and reproduce themselves, relative to others' (38).

Boundary tensions between professions have become ever more visible over recent years, as healthcare services are increasingly opened to competition and trans-disciplinary practices. Brian Hodges has argued, though, that while we should be '[m]atching the supply of health workers to need' if we want 'sustainable, affordable and fit for purpose' health services, 'I see our professional organisations concerned with clinging to their current scopes of practice, replaying tired historical battles for control of little patches of professional turf' (39). The problem is that '(t)he medical profession has effectively controlled the healthcare division of labour, with its unique capacity to determine its own role boundaries as well as those of the health occupations lower on the hierarchy' (30). But all social action theorists believe that fields like healthcare are in a constant state of flux, so much of their interest has focused on *how* Western healthcare has remained so stable for so long. One of the contests constantly being played out in healthcare is around encroachment.

Encroachment

Professional boundaries are always being tested: by competitors and superior and subordinate allies who see some advantage in taking over particular professional territory (22); by funders and legislators who want service reform; and by service users and advocates who want more or less from their providers. There are two sorts of encroachment: horizontal and vertical. Horizontal encroachment often comes from other professional groups that have similar social power and prestige. *Upwards* vertical encroachment, on the other hand, occurs when a subordinate group seeks to take over territory from a more prestigious one. The much less common *downward* vertical encroachment, occurs occasionally when a dominant group claims an aspect of the work of a subordinate.

It is often thought that the elite professions would rather not have to face encroachment and dislike competition, but neo-Weberians argued that, in reality, territorial disputes are used by professional groups to define and solidify their own position. Valerie Fournier and Caragh Brosnan, for instance, showed that medicine had actively used the idea of charlatans and 'quacks' to its advantage (40, 41). On the one hand, the quack was vilified as an amateurish corruption of 'real' medicine. But, at the same time, medicine relied on quackery to develop and demonstrate its distinctiveness, when little evidence existed for medicine's own therapeutic efficacy.

Social action perspectives do not see subordinated professions as passive in their subordination, but rather actively involved in their own struggles for prestige and social status. Work on complementary and alternative therapies (CAMs) has been particularly important here. Deborah Lupton considered the ways that alternative therapists had traded on their rejection of Western biomedicine's reductionism and objective detachment to 'reconnect the bodily and social worlds and often to effect social transformation' (42). Being able to claim 'that their approach offers a viable, non-alienating, more 'natural' and less invasive way of promoting health and curing ills' (ibid), has given non-orthodox practitioners a way to define their distinctiveness without having to default to biomedical concepts and language.

What such contests show is that a whole range of occupational closure strategies have been used by professions to negotiate jurisdictional conflicts and increase the profession's market value. These include systems of:

1. Exclusion — or containment strategies by dominant groups designed to restrict access to people, resources, training, employment, and so on, to allow a select few to have privileged access;
2. Inclusion — normally performed by an excluded group involving efforts to be accepted (gaining licence, allowing dominant group control, or adopting a dominant group's philosophy, etc.);
3. Demarcation or limitation — in which a dominant group defines a unique territory for a subordinate that does not impinge on that of the dominant group;
4. Usurpation — where a socially inferior group eats into the power of a more dominant group (this can relate to all marginalised groups, but also subordinated professions generally);
5. Expulsion — where a socially inferior branch of a dominant group is removed to consolidate the power and status of the majority;
6. Subordination — where a dominant group delegates activities and allocates professional scopes to others in order to raise its own prestige and reinforce the subordination of another;
7. Mystification — in which the profession alludes to aspects of practice that are hard to define for 'outsiders', or deliberately creates social distance (43) between the profession and the 'other' in order to justify their distinctiveness;
8. Dependence and protection — where a dominant group relies on a subordinate group for a specific service, and restricts change by conferring socially advantageous forms of privilege and protection.

Of course, encroachment practices may involve the complex interweaving of many of these strategies at the same time, and their effects can be equally convoluted. Susan Roberts, for example, argued that it was often difficult for marginalised or oppressed groups to take on the norms of the dominant group, but that by adopting the philosophy of the dominant profession, the subordinate could achieve more power, control, and social status (44).

Andrew Abbott thought that it was possible to distinguish super-ordinate professions, or professions with greater social prestige, from subordinate professions, by their approach to distinctiveness or similarity. Superior professions, he argued, tended to emphasise their difference from others, while subordinate professions tend to focus on similarities. Different professions can hold different kinds of positions depending on the status of the other profession in question. So nursing, for instance, has moved to show its similarity to medicine by adopting evidence-based practice, diagnostics, and a curative ethos. At the same time, it has used these philosophies to distance itself from low-prestige care and the work of healthcare assistants (45). Such moves can be problematic, however, particularly if they involve a profession turning away from a philosophy of practice that it once used to define itself. Nursing has discovered this in recent decades, with its desire to raise its prestige by adopting 'scientific' nursing principles, whilst also feeling the pull of its heritage and the crucial role it plays in caring for patients (46, 47).

Educational credentialing and legal strategies have long been considered some of the most powerful and effective ways of dealing with jurisdictional disputes (48, 49). Educational credentialing because it can control the supply of qualified practitioners into the profession and shape the way professionals are socialised (see later), and legal strategies because these can protect a profession's claim to a particular knowledge base or skill, protecting it in an otherwise competitive market (30). But the same strategies can be used ideologically to protect privilege in a particular professional 'territory', excluding people on the basis of race, gender or religion, for instance, and thus playing a part in the structured inequality of society' (4).

For this reason, Keith Macdonald has argued that strategies of exclusion are often 'aimed not only at the attainment and maintenance of monopoly', but also the 'upward social mobility of the whole group' (ibid). Rather than choosing to take up a position outside of the mainstream where it can advocate for minorities and vulnerable communities, prestigious professional groups have often chosen to side with a majoritarian position, in order to secure social prestige and 'improved life chances' (50) for its members. A decision evident in the gendered, racial, and non-disabled profile of most of the Western health professions today.

Crucially, a profession will not be successful in its claim to exclusivity simply on its own terms. Neo-Weberians believe that professional prestige is a relational, trade-and-exchange process, that requires professional groups to provide a service that a controlling interest requires, in return for specific privileges. Neo-Weberians believe many professions have spent too long considering their own autonomy and ability to influence their own prestige, and not enough time on the power they have to influence the autonomy of others. Here neo-Weberians agree with functionalists that a balance of interests will have been met with any process of occupational closure (17). But this also means that the way a profession defines its identity must always be done in relation to others, as a constantly shifting process of negotiation and status claim.

Caragh Brosnan has argued that we should also pay more attention to the divisions and boundaries *within* professions. Using the chiropractic profession as her example, Brosnan argues that much of the literature on boundaries in the complementary and alternative therapies relate to its sometimes fraught relationship with Western medicine. Many professions, though, also expend considerable energy negotiating significant ethical, jurisdictional, relational, and professional disputes that are *internal* to the profession (48, 49, 51). In the case of chiropractic, there remains an ongoing dispute between traditionalists who see the roots of the profession 'outside' mainstream healthcare, and reformers who call for a shift in the profession's ideology to bring it more in line with the orthodoxy (51). These, as much as 'external' conflicts, shape the profession's identity.

Ultimately, Weber believed that all acts of occupational and wider social closure were part of modern society's drive towards rationalisation. Only in the West, Tony Bilton argues, have we seen rationalisation emerge as a primary cultural orientation for social life (52). Occupational closure plays a crucial role in the rationalisation of society because powerful groups like health professionals have been rewarded with prestige and monopoly control of common human resources, like health and healing work, because of their efforts 'master[ing] all things by calculation' (53).

Influential though it is, critics argue that Weberian approaches to social action remain largely *macroscopic*, focusing on the professions as large, impersonal industries. Alternative approaches to social action were also developing in the second half of the twentieth century, however, and these focused much more on the everyday, micro-social lives of the people involved in healthcare.

Symbolic interactionism

There has been enormous interest in people's 'struggle to make meaning' (54) from health and illness over the last 30 years. Central to this struggle has been the search for meaning in people's everyday experiences, interpersonal relationships, and the everyday small acts of social formation. Combined with an abiding interest in those who had long been marginalised by society, some social action theorists have turned away from the grand sociology of Marx, structuralism and critical theory, and turned, instead, towards sociology on a more human scale.

Healthcare has been a particularly fertile field for this work. Alfred Schütz (1899-1959) was one of the first sociologists to explore the sociology of lived experience, using the phenomenology of Martin Heidegger, Edmund Husserl, and Maurice Merleau-Ponty to argue that modern science had treated people like inanimate objects, and what was needed was an understanding of the ways in which people made sense of the world 'as themselves' (55, 56). 'People are desperate for stories they can call their own' Frank argued, 'because the medical complex chews up individual identities' (54). Once again, medicine became a particular focus for sociologists, who recognised that it somehow 'manages the extraordinary feat of homogenising people while reproducing and accentuating inequalities between them' (ibid).

All relational acts of meaning-making are profoundly complex; what Harold Garfinkel called 'interactional accomplishments' (57). So, it is perhaps not surprising that it takes decades for people to develop personal attributes and skills necessary for professional practice. Sociologists have become fascinated by the 'peculiar and distinctive character of interaction as it takes place between human beings' (58), and much of this work developed in a field known as symbolic interactionism.

Herbert Blumer — who, along with his mentor George Herbert Mead, and Erving Goffman, pioneered symbolic interactionism at the University of Chicago in the middle decades of the 20th century — suggested that human interactions were peculiar because people did not have direct access to other things, people, events, ideas, and actions. Rather, people act on the basis of the *meaning* that they, and others, give to things. Everything we think, know, and experience, they argue, is mediated by symbolism and our interactions rather than detached and objective truth (hence, symbolic interactionism, or SI). Mead, for instance, argued that we can only talk about people having 'minds' because we interact with one another (59).

Symbolic Interactionists argue that we develop our self-image by incorporating others' views of us into our own sense of self; what Charles Horton Cooley called a 'looking glass self' (60). People are 'skilled interpreters of their world' (1), and use these interpretations to make meaning from the world around them. SI sees people as much more active social entities, shaping the world around them, rather than passive biological entities bumping into, or reacting behaviourally to other entities in the course of everyday life. Perhaps understandably, this approach has become hugely important in the development of narrative inquiry, reflective practice, qualitative inquiry, person-centred care, and other relational approaches to health over the last 30 years.

SI focuses especially on theories of action; 'individual behavioural creativity and micro-level social processes' (61), rather than the structures governing social life. 'Social roles, institutions, and power', Ryan argues, 'are all understood as being the result of a 'negotiated order'' (62). SI is concerned with the ways 'different groups of workers with diverse skills negotiat[e] with each other and secur[e] each other's cooperation or consent' (63).

Edgar Burns suggested that one of the reasons for the rapid rise to prominence of SI was the fact that 'Science with its strong, modernist claims to knowledge and truth had for the most part forgotten that knowledge is held by people and groups. It does not exist on its own in some metaphysical library or cosmic-virtual database' (64). Medicine, and some structural sociologies too, had forgotten the agency of individual actions, behaviours, interactions, and relationships (65). People had become pawns in a grand chess game played by hegemonic forces like the state, doctors, and 'patients'. SI, in contrast, 'accords priority to the individual choosing his or her social behaviour' (61).

A number of landmark studies emerged from SI in the 1950s and 60s, including Hughes' work on the social drama of work (66, 67), which argued that professional expertise only exists as a function of social interaction, and there can be no definition of expertise that stands in and of itself. But perhaps the best known and most far-reaching example of SI came from Erving Goffman's studies of labelling theory and stigma.

- Labelling theory argued that health and illness have no innate biological basis, nor are they the product of one's class or gender. Rather, they exist because the sufferer violates certain social norms; norms that emerge from people's interactions, conversations, thoughts, and everyday practices. Thomas Scheff argued that societies created certain codes of conduct and ways of behaving that he called 'residual rules' (68). These were informal social conventions that go largely unnoticed. But when someone breaks one of these residual rules, they are prone to be labelled as a troublemaker, disruptive, or even 'deviant'. Importantly, it is not the behaviour of the individual, per se, but people's reaction to the social breach that defines the issue.

In his 1961 study *Asylums* (69), Goffman argued that in Western societies, the development of mental illness concepts and labels had served as a useful construct to help explain rule-breaking behaviour, and manage anxieties about people who deviate from society's residual rules. The negative consequences for those who have fallen outside of social convention can be severe, however. Not least because the rule breaker is thrown into an almost impossible position. Accepting a label of being deviant, psychotic, backward, handicapped, needy or malingering, can lead to the person being exposed to social judgement, unpleasant and humiliating treatments, isolation, toxic medication or other invasive therapies, loss of work, and humiliation. But resistance to the label can be used as proof of the person's deviance, resulting in even worse treatment.

Two years later, in a separate body of work, Goffman concentrated on the problem of social stigma. He argued that there was a profound difference between our 'real' selves, and what he called our 'virtual social identity', or the image we present to the world (70). Goffman argued that some people's real social identities came with certain traits that were known to be embarrassing or unappealing, shameful or unpleasant. People felt stigma when they had to try to present a different image to society to avoid others' negative judgements. He argued that we experience stigmas because not only are our social identities bound up with how society sees us, but because we know it too. And so in order to develop a sense of self-esteem, we must constantly work on how the world sees us, through what Goffman called 'impression management' (ibid). This is a form of performance acting that becomes necessary because of the perceived distance between our real and virtual selves.

There are clear parallels here to healthcare, but also for health professional practice because one's virtual social identity — the image we project to the world — may often be derived from the meaning we attach to our professional work. And so, feelings that one is a different person in reality to an idealised professional identity is a significant issue, not least because many professions rely on their

ability to project a spuriously homogenous professional identity, in order to maintain their occupational closure (71). Perhaps for these reasons, many professionals feel at odds with their virtual professional identities. The process of taking up a virtual professional identity begins as soon as students enter training (72, 73). Key to this process is the work of socialisation.

Socialisation, or becoming a health professional

'The ultimate goal of nursing education' Joseling Mariet wrote in 2016, 'is to teach a student to think and act like a nurse' (74). This is socialisation, or what is sometimes called 'professional identity formation' (75). Socialisation refers to any occasion when an individual takes up and internalises context-specific collective rules, distinctive skills, particular group values, attitudes and behaviours, or ethical standards of conduct, and in so doing, transforms their identity (76). This process does not refer only to professional groups, but many sociologists believe that the professions provide some of the most refined and sophisticated examples of socialisation at work.

Some sociologists have seen socialisation as a way for people to learn the 'rules of the game' (77), suggesting that there is a pre-existing culture made up of norms and core values that the person must adapt to. Others have argued that people will not always respond in the same way to the same rules because people are not equally constrained by them. Critical theorists, for instance, argue that rules and standards established in white, Western, male culture, present greater barriers to some than others. Marxists suggest that socialisation is more about legitimating a class-based system that continues to favour those in power, using techniques of socialisation to instil the 'false consciousness' necessary for people to believe the situation is natural and inevitable (78, 79). What functionalists and Marxists share in common is a belief in the importance of institutions like schools, families, governments, and religions in defining social norms. Perhaps not surprisingly, sociologists have shown that it is these institutions that practice socialisation most aggressively.

Socialisation can take many forms, including:

- Specific approaches to learning that encourage deference to authority, 'detached concern' and the 'supple balance' of equanimity and compassion (28) favoured in Western healthcare;
- Unacknowledged reliance on an extensive hidden curriculum;
- Extensive use of 'status passages' as compulsory steps to prove the student has inculcated appropriate knowledge, skills and attitudes;
- Deliberately maintaining distance between academic theory and 'real' clinical practice, to encourage practice humility and the belief that the true professional exceeds even what the formal qualification can offer;
- Having expectations that the students will develop complex humanistic skills, without significant curriculum support, reinforcing the belief that biomedical beliefs about health and illness are more complex and powerful.

Socialisation plays a crucial role in professional projects because occupational groups use it to perpetuate their profession's legacy, shared skills, knowledge, and culture (80–82). Professions that

have the weakest or least 'natural' claim to a particular field, or face the greatest boundary pressure, need to work the hardest to establish and maintain their professional cultures, and socialisation can play a key role in this. Socialisation emphasises the point common to all social action perspectives, that it takes much more than knowledge of particular theory or technical competence to *become* a professional (28).

Socialisation does not only deal with the 'positive' aspects of becoming a skilled professional, though. It has also been deployed as a tool to better understand how Western medicine continues to favour patriarchal, white, ableist, coercive male values, after decades of criticism (76). For example, if male doctors occupy vastly higher numbers of certain medical specialties, like orthopaedics, neurosurgery, and other 'heroic' specialties, and female doctors tend to gravitate towards areas that, like nursing, reflect socialised values about women's domestic preferences (public health, general practice, family medicine), then socialisation must be playing a part in the way doctors are trained to think about health and healthcare. From a sociological point of view, what is particularly interesting is that while Western medicine does not set out to actively *promote* misogyny, heterosexism, racism, ableism, or any other form of discrimination, these discourses persist, despite the fact that well-trained health professionals are supposed to be champions of objectivity, value-neutrality, and disinterest in culture and history.

Symbolic interactionists argue, therefore, that socialisation must be a process of dynamic meaning-making that occurs between members of a particular community (83). Professional values are not obtained or acquired, but created, developed and constantly re-performed. Competence is, at best, a fleeting, temporary state, always open to change and challenge. And because professional values exist within their own cultural context, it is impossible to anchor any particular set of values to professionals, without making them so generic that they become meaningless. In SI, the individual practitioner is 'an active, constructive and transforming agent who shapes and is shaped by their experience of participation in cultural practices' (84).

The performative dimension of socialisation became a particular interest to sociologist Harold Garfinkel in the 1960s. Garfinkel was interested in the way people negotiated their everyday lives, and in doing so, crafted personal and professional identities. Garfinkel developed an approach to social action called ethnomethodology, and he used this to better understand the skill and creativity needed to navigate everyday life.

Ethnomethodology

In keeping with many other approaches to social action, ethnomethodology focuses on the way people practice or *perform* their everyday social roles and work through their daily lives, rather than focusing on the grand social institutions that other social theories concentrate on (85). For ethnomethodologists, being a 'patient' requires a certain kind of labour to distinguish it from being a relative or a professional. Some of that work involves context-specific actions that all patients perform, other work is specific to that person's particular situation. But ethnomethodology is 'the study of how people do the work of sustaining commonly shared understandings and the institutions that depend on these understandings' (54), or more simply, 'the methods that people use' (62).

As well as studying the work that people do to be themselves, ethnomethodologists are interested in what makes this work recognisable. For instance, what needs to be in place for people in society

to recognise this person as a physiotherapist and not an osteopath? It asks how this person's actions become 'mutually recognisable and acceptably predictable' (ibid). Because it concentrates on the ways we build up shared understandings about people's actions, it centres on the everyday and mundane ways people make order and create stability out of what might otherwise be a chaotic existence. Ethnomethodologists believe that 'the skilfulness and creativity involved in conducting everyday life has gone unnoticed' (1), but that it could offer important insights into how things like education and healthcare function.

In a professional sense, ethnomethodology has been used to study the ways people come to understand practice through its common routines, rules and rituals. Some of these things are common to all aspects of society (expressing concern and asking questions, for instance), others less so (examining naked bodies, injecting). And some are specific to only one or two groups (dental extractions, arthroscopy, diagnosing someone as psychotic). Ethnomethodology drew inspiration from the work of phenomenologists like Alfred Schütz (55, 86) and sociologist Michael Polanyi (87), shaping our understanding of what Weber called the 'incommensurability' of expert practice, and Polanyi called tacit knowledge.

Like other social action perspectives, Garfinkel believed that there were no social structures or concrete reality lying *behind* the workings of social actors, and the only thing we could say represented reality was that which was created through social interaction. Reality was whatever we perceived it to be. And it was one of our 'interactional accomplishments' (57), that we could, each day, make enough sense of the world, between each other, to function as a society. This, for Garfinkel, has particular resonance for our understanding of trust.

Trust relies on people sometimes going to extraordinary lengths to 'conspire' with each other to be convinced that they know what is going on. People act as if their perception of reality is objectively true, and that there is a world 'beyond' their actions and shared meaning-making. Garfinkel believed that this serves two important functions: firstly, it gave us comfort that our daily routines sit 'above' reality, which means that there must be some fundamental stability to the world; and secondly, that it engenders trust between us because the other person conspires with us in this fiction. This act of conspiring with others has created *all* of the shared customs and practices that make the world work as it does.

To test this idea, Garfinkel developed a series of what he called 'breaching experiments' to examine the ways people used common-sense knowledge to give meaning and order to everyday situations. He attempted to show his students how prevalent and taken-for-granted these practices were, and how dislocating it was when these everyday rules were broken. Garfinkel asked his students to stand too close to people in queues, speak too loudly, laugh out of context, or interpret what people said literally. In one example, a student met a friend in the street who greeted her by saying "What's up?". Garfinkel's student replied, "Clouds, the sun, the sky." Sometimes these actions caused people to become confused or irate, thinking they were being made fun of, but Garfinkel's point was that there are social norms and 'patterned regularities' (88) implicit in social life that we often take for granted. By violating these common-sense norms, we can see more clearly the impersonal forces, like trust, that shape our lives.

Garfinkel believed trust was a particular problem in healthcare, where experts repaired, reconstructed, or *tinkered* with other people's bodies (69). Unlike car maintenance, the patient cannot leave the faulty part with the therapist. And so encounters between lay people and health experts become sites of 'social drama', in which the technical or 'non-person treatment' (69) has to be

supplemented with rules and rituals that operate over-and-above fundamental caring and healing work (89). Garfinkel's work here coincided with interest in the voices of marginalised people, newfound interest in people's personal health narratives, and growing criticism of the power of authority figures in society, to initiate a field of sociology interested in lay-professional interactions.

Lay-professional interactions and social distance

Prior to the 1960s, the predominant view in Western healthcare was that experts operated with a certain social distance from their patients, and that health professionals were largely disinterested in people's subjective opinions and experiences. The increasing prevalence of chronic illness, people's growing desire to have their voices heard, increasing levels of frustration with the power of health professionals, and economic reforms that gave people greater choice and personal responsibility for their healthcare, led sociologists to argue that people had far more ability to develop 'sophisticated accounts about health and illness' (90), than health professionals had given them credit for.

The emergence of qualitative research over the last half century, has shown that people's 'lay' interpretations of health and illness are often at odds with the conventional wisdom of traditional 'experts' (89). Grudgingly, clinicians, educators, researchers, and health systems at large, have recognised the importance of healthcare user's personal perspectives (91). As Arthur Frank says; 'People are desperate for stories they can call their own' (54).

The traditional functionalist account of lay-professional relationships placed medicine on one side of the ledger and patients on the other. Society gave health professionals the power to deliver care, but held them to account for doing so (90). In Thomas Szasz and Marc Hollender's work, the authors showed that in traditional healthcare the doctor's primary motive was to focus on the biological processes underpinning the patient's illness (92). This had the effect of creating a relationship of activity/passivity in which the doctor was the active, dynamic, 'parental' voice in the relationship, and the passive patient was subject to the doctor's expertise.

Many disputed this functionalist reading of the professions, though, because it assumed that healthcare professionals *could* be detached and objective (42, 93). It also ignored the powerful ideological beliefs about the body, about what was normal, and about gender, class, and race, that functionalists accepted as a necessary condition of medicine's expertise (94). Some even suggested that doctor-patient encounters were one of the principle locations where ideologies of class, race, and gender domination were established, with Habermas arguing that medicine was 'all the more sinister' for its much vaunted objectivity (95).

Sarah Nettleton developed this critique by suggesting that, 'The extent to which consumers are dependent on an occupational group is not a function of professional expertise and lay ignorance', but rather 'a function of social distance between them' (93). Haroun Jamous and Bernard Pelloile described this social distance as a function of indeterminacy and technicality (96). Indeterminacy referred to the aspects of the profession's work that are hard to see and measure, and technicality to 'the concrete knowledge and skills constituting an occupational role which can be codified, communicated, taught and learned' (30). Elite professions had succeeded by mystifying large aspects of their work and distanced themselves from their competition and their clients. They did this in order to 'meet their obligations as objective professionals' (97), and to control the healthcare process (5, 98).

Of the pair, it is indeterminacy that holds the key to social distance because 'even if laypeople had access to the same medical textbooks, professional journals and lectures as medical students' (97), it would be the enculturated and socialised aspects of practice that distinguish lay people from experts. As physiotherapist Julius Sim wrote in 1985; 'the medical student does not merely learn about medicine, he *becomes* a doctor' (99). Without the ability to absorb the 'intangible aspects' of practice (97), the student cannot become the professional. But social action theorists argued that the reliance on a degree of mystification has primarily been used to insulate elite professions from encroachment and reduced the need to explain practice with reason and logic (17).

In recent years, recognition of past paternalism has led to many within the Western healthcare system to move away from earlier conceptualisations of lay-professional relationships (100–103). Health professionals are much more open to seeing patients as lay 'experts' and providing information so that people can exercise some choice. Isabelle Stengers has described a rise of 'connoisseurship' amongst health service consumers, and the development of intelligent relationships between health professionals and service users (104, 105). By implication, many of the conversations health professionals now have with patients include a degree of uncertainty. But rather than the health professional taking on the burden of uncertainty and risk and acting on the patient's behalf, they are now acting *as if* the patient has a say, by soliciting opinions before coercing the patient into doing what the health professional planned to do all along (106–109). Nigel Malin has argued that 'Bringing users into the matrix contributes to the extension of knowledge and confronts biomedical knowledge with new perspectives of lay knowledge' (110). 'Titles and qualifications which formerly gave access to market power and state protection', he suggests, 'no longer guarantee these privileges' (ibid).

Of course, not everything about the move towards more egalitarian lay-professional relationships is welcome. David Silverman, writing in 1987, suggested that;

> *'To ask of medicine that it should cease to survey objectified bodies or give up its search for hidden truths concealed in organic processes is to demand that medicine should dissolve itself. This, of course, would be unacceptable not only to doctors, but also to all people who demand of medicine precisely that it should provide such truths'* (111).

A number of authors have argued that hearing more of the patient's voice has resulted in people distrusting the advice they are given, challenging the profession's authority, 'shopping around' for second, third, and fourth opinions, and looking outside of orthodox healthcare services for support (97, 112, 113). These effects are radically reshaping the landscape of lay-professional relationships, creating trepidation and ambiguity for both parties, where once patriarchal certainty was the norm. Ivan Illich put the issue most starkly, perhaps, when he stated that 'the age of disabling professions… When people had "problems", experts had "solutions" and scientists measured imponderables such as "abilities" and "needs"… is now at an end' (114). How then does social action relate to physiotherapy?

Social action and physiotherapy

In Chapter 3 I used Karl Marx's historical analysis of the birth of capitalism to argue that physiotherapy had come to play a key role in maintaining a population of fit workers able to fuel the

engine of capitalism. In Chapter 4 I argued that the profession's affinity with Western biomedicine added a gendered, racial, heteronormative and ableist tinge to this work. From this chapter, we can add Weber's concept of the Protestant work ethic. Weber's analysis explains how the entrepreneurial spirit changed Western culture in the 18th and 19th centuries. But for physiotherapists, it helps to explain the profession's longstanding interest in bodily function, work and productivity, independence and autonomy, resilience, rehabilitation, and reablement (115).

Work on the working body is the physiotherapy profession's mechanism for influencing human performance, and influencing human performance is the profession's way of showing that physiotherapy matters. As Chris Shilling argued, we are 'bodies-working-on-bodies' (116). The Protestant work ethic shows us, however, that it is not any human performance that matters socially, but purposeful, task-focused, productive movement. Rest, indulgent luxury, and idleness have no place in 'normal' function, and so they have no place in physiotherapy.

But the nature of work is changing, and few people now expect to be labouring in the future in the way that was the norm when physiotherapy was becoming established. From agriculture and banking, to education, transportation, and manufacturing, the working lives of people will be vastly different in the future. Bodies are also changing, and have become 'the product we both manufacture and consume' (117). And so, if two of the main physiotherapy 'fields' change, the profession must change too, which raises a number of issues at the heart of social action. The first is around the profession's boundaries.

As neo-Weberian theorists have shown, social closure has been an important way for professions to manage boundary tensions since orthodox healthcare began to incorporate more professions in the 1930s. The incorporation of physiotherapy into the welfare state in the 1940s brought security of income, training subsidies, and legislative protection, but physiotherapists had 'won recognition but only to a degree which met with medical and state approval' (118). Attempting to extricate itself from the perception that it was merely a 'medical auxiliary' (119), whilst not wanting to lose the valued patronage of medicine, meant many professional bodies pursuing professional autonomy, which led to a flush of social theory work by physiotherapists (120, 120–124). In the 1990s attention turned to new managerial practices, audit, and financial accountability for professional decisions (125–128). This pre-empted today's focus on legitimate boundary-breaching practices like extended scopes and interprofessional practice (129–134).

From a social action perspective, the challenge for physiotherapists here is how to transgress its traditional profession enclosure (132, 135). Having spent decades establishing mechanisms to police the professions vulnerable margins, physiotherapists, and every other health discipline, are being asked to change. Narelle Patton and Joy Higgs have suggested that because professional practice is 'rich, complex, embodied, and inherently human' (136), embracing a more person-centred approach to practice demands more than just the bland acknowledgement that physiotherapists care about people. Being person-centred means giving the patient the power to decide that they might not want your input. Would a profession risk such a transfer of power if it might result in it becoming obsolete? Adopting person-centred practice also involves 'hearing' clients/patients in ways that physiotherapists have never emphasised. Physiotherapy has pursued the kinds of objectivity, quantitative detachment, and value-neutral ethical judgement that have earned the respect of medicine. To relinquish this to give priority to the patient's subjective lived experience, or to a reality based on shared meaning, qualitative, humanistic practice, might create a rift with medicine and inducing a rapid decline in the profession's social prestige.

