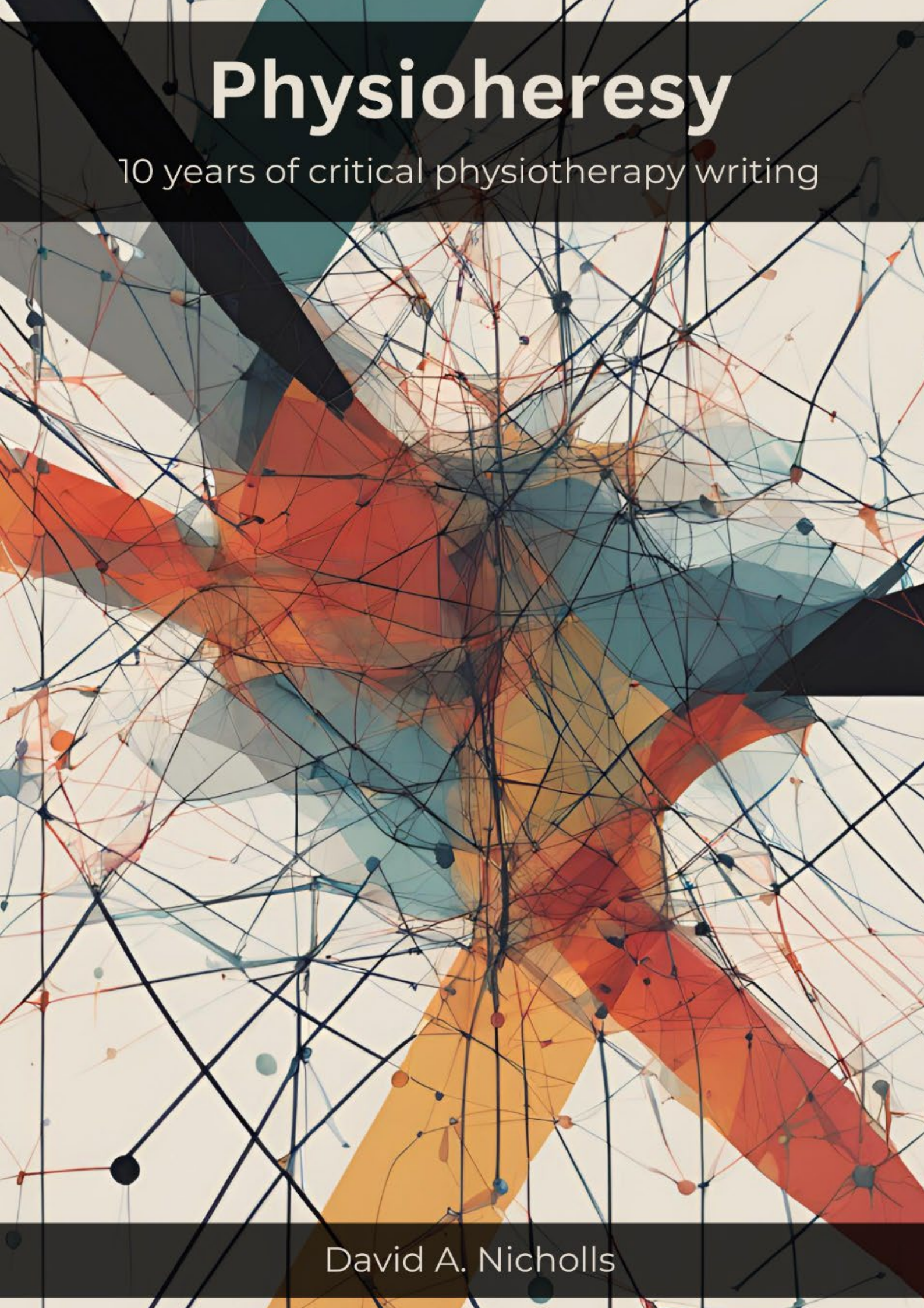
Physioheresy

10 years of critical physiotherapy writing



David A. Nicholls

PHYSIOHERESY

10 YEARS OF CRITICAL PHYSIOTHERAPY WRITING

David A. Nicholls

TUWHERA
OPEN ACCESS BOOKS

Published in 2024 by Tuwhera Open Books

Auckland University of Technology

Tāmaki Makaurau, Aotearoa New Zealand

Freely available online at https://tuwhera.aut.ac.nz/

ISBN (online) 978-1-99-101143-5 (pdf)

ISBN (online) 978-1-99-101142-8 (epub)

For everyone who answered my email and said they were keen

Contents

Acknowledgements

I have to begin by acknowledging the CPN's long-time site administrator Jo Bloggs (a nom de plume adopted early on to separate their work on the site from their academic CPN work). Jo put in so much work to keep the CPN site running and safe from malware. There would have been no blog without their incredible behind the scenes work. I'd also like to thank the various members of the CPN Exec who offered endless encouragement as well as useful editorial advice and suggestions. Then there are the dozens and dozens of members who chipped in with content, interviews and images, links and suggestions. You made the site richer and warmer for your contributions. And finally, a big thank you to all the people who emailed me about things they'd read in the blog or sent in comments. I've made so many friends from all corners of the world as a result of the blog. Thank you all for your inspiration and support.

Chapter 1: Introduction

As I write this, on a cold and sunny winter's morning in Auckland, it's 10 years almost to the day since the Critical Physiotherapy Network was formed: a decade since we began the process of trying to be a positive force for an otherwise physiotherapy. Over the course of those ten years, critical physiotherapy has become a real thing; a living, breathing collective of more than a thousand like-minded people from over 50 countries around the world.

Before the CPN began, there was no real critical *discipline* in physiotherapy. There had been authors who had written critical, theoretically-informed pieces, for sure, but there had never been a concerted, focused, dedicated attempt by a group of physiotherapy academics, clinicians, researchers, and students to systematically interrogate the profession's axioms, customs and beliefs. The fact that the CPN came in so fast and pushed the profession so far speaks directly to how needed critical thinking was in the profession, and how ready we all were to give voice to it.

The CPN blog was a big part of that voicing. It was for me, at least. And I suspect it's been one of the main ways we've kept the fire of critical physiotherapy burning since 2014. It became a way to promote critical physiotherapy, learn and explore new ideas, collaborate on writing projects and courses, and bring to the surface the voices of people from around the globe who had often felt at the margins of mainstream physiotherapy.

Forming the CPN and acting as its chair for the first 10 years has, without doubt, been one of the greatest joys of my entire professional career. Through the CPN I've made lifelong friendships, enjoyed dozens of opportunities for academic collaborations, run courses and salons, helped people get promoted, and shared barely formed ideas with people who don't need telling who Foucault was or what embodiment means. And so much of that has been mediated through the CPN blog.

Published weekly, sometimes twice weekly the CPN blog has become something of an institution. Sometimes the posts would almost write themselves, and at other times I would spend days labouring over them. Looking back now though, I realise how almost none of that work was wasted. So often, I would write a post as a forerunner of an article or presentation that followed. If not that, then it would be the germ of an idea that would help me sometimes years later in a discussion with a student or a colleague.

Over the 10 years I wrote more than 1,000 blogposts. And even if you take out the *Weekly Digests* and the posts that were simply notices of upcoming events, calls for papers, and links to research, it still leaves more than 500 substantive, scholarly pieces ranging from learning

and teaching issues, philosophy and sociology, the future for the profession, and everyday physiotherapy work. Most of those substantive pieces have been included here.

Working out how to organise and collate this collection has been an interesting exercise. In the end, I decided to start with a short Chapter (2) on the first few months of the CPN, and then follow this with a series of chapters focusing on particular themes.

Chapters 3, 4, 5 and 6 are about different sorts of ideas that emerged over the decade. Chapter 3 is about challenging conventions. These posts were attempts to think critically about some of physiotherapy's sacred ideas and practice: our over-reliance on anatomy and pathology, the emergence of interest in pain, and so on. Chapter 4 is about everyday physiotherapy work; things like everyday problems and the diminishing role of touch in practice.

Chapter 5 collects together posts around the future of physiotherapy work; future boundaries and borders, the disruptive effects of COVID and AI, and whether PT is really a bullshit job.

Chapter 6, the last chapter in this mini-section, is all about using theory to rethink physiotherapy. Here there are posts on slow physiotherapy, fragility, 'good' movement, and the value of social theory.

Chapter 7 brings together all of the posts focused on learning and teaching.

Charter 8 is a collection of the long series that I sometimes wrote, especially unpacking qualitative research and, later, posthumanism and post-professionalism.

Chapter 9 delves into the business of the CPN and includes news updates, event announcements, calls for papers and conferences. If nothing else, this served as a nice reminder of the busyness of the group over the last 10 years.

Chapter 10 is all about the CPN members and links. Profiling members through written interviews was an important way early on to raise the profile of people in the Network. We also did this in 2016, 2018 and 2021 as part of the annual 30 Days of September campaigns, which you can see more of in Chapter 11.

Chapter 12, the last chapter, is about blogging itself. I never wanted to use the blog as a personal journal, although there were times when some of this kind of writing bled through. So this chapter looks at why I wrote the blog and why, later on, I stepped away from the CPN Executive and started ParaDoxa.

I made the editorial decision to remove all of the hyperlinks from the text partly because I wanted the book to be a book to read, not jump around back and forth in. So, any reader interested in following up on any links can use the title and date at the head of each post to navigate to the original blog and go from there. I also decided not to include an Index at the

end of the text. Publishing in eBook format means that the easiest way to find specific things like people's names, theoretical concepts, or events is to use the search box, making an Index redundant. I have not published any guest blog posts or any material published on the site that was not my own. And the blogposts in each chapter have been arranged in date order, from oldest to newest. And my final editorial decision was to exclude from the book the many mundane announcements, composite posts, and notices of everyday events, as well as all of the Weekly Digests.

Even without these omissions, *Physioheresy* runs to more than 300,000 words. Which is a sizeable output from 10 years of writing. Taken as a whole I'd say I stand by 99% of the things I wrote here. I loved every minute of writing the blog and still enjoy this kind of writing today. In some ways I think one of the most important things the CPN did was to encourage people to put theory first in their articles and book chapters, and I think the blog helped to nurture that. It certainly helped me, and I'm immensely grateful to have had the good fortune to find the CPN — an idea whose time had surely come — and to see it grow into the force it is today.

Chapter 2: The early years

The CPN came along at a really important time in my life. In fact it was the one thing that lifted me out of a funk I'd fallen into as my University's Head of Physiotherapy. For as long as I can remember I'd wanted to shake up physiotherapy. I can vividly remember as a student wondering why the amazing skills and knowledge we'd gained about the body, touch and movement were being slowly suffocated by narrow-minded automatons masquerading as clinicians, and by a profession that seemed bent on turning the vivacious into the ordinary. Surely there was more to physiotherapy than this, I thought.

So in 2012, when I took over as head of the physiotherapy programme at AUT — having spent the previous six years developing a radically new physiotherapy curriculum — I thought I had found my home. Unfortunately, things didn't work out as I'd hoped and the three years in that role were the unhappiest years of my 30-year professional life.

You'll see in Chapter 2 that some of the first posts I wrote for the blog touch on that time and how the CPN quickly made me feel so much better. And boy, did it do the trick!

Here's my original invitation email (27 June 2014)

> I've been thinking for some time about setting up a network of physiotherapists who think 'differently' - people who are critical thinkers, philosophers, social theorists, educators, historians, qualitative researchers, PG students doing things other than clinical trials of hamstring stretching, etc. I thought a good way to do it might be to contact the people I knew who are like this and to ask them to nominate their friends and contacts, who I would then contact in turn - a bit of a snowball referral process. The end result would be a network of people who could then be brought together in hyperspace to share ideas and plan for world domination. What do you think of the idea? If you think it sounds a bit too much like one of those dreadful email chain letters, I'll revise my plan!
>
> Regards, Dave Nicholls, Head of Physiotherapy, AUT University

I still look back on that first year of the CPN as a magical time. Almost every day I'd get an email from someone who had heard about the group from a friend and wanted to know how to join.* Suddenly, there was a community here that spoke the same language and was comfortable talking about blending physiotherapy with the arts, history, philosophy, and sociology. I hadn't realised that there were so many other people 'out there' who were also passionate about these things. I quickly came to realise that I'd finally found my community.

Setting up the first CPN Exec only served to enhance that feeling. Here were a group of people who were prepared to give their own time to meet sometimes late at night, sometimes early in the morning, and put up with dodgy Skype connections (in the days long before seamless video conferencing), to plan and scheme for an otherwise physiotherapy. Over the years, the membership of the Exec remained remarkably stable, and that handful of people have become some of my closest friends.

The CPN started in earnest with an email to just a handful of people who I thought were writing in critically interesting ways. Initially I thought there'd only be a handful, maybe 10 people at most, who would be interested in a semi-regular get-together, but within just a few weeks the Network had grown to 50 members, then 100, then 500. Within a couple of years it had grown to a thousand members spread across more than 50 countries and could justifiably claim to be a new professional sub-discipline.

I decided early on that I wanted to write a regular blog, in part as a way to keep the CPN alive in people's minds, but also for myself as a way to work out ideas. It's really striking looking back over some of those posts now, thinking about how many of them worked like test balloons for ideas that would later appear in books, chapters, articles and talks. Blogging was, for me, an ideal medium for that kind of experimentation because I always tried to see it as something ephemeral and impermanent. It's a different discipline to writing for academic journals and readers, and I enjoyed it all the more for that.

Reading these blogposts again now, I can vividly recall the excitement and no little surprise I felt at the time. Word spread so quickly that within days I was fielding emails from all over the world. I can't tell you what it meant to me, and still remember that feeling of relief knowing I wasn't the only person in the world thinking and feeling this way. To me, that sense of joining a family — a community I confess I'd never before found in my profession — has been one of the greatest joys of my life.

Some of the early blogposts were naturally taken up with setting up the CPN as a group. You can see how the group was going to run, the way the Exec would work, how people would become 'members', and the problems we were going to have with the technology.

You can also see how the spirit of the CPN, as an open, safe space for people to share critical and radical ideas about their profession without needing to explain themselves to their colleagues, was already taking shape. The blog certainly helped this, by foregrounding philosophers and theorists that were largely unknown within mainstream physiotherapy, but were welcomed as refreshing new voices within critical physiotherapy. In the *10 reasons why we need the Critical Physiotherapy Network* post I wrote that;

> ’The profession will need its historians to remind us of the lessons of the past; it's philosophers to help us decide how we might adapt to the new world; and our social theorists to map a course to a better future.’

And that feels like it was a constant theme running behind the writing on the blog.

Of course, the Network and the blog always had its detractors. Some people found the language too academic; too wordy. Others thought that the CPN was functioning as a clearing house for the disaffected and disillusioned; and that it would ferment anarchy at a time when people in the profession really needed to pull together. Early on, some people joined thinking we were a special interest group for physiotherapists working in intensive (critical) care. I think you can see from these early posts that we were already aware of all of these criticisms, and wanted to set down our objectives and terms of reference pretty quickly. As it turns out, the objectives that the Exec wrote in the first months of our meetings did such a good job that they remained unchanged throughout the decade that followed, and served us well whenever we were faced with ethical questions about the kind of organisation we wanted to be.

Many of those questions were fielded by an Exec that reflected almost perfectly the demographic profile of the Network. For its first 10 years, the CPN was centred in Australasia, Canada, the UK, Scandinavia, South Africa and, latterly, Latin America, and the membership of the Exec mirrored that. Participation on the Exec has always been entirely voluntary, and we decided early to operate with a flat structure with a few nominated roles (a Chair — which was initially fixed, but later rotated each month, web support, and a note-taker being the exception). Nicky Wilson’s minutes from those meetings are still the best I’ve ever seen, and Gwyn Owen dealt with all of the complexities of building the site(s) that would give us a real virtual presence in the world. This was no small feat in the days before Web 3.0, chatbots and glitch-free Zoom calls.

Perhaps the biggest marker of the CPN’s early success, though, would be the collaborative projects we embarked on as a way to bring people together. Our first big collaborative effort was to work on an article for publication, and you can see in the blogposts surrounding it how the *Connectivity* paper took shape. The article had eight authors from five countries who had never published together before. It took six months to write from conception to submission and was approved with only minor revisions. It showed us that we had the passion and skill to do this, and would provide the template for numerous collaborative writing and presenting projects to follow.

There’s so much joy in these early blogposts; a real sense of inspiration and hope. Little did we know just how big the CPN would get, or how much joy it would bring.

(I decided to add the piece about the founding of the International Physiotherapy History Association in here too, because its founding was so integral to the work I was doing with physiotherapy's history and, like the Environmental Physiotherapy Association, followed closely to the organisational structure of the CPN.)

* As of mid-June 2024, I have more than 6800 email messages in CPN folder, which equates to an average of two CPN emails from people every day for 10 years.

Critical Physiotherapy Network is born!

29 July 2014

Today is a momentous day!

After some weeks of planning, I am proud to announce the formal arrival of the Critical Physiotherapy Network.

For a long time now, I've been thinking about bringing together a group of critical-thinking physiotherapists from around the world who are interested in philosophy, history, cultural studies, sociology, qualitative research and education.

A few weeks ago I decided to step down from my role as Head of Physiotherapy at AUT University, and that induced me to think about some of the projects that were lying in wait ready for when I had more time.

So I began by contacting half-a-dozen colleagues I knew around the world who were critical thinkers, and asked them if they would be interested in forming a group, and if they could pass the invite on to others that they knew. I thought we might be a small group of no more than a dozen like-minded colleagues. How naive I was!

Within a few days, the snowball had gathered momentum and begun to roll off in all kinds of different directions. I started getting responses from Scandinavia, the UK, Canada, and Australia, and a host of other corners of the world, and everyone spoke as if this were an idea whose time had come.

To date, we have 65 confirmed 'members' from 13 different countries, with a further 25 being organised.

We've decided that we want the group to be accessible, supporting, fun and friendly, and we want to be a forum where people can feel comfortable expressing a diversity of ideas.

We're going to start by forming an organising committee and finding out a bit more about each other because there are clearly more critical thinkers out there in physiotherapy than any one of us knew before.

At some point soon, we'll organise a central repository for our information and resources, and send out invites to every jurisdiction to encourage practitioners, lecturers, researchers and students who think differently about physiotherapy to participate. We'll be organising meetings, webinars, unconferences and the like, and looking for every opportunity to encourage physiotherapists to think differently about their profession.

So if this network sounds like it might appeal to you, contact me directly at david.nicholls@aut.ac.nz, or send a comment to this post, and I'll be in touch.

10 reasons why we need a Critical Physiotherapy Network

1 August 2014

The response to the formation of our Critical Physiotherapy Network has been amazing, and it's made me think about some of the reasons why physiotherapy is now ready for a group like this:

1. Health care is increasingly complex

The sheer size and complexity of the health care system is profoundly challenging the old medical model. Writers like Bryan Turner, Simon Williams, Debbie Lupton, Chris Shilling, Nick Fox, Alan Petersen and others have shown that biomedicine has brought about many great achievements, but it has also contributed to the present dysfunction in the health system. As the old system is slowly dismantled (and with it, many of the principles that have underpinned physiotherapy in the past), we will need help to navigate our way to new models of practice. Critical thinkers in physiotherapy won't be the only people to do this, but they will certainly be important.

2. The breadth of physiotherapy's current knowledge isn't enough

Physiotherapists' training has long been focused on treating the body-as-machine. That approach has worked up to a point for most of the last century, but it will not be sufficient for the future. If physiotherapy is going to be more than it has been in the past, we will have to engage in lengthy discussions about how we will change, what we will gain and what we will relinquish, and what our future role will be. The profession will need its historians to remind us of the lessons of the past; it's philosophers to help us decide how we might adapt

to the new world; and our social theorists to map a course to a better future. We will not be able to do any of this if we don't engage our students teach our students to be historians, philosophers and social theorists as well as capable clinicians.

3. Without critique, we can't really know our limits and possibilities

Our professional ignorance of 'other' ways of understanding the world of health and wellbeing now presents one of the greatest barriers to our progress as a profession. How can we move forward without the right vocabulary to help us define our future? The language of history, philosophy and sociology is so alien to physiotherapists that we have come to think of critiquing as meaning only that a student can review a research paper and tell you whether it is methodologically sound or not. We are going to need much greater depth of insight than this, or the change we bring to the profession in the coming years will be limited by the breadth of our insight and imagination.

4. The government and the public are increasingly demanding more from the health professionals it supports

The 'technical rationalism' that is the hallmark of orthodox health professions (Schön, 1987) is out of step with what the public and our state governments now want from us. It has long been known that our practices are too focused on short term, acute models of cure (not care), and not on the complex problems that beset our modern health care systems. We cannot hope to retain our relevance if we don't adapt to what the government and the public now want from us. Physiotherapy has a long history of responding to political pressure. Look, for instance, at the role physiotherapy played in establishing a nationwide rehabilitation service after World War I. The changing economy of health care is now calling for another seismic shift from the orthodox health professions, as non-communicable diseases and the burden of chronic illness threaten to overwhelm our health care systems.

5. Knowledge is no longer fixed

We live in uncertain times. No-one trusts doctors, judges or priests the way they used to. Physiotherapy, for its part, is based on quite fixed ideas about the body, movement, function and ability, that we like to think are stable and unchanging. The truth is, however, that none of these concepts are immutable. As we move away from the mind-body splits towards a more embodied or holistic view of health and illness, we have to reject many of the reductive ways we have previously learnt to approach the body. This means revising the central role that anatomy, biomechanics, kinesiology, pathology and physiology play in defining our practice; replacing them with more patient-centred, socially-responsive, complex and nuanced understandings of the body in health and illness. It will take a great deal of skilled effort to move traditional physiotherapists away from their positions of past strength.

6. Our clients/patients are all unique, after all

Despite our affinity for biomedical understandings of the body, we have always known that each one of our patients is unique — just as we are unique people as well as physiotherapists, parents, joggers, and whatever else. So student physiotherapists have always had to go through a kind of transformation — usually after graduating — to allow them to make sense of the real world of practice. The transformation takes them from the pure, rational world of the body presented in their textbooks (where one hamstring is pretty much like the next), to the messy, ambiguous, and uncertain world of clinical life. Sadly, most of us have had to endure that experience of transformation: of realising that our training was woefully inadequate; of realising that we had been given no help to transition into professional practice. This will need to change in the future if we are to better prepare the next generation of practitioners for the real world of work.

7. Critical thinking is now well established in other health professions, so why not ours?

Lest we think, for a moment, that the idea of a Critical Physiotherapy Network is a new one, we should reflect on the fact that critical philosophical and social theory has been a feature of health professions like medicine, nursing, psychology and occupational therapy for decades. We can benefit from this because others have shown us how it might be possible to adapt, but we must also learn from their lessons. The debate around the future of nursing, especially, has shown us that we need to concentrate as much on creating a safe, supportive environment for critical thinking, as it is about arriving at a final answer. There is not one right answer to the problem of physiotherapy's future, only an ongoing engagement with the problem to hand. What matters most then is that we can nurture our colleagues to engage in the debate and never stop wanting to improve their work without fear of being marginalised or persecuted for speaking truth to power.

8. Our student education has been poor

We could do worse than begin by acknowledging that the educational philosophies we have applied to physiotherapy in the past have been poor. Didactic, often reductive, and designed around knowledge translation rather than critical thinking, we have systematically robbed the profession of critical voices that could have been the drivers of change now. And so we are forced to play catch-up — hoping to use the experience of others to accelerate our progress and make the necessary changes to prepare our profession for the 21st century. We have to accept this, but we should at least consider how we perpetuate the poor practices of the past, and look to ways to correct ourselves so that we don't limit the chances for future generations to act critically in the face of profound change.

9. Our university trained practitioners, researchers and teachers are branching out

Fortunately, physiotherapists are dynamic, pragmatic, inspirational people, and—despite their training, rather than because of it—have taken wholeheartedly to change, not least in the move from the old training school system to university education, which promises to yield a cohort of critical thinkers with the skills and credibility to drive change in the profession. We now have a number of professors, senior academics and postgraduate students who are pushing the boundaries of physiotherapy knowledge and driving change for the future of the profession. We could not have contemplated making this change 30 years ago (maybe even 15 years ago!), but now the time is ripe for these people to come together to help their colleagues respond to the pressures they now face in everyday practice.

10. We have the people

Looking at some of the profiles of the people now in the Critical Physiotherapy Network, it's plain to see that we now have the people who can lead the profession into the next century and provide the critical voice that the profession has long since needed. Over the next few months and years we will be working to support these people so that they, in turn, can do what they do best and provide critical commentary on physiotherapy. Our hope is that this opens doors to the possibility of an 'otherwise physiotherapy.'

Vive la revolution!

Reference

Schön, D A. Educating the Reflective Practitioner : Toward a New Design for Teaching and Learning in the Professions. San Francisco: Jossey Bass, 1987.

Report on 1st meeting of the Critical Physio Network Organising Committee

1 November 2014

We had the first meeting of the Critical Physiotherapy Network Organising Committee (neatly abbreviated to CPN-OC).

You'll remember we had six fabulously enthusiastic volunteers: Barbara Gibson (Canada), Jenny Setchell (Australia), Nicky Wilson & Gwyn Owen (UK), Simon Kirkegaard (Denmark), with me — Dave Nicholls (New Zealand) — in the Chair.

The plan for the first meeting was to get the video conferencing software to work (why is it that the technology is always the biggest stress!), and to meet each other. I thought that if we could just achieve that, we would have achieved something quite momentous.

I'm pleased to say we did achieve our objective, but with only minutes to spare!

Barbara, myself and Jenny (calling in from Cairns rather than her normal home in Brisbane), could see and hear each other perfectly, but Nicky was having problems hearing us and had to move to a different computer after half-an-hour of frustration. We knew Gwyn would be joining us a little late, but we didn't have Simon until five minutes from the end. Thanks to Daylight Saving, I'd managed to give Simon the wrong start time!

However… all that notwithstanding, we did have 10 minutes or so to say hello to each other and to formally launch the Committee.

We also had time to make some important decisions. We agreed that:

We wanted the meetings to have a formal structure—with a proper agenda, minutes and papers for discussion when it was relevant.

Our first priority would be to propose and establish the aims and objectives of the Critical Physiotherapy Network, including fundamental things like our particular interpretation of the word 'critical,' our values and principles, and our long-term vision. Our thought is that if we got the groundwork right, a lot of the governance and organisational detail would be easier to sort out. We agreed that the job of setting up the aims and objectives might take some time, but an hour spent on it now might save us all days of work later on.

After establishing the aims and objectives of the group, we would move on to the Terms of Reference for the Organising Committee, membership arrangements, fee structures (if we're going to have them), etc.

We decided to have monthly meetings, and to hold them on the last Friday of the month (New Zealand time). We're also going to stick with Scopia as the video conferencing software for now. At first glance, it seems a lot more stable than Skype, and it comes with tools that other similar tools don't have.

So our next meeting will be on Friday 28th November (Auckland time). We'll post up an agenda in advance and minutes will be available soon after.

POST UPDATE: CPN members can access copies of the agenda & minutes here

Connectivity—Contributions from the Network #11—Planning our article

14 November 2014

Over the last three weeks, I've posted up some prompts to start a conversation around connectivity—one of the many ideas that might help us think practically about how physiotherapy might respond to the changes taking place in health care.

Over that time, I've had lots of responses from members of the group, and I've posted these on the blog.

It's time now to start thinking about a paper that will communicate some of these ideas to the broader physiotherapy community. I said we would have written within three months and with a bit of collective effort we'll do this easily.

First we need to define the structure of the article, and then allocate people to draft sections. I said all along, that people who made a substantial contribution to the paper would be co-authors… it's not too late to through your hat into the ring.

My suggestion would be to mirror something like the structure of the paper Barbara Gibson and I wrote on 'The body and physiotherapy.' This seemed to work reasonably well as a way to communicate ideas. We have to assume that papers like this are read by people who actively make use of the ideas promoted in the paper, and this is most likely to be graduate students, academics and researchers who in turn translate these ideas into local practice. So our emphasis should be on translating the complexities of connectivity to best communicate the principles to people, who can then develop their own variations. We shouldn't try to be too prescriptive or pragmatic about what people should think, or how people should use the concepts talked about in the paper.

So the article might be laid out as follows:

Introduction/background (500 words)

Basic definition of connectivity

Brief statement of its rising significance

Some of the tensions surrounding physiotherapy that make it relevant

Briefly what it might mean to physiotherapy

Justification for exploring it in more depth

Philosophical/theoretical background (2500 words)

Explain and delimit connectivity as a concept—what it is, and what it's not

Brief overview of similar concepts (i.e. intersubjectivity, symbolic interactionism)

Deleuze and Guattari's conceptualisation of connectivity

Application of theory (2500 words)

How connectivity might change how we view the world

How it might change how we view health care

... and then physiotherapy

Discussion (500 words)

Why is it new?

Why is it so relevant now for us?

What possibilities does it hold?

What are its limitations?

Where to from here?

Conclusion (300 words)

Total length—6300 words (within recommended limits for Physiotherapy Theory and Practice).

What do you think? Would you want the paper to work any differently? Should it have a different structure or purpose? Send me your thoughts, and I'll collate these for a subsequent post.

Connectivity—Stating the obvious?

18 November 2014

Thanks to everyone for their comments on connectivity. It's clear that the concept has captured people's imagination. I've had a few queries about the concept that I thought would be worth discussing here. Most revolve around whether connectivity is just stating the obvious—describing very common aspects of practice in high-minded language. So I thought I'd try to address this question here.

Is connectivity just stating the obvious?

Some people have commented that connectivity, at its basic level, sounds a lot like everyday practice. Connecting people with mediating technologies like other people, things, and new ideas is something that physiotherapists, OT, doctors and nurses have done for generations. Massage, mobilisation, exercise, electrotherapy, hydrotherapy, etc., all involve some kind of connection with something, so isn't this connectivity? In which case, what's all

the fuss about? Aren't we just attempting to give a fancy name to something that is really quite normal?

For me, this isn't a criticism, but a strength of the concept—at least as it applies to physiotherapy. If a new idea is going to gain any critical purchase with the profession, it must already resonate with people. Like the new record that sounds like it came out years ago, it must have a ring of familiarity to it. Connectivity makes some sense for the profession, simply because it is something we've been doing for years. But, it wouldn't also have its radical power if it didn't also change something fundamental about how people think and practice.

If connectivity is only seen as the everyday links we make between people, objects and ideas, then yes, it's no different to what we've done for years. But what if connectivity wasn't just a description of an aspect of our practice, and instead became its purpose?

Connectivity, as it seems to be emerging in the literature, offers a new way to theorise health and illness. We're familiar with the biomedical way that dominated health care for much of the 20th century (the search for specific aetiology, the body-as-machine, reductionism, quantification and experimental objectivity), and we're familiar with the critical response from sociology that emerged after WWII (social construction, personal value and meaning, systems and structures, emancipation and voice). One looks for disease within the physical body, the other looks for illness in the experience of the individual or collective.

All of us have become used to situating ourselves along a line somewhere between a biomedical quantitative view of the world and the social qualitative end. If you're a critical theorist, you sit out at one end with the phenomenologists and ethnographers. If you're a biologist and scientist, you sit at the other. And ne'er the twain shall meet.

The biologists have their methods; their experiments and clinical trials, and the sociologists have their interviews and observations. Neither particularly likes the other nor understands their world view, and the rise of post-positivist research and mixed-methods designs has simply shown that if you stand in the middle of the road you get hit by traffic from both directions.

Connectivity is different, literally different. If this was a tug-of-war competition with the biological sciences at one end of a rope, and social sciences at the other, connectivity would be standing off to one side drinking cider with the choir. It stands apart, in a way that few philosophies of thought and practice have been able to before. It does this because its purpose is not to deduce the biological basis of a person's disease, or understand the personal or social meaning of illness, but, radically, the everyday practices; the doing of life.

What makes it so different, is that the focus is not on the physical body at the expense of the person's lived experience or social context, or the lived experience of the person devoid of a

body. Connectivity focuses on what is being done, the practical doing of the world. It's not about whether a person has 93 or 96º of elbow flexion, but what they do with it. Equally, it's not about what a person says they do, it's about what they actually do.

Surprisingly, what people actually do in their lives has not been the focus of much research interest in the past. Quantitative research into people's activity and function generally reduces their individual actions and strategies for living down to measurable variables and assesses against a validated normal. Qualitative research—particularly phenomenology—looks at what people say matters to them, not directly at what they do. Neither particularly looks at the strategies people use to manage and normalise disadvantage, illness, pain, loss of function. Which is ironic, really, given that this is what physios and OTs spend most of their life assessing.

In the past, we've resorted to quantitative and qualitative tools to assess our patients, and have used biological and social reference points to evaluate people's activity. But what if we stopped doing this and, instead, evaluated our success on the basis of whether we helped the person connect with the mediating technologies that allowed them to feel movement, happiness, relief, comfort, strength, and maybe even the wind in their hair?

Connectivity argues that physiotherapists have focused too much on the objective measure of function (our biomedical impulse), but that the turn towards hearing the voice of the client/patient is also fraught with difficulty because it pulls on the same rope as biomedicine in the game of philosophical tug-of-war (see the example of the medical and social models of disability in an earlier post).

Instead of focusing on returning the person to society's idea of normal, our role becomes one of helping the person achieve things that are meaningful to them by connecting them with techniques, people, objects, practices, strategies, tools and ideas that make these things possible.

In the past, we've connected people with these things in order that we might better meet a biological or social function. Connectivity suggests a different way, a third way, that makes the connection the very goal of the therapy, its ultimate point. You succeed as a therapist if you maximise the diversity and significance of the connections a person makes with things that help them live a meaningful life.

The fact that physios have been doing work like this for generations is just a bonus!

A note of caution

I've used connectivity as the first of possibly many ideas out there in the world of philosophy that I think physios might find interesting. Our primary goal as a network this year is to help introduce a bit more philosophy into physiotherapy practice, so this seemed like a good place

to start. This doesn't mean that we're advocating for connectivity to be the new face of physiotherapy. I'm a postmodernist and critical theorist at heart, so anyone that suggests they have the answer to anything will make me very suspicious. So we will soon move away from connectivity to explore some other equally interesting ideas, leaving you with the task of making your own connections with new ways of thinking and practising.

The CPN is 1 year old today

1 July 2015

The CPN is 1 year old today.

To celebrate how far we've come in such a short space of time, I thought it might be timely to look back on some of the things we've achieved as a Network:

The Network started with an email to six people who had talked informally about forming a group of like-minded critical thinkers in physiotherapy. This email snowballed until we had 24 people signed up by the end of the first week, and more were added each week as people heard about us. People were saying that the group was an idea whose time had come, and it quickly became clear that there were dozens of physiotherapists who thought 'differently' about physiotherapy, all looking for a safe place to share their ideas and explore their passion for an 'otherwise' physiotherapy.

The group grew so quickly that we needed to form an Executive. A call went out and the current five members of the Exec generously responded. We held our first videoconference meeting on 31st October 2014 and have met once a month ever since.

The '30 days of September' (30DoS) campaign drew people's interest and activity in the Critical Physio website grew rapidly. Since its inception, there have been 50,000 views of the site and 30,000 visitors. One day alone, the site was viewed more than 3,000 times.

During the 30DoS campaign, people voted on the things that they would like the Network to do for them. The most popular options were explaining philosophy to physios; starting a critical physiotherapy journal; running a colloquium in the South of France; collaborating on a critical physiotherapy book; and running a webinar.

This gave the Executive a clear steer, and we've been working through these over the first six months of 2015. We began with a bold project to write a journal article on a subject that was both contemporary and philosophically challenging, with invited members — most of whom had never met — setting ourselves the challenge to complete it within six months. Anyone who felt they could make a substantial contribution to the paper became an author, and as a result, we had eight contributors to a paper called Connectivity: An emerging concept in

physiotherapy practice, which will be ready for publication by the end of this week. We're now undertaking the same process with our first edited book, provisionally titled *Critical Studies in Physiotherapy*.

In June, a number of CPN members met up at WCPT in Singapore, and a dozen members congregated at the In Sickness and In Health conference in Mallorca. At these meeting the depth of critical scholarship now emerging in the profession became clear, as a host of diverse thinkers showed they could hold their own with some of the most advanced scholarship happening anywhere.

So how are we celebrating the CPN's birthday over the next few days? Well, we'll be unveiling some new ideas and developments that coincide with the launch of the site, including an entirely new website with a host of new features including a discussion forum, membership database and archive. We'll also be launching our new constitution translated into 11 languages, some new logos, and access to full-text articles published by members of the group.

We'll be posting regularly through our Twitter handle @CriticalPhysio and on our Facebook page CriticalPhysiotherapyNetwork, and keeping members updated through regular emails.

We look forward to seeing you soon!

Women's work - the handmade history of physiotherapy

8 February 2018

Last week, we had the first meeting of executive of the new International Physiotherapy History Association (IPHA), and one of the items on the agenda was a proposal to host a Focused Symposium on physiotherapy history at next year's WCPT Congress in Geneva.

We've got some fabulous ideas for topics, including possible talks on the history of non-medical prescribing, the roots of manual therapy, the German gymnastic movement in 1920s and 30s, and the history of needling therapies. Thinking about a theme that ties them together has been an interesting process.

Physiotherapy's longstanding affinity with biomedicine might well win out, but an equally powerful discourse running through these talks is the way gender issues have influenced the profession.

2018 commemorates 100 years since the signing of the Representation of the People Act, which granted some British women (and more men) the right to vote. Sheila Rowbotham's

excellent Rebel Crossings offers a great account of this, and commemorates the significant victories achieved by many in the name of women's suffrage.

We often don't realise quite how important women's suffrage was to the founding of physiotherapy in Britain, and how this shaped the model of the profession around the world in the coming decades.

All of the founders of the Society of Trained Masseuses (STM) were independent women with ties to the suffrage movement. Rosalind Paget, one of the founders of the Society and a pioneer of the midwifery profession in Britain, was drawn, with her friends in the Midwives' Institute, 'from the same class background and had close friendship and family ties with the leaders of the women's movement and with those who took an interest in social welfare issues' (Hannan, 1997, p.84). Rosalind Paget - later Dame Rosalind Paget - was a niece of William Rathbone (1819-1902), the influential Member of Parliament, philanthropist, and close friend of Florence Nightingale. And Paget was also cousin to prominent suffragette Eleanor Rathbone (1872-1946).

There have been many times in the history of physiotherapy where its women leaders battled against almost overwhelming misogyny: in fighting to legitimise their massage practices; in showing they could treat injured servicemen; in becoming the leaders of physical rehabilitation movement; and differentiating themselves from nursing and midwifery.

And still to this day, female healthcare professionals are less likely to be in management roles; more likely to in low-paid supporting roles; more likely to be held back from promotion if they take career breaks to have families; and significantly more likely to experience harassment and bullying in the workplace.

In recent years, physiotherapy scholars have paid a lot more attention to the gendered aspects of the profession. So perhaps 2018 affords us an opportunity to celebrate the remarkable women who made it possible for us all to be here today, and to remind ourselves that the battle for women's suffrage has not yet been won.

References

Barclay J. (1994). In good hands: The history of the Chartered Society of Physiotherapy 1894-1994. Oxford: Butterworth Heinemann.

Hannam J. (1997). Rosalind Paget. The midwife, the women's movement and reform before 1914: In: Marland H, Rafferty AM. Midwives, society and childbirth: Debates and controversies in the modern period. Routledge: London.

Chapter 3: Challenging convention

This is the first of four chapters organised around critical physiotherapy 'issues'. This chapter pulls together blogs that attempted to challenge convention, subvert some taken-for-granted professional axioms, or perform a little blood letting on some of our holiest of cows.

There are pieces here on touch, loneliness and intimacy, over-diagnosis and over-treatment, CBT and ACT, person-centred care, the social construction of pain, the power of metaphors, professionalism and breaking the rules, disability activism, and the self evidence of evidence-based practice.

Underlying all of these is the critical principle of talking 'against' ourselves: of focusing on the aspects of practice that are most quotidian, and asking why this, why now? There is a strong leaning into the sociology of the professions and, in contrast to the common mantra that physiotherapists are innately practical people, an opening to strong theory, following Kurt Lewin's adage that there's nothing more practical than a good theory.

There are arguments about the 'tyranny of clinical implications', borne of a frustration that every article reviewer always wanted to be told what the clinical implications of strong theory were. It hurt my Foucauldian soul sometimes to have to do this but, as Bob Dylan once said, "you've got to be smart enough to play the game and dumb enough to think it matters". And lest we should become too poe-faced and serious about all of this convention challenging, there's also material here on finding the fun in critical physiotherapy.

A pill to make you a better physio

21 May 2014

There's been a lot of talk recently about the way we may be able to transform ourselves as humans in the not-too-distant future.

The trans-humanism movement is gaining momentum, with some people writing about a future where people will be able to take a pill to make themselves vastly more intelligent, or unlock the possibility of unlimited memory. Others are talking about never again growing old and using robotics and prosthetics to vastly enhance our physical capabilities.

In the latter case proponents ask why should we restrict ourselves to adaptive devices only when we become ill? And then why should those adaptive devices only seek to mimic so called 'normal' activity? What if, for example, we all decided to replace our existing legs with stumps that were fashioned to accept a range of prosthetics - one of which could allow you to

run faster than a gazelle (another might give you a height extension, or be an adaptive device to help develop better balance).

This got me thinking about physiotherapy and how it would adapt to this new world. Putting all ethical questions to one side for now, I'm interested in the idea that there might be a pill available in the future that could simulate illness. You could take a pill, for example, that would give you the experience of having a stroke for a day, or Parkinson's Disease, or chronic breathlessness. You could take a pill that simulated chronic fatigue or period pain. Would this not be a really valuable way to develop people's sense of empathy for others and give our student health professionals a much better sense of the lived experience of illness? Or would they be too scared to treat people if they knew what they were going through?

Sitting is the new smoking...really?

3 July 2014

Sitting, we are told, is the new smoking (see, for example recent articles in Runner's World, Wired, LA Times.)

Apparently, 'Sitting for hours on end, every day, is bad for your health. Sitting at work is bad for you. Sitting after work is bad for you. Sitting is the new smoking, except that the furniture lobby probably isn't as powerful as the tobacco one'.

Now while I don't for one moment decry the volumes of research that are supporting this recent phenomenon, my question is why now? Why has prolonged sitting become what Gilson, Straker and Parry recently described as 'a contemporary and highly topical area of study within public health research'?

It's not like people haven't been sitting down for long periods of time to do their work. One doesn't have to look far back in human history to find that many menial jobs performed by low-paid workers (often women and children) were conducted sitting down. Seamstresses and textile workers have worked at cramped, poorly designed tables for centuries, often in overcrowded, unsanitary conditions and this continues today in some of the countries where labour is cheap and replaceable.

And what about secretaries and machine operators, bus drivers and call-centre workers? Haven't they been victims to the same conditions that are now exercising the brains of our health promotion advisors? And then, of course, we could ask about the people who are wheelchair users. Beyond the research concerned with pressure area care, why wasn't there the same interest in the health risks associated with their prolonged sitting?

'You've no doubt heard the news by now: A car-commuting, desk-bound, TV-watching lifestyle can be harmful to your health. All the time we spend parked behind a steering wheel, slumped over a keyboard, or kicked back in front of the tube is linked to increased risks of heart disease, diabetes, cancer, and even depression—to the point where experts have labeled this modern-day health epidemic the "sitting disease."' (Runner's World)

As a discourse analyst I'm always interested in new knowledge - particularly the kinds of common-sense knowledge that people take for granted. Who could argue, for example, with statistics that show that people spend on average nine hours a day sitting, that they tend to sit more when they've engaged in vigorous exercise, or that sitting can cause everything from back pain to impotence? No-one, of course, because that's the point. It only works as a powerful message if it's hard to dispute.

Now if, along the way, a few exaggerated claims are made, or some broader, less palatable, social issues get bypassed for the greater good of the population's health, then should anyone complain? Well, maybe.

There is a distinctly white, European, elitist feel to some of the hyperbole surrounding sitting; a zeal for giving advice that you rarely see emanating from more marginal communities, where the focus is on the 'substantial' questions at the more 'physiological' end of Mazlow's hierarchy of needs. There is the same zeal evident in a lot of the health promotion literature where a sense of 'culpability in the face of known risk' prevails (Galvin, 2002).

Sadly, most of the physiotherapy research to date has reflected this fervour for judgement. Although couched in the language of objectivity and value-neutrality it does, nonetheless, carry a powerful political message about the profession's priorities and interests. Although seemingly directed at working age adults figurativeley 'chained' to their desks, much of the research says as much about the populations of people physiotherapy is, and is not, particularly interested in.

If physiotherapists are really interested in the problems of prolonged sitting and its dire effects are to be believed, then surely the profession should adopt a position towards social justice that sees it working to transform the working conditions of millions of poor, non-white, non-male, non-European, non-abled-bodied people who do not have the luxury of seat warmers, sit/stand desks, and air conditioned gymnasia.

References

Gilson, N., Straker, L. & Parry, S. (2012). Occupational sitting: practitioner perceptions of health risks, intervention strategies and influences. Health Promotion Journal of Australia, 23: 208-12.

Galvin, R. (2002). Disturbing Notions of Chronic Illness and Individual Responsibility: Towards a Genealogy of Morals." Health (6)2: 107-137.

76% of New Zealanders are not disabled!

18 July 2014

Statistics New Zealand (SNZ) released its *2013 Disability Survey* yesterday - the first report of its kind since 2001 - and it says some interesting things about disability in New Zealand. The study's main findings indicate that:

- 24% of New Zealanders self identified as disabled - which equates to 1,062,000 individual people
- The 3% increase in self-reported disability since 2001 can be partly explained by our ageing population
- 59% of people aged 65 or over were disabled
- 11% of children were identified as disabled by their parents
- Māori and Pacific people were over-represented in the data
- For adults, physical limitations - note, not 'disability' - were the most common type of impairment.
- 18% percent of people aged 15 or over, 64% of disabled adults, were physically impaired.
- For children, learning difficulty was the most common impairment type. 6% of children and 52% of disabled children 'had difficulty learning' (equated, in the report, to being disabled).
- Just over half of all disabled people (53%) had more than one type of impairment.
- The most common cause of disability for adults was disease or illness (42%) (note, that disability here is caused by disease or illness).
- For children, the most common cause of disability was a condition that existed at birth (49%).

A closer reading of the report shows up some other interesting findings. For instance, the population is ageing, and this is supposedly resulting in both higher rates of reported disability, and greater prevalence of multiple co-morbidities. (63% of adults over 65 report having more than one impairment). But age is a confounding variable here because 48% of children were also reported as having multiple impairments. And although percentage rates of self-reported disability among Māori and European populations were similar (26% vs 25%), the demographic profile of Māori is much younger and so if age is a factor in developing

disability, we can predict that there will be suggestions of an explosion of dependence in both of these groups in the coming years.

A full set of data can be found at the Statistics New Zealand site.

From a critical theory perspective, there are some things about the report that are troubling.

Firstly, there is the persistent medicalisation of disability. SNZ defines it as 'as long-term limitation (resulting from impairment) in a person's ability to carry out daily activities.' To continue conflating disability with impairment may be consistent with the approach taken in 2001, and reflect the way the public still views disability, but can it really be countenanced after years of struggle to overcome the limitations of the medical model of disability and attempts to move away from defining disability only as the result of an impairment? What happened to the work to establish a social model of disability that argued precisely that impairments are often irrelevant to a person's meaningful engagement in a world devoid of the barriers imposed by a normalising culture?

Then there is the tacit assumption that disability is by necessity bad or a problem. Accepting this normative judgement of disability ignores literally thousands of research studies that have shown that people neither presume that all disability is bad or that more than one kind of impairment makes matters worse (see, for example, Albrecht and Devlieger's classic paper 'The disability paradox: High quality of life against all odds). Of course the report does not overtly claim to make these judgements. It is a statistical report, after all, and we all know how objective and value-free statistics can be (!), but it doesn't need to make overt claims for the 'badness' of disability to imply that this is exactly what is meant. Promoting a press release that states that 'One in four New Zealanders (are) disabled' carries quite a different message than saying 76% of New Zealanders are not. Will health professionals take a balanced view of disability when arguing for increased funding to manage the 'growing problem of disability' that this report promotes? I think not. The report is exactly what's needed if you want to push for more funding, but in doing so whose interests are being served and whose rights are being marginalised, again?

Speaking of which, there also the problem of the ongoing quantification of a deeply human phenomenon. What harms are done to our appreciation of the nuances and subtleties of disability: its good and its bad sides; its variation among people with different socio-cultural and lived experiences; and its significance as a phenomenon that speaks volumes about our attitudes to diversity and inclusiveness in society, when we reduce the full breadth of this experience to the level of incidence and prevalence rates? Are the 2% of people reported as having an intellectual impairment suitably grouped together? Are they all of the same ilk? I think not. As a physiotherapist, I have always known that each of my patients is unique. Why

then should I suspend this belief for the lazy convenience of thinking about all people with mobility impairments (10%) as the same?

On the surface, the report purports to tell us a great deal about the growing 'problem' of disability in New Zealand. But I suspect what it really does is to offer the veneer of objectivity and the allure of transparency, while all the time concealing more than it reveals. We should be very skeptical about this kind of data and look beyond the simple slogans and press release headlines. Disability is not universally understood - despite what the report would have us believe - and we should be careful implying that it is either bad or a problem to be fixed.

Reference

Albrecht, G.L. and Devlieger, P.J. (1998). The disability paradox: High quality of life against all odds. Social Science & Medicine 48, 977-988.

The surprisingly short history of heterosexuality

27 July 2014

I did some research into the writings of Hanne Blank, the author of 'Straight: The Surprisingly Short History of Sexuality,' see this brief interview with Thomas Rogers at Salon.

I realised that there are some surprising and interesting links between Hanne's work and the history of physiotherapy.

Firstly, Blank reminds us that heterosexuality was a social construct invented to normalise sexuality at a time when late-Victorian anxieties imposed some now taken-for-granted, but no less draconian notions of 'normal' sexuality. This was exactly the time when physiotherapy as a profession was being formalised.

Normative values around (hetero)sexuality were pivotal to the founders of physiotherapy. The founders of the Society of Trained Masseuses - the forerunner of the Chartered Society of Physiotherapy, and many other physiotherapy professional bodies around the world - were heavily 'gendered' in their early years, as Grafton made clear in 1934 - 'We will make massage a safe, clean and honourable profession, and it shall be a profession for British women’ Grafton, S. A. (1934). The history of the Chartered Society of Massage and Medical Gymnastics. Journal of the Chartered Society of Massage and Medical Gymnastics, March, 229.'

The professions' founders in the UK forebode men joining the profession and only massaged men under strict instruction of a referring doctor (and only then for 'nursing' cases). Still to this day, physiotherapy is a predominantly female profession.

I discovered that Blank had also published a book titled *The Unapologetic Fat Girl's Guide to Exercise and Other Incendiary Acts*. Which reminded me of a similar book written by Linda Finn called *Largely Happy*.

Linda's work was interesting. She lived in Auckland near to our physiotherapy school and we would bring her in to talk to the students about exercise for large people. Like most developing countries, New Zealand has its own issues with body size, and we wanted to get our students to grapple with some of the issues around largeness and activity.

The conventional wisdom is that fat people are lazy, overeat, and don't do enough exercise. They gain weight because of the imbalance of inputs to outputs, and that our role as physiotherapists is to increase the outputs. Linda's book challenges a lot of those assumptions. With an exhaustive analysis of the existing literature, she argues that one of the greatest causes of ill health for large people is actually the constant dieting.

Dieting, as we know, deliberately denies the body resources and sometimes these can be vital calories, vitamins and minerals. Forcing the body to consume itself to lose weight may, she argues, be as much of a cause of heart disease, diabetes, liver problems, etc., as the body weight itself.

Linda's suggestions for activities to keep people healthy and active relied on the acceptance of people's size, not a persistent criticism of it. Physiotherapy is very body-centric, and sometimes we can inadvertently focus on the very thing that people dispose and distrust the most. This does nothing for people's motivation or perseverance.

Both Blank and Finn's work reminds us that our assumptions about what is normal are socially constructed. They have their own history and are specific to their time. Revisiting our assumptions - particularly the ones we take most for granted - is a key feature of critical thinking today and one that we could do with nurturing a lot more in our students and professional colleagues.

Social determinants of health and physiotherapy

22 August 2014

I start a week of teaching on the social determinants of health on Monday with our 1st year physiotherapy students. It's part of a course/module we run at AUT called 'Physiotherapy and Health Priorities' and it looks at applying public health principles to our practice.

Social determinants aren't something that physios have spent a lot of time studying in the past, and it's a bit alarming to see how little research is out there that points to a role for the profession. We're not even driving the ambulance at the bottom of the cliff on this issue: we're the people who pick up the patients who have left the ambulance after it's already crashed. Clearly this is not a wise or enviable position for a profession to be in with an increasingly ageing, chronically ill population of people who are suffering from a plethora of preventable 'lifestyle' disorders.

Social determinants of health are those things that people are born into, or are forced to live with, that adversely affect their health. Poverty and income inequality, unemployment, education, housing, culture and ethnicity, access to services, the physical environment, and personal safety, are just some of the key determinants that have been extensively studied (for a brief summary see, for example Marmot et al, 2008).

A recent study in America suggested that as much as 40% of the impact of health was due to socio-economic influences, with 30% being due to health behaviours like smoking, drinking and lack of exercise, and as little as 20% of the influences on health due clinical services and the quality of care (Maynard, 2014). And while I'm always highly skeptical of such gross statistics it's not hard to see that social determinants play a huge part in the health of our communities.

In New Zealand - a developed country with a small population and temperate climate - some of the figures are quite startling:

- Nearly 1 in 3 children live in poverty, while just 29,000 people hold 16% of the nation's private wealth - 3 times more than the lowest 50% of the population (Rashbrooke, 2013).
- The number of poor people in New Zealand has doubled since the 1980s, and the majority of these are women, children, Māori and Pasifika (Rashbrooke, 2013).
- Income inequality in NZ is on a par with Australia, the UK and Portugal, and while not as bad as the USA, shows a strong correlation with health and social problems (see figure below, and also this link to the Health and Social Problems Index).

A 2012 UNICEF report put New Zealand above only the USA at the bottom of a league table showing the link between poverty and child health (Innocenti Research Centre, 2012).

Unemployment is an ongoing problem for many disadvantaged people in New Zealand (Waddell & Burton, 2006). (One of the contributors to this report - health consultant Nick

Kendall - claimed at a Physiotherapy New Zealand conference a few years ago that long term unemployment had an equivalent effect on one's health to smoking 10 packs cigarettes per day).

'People who live in deprived areas are more likely to experience poor air quality, high risk water supplies, and low quality housing that has a higher likelihood or being built on a contaminated site. They experience increased hospitalisations, total mortality, injury related mortality, asthma prevalence in adults, sudden infant death syndrome, and mortality due to causes that are potentially preventable by medical treatment' (Shaw, 2004).

When it comes to discussing these issues with physio students, what is most telling is that they struggle to see themselves even having a role in tackling social determinants. Even in year 1, they don't see themselves as professionals with a responsibility for community engagement, advocacy or health policy work. Their working life will be spent fixing the problems of the patient that lies immediately under their hands.

The problem, though, is not so much trying to show them that social determinants matter - they can see perfectly well what a devastating impact poverty, pollution and lack of personal safety have on communities - it's that they don't think they can do anything about it. And their profession hardly helps.

And so, at the risk of sounding simplistic, there are (at least) five things I try to get them to think about in the hope that they recognise that they're not impotent, and that it's not somebody else's job:

- Firstly, and most basically, don't make it worse. In New Zealand, almost 60% of the profession is in private practice. Naturally, these practices aggregate in areas where people can afford the cost of care. This decreases access to physiotherapy for those who cannot afford the treatment or the costs of getting there. We could do a lot of good for people on low incomes if we could find a way to provide affordable physiotherapy in communities of need.
- Use social measures for social problems. Everything in health care is about personal responsibility these days. Rose Galvin (2002) has an interesting take on why this is. She says that we have so much health promotion and health information these days because we need to be made responsible for our own health, so that we will be liable for paying for all our care when we get older. She calls this 'culpability in the face of known risk'. Personal responsibility can be really judgmental at times, and often sounds like victim-blaming. Social determinants require a different response - a response that is about the community - the family - or society at large. Social action doesn't single people out for blame, but looks at the conditions that make good health

possible for all. Action targets the structural societal problems and not the people who suffer from them.

- Enable, don't fix. Unless you live in the community you are taking action with (and that's not a bad place to start), you will be an health care worker employed for your expertise who gets to go leave the community you're working with at the end of the day. So try to enable the people in the affected community to take their own action. Help them analyze what's going on and use your expertise to help them to make their own decisions.
- Build dependence. It sounds counter-intuitive these days when everyone is supposed to be autonomous and independent - or at most 'inter-dependent' - to advocate for dependence, but dependence is the life blood of communities: people relying on each other for help and support. Make connections, bring people together, share resources, etc. Building dependence doesn't have to be about possessiveness. If you have also helped empower people to take action for themselves they will soon let you know when your expertise is no longer needed.
- Change the economy. Find a way to channel funding to communities of need. If people earn poor wages because of poor quality education, and so have to move to areas where housing is cheaper (assuming they can afford a house), then they are more likely to live in conditions conducive to poor health and limited choices. Find a way to provide the same services in these communities that the 'worried well' have come to expect.

Governments all over the developed world are looking for 'joined-up solutions' for health problems that have their origins in the social conditions that people are born into and live with despite the choices they might like to make. If physiotherapists focus only on 'the body to hand' we will be gradually sidelined in favour of practitioners who can better meet the needs of the community.

I'll be trying this week to inspire some of our 1st year students to think that their role here involves more than telling people to lose weight, stop smoking and get more exercise. It will be interesting to see if, in the future, they're ready to take up the challenge.

References

Galvin, R. (2002). Disturbing Notions of Chronic Illness and Individual Responsibility: Towards a Genealogy of Morals. Health, 6, 107-137.

Marmot, M., Friel, S., Bell, R., Houweling, T.A.J. & Taylor, S. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. The Lancet, 372, pp. 1661-9.

Maynard, A. (2014). "If you could do one thing..." Nine local actions to reduce health inequalities. Report published by The British Academy, January 2014. Available at http://www.britac.ac.uk/templates/asset-relay.cfm?frmAssetFileID=13320. Accessed 20th August 2014.