Perhaps physiotherapists already sense this. We have known for a long time that the female-dominated professions that emphasise caring and partnership (especially nursing, midwifery, social work), command high levels of social prestige, but much lower levels of economic reward, than those that subscribe to biomedical discourses. But physiotherapy's affinity with biomedicine presents other barriers too, not the least of these being that the profession has no history of significant creativity and innovation. Indeed, it works hard to ensure people do not 'fail fast and often'. Creative professionals are trained from day one to anticipate people's future needs and wants, to break things, to be playful, to de-emphasise conformity and concentrate on innovation. Not so physiotherapists. Physiotherapy education and practice is about learning trustworthy and repeatable techniques, using proven methods in predictable situations, conformity, rule-following, accountability. Anyone found practicing outside of their scope is liable to be sanctioned by the regulatory authority. In such a climate, it is hard to imagine how boundary breaches will occur that will allow for the kinds of transformations in healthcare now being called for.

Physiotherapists traditionally emphasised their social distance from patients as a way to demonstrate their legitimacy, expertise, and authority, but growing interest in the biopsychosocial model, person-centred care, patients' perspectives in evidence-based practice, and the emerging field of the humanities in rehabilitation, have seen many clinicians question the profession's longstanding affinity with paternalistic, detached, and reductive healthcare (137). Some of the challenges of narrowing the social distance to clients/patients (whilst also not overly extending the distance between physiotherapist and Western biomedical healthcare), are currently being played out in the management of chronic pain, lung disease, and neurological disability, for which the client's subjective worldview is significantly more important than their pathology. But this has created some problems for physiotherapists because although patient values are considered important in high-value care, and are explicitly a part of concepts as EBP (evidence-based practice), VBP (value-based practice) and PCC (patient- or person-centred care), they are largely unclear and unknown how to be 'integrated' in clinical decision-making (138).

Key to this transformation, then, will be the way physiotherapists are socialised to become practitioners. Recent studies are showing that physiotherapists are uncomfortable and unprepared for person-centred practice. They prioritise their authority and expertise, and 'overrule patients' (139). Physiotherapists respected patients' concerns more when they gave up some of their own priorities, techniques, and goals (140), but often found it uncomfortable dealing with a patient narrative that did not resonate with their professional learning (141). The therapists had been socialised to treat patients paternalistically, and felt ill-equipped to manage even some of the most basic communication skills like rapport-building (ibid). Some of the reasons for this become clearer when the subtle depth of the profession's reductive, paternalistic approach to practice is explored (142).

The extent to which the practitioner should assert their authority had been problematic for all Western health professions since the rise of consumer-led healthcare in the 1970s. If the practitioner believes 'they have greater knowledge about what is 'best' for the patient' Sarah Nettleton asks, 'should they insist that the patient complies with their instructions, or should they defer to the patient's wishes' (90)? If they risk being accused of paternalism, or 'medical imperialism' (143, 144), then the answer may be no. But if they demur from a therapy for these reasons, they may well cause more problems for the patient and abdicate their professional duty.

In the past, functionalists argued that society had given elite professionals like doctors the power to make difficult health decisions *for* people; a responsibility for which they received special status

and reward. But functionalism largely ignores the immense social power that this gave to doctors and their allies. Seeking a new more democratic and egalitarian approach to healthcare, some authors after the 1990s began to explore the idea of 'partnership' as a radical alternative to biomedicine (25, 145). These approaches propose 'a shift away from the biomedical model of care, in which medical intervention is the solution to health problems, to a holistic approach in which the patient is an active participant in care' (25). But, as these new approaches show, the fundamental question is never one of policy or legislation, the value of evidence, or the importance of diagnosis and treatment, it is about power; whether healthcare workers are prepared to relinquish their authority to 'empower' consumers; whether it can even be 'transferred', or whether it is 'performed' in social encounters, as social action advocates argue.

The question of how one 'becomes' a physiotherapist, therefore, cannot be answered without considering the social context in which physiotherapy practice operates. Social action argues that all good practice is fundamentally context-specific, making it very hard to standardise, regurgitate, and repeat. It is radically relational (146), and challenges the longstanding axiom that 'the doctor knows best'. It is, in many ways, the opposite of our historical approach to physiotherapy. Of course, social action perspectives are not without their critics, and so we close this chapter with a brief review of where some people believe social action falls short.

Critiques of social action

One of the most useful methods used by sociologists to critique different schools of thought, is to compare their respective strengths. This makes it easier to see what a theory does well and what it lacks. By knowing more about gender theory, for instance, you can see that functionalism and Marxism both fall short when it comes to gender. By the same token, one of the main limitations of social action comes from critical theory, being that it takes our attention away from structured power.

Social action is very much focused on individual or group agency: the things people do to shape their world. The world we know is 'the result of our perceptions of the world' (62). There is nothing lying 'behind' people's actions. No pre-existing social structures, and so no real acknowledgement of class, gender, and race. There is little about gendered social relations in the work of Weber, Blumer, Mead, and Garfinkel (although people like Anne Witz and Magali Larson have combined social action and critical theory to talk about gender). And there is little consideration given to colonial power, normalisation, othering, or disability, beyond thoughts about the way we stigmatise others for their otherness. The world is only what we perceive it to be, and the only world that exists is that which is created by our 'interactional accomplishments' (57). As a result, social action has been criticised for focusing too much on micro-narratives and small-scale interactions, and ignoring the grand social structures talked about in Chapter 4.

Much of the socialisation literature has also been criticised for focusing on single professional disciplines in 'effective monocultures' (147), with the professions operating in isolation to one another. In doing so, Shân Wareing argues, 'we underestimate the complexity of other disciplines' and the relationships between them that shape the way healthcare operates. Because social action emphasises the work that professionals do to shape their worlds, it promotes the belief that professions are very powerful social actors. But Keith Macdonald argued that 'Although there is no

doubt that professions have pursued social closure, or broad-based attempts to secure market dominance, we should be careful not to read too much into this' (4).

Just because we can see boundary closure, encroachment, labelling, and other social action concepts in practice, does not mean that they are necessarily powerful or significant. Martin Lipscomb has asked, for instance, 'what would happen if boundaries (between professions, and between the professions and the public) were overtly rejected? Sadly, he argues, the answer would be 'not a lot' because 'entrenched ('structural') blocks upon wider participation and openness would remain' (148). This has become an important issue in the discussions about inter-, multi-, and trans-professional practice, with critics arguing that the professions have been too concerned with their own inculturation, and have forgotten that their primary purpose is patient care (28, 129–131).

Structural criticisms aside, social action perspectives have also been critiqued for being anchored in the Global North, particularly North America. Daniel Johnson has suggested that social action relates closely to neoliberal and bourgeois beliefs (149), emphasising people's individuality, their power to change, the importance of self-help, reflective practice, and self-actualisation, combined with a general disregard for the social and historical conditions that shape people's choices and underpin oppression. It implies that the reasons why we might feel bad or ill, or experience discrimination and unjust treatment, is because we have internalised a particular way of seeing the world, and that it is possible just to think and act differently and, through this, transform ourselves into better people. It is perhaps easy to see, then, why social action theories have been popular in the self-help movement, in health promotion, and personal psychology, but offer little when it comes to addressing the social determinants of health.

Notwithstanding these limitations, however, the works of people like Weber, Larson, Garfinkel, Witz, Blumer, and Goffman offer important insights into the way healthcare operates. It is a shame, then, that their work has been almost entirely ignored within the physiotherapy literature; a situation Martin Lipscomb argued was also true of nursing. To take just one example, Max Weber's work 'is rarely mentioned by name and this is perplexing for, if we grant that he spoke to (a host of issues relevant to nursing) in a sophisticated and nuanced manner, if his writings still stimulate fresh thinking regarding these topics, then his near-invisibility from our literature is disquieting' (150).

Lipscomb goes on to suggest that;

> *'(O)ne does not have to accept or even agree with Weber to realise that his thinking continues to resonate with present-day concerns and, just as ethicists do not need to be Aristotelians to read and take inspiration from Aristotle, nurses (and other health professionals, like physiotherapists presumably) interested in the themes addressed by Weber can gain much from his work while recognising and perhaps preferring modern theorists'* (150).

In the next chapter, we will look closely at some of these modern social theorists, and explore what they have to offer the sociology of physiotherapy.

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6. Complexities and intersections

Foucault, the professions, and the state — Technologies of discipline — Intersectionality — A third way: Bourdieu, Giddens, Bhaskar — Postmodern thinking and physiotherapy — Criticisms of postmodernism

Beginning quietly in the 1970s, postmodernism, poststructuralism, and various other 'posts', have now come to play an increasingly important role in the ways people think about society - particularly in the West. More than anything, the 'posts' challenge the kinds of binaries that had long dominated the way people thought. Distinctions between nature and nurture, biology and society, male and female, straight and queer, right and wrong, non-disabled and disabled, good and bad, have all been the subject of skeptical inquiry over the last half century. And this has been especially true in healthcare, where earlier ways of thinking about society that separated those who believed in the power of social structures (functionalists, Marxists, and critical theorists), from those who emphasised people's individual beliefs and actions (symbolic interactionists, ethnomethodologists, and phenomenologists), have been seriously challenged in recent years.

The seeds of this change began with the critical theory movement of the 1960s, with its critique of the 'old' ways of understanding society, and the concurrent emergence of entirely new ways of thinking about and researching the social world. The methods that had gone before (positivism, empiricism, functionalism, Marxism, existentialism, etc.), began to seem too linear and simplistic. Society had become too messy, too uncertain, and dynamic. Added to this, there was a growing sense of distrust towards traditional forms of authority (from the family, to the church, doctors, politicians and teachers), most strongly expressed within the print media, radio and, increasingly, television. This phenomenon has only accelerated in recent years with the growth of social media and the Internet. And we have also seen a growing appetite for new forms of knowledge and power that allow for more diverse forms of individual expression, no longer bound by traditional constraints around what is normal, possible, or desirable. The various 'posts', then, are a direct response to these tensions. They attempt to analyse and, in some cases, anticipate, the myriad ways societies now operate.

There are, perhaps, six main principles governing the 'posts':

1. A distrust of singular truths, particularly grand claims about the nature of reality. Jean-François Lyotard defined postmodernism, for example, as a 'scepticism towards metanarratives' (1), or a suspicion of anyone who believes they have *the* answer for anything. This scepticism strikes at the heart of what it means to be an expert or a privileged professional;

2. A belief that knowledge is socially constructed and mediated through language. So while 'real' things might exist regardless of whether we perceive them or not, we can only access these things through some kind of language;

3. That people 'grasp for emergency supplies of meaning' (2) because life is messy, complex, unresolved, ambiguous, and uncertain. Science, religion, and consumerism have all, at times, offered promises of the truth, clarity, reason, comfort, and certainty, but postmodernists argue these are only ways of 'addressing the wound of non-meaning' (ibid). But since true meaning is impossible to capture, our pain and frustration comes from our hubris in *wanting* (and failing) to command and control the world, and from putting too much faith in certainty;

4. People do not create the world, they are created by it. Ideas like personal or professional agency and 'identity' assume that a body or a mind creates the meaning we give to things (3). But postmodernists argue that this is a fantasy of the Enlightenment. Rather, we are the *effect*, or the *achievement* of a series of competing subjects, objects, concepts, and strategies — what postmodernists call 'discourses' — that define who we are. This belief holds whether we are talking about individuals, groups like physiotherapists, social structures like healthcare, or concepts like the body and illness;

5. That history is not progressive. Most history is written as a story of progress, suggesting that we are slowly becoming more sophisticated and enlightened. Postmodernists dispute this, arguing, instead, that we respond to the myriad competing discourses that confront us here and now (immanence), and that reality is specific to a particular situation (contingent) (4).

6. We have given too much authority to the voice of experts and are too ready to accept what they say. As well as overstating the power of social structures like gender, race, and class, we have also given people's personal accounts and opinions too much attention. Postmodernists believe that we need approaches to understanding the social world that do not default to social structures or individual narratives.

Postmodernism is, first and foremost then, an attempt to break away from the dogmatic ways we have come to think about ourselves and the world around us; to find ways to break the stranglehold of structural and interpretive thinking that says we are either governed by social structures we cannot see, or that we hold in our own hands the power to change. In the following chapter, I will look at three different approaches to this problem that have emerged over the last 40 years. Each comes at the postmodern problem from a different position. First we have the iconoclastic work of Michel Foucault, then a partial return to Chapter 4 with the development of intersectionalism, and finally, some discussion of some 'third way' theorists, notably Pierre Bourdieu, Anthony Giddens, and Roy Bhaskar.

Before launching into Foucault's work, I should clarify some terminology. There is a lot of overlap in the literature between postmodernism and poststructuralism. The difference between these two is unimportant here. What matters is that they refer to something coming *after* an event. Postmodernism refers to something *after* modernism. In the case of medicine, modernism is the period since the Enlightenment that provides the foundation for Western healthcare. It gave us the ideas of reason and logic that underpins modern science, as well as the concept of the sovereign, autonomous human being that is the basis of Western beliefs about disease and illness. Some authors prefer to think we

are now in a different new era, or in an era of 'late' modernism (5), but these are largely discussions for purists and need not concern us here.

Foucault, the professions, and the state

Over a roughly 20-year writing period between 1961 and his death in 1984, Michel Foucault revolutionised the study of Western society, and especially the role that experts and professionals played in its machinery. The first decade of Foucault's writing showed that what we had come to believe as the truth had shifted over time, and so different kinds of knowledge were better understood as 'discourses' that worked to bring about certain ends, rather than bald 'facts' that could be discovered through scientific investigation. Foucault was interested in what truths *did*, not how they could be captured and categorised. The concept of 'reason' that emerged from the Enlightenment, for instance, made it possible for some authority figures in society to define some people as sane, healthy, and fit, and others as insane, sick, and 'handicapped'. This, in turn, helped explain why the health professions were invented, and why we created a Western healthcare system in the image of medicine.

Foucault's second period of writing in the early 1970s concentrated on power and how society had become 'disciplinary'. Mapping the shift from religious and sovereign rule before the 18th century, Foucault showed how we created the idea of modern government through acts of discipline and control that achieved their ends *without* the use of force. Institutions like the family, school, the hospital, the factory, and the professions, all became vital to the exercise of this new governmental power. And then in Foucault's third and final period, his attention shifted to the ways in which we each take up the responsibility to fashion ourselves, creating our own subjectivities as ethical beings.

Tellingly, there are echoes of many different social theories in Foucault's writing on expertise and the professions. He agrees with the functionalist claim that the professions are a specific response to a social need. And there are definite strands of Marxian and critical theory in his belief that deeper structures favour some kinds of subjectivity over others. But in both cases Foucault argued that there was something missing from these accounts, something that Foucault believed revolved around the idea of power.

Unlike the functionalists, Foucault did not believe that the professions had acquired prestige and social capital as a reward for their noble service. He believed that it was wrong to talk about some people 'having' power, whilst other people were denied it. Consequently, he rejected the critical and Marxian idea that we had to overturn power asymmetries in society and speak up against oppression. He was disinterested in revolutionary change or providing the 'theoretical foundations for furthering social enlightenment and democracy' (3). This obviously put him at odds with many traditional social theorists, who celebrated the ways that his methods shed new light on class and gendered power, colonisation, and ableism, but were less enamoured with his argument that oppressive power had been overstated.

Foucault's radical idea about how power circulated in society changed the way many people thought about the professions. Earlier theories had concentrated on power as a 'fixed capacity' (4), that some, like white men and doctors, held, and most everyone else wanted. But Foucault was more interested in how power worked as a more positive force for making things happen. Power was not something that a person or group wielded, but rather an 'arena of struggle' (6). And power only

operated when people are free to resist. So, where oppression is about brute force, the *real* power operating in society works best when people do things *without* force. The ability to resist power is key here then because for real power to work, people have to have the ability to do otherwise and yet choose to do what you want, seemingly exercising their free will.

Foucault used these ideas to study how societies had learnt to govern the population. Foucault showed that the mass migration of people from the countryside to the towns during the 17th and 18th centuries created enormous problems of civic rule. Foucault identified a gradual shift from early forms of 'sovereign' power to approaches that were less punitive. The emerging nation states of Western Europe, needed people to work in the factories and serve in standing armies. They needed obedient, loyal subjects to fuel the machinery of growth and expansion around the globe. But this could not be achieved through violence and oppression alone. And so, the idea of citizenship, and civic rights and responsibilities were developed (the right to safe working conditions and the responsibility to pay taxes, for instance); new ways to measure and monitor the population were implemented (censuses, bureaucracy, surveys, the police, etc.); and new institutions of governance were designed (the family, schooling, professional education, and so on).

Foucault showed that the state, and its experts and professionals, were not born from their own initiatives and interests, but from a desire to administer society to ensure the health, wealth and happiness of the population. So, Foucault argued it is mistaken to think of 'the state' as a distinctive body *separate*, and often at odds, with the professions. The professions are not isolated entities working *for* the state (functionalism), or competing interests vying for control of the market (neo-Weberian). Neither are they power*ful* organisations that oppress minorities (critical theory, Marxism). Instead, both the state and the professions are 'inextricably fused' together as 'progenitors' and 'beneficiaries' of a complex network of interrelated social realities which both constitute the world they operate within, and render it governable' (7). For Foucault, there is a 'warm friendship' between the professions and the state (8), and both are 'integral to the process of governmentality'[1] (9). Following a Foucauldian reading, then, we might say that physiotherapy does not *have* or *lack* power, but that it is the *result* of power, and is one of its effects, residues, or 'achievements'.

The 'shape' that modern forms of government take insinuates physiotherapists, patients and families, case managers, other professionals, government ministers, and myriad others, in a network of power relations that *produce* what we call healthcare. There is no healthcare pre-existing these relations, waiting to be discovered and competed over by professionals. There is no biological basis to illness that is not, in turn, mediated through language and meaning. And so, the exact specifications of healthcare that we see in different places depends upon the myriad discourses that compete to define what it is reasonable to believe, what is right and wrong, and whose authority offers the most seductive truth narrative. Not surprisingly, Foucault spent a great deal of time exploring how contests over the truth, power, and knowledge, had shaped the structure of Western society over the last four centuries, and much of his most powerful work centres on what he called the *Technologies of Discipline*.

[1] Governmentality is a phrase Foucault used to describe the inclination to govern that developed in the West after the 17th century. Foucault saw that the various 'technologies' of government (making laws, securing borders, managing people's time and labour, facilitating enterprise, supporting alliances with experts, etc.), were specific to a particular set of problems created by society after the Industrial Revolution. The creation of a professional class, physiotherapy included, was a part of that governmental process.

Technologies of discipline

Technologies of Discipline (ToD) are the methods developed to organise society so that people did what was considered right or necessary, and maximised their productive value without the need for force (10, 11). ToD begin with thoroughgoing knowledge of people's bodies and behaviours. Through the systematic study of people's movements, attitudes and beliefs, conduct, connections, habits and routines, Terry Johnson argued we have divided the normal from the pathological, and maximised every facet of life for the presumed betterment of the individual and society at large (12).

In *The Birth of the Clinic* (10), Foucault showed how medicine had been particularly effective as a ToD, through what he called the *medical gaze*. Foucault showed that the kinds of medical practices we take for granted today (systematic examination of the body, the emphasis on pathological anatomy, and judgements about what is normal and abnormal, for example), were techniques developed by physicians to acquire enormous social power on the basis of the profession's extensive knowledge of the inner workings of the body (13, 14).

Before the 1850s, medical practice worked from general statements of the patient's wellbeing, and the belief that illness affected the person as a whole (10). 'Surveillance medicine' — as David Armstrong calls it (14) — shifted this focus to a specific medical examination, designed to classify and categorise different disease presentations, and reveal 'discrete bodily structures and tissues; the specific 'grammar' of signs and symptoms; the trajectory that diseases took; the body tissues that became disrupted; and the specific locations where the patient experienced pain or abnormality' (10).

Unlike the spiritual practices that saw the priest as a conduit for the word of God, doctors now argued that they interpreted only what they saw, without bias or subjectivity. This connected medicine squarely with Enlightenment science, and justified the accumulation of massive amounts of patient data, not least because the new 'objective' medicine could claim to be able to *predict* more accurately the likely course of illness and injury without any claim to abstract faith.

The ability to connect the patient's reported symptoms, and then later specialised test results, to the detailed knowledge of pathological anatomy, unavailable to the lay person, afforded medicine enormous social prestige. With this prestige came the ability to define what forms of knowledge about health were to be deemed valid, and, perhaps more importantly, how validity itself would be defined.

Critically, the medical gaze always served broader political ends. From the 18th century onwards, attention increasingly turned to any aspect of society that threatened the prosperity of the Western economic powers. Criminality, madness, sexual 'deviance', political dissent, and illness, all became 'particular field(s) of special enquiry' (15), requiring new disciplines, codes, procedures, and ways of thinking and practicing that would inscribe the patient 'into a medical code, thus turning the individual body into a valid object of scientific knowledge' (ibid). So while the idea of the 'sick poor' had existed for centuries, it was peoples' 'economic relevance rather than their need for assistance' (ibid, p.70-1) that gave the medical profession the impetus to invent the body as the site of legitimate scientific inquiry. In other words, it was 'the concern for the preservation and reproduction of the labour force' (ibid), that created the conditions within which medicine could construct a professional enclosure.

Perhaps one of the best examples of this comes from work on the role that normalisation plays in disability. Foucault argued that 'The judges of normality are everywhere… and each individual, wherever he may find himself, subjects to it his body, his gestures, his behaviors, his attitudes, his achievements' (11). This resulted in beliefs about normalisation that are so pervasive today, that any

form of deviance or difference becomes 'everyone's fiefdom of oversight' (16). Crucially, though, such beliefs only work because they conceal their immense power to shape our conduct without force. Physiotherapists are no less folded into this network than disabled people themselves, as normalisation becomes the default way to think and shape everyone's practices. The same logic can be seen in the way ToD have come to define our attitudes to work.

In *Madness and Civilization* (17), Foucault explored how the need to maximise human productivity in industrial capitalism had shifted attitudes towards idleness and rest. But Foucault showed that the new approaches to work developed in the 18th and 19th centuries also applied to education, the military, and medicine. At the heart of these institutions were efforts to 'capture' individuals, opened them to constant surveillance, and engender compliance and docility. From pre-school to school; school to college, factory, or barracks; and from the hospital, asylum, prison, and rest home, the goal was to bring everyone under the unremitting 'calculating control of discipline' (18).

Key here were forms of surveillance that were actually *built into* all of the institutions people passed through, from gymnasiums to shopping malls, libraries and doctor's surgeries. Surveillance was deemed necessary to quickly identify individual 'irregularities' in bodies, movements, thoughts, activities, histories, and achievements. These could then be used by a new cadre of experts, who would then claim the prestige associated with specifying 'empirical norms for all manner of physical and mental attributes and functions of human bodies' (19).

The invention of the hospital is one of the best examples of this. The move away from bedside medicine to the 'surveillance medicine' of the hospital, fitted the industrial idea of more organised and efficient healthcare. Patients could be 'managed' in hospitals more easily, and the delivery of medical care made more efficient. But hospitals also gave doctors three significant advantages: it brought a mass of patients into one place, allowing medicine to accumulate enormous amounts of data about the subtle variations between clinical presentations; it created enormous amounts of new work, requiring new professional roles and hierarchical ordering of tasks under the guidance of doctors; and new centres of practice could become sites where 'ancillary' professions could become enculturated into ways of working that complemented medical practice and reinforced biomedical discourses (20). Hospitals were places of healing, but they were also important sites for the concentration of medical discipline, surveillance, and science.

But because power can never be total or absolute, and real power only exists where people have the ability to think and do otherwise, institutional forms of authority can never afford to rest. They must always be attentive to exceptions, disputes, disagreements, and differences. So in Western healthcare, for instance, doctors and other orthodox professionals must constantly find new ways to overcome acts of resistance if they are to assert their knowledge as the most authentic, reasoned 'truth'.

Because medicine has been so effective in doing this over the last century, there is no need here to force professions like physiotherapy to conform because the profession learned long ago that medicine's 'truth' was a much more valuable conduit to professional legitimacy than any of the other circulating discourses. So, rather than seeing physiotherapy as autonomous, physiotherapists have learned to be part of the constantly negotiated social order. By keeping 'themselves "in order" through internalised discipline', they are now 'qualified to participate in the maintenance of social order at a large-scale' (19).

Because no profession has any pre-ordained right to assume a position of prestige and authority in society — on the basis of a set of 'traits', for example — professions constitute as much as reflect

the realities they help to construct (15). Professionals 'exercise significant social power in shaping their professional context' (21). Their prestige is based on discourses that are mobile, fluid, and malleable, rather than fixed and predetermined[2]. It is entirely possible 'that at some future time we might come to hold a different view' (20), and shift our reality entirely, and the professions will be both subject to, and architects of this shift. We should not forget, then, that, 'The apparent objectivity of the body and the permanence of the medical model are open to question and change' (13).

This has important implications for the way we think about bodies, impairments, disease, illness, and disability because Foucault is arguing that these things are social constructs, rather than 'hard' biological 'facts'. This is not the same as saying that the body is not 'real', however, only that we cannot refer to the body without, at the same time, constructing it through language (22). There is no objective reality to the body that is not, at the same time, an expression of someone's desire to say certain things about what the body is and is not. Every description of the body, as Shelley Tremain argues, is also a '*prescription* for the formulation of the object (person, practice, or thing) to which it is claimed to innocently refer' (23).

Intersectionality

The emergence of Foucault's writings coincided, almost exactly, with the rise of neoliberal economic reforms in the 1980s and 90s. Part of their appeal stemmed from the somewhat moribund state of critical theory, which had become fractured by infighting and the general decline of progressive politics. Foucault offered new ways to critique power and, along with others like Pierre Bourdieu, Jacques Derrida, and Jürgen Habermas, revived sociologists' interest in the professions. Foucault's work also coincided with the belief that the radical sociology of the 1960s and 70s had put too much emphasis on peoples identities. And although this approach proved 'almost too useful' (23) as a way of countering biological explanations of things like class, gender, ability, and race to want to abandon, and a 'strategic necessity' (24), it relied on the idea of identity as a 'stable subject' (25), in order to signal oppression and fight for people's emancipation. This unwittingly brought about the breakdown of radical sociology internationally because it could not speak to the experiences of people who were women, as well as being racialised, poor, elderly, queer, or disabled. So, although many activists have mourned the loss of identity politics of the post-war years (26), many embraced the new possibilities offered by intersectionalism.

Beginning in the late 1980s, theorists like Judith Butler, Jane Flax, Stuart Hall, Kimberlé Crenshaw, and Iris Young began to challenge the idea that people had a core, singular, autonomous, and sovereign identity that became overlaid with multiple other identities through life experience and our being in the world. Intersectionality theorists argued that while beliefs in identity as a 'point of origin' (27) had been perpetuated in society, especially by health professionals using diagnostic labels and normalising categories, the belief that people could share common traits with others only served to reinforce the kinds of Enlightenment reason that lay at the heart of modern forms of discrimination

[2] 'Discourse' is another Foucauldian term that refers to a set of practices, theories, and statements that drive a particular argument. Biomedicine is a powerful discourse in healthcare, promoted through thousands of ideas and actions that ensure its ideas supersede all others. How some discourses dominate others features heavily in Foucault's writing. *EoP* was a book written to uncover what makes the discourse of physiotherapy historically and socially possible.

and oppression (28). So while labels like 'deaf' and 'disabled' had served as anchor points for advocacy and resistance, intersectionalists increasingly saw them as reinforcing stereotypes and stigma. Rather, as Crenshaw's work on the experienced of Black women suggested, our multiple identities operate like a traffic intersection (hence *intersectionality). At any moment, the 'traffic' of one identity may be flowing one way, while another may be flowing in a different direction (29).*

Judith Butler's work on performativity was also crucial here. Butler was also one of the most important voices arguing that second wave feminists had been wrong to politicise the idea of 'woman' as a distinct social identity in efforts to bring about gender equality. Her work centred on the way gender was 'performed', but has spread to many other areas of critical theory and postmodernism since (25, 30, 31). Butler argued that there was nothing 'natural' or biological about sex or gender, and the way that we expressed our sexual differences was really a social or cultural phenomenon. People 'performed' their gender through 'stylistic acts', but the person does not 'choose' their gender in the way they might choose which clothes to wear. Rather, their gender identity is created by forms of power circulating in society. To use Butler's own phrase; 'Performativity is the way that discourse produces its effects' (25). Gender, therefore, has little to do with biology or individual choice, and more to do with 'scripts' that may be passed down through generations. Butler argued that gender was far more fluid than traditional binary stereotypes allowed.

Many postmodern theorists picked up Butler's ideas of performativity, arguing that race and ethnicity, social class, sexual preference, and bodily ability, should also be seen as the *effect* of circulating cultural values and beliefs, and had little to do with biology or behaviour. This is not to say that material differences between bodies do not exist, only that these differences are 'always already signified' (23). In other words, there are no structures, concepts, or processes we can think of that are not based on language and discourse. A person's sex or race is not a genetically invariable foundation onto which we overlay gender and ethnicity. One is no more *real* than the other, since both are discursively constructed. Postmodernists, therefore, argued that we needed to take much more account of the way people's subjectivities were relative, and historically and socially constructed. Judith Butler expressed this argument perfectly in her book *Gender Trouble* when she argued that 'sex' cannot be thought of as coming *before* gender because to think about sex as a biological precursor derives from a particular patriarchal scientific view of bodies (25).

From the 1990s, postmodern ideas began to appear in the healthcare literature, where the assumed 'naturalness' of ideas like physical impairment, sex, and race, were seen as 'dangerous' technologies of discipline (32). Disability activists were important here, arguing that the medical model had failed to recognise the 'lived challenges' of disability, particularly for people in the Global South (33–35), and the social model for ignoring problems grounded in pathology (36–41). For many disabled people in low- and middle-income countries, for instance, basic survival featured much more prominently in their concerns than the need for accessible environments (42).

This is not to say, however, that postmodernism revived interest in the biomedical sciences. For much of the last half century, there has been 'a growing disillusionment' with the effectiveness and assumed benevolence of scientific medicine on the part of both intellectuals and some consumers' (43). Medicine's claim to 'inaccessible and arcane knowledge based on objectivity and political neutrality' (ibid) was challenged by Eliot Freidson and others, who argued that, in reality, 'the medical profession had no more right to decide on health-related issues than any other group in society' (44).

In rejecting much of what had gone before, postmodernists sought new ways to define concepts like sex and gender, race and ethnicity, impairment, and barriers to participation in ways that

acknowledged the biological basis of many health issues, whilst also recognising the 'global histories of power inequalities and exploitation' (45). The main way this was achieved was seeing identities, or rather 'subjectivities', as discourses 'produced and shaped through various social and political power relations' (35). 'Bodies participate in social forces and social forces participate in shaping bodies', as Raewyn Connell put it (46).

Intersectionality and postmodernism brought 'the natural ambiguity and complexity of modern life' (23), to the fore by emphasising the multiplicity and complex interplay of our various subjectivities. Alongside globalisation, the Internet and social media, their rejection of the traditional binaries used to define nature as distinct from culture, men from women, black from white, science from art, and so on, has contributed to the opening of long-held borders to a new 'traversal' politics. And the insistence of intersectional and postmodern thinkers on difference and inclusiveness, and the 'dynamic, situational, and provisional' (47) nature of reality, have shifted the focus away from the idea that we have a stable 'identity' acting in 'opposition to power', and more multiple, context-specific, culturally constructed, unstable, and fluid subjectivities that are constituted *by* power (25).

The traversal politics of intersectionalism has important implications for healthcare practice. Because subjectivities intersect across multiple axes, we can no longer think of people as individual biological sovereign and autonomous entities, overlain with cultural experiences. Nor can we view them as defined by class, gender, age, race, and ability. Raewyn Connell suggested in 2011, that 'We need a concept, which I call social embodiment, to refer to the collective, reflexive process that embroils bodies in social dynamics, and social dynamics in bodies' (46) because, 'Biology and society cannot be held apart; but also cannot simply be added together. A much deeper and more complex interconnection must be acknowledged' (46). Gilles Deleuze suggested we should be talking about aggregated, measured, distributed, multiple, plural, and diffuse 'dividuals' (as opposed to 'individuals') (48).

Rosi Braidotti saw the body as the site where a host of physical, cultural, social, political, spiritual, and other forces converge, and become embodied. For her, the body was better seen as an interface, threshold, or field through which these forces converged (49). The presence of anomalous bodies in society, then, ceases to be something needing to be fixed, repaired, or rehabilitated, since 'human variation is a fundamentally good thing' (50), and the work of health professionals can become one of rehabilitating *society* to respect and value diversity.

In many ways, this is a radical re-imagining of trans-disciplinary practice; a 'trans-disciplinary space', as Carol Thomas called it (40), which breaks boundaries, deconstructs and decolonises the power that currently divides professionals and the public, and opens healthcare to more than just medicalised understandings of health and illness.

As Margrit Shildrick and others have argued, we can now engage with an enormous array of concepts and ideas, drawn from 'feminism, postmodernism, queer theory, critical race theory or long-established perspectives like the phenomenology of the body and psychoanalysis' (51, 52) to explore the 'inherently transgressive' kinds of 'anomalous embodiment' (ibid) that physiotherapists claim lie at the centre of their professional work (16, 53–59).

Margrit Shildrick has also suggested that 'the key to the new scholarship is critique, not in the sense of the destruction of old certainties, but as a bold and risky enterprise that subjects all the conventions to potentially disruptive analyses' (51). Sar Salih and Judith Butler have echoed this sentiment, arguing that;

'What critique is really about is opening up the possibility of questioning what our assumptions are and somehow encouraging us to live in the anxiety of that questioning without closing it down too quickly. Of course, it's not for the sake of anxiety that one should do it… but because anxiety accompanies something like the witnessing of new possibilities' (31).

A third way

Bourdieu

An alternative to postmodernism and intersectionality came from a group of social theorists who also sought to develop a 'third way', that did not default to agency or structure. The most prominent of these was Pierre Bourdieu. Bourdieu's work 'emphasises the external nature of the social world *and* how that affects individuals' (60). Bourdieu, like Garfinkel, was interested in theories of practice. But also like Foucault, Bourdieu was concerned with questions of power and privilege. His is a very practical sociology, concerned with what was actually happening in the world.

Bourdieu believed that the social world had a 'double' structure. When viewed objectively, it appeared to be structured around hierarchies that privileged some individuals more than others. But when viewed from an individual perspective, the social world seemed to be constructed by the perceptions we hold of people's power relative to one another. He believed these two perspectives often coexisted, giving the world a sense of natural stability and common-sense obviousness (61). Bourdieu believed that people were totally situated within social structures, but were also agents with 'capacity to act in their given fields of social action or interaction rather than simply being passive… subjects' (62).

Bourdieu argued that the 'currency' that people traded in, as they move through the social matrix that makes up their lives, was what he called 'capital'. Capital amounts to different resources that 'social agents can mobilize in pursuit of their projects' (4). Unlike Marx, whose emphasis was firmly on economic capital, Bourdieu was interested in the many different forms of capital. But the four main types he concentrated on were:

1. Economic capital — the income, wealth, and the monetary value of the goods a person or group possesses;
2. Social capital — the value inherent in networks of social relations between people, but also the value of the network itself;
3. Symbolic capital — the status we hold within a specific community;
4. Cultural capital — culturally valued resources in the form of objects (books, paintings, clothes, etc.), institutions (going to the right school, gaining degrees and professional qualification), and embodied competencies (being well-read, dressing fashionably, etc.).

The key to these forms of capital for Bourdieu was in their exchange value. If a person goes to a prestigious school and uses their connections to obtain a high-paying job, they have exchanged cultural and social capital for economic. For many of the orthodox health professions, affinity with biomedicine has brought high levels of prestige through the same process of exchange. Bourdieu

believed that society was organised by the ongoing play of different forms of capital. Forms of capital endure, and are often inherited from one generation to another, ensuring that the conflicts and achievements of the past are not forgotten by future generations. Indeed, some forms of capital, as physiotherapists and others well know, take generations to accumulate.

The kinds of cultural capital that health professionals work hard to acquire have particular value because of their ability to be exchanged for economic capital (or higher pay). This is because cultural capital is a reflection of a person or group's practiced affinity with something (i.e., balance assessments or the management of chronic pain), and something that society at large finds to be of value (63). Bourdieu saw this practiced affinity — or 'habitus' — as particularly important.

In many ways like socialisation, habitus refers to the way we are civilised into certain ways of thinking and behaving, and then internalise these lessons so that they become second nature. There is a 'positive' aspect to this, in that we learn ways to 'get along' with each other. But habitus also recognises that 'control mechanisms' (4) mould us into suppressing urges that some may see as uncivilised. Most importantly for physiotherapists, perhaps, Bourdieu argues that habitus manifests most clearly in people's bodies. Kate Cregan suggested we 'learn to train, restrict, dispose and quarantine' our actions, and through this, shape the world we live in;

> *'We embody our habitus through the way we walk; the way we conduct ourselves with others and in different spaces; why we are disposed to particular ways of dress and a rejection of others; the places we do and don't go; the way we regulate our behaviour in certain areas of homes and in different public spaces; the way we act depending on whether we are adults or children, male or female, young or old, etc., etc.'* (62).

Bourdieu was heavily influenced, here, by the work of Marcel Mauss, who developed the concept of bodily *hexis*, or the way that societies expressed their differences through the way people moved (64–66). The way we swim, walk, sit, and so on, reflects social changes like attitudes to seeing bodies in public, cultural styles, and inventions like the mobile phone and personal computers. Habitus concerns everything from 'Ways of walking or blowing one's nose, ways of eating or talking', to grand social distinctions 'between the classes, the age groups and the sexes' (67). Importantly then, when we think we are acting autonomously, we are actually only demonstrating another facet of our habitus (4).

The specific context in which a person's habitus operates was called a 'field' by Bourdieu. These are a 'structured space of social forces and struggles' (68). Within each field, actors (which might include small or large groups of professionals, consumers, governments, communities, and so on), negotiate and compete with each other to decide what matters and what is at stake for people in the struggle. Each party brings its own presumptions and taken-for-granted beliefs (what Bourdieu called *doxa*: that which goes without saying, and what we do without thinking), and their *habitus* is reflected in each group's specific histories, tastes, preferred ways of doing things, values, and shared experiences. If a group's habitus does not position them well to convert different forms of capital into economic advantage, they often seek to challenge the doxa, and disrupt what others take-for-granted. This is one of Bourdieu's formulae for understanding professional boundary tensions.

Like all of his postmodern compatriots, Bourdieu was skeptical of those who saw professions as having a solid identity. He believed that formal legalistic definitions of professions had largely ignored the power dynamics that shaped professional groups (68). Nick Crossley suggests that simple trait-

based definitions of the professions have made us all 'unwitting conspirators' in granting some groups in society enormous prestige on the basis of their claims to different forms of capital (4).

Bourdieu showed that the power of the professions had become self-fulfilling because we have accepted the 'rules of the game' that the professions, themselves, have put in place (ibid) — what Bourdieu called 'illusio' (69). We have been convinced that without such rules and systems, people might mis-recognise a charlatan, or an authoritative voice for a true professional. What this makes possible is the myth that only a true professional can know what it takes to achieve professional status, so only they can define the criteria that the rest of us should use to distinguish the quack and sham practitioner from the 'real thing'. And so 'certain social agents are empowered, in part, by our belief that they are powerful' (ibid). The social capital held by the professions, then, has become 'particularly useful for reproducing existing power dynamics' (61).

Social capital refers to 'the resources, tangible and intangible, that we can access by virtue of our place in the social world' (70). These resources are often described by Bourdieusian scholars in the form of a network of social relations that a person or group is enmeshed within. The value of the network lies both in the relationships between the various actors, and the value of the network itself (71). Rather than seeing professional entities as stable and autonomous, Bourdieu argued that all social fields were structured around quite arbitrary and fluid conventions and principles (72), and there was no authentic reality that was not in some way mediated by even the most basic rules, principles, or social conventions. A similar approach to social reality can be seen in the work of Anthony Giddens.

Giddens

Giddens' structuration theory proposed that structure and agency must co-exist, and neither precedes the other. For Giddens, social structures are not concrete phenomena, like physical objects, but their effects are no less 'immanent'. They provide resources that shape our agency. But, at the same time, they have no meaning without people's agency reproducing them through their daily habits and routines, forms of work and play, institutions and beliefs. Giddens called this the 'duality of structure', in which agency 'reproduce(s) the conditions' that make such structural effects possible (73).

Giddens' work on relationships offers a useful example of how he believes agency and structure co-exist. Giddens argues that relationships depend on the resources that people bring to the encounter, and those with the most resources to bring, carry the greatest transformative capacity to influence social structures. In this way, actors and society can be seen to be interwoven and interdependent, inseparable from one another. Social structures are reproduced only through people's interactions, and people's agency is a condition of people's access to social resources. Social structures are not constraints on people's actions, as is often argued by Marxian and critical theorists, but rather *enable* action (74).

Although sociologically grounded, Giddens' approach is also rooted in everyday realism. He has argued that radical social change can come from rejecting traditional binaries. Like Ivan Illich, he has criticised social welfare and the power of the professions for inducing dependence and passivity in people, and trapping people in need in cycles of poverty. He has chastised sociologists for their grand theories, and followed Garfinkel and others in arguing for much more attention to everyday praxiological approaches (75). He has also been a fierce critic of governmental regulation for stifling innovation.

Giddens' work emphasises the co-existence of autonomy and dependence. Recalling Hegel's master and slave dichotomy, and Foucault's alternative reading of power, Giddens argues that even in situations of oppression, the oppressor still *needs* the person they are oppressing (76). Giddens argues that such dependence makes it possible for people to resist, boycott, strike, and perform acts of civil disobedience because the person in power does not have complete autonomy, and the oppressor relies on the other having a voice[3].

Perhaps most tellingly for health professionals, Giddens saw social groups as distinct entities that could not be understood by looking at their smaller units: their 'genetic code', so to speak. Nor can they be analysed as the product of social structures. They are unique realities unto themselves, held together by long-lasting relational patterns, enduring in certain places in society over time, defined by particular routines and resources, and by certain characteristic structural features that give the group 'reproduced permanence' (ibid). These features are never fixed or permanent, but always shifting in intensity and duration.

Bhaskar

Roy Bhaskar's critical realist work also attempts to bridge the divide between structure and agency. Bhaskar's approach shares a criticism of Humean empiricism with Stephen Mumford and Rani Lill Anjum's *causal dispositionalism* now becoming popular in physiotherapy (78, 79). Where Hume believed we could only truly know something by experiencing it (empiricism), but that the *causes* of events always lay hidden, Bhaskar argues that causes of events are real, whether we perceived them or not (80).

Reality for Bhaskar is the capacity to bring about change in material things (81). Causes are more like 'tendencies' that do not always lead to predictable outcomes. Operating in a complex, open system, the effect of any action will depend on the nature of the interaction as much as any structural factors. In many ways, recalling Durkheim, Bhaskar sees social causes as similar to natural causal mechanisms like gravity and electromagnetism (82). Social causes are 'transitive', however, meaning that they can be 'altered by humans' (ibid).

Bhaskar's critical realism is interesting from a sociological point of view because it makes a serious attempt to resolve the tension between human agency and social structure by essentially ignoring them. Society for Bhaskar is a 'matrix of structured and relatively enduring relations, rather than a collection of individuals' (ibid). Individuals may be subject to these relations, but they also have the capacity to shape social structures, depending on their position within this matrix (83, 84). A child may well be born into social disadvantage, for instance, but critical realists argue that this, in itself, does not define them. As Sam Porter suggests, 'agents interpret their position and choose to act on the basis of those interpretations' (82).

Equally, this approach to realist analysis can be applied to a concept that Margaret Archer called 'morphogenesis' (83). All too often, we see research and innovation in healthcare that does not take account of the relational matrix that constantly shapes what is possible to do and think. In healthcare

[3] Note how, for instance, in the recent study by Lynn Clouder, Mark Jones, Shylie Mackintosh, and Arinola Adefila, on the development of student 'relational' autonomy, rather than gradually separating themselves from those around them, the student transfers their dependence on the educator to other forms of dependence, such as more direct client, peer, and service connection. Autonomy can be misleading here then, because it implies a process of distancing, rather than the re-allocation of dependence that takes place through maturation (77).

reform, for instance, new ideas are promoted as solutions, ignoring the fact that the people working in the system are already embroiled in one reality, and now have to grapple with the old *and* new systems. Archer argues that our tendency is to oversimplify the current system, in order to minimise the problem inherent in adapting to the change. Critical realism, by contrast, argues that we need to take into account the agential and social mechanisms at play, some of which are latent, and others already recognised (ibid). We see the same thing in clinical trials and RCTs, when we are asked to analyse the findings of studies without considering the 'social dynamics that result from the constant interplay of structure and agency' (82).

In recent years, Bhaskar's critical realism has been used to better understand decision-making in healthcare, arguing that interventions with the greatest rational, empirical evidence behind them, may not, in fact, be the most reasonable, moral, ethical, professional, or human approach to take (85). But where other approaches — including positivist and empirical science, interpretive and structural research — struggle to embrace this kind of realism, Bhaskar's approach centres on these kinds of context-specific analyses (81, 86).

Postmodern thinking and physiotherapy

Although the approaches touched on in this chapter cover some quite diverse concepts and ideas, they share in common the belief that the old ways of analysing the professions, that emphasised different forms of structure and agency, are too linear and simplistic to really explain what the professions really are. From a postmodern perspective, physiotherapy cannot be defined by its functionalist traits, nor as a product of Marxian beliefs in economic capital. It is too diffuse to be seen as a solid entity in competition with others for market advantage, as neo-Weberians suggest. It has less agency than social action perspectives argue, but has more agency than critical theories allow. What is physiotherapy according to postmodernism, then?

Firstly, a postmodernist might suggest that physiotherapy — like all things in postmodernism — is an assemblage of ideas and practices, that have coalesced in a fluid and ever-changing field, in response to a temporary set of context-specific circumstances. Rather than having a solid, bounded identity, the myriad physiotherapies that exist represent an amorphous set of temporary and loosely coherent subjectivities. The fluid and amorphous nature of a profession like physiotherapy stems from it being the outcome, effect, or achievement of discourses circulating in society, and its perception of solidity reflects the endurance of some powerful discourses (governance, biomedicine, science, objectivity, etc.). And so, physiotherapy is no different, in this regard, to the state, the family, medicine, care, and chronic pain, and other discursive effects of governmentality.

Secondly, a postmodernist might suggest that physiotherapy is deeply woven into the fabric of contemporary healthcare and relies entirely on its interconnections and dependencies to convey the sense that it is a real 'thing' (87). It is misleading, therefore, to think of physiotherapy as autonomous, hindered, controlled, or oppressed by 'the state'. Rather, physiotherapy's prestige derives from its ability to exercise its freedom *in appropriate ways* (88–90). One of the most important of these is its tendency to be 'constantly suspicious of its own authority' (91), and change its shape and focus as its field morphs and mutates.

And finally, there is nothing inherently stable about physiotherapy knowledge. The subjects that we think are 'core' to the profession remain so only as long as they allow members to translate

particular forms of knowledge into better forms of governing. Biomechanics will matter more than cognitive psychology as long as physiotherapists can use this to render 'the complexities of modern social and economic life knowable, practicable and amenable to governing' (7). What is more, the concepts that reside at the heart of the profession's subjectivity, will derive their stability from their ability to conceal their power to shape professional thinking and practice. Concepts like the body-as-machine, for example, have succeeded because they have naturalised, 'embodied and habituated' prejudices (4), and suppressed concerns over intersecting issues of social justice, especially patriarchy, prejudice, and paternalism, evident throughout healthcare in the Global North (92).

If physiotherapy is the *outcome* or *effect* of discourse, it begs the question whether it can ever change of its own accord. In functionalism, it is easy to see where change came from because physiotherapy enters a 'contract' with society to offer certain skills and abilities, in exchange for patronage and security of tenure. As it changes, 'society' simply asks the profession for a different service, and the willing profession provides. A neo-Weberian alternative might be that physiotherapy is actually in competition with others in a market for services, and the 'winner' is the one that best matches up to society's needs (93). Postmodernism shares something of both of these, but is also quite close to a critical theory position. Critical theories argue that professional 'success' is about power: the power of the Global North to define what health and illness means; the power of elite social groups, especially white, anglophone, heteronormative, non-disabled, and affluent men, to establish a social norm in their own image.

In all three cases, though, resistance and change comes from within; from the solid sense of 'identity' that derives from 'being' a physiotherapist. In critical theory, for instance, activists argue passionately that it is the responsibility of the professional to reflect on their privilege and transfer power to those who are socially marginalised. This belief manifests in a number of ways:

1. It has surfaced in the editorial of the *Journal for Humanities in Rehabilitation*, calling for health professionals to become 'moral agents of change', to 'reimagine a more equitable and just future', and to 'dismantle the systemic racism that has plagued Black bodies and communities for centuries' (94);

2. It is evident in recent calls for health professionals to develop 'critical consciousness' (95–98), as opposed to the cultural competence and cultural safety that are now thought to reinforce the sense that professionals can become experts in others' culture, or tick off competence without engaging in longstanding change (99–104).

3. And we see it in work on social determinants of health. These conditions have far more significant long-term effects on the health and wellbeing of people and communities than the 'soft targets' (105), and 'weak utility' (106) of behaviour change. But they also require physiotherapy confronts its historical lack of focus on social justice[4]. Anna Luise Kerkengen,

[4] It should be noted that the American Physical Therapy Association has recently trumpeted its vision of 'transforming society', and the NHS in the UK is promoting the idea that 'if all AHPs in England were used effectively, it would signal the total transformation' on the basis that 'we understand the social determinants of health' (107). Yet, at present, no population-based approach to practice exists in physiotherapy. Nor is there a recognised approach to social justice (108)., or any concerted evidence in the literature, that physiotherapists take the social determinants seriously. In his Penny Cerasoli Lecture, Terrance Nordstrom asked 'what parts of (society) are we (APTA members) committed to transforming

writing recently about the causal complexity lying behind medical diagnoses, has suggested that the professions allied to medicine have become 'complicit in obscuring abuses of power and all kinds of societal injustice' (110). 'Must such consequences remain unexplored within medicine', she asks, 'because they are defined as lying outside the mandate of the profession?'

All of these social issues derive from the premise, common in critical theory, that power operates asynchronously in society, privileging some and marginalising others, and it is the profession's responsibility to identify its privilege and emancipate the voice of the marginalised 'other'. As I have tried to show in this chapter, postmodernists take a different view, and this alternative viewpoint has important implications for how one might rethink what physiotherapy is and might become. Firstly, postmodernism challenges the seeming *obviousness* of physiotherapy.

Postmodernism encourages us to see our professions as less *natural* or less *available* to us than we normally think. For example, in 1983, David Armstrong, a doctor and longstanding postmodern writer on medicine, puzzled over what he saw as the common-sense obviousness of the way medicine viewed health and illness;

> *'At first it seemed strange to me how the apparent obviousness of disease and its manifestations inside the body had eluded scientific discovery for so long. How had pre-enlightenment generations failed to see clearly differentiated organs and tissues of the body? Or failed to link patient symptoms with the existence of localised pathological processes? Or failed to apply the most rudimentary diagnostic techniques of physical examination?'* (111).

But Armstrong realised that these questions began from the presumption that medicine *was* the natural starting point for thinking about health and the body. Turning the question around, Armstrong asked how it had been possible for biomedicine to assume such obviousness? What kinds of social mechanisms, forces, relationships, concepts, strategies, subjectivities, and technologies would you need to implement to convince millions of people that cure, experimental logic, colonial patronage, reductionism, androcentric bias, seeing the body-as-machine, and affective detachment, are the norms against which all other systems should be judged? In other words, Armstrong was attempting to do what many postmodern sociologists of the professions strive for, and make his profession strange to itself.

A slew of postmodern and intersectional thinkers have emerged in recent years, and their work centres on the complexities and ambiguities inherent in healthcare practice (56, 112–122). Key to this work is the desire to open up thinking and practicing to the complex material effects that discourses enable and constrain in people's lives whilst, at the same time, not reducing them to a homogenous, undifferentiated whole. The idea of postmodernism celebrates 'the multiple and entangled categories' (104), that make up our subjectivities as people and professionals.

Just as David Armstrong's work reframed how people understood medicine, Barbara Gibson's work has been important in showing how physiotherapy and rehabilitation might be reimagined. Gibson's work spans post-critical rehabilitation and disability studies, biomedical ethics, and poststructural philosophy (123). In her book *Rehabilitation: A post-critical approach*, Gibson argued that

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and how? Every corner? Does that transformation include people whose voices are often the least heard because of their gender, how much money they make, their skin color, or if they use a wheelchair? How are we creating a shared vision of how we will transform society?" (109).

concepts like *movement* might provide a useful vehicle to help physiotherapists and other rehabilitation practitioners challenge the obviousness of their practice. She writes;

> *'Movement is central to rehabilitation; it is an outcome, a practice, and an ideology. It can also be mobilized to foster connectivities, to re-form, re-consider, re-fuse, re-figure, re-collect, and re-assemble care, research, and education practices. Rehabilitation clinicians, researchers, and educators mostly discuss movement in terms of the physical movements of joints and limbs, and in relation to the anatomy, physiology, and biomechanics of the biological body. Collectively, we may speak of gross and fine motor function, or more recently in our history, how movement facilitates participation in activities and social roles. Despite this growing interest in the social and human aspects of persons' lives, movement remains primarily focused on the mechanical: on mobilizing material bodies'* (56).

Gibson's work, along with Tremain, Shildrick, and others (24, 116, 124, 125) exemplifies the 'tangled nature of bodies' (26), and the idea of disability as possibility and potentiality (ibid, p.638). These challenge the 'psychosocial imaginary that sustains modernist understandings of what it is to be properly human' (51). And they remind us that even the idea of what it is to be human today 'is increasingly contested in the era of postmodernity' (ibid).

The kind of body that discursively shapes physiotherapy practice has changed dramatically over the last few decades, suggesting that new approaches to practice, education, research, and theorising are needed by the profession. Margrit Shildrick argues that, 'all putative categories are slippery, unfixed, permeable, deeply intersectional, intrinsically hybrid and resistant to definition' (51). Accepting this slipperiness, and rejecting binary distinctions between normal and abnormal, straight and queer, non-disabled and disabled, male and female, collapses the distance between 'us' and 'them', professional and patient, the healthy one treating the sick one. We come to see the real resemblance between each other, not the 'not-me-ness' (ibid, p.42) of Western healthcare practice. We are forced to 'reflect back aspects of ourselves that we do not usually acknowledge' (ibid), and the idea of the self (person, patient, client, other etc.) takes on an 'indeterminate status — as neither wholly self nor absolutely other', and so 'becomes deeply disturbing' (ibid).

This is not to suggest that postmodernists are disinterested in professional traits, inter-disciplinary competition, class struggle, or the 'roles of power and privilege in creating health disparities' (126), only that they see these struggles as other material effects of societies that are constantly being constructed, deformed, and reformed by discourse. And so, the principle task of postmodern analysis is not to stabilise the profession around a fixed 'identity', fight for greater prestige, or locate injustice and argue for alternatives, but to see all of these as discursive effects, and to open doors to a thousand alternatives. The task is to locate the 'multiplicity of possibilities' (51), that are open to us when we move away from thinking about our professions as stable, codified, semi-permanent, and solid identities. For postmodernists, the professions are not the originators of ideas and forms of practice, but one effect, among many, of discourse and the urge to govern.

Criticisms of postmodernism

Consistent with their underlying belief in the importance of ambiguity and difference, postmodern approaches are diverse and variegated. They do, however, share in common a desire to move beyond older ways of thinking and practicing. For this reason alone, they have garnered no shortage of critics.

Perhaps the first and most significant criticism of postmodernism is directed at its relativism. Because it rejects the idea that power is something people can have and hold and use against others, postmodernism undermines one of the main tenets of critical theory. Postmodern thinkers are often less interested in campaigning for the rights of the marginalised and dispossessed, seeing that this often replaces one bad hegemony with another (127). Critical theorists argue, though, that this means critical issues like gender politics, race relations, and the rights of disabled people, are effectively ignored. Kevin White has accused Foucault, for instance, of operating with a phalocentric, 'masculinized' model of the body by showing no interest in gendered bodies or patriarchal power (128).

Postmodernists have also been accused of nihilism. Because they see knowledge as the *effect* of discourse, and distrust approaches that look to apply 'rational thought to the dilemmas of contemporary society' (3), they have been accused of being more interested in unsettling dominant views and providing 'tools to allow people to establish a distance from their taken-for-granted world and see things differently' (129), than agitating for progressive social change or speaking up against oppression and injustice. Critics suggest that when new forms of knowledge are seen as neither better nor worse, only different, from what went before, postmodernists convey the sense that all social reform is naive or futile. So, as Matt McManus suggests, 'While some forms of resistance may be possible and even admirable, we should look on them with caution and recognize that they may just conceal deeper drives towards new kinds of oppression'; a condition that, he argues, reflects a 'depressingly totalizing approach to power and our limited capacity to resist it' (130).

Others have argued that postmodernism struggles to locate where resistance actually emanates from. Foucault, for instance, argued that there could be no real power without resistance, but also argued that the body was either 'a wholly historical phenomenon and has no 'nature'' (4), or was too 'analytically thin' (131) to explain how resistance actually came about. So, where does resistance actually come from, then? If it is people that do the resisting, surely they must do that with their bodies? But if bodies are only discursive 'effects' and have little material significance, what is it that blows up an oil pipeline or pepper-sprays a protester?

The confusion over what the body actually *is*, has led some to suggest that postmodern approaches lose both the specificity of the biological body in Western science, *and* the experiential, subjectively-experienced body of the humanities (132). This has particular resonance for disabled people and their professional colleagues, who have seen postmodernism undermine both the biological and socially constructed body. And yet, some argue, the disablism that disavows 'morphological imperfection' persists (51). As a result, we now have 'no notion of a clear or stable power discrepancy between professionals and clients or between dominant professions and subordinate ones. Power is dispersed, it cannot be simply and easily located in any elite group' (133).

Some postmodern approaches have attempted to maintain links to more traditional ideas of identity. Intersectionality, for instance, goes some way to maintaining the legacy of critical theory, but some argue that it also struggles to reconcile performativity and identity (59). This is particularly evident in addressing the social determinants of health. Poverty, polluted environments,

discrimination and violence, poor quality education and housing, limited access to basic services like healthcare and transportation, are things that billions of people around the globe are born into and have to live with, and have little to do with their 'lifestyle choices', but are forced upon them and their families *against* their will. The social determinants of ill health cause some remarkable health disparities. Economic and racial inequality, for instance, kills more people than cigarettes, the poorest Australians are twice as likely to die before age 75 than the richest, and mould and damp health costs are three times greater than those for sugary drinks (134–140). The problems of the social determinants are so massive that The Lancet recently calling for 'A radical shift of life sciences funding priorities, away from the biomedical bubble and towards the social, behavioural, and environmental determinants of health' (141). Given this, many critical theorists dislike and distrust postmodernism for its seeming indifference in the face of ongoing and pervasive injustice.

Along a different line, the work of Bourdieu, Giddens, Bhaskar, and other 'third way' thinkers, has been critiqued for failing to reconcile the problem of structure and agency that they set out to resolve. Bhaskar's work has been accused of understating people capacity to change the world (3), and focusing more on the 'is', and the practical world of people's experience, than the 'ought', which would presume a strong moral position (76). Giddens work, by contrast, has been criticised for overstating people's ability to change their circumstances; 'The overall charge is that Giddens gives too little attention to all those situations where actors really do lack the power to alter their circumstances for the better' (ibid, p.171).