Rashbrooke, M. (2013). Why inequality matters. In, M. Rashbrooke, Inequality: A New Zealand Crisis. Wellington, NZ: Bridget Williams Books, pp. 1-17.

Shaw, M. (2004). Housing and Public Health. Annual Review of Public Health, 25, pp. 397-418. DOI: 10.1146/annurev.publhealth.25.101802.123036

UNICEF Innocenti Research Centre, (2012). 'Measuring Child Poverty:New league tables of child poverty in the world's rich countries', Innocenti Report Card 10, UNICEF Innocenti Research Centre, Florence. Available at http://www.unicef-irc.org/publications/pdf/rc10*eng.pdf. Accessed May 15th 2013.*

Waddell, G. & Burton, A.K. (2006). Is work good for your health and well-being? Norwich, TSO. Available at http://www.activeohs.com.au/userfiles/hwwb-is-work-good-for-you-exec-summ.pdf. Accessed 10 December 2011.

What is Mobilities (WiM)?

2 October 2014

In May 2013, scholars from around the world gathered in Montreal for *Differential Mobilities: Movement and Mediation in Networked Society*. The international conference, hosted by the Mobile Media Lab (MML) in the Communication Studies department at Concordia University, brought together researchers, artists, community organizers, activists and students concerned with issues, questions and articulations connected to what Mimi Sheller and John Urry (2006) have coined, the "new mobilities" paradigm. This paradigm has been described as a turn within humanities and social science research. It focuses on contemporary social, cultural, spatial, and technological practices within an increasingly mobile world. It opens frameworks for critical inquiry and, simultaneously urges the question: what is mobilities?

A memoir of chronic pain

4 October 2014

Courtesy of my good friend and colleague Dinah Bradley (Breathing Works), a new phenomenologically-inspired non-fiction work on the lived experience of chronic pain.

How Does It Hurt?, is a memoir of chronic pain—a condition which, despite advances in the science of pain and alleviation of acute or temporary pain, remains little understood and poorly communicated, while silently reaching epidemic proportions. The narrative aims to bring visibility and a measure of clarity to the lived experience of continuing physical pain. In particular, it confronts the paradox of writing about personal pain, notwithstanding pain's resistance to verbal expression, and reflects on the ways in which other writers have lived with and written about pain; those writers include Polish poet and intellectual, Aleksander Wat, English novelist and social theorist, Harriet Martineau, and French novelist, Alphonse Daudet who believed that for victims of incurable pain, literature is 'a solace and relief... a mirror and a guide'.

Metaphors in medicine

6 November 2014

The Twitter post on Wednesday from Mike Stewart (@knowpainmike) followed on from our Tweet chat on philosophy and physiotherapy on Monday night, and quite a lot of work from people like Jack Chew (http://chewshealth.co.uk) to explore the role of metaphors in health care.

It reminded me of a meeting I had some years ago with Alan Bleakley, Professor of Medical Education and Medical Humanities at the Plymouth University Peninsula School of Medicine in England (click here to read his profile on the International Health & Humanities Network website).

We met in Reykjavik at my first In Sickness and In Health Conference and his presentation blew me away. Alan was talking about the power of metaphors in medicine. He has a passion for medical humanities (another subject vastly under-explored in physiotherapy), and talked about some of the changes that they were implementing in the medical school curriculum as a result of their research.

He presented a study where he had put visual artists in the same room as pathologists. Pathologists spend their lives looking at tissue samples under microscopes, but they learn to 'read' the images in quite biomedical ways. They look for the presentation of abnormality based on their extensive knowledge of human pathology, but it's well known that their accuracy is very variable - partly because their ability to think in literal terms is essentially an abstract and unnatural way to view the world.

So Alan got visual artists to look at the same slides that the pathologists were looking at and realised that they looked at them very differently. They had none of the pathological schooling of the scientists, but had the trained eye of a visual artist. They saw negative space,

visual fields, and, most importantly, visual representations of common objects and everyday things. One photographer looked at a slide of cirrhotic liver cells and thought it looked like a strawberry. Which, you'd have to admit, would be pretty memorable!

This got them thinking...if the pathologists could be trained to see the way the visual artists did, would it help them to be better pathologists? So they worked together looking at different slide samples, and the artists offered the pathologists their metaphors and methods of learning and, sure enough, the pathologists retained much more and dramatically reduce the error rate. Now every time one of the pathologists sees 'strawberries', they instantaneously know what they're seeing.

Metaphors are not only the province of visual artists though. Most of our patients tell stories in metaphors as ways of getting across the complexities of their life stories in the limited time we give them to explain why they need us. Like the pathologists, we're often not that great at seeing what they're saying because we've focused so much on our objective measurement skills. Hopefully, Mike, Jack and the other physios now looking at metaphors in pain, neuroscience and elsewhere will provide some good advice on how to make more of metaphors in the future.

Check your privilege: Diagnosing cultural agnosia

27 November 2014

Without wanting to sound like a pollyanna, I sometimes wonder if I'm not the luckiest man alive. I live in a beautiful country where human and natural disasters can often seem a long way away; I'm well paid for a job I love; I have ready access to fresh food and water; I'm healthy, and can fall back on public services that have reliably educated my children, emptied my rubbish bins, and generally kept the lights on. I live in a democracy where I can vote to bring about a change, I enjoy a free press, long hot summers, and TV channels that show regular baseball. There are billions of people around the world, who would give their right arm to be blessed with only half of these things.

Bill Bryson has talked about how we're all blessed in some ways. Over the long stretch of the history of the universe, we are at the height of our technical and social sophistication. Poverty and pestilence are behind us and the worst effects of climate change are a problem for tomorrow. Given all of this, I think I could be forgiven for taking a long summer holiday basking in the glow of my own personal achievements, and looking forward to another year of socially validated magnificence. The only person who could gloat more

than me is the Queen of England who, by some freakish act of birth, is enjoying even more sumptuous prosperity than I am. (A fact for which I am justifiably jealous).

Being a white, European male certainly has its advantages, not least the ability to take these privileges for granted. Glenn Colquohoun - a New Zealand GP and poet - put it beautifully when he said that 'The most difficult thing about majorities is not that they cannot see minorities but that they cannot see themselves.' (Glenn Colquhoun, 2004, Jumping Ship, Four Winds Press). Colquohoun was talking about the dominant European culture in New Zealand and its relationship with New Zealand's indigenous 'people of the land' or tangata whenua, but the same could be said for almost every dominant culture.

One of the characteristic features of dominant groups in society is that they think that 'culture' is something other people have. Culture becomes synonymous with ethnicity, so culture is something that brown- or black-skinned people have not 'us' whites. It largely ignores the full richness of culture that, of course, frames everyone's existence. White European males are as immersed in their own cultural heritage as everyone else, we just don't often seem to feel the need to acknowledge it, because we're the ones at the top of the social heap, and difference is something you don't have to worry about if you're getting all the plaudits.

Profession's can have cultural identities as well as people. But ask a physiotherapist about the culture of their profession and they will be hard pressed to tell you (a sure sign that physiotherapy is a profession enjoying some cultural privileges by virtue of its white European history.) The truth is we pay almost no attention to the profession's cultural identity (or the plural 'identities' would probably be more accurate here.) We don't articulate our professional culture to our students, preferring instead for them to imbibe it through a curriculum which emphasises objectivity, biomedicine and orthodoxy. We don't write about our culture in the literature. And we don't define it in our scopes of practice or professional definitions. Interestingly, over the last few years we have begun to have some of these discussions, and these discussions have coincided with the profession moving to university-based education and losing some of its prior authority. As physiotherapy is increasingly forced to account for itself, it is increasingly asking what it is and where is it going.

Our Critical Physiotherapy Network has a vital part to play here. We can critique some of the taken-for-granted assumptions that underpin the profession. We can be much more vocal about checking our own privilege and recognising that good quality health care begins with a desire to work alongside others who have as much right as we do to enjoy the pleasures of good health, a full stomach and a comfortable home. We can privilege our stories, build communities and networks. We can talk about our history, our present tensions and future dilemmas. We can show solidarity with our colleagues and advocate for those who have been systematically marginalised throughout decades of scientifically-dominated health care.

So here are six suggestions for positive steps you can take today to open physiotherapy up to more cultural diversity:

- Recognise your own cultural identities - make your cultural difference a part of your practice, talk about it and share it with people
- Create learning and therapeutic spaces where everyone can feel safe to be themselves. The profession is made up of myriad people from so-called 'minority' cultures. We owe it to our students and colleagues to embrace the full diversity of our cultures
- Talk about the cultural histories of the profession and explore what cultural influences affect physiotherapy today
- Set up networks or groups of people who share something of your cultural identities. We need LGBT lobby groups, women's issues groups, physios of colour, disabled physiotherapy collectives, and a host of other diverse groups to open up the profession
- Take a critical stance to challenge, critique and actively resist attitudes that overtly ignore cultural difference
- Search out those hidden attitudes that perpetuate casual sexism, homophobia, racism and other forms of bigotry and make them visible

These are just some ideas. Of course, there is something very wrong about a white, male, European physiotherapist claiming any kind of mandate to advocate for these things. At best it can sound earnest and well intentioned, at worst horribly patronising. But these things need to be said, and if it comes from someone in a position of relative privilege then all the better.

There will be lots of people in the profession who vehemently disagree with this post and I understand that. It would be a terrible thing to replace our current myopic view of our own cultural histories with a new, equally autocratic hegemony. So we need to keep in mind that our role is about opening space for difference, inclusiveness, respect and dignity for all rather than dogmatic imposition of our own cultural biases. If we can do this, we will be taking important steps in resisting more than a century of cultural agnosia.

Being critical

6 January 2015

In yesterday's post I mentioned the Hybrid Pedagogy site and the work they had done to define what it means to be critical in education. As a critical physiotherapy network, it's

probably important that we do the same thing and articulate how we think we are critical, because there are so many different meanings for the word, it could easily be misleading.

Critical can mean:

1. Intensive care and the physiotherapy that is given to people in life-threatening situations
2. Critically and systematically analysing the quality and content of research articles

These are almost certainly the approaches to criticality most familiar to physiotherapists today. The first is a very specialised field of practice. The second is driven by the requirement for our practice to be research- and evidence-based and is something that every physiotherapy student has to be familiar with if they are to become registered professionals. But there are other meanings to the word critical that unite people in the Critical Physiotherapy Network and these are more relevant to our work and so need to be unpacked.

While some members of the Network operate in intensive care units and most will critically analyse research articles, what unites members of this Network is the sense that:

- There is a time-critical project to reform the physiotherapy profession so that it can better serve the needs of the population in the 21st century;
- A necessary part of this project is the critical analysis of the profession's cultures, histories and philosophies (note the plurality here. Getting away from the idea of the profession as a singular entity is just one of the ways this approach to criticality can be applied to future practice);
- There are power asymmetries implicit in health care that the profession perpetuates that need to be understood and challenged. Our beliefs about what is normal (movement, function, ability, etc.); the privilege we give to our knowledge compared with the knowledge of our service-users; and our profession's limited acknowledgements of diversity of gender, ethnicity, culture, sexual orientation and language, for example, are powerful sources of social oppression that demand critique;
- There are well established methodologies, philosophies and theories that extend beyond the confines of quantitative research and positivism that the profession knows little about but could bring important insights into our past, present and future thinking and practice, and that these warrant greater examination;
- A constant critical attitude towards those things that appear to be most taken-for-granted and obvious in the profession is good and necessary if we are going to open the door to thinking otherwise and better prepare the profession for the future.

In the social sciences, the concept of Critical Theory is well established (see Agger, 1991; Cheek & Rudge, 1994; Crossley, 2005; Kincheloe & McLaren, 2000, for example), and derives from the work of The Frankfurt School - an influential and independent group of researchers and theorists who were influenced by anti-capitalist ideas about society in the years between the two World Wars.* Some famous social theorists were associated with The Frankfurt School including Max Horkheimer, Theodor Adorno, Erich Fromm, Herbert Marcuse, and the school influenced continental philosophy for much of the twentieth century. Many of the approaches to qualitative research that people use today (including ethnography, grounded theory, social surveys and observational studies), derive from approaches to the analysis of the social world pioneered by The Frankfurt School.

But today, critical theory is a major strand of research in health care generally and has moved well beyond the early work of The Frankfurt School, and there is a large body of work in nursing, psychology, medical sociology and education to refer to. Here, gender studies, disability theories and post-colonial research offers a powerful critique of our long-standing affinity with Euro- and andro-centric, science-based practice. These are all things we as a group are eager to pursue and promote in our attempt to move beyond seeing the word critical as only the province of people who work in ICU or students who do systematic reviews of the literature.

References

Agger, B. (1991). Critical theory, poststructuralism, postmodernism: Their sociological relevance. Annual Review of Sociology, 17, 105-131. doi:10.2307/2083337

Cheek, J., & Rudge, T. (1994). Been there, done that? Consciousness raising, critical theory and nurses. Contemporary Nurse, 3(2), 58-63.

Crossley, N. (2005). Key concepts in critical social theory. London: Sage.

Kincheloe, J. L., & McLaren, P. (2000). Rethinking critical theory and qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 281-285). London: Sage.

*With growing concern for the rise of National Socialist in Germany, Horkheimer moved The Frankfurt School to Geneva in 1931 before relocating it to Columbia University in New York in 1934.

Uncertainty, luxury and creativity - a brief compendium

13 Jan 2015

Last week I posted a compendium of some of the things I had found over the Christmas holiday that I thought might be interesting to people interested in all things critical. Here is another post pulling together some interesting loose strings and ephemera from the last 3 or 4 weeks.

Uncertainty is a major theme for me in the pursuit of a more critically-informed physiotherapy. It seems to me that the ability to embrace uncertainty will be a vitally important capability for future practice - a point made in this post from the ever reliable and interesting Steve Wheeler.

David Warlick once said 'for the first time we are preparing young people for a future we cannot clearly describe.' In a fast changing world where everything technology touches grows exponentially, we really are in serious trouble if we cannot prepare children for uncertainty. And yet that is exactly what many school curricula are failing to do.

One critique often missing from the physiotherapy literature surrounds it's strongly Western heritage. Physiotherapy is a very white, European, some might even say male and Judeo-Christian profession. Part of the support for this statement comes from its affinity with the Western idea that individual autonomy is good and collectivism is bad. This recent paper by Thaddeus Metz (How the West Was One: The Western as individualist, the African as communitarian) provides a good background to these ideas.

> Abstract: There is a kernel of truth in the claim that Western philosophy and practice of education is individualistic; theory in Euro-America tends to prize properties that are internal to a human being, such as her autonomy, rationality, knowledge, pleasure, desires, self-esteem and self-realisation, and education there tends to adopt techniques focused on the individual placed at some distance from others. What is striking about other philosophical–educational traditions in the East and the South is that they are typically much more communitarian. I argue that since geographical terms such as ‘Western’, ‘African’ and the like are best construed as picking out properties that are salient in a region, it is fair to conclude that the Western is individualist and that the African is communitarian. What this means is that if I am correct about a noticeable contrast between philosophies of education typical in the West and in sub-Saharan Africa, and if there are, upon reflection, attractive facets of communitarianism, then those in the West and in societies influenced by it should in some real sense become less Western, in order to take them on.

The article provoked a set of questions for me: How did physiotherapy become so 'western', and what has been gained and what has been lost in the pursuit of Westernism?

Over the next few months I'm going to be doing some work into the concept of luxury (see link) to think about how this idea has influenced the history of physiotherapy. Luxury is related closely to the idea of surplus which, in turn, has played a big part in the development of things like trade and commerce which have profoundly shaped global culture over the last 500 years. In some ways physiotherapy is a product of luxury. The modalities of treatment we claim as our own don't require a physiotherapist to perform them - or else they wouldn't have existed until we came into being as a profession at the end of the nineteenth century. Instead, they became 'ours' at a point when there were enough people able to afford our services (they had surplus income). I wonder how this idea will affect how the profession develops in these post-welfare days where people will be expected to use their own disposable income again to pay for our care. And what will it mean for those who have no surplus?

And on the theme of surplus and uncertainty comes this from the site Explore.

> How can creativity be associated with all of these things: openness to experience, inspiration, high energy, impulsivity, rebelliousness, critical thinking, precision, and conscientiousness? … Creativity involves many different stages. Those who are capable of reaching the heights of human creative expression are those who have the capacity for all of these characteristics and behaviors within themselves and are flexibly able to switch back and forth between them depending on the stage of the creative process, and what's most adaptive in the moment.

So much of this speaks to the shifting attitude we are all now required to adopt if we're going to prepare our students for work in the 21st century.

And finally, if you're a Twitter fan, the #physiotalk tweet-chats start again today with the first of the year co-hosted by Anna Lowe (@annalowephysio) and Rachael Young (@physioyoung) from my old alumni at Sheffield Hallam Uni. The chat runs on Monday 12th January 8pm (GMT) - about an hour away. So hopefully see you there.

Walking, disability rights and embodiment

13 January 2015

In her short video, Judith Butler explores the lived experience and some of the social and political dimensions of disability with Sanaura Taylor in a walk through the streets of San Francisco. During the walk they challenge the normative definition of the idea of walking and talk about how disability is often projected on to people by our stereotypical attitudes.

One of the things that really moved me was their discussion of the normality of obtaining help from people. This feeds into one of the growing critiques of Western culture - and we see it coming through really strongly in health care, particularly when funding cuts are being made - and that is that we should not be looking for autonomy and independence, but rather mutual support and community. At one point Butler comments that "maybe we have a false idea that the able-bodied person is self-sufficient."

An interesting paper that looks at some of the complexities of autonomy in the context of physical illness is Dekkers, W. J. (2001). Autonomy and dependence: Chronic physical illness and decision-making capacity. Medicine, Health Care and Philosophy, 4(2), 185-192.

A short history of medicine

17 January 2015

I have a headache:

> 2000 BC: Here, eat this root.
>
> 1000 AD: That root is heathen. Here, say this prayer.
>
> 1850 AD: That prayer is superstition. Here, drink this potion.
>
> 1940 AD: That potion is snake oil. Here, swallow this pill.
>
> 1985 AD: That pill is ineffective. Here, take this antibiotic.
>
> 2015 AD: That antibiotic is artificial. Here, eat this root.

The remarkable Flo Fox

9 March 2015

The celebrated New York City street photographer Flo Fox is partially blind, has lung cancer and has been living with multiple sclerosis since the age of 30. In a wheelchair since 1999 and unable to handle her camera on her own, she needs help – from her attendants, friends, even passersby – to take photographs. Amazingly, Fox not only remains humorous and energetic, she has also retained her keen sense for reframing moments, people and places in an endlessly chronicled city, bringing surprising new life to her subjects.

Intimately shot with a focus on how Fox navigates the streets of New York City, Riley Cooper's short documentary was a festival favourite in 2012, taking home awards at DOC NYC and

the Lower East Side Film Festival, and playing in programmes at the Camden International Film Festival in Maine, Hot Docs in Toronto and Palm Springs International Shortfest.

Director: Riley Hooper

Editor: Riley Hooper

Original music: Chris Zabriskie

Language: English

Sound: Riley Hooper, Sonia Lessuck

Website: rileymakesdocs.com/

I love superstitions - Oscar Wilde (and here's why)

11 March 2015

“Bring something incomprehensible into the world!”

— Gilles Deleuze, Thousand Plateaus: Capitalism and Schizophrenia

Founded in the 1880s by Manhattan rationalists, the 13 Club held a regular dinner on the 13th of each month, seating 13 members at each table deliberately to laugh at superstition.

> “I have given some attention to popular superstitions, and let me tell you that argument is powerless against them,” founding member Daniel Wolff told journalist Philip Hubert in 1890. “They have a grip upon the imagination that nothing but ridicule will lessen.” As an example he cited the tradition that the mirrors must be removed from a room in which a corpse is lying. “Make the experiment yourself, and the next time you are called upon to sit up with a corpse, notice how uncomfortable a mirror will make you feel,” he said. “Of course it is a matter of the imagination, but you can’t reason against it. All the ingrained terrors of six thousand years are in your bones. You walk across the floor and catch a glimpse of yourself in the glass. You start; was there not a spectral something behind you? So you cover it up.”

As honorary members the club recruited 16 U.S. senators, 12 governors, and six Army generals. Robert Green Ingersoll ended one 1886 toast by declaring, “We have had enough mediocrity, enough policy, enough superstition, enough prejudice, enough provincialism, and

the time has come for the American citizen to say: ‘Hereafter I will be represented by men who are worthy, not only of the great Republic, but of the Nineteenth Century.'”

But Oscar Wilde, for one, turned them down. “I love superstitions,” he wrote. “They are the colour element of thought and imagination. They are the opponents of common sense. Common sense is the enemy of romance. The aim of your society seems to be dreadful. Leave us some unreality. Don’t make us too offensively sane.”

’La Masseuse' by Degas

15 March 2015

Originally modelled in plastiline clay in the mid-1890s, this version cast in bronze after 1918. Height 42cm

Best known for his impressionist painting, sculpture was for Degas mainly a private activity. He thought of his sculptures like sketches or drawings, as a way of developing a composition.

'La Masseuse' is Degas’ only two-figure sculpture. The masseuse massages the thigh of a naked woman, who holds her buttock in relief or pain. The emphasis of 'La Masseuse' on the effects of physical activity on bare female flesh highlights the artists dedication to depicting human, and in particular female, endeavour.

Information courtesy of the Walker Art Gallery, Liverpool.

Childhood obesity, play and critical thinking

30 March 2015

One of the most important functions of critical thinking is to go 'against' the prevailing wisdom: to go against convention; to think the impossible or the unreasonable; to entertain the possibility that our present way of thinking is neither the best or most appropriate way. One way to do this is to look back to a time when people thought otherwise and to ask whether we are necessarily smarter today, or just different.

This is not easy to do. Thinking against conventional wisdom immediately puts you in a minority position and opens you up to the easy dismissal of the comfortably popular. But that's exactly why critical thinking is so important, because it is directed at tomorrow, not today.

So as Karl Popper argued with his theory of falsificationism, we should pay attention to those arguments that challenge and maybe even contradict our present way of thinking, not seek to bolster that which is taken-for-granted and obvious.

There are lots of examples of quotidian thinking in health care at the moment. Things like 'evidence based practice is vital,' 'people should exercise for 30 minutes three times a week,' 'sitting down for long periods is bad for you,' and possibly the most pernicious 'obesity is a silent epidemic threatening the present and future health of the population.'

The power of such discourses creates the possibility for equally powerful counter-narratives - or countervailing powers, as Donald Light called them (Light, 1993) - and the authors of a recent article in Sociology of Health & Illness have certainly attempted this in their paper 'You have to do 60 minutes of physical activity per day … I saw it on TV': Children's constructions of play in the context of Canadian public health discourse of playing for health (Alexander, Fusco & Frohlich, 2015).

> Abstract: Public health institutions in many industrialised countries have been launching calls to address childhood obesity. As part of these efforts, Canadian physical activity campaigns have recently introduced children's play as a critical component of obesity prevention strategies. We consider this approach problematic as it may reshape the meanings and affective experiences of play for children. Drawing on the analytical concept of biopedagogies, we place Canadian public health discourse on play in dialogue with children's constructions of play to examine first, how play is promoted within obesity prevention strategies and second, whether children take up this public health discourse. Our findings suggest that: (i) the public health discourse on active play is taken up and reproduced by some children. However, for other children sedentary play is important for their social and emotional wellbeing; (ii) while active play is deemed to be a solution to the risk of obesity, it also embodies contradictions over risk in play, which children have to negotiate. We argue that the active play discourse, which valorises some representations of play (that is, active) while obscuring others (that is, sedentary), is reshaping meanings of play for children, and that this may have unintended consequences for children's wellbeing.

What's interesting to me about this paper is how physiotherapists are being pulled into this debate about children's health and wellbeing. These arguments create some real tensions for our profession, and they're not something we're particularly good at grappling with. How do we see ourselves helping these children best? Do we see ourselves competing with physical activity campaigners and practitioners in order to secure the government

funding that often accompanies these kinds of panic? Are we targeting our action at the children and their families, which is easier and fits in nicely with a dominant blaming culture, or are we looking at the deeper and more complex social determinants of these problems?

Whatever our response, we should not be afraid to think against convention wisdom and ask critical questions about our role in future health care. Indeed our own future health may depend on it.

References

Alexander, S. A., Fusco, C., & Frohlich, K. L. (2015). 'You have to do 60 minutes of physical activity per day … I saw it on TV': Children's constructions of play in the context of canadian public health discourse of playing for health. Sociology of Health & Illness, 37(2), 227-240. doi:10.1111/1467-9566.12179.

Light, D. W. (1993). Countervailing power: The changing character of the medical profession in the united states. In F. W. Hafferty & J. B. McInlay (Eds.), The changing medical profession: An international perspective (pp. 69-79). Oxford: Oxford University Press.

What work is, by Phillip Levine

4 April 2015

Something reflective for your Easter weekend. Happy holidays everyone.

We stand in the rain in a long line

waiting at Ford Highland Park. For work.

You know what work is--if you're

old enough to read this you know what

work is, although you may not do it.

Forget you. This is about waiting,

shifting from one foot to another.

Feeling the light rain falling like mist

into your hair, blurring your vision

until you think you see your own brother

ahead of you, maybe ten places.
You rub your glasses with your fingers,
and of course it's someone else's brother,
narrower across the shoulders than
yours but with the same sad slouch, the grin
that does not hide the stubbornness,
the sad refusal to give in to
rain, to the hours wasted waiting,
to the knowledge that somewhere ahead
a man is waiting who will say, "No,
we're not hiring today," for any
reason he wants. You love your brother,
now suddenly you can hardly stand
the love flooding you for your brother,
who's not beside you or behind or
ahead because he's home trying to
sleep off a miserable night shift
at Cadillac so he can get up
before noon to study his German.
Works eight hours a night so he can sing
Wagner, the opera you hate most,
the worst music ever invented.
How long has it been since you told him
you loved him, held his wide shoulders,
opened your eyes wide and said those words,
and maybe kissed his cheek? You've never

done something so simple, so obvious,

not because you're too young or too dumb,

not because you're jealous or even mean

or incapable of crying in

the presence of another man, no,

just because you don't know what work is.

Social determinants of health - are we doing enough?

14 April 2015

Physiotherapists don't generally think our profession is 'political.' We mostly work on people's bodies, in one-to-one sessions, and few of us use our social standing as respected, orthodox health professionals to campaign for community causes. There are no physiotherapy-specific models of population health, and subjects like primary health care and health promotion are only just beginning to appear in undergraduate curricula. So while physiotherapists are experts in the assessing and treating the body-as-machine, and we are increasingly interested in people lived experiences of health and illness, we are less aware of the social determinants of health.

Social determinants are those things that people are born into or live with against their will. These are not the behaviours people exhibit, like smoking, eating poor quality food, playing contact sports, but the things they have little or no choice over. These are things that negatively affect their health and wellbeing: poverty and incomes, housing, education, access to services, environmental pollution, food, social justice, etc.

The evidence is now absolutely clear: the worst health is not the result of bad choices - although this is certainly a factor further down the line - but the result of conditions that people often have little or no control over.

To give an example, a child born into a poorly insulated, cold damp house is significantly more likely to suffer respiratory illness, die prematurely, or suffer from community-acquired illness. Because their family is poor, they will often live in an area where the schooling is less than ideal which compounds the time off taken by the sick child. The child leaves school early and gains few qualifications. This results in a lifetime spent in poor paying, unstable, mostly part time jobs and struggling to make ends meet. The cost of housing in the nice parts

of town is prohibitive, so the young family moves to a poorer area where the roads are noisy and polluted, the services are less well connected and the housing stock is poor. They are naturally further from health care services and can't afford to travel the extra distance to clinic appointments. They consume poor quality food because it's cheap and available and the most available calories at the lowest cost. Their children are born into poorly insulated, cold damp houses...and so the cycle continues.

These are stereotypes, for sure, and I do not wish to portray everyone who is struggling to make ends meet as the warden of a failed state. There are many admirable stories of people lifting themselves out of poverty, and stories of people surviving really appalling conditions to make good. But these are rare compared with the millions of people who don't have the luxury of choice.

There is now an enormous body of work showing how important social determinants are. A recent post from the Canadian Medical Association highlighted the role that doctors should play in turning around the effects of social determinants. This pointed to an amazing collection of resources held by the Institute of Health Equity in the UK, under the leadership of Sir Michael Marmot - probably the world's leading authority on social determinants.

The question remains though, what should we do?

Firstly, we should be more aware of the problem of social determinants. For some years I've taught this subject to physiotherapy students at AUT, and you can find a link to an introductory lecture I do here. You're free to use this in whatever way you want. There are many other freely available resources on the internet too should you want to be more familiar with the arguments or the evidence - see the bottom of this post for some more useful resources.

Then we should consider how we can use our professional status to fight the causes of ill health in our communities. Too much time is being spent on telling people to lose weight and get more exercise. These may be important things to say, but they stigmatise people and encourage lazy, victim-blaming attitudes instead of looking at the root causes of poor health. (What's more, you don't need a three or four year degree to tell someone to try stop smoking.) We should be looking further than this; going beyond the rhetoric to more insightful interventions.

As Helen Kelleher and Colin McDougall say in their excellent book Understanding Health, ‘One of the problems with contemporary health care is that it focuses on ‘soft target’ risk factors ‘such as physical activity, nutrition and weight control that target individuals rather than environments and structural conditions that in turn, are causal pathways for heart disease, diabetes and cancer’ (Keleher & MacDougall, 2009, p. 28).