And intersectional approaches have not avoided criticism either. Advocates for classical critical theory have argued that the problems of the social determinants of health can only be tackled by advocacy and action, highlighting, for instance, the links between the oppression of the myriad marginalised groups (142); the medicalisation of healthcare (43, 143); the tyranny of while colonial power, ableism, patriarchy, and the capitalist status quo (144–146); and the barriers that healthcare policy has created between people (147). But postmodern intersectional approaches reject classical ideas of oppression in favour of performativity and the diffuse nature of power, and this has left some to argue intersectionality has created a theoretical vacuum that has allowed many of the 'old' injustices to resurface (148–155).

Part of the 'problem' for postmodern approaches is that they focus more on differences than similarities, and so the critical power of the collective struggle seems to be lost in an atomistic individualism, whilst, at the same time, individual subjectivities are seen only as outcomes of discourse (3). Postmodernism rejects the power of oppression *and* people's lived experience as valid forms of knowledge. Because of this, some argue it fails to provide a better alternative to the structure/agency binary that it set out to critique. Bourdieu's work, for instance, has been critiqued for being too bound to habitus; for not giving enough attention to people's individual agency, how they become expert, or 'escape' from a field of practice (62).

Given all of this, rather than seeing postmodern approaches as 'answering' all of the criticisms of positions outlined in the previous four chapters, it would perhaps be more accurate to think of them as offering an alternative. An advocate for postmodernism might argue that it shows just how complex and uncertain our thinking has now become, and how risky it is to embrace decisive ways of thinking common in Western health professions like physiotherapy (156). Undoubtedly, the world we operate within as health professionals has elements that might be interrogated very successfully by approaches like postmodernism. But that does not mean that functionalism, Marxian, neo-

Weberianism, critical theory, or any of the other approaches to the sociology of the professions do not also, at times, provide insights.

In the following chapter, I want to bring all of the various theories set out in the book up to date, and reflect on the current state of the health professions. This chapter will introduce the idea that we are entering a *post-professional* era, and will explore what this means and why. Then, in the final two chapters, I will relate all of this work back to physiotherapy, and ask what the sociology of the professions might tell us about the future for the profession.

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7. Post-professionalism

Western healthcare has always been capitalistic — Being responsible — The future or empathy and care — The centrifugal effects of late capitalism — Professions under fire — Unbundling goodness and expertise — Complexity — Implications for physiotherapy — Closing words

In this chapter, I want to bring the study of the professions up to date by examining post-professional healthcare. Although the idea that we are now entering a post-professional era goes back to the 1980s in sociology, only a handful of writers have so far discussed it specifically in relation to healthcare (1–3). Post-professionalism refers to the decentralised role professionals are now playing as governing powers in society.

Although Ivan Illich was perhaps the first person to use the term 'post-professional' in an academic context (4), the ideas and principles it encompasses developed significantly in the earlier work of Eliot Freidson and Terry Johnson (5, 6). In sociological terms, post-professionalism refers not to the *end* of the professions, but rather a world in which the professions are seen as one actor amongst many in the organisation of social fields like education, business, engineering and design, healthcare, entertainment, the law, and government itself (7). And so, while post-professionalism does not deny that 'Society needs the service of articulate, clever, society-oriented actors and professionals' (8), who can be a 'human beacon in a world of juridified, formalised, corporatised correctness' (ibid, see also, 9), it does assume that professionals will be less important than they used to be.

Post-professionalism works on the basis that professionals will see their power and prestige diminish over the coming years, as social capital becomes more widely distributed amongst a much more diffuse set of social agents: from individual and communal, to public and private, real and virtual, informal and formal. This chapter considers three important questions that arise from this shift: who is now acquiring this more widely distributed social capital, how is it being distributed, and what role will the professions — especially physiotherapy — play in the process?

What makes this analysis more relevant and prescient for people in healthcare, is the belief that there is something qualitatively different about the present moment; that healthcare is in the midst of a transformation unlike anything we have seen before. This is a bold claim and one that is open to challenge. Surely, Western healthcare has experienced enormous ruptures before, not least with the imposition of managerialism and neoliberal economics in the 1970s and 80s? And what of the discovery of antibiotics, or the birth of the welfare state? Were these not as significant as today's disruptions?

In one respect they are. But the economic reforms of the last 50 years have been insufficient, on their own, to radically transform Western healthcare, with the orthodox professions showing remarkable resistance to reform, (at least by comparison with other industries like manufacturing, coal mining, banking, and tourism) (10). Edgar Burns suggests that, 'A lot of effort is required in repositioning professions' (8). And perhaps because of this, there have been explicit attempts in high-income countries to restructure health services by 'bypass[ing] resistance from the medical profession' (11). And then, secondly, many of the other social disruptions (war, drug discoveries, public health crises, reform of the healthcare system, etc.), seem to have been disruptive largely in the health professions' favour, and have only served to consolidate orthodox professional power.

What makes this moment different, and so important, then, is the *confluence* of two forces that are now acting together to reshape healthcare. These forces are late capitalism and the growing critiques of the professions, and together they are giving shape to post-professionalism.

Western healthcare has always been capitalistic

At the very outset, we should remember the arguments made in previous chapters, that health professionals have been just as driven by capital markets as any other field over the last century (12, 13). As Thomas Foth says, 'The recent history of healthcare shows that professionals… have demonstrated little resistance to the neoliberal developments', and 'any protest that has arisen has not attacked the broader political conditions that made these transformations possible' (14). So, although health professionals have been more able than others to bury their politics more deeply, and use the functionalist mythology to project an image of altruism and public spiritedness, they are no less embroiled in the messy realities of human function, work and labour, efficiency, and productive social value. But post-professionalism argues that there is something different about the 'late' capitalism that we now associate with neoliberalism, globalisation, and digital disruption.

Late capitalism is so called because it deviates from the kinds of capitalism that evolved after the Industrial Revolution. Early forms of industrial capitalism created the belief in the Global North that there was no limit to human growth and flourishing. To achieve this growth, however, enormous human and ecological resources were needed to generate the profits necessary for further growth. Slavery, colonisation, the 'naturalisation' of unpaid women's labour, a new focus on productive work, and, importantly, the creation of an enabling class of professionals trained to ensure the prosperity of the West, were some of the effects of this (see especially Chapters 3 and 4).

Unsurprisingly, perhaps, the belief in unlimited growth and its effects on people and the environment came up against resistance in the 1960s. As a response to this, the 'late' capitalism of the last 50 years has increasingly looked to perpetuate the idea of unlimited growth in the commodification of ever more atomistic aspects of social life. By disassembling, disaggregating, and marketising, increasingly granular divisions of human and material existence, late capitalism has turned individual humans into 'an infinite number of data points… to be divided and sold' (15).

Alongside capitalism's search for new markets, governmental reforms became increasingly neoliberal. Advocates for neoliberalism espoused that human flourishing could best be achieved if individuals were economically self-interested, with the ideal citizen in a globalised neoliberal world being an 'autonomous, entrepreneurial, and endlessly resilient, a self-sufficient figure' (16). The role of the 'state', here, ceases to be a welfare safety net against hardship, and becomes an increasingly

permissive facilitator of private property ownership, free trade, and free markets (17), with the self-regulating free market as 'the best way to allocate resources and opportunities' (18).

Perhaps the best example of this is the way we now think of bodies in health and illness. Just a few decades ago, people defined health largely as the absence of illness: a simple binary state. Susan Sontag put it this way;

> *'Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place'* (19).

By the 1980s, this idea had been replaced by the much more slippery concept of 'optimal' health; an amorphous and unachievable goal that gently pushed the expert's objective diagnosis to the back, and gave primacy to the individual's beliefs and desires. It allowed the concept of health to be seen as a much more holistic concept, and made it harder for 'traditional' disciplines to define. It made health a personal goal, rather than something the healthcare system took responsibility for. It made good health aspirational — for whoever can say that they are in 'a state of complete physical, mental and social well-being and', note, 'not merely the absence of disease or infirmity' (https://www.who.int/about/who-we-are/constitution)? And it opened up all of the new dimensions of health and wellness to a new marketplace for goods and services just as neoliberal economic reforms began to take hold. Health could now be individualised, and the social causes of illness pushed to the background, as people were encouraged to make their bodies sites for endless monitoring and improvement.

Crucially, the concept of optimal health has allowed late capitalism to extend its reach into health by finding ways to extract profit from the litany of bodily frailties and imperfections that we are all now encouraged to diagnose and treat in the name of embodied 'improvement' (20). The 'juggernaut of modernity' (21), has re-shaped how we think about bodies in a way that cannot help but influence future physiotherapy, not least because approaches to practice that were once concentrated on relatively discrete populations of ill, injured and disabled people, are increasingly being seen as necessary for all (22); 'as all citizens grow increasingly responsible for policing their own bodies as a foundational aspect of their well-being' (20).

The ambivalence that people increasingly feel in the face of the 'avalanche of information, commentaries and analyses' (23), only helps late capitalism because it forces us all to be more reflexive, and take more responsibility for decisions that previously might have been shared; loosening the social bonds 'through which we gained our identity' (24). And by being increasingly responsible for our decisions, we can also become increasingly responsible for the costs of treatment and care, further driving healthcare away from its traditional centres of control, opening a marketplace for a thousand new experts and services to match whatever people need. Assuming, of course, you have the surplus time and money to enjoy your newfound freedom (25–27).

Although 'attending to oneself is a privilege', and has been a 'mark of social superiority, as against those who must attend to others' (28), ideas of optimal health and personal responsibility are quintessentially late capitalist concepts because they are based on the principle of unlimited growth, a concept that only found a home in healthcare when it was realised that health could be seen as an endlessly divisible series of subunits that could be extracted, monetised, and recomposed.

What has made the influence of late capitalism even more pervasive, however, has been the confluence of neoliberal political economies, with globalisation *and* digital disruption (29). Anthony

Giddens — who originally coined the term 'globalisation' — has suggested that no other civilisation has remotely approached the level of interdependence we now experience (30)[1]. Giddens sees globalisation as 'a fundamental restructuring of the basic institutions of the societies in which we live' (ibid), working by drawing power away from the 'old' nation states and re-siting it in the hands of global corporations, whilst at the same time pushing services closer to local communities, encouraging devolution of power and local cultural autonomy (32).

But although neoliberal economic reforms and globalisation have profoundly affected almost every sphere of society, from banking to music production; architecture and accountancy; religion and self-help; manufacturing, tourism, and journalism; social media, education and writing; leisure and work, healthcare remained largely immune. In part, this may be because, 'to realize a neoliberal agenda in healthcare, it was first of all necessary to transform hospitals and healthcare services into economic entities' (14). And this took time, not least because the earlier ideas of healthcare needed to shift from personal value to economic cost, and from a culture of idiosyncratic service to one of predictable, risk-managed, standardised processing.

Health professionals took time to naturalise this shift, and still many resist, but the key may now have been turned by digital disruption because it provides the tools to take medicine's reductive logic to its logical conclusion, and create an infinite number of ways to disassemble and reassemble a person's health and, in doing so, create an enormous market for the sale of personal goods and services to rival any of the gold seams, coal fields, or oil reserves of the last two hundred years.

From 'hospital at home' (33), and the hospital without walls, that prioritises 'surveillance and early intervention' (34, 35); deep learning systems to aid diagnosis (36); AI-based exercise machines (37); robot-assisted surgery, personal care, and rehabilitation (38, 39); the 'molecular politics' of wearable health tracking technology (40, 41), whose 'target is habits of moving, eating and drinking, sleeping, working and relaxing' (42), and offers 'improving daily productivity' (43); work routinisation and disintermediation are rapidly becoming everyday features of contemporary healthcare.

The reaction from orthodox health professionals has been mixed. A number of writers are now suggesting that the rapid pace of change in healthcare has revived forms of medical paternalism that neoliberals and critical theorists had both sought to tackle over the last half century (44–48). But other initiatives, like the drive for evidence-based practice, the pursuit of precision medicine and novel genetic therapies, and attempts by medicine to be seen as more holistic, through the biopsychosocial model, may well reflect an attempt to shore up medicine's historic base in the face of post-professional reform.

Because the health professions command such high levels of power and prestige, some of the most profound reforms have often come quietly, without fanfare. Some of the changes show, however, just how deeply the logics of late capitalism have penetrated healthcare. In Thomas Foth's critique of the nursing process, for instance, he shows that nurses' use of a systematic assessment of the patient's problems and resources — a process very close to the evidence-based, problem-solving, and decision-making process used by physiotherapists — leans heavily on accounting and cybernetic practices common to industrialisation (14). The ideals of an instrumental, 'objective, transparent, rational, and comprehensible' approach, reducible to the kinds of 'means-ends analyses' of inputs and outputs, links every action of the nurse (or therapist) to 'discrete sections each measurable and

[1] It is chillingly prescient, given the COVID pandemic, that Bryan Turner commented in 2008 that, 'The deregulation of global markets as a consequence of the neoliberal policies of Reagan and Thatcher will have the unintended consequence of bringing about the globalization of disease' (31).

linkable to monetary value' (ibid). The work of the therapist seemingly continues as before, but now 'health itself is conceptualized as a profit/loss situation, and the patient as human capital in an expense account' (ibid)[2].

In a similar vein, Arseli Dokumacı has questioned the taken-for-granted obviousness of medicine's adoption of quality of life (QoL) as a guiding framework. Dokumacı, Arndt and Bigelow and others argues that healthcare measures like QoL speak directly to the emerging managerial and corporate culture in healthcare (ibid; 50), and focus on the 'lack of correlation between the amount or type of care provided and the level of improved health' (51). QoL places much more emphasis on the consumer's voice, and increasingly holds professionals to account for poor productivity, service quality, and value for money. Rather than being an earnest attempt to improve care for patients, then, the adoption of QoL has been seen by some as a way for medicine to share in some of the spoils of late capitalism and align the profession with new neoliberal market ideologies (ibid).

Being responsible

One of the most surprising, and yet powerful, features of healthcare in late capitalism, is the speed with which people have taken up the rhetoric of personal responsibility. Personal responsibility is underpinned by the belief that illness represents 'culpability in the face of known risk' (52). Given how much health information is now available to us, we have no excuse *but* to be healthy. And if we do become ill, we only have ourselves to blame. Ergo, when a person becomes ill, it is their responsibility, and so they should pay for their treatment and care. The genius of this rhetoric is that it effectively reduces the state's responsibility for healthcare — a central plank of neoliberal reform — without appearing to be punitive, whilst also opening healthcare up to greater choice and a massive marketplace for newly privatised services. 'There is no doubt', Bill Hughes argues, 'that this apparent democratisation of the relationship between professional and patient suited Western governments intent on reducing public expenditure and squeezing the welfare state' (53, 54).

But the corollary of personal responsibility is that 'individuals themselves should be "supported" *only* in their quest to cease needing support' (55), leaving us all with the sense that we are now vulnerable to our own fates (ibid). In their efforts to mine one of the last vast untapped markets for capital resources, Western governments — 'intent on reducing public expenditure and squeezing the welfare state' (53) — have fundamentally changed the relationship between the health professional and the public.

> *'In the post-professional age the state — no longer the 'nanny' of old — expects its 'active citizens' to take responsibility for their own bodies. The layperson has been transformed into the rational consumer and medicine has been subjected to political, social, cultural and economic forces that have driven it further into the logic of commercialism'* (53).

[2] Max Weber famously argued that the vaunted objectivity of bureaucracies and modern science-based professions, meant they were often unable to engage with the basic humanity of the other' (49). In contrast to the image portrayed by professions like medicine (and by extension, physiotherapy), these professions can be 'cold, impersonal and anonymous' social forces, lacking a sense of public responsibility. Such values make them ideally suited to the market-driven ethos of neoliberalism (12).

Isabelle Stengers (56) has argued that health service 'consumers' should now be seen as 'intelligent 'connoisseurs' of complex, highly refined, social bodily practices and the scientific knowledges associated with them' (57). Connoisseurs have the advantage of both first-hand experience, and access to knowledge and information available to all. Similarly, the idea of 'active patienthood' is now widely acknowledged as a normative good (58), with the expectation that 'patients should inform themselves, claim their expertise, and participate in their care' (59).

The rhetoric of late capitalism assumes, of course, that everyone has equal access to the resources that have emerged from the deconstruction of earlier social structures. What is also clear is that a significant divide now exists between those who can take advantage of new cultural, economic, political, and social freedoms, and those who cannot (60). And the increasingly wide social gradient between the richest and poorest in society that neoliberalism and globalisation perpetuate (61, 62), are deepening the divide between the traditional centres of power and affluence and everyone else[3].

The future of empathy and care

Many people have suggested that one of the reasons healthcare has resisted the kinds of reforms that have swept through other industries in recent decades, is that it is deeply rooted in inter-subjective human experiences. But even if it were true that healthcare was more relational than other disciplines, there are still few who have 'concluded that the professions will carry on indefinitely as they have for the past fifty years' (Susskind and Susskind 2015, 104-5). The professions, 'are approaching the end of an era' (ibid), that is no more secure simply because health professionals believe healthcare to be fundamentally empathic and relational.

The main reason for this is, once again, tied in with the logic of late capitalism. If, as Daniel and Richard Susskind suggest, healthcare will now be increasingly subject to the logic of 'more for less', alongside growing automation and innovation; new modes of personal interaction and forms of knowledge and data management; new relationships with technology, and diversified roles; routinisation (tasks becoming increasingly regular and repeatable), disintermediation (professionals losing their role as arbiters, brokers and experts), and decomposition (breaking complex work into divisible tasks and distributing these among lower-skilled workers) of work tasks; digitally-enabled labour arbitrage (the global 'offshoring' of work), and para-professionalisation (task encroachment by lower cost workers into work that was once held by professionals); robotics, AI and natural language processing; personalisation and mass consumerisation (personalised medicine and the consumer culture invading healthcare); new business models and forms of specialisation, then there will be few areas of healthcare practice left untouched in the coming years (3).

Work decomposition alone may radically reshape the nature of professional expertise. In the near future, anything that a professional currently does that can be described as a series of tasks, standardised, or explained, will, in all likelihood, be taken from the profession and given to someone, or some*thing*, that is easier to train and employ, more readily updatable (in the case of networked technologies), more reliable, and accurate. We are seeing this already with robotic surgery, radiography, and pharmacy dispensing (64). But the effects of decomposition may extend beyond the loss of mundane or laborious work. To become an elite neonatal cardiac surgeon, for example,

[3] For an example of this in the context of rugby-related spinal cord injury in South Africa, see (63).

currently takes many years of training and thousands of routine operations. How will people become neonatal cardiac surgeons in the future if robots take over all of the basic components of surgery that were once an intrinsic path on the road to becoming a specialist? Decomposition, then, is as much about the 'hollowing out' of traditional professional pathways to expertise as it is about workplace skill mix.

Decomposition may have a particularly telling effect on professions that have traditionally depended on their technical competence, with physiotherapy being a prime example. But even if all of the technical tasks of healthcare were given to healthcare assistants and robots, many still believe healthcare will still require personal care (what the Susskinds call 'empathy workers') (65–69).

But even here, traditional healthcare assumptions are not safe, in part because although 'health professionals often claim exclusive license to empathy', they 'provide it only during the infrequent, short encounters made possible in our harried, underfunded institutions' (70–72). Aged care and community mental health support are telling examples of this. In localities where we encounter some of the most vulnerable people in society, it might be reasonable to expect the highest standards of personal care. But inquiry after inquiry has found that here abuse is rife, care practices are often inhumane, and even the most basic forms of caring support can be absent (73).

Not surprisingly, then, some have argued that even basic empathic caring might be delivered more consistently by non-human systems, like robots and online apps, that are available around the clock, never get irritable or tired, are never judgemental or stigmatising, are consistent and up-to-date. It is not difficult to imagine these replacing the poorly paid, untrained, and unskilled shift-workers currently delivering most of the personal care. As Amelia DeFalco suggests, 'we must also move beyond the assumption that human care is the gold standard' (71).

Of course, what is missing from this argument is consideration of the fundamental conditions of late capitalism that justify the shift to technological replacements in the first place. In the case of care homes, few advocates for change suggest that the problem lies with a system that encourages employers to pay wages below the poverty line for work that is often abject, emotionally and physically draining (74–77). Care facilities are often staffed by women, and especially women of colour because it is assumed that their labour will be cheap (this kind of caring work being seen in the West as 'natural' labour for women). Perpetuating such gender stereotypes allows employers to offer little investment in lengthy training, and because the work is less likely to command the same prestige as the more elite professional work dominated by men, there is little perceived need to create a meaningful career structure.

By reducing costs and maximising profits for the organisation, late capitalism perpetuates the belief that disruption is inevitable, effectively masking capitalism's atomistic and socially divisive tendencies. And advocates for human-centred healthcare are increasingly pitched *against* the very system that was once the safe harbour for true empathic care: a system which is increasingly turning to digital disruption to alleviate its shortcomings.

The centrifugal effects of late capitalism

What we are seeing in Western healthcare systems today, is the centrifugal effect of neoliberalism, that is reshaping healthcare by de-centring it. As healthcare spins ever faster, services escape the centre and relocate at the peripheries, into communities, new localities, sometimes with new

identities. The effect of this centrifugal motion has been the gradual migration of expertise to the margins. This process has accelerated rapidly in the last decade, with advances in person-centred care, the decline in professional power, and, especially, digital technologies like YouTube, and other knowledge brokering platforms. But the pace of decentralisation has become exponential with the COVID-19 pandemic, as essential services retrenched around acute care, and most other forms of healthcare escaped traditional silos and had to find new 'asynchronous and location agnostic' spaces (78), from online support services to DIY healthcare, that do not 'expect co-presence, synchronicity, or dependency' (ibid). This is what Dara Ivanova has called 'placeless care' (79).

The concept of de-professionalisation began to express some of this shift in the 1990s, seeing the neoliberal economic reforms sweeping through healthcare as a direct challenge to medical autonomy (80). Jonathan Gabe (one of Catherine Coveney's collaborators, above), argued that a more informed, critical public had become less inclined to be deferential to all experts, a process that had been fostered by digital media that fed on counter-narratives and subversive ideas (81). Writers like Nigel Malin, Valerie Fournier, John McKinlay, and Lisa Merceau have suggested de-professionalisation is happening for a number of overlapping reasons:

- Nation states being more interested in globalisation than the domestic stability they once derived from prestige professions like medicine;
- The insistence that all healthcare practices and decisions carry the burden of cost, reducing professional clinical autonomy and control;
- An audit culture that encourages the decomposition of health work into discrete tasks, altering the indeterminacy:technicality ratio (see Chapter 5), allowing for more external interference in day-to-day work;
- The loss of exclusive access to medical knowledge with the advent of global communication technologies, and the concurrent de-mystification of healthcare work
- The increasing focus on noncommunicable diseases and lifestyle disorders, and the commensurate decline in the idea of the heroic doctor/therapist;
- The 'feeling' of a loss of position, strength, or status as a result of restructuring and health service reorganisation;
- The slow decline of public trust in authority figures, amplified by ongoing reports of abuse, malpractice, profiteering, and privilege amongst healthcare professionals;
- The loss of specialist knowledge and task specificity, with increasing diversification of healthcare alliances, and pressure to adopt inter-/multi-/trans-professional working models, disrupting traditional hierarchies (82);
- And the replacement of specific work responsibilities with a less well-trained, more robotic or automated workforce (12, 83, 84).

Ironically, perhaps, much of the impetus for de-centralisation of health professional work has come from the sociology of the professions. Over the last 70 years, the sociologists who featured in the previous four chapters have argued that the health professions are too self-interested, and need to be reformed. The fact that '[w]e are on the brink of a period of fundamental and irreversible change in

the ways that the expertise of the specialists is made available in society' (3), would be a huge source of relief for many sociologists, if it were not for the fact that the change has been brought by late capitalism. Rather than seeing healthcare become more equitable and accessible, diverse and inclusive, late capitalism has only widened and amplified the disadvantage and poverty of access, fostered a solipsistic individualism, and 'transformed healthcare interventions 'into a commodity exchangeable between consumers and (healthcare professionals) in a free market' (14).

At the same time, new attitudes towards role permissiveness are creating much more fluid professional boundary definitions; new attitudes toward the body in health and illness are creating new logics of care; and new cross-sector alliances are disrupting traditional provider/purchaser binaries (85). People have much more choice, and the options available to many people are much wider than they were, even a decade ago. Cultural assumptions about consumers' subordination to medical expertise have changed markedly, 'from patients abiding by 'doctor's orders' to managing treatment regimens to fit in with their personal life' (81). And with large parts of the healthcare system sequestered into acute respiratory care during the COVID-19 pandemic, people who would normally have accessed nurses, doctors, and orthodox allied health professionals for support, have been forced to go elsewhere, showing once again that healthcare functions in an increasing number of localities beyond the reach of traditional professionals.

Cecil Helman has described this as an evolving form of health pluralism;

> *'In most societies people suffering from physical discomfort or emotional distress have a number of ways of helping themselves, or are seeking help from other people. They may, for example, decide to rest or take a home remedy, ask advice from a friend, relative or neighbour, consult a local priest, folk healer or 'wise person', or consult a doctor, provided that one is available. They may follow all of these steps, or perhaps only one or two of them, and may follow them in any order. The larger and more complex the society in which the person is living, the more of these therapeutic options are likely to be available, provided that the individual can afford to pay for them. Modern urbanised societies, whether Western or non-Western, are more likely, therefore, to exhibit health-care pluralism'* (86).

Others have explored the changing therapeutic 'landscape' that all health service users and professionals now operate within. Catherine Coveney, Alex Faulkner, Jonathan Gabe, Michael McNamee, and Mike Saks have shown how porous boundaries are between formal and informal care now (87, 88). The study of the care of elite athletes, by physiotherapists and others conducted by Catherine Coveney and colleagues, for example, shows a remarkable hybridity, with myriad credible options now available to consumers (89). Coveney et al suggest that opportunities now exist for people to take advantage of a globally connected world to build 'variegated' networks of support, drawn from orthodox and unconventional sources. These opportunities bring their own challenges, not least 'the litany of other voices in therapeutic decision-making' (ibid), which presumes a great deal about the resources available to people looking for care and support.

Thomas Friedman has suggested we are facing 'the most profound eras of Schumpeterian creative destruction ever' (90)[4], in part because never before in the history of humanity have so many people 'had access to so many cheap tools of innovation… and cheap credit' (ibid). The triple crosshairs of neoliberalism, globalisation, and digital disruption, have effectively led to societies all over the world

[4] The phrase 'Schumpeterian' derives from the Austrian economist Joseph Schumpeter (1883-1950), who believed economies engaged in an incessant process of annihilation and reconstruction.

throwing out the idea that elite professions should be allowed by the state and its various supporting bodies (universities, publicly-funded healthcare services, regulatory authorities, etc.) to form largely self-regulating bounded territories of professional control (14, 91). And so, having been 'successful contestants in the game of modernity' (8), we are now undoubtedly entering a post-professional era that 'names an emerging if not already here progression from present-day arrangements' (92).

Professions under fire

Although it may be tempting to lay *all* of the responsibility for the plight of health professionals today at the door of late capitalism, this would be misleading because at the beginning of the chapter I commented that there were *two* forces shaping post-professionalism, with the second being the critique now being levelled at the professions themselves. And despite the protests from within the professions that their autonomy, prestige, and everyday work is being increasingly disrupted, there remains much to criticise about the professionalisation of social life in the 21st century.

Central here are what are known as the *professogenic* effects of healthcare, or what Julian Tudor Hart called *inverse care failures* (93). These are often thought to stem from shoddy work and clinical errors, or institutional and individual malpractice (94–98). But they also derive from the prestige and privilege health professionals claim for themselves by virtue of their perceived 'goodness' and expertise. These attitudinal mythologies surround elite, orthodox healthcare professions, and are performatively burnished by the professionals themselves, as a way to bolster their cultural, economic, and social capital. They are part of their habitus, and convey the sense that there is something natural and obvious about their command of Western healthcare.

Part of this mythology derives directly from the work of earlier functionalists, who codified a set of traits that the professions themselves were only too willing to embrace. These included altruism, public spiritedness, disinterest in personal gain, affective neutrality, ethical scrupulousness, balanced judgement, and social order (99, 100), all of which have subsequently been disputed.

But the innate desire of all professions to secure and protect their hard-won boundaries, has often resulted in a resistance to any external critique that might weaken the profession's position (101). The result of which led Heather Simpson to complain that although criticisms of health professional conduct had been 'expressed, and supposedly agreed with, for decades… system changes have been only marginal at best' (102).

20 years ago, the UK's Chief Medical Officer, Liam Donaldson, stated that future healthcare must 'address the deep-seated problems of the past', and health services must 'give priority to developing health professionals equipped to practice in a new way' (103). 'The current system of health professions is too rigid', Claire Warnes argues, and professional silos are 'everywhere' (104). Professional boundaries could be much more porous, and healthcare professionals could embody a much 'greater breadth of skills' (105). Perhaps it is not surprising, then, that many people agree that healthcare professionalism remains 'an inherently conservative discourse', demanding of its members '"unquestioning obedience' to a set of impersonal rules and procedures laid down by the authorities within the profession' (106). It is for this reason that Max Weber argued that the content of the professional's conscience should be of 'immediate concern to us all' (107), or as Alan Petersen puts it;

> *'If it is accepted that professional struggle is as much, if not more, to do with occupational groups self-interest and their attempts to gain power as with client advocacy and social justice, then any serious change strategy should as a starting point include critique of the nature of professional practice and of professional training'* (106).

At the heart of this critique would be the professogenic effects that are 'systematically produced as part of the social organisation' of the professions (108).

Edgar Burns argues that we need post-professionalism to act as a direct challenge to the kinds of protectionism and insularity so often seen in professional conduct, and to the 'disproportionate advantage' achieved by those professions that have increasingly claimed power and prestige for themselves to enable them to become 'apex social actors' (8). All too often, Burns suggests, the 'latent consequences' of the well-intentioned professionalising projects of doctors, nurses, physiotherapist, and others, are simply 'written out of the script' when the professions define themselves and their work (ibid).

We have perhaps seen echoes of this in the way physiotherapists adopted evidence-based practice in the 1990s, without giving adequate thought to its links to the marketisation and accounting logic creeping into healthcare (109). So whereas evidence-based practice could have 'challenged physiotherapists to discuss more overtly the ontological basis of professional knowledge, its professional ethic, practice and ongoing, career-span development' (109) — and thereby turning more away from professional protectionism and towards its clients — it, instead, encouraged physiotherapists to see the patient as 'something additional rather than integral to 'evidence'' (110), and drove aggressively towards medicine and the pursuit of greater objectivity, reductionism, and positivism. It did this, perhaps, in an attempt to 'shore up its jurisdictional claims' (109), and keep 'decision-making practitioner-led rather than person-centered or shared' (110).

Western health professions often cite the advent of managerialism and an audit culture for their declining fortunes (as in the rhetoric of de-professionalisation above), but health professions are equally complicit when they, perhaps unknowingly, put their own security and prestige above public service. When they do this, their oft-repeated claims to be altruistic, trustworthy, and caring can sound like 'a litany of intention or aspiration at best and special pleading for more average performance' (ibid). As Edgar Burns reminds us; 'all professional interventions across every profession have the potential for adverse consequences' (8), and there is nothing *inherently* good about being a professional. But Burns also suggests that, 'letting go of such automatic claims' (ibid) to goodness, as implicit explanations for the privilege professions give to some people, practices, and ideas, may allow us to focus more on people's needs and the knowledge and skills needed to meet them.

Unbundling goodness and expertise

Three of the main tenets of post-professional critique have been: (1) the professions' own claims to goodness and expertise, (2) the way group morality and highly abstract forms of knowledge have been bundled together and converted into status and reward (111), and (3) how these have largely survived attempts at organisational reform (8, 112).

The link between goodness and expertise was perhaps first established in the gentlemanly secular health sciences of the 18th century (113–115). Through the Industrial Revolution, medicine's role as

a disciplinary technology directed at improving public health, and its 'warm friendship' with the state (116), became increasingly significant (117). Medicine's success in 'conquering' illnesses that had decimated earlier societies (smallpox, diphtheria, typhoid, etc.), also indexed closely to the 20th century's cultural desire to find technical solutions to human problems (118), and led to the 'morally satisfying' alliance between the health professions and the welfare state (119, 120). Along the way, ethical, service, and care values, were laminated onto the health professions, giving them the tools to turn abstract knowledge into social and economic capital.

We know that goodness and expertise are vital to the professions because there have been many occasions when one or other has been threatened. Numerous cases of medical malpractice and reports of ethical misconduct, for instance, have seen the public's trust in doctors decline (121–124). Deborah Lupton has commented on what she called the 'cultural crisis of modern medicine', in which healthcare under capitalism is perceived as largely ineffective, overly expensive, under-regulated and vastly inequitable' (125).

In recent years, health professionals have been accused of being 'agents of the capitalist state' (126), for being patriarchal, racist, discriminatory, ableist, ageist, homophobic, and heteronormative' (ibid). 'What is common to all these challenges', Pamela Abbott and Liz Meerabeau argue, 'is their dissent from the view that professionals can define problems and solutions to them, that professional practice is disinterested and client-centred, and that the caring professionals have a scientific knowledge base that enables them to be objective and value-free' (ibid). Repeated critiques like this, reflect the fact that the professions' claims to goodness and expertise are being treated with increasing scepticism. As a result, 'The generic ideal traits of service, altruism and goodness have been increasingly unbundled from the role of guarantor of expertise in contemporary society' (8).

Post-professionalism reminds us that there is nothing inherent in goodness or expertise that demands the person be a professional, and there is nothing innate in professionalism that makes the person a good person or knowledgeable practitioner. After all, civic society functioned for thousands of years before the invention of the health professional, and there are many things we trust in life that are not controlled by professional elites. Perhaps this vulnerability explains why the professions indulge in 'normative strategies of defence, boundary keeping, entitlement to substantial earning and maintaining public plausibility as central to professional performance' (ibid)? Perhaps, as Edgar Burns argues, goodness and expertise speak more to professionals' attempts to 'lean the market in their favour' (ibid), than to be true public servants? After all, if the success of a health profession was judged by how well it increases the ability of people to look after themselves, then we would have lost most professions by now, either because they had succeeded, or because they had demonstrably failed. And yet, the professions persist, and so do the health problems they claim to be the response for.

So, perhaps we have arrived at a point where the goodness and expertise of the health professions are no longer accepted uncritically? Andy Grossman has asked whether professions like medicine would still even be *thought of* as a profession if it lost its social prestige and authority (127)? And Jonathan Gabe has asked whether healthcare in the hands of consumers would even *need* professionals (81). These questions suggest that some, at least, believe that the professions are now much more reliant on their cultural legacy than any innate qualities of goodness and expertise. Post-professional scholars like Grossman and Gabe are, therefore, much more likely to ask whether the health professions have become a convenient accompaniment to poor health, rather than an effective response to it.

But it is also perhaps worth reiterating here, that post-professional critiques are not suggesting that the professions are neither good nor expert, only that claims to goodness and expertise should not be seen as 'fact', but as claims made by the professions in service of their social goals and, therefore, open to challenge in a manner that the professions themselves have been historically reluctant to perform.

Complexity

One of the inspirations for more post-professional thought in healthcare has been the growing realisation of just how *complex* health and healthcare have become. So, as well as exploring the possibilities of unbundling the professions' claims to goodness and expertise, post-professionalism also examines many of the other 'logics' of traditional Western healthcare that flow from this, especially the ways Western health professionals have traditionally dealt with complexity. This has become important given the gamut of healthcare practices now available to people, and the increasingly diverse ways people conceptualise what it means to be healthy.

Providing healthcare to a single person, never mind a large, diverse population, has always been complex (81, 128, 129). But in recent years, the idea that social problems, like healthcare, are so complex and multi-layered that they are beyond the reach of service users, expert professionals, or even governments, has become a recurring theme (130).

Increasingly in the West, we see 'tired, distracted patients struggling to manage their lives in the face of multiple conflicting challenges, with insufficient energy for the level of personal agency required to deal with the self-management approach' (131). 'Each day on earth,' Mary Cappello has written, is 'an endless adjustment to there being too much or not enough' (132). But post-professionalism argues that these are symptoms of the system itself, since 'every system is perfectly designed to get the results it gets'[5]. In our drive for personal responsibility, autonomy, productivity, and efficiency, we have created what effectively amounts to a care crisis (133, 134), that now seems to be leaving many people behind.

Paradoxically, it may be that the desire for orthodox health professionals to be seen to be taming the complexity of health and healthcare, with the same reason and logic that gave medicine its prestige and power, is actually *contributing* to the crisis (135–137). Renee Fox has shown how healthcare students, for example, use a range of tactics, from reducing healthcare problems to probability-based, scientifically defined issues, and disregarding the affective, personal nature of the patient and the consultation' (138). But they are doing this out of 'poorly disguised longings for a kind of control and certainty that, if it ever existed, is certainly long dead now' (139). We have put our faith in our ability to 'master all things' (140), and have learned to distrust ambiguity and uncertainty, in part because it makes us professionally vulnerable; a problem made worse when 'certainties become destabilised', and we engage in more complex 'relational forms of knowing against a knowledge that espouses singular truths' (141).

Post-professional writers like John Law and Annmarie Mol suggest that complexity exists when 'things relate but don't add up', when 'events occur but not within the processes of linear time', and

[5] This quote often attributed to business commentator David Hanna, but there are many variations of this idea in the literature.

when 'phenomena share a space but cannot be mapped in terms of a single set of three-dimensional coordinates' (142). Complexity of this sort requires tools adequate to the task of not capturing and collapsing the surplus space of unpredictability, uncertainty, and opacity, but *transgressing* it (143–146).

A plethora of approaches to this have emerged in recent years. In Chapter 6, I cited Avital Ronell whose work on the value of stupidity in thinking (147), has shown how hard it is to retain the tension of openness to difference. Ronell argues that we grasp for meaning in transcendent signifiers (God, patriotism, reason, one's profession), and forms of shallow gratification (consumption, shopping, food, exercise), as ways to salve 'the wound of non-meaning' (ibid). Ronell's call is for us to embrace the inappropriable; resisting the urge to collapse non-meaning with shallow logics.

A similar argument has been made by Erin Manning in her book *Relationscapes* (148). Here, Manning argues that every action carries a thousand risks that must be resolved for movement of any sort — physical, conceptual, or existential — to occur. But the 'juice' of life is not in the resolution of the thousand tensions into a definitive answer, but in the instances *before* movement manifests, when the risks of a misstep are held in tension. Alfred Hitchcock used to say that a real thriller is not one where the bomb goes off under the table of the couple sitting in the restaurant, but when it does not. Manning's argument is similar: life is in moments pregnant with possibility and resolution, or the collapse into meaning — as Ronell might say — only serves to bleed the moment of its life force.

Philosopher Jacques Derrida suggested that the ambiguity that is an inherent part of decision-making, acts like a surplus capacity that defies our desire to know and capture the answer we seek. He called this undecidability, and suggested it is the reason why we have experts in society (149). We need judges, for instance, not because sentencing can follow standard formulae in which Crime A deserves Punishment B. Rather, we need judges precisely *because* decisions often defy formula. Nothing hangs in the balance when a conclusion can be reached by means of rational argument, algorithm, or calculation. We need judges to help us navigate the ambiguities and complexities of the case that cannot be resolved with routine formulations, standard rules, linear pathways, predictable logic and, sometimes, even reason.

Barbara Gibson applied Derrida's undecidability to her post-critical analysis of physiotherapy ethics, opening ethics to possibility and doubt (150). Anna Rajala suggested that because physiotherapy is a 'material' practice, it 'ought to be understood as more than a mere economic exchange of services, technical knowledge and skills' (151). This is because 'it involves working on, with, for, around and through bodies that encounter, interact with and touch each other, move and are moved physically, psychologically, socially, culturally, biopolitically, and emotionally' (ibid). And in his doctoral thesis, Filip Maric spoke of the violence we do to things when we attempt to diagnose, label, capture, assess, and treat people in physiotherapy (152). Emmanuel Levinas — a major influence on Maric's work — argued that when 'the known is understood and so appropriated by knowledge… (it is) freed of its otherness' (153, 154).

Annemarie Mol has written extensively about the multiplicity and contingency of healthcare (155–158), but most especially about the 'fuzzy, complex, and adaptable styles of knowing and acting that are crucial' for clinicians in clinical settings (159). In *The logic of care,* Mol advanced the idea that the choices customers face in navigating the complexities of healthcare are always based on limits imposed by healthcare itself (i.e., clients/patients never have complete freedom) (157). And so, healthcare functions as a tool for limiting care rather than opening it up. Mol asks why care operates this way, if not because it is based on an economy of reason and resources?

Mol's work draws on Georges Canguilhem ground-breaking 1966 study *The normal and the pathological* (160). In the book Canguilhem argues that our faith in the biological basis of normality is misguided, suggesting that new norms are always being created, and people live in a 'multiplicity of norms' (161). Rather than being fixed, norms and pathology are 'dynamic, adaptable, and diverse' (ibid). Their existence is only evidence of a system designed to give artificial stability to the biological sciences; a point that Foucault interrogated extensively (162, 163).

The reason why many post-professional writers are at pains to critique programmatic thinking — a phenomenon increasingly at the heart of late capitalist approaches to healthcare — is because the rejection of the idea that practice can be guided by singular, fundamental truth, demands a 'mega-ethicality' in people (164). It is much easier to live and work under conditions where someone else tells you what is good and bad, right and wrong. But if professionals are prepared to let standard rules and guidelines govern their ethical reasoning, they cannot, at the same time, claim ethical 'goodness'. Falling back on standardised assessments, evidence-based 'best practice' mandates, pre-formulated care plans, and even rules of professional conduct, can have the perverse effect of *reducing* the ethical conduct of practitioners. As the anxieties of undecidability are substituted for formulaic ways of thinking and acting, we increasingly 'evacuat[e] ethical decision making' (165), and substitute complexity for systems and structures that are de-contextual and reductive.

'Post' perspectives argue that all attempts to prescribe a method for living, diagnosing an illness, or treating a patient, are thinly disguised forms of cultural imperialism, particularly when group morality is tied to rules defined by reason and logic (166–169). Instead, we should look to celebrate the ambiguities, paradoxes, and differences inherent in health, as it *is*, not as a group of elite professionals would like it to be (139).

Many of the authors now looking at the value of ambiguity and complexity in healthcare have been heavily influenced by the work of French philosopher Gilles Deleuze, who argued that we should always look to open space for diversity and difference, and limit the extent to which we close these off (129, 170). Deleuze believed we were naturally drawn to collapsing ambiguities; a process he called territorialisation. But equally, and with effort, we could recognise our habit and work to *de*-territorialise ways of thinking and practicing. The goal, he argued, was to create spaces for thinking and action that were unencumbered by rules and regulations, barriers and obstacles (what he called 'smooth space' rather than 'striated space').

Along with his long-time collaborator, Félix Guattari, Deleuze argued that our tendency towards reason and logic had created a misunderstanding about the way learning and knowledge really worked in society (171). Deleuze and Guattari suggested that Enlightenment thinking had led us to think of learning as 'arborescent', or tree-like, with knowledge grounded in deep roots, that formed large branches, and from these endless specialised stems grew. The purpose of arborescent thinking was to produce the shiny fruit (the expert professional) as the end product of years of growth and maturation. Deleuze and Guattari suggested that this metaphor reflects the linear, progressive fantasy of scientific reason, but ignores the true messiness of learning and life in general.

Deleuze and Guattari argued, instead, that society worked more *rhizomatically*, or like a virus or a swarm. Like the networks of fungal hyphae that spread out for miles underground and give life to the soil, Deleuze and Guattari argued that there was no beginning or end to a rhizome; we always occupy multiple 'middles'. People can reside on multiple nodes in the rhizome at any one time (at any one moment a person could be a patient undergoing a CT scan, a mother, a physiotherapist, a carer for an elderly relative, a goalkeeper for the local football team, etc.). People are no longer fixed

entities, but assemblages of organic and inorganic 'intensities': networks of connections and associations, arrivals and departures, connections made and connections lost; emergent entitiesp with properties that cannot be reduced to their individual components, as Barbara Gibson explains;

> *'Deleuze and Guattari reimagine the static individual of fixed identity in terms of* assemblages *that can be thought of as temporary collections of heterogeneous human and non-human elements that might include bodies, objects, ideas, animals, places etc., ad infinitum'* (150).

Implications for physiotherapy

Reform and change are nothing new in physiotherapy, but the post-professional era will be symbolised by the ways in which the professions were incrementally de-centred from healthcare. Some of the changes affecting person-centred care, for instance, show this process clearly. Others, like the adoption of the biopsychosocial model, and the emphasis on neoliberal self-care, are de-centring the professions in more subtle ways. There are examples already of physiotherapists fighting back, by claiming higher levels of professional specialisation and graduate entry qualifications. And there are examples of bland acquiescence in the face of relentless reform (see Chapter 8).

But the ability to understand the drivers of post-professionalism, in the context of a century of sociological critique, could be enormously important in the coming decades. Not least because physiotherapy is very much implicated in the change taking place, and the conscious, thoughtful, and compassionate involvement of the profession in shaping healthcare in the future is an important ethical responsibility, given the power and prestige that the profession currently holds.

Some have suggested that trusting the health professionals to bring about reform themselves is akin to the 'rabbits guarding the lettuce' (3), particularly given how adept the health professions have been in the past at ensuring their territorial security. But if this book is anything, it is an argument that it is physiotherapists' ethical responsibility to consider what will be in the best interests of our societies in the future, even if that means embracing a post-professional world in which our influence is de-centred. What are the implications of post-professionalism for physiotherapy, then? And how can we best support the post-professional promise of a very different healthcare in the future?

Below are three sociological 'tests' that can be applied to changes now being instituted in and around physiotherapy. Although post-professionalism can be read from a number of different positions (culturally, economically, environmentally, or philosophically, for instance), I have retained the focus of this book on sociological issues. Drawing on the issues raised over the last six chapters, a number of critical questions emerge that may help us distinguish post-professional practices that work in the interests of people's health and wellbeing, from those that do not:

– Firstly, we should ask how the profession is looking to divest its power and prestige and de-centre itself to allow its knowledge and skills to be used and shared by the community. All too often, defensive professional self-interest has allowed groups to claim new markets and territories, and to find new ways to entice clients/patients to value the profession over its competitors. We should ask, is the profession using this practice innovation to secure or grow its territorial claim to authority, expertise, specialisation, or coverage, or build on its historically advantageous relationships with other elites in the hope of securing its future? If so, this works

entirely *against* the spirit of post-professionalism, and will, in all likelihood, see the profession increasingly side-lined and criticised for unethical conduct;

– Secondly, we should ask whether the profession is working to enhance its networks and connections, and make its boundaries more porous. Is it looking to demystify its language, systems, and processes, to make it easier for people to access it as students and practitioners, as well as clients/patients? Is it looking to reach beyond its traditional territory to explore new possibilities for collaboration and growth, in the arts, the humanities, history, philosophy, and sociology, for example? Or, by contrast, is it looking to progress its claims to autonomy, distinctiveness, specialisation, and independence, and carve out an ever-more-distinctive niche for itself as *different* from its allies and competitors, clients and consumers, regulators and managers? Is it looking to consolidate its scientific, biomedical credibility and, through this, convince service users, funders, and legislators, that it is 'better than' others, and more deserving of special treatment? Is it looking to stabilise and ossify the profession, or perturb it, disrupt it, and keep it in motion? Again, such attempts, when tied to claims of goodness and expertise, may be seen as increasingly hollow attempts at enclosure and protectionism, and the profession's prestige may suffer accordingly.

– And thirdly, we should ask whether the profession is actively encouraging its members to think critically *against* themselves, questioning their professional socialisation and the discourses that have made their existence possible, in order that they can better understand their culture, history and philosophy (172). Is the profession developing a culture of appreciation for difference, encouraging innovation, and creative destruction? Does it ask questions about whose voices are not heard by the profession, and whose interests are not being served? Is it working directly to enhance its role as an advocate for social justice, tackling entrenched power asymmetries and disrupting traditional power structures that reinforce social oppression? Or is it reinforcing the mechanisms that have historically perpetuated these systems, by promoting normalisation and other hallmarks of Western, patriarchal, colonial, 'Northern' privilege? Or is it doing this 'passively', by seeing the profession as beyond the scope of social action, or someone else's concern? Is the profession stifling creative disruption through standardisation, regulation, and bureaucratisation, designed to retain the status quo, or only bring about change that enhances the status of the profession and does not threaten to undermine it?

These are perhaps some of the most difficult questions now being posed by post-professionalism. At their root, they revolve around active efforts on the part of the professions to relinquish their power in service of a greater good: to embody the spirit of the 'post' in post-professionalism. Ironically, if health professionals were true to the functionalist logic that says they are driven by altruism and public spiritedness, they would have been doing this work for decades already; effectively bringing about the conditions of their own de-centring. But decades of critical, Neo-Weberian, and postmodern sociology, have shown us that the professions are, first and foremost, protective enclosures that have the greatest difficulty letting go of their hard-won social capital. And so post-professionalism can seem like a threat to the professions because it exposes the conceit that the health professions are, in reality, anything but person-centred.

The greatest fear of the professional, who has invested years in training and practice and comes to believe that they are important and necessary to society, is that people will no longer want them. And this is the process that post-professionalism seems to be accelerating. How can we begin to

contemplate demystifying our knowledge and sharing our skills with anyone who wants to use them, the professional asks if the end result is our demise? But if it were in the public's interest to close the physiotherapy profession down completely, for instance, then *of course* we should do it because the key phrase here is that it would be *in the public's interest*. The healthcare system is not there to serve the interests of the professions, but the people who they claim to serve.

So, how do we turn defensive professionals into advocates for a new kind of healthcare? Why would a profession entertain the idea of a practice *designed* to drive physiotherapy into obsolescence? The first answer to this has already been stated: because it might be in the public's interest. And so, in the very first instance, we need to test the virtue of this idea. In some cases, it would be hard to imagine a community ever wanting to lose access to some experts and specialists. But in many cases, there is nothing particularly mystifying or intangible about the knowledge and skills that the professionals possess. The physical therapies — therapeutic touch, manipulation, exercise, electromagnetism, and so on — are a prime example of this. As some of humanity's oldest-known health remedies, the physical therapies have been practiced by peoples around the world for millennia, and will, almost certainly, be needed by people for years to come. So, physiotherapists' attempts to 'colonise' these knowledges and skills, and attempts to protect this knowledge from the public, increase specialisation and legislative protection in order to take physical therapies beyond the reach of 'ordinary' people, may be seen as distinctly cynical self-interest in the future.

But asking what physiotherapists might do themselves to advance post-professional healthcare also implies that they will be the primary agents of change. This would be a mistake though because one of the main effects of post-professionalism has been the realisation that health professionals are just one agent among many; one 'effect' and 'achievement' of broader and deeper cultural, economic, political, and social discourses, amidst a myriad of overlapping, complementary, and competing forces initiating change. Post-professionalism has cast doubt on the fundamental basis of any claims to autonomy and independence on the part of individual professions (80), and, instead, reinforced the inherently interwoven, collaborative, distributed, and complex nature of healthcare. Physiotherapists will undoubtedly play a part in shaping the future of healthcare, but we will be one voice among many, and post-professionalism suggests that healthcare will be all the better for the modesty and self-awareness that this implies.

What is clear is that we are already seeing the effects of significant reforms in contemporary physiotherapy thinking and practice. The move towards person-centred care, and the drift away from the management of acute, self-limiting, soft-tissue injuries, to a focus on the kinds of pain and disability that cannot be cured; the renewed emphasis on more holistic models of practice, like the biopsychosocial model; the growing concern for the UN's Sustainable Development Goals; the growth of publishing in the emerging field of critical physiotherapy, rehabilitation, and the humanities; extended scopes and advanced practitioner roles; the turn towards inter-, multi-, or trans-disciplinary practice (a subject we will return to in the next chapter), and more boundary-testing practices like vocational rehabilitation, acceptance and commitment therapy, and acupuncture; digital technologies in shaping how physiotherapy is being learned and disseminated; and a focus on stigma, power, privilege and disadvantage in physiotherapy, are all opening a space for critical conversations around the post-professional future for the physical therapies.

But we should be careful not to see *anything* that breaks with tradition as being necessarily post-professional. For something to be post-professional, it cannot merely be 'old wine in new bottles'. Post-professionalism requires the profession to be de-centred, and any change that seeks to merely

enhance the profession's standing, whilst appearing to be based on altruism and public spiritedness, will increasingly be seen as a kind of 'care-washing'.

What follows over the final two chapters is an exploration of what post-professionalism might look like for future physiotherapy. In the final chapter, I propose the radical opening of the physical therapies as one of a thousand possible futures. The arguments build directly on the work of the previous chapters, and ask what an otherwise physiotherapy might look like if it broke free from its historical enclosure. How might the physical therapies be developed in a way that makes them more available to people, and returns them to a place at the heart of everyone's understanding of bodies and movement, in health and illness: a physical therapy in common, so to speak?

Closing words

Post-professionalism may be seen as a good or bad thing, depending on one's perspective. We know, for instance, that resilient societies thrive when they have the resources to fend for themselves and do not have to rely on 'imported' expertise (see Chapter 3 and the concept of alienation). And, in many societies, professionals are in such short supply that 'the expertise of a very few', is only available to a small minority of people in society, often resulting in a 'Rolls-Royce service for the well-heeled minority, while everyone else is walking' (3). So moving away from a reliance on an elite cadre of specialists and experts, and building more 'local' support systems may well be a very important thing in the future.

But there is no doubt that for the professionals whose services are being de-centred, post-professionalism represents a worrying trend. Few professionals actively support moves to open up their field to others, preferring instead to fight changes and resist the disruption. And some have expressed concern that undermining the status of medicine and its allies through sociological critique, bureaucratisation, and digital disruption, may have the 'unintended consequence of damaging positive aspects of the wider role that medical practitioners have carried out in the past' (11).

Transformations in other sectors, however, suggest that change often happens with a striking disregard for the concerns and feelings of those with the most to lose from the disruption. Sometimes the change can come swiftly, sweeping through industries and social services like coal mining, manufacturing, publishing, and accountancy, reshaping the landscape with the speed and ferocity of a sandstorm. At other times the change happens more slowly; a 'long-fuse, big bang' (173). Either way, there are no fields or social domains into which professionals penetrate today that has not already been touched by at least some disruption. And, no matter how strong their grip, as the pace of social change accelerates, professionals will be increasingly flung centrifugally to the peripheries.

Terry Johnson suggested in the 1990s that 'the heyday of professionalism' was at an end (174). And that competition, bureaucratisation, technological advances, division of labour, the routinisation of work, mounting public scepticism, planning blight, service failures, the perceived dangers of science, ecological disasters, increasing access to higher education, and the rise of critical social consciousness, had resulted in a 'pronounced shift in public opinion that undoubtedly strengthened the resolve of the governments… to confront the professions' (ibid).

Indeed, 'There is a strong sense', Daniel and Richard Susskind argue, 'that the professions, as currently organized, are approaching the end of an era — in the work that they do, in the identities

of the providers of service, and in the nature of the service that they deliver'. 'We are', they suggest 'advancing into a post-professional society' (3).

Having said this, health and education have, thus far, remained reasonably well insulated from the kinds of profound disruption seen elsewhere. Evidence suggests that the authority of individual practitioners remains high, and 'despite much discussion of the loss of faith in the 'grand narrative' of science, medical knowledge and technology retain a legitimacy that outweighs intermittent crises (11). Valerie Fournier has suggested that we may have been too quick, in the past, to pronounce the death of the professions, 'with little consideration as to what went into the making of the professions in the first place' (84).

Even as late adopters, though, there is little doubt that 'revolutionary progression into the post-professional society' (3) is taking place, and there is now ample evidence that we are experiencing a cultural shift in the nature of health and healthcare to rival anything that has gone before.

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8. Physiotherapy in crisis

A critical sociology of physiotherapy — Updating models of change: Doing nothing, Modern heritage, Renaissance physiotherapy, Hybrid physiotherapy — So, what can be done?

Mirko Noordegraaf suggested in 2015 that, 'the contemporary study of professionalism is lively because much is at stake' (1), and, indeed, even a cursory glance at some of the challenges now facing physiotherapy would lead most people to conclude that the profession has a lot on its plate.

Years of austerity and neoliberal economic reforms have bitten into public funding. Wards and services have closed, and the threat of more cuts, more reforms, and more competition always hangs over 'non-essential' services. And yet, healthcare has fared better than most. By comparison with some other industries, healthcare is booming. Add the fact that health professionals are trained to believe their work is a 'calling' (and so should never complain), and it is easy to see why so many have acceded to the creeping bureaucratisation of their work, brought on by decades of New Public Management, risk culture, and managerialism, undermining their clinical autonomy, and transferring treatment decisions to insurers, case managers, and accountants, who seem to want to actively disincentivize optimal care.

Pressure on physiotherapists' day-to-day work has increased massively (2, 3). Many are working longer hours, and offering fewer, shorter appointments. Treatment advice is becoming more generic and formulaic, and client/patient self-care is becoming more necessary. It is becoming increasingly difficult to feel satisfied with practice, and few people feel they are doing the job they trained so hard for (4–6). They know that routinised care dumbs down their work and makes them easier to replace. They know that a raft of advanced practice nurses, osteopaths and chiropractors, exercise physiologists, therapeutic masseurs, personal trainers, acupuncturists, and counsellors are pushing hard to take over from them. And now the threat of AI and robotics, and other rapidly advancing technologies are challenging physiotherapists in new ways, forcing them to innovate and be creative, when the underpinning ethos of their training and practice has reinforced the need to conform and follow, avoid being disruptive or break the mould.

Added to this, shifts in the nature of healthcare are making physiotherapists feel that they are losing their distinctiveness and are being pulled out of their comfort zone. Treating ageing populations with increasingly complex chronic and lifestyle illnesses, requires more care and less cure, more wellness, more health promotion, and the generic 'soft' skills common in concierge-type health practices, and not the technical, pathology-based knowledge prized by physiotherapists for so long. And so, physiotherapy is slowly losing its status as 'first choice for medically trained rehabilitation… and an essential part of the continuum of care' (7).

Physiotherapists, like all orthodox professionals, are under ever greater pressure to remain up-to-date and reflect on their practice. But they are overwhelmed by the volumes of material they are expected to keep abreast of, and feel, increasingly, that, today, you can either be a clinician or evidence-based, but you cannot be both (ibid). The public are increasingly aware of health professions' fallibilities, and are far more skeptical about their claims to be the best people to manage the health of the population. People are much more comfortable seeking their own health solutions, and bypassing traditional health authorities (until a crisis occurs, of course).

And the sheer volume of unmet need in the community is becoming overwhelming (8). Even though physiotherapy is one of the largest professions allied to medicine, only 7% of the countries worldwide have more than one physiotherapist for every 500 people. One third of the world's population has less than one physiotherapist for every 10,000 people (9). Physiotherapists are clustered in the Global North, and gravitate towards urban centres where people have the most disposable income and time (8, 10, 11). In Sweden, there are 20,000 physiotherapists, three-quarters of whom work in the public system. They have direct access, and can offer heavily subsidised, government-funded treatment. People who need extended periods of treatment have it for free after a period of time. There is little unemployment of physiotherapists and physiotherapy jobs are secure. But very few other countries around the world compare with this.

Physiotherapists have come to realise that no-one is coming to save them; that no-one will speak up for physiotherapists if they do not do it themselves. Which would be OK if everyone in the profession agreed how we should move forward. But, in reality, there appears to be no 'grand plan', and physiotherapy, like healthcare generally, appears to be increasingly incoherent and fractured. Some have committed to dramatic shifts in training and education, but this has only served to ramp up student debt without offering guarantees of higher status or pay. Similarly, physiotherapists have committed vast amounts of energy and money to demonstrating the efficacy of their practice, but this has not made us more secure or more confident. If anything, it has undermined our sense of worth, and our value in the eyes of the public. Much of the research focuses on abstract clinical concerns removed from the real world of clinical practice, bypassing the kinds of knowledge that the profession needs to shape its future. Given all of this, perhaps it is understandable that many physiotherapists now feel that the 'centre will no longer hold'; that the healthcare that we fought so hard to support, is slipping away.