Physiotherapy could make a really significant contribution to social determinants of health, but we will need to move a lot away from our individualistic approach if we are to make the changes that millions of people are calling out for.

References

Kelleher, H. & MacDougall, C. (2009). Understanding health: A determinants approach. South Melbourne, Oxford University Press.

Pain or suffering?

15 May 2015

For a lot of its advocates, and there are many, pain has become a touchstone for new kind of physiotherapy practice: a more holistic, complex and person-centred practice that is more in tune with the modern face of healthcare; a healthcare where people want more from their health professional than 15 minutes of interferential and a quick manipulation.

Some of the pain specialists in our profession are treated like rock stars and their presentations are guaranteed to fill out venues whenever they speak. People like Lorimer Moseley and David Butler have built their careers on bridging the divide between science and practice, the profession and public, and finding ways to make pain understandable. They are wonderful teachers and brilliant thinkers.

But for all of their work connecting people with a better understanding of pain, however, their message is still underpinned by a scientific, biomedical view of the body in health and illness. Granted, there is much more talk about pathways, systems and structures than we used to entertain, but pain is still understood as a biological process, coordinated by the brain, organised by psychology, and objectively mapped by science.

In many ways this is serving the profession well, because it is making us think about how complex health is; how our approach might intersect with other professional discourses; and how much more might be known about multifaceted health problems like pain. But I would make two more critical observations about our present interest in chronic, persistent pain.

Firstly, why are we focusing so much on pain and not on other long term, complex, subjective phenomena like chronic breathlessness, long term mental health problems, disability, or frailty in the elderly? Why are there no rock stars of COPD or addiction, diabetes or TBI? Are these not equally as challenging as pain (for clients/patients, therapists, and the healthcare system)? Are they less of a government priority? Are they, in some way, less worthy?

Secondly, despite the rhetoric, our recent interest in pain remains firmly embedded in the biological sciences. Lorimer Moseley's book Painful Yarns for example, uses metaphors as a powerful linguistic device used to make complex things understandable. But these metaphors are not used to explain the true nature of suffering that accompanies pain, but rather to understand modern pain biology.

Equally, in the abstract to Butler and Moseley's Explain pain book, the authors use the metaphor of the orchestra to explain why the book is necessary:

Imagine an orchestra in your brain. It plays all kinds of harmonious melodies, then pain comes along and the different sections of the orchestra are reduced to a few pain tunes. All pain is real. And for many people it is a debilitating part of everyday life. It is now known that understanding more about why things hurt can actually help people to overcome their pain.

The orchestra metaphor works well to explain certain things about pain, but the metaphor is interesting because it still resonates with the kind of reductive thinking that has been characteristic of medicine since the late 19th century. Some of the proponents of the 'new pain' have trumpeted the value of the biopsychosocial model as evidence of a more holistic view, but this model itself has been criticised for being an attempt by the medical profession to appear more holistic whilst retaining its monopoly on bio-centric thinking (see, for example, Malmgren, 2005; Nassir Ghaemi, 2010; Quinter et al, 2008; Weiner, 2007). This abstract from the paper Pain medicine and its models by Quinter and colleagues provides a flavour of this criticism:

> Objective: To identify whether the biopsychosocial framework of illness has overcome the limitations of the biomedical model of disease when applied in the practice of pain medicine. Design: Critical review of the literature concerning the application of biopsychosocial models to the praxis of pain medicine and the concepts of living systems. Results: The biopsychosocial model of illness, formulated by Engel in 1977, has generated the International Association for the Study of Pain (IASP) definition of pain, two major conceptual frameworks in pain medicine, and three putative explanatory models for pain. However, in the absence of a theory that seeks to understand the lived experience of pain as an emergent and unpredictable phenomenon, these progeny of the biopsychosocial model have been caught in circular argument and have been unable to overcome biomedical reductionism or the perpetuation of body–mind dualism. In particular, the implication that pain can be a “thing” separate and distinct from the body bears little relationship to the lived experience of pain. Such marginalizing results when an observer attempts to reduce the experience of the pain of another person. Conclusions: The self-referentiality of living

> systems (through their qualities of autopoiesis, noncentrality and negentropy) sees pain "emerge" in unpredictable ways that defy any lineal reduction of the lived experience to any particular "thing." Pain therefore constitutes an aporia, a space and presence that defies us access to its secrets. We suggest a project in which pain may be apprehended in the clinical encounter, through the engagement of two autonomous self-referential beings in the intersubjective or so-called third space, from which new therapeutic possibilities can arise.

The problem physiotherapists face with coming to understand the real complexity of chronic pain is emblematic of the larger struggle the profession faces as we move into a post-biomedical, post-welfare, post-acute illness world, where people live with multiple, complex problems that, like pain and breathlessness, can only be understood by the person experiencing them.

Fortunately, there are other rock stars in the profession, whose work points to some entirely new ways to think about phenomena like pain, and many of these have been immersed for years in a deep appreciation for the lived experience of health and illness (see for example, the work of people like Jennifer Bullington, Tove Dragesund and Malfrid Råheim - references below).

What these authors address is not so much pain as suffering: the human, lived, embodied experience of spending day after day unable to sleep, worrying about your future; anxious to try to be brave, but always trying to prove to health professionals that what you feel is real; struggling even to get dressed in the morning; battling with self-doubt and feelings of worthlessness: exactly the kinds of things our clients/patients bring with them when they come to see us for care, cure, support, advocacy, reassurance, validation and the hope of a better tomorrow.

There are perfectly valid reasons why physiotherapists should continue to draw on biologically-centred models to help us to understand pain better, but pain itself remains a metaphor for a scientific approach to the body that constrains as much as it enables, and perhaps a shift in focus to the more human phenomenon of suffering might allow our practice to become more person-centred in the future?

References

Bullington, J. (2009). Embodiment and chronic pain: Implications for rehabilitation practice. Health Care Analysis, 17(2), 100-109. doi:10.1007/s10728-008-0109-5.

Bullington, J., Nordemar, R., Nordemar, K., & Sjöström-Flanagan, C. (2003). Meaning out of chaos: A way to understand chronic pain. Scandinavian Journal of Caring Sciences, 17(4), 325-331. doi:10.1046/j.0283-9318.2003.00244.x.

Bullington, J., Sjöström-Flanagan, C., Nordemar, K., & Nordemar, R. (2005). From pain through chaos towards new meaning: Two case studies. The Arts in Psychotherapy, 32(4), 261-274. doi:10.1016/j.aip.2005.04.007

Ghaemi, S. N. (2010). The rise and fall of the biopsychosocial model : Reconciling art and science in psychiatry. Baltimore: Johns Hopkins University Press.

Dragesund, T., & Råheim, M. (2007). Norwegian psychomotor physiotherapy and patients with chronic pain: Patients' perspective on body awareness. Physiotherapy Theory and Practice, 24(4), 243-254.10.1080/09593980701738400.

Dragesund, T., & Råheim, M. (2008). Norwegian psychomotor physiotherapy and patients with chronic pain: Patients' perspective on body awareness. Physiotherapy Theory and Practice, 24(4), 243-54. doi:10.1080/09593980701738400.

Lundberg, M., Styf, J., & Bullington, J. (2007). Experiences of moving with persistent pain: A qualitative study from a patient perspective. Physiotherapy Theory and Practice, 23(4), 199-209. doi:10.1080/09593980701209311.

Malmgren, H. (2005). The theoretical basis of the biopsychosocial model. In P. White (Ed.), Biopsychosocial medicine (pp. 21-35). Oxford: Oxford University Press.

Øien, A. M., Råheim, M., Iversen, S., & Steihaug, S. (2009). Self-perception as embodied knowledge-changing processes for patients with chronic pain. Advances in Physiotherapy, 11(3), 121-129. doi:10.1080/14038190802315073.

Quintner, J. L., Cohen, M. L., Buchanan, D., Katz, J. D., & Williamson, O. D. (2008). Pain medicine and its models: Helping or hindering? Pain Medicine, 9(7), 824-834. doi:10.1111/j.1526-4637.2007.00391.x.

Råheim, M., & Håland, W. (2006). Lived experience of chronic pain and fibromyalgia: Women's stories from daily life. Qualitative Health Research, 16(6), 741-761. doi:10.1177/1049732306288521.

Weiner, B. K. (2007). Difficult medical problems: On explanatory models and a pragmatic alternative. Medical Hypotheses, 68(3), 474-479. doi:10.1016/j.mehy.2006.09.01.

No sex please, we're physiotherapists

19 May 2015

The physiotherapy profession has a rather odd relationship with sex and sensuality. On the one hand, it lies at the heart of everything that physiotherapists do, on the other it is almost completely invisibly; un-theorised, glanced over in graduate programmes, and almost invisible in models that try to explain what physiotherapy is and isn't. Over the course of the next few blogposts, I want to tackle some of the issues that surround sex and physiotherapy and see if we can't develop a more mature appreciation for it's everyday role in defining our professional subjectivity. To begin with, we should acknowledge the role that sex played in the formation of the physiotherapy profession.

The physiotherapy profession as we know it today, began when four young nurses and midwives formed the Society of Trained Masseuses in the summer of 1894 in response to what the British Medical Journal called the Massage Scandals (BMJ, 1894). Massage had become extremely popular, especially among the affluent classes in the large towns and cities of Europe and North America. Unfortunately, its popularity meant that it attracted all manner of practitioners, many of whom were self taught, or had received only the briefest training. It was possible for a masseur or masseuse (the gender differentiation is significant here), to obtain a certificate from a doctor or training school after only half a day's study, and so it became increasingly difficult to distinguish who was a legitimate practitioner and who was a quack.

Worse still, massage became known as a way for brothels to avoid being closed down by police, which led many legitimate masseuses to despair that they would always be confused with prostitutes. Well paid, reliable work was hard to come by and there was no efficient way to convince the government of the day, the medical profession, or the public that massage could be performed without impropriety.

The Massage Scandals forced a small group of young nurses and midwives to form the Society of Trained Masseuses (STM), and their singular purpose was to make massage 'a safe, clean and honourable profession, and it shall be a profession for British women' (Grafton, 1934 p.229). In other words, they had to find a way to show that it was possible to touch people - sometimes in quite intimate and private ways - without any accusation of licentiousness. How they did this was both fascinating, brilliant and profoundly influential in the history of the physiotherapy profession (for a more detailed account, see Nicholls & Cheek, 2006; Nicholls & Gibson, 2010).

The founders of the STM - the organisation that would be the progenitor of most physiotherapy professional bodies around the world - did four radically important things; each one designed to restrain the sensual nature of massage practice:

- They only trained women. For the first 20 years, no men could register as STM members or gain access to patients.
- They only treated women. Prior to WWI, men could be treated but only rarely, and under the strictest medical conditions
- They aggressively promoted the medical view that the body should be treated as a machine - thus securing the trust of many doctors and guiding tutors to train their students to see 'body' parts not 'private' parts (apologies, I couldn't resist this pun.)
- They only allowed people to register and gain access to medical referrals if they passed the Society's examination, which focused on the twin disciplines of their biomechanical view of the body, and the Society's highly moral code.

What these steps were brilliantly effective in doing, was distancing the profession from scandal, and giving practitioners a de-sensualised view of the body that would be reassuring to the practitioner, the doctor and the patient. What they were not able to do, however, was completely remove sensuality from the experience of touch - a problem that has always, and will always remain for those who use intimate forms of touch in their practice:

> 'Many of us are led to this work (massage) for high-minded reasons. For most, there's a wish to bring greater ease into the lives of others. Some even see this work as a sacred calling, a way to heal the soul and enliven the spirit. But despite the good intentions we bring to our sessions, because we're working closely with the physical body, we can't avoid the murkiness and confusion of sexual issues' (McKintosh, 2005, p. 100).

The sensuality of touch cannot be avoided. We might choose to manage it and regulate it, but it cannot be entirely effaced. This, then, creates an enduring problem for anyone who practices touch-based therapy. Speaking specifically about physiotherapy, it might be argued that the profession has benefited hugely from our legitimate and orthodox history, and maybe this explains why sex and sensuality are so rarely discussed within the profession. But equally, there may be things that physiotherapists are not able to do because of their highly regulated approach to sex and sensuality, and these things may be becoming increasingly important as people demand more from their professional practitioner than a technician who views their body as a machine (see, Nicholls and Holmes, 2012).

Some have argued that physiotherapy's over-regulated approach to touch is now getting in the way of a more holistic engagement with people and the full sensuality of massage:

> '…the term "massage," alas, still seems to be tainted in many quarters by its common associations with touchy-feely parlors, and even with disguised prostitution. This is an unfortunate situation, and one that is unfair to a large number of legitimate practitioners... It is not that I sternly deplore touchy-feely. In a culture that is as starved for touch as ours, I suspect there may be some healthful benefits to pleasant tactile stimulations in almost any form whatever. But in order to discuss the kind of bodywork I mean, I strongly feel the need for a word (other than massage) that in no way implies contact that is merely sensual, or that is sexual in any shape or form.
>
> The term "physical therapy" avoids these associations, but it is too narrow in the scope of its normal use. It refers to an official medical discipline, one which is licensed only after protracted and highly specific studies, prescribed only by physicians, and applied through fixed procedures. Such academic rigor certainly does not count against it as a responsible therapeutic practice, but it does effectively partition "physical therapy" off from many other useful kinds of touching and manipulation. In particular, it typically eliminates a good deal of the intuitive element which seems to be such an important part of other approaches and which is fact many physical therapists have confessed to me that they wish they could use more freely in the clinical practice (Juhan, p.xx).

Clearly this is a topic that needs much more open, honest and thoughtful discussion, because it may well be an important part of the profession's reform.

References

British Medical Journal. (1894). Astounding revelations concerning supposed massage houses or pandemoniums of vice, frequented by both sexes, being a complete expose of the ways of professed masseurs and masseuses (pp. 3-15). Wellcome Institute Library, London, Ref. SA/CSP/P.1/2: British Medical Association.

Grafton, S.A. (1934). The history of the Chartered Society of Massage and Medical Gymnastics, JCSMMG, March, 229.

Guthrie Smith, O. F. (1952). Rehabilitation, re-education and remedial exercise. London: Bailliere, Tindall & Cox.

Juhan, D. (1987). Job's body: A handbook for bodywork. New York: Station Hill Press.

McIntosh, N. (2005). The educated heart: Professional boundaries for massage therapists, bodyworkers, and movement therapists. Philadelphia: Lippincott, Williams & Wilkins.

Nicholls, D. A., & Cheek, J. (2006). Physiotherapy and the shadow of prostitution: The society of trained masseuses and the massage scandals of 1894. Social Science & Medicine (1982), 62(9), 2336-2348. doi:doi:10.1016/j.socscimed.2005.09.010.

Nicholls, D. A., & Gibson, B. E. (2010). The body and physiotherapy. Physiotherapy Theory and Practice, 26(8), 497–509. doi:10.3109/09593981003710316.

Nicholls, D. A., & Holmes, D. (2012). Discipline, desire, and transgression in physiotherapy practice. Physiotherapy Theory and Practice, 28(6), 454-465. doi:10.3109/09593985.2012.676940.

Why you need to reject ethical guidelines if you want to practice ethically

23 May 2015

Being critical to me is not about learning how to systematically review an article or deciding whether someone has used the right statistic test in their study. Rather, it's about asking fundamental questions about what I believe in, why I believe in those things, and what those things make possible and what they deny. I've tried to illustrate these principles this week with some posts that are superficially about sex and sensuality, but are really about how physiotherapists treat people.

Sometimes this means subverting fundamental beliefs and upturning things that seem so obvious and taken for granted (quotidian, to use the fancy word), so that you can be sure that your moral compass is still pointing in the right direction. This can sometimes be a risky practice, particularly when you make your questioning visible to others. After all, who wants someone coming along challenging deeply held beliefs? But it's so vitally important for a profession like physiotherapy, which is searching for how to remain as relevant in the 21st century as it was in the 20th. And it seems on the basis of the feedback I've had this week that I'm not the only one concerned about the direction our profession is taking.

One of my biggest concerns is with the blind faith that we have placed in ethical guidelines. These guidelines are now so commonplace that it's hard to imagine a time when they didn't exist. The World Confederation for Physical Therapy's 2007 Declaration of (Ethical) Principles, are similar to those you will find published by the CSP, APTA, APA and elsewhere, with most borrowing directly from Beauchamp and Childress's four founding principles of autonomy, non-maleficence, beneficence, and justice (Beauchamp and Childress's, 1994).

It's a brave person who argues that there's something fundamentally flawed about these guidelines - particularly when they are designed to explain how to be good. It's hard to argue that physiotherapists should not 'respect the rights and dignity of all individuals' (WCPT), or that 'Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability (APTA). My problem is thought that these guidelines might actually make ethical 'abuses' possible.

I'm not talking here about the kinds of things that get therapists struck off (sexual impropriety, fraud, etc.), but the kinds of subtle abuses that pass for normal, everyday physiotherapy practice.

For generations, physiotherapists have encouraged, no mandated, that we learn to treat bodies like machines; assessing and treating the faulty body part and using physical means to return patients to normal. I've argued elsewhere that we did this to remove the sensuality from touch. But what did this simple, and understandable response do to our profession?

It made us believe that anatomy, physiology and pathology were core subjects, when all along it should have been people at the core. It made us think that having the social status that came with having the power to fix people was a good thing, and that we should do whatever we could to secure more of that (or 'Recognise their role as advocates for the physiotherapy profession' as the CSP puts it). And it made us believe that if we had a set of ethical principles to guide our conduct, abuses wouldn't happen.

But they do not and never will. I do not want to be accused of hyperbole here, but think about other organisations that have ethical guidelines. Did it stop some of them abusing their power? I'd like to bet that all of those failed finance companies who stole people's savings in the Global Financial Crisis had whole departments making up sets of ethical principles. Did the American Psychological Association not have ethical guidelines when it colluded with the American Government to promote and practice torture after 9/11 (link)? Did the fact that there were 10 supposedly 'holy' commandments prevent church leaders abusing children? One of England's biggest mass murderers was a GP (Harold Shipman). Did ethical guidelines stop him?

Of course, ethical guidelines don't cause these abuses and people who draft, support and promote them are not at fault. We will always be able to argue that there were rogue practitioners who failed to comply with the ethical guidelines and that is the reason for abuse. But this fails to address the kinds of systematic and instrumental abuses that ethical guidelines make possible.

Part of the problem is that they are based on the seemingly obvious belief that ethics can be rational: that we can arrive at guidelines through reason and objectivity. But believing that

science can provide us with our moral compass is about as dangerous as thinking can get. Was it not the Nazis who believed that the Aryan race was biologically superior, and that the killing of Jews, political activists, homosexuals and disabled people was a scientific necessity?*

People can use belief systems like science to justify all manner of abuses. But there have always been voices of dissent too. These voices are easy to find because they are usually the ones that challenge us to think differently. The Dada art movement in the 1920s and 30s is one of my favourite examples.

Dadaism was partly responsible for surrealist art and the kinds of art that make you ask 'what on earth is that'? It pioneered the use of new techniques like collage and mixed media (like scrapbooking today), and focused on things that were deliberately ridiculous and trivial. Dadaism, though, was far from trivial. It emerged out of a disgust with the machinery of killing that had seen millions of people slaughtered in World War I. Dadaists could not believe that humanity had 'progressed' to the point where such things could be justified by the same kinds of reason that underpin all claims to rightness and the truth. So their art was deliberately anti-establishment, anti-science, anti-art. Pablo Picasso, Jackson Pollock, Damien Hurst all followed the Dadaists in using art to counter the cynicism of reason.

Returning to my bigger point, the problem with ethical guidelines guidelines is that they 'evacuate ethical decision-making of its ambivalence and discomfort' and 'offer a set of best-practice guidelines to produce ethical “outcomes,” to pre-empt lawsuits, and to safeguard the putative goodness of one’s good conscience' (Murray & Holmes, 2009, p.1).

Ethical guidelines make it possible for physiotherapists to treat 'the stroke patient' and the research 'subject'; they allow for the belief that the origins and insertions of gracilis are more important than an understanding of people's lived experience or the social determinants of health; they say that it's okay to show a video of three men manhandling a passive female model as long as the men are using 'physiotherapeutic techniques’.

Thinking critically about ethical guidelines, one might well conclude that 'real' authentic ethical practice demands, first and foremost, that we reject ethical guidelines and look elsewhere for advice on how we might practice otherwise. You could do worse.

References

Beauchamp, T.L. and Childress, J.F. (2009). Principles of Biomedical Ethics. Oxford: Oxford University Press.

Murray, S. J., & Holmes, D. (2009). Introduction: Towards a critical bioethics. In S. J. Murray & D. Holmes (Eds.), Critical interventions in the ethics of healthcare: Challenging the principle of autonomy in bioethics (pp. 1-14). Farnham: Ashgate.

* We should remember that the eugenic ideas that were the basis of National Socialism in Germany were also very popular throughout Europe between 1880 and 1920, and that many prominent figures were eugenicists. Eugenics and social darwinism have also had a strong historical influence on the practice of physical therapies.

Is this really a vision for physiotherapy?

2 July 2015

The CSP has just released a new video titled *The vision for UK physiotherapy*, which is in a similar vein, and follows closely on from the Physiotherapy Associate of British Colombia's recent Choose to move video, which I wrote about recently, and the APTA's call for a 'transformative year in physical therapy.

Each of these calls carry a similar message about the transformative possibilities of physiotherapy and the importance of physiotherapists reaching beyond the narrow confines of the body-as-machine. It's hugely significant that physiotherapists are now recognising this and seeing that unless they can connect people to the bigger, more emotive aspects of their health, they risk being sidelined as (albeit very skilled), expensive body technicians and, in all likelihood, replaced by people who do not need a four year undergraduate training, a masters degree or a doctorate.

What is a little less reassuring though, is the broadly political and social message that is carried by these calls - messages that may appear to be obvious and taken-for-granted on the surface, but are, all the same, no less problematic.

It seems to me that there are three broad criticisms one can make of these calls: that they focus too much on the individual, on independence and on population health. Taking each of these in turn.

The focus on individual health care today is dominated by messages about personal responsibility. Who could argue with the logic that we should all sit less, do more exercise and eat better food. But while these messages seem obvious, we should remember that they are a relatively recent 'invention.' Not so long ago, health services were organised around the things that governments felt responsible for: the casualties of war, poverty, poor housing conditions causing the spread of communicable diseases, etc. This was the model of the welfare state. Governments have long since realised that this model of health care is unaffordable, however, and so have looked for ways to shift the burden away from the state. The preferred method seems to be to shift the responsibility on to us.

Rose Galvin's paper Disturbing notions of chronic illness makes this point brilliantly. She argues that at no time in our history have we been so saturated by health information. We can find advice on what to eat, what to drink, how much exercise to take, when to check for lumps, when to know we're stressed, etc. She argues that there are good reasons for this, and it may not be what you think. The real virtue of all of this knowledge, Galvin argues, is that it serves an important political function. When, in the future, we go to the doctor complaining of hip pain and ask for physio, or a hip replacement, the doctor will be able to say "if you had followed our advice years ago, you wouldn't have hip problems now. Clearly you didn't, so you must be responsible. If you are responsible, you must pay." Galvin calls this 'culpability in the face of known risk' and it is a powerful driver of health education and 'behaviour change' in the developed world.

So where do we fit in? Clearly government ministers can't walk the streets handing out health advice to people (although many of them would like to!) No. Governments 'empower' agencies like doctors, nurses and physiotherapists to do this, and in return they get access to special treatment denied to other professions (legislative protection, access to patients in the public health system, etc.). Our role is to ensure that we anticipate the government's political motives and comply. We are the ones who uncritically push messages about personal responsibility and sell these ideas on the basis that they are common sense and obvious. Critical thinking is about challenging the taken-for-granted obviousness of these beliefs however and asking if they are quite so benign as they first appear. Importantly, critical thinking is not about saying these ideas are either simply good or bad, only that they are dangerous.

The focus on independence The messages about independence might also be seen as problematic in these calls. Autonomy and independence are central to western ideas about health, but they are also fictions. Watch the video and you will see anything but independence. You will see people who are dependent on other people, people dependent on feeding tubes and prosthetic limbs, neighbours and friends, therapists and carers. Dependence has become a dirty word in health care because it suggests that the person is a burden to the state (and thereby you and me, the taxpayer and voter). Physiotherapy has long functioned as a social practice designed to alleviate this burden. Much of its credibility has been gained by returning people to work and reducing the burden of care that falls on the taxpayer, the state, families and communities. Think, for example, of how much investment went into physiotherapy after WWI as a cog in the new field of re-habilitation.

So it may be logical that physiotherapists champion 'independence' but is it a good idea for a profession that claims to also be an advocate for the needs of the ill and injured? Independence stigamtises. Those who are 'dependent' on others (children, frail elderly,

disabled people, etc.) are marginalised because they cannot be independent. Physiotherapists struggle with these populations in some ways, because our practice is so heavily 'biomechanical' that we prefer cure over care; fixing things to supporting things; working on rather than working with. New messages about the importance of independence do nothing to change this. Should we not look to the idea of positive dependence, where everyone's connections with the people and things they need to live a meaningful life are acknowledged instead, and look to challenge the uncritical acceptance of independence as an obvious good?

Focus on population health Finally, and briefly, the focus on population health. Simply put, physiotherapy has never had a model of population health and so to claim it now seems more of a political move than a reality. Unlike doctors, nurses, even dentists, who have always been invested in mass screening programmes, public health drives and global health initiatives, physiotherapy has preferred to focus on the individual body beneath our hands. In fact our almost obsessive focus on the body beneath us has meant we have allowed ourselves to ignore all of the cultural, economic, political and social explanations for health and illness, and concentrate only on the body-as-machine. For that reason our work has always been one-to-one. There are no published models of population health that overlap directly with physiotherapy, in the same way there are not models of primary health care that relate directly to us. It has never been our focus, so to claim it now seems disingenuous. To summarise this rather lengthy post, critical thinking, for me at least, is not about being able to systematically review research articles, but about asking deeper questions about why things are the way they are, and how might they be otherwise. Hence the strap line for the Critical Physiotherapy Network states that we are 'a positive force for an otherwise physiotherapy.'

Karl Popper once argued that the task facing the scientific community was not to support the latest thinking, but to try with all our might to refute it, with the best ideas being the ones that survived the onslaught of criticism. I really do applaud the CSP (and the PABC and APTA) for their efforts to promote physiotherapy - particularly where they identify the transformative possibilities of our practice.

I do think though that some of the messages now appearing sound some alarms about how the profession will develop in the coming months and years and more critical insights are definitely needed.

Reference

Galvin, R. (2002). Disturbing notions of chronic illness and individual responsibility: Towards a genealogy of morals. Health, 6(2), 107-137.

Physiotherapy, politics and evidence

4 July 2015

Some of the discussion following the release of the CSP's recent video A new vision for physiotherapy prompted some interesting thoughts about the constant tension we face if we are to anticipate the future for our profession. A couple of issues surfaced from the blogpost and the comments that followed that prompted me to think about the link between physiotherapy, politics and evidence-based practice.

Firstly, in defence of the CSP, it cannot be easy being a professional body these days. Social media has opened up great opportunities for communication and sharing of ideas, but it has also made a critic of everyone. This is perhaps one of the most important and challenging aspects of a social media landscape where n0-one has to obey anyone else's code of conduct and can say pretty much whatever they want. As someone deeply invested in the idea of critical thinking, my hope is that groups like the Critical Physiotherapy Network help stimulate critical debate about the profession and function as 'a positive force for an otherwise physiotherapy.' More than anything, I hope we can engage in debate that is serious, constructive, respectful and a never-ending act of opening.

In the discussion following the blog about the video, @HelenOwen3 made the very valid argument that ‘we need to stick true to our goal of improving patient care,’ and I think everyone can agree that that is vital. But it only represents one half of the primary function of a professional group - the other half being that it must always remain 'relevant': relevant to the government that provides the bulk of its funding and legislative protection; relevant to other health care professionals; and relevant to the public at large. Health care professions are 'political' not only because they influence politicians to spend money in different ways, but because being a professional is inherently a political act. Imagine if physiotherapy decided that it did not want to be 'political,' and decided to ignore the government's concerns about the future cost of healthcare, the ageing population and the prevalence of long-term illnesses and lifestyle disorders. It wouldn't be long before we were replaced by another profession that were happy to tow the party line, leaving us with the luxury of practicing our long-established model of care in unsubsidised clinics treating short term conditions that don't cost too much to resolve, in competition with people with a weekend's training in massage and underwater basket-weaving.

A lot of physiotherapists believe that strategies like evidence-based practice will protect us from this fate, but I suspect that's because they are wedded to a biomedical/biomechanical philosophy of practice and don't see that all practice is inherently political. Thus they believe that it is enough for EBP to inform their clinical decision-making but fail to see that it will not

help the profession decide whether it should be evidence-based in the first place. There is now an enormous body of literature suggesting that EBP may constrain as much as it enables (link), but to locate this literature, one has to step out from underneath the cloud of EBP that now saturates physiotherapy practice, and this is not easy to do if treating the body-as-machine is the beginning, middle and end of your practice philosophy.