Clearly, this is a bleak reading of the current situation, however much it reflects the realities for some therapists for some of the time. But there is also something wrong with this picture. Because surely physiotherapy is also a highly respected, popular, well-supported, and growing profession, with lots of things to offer the changing landscape of healthcare? In *EoP*, for instance, I suggested that;

> *'One of the first question physiotherapists might ask themselves about their future role in the changing economy of healthcare, is whether there is currently anyone better placed to take advantage of the changing economy of healthcare? Who else can claim to be a highly respected, orthodox, first-contact diagnostician; with a focus on the whole body, and skills in the assessment, treatment and rehabilitation of activity, movement and functional disorders; with discretion in day-to-day practice and a long history of working within today's health priorities, and the delivery of highly personal, low-cost skills; in a manner that the public trusts, and sits comfortably alongside the work of doctors, nurses and other allied health professionals? Physiotherapy is, in many ways, perfectly positioned to be a major force in the healthcare services of the future'* (12).

There are now more than two-thirds of a million physiotherapists practicing worldwide, and nearly 250,000 physical therapists in the United States alone (13, 14). There are now more practicing physiotherapists in Australia than there are general practitioners, and the profession is estimated to increase in size by 28% in the next 10 years (ibid). And to this, we might now add that the COVID-19 pandemic has reminded people how important well-trained health professionals are to a country's infrastructure; how popular health professional careers are becoming in the face of technological disruption in other sectors (15, 16), and how much physiotherapists might contribute to mitigating the costs of climate change, with their relatively low-tech, 'low-carbon' approach to healthcare (17, 18)[1]. Surely, as the NHS report *Allied Health Professions into Action* suggests, professions like physiotherapy 'are everything that a rejigged, refocused, public healthcare sector should focus on' (19)?

There is also, surely, a case to be made that we have seen this upheaval and talk of crisis before; that if one travelled back to any point in the history of modern healthcare, you would be likely to find similar talk of unprecedented change and complaints about the failure of healthcare to adapt. This passage from physiotherapists Joy Higgs, Kathryn Refshauge and Elizabeth Ellis was written 20 years ago;

> *'The current context of healthcare is one of contradictions: of highly advanced medical technology and increasing globalisation but lack of universal availability of solutions to health problems, of a growing number and range of health solutions but for many people, limitation of funds to purchase adequate health (Higgs, J. et al., 1999). Internationally, the practices of health and healthcare are changing dramatically. 'In global terms, there is a considerable shift away from the cure of individuals presenting for service towards the prevention of illness in populations and the strengthening of the community's capacity to deal with its own health' (Lawson et al., 1996, p. 11)'* (20).

And so, although it would be fair to say that physiotherapists have little of the foundation mythology of professions like medicine and nursing (we have no Pasteurs or Nightingales), physiotherapists have secured their place within orthodox healthcare by being highly adaptive; moulding the physical therapiesto their social purpose for generations. Physiotherapists are great responders. So, is physiotherapy in crisis or is it not? Is there anything new about the current moment that marks it out as different from all of the other ruptures met before by physiotherapists? Is physiotherapy at a tipping point, or is it on the cusp of a new period of growth and expansion? And if it is, how would we know?

A critical sociology of physiotherapy

This question of how would we know was really the inspiration for this book. In an effort to unpack the discourses shaping physiotherapy, I was looking to add sociological depth to our understanding of the profession, and build on the critical historical analysis in *EoP*. My belief is that by understanding

[1] Recent years have seen the emergence of an environmental physiotherapy movement that is advocating for the ways physiotherapists might contribute to addressing multispecies equity and planetary justice, and ameliorating the catastrophic effects of anthropogenic climate change (see the Environmental Physiotherapy Association for more information).

physiotherapy sociologically, we will be better able to make sense of the profession's past, present, and future. In very broad terms, I think this book explains why so many physiotherapists feel that healthcare is getting away from them, and why orthodox healthcare feels as if it has lost connection with 21st century society.

The sociology of the professions tells us that part of the reason for this is the gradual unbundling of all professions' claims to goodness and expertise. And that this is de-centring even the most elite and established disciplines. Orthodox health professions, like physiotherapy, are increasingly becoming only one among many ways in which people now engage in health and wellbeing.

Added to this, neoliberal economic reforms have also been building on late capitalist atomisation, globalisation, and new forms of technological disruption, to turn healthcare into virgin territory for innovators, speculators, and investors. Having said that, the biggest initial disruptions for physiotherapists may not come from digital technologies like AI, robotics, and natural language processing, because healthcare speculators currently have their eye only on the money to be made from healthcare's low-hanging fruit: technologies like image processing, routine surgery, genetic screening, drug development, and prescribing (21, 22). But physiotherapists are certainly open to widespread late capitalist professional work reconfiguration, routinisation, role delegation, and decomposition (23), and so cannot assume that they will be immune from disruption.

Physiotherapists have been guilty in the past of ignoring societal shifts, and many of the profession's present dilemmas have, in many ways, been brought about by physiotherapists' intransigence (24). Sarah Barradell has suggested that physiotherapists have 'lacked the careful systematic criticality that can be observed in some other health professions, such as nursing' (25–28). Arthur Frank has suggested that this is a common problem because 'our times condition people to lack… a reflective sense of how engagements in their own practices weave the nets that impair their freedom… We ourselves weave the nets that hold us' (29).

Physiotherapists have long grounded their practice in the idea of the body-as-machine, believing that thorough knowledge of the pure sciences, the application of objective tests and measures, and a dispassionate approach to the patient, they would engender trust in the therapist's touch and gaze (12, 30). What was never acknowledged, though, was that these approaches were underpinned by androcentric bias, the othering of colonisation, and the normalising practices that perpetuate disability (31). They have been strategies utilised and promoted because they helped physiotherapists enclose certain physical therapies and advance the profession's pursuit of prestige and social capital (Chapters 3 and 5). They were used to project the notion of physiotherapy expertise, and deliberately created an asymmetrical power relationship with patients (Chapter 5). And they allowed physiotherapists to ignore the cultural, economic, political, spiritual, and social conditions shaping people's health so that the therapist could appear politically neutral and retain its favoured status with the state (Chapters 6 and 7).

But perhaps the most pernicious effect of physiotherapy's adoption of the body-as-machine, has been its ability to hide the professogenic effects of physiotherapy from the therapists themselves. Because physiotherapists are not given the vocabulary or the analytical tools to 'perceive' the wider world of healthcare, they do not see how their acts of choosing carry an implicit rejection of 'other' ways of understanding health and illness. And because physiotherapy is a performative act (32), it requires the same biomechanical bias to be invented anew each day by people perpetuating the very ways of thinking and practicing that have *created* the problems they are now experiencing. This is the physiotherapy paradox discussed in *EoP*. The genius and the most serious latent danger of

physiotherapy's historical approach to health, then, may be its ability to convince therapists that their work is inherently good, and their expertise remains valid, whilst almost completely shielding the deleterious effects of their approach from view. So, what physiotherapists may be experiencing now, may be the social effects of Western healthcare bubbling to the surface in a way that cannot be ignored, nor easily explained. As Chijioke Nze, Elorm Avakame, Olusola Ayankola, and Jamaji Nwanaji-Enwerem argue, these issues are now in 'our lane too' (33).

I believe this book shows that sociology can bring a much-needed critical perspective to bear here because sociologists are much more objective when it comes to the professions' claims to goodness and expertise. Sociologists assume that the professions, on their own, are unlikely to consider the unintended and problematic issues arising from their practice because to do so might harm their power and prestige. Jenni Aittokallio and Anna Ilona Rajala recently argued for 'a greater understanding of the complex sociology of rehabilitation' (34), including an 'Understanding of how power relationships, inequality, inequity, injustice, ableism, racism, ageism, sexism, heteronormativity, geography, and demography operate in a constellation around person-centeredness' (ibid). So, if critical thinking, as it is applied here, implies 'a sense of self-appraisal; re-assessing where we have come from, where we are at and where we might be going' (35), then there is surely a place for more sociologically-informed criticality in the professions now. But, as well as using sociology to understand the problems now facing the profession, we can also use sociology to analyse how physiotherapists are responding. This becomes vitally important if we want to know if we are on the right track.

Given the depth of critique directed at biomedicine over the last seven decades, one of the important issues now facing contemporary physiotherapy is how the profession shapes its professional identity into the future. Should it attempt to secure its cultural capital through slavish adherence to the dominant, but increasingly de-centred, biomedical discourse? Or strike out on its own, in the hope of defining new cultural processes and artefacts that justify its distinctive work and interests? Sociology shows that this is not simply a question of what is best for the profession. Should women, queer, disabled and racialised people simply absorb the cultural artefacts that are associated with biomedicine (normalisation, othering, objective detachment, marginalisation, etc.), so that physiotherapy can secure social privilege for itself? And what are the costs for the profession if they choose not to do so? Analysing the ways that physiotherapists are attempting to shape the profession can, therefore, provide some useful insights into the discourses that are having the greatest bearing on their thoughts about the future.

Updating models of change

In 2005, I wrote a short paper titled *Possible futures for physiotherapy* with my colleague, Peter Larmer (36). In the paper, we suggested that there were broadly four directions of travel available to future physiotherapists: to do nothing, to return the profession to its roots, to develop an entirely new professional identity, or to find a way to combine the best of the old with the best of the new. We suggested there were good and bad aspects to each of these approaches, even doing nothing. But in a follow-up paper in 2009 (37), we argued that, in reality, the fourth option was the only real choice. Now I am not so sure.

The four approaches represented broad archetypes of the ways physiotherapists are adapting to the changing face of healthcare. And although they appeared to take the profession in radically different directions — either by attempting to restore it to former glory, fundamentally reshape it, or find some middle path — they all shared a common desire to promote the physiotherapy profession and see it prosper. The four approaches are summarised in the table below. After that, I consider each in turn in more detail.

Table 1. Table of four options

Strategy	Why might this appeal?	Examples	Why might it be problematic?
Doing nothing Watching and waiting	Places trust in our heritage. Not seen as being reactive.	Current status quo. Seen in most physiotherapists struggling to know how to respond.	Risks the profession being left behind, becoming obsolete, and replaced by more agile competition
Modern heritage Return to the body-as-machine	Easy to teach and sell. Strong, well-known identity.	Specialisation, advanced practice. Masters/doctorates as entry qualifications. Stronger connections with medicine: diagnostics, evidence hierarchies, clinical trials, scientific objectivity. Focus on pathology, disease and illness located within anatomy, physiology, pathology. Push for greater diagnostic/treatment skills. Emphasis on technical skill as point of difference. Rejection of 'other' ways of thinking as distractions from 'core' practice. Resisting any role-blurring. Protecting professional boundaries, work to preserve influence. Promoting profession as *the* authority on physical therapy and rehabilitation. Reinforcing (Western, male) image of heroic healer-therapist. Disinterest in social determinants, social justice, climate change issues.	May appear regressive and defensive to those outside profession. By reinforcing 'core' biomechanical discourses, PT risks being seen as ignoring key social health problems and lay voice, leading governments and funders to look elsewhere for professions willing to meet their priorities. No guarantee that specialisation leads to greater prestige or reward, so passes debt burden on to clients. PT becomes a luxury of white worried well, and practice becomes limited to acute, short-term conditions, further distancing from government priorities and more easily replaced by automation/decomposition.
Renaissance Throw baby out with bathwater	Seen to be responsive to client voice. Much more humanistic.	Qualitative research, the focus on lived experience over biological definitions of health and illness. Relational practice, person-centred care. The emphasis of the patient's beliefs in evidence-based practice. Consumer-led commissioning. Self-care, personal choice.	By rejecting idea that the physical, material body is the centre of illness, calls for entirely new professional identity for physiotherapists. Unappealing to most practitioners, so highly unlikely to be anything more than a fringe concept.
Hybrid Combine best of old and new	Appears holistic, encompassing a much broader image of physiotherapy. Expands the profession's 'reach'. Demystifies passive language of traditional healthcare. Undermines mechanical models of passive, low-value therapies. Less emphasis on heroic skill of therapies, appreciative and affirmative approach to self-care. Embraces objective and subjective health. Open to broader, more porous professional boundaries and collaborations. Keen on knowledge translation for digital age. More outward facing physiotherapy.	Various holistic health models, especially biopsychosocial model. Physiotherapists 'owning' broad concepts like 'movement'. The move away from mechanical models of illness to neuro-biological, cognitive, and behavioural. Complex adaptive systems.	Superficial understanding of fundamental differences between distinctive philosophies would allow biomechanical approach to dominate whilst making misleading claims of holism. Attempts to teach a respect for distinct philosophies would add years to training and may create conceptual conflict (illness is either bodily, existential, or social, for instance). Attempts to create holistic practice would result in loss of physiotherapy's traditional identity. Opening healthcare to other approaches, but too dominated by neoliberal ideals of DIY healthcare. Might accelerate demise of physiotherapy by speeding up atomisation and recomposition of practice outside traditional fields. Relies on 'gold-rush' pioneers of new markets to retain prestige and privilege for class of new experts, so not a long-term solution for most. Risks only focusing on areas

			of care where new markets can be exploited, so again failing in the profession's social mandate.

Doing nothing

Being 'late adopters', watching and waiting, being cautious, or simply hoping that when change comes it isn't too disruptive, seems like a dangerous approach to take, given what is now happening in healthcare. It seems inconceivable that physiotherapy can rely on the fact that it has enough social credit in the bank to wait out the maelstrom that is 21st century healthcare and come out on the other side intact. So, we should probably dispense with the first of our four approaches straight away. And yet, a significant number — perhaps even the majority — of physiotherapists are either choosing to take this approach, or feel they have little capacity to do otherwise. Some of this may stem from their lack of structural power, but some also derives from not knowing how to engage in socio-political reform (12, 38). For many it is the busyness of daily practice, or a misplaced confidence in the security of the profession that engenders inertia. Whatever the reason, many physiotherapists are choosing to concentrate on their clinical practice, teaching, and clinical research, rather than on structural reform. And so doing nothing *has* to be considered as one of the ways physiotherapists are shaping the profession in the future.

Modern heritage

The second approach is much more purposeful and directive, and concerns efforts to restore some of the profession's prestige and confidence by reviving what are seen as the profession's core principles (see Table above for examples). I refer to this approach here as *modern heritage*. The hope of a modern revival of the profession's heritage is that a return to the values that established physiotherapy as a profession will still have currency today, and can still be traded in for greater professional autonomy, social, and economic capital.

For a contemporary example of this logic at work, see the recent Australian Physiotherapy Association's 2020 report on the value of physiotherapy in Australia (https://australian.physio/economic-value). Note that the economic value of the physiotherapy *profession* is conflated with the benefits of particular treatment modalities. And that while benefits are expressed in highly specific dollar values (i.e. an average $6,626 net economic benefit of physiotherapy in the treatment of episodes of Parkinson's disease), no such detail is provided about costs.

Modern heritage can be found in attempts to revive what some see as the historical core of the profession: a strong connection with biomedicine; a focus on illness and injury as a biological (as opposed to interpretive or social) phenomenon; depersonalised objectivity, scientific reason, and rational empiricism. But modern heritage is not merely an act of reminiscence. Rather, it emphasises the use of evidence-based practice, systematic clinical trials research, and the latest advances in bioscience to promote the idea of a rigorous, efficient, and effective 21st century profession.

There is much to commend this approach. In the first instance, it is a very familiar image of physiotherapy for most practitioners. The vast volumes of quantitative clinical research now being conducted mean that even those who felt insecure about their knowledge of systematic review methodology, would at least be comfortable with studies that took traditional physiotherapy subjects, such as common injury pathways, the reliability of diagnostic tests, and treatment efficacy, and analysed them in new ways. A modern heritage approach is also a relatively easy approach to market because it retains many of the hallmarks of physiotherapy known to the public, funders, and

legislators. Educators have little difficulty adapting curricula, and the development of specialisms and advanced practice stay true to existing professional structures.

There are some significant risks attached to the modern heritage approach, though. Firstly, it relies on the latest research to show that the profession *is* rigorous, efficient, and effective. Clinical trials research to date has been ambivalent on this point, and many of the approaches used by physiotherapists in the past have been shown to have limited efficacy. There is a risk, then, that the pursuit of greater scientific rigour undermines the very essence of the profession that modern heritage approaches seek to promote. Politically, in a time when the professions' claims to goodness and expertise are being unbundled (see Chapter 8), attempts to re-assert physiotherapy's prestige may appear self-interested and retrograde.

While these tensions can appear somewhat abstract, they are having a direct impact on physiotherapy practice. One of the key ways modern heritage approaches assert themselves, for instance, is through specialisation. Over recent decades, we have seen real interest in the development of different forms of expert, advanced, and specialised practice. Critically, these conform to classical reductive medical specialties like musculoskeletal, neurological, and cardiorespiratory physiotherapy, and pathway programmes are looking to link specialisation to improved social, and economic, capital.

A second example comes from the astonishing debt crisis now affecting physiotherapy students in the United States. According to the American Physical Therapy Association, 'PT graduates are in debt for an average of nearly $153,000 — an amount that doesn't include mortgage debt. For nearly all of those PTs, most of their debt load is related to their PT education, with an average balance of $116,000 in related debt' (39). The average amount of educational debt alone owned by entry-level APTA member PTs in Florida was equal to almost two years of salary (197% debt-to-income ratio). More than a new grad doctor or vet (40). The APTA recognises that the cost of physiotherapy education is a major barrier to the diversity of the profession, but puts the importance of demonstrating the special status of physical therapists above all of these concerns (41, 42).

Specialisation is always an arms-race based on the capitalistic idea that competition for limited resources is the engine for unlimited growth. But there have to be limits at some point, and these may now be being reached in healthcare. As Cornell Professor of Management and Economics, Robert Frank, argued, specialisation is ultimately like going to a concert and standing to get a better view of the stage. Now, suddenly, the person behind you can't see so stands up as well. Soon everyone is standing, no-one has a better view, but everyone is less comfortable.

If specialism means that 'there can be few beneficiaries of the genuinely outstanding' (23), or where 'The expertise of a very few… (is only) bestowed upon a few' (ibid), then it is unlikely that governments and other funders will be keen to support such a project. And so, as with the new student debt crisis, the costs of elitism will need to be borne by the consumers, creating 'a Rolls-Royce service for the well-heeled minority, while everyone else is walking' (ibid). Physiotherapists may be forced to focus on cheaper, measurable, short-term interventions for acute, self-limiting conditions to counterbalance the rising cost of their labour. This may be to the profession's advantage in the short term, particularly if the goal is to raise the prestige of the profession with affluent clients in high-income countries, but it is the exact opposite of the kinds of flexible and holistic healthcare that many nation states are now calling for from their health professionals. Technological disruption would also make this kind of instrumental labour a prime target for future work decomposition and automation.

The deeper tragedy here is the failure of advocates for the modern heritage approach to realise that expertise does not occupy the same social space today as it did in the golden age of medicine. This is one of the unfortunate consequences of the physiotherapy paradox. By focusing on the body-as-machine, many physiotherapists have failed to recognise the real drivers of change in healthcare, and believe that more of the same, done better, will be the answer to the profession's future prosperity. But consumers have many more options available to them these days, and governments are no longer eager to centralise services around a few 'elite' biomedical professions.

But if this were not enough, we should not forget that there are other, perhaps more pernicious, dangers hiding in the modern heritage approaches that need to be considered. Any way of seeing is also a way of 'not seeing' (43), and the profession's heritage has allowed generations of physiotherapists to ignore the myriad other ways of understanding health and illness, in favour of seeing the body-as-machine. The danger is, then, that a modern heritage approach perpetuates the kinds of gendering of healthcare, normalisation of disability, and othering of colonialism, that have been some of the worst professogenic effects of biomedicine over its lifetime. For all of these reasons, I would argue the modern heritage approach is an unsuitable and, in some cases, unethical, route to take for the profession into the future.

Renaissance physiotherapy

One of the characteristic features of the modern heritage discourse is its turn back to the body-as-machine, and the rejection of interpretive and sociological aspects of healthcare. As its name suggests, renaissance physiotherapy is a radical departure from this approach, arguing that the future for physiotherapy lies in departing from the profession's traditions, placing the focus, instead, on the client's subjective lived experience, experiential philosophies, and the relational nature of contemporary practice.

Renaissance physiotherapy draws heavily on the social action theories of symbolic interactionism and phenomenology outlined in Chapter 6. Its primary concern is to shape therapy around the meanings people give to health and illness, either as people in themselves, or through their relationships with others. Illness resides not within the body, but in the person's meaning-making, and healthcare is a relational process of meaning-making, rather than a biological construct. So, a therapist who believes that each client/patient's experience of health and illness is unique, or that the subjective experience of illness is a more significant determinant of a person's health than any underlying pathology, might favour renaissance physiotherapy.

As with modern heritage, there is also much that supports this approach, not least because, in the West at least, people's individual opinions matter much more than they used to. Asking people for their opinions, their views on events, or their consumer preferences, is a relatively recent phenomenon dating back to the birth of modern advertising (44). And this has been made even more significant by the advent of social media. Now, the most common complaints from healthcare service users are about poor communication and being heard. Renaissance physiotherapy puts the client's voice at the centre of the relationship, critiquing the over-medicalisation of health, and rejecting the idea that pathology defines illness. In this sense, this approach shows those outside physiotherapy that the profession is willing to adapt to a healthcare environment that is much more person-centred and open to reform.

Advocates draw heavily on qualitative, hermeneutic, relational, and interpretive approaches to healthcare, pioneered in nursing, psychotherapy, and the medical humanities. To date, however, only a handful of studies have explored the possibility of this approach in physiotherapy. And of these, none have extrapolated the approach from day-to-day practice to the renaissance of the profession as a whole.

In part, this is because advocates for renaissance would struggle to account for the pivotal role the real, material body plays in physiotherapy. Not unreasonably, if the material body is dismissed altogether, physiotherapy would need to find an entirely new locus for its identity. It would lose its connection to its past and would, in all likelihood, need to make new connections with the public, governments, and funders, at a time when they may balk at more instability.

An interpretive approach also falls short in saying little about gender, class, poverty, race, ableism, homophobia, activism, stigma, and a host of other sources of social oppression. These are often absent from the qualitative literature in physiotherapy, which has tended to focus on people's lived experience, but not the social conditions that shape the ways it is possible for people to think and act. This is a criticism that has been levelled at nursing in recent years (45), leading to 'patient-focused nursing practice being conceptualised, taught, and promoted as an apolitical process' (28).

In reality, an interpretive, relational renaissance is highly unlikely in physiotherapy, but that does not mean it should be discounted. Healthcare is becoming increasingly person centred, self-care, consumer choice, and personal responsibility are all very much in vogue (46). In reality, though, physiotherapy is so inexorably tied to the material body that any approach that incorporated more interpretive and relational approaches would need to do so as a hybridised version of contemporary practice.

Hybrid physiotherapy

Where modern heritage discourses appear regressive and overly defensive, and renaissance approaches too much of a departure from the profession's past, hybrid physiotherapy feels, to some, the ideal solution because it blends the best of the old with the best of the new. There are three major claims made by the constellation of existing approaches to physiotherapy that we might call 'hybrid' that physiotherapy can be:

1. Holistic, marrying psycho-social approaches to the biomedical and moving the profession beyond its traditional focus on the body-as-machine;
2. Person-centred;
3. Responsive to the changing healthcare environment, allowing physiotherapy to achieve its full potential by embracing both the heightened acuity and complexity of contemporary healthcare.

The biopsychosocial model (BPSM), person-centred care, 'active' patient management, and the recent turn towards psychologically-informed physiotherapy, are perhaps the most recent examples (47). These approaches have struck a chord with many physiotherapists because although they critique some of the passivity of past practices, they are primarily about professional expansion. They embrace the latent humanism of physiotherapy, whilst holding on to the profession's roots in biomedicine. They show that physiotherapists still know how to fix problems when the patient needs to be more passive (in acute illness or injury, for instance), but can also be responsive and supportive when the

client needs to be in charge of their own rehabilitation. They also reflect the truly holistic nature of 'real' clinical practice. Hybrid physiotherapy captures the complexity and person-centredness that advocates claim has long been part of the profession, whilst holding on to the rigour and objectivity of more traditional biomechanical physiotherapy.

But there are some significant problems with contemporary hybrid physiotherapy that the chapters in this book hopefully expose. Firstly, hybrid approaches may be encouraging physiotherapists to claim a degree of holism that they are not really entitled to. In almost every example of the biopsychosocial model applied to physiotherapy, for instance, the social aspects of health, including power, gender, class, race and ethnicity, and sexuality; social determinants of health, such as poverty, access, discrimination, environmental degradation, colonisation, employment, and housing; and cultural fields such as the media, economics, history, indigeneity, human and non-human relations, are entirely absent[1]. And even the full existential, relational, and inter-subjective breadth of human psyche is reduced to a set of behavioural and cognitive 'psychosocial' variables. Tellingly, these variables reside at the biomedical end of approaches to the human psyche, and sit comfortably alongside other biomedically strong disciplines like cognitive behaviour therapies, acceptance and commitment therapy, the science of brain and behaviour, and the new neurosciences. But these are a world apart from fully subjective, phenomenological, and non-Western approaches to thought and human connection. So claims that hybrid approaches make physiotherapy holistic may be overstated.

Secondly, because hybrid approaches are 'expansive', they threaten long-standing territorial alliances with other orthodox professions. To some extent, this is the nature of post-professional healthcare (see Chapter 7), and the end of the functionalist fantasy of healthcare as a cosy alignment of a few elite professions, will be no bad thing. But there is also a distinct risk that all of the established professions may unknowingly embrace the neoliberal ideal of a competitive healthcare marketplace by engaging in a territorial gold rush. Most established professions are now finding inducements to raise their professional prestige by managing higher acuity (usurpation and vertical encroachment from new intensive care paramedics, nurses taking over endoscopy, and podiatric surgery, for example), matched by the need to find solutions for the mushrooming social welfare crisis, caused by the explosion of complex comorbidities and the dearth of medical care in the community. The professions are being pulled, or, perhaps released, from their traditional moorings without a clear sense of who will do what in the future. This has serious implications for patients, who may find future healthcare much harder to navigate.

The growing complexity of healthcare points to the third problem with hybrid approaches, being the ways in which health professional ignore being more patient centred may be a proxy for the late capitalist deconstruction of healthcare. As Bill Hughes suggested;

> *'there is no doubt that this apparent democratisation of the relationship between professional and patient suited Western governments intent on reducing public expenditure and squeezing the welfare state. The idea of self-care and health maintenance is the layperson's responsibility rather than the professional became…, in the 1980s, important ideological tools in the privatisation of healthcare activity'* (49).

In the recent physiotherapy literature, person-centred practice has been interpreted quite specifically as the need for the patients to become less reliant on the therapist, and more focused on self-

[1] For a brief overview of the ways sociologists view the many bodies that are colonised by the BPSM, see (48).

management (46). So, rather than understanding person-centred care as a process of democratisation and empowerment — what Hannah Arendt might call 'action' — physiotherapists are describing the 'ideal citizen under neoliberalism', who is 'autonomous, entrepreneurial, and endlessly resilient, a self-sufficient figure whose active promotion (has) helped to justify the dismantling of the welfare state and the unravelling of democratic institutions and civic engagement' (50). Emphasising the patient's 'active participation in the planning of their care' (51), physiotherapists are realising 'the neoliberal idea of self-responsibility and entrepreneurial decision-making', alongside its accompanying technologies of neoliberal transformation: evidence-based practice, best practice guidelines, quality management, and hospital at home (ibid).

Perhaps the most important flaw in hybrid approaches to physiotherapy, though, stem from their inability to reconcile biological, experiential, and social philosophies of health. Truly embracing existential understandings of health and illness, or, conversely, grounding oneself in sociological philosophies, cannot be done without fundamentally challenging the basis upon which biological health is measured and understood (52). Many social theories, for instance, directly contradict biomedical beliefs about causality, truth, and reality, arguing that health and illness are socially constructed. Attempting to absorb or bolt conflicting philosophies on to biomedicine can only work, if practitioners operate only at the most superficial level and don't really question what their practice is actually doing.

The danger is that hybrid physiotherapy remains ostensibly the same, but now carries with it a veneer of holism: a form of 'holism-washing', if you will. In failing to engage deeply with the conceptual depth and plurality of the physical therapies, hybrid approaches risk accelerating the atomisation of healthcare, something we are already seeing with new language around the management of pain, breathing, movement, and some of the profession's other 'grand' concepts. I would argue, therefore, that the hybrid approaches accelerate the neoliberal drift of healthcare, do little to challenge biomedical hegemony, and do little to democratise access to the physical therapies.

So, what can be done?

How can physiotherapy advance the cause of the physical therapies in an increasingly interconnected world? How can we *improve* society's stores of knowledge and practices of the physical therapies, so that communities are more resilient and able to cope with adverse events in the future? How can we release the truly transformative potential of physical therapies, not just in the interests of human flourishing and social justice, but the planetary health of all things? In other words, how can we re-root the physical therapies?

Any viable alternative to the existing systems and structures must, at the very least, reflect and respond to the criticisms levelled at professions like physiotherapy in this book. It must do at least five key things:

1. Secure the best possible physical therapies for people, even if this is at the detriment of the physiotherapy profession's own power and prestige;
2. Reflect the fact that we are entering a post-professional era, where all orthodox professions are being displaced as the controlling voice at the centre of contemporary healthcare. It must

anticipate the unbundling of the health professions' privileged social enclosures, whilst re-imagining how people access the physical therapies in the future;

3. Help break Western hegemonic notions of health and illness, embracing much broader cosmologies. It must put intersectional social justice and social action at the forefront, rejecting the patriarchal normalisation and othering of Western healthcare;
4. Address the alienation of therapists from their communities and themselves, using the physical therapies as a tool for healing and re-connecting, not only with other people, but with the entire ecosystem. To do this, it must offer a revised understanding of the physical therapies that is adequate to the task;
5. And it must be able to function without defaulting to the controlling and exploitative interests of 'the state' and the late capitalist exploitation of 'the market'.