Evidence from the profession's history points to the fact that the greatest successes have been achieved without any recourse to EBP. Physiotherapists did not establish their legitimacy with EBP - they did it by imposing rules that convinced the government, the medical profession and the public that they could be trusted (link). We did not establish our role as the providers of orthodox health care with the weight of evidence for the efficacy of our sling suspensions and effluerage. No, we did it by demonstrating that we could be trusted professionals allied to medicine. History teaches us that the future vitality of physiotherapy is unlikely to be achieved by the weight of evidence for the efficacy of our practice, but rather our ability to anticipate the prevailing political climate and adapt accordingly.

That is not to say that evidence-based practice is not important in the current tug-of-war over healthcare resources. Clearly it is. But some people seem to be quite selective about the kinds of evidence they want to support (which is quite ironic given that EBP is supposed to transcend such subjective judgements.) There is almost overwhelming evidence now, for example, that social determinants of health (poverty, poor housing, access to services, substandard education, etc.) are the most important contributors to people's health - far more significant to behavioural interventions.

> ‘One of the problems with contemporary health care is that it focuses on ‘soft target’ risk factors ‘such as physical activity, nutrition and weight control that target individuals rather than environments and structural conditions that in turn, are causal pathways for heart disease, diabetes and cancer’ (Keleher & MacDougall, 2009, p. 28).

But social determinants demand political action, sometimes against the directions taken by the governments that 'sponsor' us. They require coordinated, sometimes centralised action to transfer power away from the hands of professionals and put it in the hands of clients/patients, families and communities. And they demand that we do this while at the same time advocating for people who otherwise would be voiceless. This is not the approach we are 'sold' today though. What we are told to believe in is the power of individual responsibility, behaviour change strategies and the importance of making people independent. Clearly EBP is not as 'neutral' as some suggest.

References

Keleher, H., & MacDougall, C. (2009). Understanding health : A determinants approach. Australia: Oxford University Press.

If I can

11 July 2015

There are many things I love about William Morris, the 19th century textile designer, poet, novelist, translator, and socialist activist. I've always had a passion for the Arts and Crafts movement that he contributed so much to. I love the idea that things should be done once and done well. I love his socialism and belief in the struggles of people less well off than us. But it was his belief in the need to do the best one could, and to be satisfied with one's achievement - no matter how modest - that has always drawn me to him.

Late last week, I posted a blog about how I didn't think that physiotherapy could claim to be patient-centred. Thank you to the people that emailed me or commented on the post on social media. It seems to have struck a chord. One particular response from KeithP at Keith's Korner really struck home.

In his post 'Guised as therapy,' Keith talks very openly about coercing a patient to stand who otherwise wouldn't want to. The post got me thinking about how we desperately need a conversation within the profession about the complexities of patient-centred care. In a reply I wrote to the post I said that I would always try to help a patient "if I can." And that got me thinking about the phrase that William Morris used as a sort of personal 'ethic' for how he would make his own way through life. Wikipedia says that he adopted the phrase 'If I Can' as his personal after reading about it by fifteenth-century Flemish painter Jan van Eyck. The phrase 'If I can' was embroidered on to a tapestry in 1857 and it was Morris's first attempt at embroidery. The idea of the phrase was to say that Morris would do what he could, within the limits of his capability.

It occurred to me, reading Keith's blogpost, that the idea "If I can help" might be a suitable basis for our attempts to discuss patient-centred care. Sometimes helping can mean making people do things they otherwise wouldn't want to. At other times it might mean relinquishing all of our professional power and status and letting the person, or the community decide. But at its heart lies a belief that we should always do whatever we can, within the limit of our capability (and then accept that we are not superhuman!)

I'd be interested to hear what others think about this phrase as a departure point for a conversation about patient-centred care.

What do Pixar Movies and physiotherapy have in common?

20 July 2015

A post by James Douglas July 15, 2015 on The Awl website last week titled *The Pixar Theory of Labor* made some interesting connections between the ethos of Pixar movies (Toy Story, Wall-E, Brave, Monsters Inc., and the new Inside Out, for example) and a productivist culture. What was really interesting for me reading this post though, was how much Pixar's movie motives are shared by physiotherapists.

Douglas's thesis (and it's well worth reading the whole piece because it's very funny as well as being very insightful), is that Pixar trades on characters that are striving to achieve;

> Pixar has created a stable of films for children that is founded on narratives of self-actualization—of characters branching out, embracing freedom, hitting personal goals, and living their best lives. But this self-actualization is almost exclusively expressed in terms of labor, resulting in a filmography that consistently conflates individual flourishing with the embrace of unremitting work.

Nothing wrong with that you might say. But Pixar's stories almost fetishize work and employment as the principal measure of human worth;

> Is there any other production house operating today that is more obsessed with narratives of the workplace and employment? The basic Pixar story is that of an individual seeking to establish, refine, or preserve their function as an instrument within a system of labor. The only way Pixar is able to conceptualize a protagonist is to assign them a job (or a conspicuous lack of one) and arrange the mechanisms of plot to ensure that they fulfill that job.

Douglas gives ample evidence of this in the narratives from all Pixar movies. What is interesting about this argument is how much Pixar pushes 'how bad retirement is, and how awful it is to be made redundant.'

Douglas takes a hefty swing at the culture of Pixar, Google and other Bay Area tech giants, arguing that their practices of blurring the lines between productivist work culture and 'play';

This excess, epitomized as the complete entanglement of an individual's private life with their employment, is at the core of Pixar's conceptualization of what it is to be a person: In every Pixar film, the protagonist's arc is oriented toward the ultimate goal of being an efficient,

productive worker—whether employment has been thematized as being a father, princess, robot janitor, toy, ant colonist, harvester of screams, adventurer in South America, or otherwise. For Pixar, to live is to work.

And here is where Pixar's ethos comes closest to a rehabilitation philosophy so valued by physiotherapists. Death and obsolescence for Pixar are played out through almost every one of their movies as a problem to be overcome. As in therapy, those who cannot work must be brought back to normal so that they remain a functioning member of society (or at least not a drain on resources);

Pixar conceptualizes death not as the end of existence per se, but as the state of becoming waste. Waste does not work. Waste does not have a function. Waste is obsolete. Waste is undifferentiated. For Pixar, the model individual represents usefulness in their own unique way. A virtuous accountant can't just be like all the other accountants—they have to be their own special kind, they have to be the lead in their own story.

At its bottom, this is the logic of pure capitalism. In an economy structured around limitless growth, dynamism must become the natural state of things. Idle capital is unproductive capital and an unproductive worker is a waste of resources. The virtuous citizen cannot only consume but must produce, an imperative that finds its current (and particularly American) incarnation in the entrepreneur, the boot-strapper, the rags-to-riches hero, who is too busy pulling themselves up by their laces to notice that there's no top to reach. The natural and profitable ideological by-product of this fixation is an abhorrence of collectivism—and therefore organized labor. To be collective, to be one among many, is to no longer be a special individual producer, which is its own kind of death. This is why Toy Story 2 abhors the idea of Woody becoming part of a box set.

For us, disability, deviation from the norm, difference, luxurious idleness, non-compliance, abnormality, less than optimal health, a lack of personal responsibility for one's own conduct, bad habits (smoking, drinking), being out of shape, obese or unfit, are all expressions of waste that must be rehabilitated.

Whilst it would be churlish to suggest that physiotherapists should not strive to help people return to 'normal' (even if we could agree what that meant), it would be nice to think that physiotherapists recognised that their work was deeply rooted in capitalist notions of productivity and value, and recognised that sometimes these things are privileged over such notions as patient-centred care, which is what we like to think our audience comes to see.

Doomed to repeat

30 July 2015

A friend of mine recently sent me this cartoon after hearing me talk about some work that I've been doing looking at the history of physical therapies in New Zealand in the 19th century (in short - there was none).

It got me thinking about the lack of really good critical historical work in physiotherapy; the kind of thing that goes beyond just the linear narrative of one event following another and, instead, tells you something about the conditions that made the present possible.

There are some really stunning historical works in health and medicine, particularly around how we have come to understand the body and health care (see a very selective sample of references below), but it seems few of them are ever read by physiotherapists when they think about the problems now facing the profession.

This is a real shame, because a lot could be gleaned by reading Sarah Nettleton's study of the way dentists 'invented' the mouth as a problem to be managed; how David Armstrong critiqued the idea of posture and attitude; or how Caroline Daley described the history of leisure and pleasure. Unfortunately texts like these rarely get a mention.

I've been working on a book for some time now that uses critical history as the basis of an analysis of physiotherapy, and I have been astonished at how 'local' physiotherapy history is. Few authors go beyond the familiar territory of practice innovations or changes to the organisation of the profession. Where is the critical thinking? Where is the interrogation of the ideas that we seemingly take for granted?

Fortunately there have been some exceptionally good histories written by physiotherapists in recent years, and these need wider distribution (see below for a very partial and selective list). If physiotherapists are not going to be doomed to repeat the lessons of yesteryear, we would be well served by a closer engagement with critical histories of the present, within and without the limited boundaries of the profession.

References (highly selective)

Armstrong, D. (2002). A new history of identity. London: Palgrave Macmillan.

Dixon, L. (2003). Handmaiden to professional: Physiotherapy's history of the present: discourse analysis of the rules of professional conduct of the CSP 1895-2002. Thesis.

Heap, R. (1995a). Physiotherapy's quest for professional status in ontario, 1950-80. Canadian Bulletin of Medical History/Bulletin Canadien D'histoire De La Médecine, 12(1), 69-89.

Heap, R. (1995b). Training women for a new "women's profession": Physiotherapy education at the university of Toronto, 1917-40. History of Education Quarterly, 35(2), 135. doi:10.2307/369630.

Kell, C., & Owen, G. (2008). Physiotherapy as a profession: Where are we now? International Journal of Therapy and Rehabilitation, 15(4), 158-167.

Linker, B. (2005). The business of ethics: Gender, medicine, and the professional codification of the american physiotherapy association, 1918-1935. Journal of the History of Medicine and Allied Sciences, 60(3), 320-354.

Morus, I. R. (2006). Bodily disciplines and disciplined bodies: Instruments, skills and victorian electrotherapeutics. Social History of Medicine, 19(2), 241-259. doi:10.1093/shm/hkl037.

Morus, I. R. (2007). The two cultures of electricity: Between entertainment and edification in victorian science. Science & Education, 16(6), 593-602.

Nettleton, S. (1992). Power, pain and dentistry. Buckingham: Open University Press.

Ottosson, A. (2010). The first historical movements of kinesiology: Scientification in the borderline between physical culture and medicine around 1850. International Journal of the History of Sport, 27(11), 1892-1919. doi:10.1080/09523367.2010.491618.

Ottosson, A. (2011). The manipulated history of manipulations of spines and joints? Rethinking orthopaedic medicine through the 19th century discourse of european mechanical medicine. Medicine Studies, 3(2), 83-116. doi:10.1007/s12376-011-0067-3.

Owen, G. (2014). Becoming a practice profession: A genealogy of physiotherapy's moving/touching practice. Thesis.

Wikström-Grotell, C., Broberg, C., Ahonen, S., & Eriksson, K. (2013). From Ling to the academic era – an analysis of the history of ideas in PT from a nordic perspective. European Journal of Physiotherapy, 15(4), 168-180. doi:10.3109/21679169.2013.833985.

The social construction of pain

14 August 2015

Medicine convinces us that we can understand the human condition biologically. Pain teaches us otherwise. Pain, as we know it today, bears all the hallmarks of a subjective phenomenon that can only be understood by the person experiencing it. Yet even this belief has a history; a history that is closely tied to the genealogy of the physiotherapy profession.

Tony Ballantyne has explored the way pain became a vehicle for social reformers after the 17th century, shaping many of the health and social welfare reforms that were to follow. Ballantyne argues above that pain narratives were a powerful way for humanitarians to promote the belief that the state should take responsibility for the social ills it had caused

(through war, communicable diseases, poverty, etc.). Physiotherapy grew from many of these social issues.

But how will it fare now that 'the state' has effectively shifted the burden of responsibility from itself, on to the individual to care for themselves? Should we be looking to the way we are now valorising pain science not only for what it can tell us about the body and the human condition, but also what it can tell us about the future for the profession?

Physiotherapy and the zone of play

17 August 2015

I'm doing a public lecture next week on physical therapies in the 19th century (you will be able to see a live feed or delayed broadcast of it here if you're interested in hearing about it), and the whole project has been fascinating.

One thing that occurred to me doing the preparation for the talk was how many images there are of people sitting in mud baths and hot springs.

There was never any real proof that these things did anything other than warm you up, but there was a lot of anecdotal evidence that they were used to treat all sorts of diseases, from syphilis to sciatica, asthma to psoriasis. Suffice to say, in 19th century New Zealand, hot pools were a natural phenomenon, and an exotic and very popular experience for weary travellers, warriors and the sick and injured alike.

Today, the popularity of ideas (or the Facebook 'like' factor) has become an important test of the truth value of an idea. This is a different kind of 'truth' to the one that health professionals are encouraged to value. It does not assume that there is some independently verifiable reality outside of people's consciousness, but is a more pragmatic truth that is largely socially constructed. Ironically, this alternative notion of truth is overpowering the one that scientists would like to promote simply by dint of its own popularity. Physical therapies like massage and hyrdrotherapy simply won't go away, despite what the advocates of evidence-based medicine might like.

But the popularity of ideas, as a concept, is as old as mud baths themselves. Likability has always been an important determinant of what people are prepared to accept as the truth, and advocates for new ideas about the nature of truth argue that the emergence of the scientific method has only replaced one set of ideologies with another. And anyway, it doesn't seem to matter that scientists would like to dictate how we should all think about the truth, people have always voted with their feet and chosen to take a dip in the mud bath anyway. After all, what harm can it do?

And this points to an interesting phenomenon about truth. Seemingly, the popularity of a particular idea matters more when the person doesn't place too much stake on the effect of the particular truth. So things that people are happy to negotiate over, let go of, or change, are much more fluid than truths that people hold on to dearly.

We see this in truths that people hold about their health, their families, politics and religion, work, etc. One of the best examples of this is in health care itself, where people are increasingly experimenting with unconventional health care practices. That is until they become really ill, at which point they return to the things that have a strong scientific basis to them and are established or orthodox (like conventional medicine). So people are much more relaxed about the truths they engage with when their lives don't depend on it.

The question for physiotherapy then is which zone do we occupy? Do we sit within what I'll call the 'zone of certainty' where truths are much more likely to be fixed, conventional and orthodox? Or do we reside within the 'zone of play' where people will more readily treat truths with much more subjectivity and indeterminacy?

If it's the former, then evidence-based practice and establishing the profession's orthodoxy may well be the best way forward. But few people have ever argued that physiotherapy is essential to life. Rather we have traded off our orthodox status to legitimise our place within the public health system. Popularity wasn't an issue for many physiotherapists because patients were either already lying on the ward waiting for us, or came to us because their insurance company or state-supported funder allowed it. But times are changing.

Now that choice and personal responsibility are becoming much bigger drivers of health care, and people are seemingly eager to express their subjectivity through endless body 'projects,' we may find that ideas like evidence-based practice become less important drivers for people than the popularity of the idea itself. This may have significant implications for a profession that sits firmly within the Zone of Play.

Why pain, why now?

19 October 2015

I've been puzzling for some time why it is that chronic pain seems to be so much in focus for physiotherapists at the moment. For many years, chronic pain resided along with depression, rheumatoid disease and cerebral palsy as one of the many 'Cinderella' disorders and syndromes that physiotherapists in the public system endured (though had little remedy for), and those in the private system indulged, whenever someone could afford to pay for the treatment which was lengthy and, at best, marginally effective. Then, a few years ago, people like David Butler, Louis Gifford and Lorimer Moseley began writing about the neuroscience

of pain and it seemed practitioners began to abandon mobilisations and manipulations, and started to champion the bio-psycho-social model, Melzack and Wall, and the NOIgroup.

Perhaps it is an indication of a maturing profession finally having found a problem that expresses its more profoundly holistic, embodied tendencies? But this argument doesn't stand up to much scrutiny, since there are plenty of other health problems familiar to physiotherapists that bear the same subjective, socially-constructed tendencies as chronic pain, but are far more prevalent and, arguably, more clinically significant, like chronic breathlessness. Chronic breathlessness is a feature of some of the largest causes of morbidity and mortality in the developed world, and because it is closely associated with death and decline, is perhaps an even greater motivator for action than unremitting pain.

So perhaps pain represents a complex problem that physiotherapists can understand and get their teeth into: a problem that we can make a real difference to? Well again, chronic breathlessness wins that race by a country mile. Pulmonary rehabilitation is one of the most effective interventions available to physiotherapists and does it without needing to argue that it is making permanent structural change to the person's lung function. So then perhaps the thought of all that sputum puts people off? But here again, there are far more prevalent problems that bear the same hallmarks of complexity as pain, and for which physiotherapists have all the requisite skills to impress. Neurological rehabilitation from accident or degeneration has gone through a revolution in rehabilitation in recent years, but it seems it remains a specialised field for only the highly skilled and well supported.

So why has chronic pain become so popular since Butler and Moseley wrote Explain pain in 2003? I think there are three broadly overlapping reasons for this, and none of them are particularly ennobling:

- Chronic pain is dominated by private practitioners who have learnt that the management of chronic pain avoids the regulatory and funding restrictions that had increasingly accompanied treating spinal and peripheral joint problems.
- Chronic pain allows us to keep our biomechanical knowledge intact, and offers a new vocabulary of neuroanatomy and psycho-neuro-immunology that can be superimposed on top of our existing knowledge without needing any radical revision to the fundamental scientific, evidence-based, knowledge-stable system that we value so highly.
- Chronic pain generates a bank of stories and metaphors that the new gurus of pain science can use to explain the nature (and I used that word advisedly) or the phenomenon at hand.

It would be a fine thing indeed if chronic pain provided a vehicle to move some of our most unashamedly biomechanical brothers and sisters away from their technical rationalistic

backgrounds and into the world of phenomenology, social constructivism and critical theory, but this will only happen if there is a genuine attempt to break with a fixation for neuroscience and the search for the biological basis of pain, and this may be some way off into the future yet.

The upsurge of new professional interests, like our interest in trunk stabilisation, spinal mobilisation, and before that ACL injuries and fractures, amputee rehab, spinal cord injuries, and so on, and so on, happen because different ways of thinking and practicing make new affordances possible. Rarely can these ever be explained by scientific reason or political contingency alone. They are complex, but they can tell us a lot about where the profession has come from and where it might be going to. To paraphrase Foucault; 'I'm not saying they're bad, only that they're dangerous.'

Reference

Butler, D.S, Moseley, L. (2003). Explain Pain. Adelaide. Noigroup Publications. ISBN 0-9750910-0-X.

Is there such a thing as a payment placebo?

20 October 2015

A quick question, to which I'm sure there is probably an easy answer:

I've heard it said many times in recent years that physiotherapists in private practice should be confident enough to charge what they think they are worth, and that people only truly value something if they have to pay for it.

If which case, isn't this just another form of placebo where people gain additional benefit because they've paid more?

And isn't that at odds with the idea of evidence-informed practice?

Sleep walking to South Africa

3 November 2015

In the same week that WCPT sent out a call asking for us all to contribute to its future strategy, a paper showing that 'Even walking is more dangerous if you're black' reminded me that the next WCPT congress will be held in South Africa in 2017, and this should represent a golden opportunity to show that physiotherapy has something critical to say about things that are an everyday reality for many people around the world.

The study from the journal *Transportation Research* titled *Racial bias in driver yielding behavior at crosswalks* showed that there was clear racial bias in driver yielding behaviour directed at pedestrians, and that 'black people are more likely to be ignored or neglected by drivers, which could lead to a greater risk of getting hit by a car' (Vox). This follows on from a similar study which showed that white people sleep much better than blacks, and this has some significant downstream health effects (link);

> 'The study was just one data point in a mount-ing pile of evid-ence that black Amer-ic-ans aren't sleep-ing as well as whites. This past June, the journ-al Sleep pub-lished a study on the sleep qual-ity of black, white, Chinese, and His-pan-ic adults in six cit-ies across the United States. The par-ti-cipants were pooled from the Multi-Eth-nic Study of Ath-er-o-scler-o-sis (MESA), a co-hort of more than 6,000 people who, for the last 15 years, have been in-ter-mit-tently pricked, prod-ded, and as-sessed to dis-cov-er how geo-graphy and race in-flu-ence health over time. (More than 950 pa-pers have been pub-lished on this co-hort. It's from them that re-search-ers have found evid-ence that the farther people live from a wealth-i-er area, the more likely they are to de-vel-op in-sulin res-ist-ance—or that blacks ap-pear to have high-er levels of the sub-stances that cause blood to clot.)'

The call for ideas that came from WCPT included a survey asking for feedback on different strategic directions which centre around nine 'exciting opportunities for physical therapy.' These opportunities are instructive because they give a clear indication of the things that WCPT thinks are important.

Notwithstanding the chance to add your own ideas, there is clearly a lot of interest in the economic changes that physical therapists are having to face up to, and some recognition of emerging populations of need (elderly, for instance), but there is precious little suggesting that WCPT is thinking about taking a more critical stance on things that might bring about significant structural changes to people's health and wellbeing.

Perhaps we have never thought of ourselves as 'political,' even though we've been happy to work for The State in most developed countries for the best part of a century. Perhaps we think that it's enough to understand the biomechanics of elbow flexion, and not to think too much about what it means to drink water from a polluted pool? Perhaps we think that sleeping, walking, and all the other human functions that we rehabilitate on a daily basis fall below the threshold of interest for people, and don't really make for interesting (or well funded) research and practice? Perhaps we are happy to leave these things to others so that we can concentrate on treating the body-as-machine, in the hope that people will still think that's enough in the years to come.

Two recent papers suggest that others are looking at things issues like walking and movement - things that physiotherapists believe are rightfully their territory - and seeing much broader, deeper meaning in these actions (see this and this). Surely this kind of work is not beyond the scope of physical therapists? What is needed is a steer. And so, perhaps, WCPT could be the ones driving this radical change.

WCPT could look at the symbolic importance of its congress in South Africa as an opportunity to shake the profession out of its self-induced slumber and provide a new, bold direction that doesn't simply give us old wine in new bottles. South Africa in 2017 gives us a golden opportunity to do something radically new, and WCPT needs to give us a vision for a new professional future that will sustain the profession for the next hundred years.

More on the measurement of pain

26 November 2015

Neil Maltby's excellent blogpost yesterday (*Algorithm is going to get you*) was a refreshing reminder of some of the odd things we do in the name of science-based physiotherapy.

Neil's post was about how we look for pseudo-scientific measurement of things that otherwise can't (and shouldn't) be measured. I've blogged about this before (see here, for example), and complained bitterly about our lack of sophistication when it comes to subjective phenomena like breathlessness, pain, loss (of functional ability), etc., that are the bread-and-butter of everyday life for working physiotherapists.

No-one ever wakes up in the morning with a bad headache and says "Wow, I've got a really bad number four today!" and yet we insist that this is the most useful way to interpret other people's pain.

It is an evolutionary miracle that we cannot remember pain - only the remembrance of being in pain persists. And it is the embodiment of a subjective phenomenon. Given this, the last thing a real scientist would seek to do is try to measure it objectively. And yet, in the absence of anything better, and a belief that we must measure things to be credible, we persist in asking ridiculous questions like "On a scale of zero to 10..."

Coincidentally, at the same time Neil posted about the dangers of visual analogue scales, the very eminent Lorimer Moseley was explaining pain to the readers of theconversation.com. Starting the piece with a lovely quote from Ludwig Wittgenstein - himself no stranger to the existential struggles offered by pain - Moseley proceeded to explain pain as an entirely biological phenomenon. Pain is not 'in' the body; 'The brain produces pain' (note the Cartesian mind/body separation here).

“We aren't going to uncover the genius of physiotherapy at the end of an axon"

Moseley's acknowledgement of lived experiences, cultural and social norms, beliefs, etc., was a welcome change from the kind of purely neurophysiological explanations that would have made Melzack and Wall happy, but everything still returns to the brain. It is the brain that must make sense of these things and moderate the neural signals that tell you whether something hurts or doesn't.

Notwithstanding the almost constant rhetoric that pain is always bad and must be managed or removed - something we really do need to have a professional conversation about at some point - I'm not really sure where a biologistic understanding of pain really takes us professionally. It’s not as if physiotherapists are adept at changing the biological structures that we concentrate so much on in our explanations of pain. Where we do come into our own, however, is in helping people to adapt to their lives in pain, in breathlessness, in recovery, and in rehabilitation.

Problems like breathlessness and pain are complex, inter-personal, culturally-nuanced, socially-mediated, existential experiences that form the bedrock of skilled, experienced everyday physiotherapy. Although we think we have to measure pain, perhaps we are inadvertently doing ourselves a disservice by focusing on this and ignoring the 'other' ways that physiotherapy matters? Truth be told, we aren't going to uncover the genius of physiotherapy at the end of an axon, and the sooner we stop telling ourselves that pain is all in the brain, the better.

Do you need a four-year degree to tell someone to stop smoking and do more exercise?

1 December 2015

One of the biggest growth areas for physiotherapists in the coming years will be the management of chronic illness. The numbers of people now living with conditions that were once relatively rare is quite staggering, and they are becoming more complex.

A report released last week by the Australian Health Policy Collaboration has once again highlighted the need for us to take a society-wide approach to managing the threats posed by conditions like heart disease, diabetes, cancer and respiratory illnesses, through a concerted effort to tackle the 'upstream' causes: alcohol consumption, sedentary behaviour, high salt intake, smoking, etc.

Obesity, diabetes, hypertension and poor mental health are now competing with more familiar chronic disorders like joint degeneration, pain, loss of function, falls, etc., and are exercising government minds, not least because they represent a seemingly bottomless pit of future health care spending.

Clearly something needs to be done.

Thus far, health funders have looked to the established health professionals to see if they can shift from specialist care to more primary and patient-centred approaches, but results have been patchy. Some health professionals are struggling to relinquish positions of authority and power that were so important to them in the 20th century, others just don't know what to do. All have been affected by the changing economy of (health)care though.

So far, you would have to admit that the response from physiotherapists has been woefully inadequate. We have had a burst of interest in smoking cessation, and rushed to be spectators in the Elizabethan bear-bating parody that is obesity management, and now it seems our latest target is sedentary behaviour, or 'the new smoking.'

In truth, these approaches appear more like the unedifying spectacle of the January sales than a reasoned, well theorised and conceptually robust approach to a genuine problem of real significance to the future of health care.

A lot of the focus is on relatively straightforward early interventions; things that are designed to improve people's lifestyles - smoking, exercise, diet and alcohol consumption. But there has been much less focus on the management of people with complex and chronic health problems. And so, physiotherapists have found themselves competing with personal trainers, green prescription providers, practice nurses and others for the right to tell people to stop smoking and do more exercise.

But here's the problem. You don't need a four year degree to tell people to stop smoking and do more exercise. You don't need to be a Doctor of Physical Therapy to tell people that they should walk 10,000 steps a day or that red wine is good, but only in moderation. So if this isn't where the future of physiotherapy lies, where is it?

Clearly there is some virtue in having orthodox, respected health professionals telling people to live better lives. Health professionals do, after all, still command a great deal of public respect. But beyond this it seems a considerable waste of resource to have skilled diagnosticians with expertise in human movement and the management of multiple co-morbidities that affect people with chronic diseases, delivering green prescriptions to people who already know they don't do enough exercise.

Our role, surely, needs to concentrate on the elderly man struggling to cope with peripheral vascular disease, COPD, chronic back pain and depression; the woman with MS struggling to

bring up three children, work full time and retain a meaningful sense of hope for the future; or the teenage boy with muscular dystrophy coming to terms with a compromised respiratory system, chronic fatigue, a changing body image, and acute anxiety about his premature death?

There are many people who can, and will, chastise others for smoking, drinking too much, and sitting in chairs for too long. But let us not be those people. Let us work in a way that does justice to our considerable skills and draws on our unique experience and position within the healthcare system. There is a huge need for our services, but we need to go beyond the obvious and taken-for-granted simplicity of current thinking in healthcare, to offer a more critically sound approach to future practice. Only then will we be able to justify our place in the new economy of care.

Exercising our demons

4 December 2015

First published on 24 July 2011 at www.criticalphysio.me.

I've just returned from the biennial NZSP conference held over the last two days in Auckland, and I find myself, once again, disheartened by some of the ideas my colleagues are promoting.

Years ago, when I was a junior practitioners and an even more novice qualitative researcher, I would go to physiotherapy conferences hoping to hear the brightest and the best, speaking about cutting edge practice. But rarely did I hear anything about people as people, social theories, politics, disability rights, gender issues, etc. There was never even the slightest mention of anything qualitative to break up the dry diet of quantitative facts and figures. (Those were the days when physiotherapy was starting to obsess about outcome measures and evidence-based medicine - the 'margarine' of health care reform.)

Lately though, we've been hearing much more about qualitative research in physiotherapy, and it seems all of a sudden physiotherapy has woken up, and there are a lot more people interested in the 'social context' of illness, or (God help me) the 'psychosocial' aspects of healthcare.

Sadly, rather than this more plural approach to health care heralding in real critical thinking, or even a bit of basic curiosity with what might be going on behind this latest fad, we are now being exposed to the incessant chirruping of well-to-do evangelists who seem obsessed with giving physiotherapists the license to act like Victorian philanthropists and social reformers.