Until recently, it would have been hard to imagine how this might be possible. But new social theories and philosophies are emerging that point to myriad viable alternatives. In the final chapter of the book, I show one way in which the above five goals might be achieved.

But before doing this, there is an important question that needs to be answered, and that is why should physiotherapists, or *any* profession for that matter, even contemplate doing this? Even if all of the arguments set down in this book are accepted, what would make a prestigious, seemingly buoyant profession, relinquish the very thing it has worked for decades to capture, especially when, in doing so, it will lead to its demise?

There is a principle known as Chesterton's Fence, which argues that you should not take a fence down unless you know why it was put there in the first place;

> *'There exists in such a case a certain institution or law; let us say, for the sake of simplicity, a fence or gate erected across a road. The more modern type of reformer goes gaily up to it and says, "I don't see the use of this; let us clear it away." To which the more intelligent type of reformer will do well to answer: "If you don't see the use of it, I certainly won't let you clear it away. Go away and think. Then, when you can come back and tell me that you do see the use of it, I may allow you to destroy it'* (53)

So, any argument in favour of dismantling physiotherapy's enclosure should be based on a clear understanding of how the profession's territorial claim was constructed, and what would be lost by taking it down. And I believe we *do* now know enough now about physiotherapy's professionalisation project to know what will happen if we do, and if we don't, make the necessary changes.

I believe all of the evidence now points to the dramatic de-centring of the professions from Western healthcare, whether they want it or not. So even the most cynical practitioner should see some advantage in exploring feasible alternatives. But I also believe that most physiotherapists care deeply about their craft and want to see the physical therapies available to the widest possible audience. Unfortunately, the systems that they are forced to operate within often make it impossible to act in the best interests of the wider public whilst remaining registered and employed. As Marx put it, we are often alienated from the essence of our humanity and slaves to our labour.

But the two fundamentally important aspects of physiotherapy that mean I believe this alternative approach is both desirable *and* feasible, are that the physical therapies are ideally placed to play a key role in future healthcare, and that there is nothing fundamentally complex about them. The physical

therapies have been practiced for thousands of years and are likely to be practiced for many years more. In most cases, they do not possess the same complexity as neonatal cardiac surgery, kidney dialysis, or the development of new vaccines, so they should be a powerful resource for people to use in their pursuit of health and wellbeing.

But the primary reason why I believe physiotherapists will be able to radically change their practice, is because they will do so from a position of strength. As I pointed out earlier, physiotherapy has the advantage of being an established, loyal, and trusted orthodox profession; a respected ally to doctors, nurses, other professions; a diagnostician, whose work focuses on activity — and one of the most important conservative approaches to health and wellbeing. Physical therapies require little expensive equipment and are highly mobile, with most therapists needing just their heads and hands, and so it is the model of a low-carbon profession. So in the immediate future, physiotherapists need not worry about their job security while they transition to a new way of working.

Students in the 1968 French street protests used to chant the slogan — "Sous les pavés, la plage!", or, "Under the paving stones, the beach!" — meaning that if we just lifted up the paving stones and used them against those who had laid them down, beauty and freedom await. The sentiment is very much of its time, but as Judith Butler said much more recently; 'Sometimes you have to imagine in a radical way that makes you seem a little crazy, that puts you in an embarrassing light, in order to open up a possibility that others have already closed down with their knowing realism' (54).

But imagining radical alternatives has not, traditionally, been part of physiotherapy's métier. So, we will need allies if we are going to be able to think radically. Our knowledge, systems, and ways of working will need to be opened up to as wide a community as possible, so that new forms of cultural capital can be developed. Walter Benjamin believed that it was the students that should be the 'authors of a transformation' for a profession (55), but even this may be too narrow for the kind of transformation being called for here.

So, what can be done? If doing nothing, or taking a modern heritage, renaissance, or hybrid approach amount to the profession acceding to the stifling bureaucracy of the state and the bleak market logic of late capitalism, then what is possible? Well, what follows is an argument that once we start to imagine the physical therapies *beyond* the narrow confines of the profession, their truly transformative potential begins to reveal itself.

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9. Physiotherapy otherwise

Intensive therapies: Essence and shadows, Intensities — Re-enchanting physical therapy — Physical therapies are everywhere — Hollowing out physiotherapy — Transforming our teaching — Deschooling physiotherapy — Vernacular physical therapies — Physical therapies in common — Threats to the commons — Physiotherapy as an act of enclosure — All physiotherapy is theft — Neither the state nor the market — From individual rights and inclusion, to common rights, belonging, and abundance — Closing words

Over the course of this book, we have moved from thinking about what the professions are, to the middle chapters focusing on what they are not, and now we arrive at the question of what they might become. The theories we have interrogated have evolved from early structural thinking, through the need for us to consider the role of people's agency, and on to the problems of how to reconcile competing world views. These approaches have, in many ways, mirrored many of the major societal shifts. And so we now arrive at a moment when social theorists are grappling with how to make sense of the complexity, ambiguity, and uncertainty of life in the 21st century.

In working on this chapter, I was eager to develop a different approach to thinking about the future for physiotherapy than had been offered before. I wanted to be able to answer, as best as possible, the criticisms of physiotherapy levelled at the profession throughout the book (summarised toward the end of Chapter 8), and to address the three critical questions being posed by post-professional healthcare in Chapter 7. To do this, I sketched out five guiding principles to help me think through how physiotherapy might become otherwise. These were:

1. That the physical therapies will be vital for human flourishing *and* planetary health;
2. That the professions will be increasingly de-centred in people's experience of healthcare;
3. That decent, compassionate, and socially just healthcare will never be realised by the state or the market;
4. That it is the ethical responsibility of all professions that they create the conditions for their own demise;
5. And that when the pressures of maintaining a professional enclosure are removed, the latent potential of the physical therapies will erupt.

I suspect that what follows from this thinking will feel, to many readers, like some of the strangest and most challenging ideas they have ever encountered as physiotherapists. I have drawn on concepts, philosophies, and language that only a handful of therapists will recognise. And I have tried to push these ideas to their very limit. I am aware that this might put many readers off. But as I said at the opening of the book, this text was always as much about exploration as explanation, and I knew that any speculation on the future of the profession would always have to stray into unfamiliar territory. I can only hope that the work you will put in to making sense of these ideas is as rewarding for you as it has been for me.

What was strange about this exercise, though, was how easily the ideas came together. There seems to be a natural synergy between them that will, I think, start to reveal itself. And while all of the concepts and practices presented here are speculative, you will see that they are drawn from a wealth of recent scholarship, and from a wide range of contemporary philosophers and social theorists.

I have tried to present them in a way that reveals some of the astonishing latent potential of the physical therapies. But this chapter can only peel away the surface layer of *one* direction of future travel. The physical therapies 'bear the lightning of possible storms' (1), and physiotherapists are 'much freer than they feel' (2). So, I hope that there is enough in here to stimulate a thousand new inquiries, open physiotherapy up to a thousand new lines of flight, and a thousand ways we can break free from the tyranny of the past.

Intensive therapy

It would have been difficult to take a radically different view of physiotherapy, without some of the ground-breaking social theories and philosophies that have emerged over the last few years. The shift towards these new theories came with the work of theorists who turned their attention from the kinds of human-centred philosophies that had always been the basis of sociology in the past, to a more fundamental focus on the matter and objects that make up all things; human and non-human. These new ideas come from a wide range of theorists, including Pamela Alldred, Karen Barad, Jane Bennett, Rosi Braidotti, Judith Butler, Gilles Deleuze, Nick Fox, Félix Guattari, Graham Harman, Donna Haraway, Manuel de Landa, Bruno Latour, John Law, Gottfried Leibniz, Annemarie Mol, Baruch Spinoza, Isabelle Stengers, and Alfred North Whitehead[1].

The work of these new theorists begins with a rejection of the kinds of binary distinctions between what is real and virtual, human and non-human, body and mind, individual and social, quantitative and qualitative, that have beset the biological and social sciences for hundreds of years. They reject both the structuralism of Western biomedicine, functionalism, Marxian, Neo-Weberian, and critical theory, *and* the humanism of symbolic interactionism, ethnomethodology, and phenomenology. They especially reject efforts to reconcile these divisions found in holistic models of health and 'third way' social theories. Instead, they propose a radically different approach to our understanding of the world, beginning with a bottom-up reinterpretation of what constitutes matter, agency, affect, creation, being and becoming.

The first principle of these new theories is that human interests have dominated our thinking for too long. Our androcentrism (human-centredness), has encouraged us to think that people are more important than other entities. And so, not only have animals, plants, and inorganic matter been abused so that humans can prosper (leading to our present-day climate crisis), but we have also overstated the importance of human flourishing in our sciences. Once we create a hierarchy between humans, animals, plants, and things, it is only a small step to also extend this hierarchical ordering, and argue that some humans are more important than others (adding to the climate crisis with countless atrocities, acts of discrimination, and hatred). Rejecting this has been an important feature of these new theories, variously called post-humanism, new materialism, and object oriented ontology (OOO).

Instead of a hierarchical ordering, these new theories 'flatten' the relationship between all things, allowing all entities the same privilege. This becomes important because physiotherapists deal with more than human tissues. Their work also involves grappling with concepts and ideas, non-human objects, physical forces and biological flows, actions and intra-actions (3), individual thoughts and desires. And we have struggled in the past to see how these different 'events' might be given equal value in our practice.

These new theories focus on the idea that all things are made up of matter that is constantly circulating, and periodically condensing into recognisable forms. Crucially, though, these theorists argue that 'matter' includes things that are 'real' *and* imagined or virtual. They argue that ideas circulate and take 'form' just as much as atoms. This is a challenging concept for many people, especially those schooled in the objectivity of biomedicine. It is, perhaps, easy to imagine how 'real' entities are formed

[1] A summary of some of the main trends and leading authors in this rapidly expanding field can be found here: https://tinyurl.com/45mzm7ht.

by matter, after all, 60% of human body mass is made up of oxygen that was taken from the atmosphere minutes before. And this oxygen was once merely cosmic dust. But there are deeper questions here too that are just as important.

For instance, we think of the human body as a solid, bounded entity, but when does an oxygen molecule floating in the room around us actually become part of 'me'? Does it constitute 'me' when it is in the room, or only when it is in my trachea? Or maybe the blood or muscle? The biological and social sciences have struggled with concepts like this in the past. But our new concepts theorise 'immaterial' forms as no less 'real' than entities like cups and cars. So fictional characters like Harry Potter, are matter just as much as the 'real' patients in your clinic. And patients' hopes and dreams are matter just as much as nerve synapses. The real advantage of this shift in approach, is that it opens doors to some new ways to theorise the complexities we know to exist in the physical therapies.

Essences and shadows

The ideas behind this philosophy are, in many ways, quite straightforward, but they are challenging because they go against ways of thinking that have been prevalent since the Enlightenment (3–8). They argue that all entities — big or small, biological or social, real or imagined — have a fundamental 'core' or 'essence'. This essence defines what the thing is, but it always *exceeds* our ability to 'know' it fully. We can know what a cup is, for instance, but we can never exhaust its possible uses or meanings.

We are prevented from knowing the essence of something fully, in part because all things are 'coated' with layers of meanings and properties. These 'surface' properties, or adumbrations (meaning 'shadows'), can be removed or exchanged for other meanings and properties without the thing losing its essential identity. So, we might recognise an apple by its shape, colour, and taste, but an apple does not need to be red and shiny to be an apple. Cars can be red and shiny too.

Recognising the adumbrations we layer on to entities is important because it can help us to understand how something like physiotherapy works. All too often we have struggled to know why it is that some therapies bring about profound change, and others fail. We have struggled because we have spent so many years adding layers of theories, concepts, data, practices, techniques, and approaches to the physical therapies, that we can no longer see the essence of the therapies themselves. We have done this for many of the reasons set out in the earlier chapters of this book, but the effect has been to increasingly obscure the therapies that we claim to have an intimate connection with. Deleuze and Guattari call this process territorialisation (9). It is what we do when we impose a label or some particular meaning on a thing in order to control it. Deleuze and Guattari argued that we needed to focus, instead, on *de*-territorialising things; stripping away the added properties and layers of meaning, and in doing so brings us closer to the 'thing itself' (the 'noumena').

Intensities

At the 'heart' of any entity is its essence. But because this always exceeds our ability to capture it, or fully know it, it would wrong to think of the essence as representing a thing's *identity*. Identity is a concept that came from Enlightenment science, and is too definitive to be useful here. Instead, Deleuze and Guattari talk of an entity as expressing a number of *intensities*. These are driving forces or concentrations of vitality rather than physical structures, but they are still specific to the entity itself. It is the intensities inherent in touch, for instance, that has seen it persist as a feature of human society for millennia. So, although touch has many different meanings and properties that far exceed

human experience (its surface adumbrations), it has intensities that give it its distinctive power. We know touch is different to annular ligaments and cardiac arrhythmias, feelings of hope and experiences of pain, or goniometers and patient records, because of its intensities.

The theoretical shift that this thinking makes possible, allows us to completely re-conceive physiotherapy. Rather than looking to holistic models of practice to reconcile competing philosophies of the body, the mind, and the social, with all of the attendant problems outlined in the earlier chapters, we can focus instead on two approaches:

1. The first involves locating the intensities at the heart of the physical therapies. We know from our own practice just how powerful the physical therapies can be. How many times have we encountered an intensive moment of transformation, when some ineffable event occurred and a patient made a remarkable leap forward? The physical therapies are pregnant with intensities. Perhaps this is the reason why we have always sought to contain them, regulate them, and standardise their delivery? But, of course, the physical therapies will always exceed our attempts to capture and colonise them because they are radically transgressive and irrepressible (10). They are 'ungovernable energies and intensities that emanate from a series of unrestrained and often unpredictable conjunctions' (11). This is why they have been so consistently used by cultures throughout the world as vehicles for healing and care. *Locating* the intensities at the heart of this kind of transformative power would be no easy task. As mentioned earlier, the essence of an entity like touch and movement can never be fully grasped, and efforts to allocate new meanings and properties to the physical therapies would only serve to *add* surface layers to them.
2. So, the second approach involves the *removal* of as many adumbrations wherever we encounter them, so that the intensities at the heart of the physical therapies can be more strongly felt. This, again, is no easy task. Every definition, system of regulation, practice standard, best practice guideline, theoretical framework, textbook example, and model we have used in the past, has territorialised the therapies. They have shaped the way some authority or other has wanted us to experience the entity, and has sought to close off possible alternatives. All of these need to be unpacked, critiqued, and ultimately removed, leaving us to experience the physical therapies in their most unencumbered state.

Re-enchanting physical therapy

There is an enchantment to the physical therapies that has almost been lost over the years, as we have become increasingly concerned with governing people's conduct, establishing our professional prestige, the efficiency of movement, and financial accountability. But most therapists still practice in the hope of what Jenni Aittokallio and Anna Ilona Rajala called 'out-of-the-ordinary physiotherapy sessions' (12). Some of the disenchantment with physiotherapy comes from the layers of adumbrations we have added to the physical therapies. And this has two important effects: firstly, it conceals the vitality of the physical therapies, but secondly, it hampers change and growth. This is important because at the heart of any therapy is the idea of transformation. So to reimagine physiotherapy, and bring about radical new growth, we need to release the vitality of the therapies themselves.

The theories of Deleuze and Guattari, Spinoza, new materialism and OOO argue that all things have vitality and a will to persist and endure. The human version of this we might call consciousness or self-awareness. For centuries, people in the West have suggested that human cognition and reflexivity set us above animals, plants, and inert objects. But all entities possess what Spinoza, Leibniz, and Hobbes called *conatus*, or what Otto Schöndörffer called *Bildungstrieb* (13), Hans Driesch, *entelechy* (14), and Henry Bergson, *élan vital* (15). So privileging only human vitality ignores the fact that the vast majority of things in the cosmos, have endured over the vast span of time, without having anything to do with human existence, and have done so without us having any conscious awareness of them.

What constitutes this concept of vitality, then? The vitality of every entity is a function of both its intensities and its *surplus. This surplus is a form of possibility or potential which, by definition, may never be expressed. A stem cell, for instance, may never mature, but it holds a degree of 'potency', that means it* could become a glial cell, myocardial tissue, or a newer version of itself. An oxygen molecule can become a highly flammable compound or the water that puts out the fire. All of this is held by the entity without being actualised, and different entities carry different surplus possibilities.

In Deleuzian terms, this surplus is a form of desire: not in the human sense of an emotion often borne of a *lack* of something — I want to be a millionaire, for instance because I don't have any money — but in the more positive sense of latent potential. An entity's surplus is where creativity and newness reside, and where properties and characteristics of an entity become realised. Deleuze gives a powerful example of this when he describes the hand as the de-territorialised paw. In other words, the essence of 'the hand' was already within the surplus of 'the paw', waiting to be realised. Which begs the question, what new entities lie within the physical therapies, waiting to be actualised, if we could only de-territorialise them?

For surplus potential to be realised, entities must 'touch' others. A flame touches cotton and it burns. The burning cotton does not become a small tree, or plan tonight's dinner because these things do not reside within its surplus. But its potential to ignite and burn does. The cotton cannot realise its potential to burn on its own, however. It needs to touch another entity that also carries the right surplus. Touch a river, and the cotton will realise a different potential entirely.

Because all entities have the capacity to affect and be affected by other things, they operate in an 'affect economy' (16), based on the formation and collapse of endless *assemblages*[2]. These assemblages become therapeutic when entities enhance another's non-trivial capacities and tendencies to endure and persist, and open space for new entities to emerge, creating a host of new intensities and surpluses.

Judith Butler described assemblages beautifully recently, commenting on the idea, inherited from 'liberal individual ways of thinking', that humans 'overcome the formative and dependent stages of life to emerge, separate, and individuate', and 'become this self-standing individual'. The liberal fantasy is 'always an adult male in his prime, who, just at this particular moment when we encounter him, happens to have no needs and dependencies that would bind him to others'. Butler sees this as comic, in many ways, but also lethal because 'who actually stands on their own?';

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[2] Assemblage is a term that Deleuze and Guattari use to describe the interacting forces and entities that are in a constant state of flux in the world, periodically giving the appearance of fixity but are, in reality, endlessly mutating, shifting, separating, and recombining. Assemblage theory breaks with the traditional idea that we can understand the world as made up of stable entities (bodies, chairs, the Internet), and instead focuses on the 'dynamic and temporary, coming-together in specific arrangements to produce objects and subjects that have the appearance of permanence and solidity' (17).

> *'We are all, if we stand, supported by any number of things. Even coming to see you today—the pavement allowed me to move, and so did my shoes, my orthotics, and the long hours spent by my physical therapist. His labor is in my walk, as it were. I wouldn't have been able to get here without any of those wonderful technologies and supporting relations* (18).

Therapy, then, should be about opening space for the intensification, displacement, flow, and movement of entities across what Deleuze and Guattari called 'smooth' space (9) — or space unencumbered by rules, regulations, structures, and impositions[3]. Physiotherapists can play a huge role in intensifying the physical therapies, and re-enthusing our practice, by allowing them to express their transformative potential[4].

Firstly, we should acknowledge that physiotherapists are by no means alone in feeling disillusioned with the changing world around us. From post-colonial Indigenous scholars, to Pre-Raphaelite and Dadaist artists, romantic poets, and new nature writers, there have been numerous attempts to **re-enchant** what seems to be an increasingly divided, fractious, and fatalistic world (19–22). Max Weber suggested in the 1920s that disenchantment (*Entzauberung*) had been the West's master narrative since the advent of Calvinism and the birth of the natural and physical sciences (23). Charles Taylor argued that disenchantment began with the Enlightenment, and that, 'the only locus of thoughts, feelings, spiritual élan is what we call minds', and 'the only minds in the cosmos are those of humans' (24). In this world;

> *'the material cosmos is drained of meaning and animate vitality, available to be managed by the forces of instrumental reason and technological control. The human person herself is reconceived as a mechanism to be disciplined and policed, part of a social machinery that thrives on efficiency, homogeneity, and prudent calculation'* (25).

Jürgen Habermas believed that;

> *'the most deep-rooted and serious problems modern societies face, from human exploitation to environmental destruction, were caused by the needs and values of 'the system' encroaching upon the 'life-world', thereby marginalising our capacity to effectively raise and address system-dominated values and practices'* (26).

So, how do we re-enthuse our practice and re-enchant the physical therapies? Our socialised instinct has always been to look for more control, more expertise, more definitional clarity, more prestige and power. But this has only distanced us from the essence of the physical therapies and the reasons we became therapists in the first place. My suggestion here, grounded, I hope, in the previous chapters of social theory and new philosophies, is that we look to doing the exact opposite of this: finding all of the ways we have added adumbrations to the physical therapies, and removing them; freeing them up so that their vitality can be accessed more easily by people.

3

4 It is perhaps no coincidence that the word enthusiasm beautifully described the idea of intensities and essence, given that it derives from the Greek words *theos*, meaning god, and *en*, within.

Physical therapies are everywhere

Many physiotherapists will be anxious about letting go of their professional identity and primary source of income and may be quite resistant to change for all of the reasons discussed in the last chapter. But there are examples we can draw on from other areas of contemporary society that suggest their work could morph and transform in a very positive sense while the physical therapies re-establish their vitality. One such example comes from food culture.

Food culture is now a vast global industry that has exploded in the Internet age. It has brought the work of chefs, film-makers, journalists, authors, and social media influencers to the public's attention like never before. And it has fuelled support infrastructures like building and interior design, logistics and supply chains, innovations and technologies, tourism, and popular culture. It has become a competitive sport, a popular pastime, and an arm of the entertainment industry. It asks fundamental questions about water and food sovereignty, the value of legislation and behaviour change, the psychology of pleasure and the morality of indulgence, the power of coercive marketing and language, the climate costs of enjoying tomatoes in winter, and the downstream impact of lifestyle illnesses like obesity and diabetes. As well as offering more granular advice, meal plans for lactose intolerant children, new ways to prepare quinoa, and ten uses for a sous-vide.

There are many reasons for the explosion of food culture around the world: television and the Internet, the neoliberal emphasis on personal choice and consumption, the masculinisation of cooking, and so on. But one of the main drivers has been the seemingly strange behaviour of the chefs themselves. These people demonstrate their prowess, not by regulating their practice and restricting access to their skills and knowledge, but by their generosity and largesse. Celebrity chefs not only do all of the work of devising new ways to cook, they design new recipes, and teach you all of their techniques. They explain their ethos and influences, and share their passion for food. And then they give it all away. Over and over again.

One might think that this would mean people stop buying cookery books because surely all of the world's recipes are known by now? And surely, it has oversaturated people and dulled the allure of food in their eyes? Apparently not. In fact, the effect has been the reverse. Cookery books and magazines are some of the market's biggest sellers, and most newspapers carry food sections. Millions of people subscribe to food YouTube channels and Instagram feeds, and streaming media are full of food programmes. The diffusion of food culture into the life-world seems to have only fuelled people's desire to become better cooks, bakers and cup-cake decorators, bread makers, wine connoisseurs and coffee aficionados, restauranteurs, and food tourists[5].

But, at the same time as we have seen an explosion of interest in food culture, a small group of registered nutritionists have also been plying their trade. In New Zealand, a country with a population of just over five million people, there are only around 400 registered nutritionists. This means that there is one registered nutritionist for every 12,500 New Zealanders (comparable with the number of physiotherapists). Their work mostly involves treating people within the health sector, advising on diets for people with complex co-morbidities, and those recovering from metabolic disorders, debility and surgery. By law, they are the only people who can do this.

[5] For an example of how physiotherapy can be analysed through the prism of contemporary food culture, see (27).

Is their claim to being nutrition experts justifiable today? Does their university qualification rightly elevate them above the many other forms of knowledge now circulating in world food culture? Does their affinity with biomedicine justify the legal protection and financial security they get from being state employees? Does it blinker their practice? Does their work require them to be registered nutritionists? Given their relative size, can nutritionists claim to 'own' any aspect of food culture today? Their work is important, but it represents only a tiny speck in the vast cosmos of modern-day food culture. The physical therapies are, in many ways, similar (28). So, what I am suggesting here is that we now need to reverse the course that the profession has taken over the last century and give up our quest for power, prestige, and autonomy, so that the knowledge and skills we have acquired over the last century become just as ubiquitous as cooking.

As I mentioned earlier, some people may argue that we need to contain the physical therapies within a professional enclosure in order to protect the public from harm. Certainly, there are some aspects of physiotherapy that are risky and require special skills, but here again comparisons with food culture are worth making because badly stored and prepared food can kill people perhaps just as easily as a therapeutic procedure. And no-one would suggest that everyone who cooks a chicken casserole should become a registered chef. It would not be possible anyway because people know that the *intensity* of food will always exceed the capacity of society to govern it. The physical therapies could, and I would argue *should*, now be seen the same way.

Hollowing out physiotherapy

But how to begin? Although professionals rarely ever ask whether 'other institutional or organisational forms than professions could deliver knowledge and expertise faster, better, cheaper, more consistently' (29), I think there could be some real benefits in physiotherapists doing this now. What I am proposing, then, is that we might begin a thought experiment, designed to map all of the aspects of physiotherapy that are already liable to disruption, and using this as the starting point for stripping away the adumbrations we have added to the physical therapies.

Consider physiotherapy as a large square drawn on a piece of paper. This square represents the entirety of different knowledges, skills, attitudes, concepts, learned approaches and dispositions, beliefs, values, and philosophies, that embody the profession today. Now consider anything that you do that can be written down or explained to someone else in a structured, logical way. Consider anything that could be written out as a series of steps, a therapeutic plan, or as an instructional guide, for instance. Imagine smaller boxes, within the larger square, representing how much space each of these take up, (keeping in mind what you think occupies the space left behind). Now 'remove' these smaller squares because these represent the things that will almost certainly be given to someone (or something) much cheaper to train, employ, and update than us in the near future.

Now consider anything that you do in your patient assessments, advice, or treatment programmes, that is routine or can be standardised, that you do repeatedly, or that is labour-intensive, or a physical task that requires little specialised knowledge or skill. Not only the kinds of work that is now increasingly delegated to assistants, but every task you perform that can be seen as habitual, generic, context independent, or conventional. Give each of these their rightful space in the bigger square, and then remove these too. It is highly likely these will be lost as part of healthcare's long-fuse, big bang.

Then look at anything that is common or shared between you and a large group of your colleagues, whether it is an established clinical approach or method of thinking or working. 'Cut' these out because AI algorithms will almost certainly take these from us. And now take out all of the work you do to advise and guide because this is already, or will soon be, available to people online.

What remains will no longer resemble a professional identity, and certainly not one that corresponds to our current understanding of physiotherapy. Why then should you try it? Firstly, you should do this because it will help you to find tangible examples of the adumbrations that may soon be lost from physiotherapy, whether we choose to strip these layers away or not. Every profession exists within a 'highly fluid, interconnected and global' social context today, and professional territorial claims that were once strong, are increasingly 'giving way to generalisation, flexibility and the erosion of professional power and privilege' (30, 31). So removing these adumbrations may help to anticipate what the future for the physical therapies may look like.

Secondly, the exercise serves to remind us that the health professions are simply one historically contingent response to a set of questions, and only one of a number of occupational arrangements in the modern division of labour (29, 32). There is nothing about the physical therapies that presupposes the existence of disciplines and professionals (33). Indeed, as I suggested earlier, there has been some significant violence done to the intensities at the heart of physical therapy in their capture by physiotherapists, and stripping away this 'exaggerated fixity' (34). So stripping away the layers of knowledge, skills and attitudes that generations of physiotherapists have added to the physical therapies might remind that the physical therapies existed long before the physiotherapy profession attempted to colonise them, and will survive well beyond the this current historical moment.

And thirdly, the experiment invites physiotherapists to anticipate the change to come and embrace the possibility that they too might be agents of change. Stripped of its adumbrations, it would be easier to feel the warm glow of physical therapy's *intensities* and envisage new physical therapy connections and relations, new assemblages, and new roles; subjectivities that seem impossible within the current ethos: physical therapy as action, touch and reciprocity, shared activity and empathic work, breathing and planetary health, movement pluralism and social justice, touch and mental flourishing, exercise and community resilience. By pruning the physical therapies back, we allow a thousand new shoots to appear.

Transforming our teaching

Hollowing out physiotherapy can also take another, more critical form, if it accounts for the layers of unseen prejudice, stigma, and injustice that are part of the patriarchal, normalising, and othering practices of all orthodox professions in the Global North (35). There is little doubt that education can be 'a modality of freedom' (36), but, as Alexander Jones argues, it can also be a tool for curating and restricting knowledge, 'brain-washing', and socialising people into cult-like obedience with troubling ways of thinking and acting (37). Education can be 'a hotbed of injustice and power imbalances' (ibid).

Physiotherapists can no longer be party to the social 'waste-sorting' (38) that modernisation and economic progress have foisted on the professions. Bauman argues that Western societies have created many kinds of 'waste', including waste people (people we have cruelly marginalised in society:

migrants, disabled, racialised, women, queer, elderly, etc.), waste goods (money, consumer products, time), and waste matter (pollution). And the economies of the Global North have depended on the professions, including physiotherapists, to manage these 'superfluous' elements in society, and ensure that they do not impede the West's growth and prosperity.

The response of health professionals in the West, has largely focused on developing practitioners' 'analytical, evaluative, synthetic, and logical' thinking skills (39), in the hope that these will allow professionals to analyse clinical data, diagnose underlying pathology, and rationally synthesise information. Arno Kumagai and Monica Lypson argue, though, that because medicine is a social practice, the 'development of critical thinking alone may lead to great technical skill without an accompanying understanding or ability to effectively address healthcare-related issues confronting society' (ibid). They call instead for greater critical consciousness (see Chapter 4), so that health professionals can better understand 'differences in power and privilege and the inequities that are embedded in social relationships' (ibid).

Our new theorists approach this demand differently. By working to strip away the layers of unseen prejudice, stigma, and injustice from the physical therapies, we allow ourselves to become, in Deleuze and Guattari's term, 'minoritarian' (9). Becoming minoritarian is a deliberately molecular political strategy, quite different to the grand, 'molar' structural politics of Marx and critical theory. It is an act of stripping away the dominant social discourses of science and reason, the biological body as source of illness, the primacy of biomedicine, objectivity, detachment, and reductionism. It rejects prevailing norms and the will of the majority. It is the active casting off of power, and opening the physical therapies to de-territorialisation, metamorphosis, and uncontrollable movement.

Deleuze and Guattari argued we should be becoming-woman, becoming-animal, becoming-queer, becoming-other, becoming-multiple (9). Becoming minoritarian is to rid ourselves of the patriarchal, humanist fantasy that we are 'makers of worlds' (40), and recognise instead that we are 'defined by precarity' (ibid); that we are always 'unfinished, open-ended, perpetually in process' (41), and using this knowledge as 'a riposte to the timeless, absolute status of official ideologies' (ibid).

Reframing physiotherapy education in this way is to embrace something of the liminal and fragmentary nature of the physical therapies. It opens practice and thought to more choice, more diversity and inclusiveness, and less power and control by institutions like the professions, the state, and corporate markets. It is to enact 'cooperative alliances, aggregations of conviviality and affinity at the level of society that materially deform the state power that threatens to saturate them' (42). It is to embrace the idea of physiotherapy as one option for people among many, rather than perpetuate our 'special pleading about how society as a whole would benefit' (29), if there were more of us and less of 'them'.

Deschooling physiotherapy

There are many ways we obstruct immanent and intense engagements with the physical therapies. Every time we try to identify what we experience; define it and try to explain it to others; build theories and concepts around it; construct models and frameworks to connect it with other experiences; decide some should control access to this special understanding, and so establish curricula, proper standards, rules, and codes of conduct; legislate to protect it; incorporate it into a grand global structure that harmonises everyone's experience; and incentivise some to ensure the

system is stable, we slowly bury the essence of the thing itself in layers of sediment. Western education systems have been powerful perpetrators of this, reminding us of the dangers of assuming that seemingly well-intentioned acts can ever be unproblematic and benign.

In his landmark 1971 book *Deschooling society* (43), Ivan Illich took issue with the prevailing post-war belief that the problems with education lay at the door of old-world authorities, like the church, the family, and the state, and that emancipatory education could be achieved by funnelling resources to poorer schools, and overturning longstanding power asymmetries. Illich believed that all such claims did little to really disrupt an education system that he believed had little reason to exist in the first place.

Over a series of books following *Deschooling society* (44–47), Illich argued that the main purpose of the education system was not to enlighten people, but to create and define the very needs it then claimed to address. In the case of Western education, the main reason for having schools was to produce experts, whose primary purpose was then to justify and support the very system that had produced them.

Illich believed that being taught to need and *consume* the services of experts had become a particularly important feature of education after 1900. For much of human history, society had been defined by mutuality, locality, immediacy, and satiety, and people developed interests in the world around them by pursuing their curiosity, engaging with others, and play (48). Modern society had replaced these relatively autonomous acts of self-discovery with institutions through which people were increasingly compelled to move (a similar argument can be seen in Foucault's notion of societies of control, see Chapter 6). Illich argued that we needed to be 'educated' through these institutions 'Because being schooled, transported, entertained, etc., — consuming a service dispensed by someone licensed to provide it — is a radical novelty in the life of humankind' (ibid).

Like Rancière's *Ignorant schoolmaster* (49), Illich believed that the task of education was to bring entities closer to each other, and to remove all of the barriers and extrinsic impositions interposing between them. From our anthropocentric position, it is hard to see how people might experience the physical therapies *without* the layers of sludge we have built up around them over the years. But most physiotherapists also recognise how overwhelmed physiotherapy has become. College training programmes, for instance, can no longer cope with the demand for their programmes to produce students who are as capable as past practitioners, as well as being evidence-informed, culturally competent, interactively sophisticated, empathic, and academically rigorous. Perhaps unsurprisingly, teachers 'are uncertain about how to educate students who are expected to know more, do more and, importantly, become more' (50). Our answer, thus far, has been to lay more and more sediment on to an essence we can now barely perceive. The time has surely come to look at ways people can engage in the physical therapies without needing to be schooled how to do so?

Vernacular physical therapies

I suggested earlier that perhaps one of the reasons why physiotherapists had always sought to capture the physical therapies, was because they are so vibrant and pregnant with intensities. Western Judeo-Christian societies have always had a complicated relationship with the sensuality of touch and movement, and so 'taming' the physical therapies allowed the profession to claim social prestige, by addressing at least one important social anxiety. But because the physical therapies also possess

exuberance and fecundity, they fed tremendous latent power to the profession, which was able to make enormous profits from physical therapies' intensities.

Attempts to impose order on the physical therapies, though, was always going to be challenging, especially when the model of elite professions was one of coherence and uniformity. Physiotherapy's answer was to select forms of physical therapy that it could contain and control, and then set about legitimising and consolidating its framework, and exporting it as a unified image of professional practice around the globe. Still, to this day, international physiotherapy curricula and scopes of practice are remarkably consistent.

Asserting the uniformity of physiotherapy has been a century-long project in socialisation and social closure, that has demanded enormous effort and significant conformity from physiotherapists. But the amount of time and energy that we have had to give to controlling the physical therapies, has only served to reinforce how unnatural and problematic this kind of action is, and how concerned the profession must be with the latent intensities of the physical therapies themselves.

But the problem of physiotherapy's lack of diversity is really only a problem mirrored throughout our ecosystem now, where species diversity is under significant threat. When there are thousands of banana varieties, for example, but we choose to draw 99% of the world's exports from only one variety (called *Cavendish*) (51), the risks to local ecosystems becomes obvious. Not surprisingly, many are now calling for an approach that is vernacular and attentive to a locality's history and culture, built on new forms of solidarity and piecemeal change (52).

Increasing diversity can only occur when intensities are understood as local, contingent and vernacular. 'Vernacular', here, means practices that are harmonious, responsive, or close to a particular community. In architecture, it means buildings that blend into their surroundings, often made from local materials. High-rise tower blocks in the middle of the rainforest are the opposite of vernacular. Ivan Illich saw vernacular forms of art as colloquial, instinctual, and, often, untaught (48).

Vernacular physical therapies would respond directly to a particular locale. In Ezekiel Emanuel's latest book, for instance, he asks *Which country has the world's best healthcare* (53)? After surveying 11 countries (Australia, Canada, China, France, Germany, Netherlands, Norway, Switzerland, United Kingdom, United States, and Taiwan), Emanuel finds, of course, that what constitutes the 'best' healthcare depends on where you live and what you want. Some people prefer centralised universal health coverage, others will be most concerned about the cost. Some will be most interested in choice, or access to the best specialists, clinics, and hospitals.

In vernacular physical therapies, therapeutic priorities derive from the community, rather than the practitioner, the market, or central government. Physiotherapists can play an important role here, by using their social capital to improve people's access to the kinds of physical therapies that can bring social equity and justice locally, and addressing the social conditions that predispose to poor health (hunger, poverty, discrimination, poor access to services, sub-standard education, pollution, etc.). But they can also use their experience and wisdom to strip away the fantasy that there can only be one physiotherapy and open the door to a thousand (local) alternatives.

Jettisoning the idea of a coherent and singular professional identity will be, perhaps, one of the most significant steps physiotherapists can take towards liberating the physical therapies. And while this sounds an immensely complex task, work has already begun on de-centring the profession (12, 54–68). These works offer pointers to the ways we might begin the transition, but much more is needed if we are to arrive at the point where the physical therapies are common to all.

Physical therapies in common

Perhaps the most radical idea put forward in this book is for physiotherapists to relinquish their claim to the physical therapies, and actively work to 'return' them to 'the commons'. I will explain what I mean by the commons shortly, but I should first say that if we accept that physiotherapy is now only one, and an increasingly de-centred, way for people to engage in the physical therapies, then any claim to be 'returning' them to the people are already spurious. Physiotherapy never really owned them in the first place. No profession could 'own' therapies that have been used by civilisations since the dawn of humanity. But, as Sarah Nettleton has pointed out, 'the development of biomedicine and the associated hegemony of the medical profession', caused a significant decline in healing systems and therapies that had been marked by much more diversity and permissiveness prior to the 19th century (69). And physiotherapy has been a notable beneficiary of this, as it enclosed some of the most stable and marketable forms of physical therapy and claimed them as its own.

The idea of 'enclosure' is a powerful metaphor here. Prior to the Industrial Revolution in Europe and North America, large areas of land were open, allowing people to move freely, graze herds, grow crops, and store supplies. These commons began to be lost in a series of enclosure acts that began in the early 1600s, eventually putting nearly seven million acres of land in the UK alone, into the hands of private interests. As well as fuelling early capitalist market economies and changing rural landscapes, the theft of the commons also disturbed customs and traditions that had defined the social order since the Magna Carta and the Charter of the Forest;

> *'Standing for the traditional practices of commoning which included mutual aid, neighbourliness, and mixed economic welfare, the Charter of the Forest was quietly forgotten with the rise of capitalism and the proletarianization of the common people, the enclosures movement, the renewal of slavery, and the rise of the Atlantic colonies. Under the yoke of the new economic principle of commodification and privatization, the common people were demonized (women gathering in the forest became witches) and criminalized (men taking from the land became thieves and pirates)* (70).

The commons, then, refer to anything that belongs 'neither to the human law nor to the divine' (71), and today includes, 'land, water, air, digital commons, our acquired entitlements (e.g., social security pensions)', as well as 'languages, libraries, and the collective products of past cultures' (72).

> *'Community gardens, food sharing, forms of credit, shared spaces/transition towns, coastal marine commons, community forests/open spaces, seed saving/sharing, commons-based peer production, Creative Commons, free software, innovation commons, peer-to-peer music sharing, shared grid electricity commons* (73) .

Indeed, consider anything that you would not want taken from you, only to be sold back to you for someone else's private gain, and anything that you would not want the state to regulate, including your freedom of movement, your cultural heritage and genetic legacy, your dignity and ethical principles, your education and ideas, beaches, forests and streets, your sport and leisure, your ability to make your own everyday arrangements and to help the people closest to you, and you have a sense of why the idea of the commons has been 'one of the most important focuses in social theory within the last decade' (74).

This shift has happened, in large part, because of our sense that the manifold challenges of the future, now demand new (old) thinking (75). People have become increasingly aware of the costs of replacing mutual co-dependence and solidarity with competition, autonomy, and human exceptionalism, and how much these costs fold directly into our health and wellbeing.

Threats to the commons

There are no shortage of vested interests vying to turn things that we all share in common, into personal and private gain. But capitalism has also always exploited less obvious forms of altruism, gifting, and social investment because these allow market economies to be run at low cost, maximising profit. Slavery and indentured labour work this way. But so does the gendered division of labour.

Silvia Federici's work has been particularly important here, drawing a direct link between feminism and the theft of the commons (72, 76–78). Her work;

> *'begins with the realization that, as the primary subjects of reproductive work, historically and in our time, women have depended on access to communal natural resources more than men and have been most penalized by their privatization and most committed to their defence'* (72).

As she wrote in her book *Caliban and the witch* (79);

> *'in the first phase of capitalist development, women were at the forefront of the struggle against land enclosures both in England and in the "New World" and they were the staunchest defenders of the communal cultures that European colonization attempted to destroy' (ibid).*

Federici argues that it is women's bodies that are always the first to be exploited by capitalism, and so any model of social organisation must be tested against the degree to which it addresses women's ongoing subordination (72). She argues that, we must be very careful, 'not to craft the discourse of the commons in such a way as to allow a crisis-ridden capitalist class to revive itself, posturing, for instance, as the environmental guardian of the planet' (76).

Nobel prize-winning economist Elinor Ostrom's work also concerns threats to the commons, but examines instead the question of people's greed. When the idea of a return to the commons first began to gain credence in the 1960s, Garrett Hardin wrote a now famous paper titled *The tragedy of the commons* (80), which argued that 'Left to collective ownership… individuals would abuse the system and wreck the commons' (81). Hardin argued that it was human nature to exploit something that was free, and look to gain personal benefit from it. Hardin believed this meant that state regulation, legislation, and private markets were inevitable. But what Ostrom and her husband, Vincent, showed was that Indigenous peoples all over the world had successfully managed common resources for thousands of years without the need for government oversight, democratic control, or private enterprise (82–85). Elinor Ostrom's work, Silvia Federici argued, showed that 'the world contained a large body of common sense' (20);

> *'People, left to themselves would sort out rational ways of surviving and getting along. Although the world's arable land, forests, fresh water and fisheries were all finite, it was possible to share them without depleting them and to care for them without fighting. While others wrote gloomily of the tragedy of the*

commons, seeing only over-fishing and over-farming in a free-for-all of greed, Mrs Ostrom, with her loud laugh and louder tops, cut a cheery and contrarian figure' (ibid).

Physiotherapy as an act of enclosure

So how does the existence of the physiotherapy profession relate to the question of the commons? Eliot Freidson showed in the 1970s that any discipline making claims about its professional status relied on being 'deliberately *granted* autonomy, including the exclusive right to determine who can legitimately do its work and how the work should be done' (86). Freidson believed that this showed that the fight for professional autonomy always came with a degree of deference to a higher authority. In physiotherapy's case, higher authority represented the twin powers of the state and the medical profession. But physiotherapy was not alone in this. Pamela Abbott and Liz Meerabeau argued that 'a sector of the middle-class — including caring 'professionals' — (was) prepared, indeed in some cases eager, to accept the historical constraints of professional status in order to acquire what it sees as its freedom of action' (87). This included obedience to 'patriarchal assumptions and definitions which then became incorporated into the new profession' (ibid).

But the pursuit of autonomy carried with it the implicit necessity to demarcate a professional territory and assiduously police these manufactured boundaries. In some cases, boundaries were crafted around inventions and discoveries that built on common knowledge and resources, and put the dividends in the hands of specialists. But in many other cases, professional enclosures have been, in George Bernard Shaw's famous phrase, 'a conspiracy against the laity' (88). And all too often, 'freedom for the wolves has often meant death for the sheep' (89).

'It is important to note', David Bollier reminds us, 'that enclosures are not just appropriations of resources. They are also attacks on communities and their practices of commoning' (51). Anything, in theory, can be enclosed if a large enough group of people have the will and the strength to do it. The idea of terra nullius, for example, was a term meaning 'nobody's land' that was set down in European law to justify acts of empire and colonisation.

Physiotherapists have historically laid claim to the body, movement, posture, physical function, rehabilitation, and a host of other commons. And in claiming the body, they follow the colonial convention of declaring it terra nullius, (or, in this case, *soma* nullius?). By adopting the idea of the body-as-machine from medicine, physiotherapists were able to treat everybody as virgin territory. The person's beliefs, culture, history, social context, spirituality, and personal values could be suppressed, allowing the focus to fall almost entirely on the landscape of pathology, and the expertise of the therapist in mapping it. The therapist creates a border between themselves and the patient, who is asked what they have to declare (the patient assessment), before being offered the passport into treatment. And these ever-shifting boundaries are policed by regulators, educators, and peers, to ensure the profession's enclosure remains intact.

All physiotherapy is theft

Physiotherapy's claim to the special privilege that it derives from its work, stems from two rights: firstly, its right based on occupation — that it was the first group to formalise a legitimate approach to the physical therapies — and, secondly, its right based on its labour. Both of these claims, though, have been shown to be spurious, most notably through the work of Pierre-Joseph Proudhon (1809-1865) (90). Proudhon is known for popularising the belief that we should be skeptical of all forms of government and social hierarchy, and for writing a book titled *War and Peace*, that Leo Tolstoy used as the title for his later work in honour of Proudhon. But Proudhon is most famous for coining the phrase, 'All property is theft'.

Proudhon asked how it was possible for someone to 'own' something. Claims on the basis of being a founder or first occupant are problematic because they demand everyone else's consent. If a hundred people settle a new uninhabited island, for instance, they should, in theory, all acquire a one-hundredth share. But what happens when a baby is born, or an invading force comes and overcomes the settlers? Is the land divided evenly again? Simply being the occupant of a territory, therefore, cannot confer 'ownership', but rather the right to be the temporary 'tenant', or user of a territory or some resource that we all have an inalienable share in common. We are justified in using the sun and the moon, fresh air, land and water, thoughts and ideas, customs and ways of living, as long as we also guarantee their use for others.

But claims to ownership on the basis of our labour are also problematic. If I labour in a river to catch a fish, do I own the fish? Do I own the river? If I make a chair, is it mine? Perhaps, but only if your labour was the only labour that made the wood, the tree it came from, the land it was on, and the resources it needed to grow (sunlight, bees, rain, etc.). You would also need to be the owner of the social system that supported you (the manufacturer of the saw you used to cut the tree down, the house you put the chair in, and so on). And if I claim ownership through my labour, what happens when I become idle, I lend my chair to someone else, or I rent out some of my land to other users? Do I cede ownership to them? And how do we redistribute resources if people claim to own something because they laboured on it a hundred years ago?

In both cases, Proudhon argued that all claims of ownership amounted to theft, and that all things are only ever borrowed. People have a right to the added value they give to things through their labour and occupation, but this value should be based on justice for all, and laws known to everyone. Proudhon argued, therefore, for a society based on local contractual arrangements among individuals free to negotiate under conditions of justice. Such a system should never be coercive, centralised, or commodified, leading to an idea fundamental to the commons, that neither the state nor the market should have control over society.

Neither the state nor the market

Part of the reason for the recent resurgence of interest in the commons has been people's perception that neoliberalism has subordinated; 'every form of life and knowledge to the logic of the market' (72), and that this has 'heightened our awareness of the danger of living in a world in which we no longer have access to seas, trees, animals, and our fellow beings except through the cash-nexus' (ibid).

But, at the same time, we have also become disillusioned with the idea of 'The State' as a viable alternative (see Chapter 7). Antonio Negri argued in support of the commons because it would mean that;

> *'we no longer cede to the state, or capital, or any other external power (the churches, the mosques, the synagogues — in short, to the force and madness of command, which works by way of charity) the role of managing what is ours'* (91).

Proudhon argued that any system that constrained our choices (through a scope of practice, for instance), forced us to act in a particular way (regulatory authority), or constrained our ability to learn to make our own decisions (professional training), was immoral, and that mutual co-dependence should replace all forms of compulsion[6]. Only through sociability, association, and mutualism based on our shared rights and duties, do we achieve the greatest justice, freedom, and equity (94). The commons, then, are fiercely opposed to both ideas like Communism and any form of state control, *and* rampant individualism. Some echoes of this sentiment in physiotherapy can be seen in the recent work of Eline Thornquist and Hilder Kalman;

> *'And increasing interest for private enterprise is evident among Norwegian physiotherapists, a development fuelled by the contemporary concern with the body and health, producing a market for exercise and training. These changes are putting the tensions between the market versus the state, between interest in profit-making versus social mandate, on the professional-political agenda anew'* (95).

The existential and physical crisis we all face as intermingled and co-dependent entities has forced Michael Hardt and Antonio Negri to argue that we now have to completely rethink the concepts underpinning collective social life on the planet. The old capitalistic language of public and private, of individual rights and inclusion, now needs to be replaced by mutual association, or an 'open network' built around common rights, belonging, and abundance. (96).

From individual rights and inclusion, to common rights, belonging, and abundance

Hardt and Negri's proposed shift moves first from the idea of individual rights to common rights. Individual rights have often attempted to retain the idea of the autonomous, sovereign, individual subject, and connect this to an abstract universal standard. Common rights, on the other hand, are embedded in a particular vernacular ecology, with its distinctive forms of labour and practice, and its customs that are independent of the law and the state (97). Antonio Pele and Stephen Riley argue that shifting from individual to common rights renews our emphasis on conviviality, shared subsistence, and resists attempts to enclose the commons by people and groups who would seek to exploit it and exclude others (98).

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[6] Although Proudhon is speaking specifically about human relations here, in recent years, the same logic of mutual co-dependence has been taken to mean relations between all things. Proudhon's work has become increasingly important in understand how we might break away from the human exceptionalism underpinning anthropogenic climate change (92, 93).

The second shift is from the idea of inclusion to belonging. Inclusion has, for many years, been a powerful term for critical theorists and social activists. But as Paul Virno argued, inclusion assumes that individuals have an affiliation with the same universal standard (everyone wants to be 'normal', for instance), and a whole that corresponds to the sum of its parts. Belonging, on the other hand, assumes all entities share a pre-individual commons, that we then supplement and build upon; what Virno calls a 'surplus-commons' (99)[7]. People's interactions, acts of caring, digital knowledge production, cohabitation, community building, and breathing, are all acts of social production that create surplus intensities: feelings, objects, ideas, and ways of being, that are impossible for anyone to own, measure, standardise, or enclose (44). They 'cannot be bought off as private property nor can (they) simply be managed or regulated by socially attuned states' (70). They are 'generative and productive power(s)' in their own right, they 'escape the problem of defining rules of inclusion or exclusion' (72), and contain the 'habits, training, and dispositions necessary for absolute self-rule of the many by the many' (70). They point to the possibility of a society built on abundance', with 'the only remaining hurdle confronting the "multitude" being how to prevent the capitalist "capture" of the wealth produced' (72).

Peter Frase's recent work *Four futures: Life after capitalism* (103), tackles this possibility head-on. Faced with a global society in which abundance for all has become attainable, how do we decide how to share what is in common? Frase proposes four possible solutions based on two axes: the first runs from abundance to scarcity, the second from equality to hierarchy. Frase sees the worst-case (of scarcity and the presence of powerful state or market hierarchies) as leading to a very bleak future, what he calls 'exterminism'. Such a system would see a few extremely wealthy individuals living on floating offshore islands, while everyone else fights to survive.

Frase's more optimistic vision is of abundance *and* equality, where hierarchies still exist, but these are not dominated by status and money. In such a society, people would be able to 'procure (their) basic needs — housing, healthcare, or just money — without having to take a job and without having to satisfy any bureaucratic condition… you get these things simply as a *right* of being a citizen, rather than in return for doing something' (ibid, p.51)[8]. And while this may sound fanciful, we should remember that much of the talk about the future of work now points to a future in which our economies decouple the link between labour and income (104–109). Of course, speculation about the 'end of work' has been a pastime of labour scholars for decades (Keynes predicted the 'end of work' and a one-day working week in the 1930s), and such speculation often presumes the kind of strong state intervention that makes mechanisms like Universal Basic Incomes or Services appealing (101). Commoning suggests, though, that one of the main reason why we have yet to fully detach work from abundance and equity is because we have always thought that the answer lay in the state or the free market, when clearly neither of these have offered workable solutions; 'The world order of economics and the educational systems that support it are uneconomic, ecologically unsustainable and intrinsically unjust, and they will continue to find new ways of being so' (36).

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[7] Note the difference between the idea of common rights and belonging, and the ideas of Universal Basic *Service* (100, 101). Some have argued that 'health, more than employment, education and welfare, is the fundamental entitlement of citizenship' (102); an approach that has underpinned welfare state models throughout the world. Common rights and belonging take a different view, rejecting the idea that central government should have a powerful hand in dispensing services like physiotherapy.

[8] Frase is not arguing here that people should not work. Only that they would not be compelled to work to survive. Abundance and equality allows for work to be done for fulfilment and to build the surplus commons, without the capitalist exploitation that historically tied work to wage slavery.

How can we re-establish simplicity, conviviality, care, and trust, and develop 'individuals, communities, a citizenry and a global village committed to simple living and dematerialising resource use' (ibid), when Western societies place so much emphasis on autonomy and independence, speed and efficiency, purposeful movement and productive function? I have argued here that actively de-centring physiotherapy, stripping away the layers of sediment we have added to the physical therapies, and reviving their use in the commons, are just some of the ways we could contribute to a future society that is ecologically sustainable, egalitarian, inclusive, and diverse.

And playing an active part in shaping a future society is very much part of the ethos of this book. It is absolutely not the case that physiotherapists should simply abandon the physical therapies to anyone and everyone. They are far too precious and powerful to be left in the hands of late capitalist colonisers and state-based bureaucracies. No, physiotherapists will play a key role in the coming years, guiding the move towards immanence and intensity, and reviving the physical therapies in the commons. There will be many docking stations along the way to a transformed physical therapy, some, it is hoped, will be expressions of much greater social justice. Given physiotherapy's history, it is clear that this will not be an easy task, and many within the profession will struggle with the evidence and reasoning now before them. Hopefully, though, this book provides some of the justification for action, and the impetus for a thousand lines of flight.

Closing words

It would be perfectly understandable if physiotherapists were worried that the healthcare system they have been such an important part of over the last century is now moving away from them. They should be worried because it is. The key, though, is what we do next. We can turn our gaze inwards, and try to preserve the profession at all costs, or we can try to anticipate what is coming and draw on the best knowledge available to us. I believe sociology holds a key to this process, but it is no panacea. Nursing has been engaging with sociology for decades now, with decidedly mixed results (110–113), and it has caused many uncomfortable conversations about the fundamental nature of nursing theory and practice. Sometimes the sharpest knife cuts well, but it might not be the best thing for putting meat in your mouth (114). But this is a conversation for another time because the purpose of this book was never to use sociology to shape a *better* physiotherapy.

Had it been thirty years ago, this might have been a valid pursuit. We could have used our new sociological knowledge to turn away from our focus on the body-as-machine and our quest for more professional autonomy, and embraced a broader view of the physical therapies as a social construct. But that time has passed now (115). Healthcare has become too expensive, too patriarchal, and too bureaucratic. The world has become too big, and people's tastes have become too *postmodern*. People today want so much more from their bodies and their health than the 'old' professions allow. The public no longer unquestioningly accepts the claims of the health professionals that their work is fundamentally good, expert, altruistic, and public-spirited. And they no longer have an appetite for the professions governing themselves. The professions are empires in decline, and the physical therapies have been under occupation for too long.

All of the theories and criticisms presented in this book lead me to one inescapable conclusion: that the future of high quality, person-centred, trustworthy healthcare, no longer resides with professions like physiotherapy. But as Deleuze says; 'There is no need to fear or hope, but only to

look for new weapons' (116). And new weapons are certainly needed, not least because many of the problems people are now experiencing with healthcare stem not from the breakdown of the 'old' system, but from what is replacing it. We face a crisis of care, not of cost, in healthcare (117)[9]; a problem made worse by the hubris of the professions and their desire to focus on their professionalisation projects, and not the underlying problems being caused by the state and the atomisation of late capitalism (119).

But if we really want to find some new weapons, we could do much worse than remind ourselves of a very ancient concept. In Greek, the word *therapeia* means 'to serve, show attention, honour, show respect or reverence' (120). It means to accompany much more than it means to heal. It is an act of conviviality and reciprocity. *Therapeia,* as Steen Lykke argues, 'is an attitude to the Other without authority; it does not rely on any scientific expertise about humanity' (ibid).

'This is the horizon that the discourse and the politics of the commons opens for us today', Silvia Federici argues (20). This is 'not the promise of an impossible return to the past, but the possibility of recovering the power of collectively deciding our fate on this earth. This is what I call re-enchanting the world' (ibid).

Clare Kell and Gwyn Owen argued in 2008, that 'Rather than comparing our professional project with (functionalist) descriptors created for a different time we must look forward and generate the future for ourselves' (121). It has always struck me as interesting, then, that, in the past, when I have asked my colleagues whether they would shut down the physiotherapy profession if it were in the public's interest, many have had to think about their answer. Our affinity with our professional identity has been so strong, that it seems, sometimes, to override even the most fundamental of ethical considerations: as if preserving physiotherapy *against* the public's interest could *ever* be justified.

But, in truth, this is exactly what is happening. We know, for instance, that there is enormous demand for people to train as physiotherapists, and most university programs are vastly over-subscribed. We also know that there is an enormous unmet need for physical therapy in the community. In most countries there are as few as 10 physiotherapists for every 10,000 people (122), and even then, the expertise of the best is only available to a select few. Given the global burden of lifestyle diseases (123, 124), there are vast numbers of people and communities in need who will never see a physiotherapist. And yet, at the same time, the profession works extremely hard to protect its 'brand', and works assiduously to restrict people's access to the physical therapies. Its colleges have for years restricted entry into programmes, and used content-heavy curricula, passive learning designs, over-assessment, and clinical socialisation strategies to ensure only a select few students succeed. And regulators have assiduously policed the profession's boundaries to ensure only registered practitioners have access to the privileges of being a physiotherapist. A thorough examination of the ethics of such practices, and the myriad other professionalisation strategies employed by physiotherapists, is overdue. This might 'not be easy for physiotherapists', as Sarah Barradell suggests, 'But in doing so, new possibilities are uncovered for what the profession might become' (125).

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[9] 'We have 820 million people starving in the world, out of which 150 million are children, and this, with a daily world production of over 1.5 kilos of food per person. If we divide the world GDP, of about 85 trillion dollars, by the world's population, we find that what we know produce could provide three thousand dollars per month per family of four. Our problem is not economic. It lies, rather, in the political and ideological machine that promotes and justifies the absurd partition of the results of human effort, with no connection be it to the most rudimentary merit criterion, or human decency for that matter' (118).

'There is no reason', John Maynard Keynes once wrote, 'why we should not feel ourselves free to be bold, to be open, to experiment, to take action, to try the possibilities of things' (126). But, of course, freedom comes with its own anxieties. All of the orthodox, Western health professionals are having difficulty imagining modern society in their absence (29), and there are some enormous risks for the future of healthcare as we move into the post-professional era. But that does not mean we should not try.

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