Repeatedly over this weekend I've heard people talk about physiotherapy needing to understand:

- the 'broader social context' (in principal, I have no problem with this)
- the 'person' behind the 'pathology' (nor this)
- cultural perspectives (often portrayed as merely ethnic differences)
- the 'psychosocial' dimensions of health care (as if they were singular)
- etc., etc.

Physiotherapy, we are told, is uniquely placed to take advantage of the more 'holistic' approaches to healthcare that have been heralded by the postmodern world we now live in, because exercise/movement/physiotherapy offers one of the most sustainable, environmentally friendly, drug-free, trustworthy and immensely potent responses to the health problems of today.

But instead of any semblance, and I mean the merest semblance, of critical thinking, we are being fed Billy Graham-esque motivational speeches and worldly-wise insights from people who really should know better: professional leaders who we are surely duty bound to believe, because surely they would know which way we should go?

We've moved from having no real interest in the person as a person, to being entranced by the possibilities of treating people like dummies; passive recipients of our ministrations; just waiting for us to bring them the good news about their obesity/poor trunk tone/lack of aerobic fitness, range-of-movement, compliance or adherence.

I heard one eminent advocate for this new wave of neo-liberal clap-trap argue today that we didn't need any more studies showing us the efficacy of exercise interventions; what we needed was to get out there and start spreading the news! As if people who were fat didn't already know it. As if people who smoked didn't already know that we wanted them to quit. As if people who sat too long in front of their computers didn't already know we thought it was bad for them? (Even though it seems that if you read the work of Nicholas Kendall or Michael Gard it might not be bad for you at all!)

And so, the agenda we are being offered is this:

- For those who take the escalator and not the stairs, we will be watching you.
- Every time a patient comes to the clinic for exercises for their knee pain, a 21-year-old will be looking at their flabby paunch and giving them advice on how to firm up and stay in shape.
- And every time someone goes for treatment on their back, we will be there giving hem advice on how to stop smoking, reduce their BMI and control their BP.

There are a few voices out there asking whether this pernicious surveillance medicine is not immensely problematic (Armstrong, 1995), but because physios do not, as a rule, engage with these debates or discussions (preferring instead to bathe in the Kool-ade of the latest micro-fascistic fashion, see O'Byrne and Holmes, 2007), their voices remain, at best, marginal.

This is a real shame, because I believe what seems to be a seductive path to greater social responsibility and kudos, is plotting a course towards the total marginalization of physiotherapy as an effective force for good.

References

See Armstrong, D. (1995). The rise of surveillance medicine. Sociology of Health and Illness, 17(3), 393-404.

O'Byrne, P. & Holmes, D. (2007). From micro-fascism to Plato's good citizen: producing (dis)order through the construction of risk. Nursing Philosophy, 8, 92-101.

The cult of the hero

9 December 2015

First published on 24 July 2011 via www.criticaphysio.me

Having talked with people about my last blog entry (*Exercising our demons*, 16th May 2010), one of the most interesting conversations centred around physiotherapy's fascination with its heroes; the 'big names' in the profession that are made famous by their inventions and innovations. The last blog entry touched on this only briefly, and only in the sense that I expressed my dislike for the naked evangelising of some of the speakers at our conference. But there is a bigger point here that deserves consideration, because - as a couple of my colleagues pointed out - physiotherapy really does suffer, at times, from the cult of the hero.

A good illustration of hero worship can be found in musculoskeletal physiotherapy. Last year I was involved in a project to celebrate the 40th anniversary of the history of the New Zealand Manipulative Therapy Association. As part of the project, I wrote a commemorative history of the group. New Zealand is well blessed with innovators and pioneers in musculoskeletal therapy: (in no particular order) Stanley Paris, Ian Sim, Ian Searle, Rob McKenzie, Brian Mulligan, who for their part followed Cyriax, Stoddard, Kaltenborn and Grieve in developing new ways to manipulate the spine. To this day, some physiotherapists are strictly Mulligan practitioners, while others are firmly in the McKenzie camp, and one wouldn't need to go far to find a therapist with a strong opinion on Maitland or, heaven forbid, chiropractic or osteopathy.

Now musculoskeletal physiotherapy is perhaps a paradigm case of the cult of the hero, but it is by no means unique in this respect, and while there have been some marginal attempts to define a unifying theory of nearly everything, most practitioners adhere to their preferred brand of therapy.

It occurs to me that our need to associate with certain paragons of professional practice says something about our profession, and reveals something about our inherent lack of theoretical depth (an argument I have made on numerous occasions before). But why does it reveal this? Well, one explanation may be that when we look at the theoretical arguments made by these various experts in their field, they qualify as what Domholdt calls 'mid-range theories'. In other words, they offer theories that answer some questions about phenomena, but that their range and scope is restricted to a particular pathology, cultural or social phenomenon, specific system or series of operations. Mid-range theories have nothing to say about the 'bigger' philosophical questions of how we might/should live; what is the nature of reality; what is being; etc. Thus McKenzie's approach to back pain has nothing to say about justice, love, or the nature of government - only about the aversive nature of back pain and pathology.

The fact that physiotherapists eagerly differentiate their practices based on whether they are Maitland or Mulligan practitioners suggests that they have little awareness of the common philosophical heritage of all these approaches and its now well argued limitations (references for this argument are far too numerous to list, but the following give a sample of the issues; (Lupton, 2003; Nettleton, 2005; Turner, 1995; Williams, 2003, 2006). Indeed, if physiotherapists were ever exposed to phenomenology, social constructivism, medical sociology, or postmodernism in any fundamentally sound philosophical sense, they might well turn away from such instrumental theories and challenge the very essence of physiotherapy practice.

All my research in and around physiotherapy has led me to believe that our historical affinity with the body-as-machine has been a blessing and a curse. It has given us enormous security as profession allied to medicine, but it has also blinded us to the multifaceted, immensely complex and incomprehensibly subtle (and not to say 'political') nature of health and illness.

Thus, when we look to our luminaries to provide us with the semblance of theory to help us comprehend the patterns of health and illness that we see each day in our practice, our eyes reach only to the level of the ceiling. Rarely, if ever, does our vision reach the stars.

Not surprisingly, we are seduced by whatever passing fad or fancy best explains the immediate circumstances, and why it is all too easy for people to waltz into our conference centre and sell us rhetorical candy-floss.

Interestingly, a similar phenomenon was recently identified in nursing. In an editorial in the excellent Nursing Philosophy, Derek Sellman wrote about nurses' fascination with reflective practice (Sellman, 2010). Like physiotherapy, Sellman argued that nursing practice had been built upon 'borrowed' practices and approaches, but unlike physiotherapy, nursing had suffered from a surfeit of 'grand ideas'. He states:

'In my own working lifetime, I have seen more than a few 'grand ideas' adopted, abandoned, left to fade away, or taken on board with a lesser or greater uncritical acceptance. That some of these ideas were subsequently shown to be merely fashionable and very much of their time hints a the propensity (at least in some parts) of nursing to be swept along in the wake of this or that grand claim originating in another discipline' (Sellman, D. 2010, p.150).

And here lies the key for physiotherapy. In the first instance we need to move beyond thinking that mid-range theory will answer anything but the most prosaic professional questions. Then - and this is the vital point - we must learn from the lessons of our sister professions of nursing and, to some extent, occupational therapy, and develop a critical attitude towards all our ideas, both grand and small, so that when we settle on a way of thinking that is amenable to our practice, we do not do so uncritically.

Postscript

From my own perspective, I hope we never do 'settle'. I hope we never consolidate on an approach to practice, for fear that we ossify in ways that we have increasingly seen physiotherapy ossify in recent years. If we can be certain of one thing, it will be that uncertainty is an unavoidable condition of future practice, and that we will need to be agile to survive. But before we can develop our flexibility, we need to do a bit more stretching.

References

Domholdt, E. (2005). Rehabilitation Research: Principles and Application. Philadelphia, Elsevier.

Lupton, D. (2003). Medicine as Culture: Illness, Disease and the Body in Western Society. London: Sage.

Nettleton, S. (2005). The Sociology of the Body. In W. C. Cockerham (Ed.), The Blackwell Companion to Medical Sociology (pp. 43-63). London: Blackwell.

Sellman, D. (2010). Musings on reflective practice as a grand idea. Nursing Philosophy, 11, pp. 149-50.

Turner, B. S. (1995). Medical Power and Social Knowledge (2nd ed.). London: Sage.

Williams, S. J. (2003). Medicine and the Body. London: Sage.

Williams, S. J. (2006). Medical sociology and the biological body: where are we now and where do we go from here? Health, 10(1), 5-30.

Looking at physiotherapy through fresh eyes

14 March 2016

A few months ago I moved to a new job.

Having been part of the Physiotherapy Department at AUT for the last 15 years, I moved into a new school at the start of the year, and the new school put me in close proximity to psychologists, psychotherapists and counsellors. My job has involved getting to know how they think and work, and trying to organise the day-to-day business of teaching and learning for these professionals who think very differently to the physiotherapists I have worked with for so long.

Working with these people has given me new perspectives on ways people think about health care, students, patients, other professions, and the things that are customary and commonplace. It has been a very steep learning curve, but everything that I've learned so far has been directly or indirectly relevant to my ongoing interest in the history and culture of physiotherapy.

Those of you who work every day with mental health professionals will know that they approach even the most basic everyday decisions in fundamentally different ways to the ways that are customary in physiotherapy. To give one example, in my department the psychotherapists meet every week for three hours to engage in a group process of decision-making. It is anathema to this group to imagine making an autonomous decision about something that affects the group as a whole.

In my experience, physiotherapists have always seemed to like decisions being made quickly and efficiently, and the idea of spending three hours discussing the process by which a decision is made would seem ludicrous to many of them. And yet, for this group of psychotherapists, it is what they know and a process they have come to respect. And if we were to transplant them into a physiotherapy department, we would almost certainly find the same sense of incredulity that I have sometimes felt over the last 10 weeks.

All of this is important, not least because, in healthcare today, there is a great deal of emphasis placed upon inter-professional collaboration (IPC). But in the way IPC is presented, we all get to retain, perhaps even enhance, our own professional identities. We are rarely asked to wholly embrace another's personal or professional subjectivity. Taking on this new role, not as a physiotherapist but as academic leader, has enabled me to draw on my

experiences of physiotherapy, but it has also required me to understand much more deeply the perspective of people who think very differently to ways that are comfortable and familiar to me.

It occurred to me that taking on roles that required us to understand and embrace the perspectives of colleagues who have different priorities to us would be beneficial for lots of people. And to fight and lobby not from one's own position, but from the position of the 'other', is something we ought to be good at as physiotherapists - given that we advocate for our clients/patients each and every day.

For me, it has felt at times as if I am learning an entirely new language, and although it has sometimes been destabilising and unsettling, it has also been enlightening and invigorating.

These experiences have given me infinitely more pause to reflect on my own professional ideologies than if I had remained within the comfortable confines of the physiotherapy profession itself. I would encourage everyone else who has the opportunity to do the same, given half the chance.

When was physiotherapy born?

29 March 2016

I've recently been reading quite a lot of new historical writing around the early history of physiotherapy. Much of it has concentrated on the effect of the First World War on the profession in North America, Britain and the Antipodes, but I've also been reading Anders Ottosson's excellent, and provocative recent papers.

Many of you will know of Anders's work, especially his paper The manipulated history of manipulations of spines and joints (pdf) and his thesis Sjukgymnasten - vart tog han vägen?: En undersökning av sjukgymnastyrkets maskulinisering och avmaskulinisering 1813-1934, which argue that physiotherapy originated with the mechano-therapy and medical gymnastics of Pehr Henrik Ling (1776–1839) and the Royal Central Institute of Gymnastics (RCIG) which 'became world famous and, as such, the normative centre of Physical Therapy in the 19th and on into the 20th century' (Ottosson 2011, 88). Anders argues that it was physiotherapists who taught doctors about orthopaedic medicine, and that this story has been obscured by strong biomedical discourses, influenced by the de-masculinisation of the physiotherapy profession in the 20th century.

This gendered analysis of the history of the profession has been picked up recently in two papers Anders has in press (Ottosson, 2015; Ottosson, in press). In both papers, Anders makes a clear argument that the gendered nature of physiotherapy has played an important

role in the development of the profession. Similar arguments have been made elsewhere (see Heap 1995a,b; Linker 2005a,b; Miles-Tapping, 1989; Nicholls & Cheek, 2006; Owen, 2016), but all of these authors promote the discourse of the gendered struggle of women within the profession. Anders, on the other hand, argues that (and apologies for quoting this section in full);

> 'The difficulty involved in seeing physiotherapy's history is, I believe, due to the fact that its consensus herstories corroborates so well with our understanding of the history of professional medicine and its allied fields of knowledge. Firstly, the herstories of physiotherapy as a semi-skilled servicing sector align well with the grand history of the medical profession's monopoly over, and intellectual developments in science. Secondly, it also fits in snugly with the equally convincing history of male physicians suppressing women's medical or scientific knowledge and work. These two factors combined have succeeded in effectively tuning out the voices of skilled, autonomous physiotherapists of the nineteenth century, male and female alike, in both Swedish and English contexts. Instead, the notion of the profession as a genuinely female occupation has become firmly established and analyses invariably operate from out of this framework. 1894 is not only viewed as the start of the profession, for example, but also as an effort to 'legitimize massage' instead of an effort to re-legitimize massage/physiotherapy, which better describes the course of events. The reason that women originally entered the field of physiotherapy, practising massage and medical gymnastics, was precisely because it was regarded as respectable. But a certain sort of historical myopia has in turn reduced all men and women (including physicians!) practising physiotherapy in England prior to the 'massage scandal' into an irrelevant historical footnote, as insignificant others. But, as I hope this article has illustrated, they are still there, hidden in plain view. They might be forgotten, but perhaps not necessarily invisible forever?' (Ottosson 2015, 19, emphasis in original).

This argument makes a number of very important points, not least questioning the date that physiotherapy began. Anders asserts that physiotherapy began long before the 'massage scandals' of 1894, but what remains uncertain for me in all of these arguments is the question of what exactly constitutes physiotherapy? Is it the use of particular modalities of treatment (massage, mechanotherapy, electrotherapy and exercise), because many others have used these modalities for centuries? Is it in the name, because the therapists at the RCIG were called medical gymnasts and it remains unclear when the term 'physiotherapy' came into common use. (This is true in many other histories of physiotherapy, for example, Wendy

Murphy's history of the American Physical Therapy Association shows liberal use of the terms 'physiotherapy' and 'physical therapy' in America prior to the 1920s). For me, physiotherapy must be seen to begin when the question of organisation and regulation around a particular professional code becomes necessary. The history of 'physiotherapy,' as opposed to the history of physical therapies (including all the various modes of assessment and treatment practiced by myriad practitioners from hundreds of different professional groups), is a history of the struggle for legitimacy and orthodoxy and relates closely to the societies and registration bodies and their various actions.

It would be very interested to hear other people's thoughts on this thorny question.

References

Heap, R. (1995a). Training women for a new "women's profession": Physiotherapy education at the university of toronto, 1917-40. History of Education Quarterly, 35(2), 135. doi:10.2307/369630.

Heap, R. (1995b). Training women for a new "women's profession": Physiotherapy education at the university of toronto, 1917-40. History of Education Quarterly, 35(2), 135-158.

Linker, B. (2005a). The business of ethics: Gender, medicine, and the professional codification of the american physiotherapy association, 1918-1935. Journal of the History of Medicine and Allied Sciences, 60(3), 320-354.

Linker, B. (2005b). Strength and science: Gender, physiotherapy, and medicine in the united states, 1918-35. Journal of Women's History, 17(3), 106-132. doi:10.1353/jowh.2005.0034.

Miles-Tapping, C. (1989). Sponsorship and sacrifice in the historical development of Canadian physiotherapy. Physiotherapy Canada. Physiothérapie Canada, 41(2), 72-80.

Nicholls, D. A. (2006). From pandemoniums of vice to a ‘profession for british women’: The future of physiotherapy through a historical lens. In New zealand society of physiotherapy conference. Auckland, New Zealand.

Ottosson, A. (2005). Sjukgymnasten - vart tog han vägen?: En undersökning av sjukgymnastyrkets maskulinisering och avmaskulinisering 1813-1934. Thesis. Göteborg University, Sweden.

Ottosson, A. (2011). The manipulated history of manipulations of spines and joints? Rethinking orthopaedic medicine through the 19th century discourse of european mechanical medicine. Medicine Studies, 3(2), 83-116. doi:10.1007/s12376-011-0067-3.

Ottosson, A. (2015). One history or many herstories? Gender politics and the history of physiotherapy's origins in the nineteenth and early twentieth century. Women's History Review. doi:10.1080/09612025.2015.1071581.

Ottosson, A. (in press). The age of scientific gynaecological masseurs. Non-intrusive male hands, female intimacy, and women's health around 1900. Social History of Medicine. doi:10.1093/shm/hkw013.

Owen, G. (2014). Becoming a practice profession: A genealogy of physiotherapy's moving/touching practice. PhD. University of Cardiff, Wales.

Fit for physiotherapy?

15 April 2016

Perhaps one of the greatest challenges facing the physiotherapy profession in the future will not be whether it can secure the necessary economic and political support to remain at the forefront of physical medicine, but whether it wants to take what's on offer.

Throughout its history, physiotherapy has benefited from world events that have consolidated the profession's relationship with the State, the public, and the medical profession (think here of the growth in the profession's size and status as a result of World War I, the polio epidemics, the birth of the welfare state, etc.). But these have all nurtured our image as a caring profession in service of the entire population. Health and social welfare reforms of the last few years suggest that the times are about to change.

There has been much talk about the unaffordable cost of modern healthcare, and a range of solutions are now being offered. Two that are closely linked are the idea of a Universal Basic Income, where the state no longer offers welfare, but gives each of us a 'salary' to cover all of our welfare needs (pensions, prescriptions, health care, benefits, etc.), and Fit For Work Assessments.

In a post on the superb New Zealand site Public Address, the ever reliable Emma Hart takes to task those who support these measures, arguing that they cost more than existing welfare provisions, carry an unacceptable level of risk to people's health, and engender a cynicism and managerialism across the entire health care sector (link).

> ”The human toll of these assessments, on people who are not job-seekers, but too physically or mentally ill to work, is appalling. On the other hand, it’s technically a success, because those 590 people are off the government’s books. If it’s morally unconscionable, at least it is actually saving money, right?" Emma Hart

There will be many physiotherapists reading this who have moved into areas like vocational rehab and 'Work Hardening' programmes, or are now involved in Fitness For Work Assessments, who believe strongly that this is good work (haven't physios always been

involved in getting people back to work?) And there will be others who have chosen, or have been forced by economic circumstances, to leave the public sector and go where the money is.

These are the economic realities of healthcare today. But that doesn't mean that the profession, as a whole, can afford to abandon those people who cannot afford individualised, private healthcare, because they make up the bulk of the burden of disability and illness in the population, and who will care for their physical health needs if we don't?

The question that physiotherapists have to ask is whether we want to be party to these health and social care 'reforms,' or whether we want to exercise moral objections to the slow, unrelenting assault on public services. Because to do so would require us to challenge the hand that has long fed us, and risk losing the generational patronage that has seen the profession rise to being the orthodox provider of physical rehabilitation services.

These are going to be difficult times for the profession and we will be forced to make some hard choices. "Fearless speech," as Foucault called it, may be the only way to retain our professional identity and dignity in the years to come.

There are no new treatments in physiotherapy

22 April 2016

A few days ago, I responded to a Tweet from Glyn Blakey (@saebouglyn) and Mary Banks (@MaryBanksy) after Mary had posted up a paper suggesting that the Saebo Mobile Arm Support (SaeboMAS) had reduced tonic muscle activity across all muscles, and that this had had a positive influence on corticomotor selectivity of biceps brachii during a counterbalanced movement tasks.

This all sounds very fancy, but what it basically means is that if you support the arm, the patient who is having difficulty moving, can concentrate on one joint activity while the rest of the limb is supported.

Seeing the paper made me wonder whether there are physiotherapists who look at this and think that it seems like a great new way to approach the problem, and wish that we had more tools like this to hand?

Well, although the Critical Physiotherapy Network is very much about looking to the future, many of the members of the CPN are historians, because, as everyone knows, looking to the future presupposes some understanding of the past.

And when it comes to body-weight supported training, we have a perfect example of a technology that past generations of physiotherapists developed and used extensively, but then largely abandoned as the profession's priorities changed.

True to form though, therapies that worked before will always find ways of working their way back into the professional practitioner's portfolio.

Olive Guthrie-Smith

Olive Guthrie-Smith is one of the few people in the first half of the 20th century who can truly be said to have been a real innovator in physiotherapy. So much of the work between 1900 and the end of World War II was concentrated on the orthopaedic management of injured servicemen (particularly amputees and fractures), and the management of devastating polio epidemics after WWI, that there was little call for any other work and little need for innovative new treatments. Massage, a bit of electrotherapy and some judicious exercises were enough.

The sheer workload of the masseuse in WWI was truly astonishing however. Sarah Chuck, Head Masseuses at Alder Hey Special Military Surgical Hospital, provides a good example:

> The Massage Department had its inception in February 1915 when two masseuses (Miss Smith and myself) treated daily about thirty to forty cases. At the present time the treatment staff at Alder Hey and its two Auxiliaries, Highfield Military Hospital and Dawpool Auxiliary Officers' Hospital, consists of fifty-eight masseuses and five masseurs. The number of cases treated daily during the current week amounts to 1,540 made up as follows:-
>
> Massage - 800
>
> Electrical - 380
>
> Hydrotherapy - 170
>
> Gymnasium - 190

Efficiency was the key. In 1919, for example, 'Major Souttar of Netley described machines to exercise 12 men at once which could be made from old packing cases and pulleys for 30s (Journal of the Incorporated Society of Trained Masseuses, May 1919, 257).

Therapies that worked before will always find ways of working their way back into the professional practitioner's portfolio.

The work of delivering rehabilitative exercise was helped considerably by the invention of a system of pulleys and springs by Olive Guthrie-Smith* that could be arranged over a metal frame and adjusted to support individual limbs, or event the entire body if needed, and

isolate joints for specific resistance work. Movement could be tailored to be gravity-assisted, gravity neutral and gravity resisted, and springs could be added to alter the load on the working limb.

Lanckenau describes four main uses for the Guthrie-Smith suspension system:

- Relaxation as a preliminary to exercise, and interspersed with bouts of exercise
- Suspension for weightless exercise
- Auto-assisted exercise for joints
- Graduated resistance exercise for muscle training and muscle toning (Lanckenau 1943; 615).

Key here was the ability to get the patient to 'work hard and do the work himself while he is carefully kept under supervision, so that adjustments and suspensions may be corrected' (Lanckenau 1943; 615).

*Guthrie-Smith passed the Society's examinations in massage (with distinction) and exercises in 1912 and joined the Almeric Paget Massage Corps in 1914 (Barclay 1995, 56). Head Masseuse at the London Command Depot in Shoreham, Sussex during WWI, Smith introduced the use of pulley and sling apparatus to help in the rehabilitation of servicemen through active and passive exercise. Some servicemen nicknamed the devices 'strafes' from the German Gott strafe England (God punish England) (Barclay 1995, 67).

There is also a connection from Guthrie-Smith back to the work of another physical therapy pioneer - Dr Jonas Gustav W. Zander (1835-1920) - who developed fantastically elaborate (and expensive) exercise equipment that is redolent of the kinds of equipment you find in gymnasiums today. Thomas Terlouw, Nils Hanssen and Anders Ottosson have written some wonderful pieces on Zander, who 'was a very strong candidate for the Nobel Prize in 1916' (Hansson and Ottosson, 2015; 3).

So perhaps if we are looking for inspiration for future physiotherapy practice, we could do worse than dust off some old physiotherapy books and see what previous generations of physiotherapists had to deal with. You might be surprised what you find.

References

Barclay, J. (1994). In good hands: The history of the chartered society of physiotherapy 1894-1994. Oxford: Butterworth Heinemann.

Hansson, N., & Ottosson, A. (2015). Nobel prize for physical therapy? Rise, fall, and revival of medico-mechanical institutes. Physical Therapy. doi:10.2522/ptj.20140284

Lanckenau, N. I. (1943). Rehabilitation by modern methods of exercise. In W. B. Doherty & D. D. Runes (Eds.), Rehabilitation of the war injured, a symposium (pp. 614-21). New York, Philosophical Library.

Terlouw, T. J. (2004). De opkomst en neergang van de zander-instituten rond 1900 in nederland. Gewina/TGGNWT, 27(3), 135-158.

Terlouw, T. J. (2007). The rise and fall of zander-institutes in the netherlands around 1900. Medizin, Gesellschaft, Und Geschichte : Jahrbuch Des Instituts Für Geschichte Der Medizin Der Robert Bosch Stiftung, 25, 91-124.

Is it time to end the tyranny of evidence based practice?

30 May 2016

Perhaps the greatest mind in the entire history of the world - well in my estimation anyway - once argued that it is the the things that are the most obvious and seemingly benign that we should focus all of our critical attention upon, because these are the things that are doing the best job of concealing the immense power that allows them to become so seemingly obvious in the first place. (If you hadn't realised already, that man is Michel Foucault).

Well of all the seemingly obvious, taken-for-granted and largely unchallenged ideas currently pervading physiotherapy, evidence based practice must surely be one of the most obvious ideas needing critical scrutiny.

Fortunately, a few physiotherapists are raising their heads above the parapet to challenge the primacy of EBP, evidenced by the latest editorial in Physiotherapy Canada.

In this editorial, the authors raise some of the limitations of EBP, most notably its lack of any acknowledgement of ethical decision-making, proposing the following new definition: EBP is 'an area of study, research, and practice in which clinical decisions are based on the best available evidence, integrating professional practice and expertise with ethical principles' (Veras, Kairy & Paquet, 2016, p.95).

The authors correctly point out that 'Several authors have criticized EBM methods, which they see as an attempt to monopolize science for standardizing methods and research tools around a unique scientific truth' (ibid), and it's refreshing to see them argue for EBP to be situated within a more contemporary social context. But in my view their argument is weakened by the fact that they promote a newer, shinier, better form of EBP, rather than asking radically critical questions about its purpose and principles.

In recent years, a number of authors have offered significantly more critical commentary on EBP. Spence recently claimed that 'Today EBM is a loaded gun at clinicians' heads. "You better do as the evidence says," it hisses, leaving no room for discretion or judgment. EBM is now the problem, fueling overdiagnosis and overtreatment' (Spence, 2016), whilst Trisha Greenhalgh et al argued that 'The evidence based "quality mark" has been misappropriated by vested interests' (Greenhalgh et al, 2014).

David Sackett himself identified that it was impossible for health professionals to keep pace with the volumes of information now available to them, and Madjar and Walton acused advocates of EBP of 'dehumanising medical reductionism' (Madjar & Walton, 2001).

Goldberg argued that 'Relying on ''the facts'' or ''the evidence'' to adjudicate between competing clinical practices or scientific beliefs assumes that the evaluative standards of EBM are transparent, neutral, objective, and universal. The numerous accounts of scientific knowledge as ''situated knowledges'' (Haraway, 1988) offered by post-positivist, feminist, and phenomenological thinkers suggest that this understanding of evidence is far too simple and no longer a tenable position in science studies' (Goldenberg, 2006: 2630).

But perhaps the most damning criticism of EBP comes from one of the journals that has spent more than 15 years presenting the latest evidence-based literature. In a 2008 editorial in the Journal of Evaluation of Clinical Practice, the authors argued that;

> 'We view with no small dismay and profound disappointment the continued refusal of the protagonists of EBM to engage in formal intellectual exchange, a position which represents nothing more than the long maintenance of an unscientific and antiscientific posture which we have come to interpret as a pragmatic mechanism designed to protect the cherished ideological convictions of the EBM community'.

If these colleagues view their settled positions as intellectually defensible and morally justifiable, then why are they so utterly opposed to confronting their critics? Why do they recoil from entering the intellectual forum of the JECP...in order to justify the generalities and specifics of their thesis, if they believe them to be so eminently justifiable?

The editors go on to accuse the proponents of EBM of 'extraordinarily lacking in intellectual credibility' of being 'profoundly revisionist and demonstrat(ing) that little has changed in terms of EBM's ideology or hubris with the exception of an increase in self-delusion and a refusal to accept that EBM is 'finished' in scientific, philosophical and clinical terms' (Miles, Laughlin & Polychronis, 2008, pp. 621-2).

A few weeks ago, I gave a talk in Norway on some of the contemporary criticisms of EBP (there is a link to the full presentation here). I had anticipated a rough ride, given that I had

assumed no-one would want to hear a criticism of something that was such an important part of physiotherapy's contemporary professional identity. I was surprised to find, then, that the audience was more than receptive to the ideas. Indeed, for some of them it only consolidated what they had already begun to ask themselves.

I wonder then if now is not the time to start agitating for an radically critical new approach to physiotherapy that does not perpetuate the kinds of dehumanising medical reductionism that caused Trish Greenhalgh to ask whether EBM was not now in crisis?

References

Goldenberg, M. J. (2006). On evidence and evidence-based medicine: Lessons from the philosophy of science. Social Science & Medicine (1982), 62(11), 2621-2632. doi:10.1016/j.socscimed.2005.11.031.

Greenhalgh, T., Howick, J. & Maskrey, N. (2014). BMJ; 348 doi: http://dx.doi.org/10.1136/bmj.g3725.

Madjar, I., Walton, J. A., Morse, J. M., Swanson, J. M., & Kusal, A. J. (2001). What is problematic about evidence. In The nature of qualitative evidence (pp. 28-45). Sage Publications Thousand Oaks CA.

Miles, A., Loughlin, M., & Polychronis, A. (2008). Evidence-based healthcare, clinical knowledge and the rise of personalised medicine. Journal of Evaluation in Clinical Practice, 14(5), 621-49. doi:10.1111/j.1365-2753.2008.01094.x.

Spence, D. (2016). Evidence based medicine is broken. http://www.bmj.com/content/348/bmj.g22.

Veras, M., Kairy, D., & Paquet, N. (2016). What is evidence-based physiotherapy? Physiotherapy Canada, 68(2), 95-96.

Half the pain, half the gain

2 June 2016

The subject of pain features quite a lot in these blogposts. Not because the members of the CPN are particularly expert in matters pertaining to pain, or because it’s of any more clinical interest than, say, cerebral palsy. Pain is interesting, I think, partly because it's become such a popular subject in the profession, and members of the CPN are prone to asking questions like 'why this, why now?'

In recent weeks a few social media feeds have explored, once again, how we might better understand pain, and improve on our assessment and treatment techniques. I've been struck by how almost all of these conversations are prefaced on the idea that pain is something bad, something noxious, disruptive, aversive, and detrimental to people's lives, and must be ameliorated. Given this view, the role of the physiotherapist (as part of the wider pain team), is to accurately and objectively assess (read 'measure') the person's pain, and find ways (to help them) to minimise pain's impact on the person's life, so that they can resume their normal activities.

I'm struck by how exclusive and limiting these definitions of pain are, and I'm drawn to wonder how much more influential, useful and interesting physiotherapy might be if we only embraced a fuller appreciation for full meaning and significance of pain.

Here are eight examples of pains that are central to people's everyday experience that, for some reason, are almost entirely ignored by physiotherapists:

- The pain people search for to know when they've had a good workout
- The pain of a good weepy movie or a hot spicy meal?
- The pain we learn to tolerate that helps us to form our identity (period pain, for example)
- The pain that is worth it because it comes with protection (i.e. injections)
- The pain that people self-inflict when they feel disembodied (self harm, for example)
- The pain induced for psychosexual pleasure (i.e. sadomasochistic pain)
- The pain as visual statement or display (tattooing or piercing)
- The pain induced in the name of fashion (wearing high-heeled shoes, corsets, etc.)

In response to some of our recent discussions, Derek Griffin posted the paper from Leknes and Bastian titled *The Benefits of Pain*, which argues that;

> Pain is most often an unpleasant experience that alerts us to actual or possible tissue damage. However, insisting that pain is always bad news may hinder understanding of pain's many facets. Despite its unpleasantness – or perhaps because of it – pain is known to enhance the perceived value of certain activities, such as punishment or endurance sports...Here, we review evidence for a series of mechanisms involved in putative benefits of pain. A byproduct of pain's attention-grabbing quality can be enhanced perception of concurrent pleasurable stimuli. This is thought to explain why pain may augment the pleasure of spicy foods. By providing an aversive contrast, pain can also improve the experience of events that follow pain's offset and lead to pleasant relief. Other potential benefits of pain derive from its ability to

> inhibit other unpleasant experiences and to elicit empathy and social support. The experience of pain can benefit our defence systems, since pain can enhance motivation to accumulate resources such as social support and calorie-rich foods. It can also reduce the guilt we feel after self-indulgence or moral transgressions. In sum, we highlight a series of potentially positive effects linked to pain. This framework can aid the understanding of why people sometimes seek out, enjoy, and gain rewards from pain as well as pleasure.

Although situated far too closely within the now well-established psycho-neuro-biological model of pain (characterised by a pain as a stimulus=response formula), the paper does at least ask us to broaden our horizons from the rather simplistic notion that we need only be interested in the kinds of pain associated with noxious stimuli.

If physiotherapists are only really interested in the noxious half of the pain experience, we should be clear about this, and be careful when we talk about pain as if we are referring to it in its entirety. Alternatively, we could start thinking about the full breadth and depth of the pain experience and begin to imagine how our knowledge and experience could be brought to bear on this most perplexing, subjective and complex phenomenon.

Reference

Leknes, S., & Bastian, B. (2014). The benefits of pain. Review of Philosophy and Psychology, 5(1), 57-70. doi:10.1007/s13164-014-0178-3.

Why do things need to work?

7 June 2016

One of the most enjoyable things about in the Critical Physiotherapy Network is the license it gives you to ask questions about the profession that other people might find ridiculous. There's a long history of the study of stupidity and idiocy in philosophy (see Shaw 2016, for example), and I'd like to think we make some small contribution to that with our Network.

Look at our Objectives and you will see that it is part of our constitution to develop 'a culture & appreciation for the exploration of all views that deviate from conventional thought & practice in physiotherapy' (Object #4, link).

So in the spirit of asking ridiculous questions, I'll confess that for some time now I've been thinking about what work means to physiotherapy.

It started with some research I was doing into the history of rehabilitation, and everyone seems to take it as read that one of the principal functions of rehab is to return people to 'meaningful occupation' (for which read 'work').

But I've also been thinking about how physiotherapy is fixated with seeing the body-as-machine, and our fascination with the idea that the body should 'work'. Bodies that don't work need fixing, and we would like to claim some authority here.

Likewise, we strongly believe that our assessment and treatment interventions should 'work', and promote evidence-based practice as our approach to show others that our stuff 'works'.

I suppose my question is, why does it matter so much that things 'work'?

Humour me for a moment, and ask yourself why it is that we think people should overcome their illness, impairment or disability and return to work? What is so wrong with people not working?

Why do we think that bodies should work? What's wrong with bodies that don't work? Why are we so intolerant to inability and suffering?

And why do our assessment strategies and treatments need to work?

Perhaps these aren't such ridiculous questions though, because by asking them we are really asking why it is that we have set the limits of our professional tolerance here and not there, per se.

Georges Batailles - an infamous French philosopher - argued that we need to transgress social norms (particularly around the things that society finds most objectionable) in order to find out why we have set our limits of tolerance the way we have.

This is an important idea in critical thinking. Rather than taking for granted the everyday and obvious world we live in, George Deleuze, Georges Batailles, Avital Ronell and many other very deep thinkers believe there is some real merit in thinking a bit more like a court jester, and less like the rational scientist; even if it's only for a short time.

Because to do so might mean that for the briefest moment you free yourself up to explore what the sane and rational world can no longer imagine.

Reference

Shaw, J. K. (2016). The life of an idiot: Artaud and the dogmatic image of thought after Deleuze. Theory, Culture & Society, 0263276416650723.

See also: Ronell, A. (2002). Stupidity. Chicago: University of Illinois Press.

See me before you go

20 June 2016

The title of this blogpost is a rather poor effort at a catchy streamline I grant you, but the message in no way belies what is an important issue for physiotherapists, health professions, or anyone who cares about the way disabled people are portrayed in the popular media.

There has been some serious criticism of the new English film *Me Before You* in recent days. The film portrays a millionaire disabled man, played by non-disabled actor Sam Claflin, who strikes up a relationship with his carer, Emilia Clarke, after being paralysed in an accident. The depiction of a man with so much, wanting to die, has enraged some disability rights activists because it offers yet another negative stereotype of disability.

Protesters at a recent screening in New Zealand chanted "assistance to live, not assistance to die" and "tell sad stories about your own lives", but it was one comment by one of the protesters that really caught my eye.

Speaking about the way disabled people were often seen in stereotypical terms, protester Esther Woodbury said, "We've seen this story so many times and we're sick of people doing anything they can to not be disabled - and that includes killing themselves - or just serving as a plot point to help other people".

That phrase '...we're sick of people doing anything they can to not be disabled..." struck a chord with me and reminded me so much of John Swain, Sally French and Colin Cameron's arguments in their chapter Practice: Are professionals parasites? from their 2003 book Controversial issues in a disabling society.

So much physiotherapy and rehabilitation work is prefaced on the idea that disability is something to be overcome rather than embraced and celebrated, that I wonder whether Woodbury, Swain, French, Cameron and many others are not making a very important point that too few physiotherapists have really thought about before.

Are you doing everything you can to make sure people are not disabled? If so, it may be that the consequences of your actions are more far-reaching than you realise.

Reference

Swain, J., French, S., & Cameron, C. (2003). Practice: Are professionals parasites? In Controversial issues in a disabling society (pp. 131-140). Buckingham: Open University Press.

Making enemies of friends

30 June 2016

When Voltaire, the French philosopher and writer, was on his death-bed in 1778, he was asked by his priest if he renounced Satan, he replied "Now, my good man, this is no time to be making enemies."

I heard the quote again the other day when I was talking to a friend about the way that the greatest enemies of progress are often one's own colleagues and friends.

The subject came up because of two instances in nursing that had shown how unstable some professional ideologies can be when exposed to critical scrutiny.

The first instance was the debate surrounding the publication of David Thompson and Philip Darbyshire's paper *Is academic nursing being sabotaged by its own killer elite?* (Thompson and Darbyshire, 2013a). In their rejoinder to the paper and subsequent protests, the authors wrote that;

> ’Before we address some of the points and issues raised in this JAN Forum, we should mention that our piece has, to date, elicited over 50 emails from the UK, Australia, and Canada. Approximately half are from current and past professors of nursing, while professors of sociology and psychiatry and various junior faculty have also weighed in. Intriguingly, we have also received commentary from faculty in the departments of our critics. Our correspondents were, without exception, encouragingly supportive of our stance, with many confirming the authenticity of our account and relating the range of damaging and negative experiences they too had suffered or witnessed at the hands of some of the ‘killer elite’ we alluded to (Thompson and Darbyshire, 2013b).'

Notwithstanding this support the authors received from within their profession, it seems that the article stimulated quite a lot of heated commentary and consternation from within the nursing profession.

A good friend of mine experienced the same mobilisation of the 'killer elite' a few years earlier when he published a paper criticising the ethics of nurses who worked on death row. How could it be, he asked, that nurses could exercise their professional mandate to care for people, in the knowledge that they were going to be electrocuted or given a lethal injection? He was roundly attacked; not by human rights workers, sociologists, prison reform advocates or others, but by other nurses, being accused of betraying his profession, embarrassing its leaders, and exposing it to unwanted public criticism.

It would be nice to think that those who are posing challenging and interesting questions of physiotherapy don't suffer the same fate. But, I suppose, whenever one critiques a set of practices, one also challenges the beliefs that go with it and, by extension, the people that hold to those beliefs. Let us hope that our own 'killer elite' recognise, like Voltaire, that now is not the time to be making enemies.

References

Thompson D.R. & Darbyshire P. (2013a) Is academic nursing being sabotaged by its own killer elite? Journal of Advanced Nursing 69(1), 1–3.

Thompson D.R. & Darbyshire P. (2013b) Reply. Journal of Advanced Nursing 69(5), 1216–1219.

Work for it - fitness, female and fascism

19 July 2016

Physiotherapists are well known for confident physicality. A friend of mine used to say that you could always tell the physiotherapy students at university because they'd be the ones walking around with hardly any clothes on. Happy are we it seems, to betray our confidence in our understanding of the body and how to 'work' it, taking every opportunity to thrust our bodily ideals on others.

Often, physiotherapists' projections of the idealised normal and able body cause little offence, but their approach can also cause a great deal of hurt and frustration in the very people they claim to be helping.

It would be nice to think that physiotherapists would be united in their opposition to such trends as Fitspo - or fitspiration - 'a growing online phenomenon with the goal of motivating individuals to pursue a fit and healthy lifestyle'.

It certainly sounds benign enough. Who could complain about a trend that encourages people to be fitter, stronger, more beautiful?

In many ways, Fitspo almost seems like a formula for creating the perfect physiotherapy practitioner. Female, toned, strong, athletic and confident. But look beneath the surface and it becomes clear that this could easily present just another unattainable, highly sexualised and degrading male marketing fantasy.

Part of the reason why this might appeal to some physiotherapists may lie in the long history of the profession's association with the normalisation of impairment and disability, the nurturing of 'strong' women who resisted the caring characterisation adopted by nursing, and

the profession's association with eugenics, and what Brian Pronger called 'body fascism' (Pronger, 2002).

So it will be interesting to see whether physiotherapists embrace this ideal of the strong, physically fit female form, and see it as a harmless, perhaps even admirable goal for their peers and patients, or whether practitioners position themselves with the 99% of the population who will never achieve such purity of form.

Reference

Pronger, B. (2002). Body fascism: Salvation in the technology of physical fitness. Toronto: University of Toronto Press.

Stop telling people to lose weight and get more exercise

22 July 2016

Sadly, it seems we cannot escape the fact that many physiotherapists now believe that part of the answer to the problems now facing the profession can be resolved, at least in part, by telling people to lose weight, stop smoking, and get more exercise.

The need to feel part of the move towards population-based primary health care has induced many traditional and orthodox health professionals to scratch their heads and ask what their social function will be in the future.

It seems reasonably clear that traditional sources of work, like the specialist care that once took place in large hospitals, and the routine self-limiting, acute musculoskeletal disorders that made up significant amounts of private practice work, are in terminal decline.

Does the answer really lie in merely 'getting patients active'?

In their place is a dire need to manage complex, multi-morbid disorders, chronic pain and long-term disability.

But based on the opinions of 'Leading physiotherapists from the UK, Canada and Australia' who 'led a symposium at the IFOMPT conference in Glasgow' recently, the answer lies in merely 'getting patients active'.

Non-specific physical activity may well be an important response to the growing concerns around lifestyle disorders, but surely we should be asking whether it requires someone with an expensive three- or four-year training and years of experience with complex co-morbidity to tell someone to lose weight and get more exercise?

Surely the future of the profession lies in more complex health issues than this?

But then perhaps this desire to move into the occupy the mundane end of public health care speaks more to our inability to imagine where the funding will come from for the kind of work that we really should be doing?

Does physiotherapy's hidden curriculum exclude men?

4 August 2016

A recent article in The Conversation explored how training to be a surgeon subtly marginalised women and promoted the idea that surgery was a man's world. Surgical training was described as 'powerful, visible, gendered and discriminatory'.

Over the last few months I've been writing and thinking a lot about the gendering of physiotherapy. Much of that has revolved around the ways that women masseuses in World War I first came into contact with young male bodies, and the brutal ways they went about rehabilitating them. (The image above is from a classic series of postcards that depicted the dominating and fearful WWI masseuse - see Carden-Coyne, 2008).

Anders Ottosson's recent papers looking at physiotherapy's herstories have also given me cause to think about our profession's longstanding gendering. And while I'm not entirely convinced by Anders' superbly executed and researched arguments that physiotherapy's masculine history was lost when physiotherapy became predominantly female in the early 1900s (Ottosson 2015 & 2016), they do offer a poignant reminder that one way in which we can begin to better understand our profession's past, present and future, is through some of the obvious structural features of our profession.

Hearteningly, there has been quite a swell of interest into physiotherapy's gendered history recently (see selected readings below), and much of this suggests that physiotherapy's history, in this regard, may be unique. Physiotherapy has not followed the path of many other female dominated caring professions, and in many ways it is closer to medicine and surgery than nursing and occupational therapy.

So recent questions about the gendered bias inherent in surgical training are worth thinking about. If surgery subtly excludes women and promotes androcentric (male-centred) ideals, with the end result being macho language, behaviours and attitudes, how do we promote our particular way of being gendered practitioners through our curricula, daily practices, cultural objects and professional attitudes? How do we perpetuate the gender distribution within the profession such that it always seems to remain 60-70% female? How is this achieved? Is it

simply about entry criteria, or something much more subtle and pervasive? What are we doing to maintain this status quo that, perhaps, we are entirely unaware of? And what might it mean for our professional identity to change this?

References and selected readings

Carden-Coyne, A. (2008). Painful bodies and brutal women: Remedial massage, gender relations and cultural agency in military hospitals, 1914-18 . Journal of War and Cultural Studies, 1(2), 139-158. doi:10.1386/jwcs.1.2.139/1.

Dahl-Michelsen, T. (2014). Sportiness and masculinities among female and male physiotherapy students. Physiotherapy Theory and Practice, 30(5), 329-37. doi:10.3109/09593985.2013.876692.

Dahl-Michelsen, T., & Solbrække, K. N. (2014). When bodies matter: Significance of the body in gender constructions in physiotherapy education. Taylor & Francis. doi:10.1080/09540253.2014.946475.

Hammond, J. A. (2009). Assessment of clinical components of physiotherapy undergraduate education: Are there any issues with gender? Physiotherapy, 95(4), 266-72.

Hammond, J. A. (2013). Doing gender in physiotherapy education: A critical pedagogic approach to understanding how students construct gender identities in an undergraduate physiotherapy programme in the united kingdom. Doctor of Education.

Linker, B. (2005a). The business of ethics: Gender, medicine, and the professional codification of the American physiotherapy association, 1918-1935. Journal of the History of Medicine and Allied Sciences, 60(3), 320-354.

Linker, B. (2005b). Strength and science: Gender, physiotherapy, and medicine in the united states, 1918-35. Journal of Women's History, 17(3), 106-132. doi:10.1353/jowh.2005.0034.

Ottosson, A. (2016). The age of scientific gynaecological masseurs. Non-intrusive male hands, female intimacy, and women's health around 1900. Social History of Medicine. doi:10.1093/shm/hkw013.

Ottosson, A. (2015). One history or many herstories? Gender politics and the history of physiotherapy's origins in the nineteenth and early twentieth century. Women's History Review. doi:10.1080/09612025.2015.1071581.

Owen, G. (2014). Becoming a practice profession: A genealogy of physiotherapy's moving/touching practice. PhD.

Sudmann, T. (1997). Gender is (also) a job! Female physiotherapists' handling of physical proximity to male patients in treatment. Nordic Physiotherapy, (4), 172-85.

Sudmann, T. (2009). (En) gendering body politics. Physiotherapy as a window on health and illness. PhD thesis.

Interesting outcome

11 August 2016

A quick quiz...

What do these outcomes measures have in common?

- The Step Activity Monitor (SAM)
- Barrow Neurological Institute (BNI) Fatigue Scale
- The Postural Assessment Scale for Stroke (PASS)
- And the Hierarchical Assessment of Balance and Mobility (HABAM)

Yes, they do all suffer from the same urge to give every outcomes measure an acronyms. (Although it has to be said that the people who invented the Physiotherapy Functional Mobility Profile Questionnaire (PFMP-Q), had no desire to give their outcome measure a memorable name or acronym). But that's not the right answer.

The answer is that they are all outcome measures developed in the last 20 years that are widely used in rehabilitation.

Now this may seem an insipid answer I know, but hopefully it does prompt some interesting thoughts.

Outcome measures are one of the biggest subjects in physiotherapy today, and there are now dozens of new measures being developed each year. The rhetoric for developing sensitive, reliable and valid measures is well known: outcome measures allow us to tell which treatments work and which don't, and they allow us to assess the effect of our therapy. But they don't, in themselves, ask more critical questions, like 'why is it that outcome measures have become so remarkably popular (and suddenly necessary) in the last 25 years?'

Physiotherapists have used outcomes measures since the birth of the modern rehabilitation movement in World War I. Muscle strength testing, range of movement and, most importantly, return to active duty/work rates, were frequently used to assess our treatments.

These few rudimentary tests remained the backbone of physiotherapy measurements for the next 60 years. But when physiotherapists became first contact professionals, moved into universities, and adopted evidence-based medicine's hierarchy of evidence, everything changed.

But this still doesn't explain why outcome measures have become so important lately.

To answer this question, we need to dig a little deeper.

Consider this statement from Jonathan Hill, Senior Lecturer in physiotherapy at Keele University, commenting recently on the new Musculoskeletal Health Questionnaire (MSK-HQ).

A key reason for using the tool, according to Dr Hill, was that...models of commissioning typically require physiotherapists to engage with service evaluation and improvement. There had been a strong demand from physios for a more appropriate, discrete and easy to use MSK outcome tool.

Whatever else we might think, the real power of outcome measures is in their ability to allow us to say that our treatments are better than theirs; that our evidence is stronger; that if there is any spare social capital left for orthodox health professionals after doctors and nurses have vacuumed up all of the hero-worship and angel dust, then we should get it rather than them.

One only has to look at the changing economy of health care over the last quarter century to realise why outcome measures have become so important.

The outcome measures that survive our newfound critical scrutiny, will not be those that are necessarily the easiest to use, nor the most valid or reliable. It will be the measures that most convincingly show that we are better than them that will endure. And so, perhaps the only outcome measure that really matters, when all is said and done, is the fact that we will still be here tomorrow fighting for our right to design more outcome measures.

Innovation in physiotherapy

7 December 2016

There's been a recurring theme in many of my blogposts this year, and a Facebook post by Adam Meakins on Wednesday summed it up beautifully.

In the post, Adam was responding to an earlier post by Brent Brookbush promoting a new educational video of a muscle tissue release technique, to which Adam made this comment;

> The continued illusion or delusion of therapists thinking they can find 'nodules' 'trigger points' 'knots' 'taut bands' 'scar tissue' ''gristly bits' 'snotty shit' 'gammy areas' still astounds me in 2016... these are just soft tissue sore

spots of an unknown origin... Meakins (2015)
http://bjsm.bmj.com/content/49/6/348.full.pdf

The issue that I've been grappling with repeatedly this year is that we have been using our physical therapy techniques for over a century now, and yet what we really know about them is really, really limited. But that this isn't necessarily a bad thing.

If we take Adam's comment above as an example, Cyriax was talking about trigger points in the 1940s, and hundreds of thousands of physiotherapists and other practitioners have learned the techniques since.

Has the lack of empirical evidence of their existence or the efficacy of the therapeutic technique reduced people's use of the term or the treatment? Has the fact that we can't differentiate between a sore spot and some 'gristly bits' harmed the profession? Is our lack of sophisticated neuro-biological determinants altered what we teach students or write in our textbooks? I haven't seen any evidence of it.

What matters in the end is not what you do, but what it means.

There are many in the profession who believe that the future for physiotherapy lies in us resolving these ambiguities; conducting clinical trials to prove what works and what doesn't; defining with biological certainty what is under our hands and what changes when we treat. As time goes by I'm increasingly unconvinced by these arguments.

To my mind most if not all of physiotherapy is socially constructed. Call them trigger points if you want. What matters in the end is not what you do, but what it means, for your clients/patients, for you, and for the people who fund your service.

We have always treated 'sore spots of unknown origin' and someone, perhaps physiotherapists, always will. But I'd like to bet it's not because we finally find proof of what Cyriax told us about 80 years ago.

There is no ‘you’ in physiotherapy

7 February 2017

Cast your mind back to your days as a physiotherapy student. Did any of your lecturers ever change what or how they were taught based on the personalities of the people in the class? Was the subject of the session changed from the lesson plan to reflect an individual or group's cultural beliefs and values? My suspicion is probably not, or if it did happen, it didn't happen much when you were learning anatomy, physiology, pathology, kinesiology,

biomechanics, assessment or treatment techniques, research methods, or any of the other 'core' subjects in the physiotherapy curriculum.

I once shared an office with a lecturer who had very devout faith, and I often wondered how she reconciled her beliefs with her practice as a physio. The profession made no formal acknowledgement of her faith, and nor did it suggest that a person's faith had any formal place within the profession. So she never spoke about it with students or staff, or helped others come to understand their physiotherapy through these kinds of personal enrichment.

So what is gained and what is lost from physiotherapy by ignoring these aspects of people's 'selves'? How much richer and more meaningful could physiotherapy be for the communities we served if the profession could find a way to formally embrace the full diversity of its people?

This is not a question of the profession's respect for cultural diversity, per se, but as much a question about the profession's approach to individual subjectivity. Is it possible to claim that the profession is person-centred, for example, if we don't formally acknowledge - in our curricula, professional scopes, and daily dealings - the very things that make us all unique practitioners?

How can physiotherapy students learn to respect the individual needs of their clients/patients, if their own personalities are sublimated in graduate courses that focus on homogenous and normalised body systems and structures; standardised assessment and treatment techniques; and rigidly applied standards of practice?

There is a lot of work going on within the profession exploring individual subjectivity and people's cultural values - a lot of it by members of the CPN, WCPT and national professional bodies - but as yet, this doesn't appear to have penetrated the profession's mainstream, where the focus still remains heavily on a biomedical, reductive and culturally agnostic approach to practice.

This is interesting to me, because if you've been in practice for more than a year or two, you will have had to learn how to be 'yourself' as a physiotherapist. You will have had to learn how to make sense of your own cultural identity as a physiotherapist, regardless of whether you had help to do it or not. But many people do this despite their training rather than because of it.

Surely the profession could give our students and novice practitioners more guidance in understanding how to express themselves through their craft. In the end it would surely make for better practitioners and a stronger, more diverse and inclusive profession.

Some readings

Fougner, M., & Horntvedt, A. T. (2012). Perceptions of norwegian physiotherapy students: Cultural diversity in practice. Physiotherapy Theory and Practice, 28(1), 18-25. doi:10.3109/09593985.2011.560238

Norris, M., & Allotey, P. (2008). Culture and physiotherapy. Diversity in Health and Social Care, 5, 151-9.

O'Shaughnessy, D. F., & Tilki, M. (2007). Cultural competency in physiotherapy: A model for training. Physiotherapy, 93(1), 69-77. doi:10.1016/j.physio.2006.07.001

Ramklass, S. (2015). A framework for caring in physiotherapy education and practice. South African Family Practice, 57(2), 126-130. doi:10.1080/20786190.2014.977006

Keys to critical thinking

28 March 2017

Last week I had the very great pleasure of teaching some critical thinking skills to postgraduate students at AUT University with my good friend Dr Barbara Gibson. The students were physiotherapists, nurses, case managers, occupational therapists and others, and few of them, in truth, knew much about critical thinking.

So we concentrated on what is perhaps the most important, but also the hardest skill in thinking critically: questioning things that we otherwise take for granted.

Because something is taken-for-granted it is, by definition, hard to see. They include things we unquestioningly support (like taking care of your own health, for instance); things that are custom and practice (patient assessments perhaps); popular attitudes (a dislike of cigarette smoking); and powerful ideas and influences (biomedicine).

The reason for focusing on these practices, is that they are often the least questioned aspects of our lives, and so play a very important role in silently shaping what we believe and trust.

In recent weeks we've seen a series of announcements about physiotherapists who have won awards for innovation. Now you would be hard pressed to find any physiotherapist prepared to critique such achievements. They raise the profile of the profession, they celebrate excellence, and they provide a pathway for others to follow. But does this mean that they should be immune from critical examination?

I would argue not, and that awards, acknowledgements and achievements are powerful indicators of changing conditions in healthcare, and so might be some of the first places to look, if we want to gain critical insights into where physiotherapy has been, where it is, and where it might be going.

Importantly, awards, acknowledgements and achievements can reflect shifts in attitudes and attempts to move away from traditional practices and ways of thinking. They are themselves subtle critiques of what went before, and they can be pointers to what is to come.

So what can we glean from some of the recent awards and announcements of innovation appearing over the last year or so? Perhaps we can see that there is:

- A move away from 'traditional' physiotherapy departments and towards physiotherapy delivered remotely;
- A much greater focus on activity and participation, and reducing the burden of illness;
- A move away from acute treatment to long-term care;
- An attention to intractable health problems like chronic pain and disability;
- A desire to reduce the costs of specialist care, increase independence, and self-sufficiency;
- A serious commitment to greater diversity of work, role sharing and devolution of old professional boundaries.

To my mind, there isn't one of these that isn't hugely problematic and fraught with difficulty, but it is worth remembering that they would not be winning awards and functioning at the 'bleeding edge' of new professional practice if they didn't, on some level, come with some benefits.

The question is, perhaps, what is gained and what is lost in these innovations? Whose voices are we hearing and whose are being silenced? Which 'truths' are being promoted and what beliefs are being marginalised?

Being critical is therefore not so much about deciding something is necessarily good or bad, but more deliberately and purposefully asking questions about what lies beneath our everyday practice, so that the dangerously banal aspects of everyday decision-making don't go unquestioned.

The politics of touch

5 April 2017

Perhaps one of the biggest points of difference in current debates around the future of physiotherapy involves the question of whether physiotherapy should be evidence-based. It is self-evidence - so some say - that physiotherapy practice should be based on the best available evidence, since to practice otherwise might put people at risk, or damage the reputation of physiotherapy as a science.

One of the less-well-often discussed issues with this argument is how much people - and by this I mean the public, our professional colleagues and peers, and the organisations that fund us and legislate for us - actually care whether some therapeutic practices are evidence-based.

An article today on touch by Steven Phelps, Associate Professor in the Department of Integrative Biology at the University of Texas, in the digital magazine *Aeon*, illustrates the point nicely. In the article, Phelps argues that 'perhaps we have become too easily ashamed of our wonder', and this got me thinking about our own relationship with touch.

There is very little support in physiotherapy for the idea that we should use our skills in touch simply because it feels nice, rather, physiotherapists should only be using modalities that have a strong evidence-base to them. Indeed, it would seem that for some in the profession, anything resembling the practice of therapeutic massage effectively labels the practitioner as a quack.

My argument is that this is a very shortsighted view. Not because we should ignore the need to be evidence-based (although there is mounting critical pressure on the EBM movement), but because by taking such a dogmatic view of touch, we miss the bigger point.

Touch is likely to be increasingly important to people in the future. There is an entire science of haptic technology telling us that people will use touch more than ever as a means of communication. Touch is also one of the things people with yearn for, particularly at times of mental anxiety and distress. Touch is pleasure and, for us, touch is diagnostic. Physiotherapists are one of only a handful of professions who have a license to touch, and one of only a very few who are trusted to use it for more than procedural reasons (putting on a BP cuff or using a scalpel, for example). Touch is one of the most powerful ways of breaking down barriers between people, and it has enormous potential for harm. And it is a metaphor for how we move through our lives (in touch with our relatives, feeling people's suffering, handling difficulties, pressing people for more information, etc.).

The point is that touch is first and foremost a political, cultural, existential, social act that transcends the more prosaic and mundane questions about whether it works or not. Physiotherapists who decry it and claim that physiotherapists should go nowhere near it may well be missing the point. Touch is not going away. Touch is perhaps the oldest therapy known to human kind, and it is likely that people will always need skilled, thoughtful, caring and compassionate touch. We would be wise as a profession to embrace it, if we want to remain relevant as a profession into the future.

Should we give up physiotherapy?

20 April 2017

One of the biggest dilemmas facing the physiotherapy profession today is how to keep it alive.

Given the unrelenting pressures to reform, cut costs, and redesign practice, it's hard to know whether to push the profession's stability, history and established culture, or to promote a radical new professional image.

And faced with healthcare innovations that seem to be dissolving old certainties, it's hard to know whether we like it or not.

Imagine, for instance, that robots were shown to be more reliable manipulators than physios, or that a low-cost assistant could do the work of post-op respiratory physiotherapy just as well as an expensively trained clinician. Would we promote it?

In some instances, like this recent trial by a 'short-stay rehab unit based at a Nottingham care home' that 'managed to cut 90-day hospital readmission rates to just five per cent', it would seem a relatively easy choice. Of course it's good that patients spend less time in hospital! But maybe the decision is made easier by the fact that it promotes the idea that more physiotherapy is a good thing. It argues that physiotherapy is a worthy and necessary thing to have and that service improvements came because of the specific physiotherapy intervention, not despite it.

We have a much harder time supporting interventions that replace physiotherapy, however. Even when they do things better. In this respect physiotherapy is just as 'political' as any other vested interest, and it is far from objective. Most people who have invested time and passion into becoming a physiotherapist will work hard to perpetuate what they've established. But is this necessarily in the interests of our patients, or the health service at large?

Evidence-based practice has been a powerful way for physiotherapists to try and demonstrate that what they do matters, but ironically, there is little evidence that EBP itself is making any difference to the perceptions of our patients, our peers or our funders.

Perhaps the answer is to see the difference between the objectivity needed to make the right clinical decisions, and the totally biased, passionately subjective, deeply invested conviction that what physiotherapists do matters and is worth fighting for?

The fundamental question seems to me to be this: if it were in the best interests of patients or the healthcare system as a whole, for us to disestablish physiotherapists, would we do it?

This, as much as anything else in current debates surrounding the profession, seems to me to be the biggest dilemma facing the physiotherapy profession today.

Are health professionals parasites?

6 June 2017

There are many powerful critical arguments about health professional practice. Anyone who has studied how health professionals came into being, whose interests they served, or how they've adapted to the broader changes happening in society, can't fail to be shaken by the belief that the fight to become the agents of our own destiny is one with many casualties, many of whom are the people we earnestly claim to serve.

Perhaps one of the most powerful arguments pertaining to physiotherapy - especially those areas of the practice that relate to long-term illness and disability - comes from disabled people themselves, who, for more than half a century, have been vocal in their criticism of healthcare professionals.

Finkelstein called it 'able-bodied chauvanism' (Finkelstein 1999, p. 23), when doctors, physiotherapists and others pontificated on questions of quality of life, ‘determining where ((disabled people)) can park their cars…and whether they are capable of working’ (Hammell 2006, p. 19).

Such criticisms remind us that 'the rehabilitation professions are not apolitical and that the rehabilitation process is often irrelevant, meaningless and useless’ for disabled people (Hammell 2006, p. 5).

John Swain, physiotherapists Sally French, and Colin Cameron asked if professionals were parasites in 2003 (Swain, French & Cameron 2003), arguing that it was in the professionals' interests to perpetuate the social stigma of abnormality, because it gave us a mandate to continue our practices of assessment, diagnostic labelling and intervention. Physiotherapists and others 'feed' off the socially constructed notion of disability, and seem to want to foster it with endless new systems of categorisation and differentiation.

A recent piece by Ray Moynihan in *The Conversation* returns to this message, examining how the diagnostic label of osteoporosis has morphed over time. We are now seeing the emergence of 'pre-' diagnostic definitions, capturing markers of disease before they even happen - opening up entirely new markets for healthcare workers to colonise and parasitise.

A study cited in the article found three features of this work of diagnostic labelling:

1. "First, the expert panels of doctors who made these changes often decided to widen definitions classifying more people as patients. Generally, the motivation was that treating milder problems, or finding diseases earlier, would benefit the newly diagnosed.

2. "Second, these panels did not rigorously investigate the downsides of that expansion; none examined how many people would be overdiagnosed.
3. "And, third, most panel members had financial relationships with drug companies that stood to benefit from panel decisions" (link).

Physiotherapists, like all orthodox health professions, are complicit in these arrangements whenever we look to broaden the classifications of problems that we work with, when it can be clearly seen that the impetus to do so is driven by professional interests rather than the interests of the clients or their communities.

More critical thinking around these issues is needed to help us see more clearly when we get the balance of these responsibilities wrong.

References

Finkelstein, V. 1999, A Profession Allied to the Community: The disabled peoples trade union, in E Stone (ed), Disability and Development: Learning from action and research on disability in the majority world, The Disability Press, Leeds, pp. 21-4.

Hammell, K.W., 2006, Perspectives on disability & rehabilitation: Contesting assumptions, challenging practice, Churchill Livingstone/Elsevier, Edinburgh.

Swain, J., French, S., & Cameron, C. (2003). Practice: Are professionals parasites? In Controversial issues in a disabling society (pp. 131-140). Buckingham: Open University Press.

Kicking up, not kicking down

16 June 2017

A friend of mine works with young people who are first- or second-generation migrants to New Zealand. Her job is to equip them with the skills they'll need to run campaigns, advocate for their communities, and improve the lives of the people around them. They're 'therapists' of a sort.

She has a simple way of knowing whether someone is doing the right thing or not. She asks "Are you kicking up, or kicking down?"

By 'kicking up', she means agitating against those people with power, the ones in positions in authority.

All too often people find it easier to kick down: taking aim at the people who are easy targets, because they're vulnerable, less powerful, less fortunate. It's the psychology of the bully.

Kicking up is an important strategy for critical thinking. First, you need to think about who, in your world, carries authority. In physiotherapy it could be managers, department heads, regulatory boards and professional authorities, national and international leaders. They're not bullies, but there is an asymmetrical power relationship between you and them that works in their favour.

That means that all of the organisations that promote and regulate particular ideas about physiotherapy are sites of critical inquiry: WCPT, The CSP, APA, APTA, and the Critical Physiotherapy Network. And you need to be constantly vigilant for those times when one of those organisations - my own included - look like we're kicking down.

"Kicking" of course, is a strong term, but we have all seen in recent times how quickly some people take to figuratively and literally kicking people less fortunate than themselves: the 'foreigner', the disabled worker, the transgender woman, the black youth, the fat kid, and so on.

Sometimes healthcare does its kicking insidiously through sanctions and restrictions, rules and rights of access. We can do it ourselves through norms and customs that seem, on the surface, to be neutral, but hide powerful mechanisms of 'othering'.

Perhaps the best example of this is the system of biomedicine itself, which is soaked in white, male, Western values. There are some stunning examples of kicking up starting to emerge from physiotherapy, and these are changing the way we're starting to see the profession.

Just beginning to ask questions about whether your actions are kicking up or kicking down could be the first step to a more critical future for the profession.

Some great kicking up reading in physiotherapy:

Carden-Coyne, A. (2008). Painful bodies and brutal women: Remedial massage, gender relations and cultural agency in military hospitals, 1914-18 . Journal of War and Cultural Studies, 1(2), 139-158. doi:10.1386/jwcs.1.2.139/1

Dahl-Michelsen, T. (2015). Gender in physiotherapy education: A study of gender performance among physiotherapy students and changes in the significance of gender. PhD.

Eisenberg, N. R. (2012). Post-structural conceptualizations of power relationships in physiotherapy. Physiotherapy Theory and Practice, 28(6), 439-46. doi:10.3109/09593985.2012.692585

Gibson, B. E., & Teachman, G. (2012). Critical approaches in physical therapy research: Investigating the symbolic value of walking. Physiotherapy Theory and Practice, 28(6), 474-84. doi:10.3109/09593985.2012.676936

Hammond, J. A. (2013). Doing gender in physiotherapy education: A critical pedagogic approach to understanding how students construct gender identities in an undergraduate physiotherapy programme in the united kingdom. Doctor of Education.

Kell, C. (2013). Placement education pedagogy as social participation: What are students really learning? Physiotherapy Research International : The Journal for Researchers and Clinicians in Physical Therapy, 19(1), 44-54.

Linker, B. (2005). Strength and science: Gender, physiotherapy, and medicine in the united states, 1918-35. Journal of Women's History, 17(3), 106-132. doi:10.1353/jowh.2005.0034

Praestegaard, J., Gard, G., & Glasdam, S. (2014). Physiotherapy as a disciplinary institution in modern society: A Foucauldian perspective on physiotherapy in danish private practice. Physiotherapy Theory and Practice, 31(1), 17-28.

Ottosson, A. (2015). One history or many herstories? Gender politics and the history of physiotherapy's origins in the nineteenth and early twentieth century. Women's History Review. doi:10.1080/09612025.2015.1071581

Setchell, J., Watson, B. M., Gard, M., & Jones, L. (2016). Physical therapists' ways of talking about overweight and obesity: Clinical implications. Physical Therapy, 96(6), 865-75. doi:10.2522/ptj.20150286doi:10.3109/09593985.2014.933917

Sudmann, T. T. T. (2009). (En) gendering body politics. Physiotherapy as a window on health and illness. PhD Thesis.

Physiotherapy and capitalism

9 November 2017

Surely one of the most important projects of the next decade in physiotherapy must be to undertake a thoroughgoing critical analysis of our professional history. By this I mean how did we get to be a profession that looked so distinctly like 'this', and not something else.

Perhaps one of the most important questions we need to ask is how has physiotherapy served The State - and how this will change as governments become smaller and push the responsibility for social welfare onto individuals.

One of the most intriguing questions that, as far as I know, no-one has really studied, is the relationship between physiotherapy and capitalism.

On first glance, it would be hard to see a connection, but watch a recent video from the BBC and Stephen Fry on the the German sociologist Max Weber, and you may be able to see a link.

Essentially, Weber argued that capitalism owes its origins to a particular branch of Christianity called Calvinism, that promised salvation for those who contributed to society through their work. Wealth, both financial and spiritual, was underpinned by one's labour, and so the need to ensure that one was always fit and able to work became an important measure of an individual and a country's moral rectitude.

Hence the need for measures like Gross Domestic Product (GDP); the setting a retirement age, to determine when work could be legitimately terminated and the person prepared for judgement; and, of course, physiotherapy and rehabilitation.

Physiotherapists became a vital cog in the machinery of production because they both returned people to work and soothed The State's embarrassment that it even had people who were unfit for work in the first place.

Sociologists like Weber and Karl Marx have provided complex and interesting critical insights into the reasons for the existence of social systems like health care and capital, and these things are often so familiar to us that we take them for granted. We could do a lot worse than pay some more attention to these ideas in the future.

Punk physiotherapy

16 November 2017

There have been times in the history of music, where the only legitimate musicians and composers were highly trained, highly skilled elites. Mozart, Beethoven and Bach were prolific geniuses who bestrode popular music and set the standard for future generations to follow. But as in all art forms, radical change came from movements at the margins with innovations born from necessity or opportunity. The new sound was often unpopular, derided as crude, and pushed to the margins from whence it came.

In the 1970s, popular music was dominated by musicians who were often highly skilled in songwriting or consummate technicians. 12 minute guitar solos and whole albums of conceptually rich, but almost unlistenable indulgence were not uncommon. But cracks were beginning to show. The first signs of change came from the urban punk scenes of New York and London and quickly spread their chaos and disorder through every record store and radio.

Soon it was enough to be able to play three chords loudly. Nick Lowe said that "When punk rock came along, the one thing that you were not supposed to be was musical". It was anti-music.

For all its detractors, it made music accessible to people in a way it hadn't been before. It democratised music and gave it to the kids who might not have been a Hendrix or a Paige, but knew how to make a noise and create a stir. Punk was about reform, revolution and disruption.

Henry Rollins said that "Questioning anything and everything, to me, is punk rock".

So is it time for some punk physiotherapy then?

Against goal setting

21 November 2017

There's an interesting piece by Amanda Ruggeri on the BBC Capital site on 20th November discussing the reasons why goal-setting might not be as useful as people think.

The piece investigates 'why a focus on outcome alone can create a hamster-wheel mentality', and argues that goal-setting is often misunderstood and misapplied.

According to the piece, the principle failings of many efforts at goal setting include:

- Getting "so emotionally attached to a goal that we're setting ourselves up for failure and disappointment"
- Setting goals for things we should do, rather than our true ambitions
- Deciding on future priorities when you don't know your future 'you'
- Moving on to the next goal without dwelling in the present
- Focusing on the glorious future goal rather than the negative conditions of not achieving it
- And setting yourself up for failure

There's more than can be said about goal setting than this article explores though.

From a sociological perspective, goal setting is closely linked to modern industrial capitalism which, in turn, borrows closely from Enlightenment science. And philosophically, goal setting is 'teleological' - meaning that it anticipates a closing - an ending - and thereby a technology of closure not opening.

Goal setting is closely linked to Enlightenment science because it is, in part, about predictability. It relies on our ability to anticipate a future different to today, and reliably

achieve this with a set of defined actions. This is one of the reasons why there are so many goal-setting tools and techniques which are generalisable across populations.

In times of hardship, be suspicious of the tools and techniques that prosper. Goal setting is also closely linked to human productivity and is always designed to enhance performance. Goals are rarely ever set to increase people's idleness or time spent watching TV. Goals are about making us stronger, faster, lighter, more capable, more flexible, less inert, more functional. They are a small but no less necessary step in making people independent, self-reliant, more active, and less of a drain on others.

Nothing wrong with that you might say. Except that we also often complain about being time-poor; over-wrought trying to balance busy families, busy work, busy lives; lacking time for rest or the enjoyment of the finer things in life. Other people seem to be less obsessed with productivity or striving for a bigger house, faster car or better overseas holiday.

The critical thing about goals from a philosophical point of view though is that they are teleological. They are orientated towards the end, the termination, the closure of something. This might be a job well done, or a patient discharge, but it could also be the end of a relationship or a lovely meal. Focusing on the end predicts the death of things and the extinction of all of the good, juicy, complex, unknown and uncertain stuff that was there when we were in the messy business of travelling rather than the clean order of arriving.

Goals are big business in physiotherapy and healthcare in general. Perhaps this is not surprising given the amount of accounting and value-management now taking place in healthcare. Where every cent is checked and every ounce of juice squeezed out of care, technologies like goal setting prosper.

Perhaps the critical lesson then is that in times of hardship, be more suspicious of the tools and techniques that prosper.

Physiotherapy's biopsycho (but not so much) social approach to future healthcare

30 November 2017

One of the interesting aspects of the recent physiotherapy discussions on social media about the benefits of the biopsychosocial model is the almost complete lack of the 'social'.

Those who advocate for the model seem comfortable with the idea that physiotherapy might be ready to embrace its psychological dimensions - although, often, the 'psychological' is lazily referred to as a singular entity - but little is said about the social dimensions of physiotherapy.

Perhaps physiotherapists are not aware of the full scale of the social dimensions of practice? Many practitioners, for instance, still ignore the fact that the social determinants of health (poverty, education level, access to services, poor living conditions, for example), are far more important than personal responsibility or behaviour in determining the incident, prevalence and burden of illness (see readings below).

This point was made this week by Dawn Skelton, professor of ageing and health at Glasgow Caledonian University and an honorary member of the CSP, in a piece that argue that the care of the frail elderly needs as much care and attention as drug prescriptions.

If we can accept the argument that the future of physiotherapy is likely to involve us working with the more complex clients, many of whom will have multiple physical, psychological and social co-morbidities, then it follows that a lot more of our work will be with the elderly, with people in chronic pain or breathlessness, and people for whom a more holistic approach to practice is vital.

I made this argument at a keynote lecture I gave recently at the Australian Physiotherapy Conference, arguing that a central feature of any successful elderly care practice is social. A recent paper in the journal Health illustrates this point. (Note here how different the language is from 'typical' physiotherapy papers - evidence perhaps of the work we now need to do to get up to speed with sociological thinking.)

There are some excellent journals and research sources where physiotherapists can up-skill in their knowledge and understanding of sociology. Try Social Science & Medicine, Sociology of Health & Illness, Body & Society or Health, the journal mentioned above, for example.

All of these offer material that is directly relevant to future physiotherapy practice. All that's needed now is a little more sociological imagination.

Readings

Baum, F. (2016). The New Public Health. Oxford: OUP.

Keleher, H., & MacDougall, C. (2011). Understanding health: A determinants approach. Australia: Oxford University Press.

Marmot, M. (2001). Economic and social determinants of disease. Bulletin of the World Health Organization, 79(10), 988-989.

Marmot, M., Friel, S., Bell, R., Houweling, T. A., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. The Lancet, 372(9650), 1661-1669.

Evidence-based practice will not help us now

6 April 2018

A few days ago, a woman posted a message on to a local community Facebook page asking for the following advice;

> Has anyone had any experience with sciatica nerve pain and useful treatment? Hubby has been in terrible pain for weeks now. Thanks for any thoughts or recommendations.

The advice that followed all came from local people and probably represented a fair snapshot of what many people currently think about the management of back pain. I've printed the whole exchange below - it's long enough to be inclusive, but not too long - so that you can draw your own conclusions, but here are a few thoughts that occurred to me reading through it.*

All posts bar one were from women. There were 39 separate postings from 29 different women over a four-day period.

A whole range of remedies were suggested, including: physiotherapy, soaking your feet in hot water and apple cider vinegar, pilates, yoga, osteopathy, magnesium, turmeric and capsicum supplements, acupuncture, chiropractic, neuro- and orthopaedic surgery, cannabis oil, ozone therapy, walking, stretches, stabilisation exercises, going to the emergency department, 'natural' healing, EFT/tapping, sports massage, sitting on a Swiss Ball, and perhaps my favourite bit of advice from Natasha that could have come from my grandmother; Try “heat and some stretches. I found walking helped."

A few people offered advice to have the pain 'checked out' by an orthodox healthcare provider or recommended caution, most didn't though, preferring instead to offer treatment suggestions.

As far as it's possible to discern, all of the treatment suggestions were locally available.

Some people empathised and offered advice from their own experience, others were interested consumers and practitioners. Direct links to treatment techniques were frequently provided - bypassing the need for an expert to assess and administer the technique.

A few complained about poor standards of care from orthodox and complementary providers.

Many referred people to complementary therapists with a small number justifying this on the basis of the failure of the 'medical' system.

Physiotherapy was favourably mentioned by a handful.

Only one person offered a research-based justification for their advice.

Despite much hand-wringing from within the physiotherapy community in recent weeks, no-one mentioned the recent findings on the management of back pain published by The Lancet.

Here's the full transcript of the exchange:

Alison: Has anyone had any experience with sciatica nerve pain and useful treatment? Hubby has been in terrible pain for weeks now. Thanks for any thoughts or recommendations.

Andie: physio.

Trish: Second physio.

Monique: Say goodbye to sciatic nerve pain in just 10 minutes with this natural method!This treatment should be done at night, before bedtime. – Put about 10 liters of water in a bucket. – The water should be at the highest temperature that can be supported by the feet. – Then add a handful of salt and a half liter of apple cider vinegar. – Shake this mixture well. – Put your feet in the bucket and keep them there until the water cools. – When removing your feet, rinse them and wrap them in a dry towel and go straight to bed to sleep. – Keep your feet warm. Therefore, it is recommended to sleep with a towel, a sheet or a blanket wrapping them to be very hot. The next day, get out of bed with slippers and do not step on the floor without them. Until it’s time to shower, do not be barefoot. Your pain will go away after the first treatment. Repeat this procedure every six months or when you feel pain again, and believe me you will be amazed by the results!

Alison: Tried this last night but no miracle cure I'm afraid.

Wendy: Be careful with physio pain is coming from spine which should be checked out first.

Juliette: Highly recommend pilates or yoga. The stretches can immediately get relief. Osteo is my go to for treatment. Also magnesium and turmeric.

Carole: Magnesium AND... Acupuncture... did it for me... worth a try?

Alison: He's been having acupuncture for over 2 weeks but looking for other possibilities as pain isn’t decreasing.

Manasi: Hi Alison, Often it depends on the practitioner of Acupuncture and other modalities, as to how skilled they are. I can highly recommend the owner of (X named clinic) is a full fledged Chinese Medicine Doctor and skilled Acupuncturist. He goes to the root cause of the problem and works very holistically to resolve it He has helped me and I am sure many others. He is ACC registered and would cost only $20 for a session. He spends good 1 hr with you

unlike many chiropractors who do a quick 10 min fix. He will also check pulse and tongue. A truly kind, generous, skilled and experienced practitioner.

Anne: Doctors visit first to exclude herniated disc, osteoarthritis or sprained ligament, nerve damage (diabetes), tumour or blood clot. Recommend resting, firm mattress, non-steroidal anti-inflammatories, applying heat or cold, sleeping on his side, knees bent and a pillow between knees sometimes provides relief.

Raewyn: Highly recommend (named person at X named clinic). My lifesaver.

Kath: Get a surgeon referral from your GP so it can get looked into further it maybe a lumber spine disk issue. I am suffering the same pain it is hideous and completely controls you. I haven't been able to work or drive. Mine is a disk issue which was picked up on an MRI. I am on a mixture of meds which takes the edge of some days. Gabapentin is a good med for nerve pain mixed with the usual panadol and brufen. I am on the above as well as tramadol and sevradol. Good luck with it all I can sympathise with you.

Alison: Oh thats awful. We did start with our GP and he just gave painkillers. All the best to you finding relief.

Kath: Alison you need to push it to get answers don't give up. Unfortunately this is our system. I have been to hospital twice as my pain relief sometimes isn't enough. I need surgery but have to wait for the hospital system as ACC declined me. I may be able to get it done privately just doing that process now. But I can definitely tell you that you need to keep pushing for answers. Pain is not normal and not ok to live with.

Alison: Thanks so much everyone. We will definitely be trying out some other avenues as per your ideas.

Miranda: Osteopath.

Nicole: Don't judge cannabis oil. Its expensive but amazing healing abilities would be good for nerve pain .Our body has its own cannabinoids to heal but over time we need to boost them .I've heard its healed a lot of peoples conditions .maybe google it . Im not a smoker or drug user in anyway .Just sick of putting more prescription pills in the body that simply don't work ..like Lyrica which is for nerve pain with too many side effects.

Camille: Exercises for Lower Back Pain.

Kelly: Oust.

Alicia: Ozone therapy.

Margo: Although walking is not what he probably feels like doing, it is actually really helpful with both lower back pain and sciatica (I know this from both experience and reading the

research). Also, glute and IT band stretches. I would also recommend Dr Stuart McGill - a top researcher on spinal health - his recommended 3 exercises might be helpful (article attached) - Enhancing Low Back Health through stabilization exercise.

Lexy: Second osteopath and my favourite stretch for sciatica is sit on the ground with your back hard up against a wall with your legs straight out in front of you. Place you palms on top of tour thighs and flex your toes up. Then, while keeping your back straight, slowly run your hands down over your legs towards your feet toes. He should feel the stretch straight away in his sciatica. Do this whenever needed. Hold the stretch for ten seconds or so and repeat a few times.

Sally: Alison, please don't muck around with trying to find alternative treatment instead of making sure you get a fast referral to either a Neurosurgeon or an Orthopaedic surgeon. Did he have an injury that has caused this? I had a prolapsed disc over 30 years ago and doctors were not on the ball and I had over two months of pain etc and ended up with permanent nerve damage. I was eventually referred to a Neurosurgeon who had to untangle the fragments from my prolapsed disc and the main nerve down my spine in an operation. My advice is to ask your husband what pain level he is out of 10, if he is 8 or 9, my advice is to go to A&E tomorrow and do not leave until they have scanned your hubbies back. Xray is pretty useless for disc matter. You are also entitled to a second opinion if you are not getting the answers you should. Feel free to PM me if you want to. I'm serious, don't muck around.

Bianca: Go see Adrian at proactive Physio.

Pamela: I had sciatic pain over 4 years ago now but have never had it again after I went to my spinal physio. He gave me a set of stretches to do and I have to do them every day to help my spine and keep sciatica away. They have changed my life completely and 4 yrs later I'm still pain free. pm me if you think the stretches will help I can explain them to you. Otherwise tell him to see a spinal physio x.

Nicole: Natural healing has been working for millions of years. While doctors give you prescriptions that may or may not work making drug companies richer. Why not try natural products when so many others fail if it works and is better for your body. So many doctors get it wrong the doctors these days aren't like the old days wanting to investigate they are now paid by different drug companies to push certain drugs. Ask your Doctor how medicine now isn't to necessarily make us well anymore .people are misdiagnosed everyday by Doctors that don't have patients care first anymore. Health systems are failing many people around the world. So why not bring ourselves back to simple remedies that have amazing healing properties. For instance a friend uses turmeric and black pepper in a smoothie to get rid of menopausal symptoms such as headaches mood swings etc. Egg yolks red onion coconut oil is fantastic for silky soft hair. Coconut oil turmeric paprika egg whites. Vitamin is great for skin.

Our bodies for years have been pushed with pills n prescription meds antibiotics etc. So why not try something that could improve our circulation or other ailments. Vinegar for cleaning vanilla essence baking soda for smells it goes on..Many people have lost faith in the medical health system so why not.

Nicole: Capsicum is very potent for nerve pain thats why its in nerve pain cremes another example.

Ashley: Paul Lagerman interesting comments don't you think?

Dominique: Yes I had it bad a few years ago and started yoga the bikram hot yoga I got relief after just a few sessions. Poor hubby.

Dorothea: Look into EFT/tapping. It's a mix of Western psychology and using acupressure meridians/endpoints. Hope you feel better soon.

Megan: Nigel (X named clinic) $20.

Alison: Is this a professional? Business name?

Megan: Alison yes (phone number) can't remember business name he's well known 4 osteo sports massage he's relieved my brother of terrible sciatica pain and myself with aches and pains over the years other people on the Shore know of him as well.

Rachael: I have it due to a disk that’s collapsed, I roll up in a ball and bring my knees to my chest twice a day when it’s bad. Physio might help as well.

Kat: I found sitting on a swiss ball instead of an armchair helpful.

Kim: I found Pilates was helpful, I got thought proper technique and exercises from a physiotherapist and was shown what movements to do to help release pressure. But my injury might be different than your husband's. Please go see a specialist before trying anything else. I was referred to my physiotherapist once I had seen a specialist.

Paula: I'm a massage therapist - he needs to get it either massaged, looked at by an Osteopath, or go to his doctor. Stretches and strengthening can really help, he may have a subluxation in his spine or tight muscles/fascia in his hip/glute region pulling or compressing the nerve.

Natasha: Heat and some stretches. I found walking helped.

Some thoughts:

It's hard to make generalisable comments on such a small sample of people's opinions, but then I'm not trying to argue that this is either possible or desirable. Rather I think there are some broad impressions that can be drawn from these kinds of events.

If evidence-based practice (EBP) represents the frontline in the efforts by the orthodox profession's to protect and secure our social standing in the eyes of the public, then it doesn't appear to have penetrated into the lives of this group, and I don't believe that they are in any way more or less ignorant, biased or immune to reason than anyone else.

The range of interventions now available to people are bewildering to all but the most informed, and few people have the time to be that well informed. Most people pay only superficial attention.

People reach out to others when they're unwell, and 'likes' on a Facebook feed carry as much, if not more, currency than the supposed wisdom of orthodox health professionals.

People are much more open to alternatives these days. Neoliberal economic reforms have given people more disposable income and most governments have opened up healthcare markets to competition. It is hard to imagine this being reversed in the near future, so competition for the public purse is likely to increase rather than decrease in the years to come.

Research evidence might occupy our waking thoughts, but to Lexy, Margo, Sally and millions of others, it appears to carry almost no weight.

A powerful argument from advocates of EBP may be that this proves the need for a more concentrated focus on EBP because we've clearly failed to get the message across adequately in the past. And this would be a reasonable argument if one believed that EBP could come close to achieving what it promises. The reality is that EBP has done nothing to clarify the marketplace for the treatment of back pain, anxiety and depression, the common cold, chronic breathlessness, or a myriad other common health complaints, and some might argue it has made matters much worse. The reality is that few people now believe that EBP will make anything other than token impact on the lives of real people, who are increasingly at the mercy of too much information and not enough time.

If traditionally orthodox professions like physiotherapy are going to make any significant impact on the public's consciousness in the future, new ways of thinking about our function in society need to be considered, and these surely cannot be found within dogmatic support for EBP.

*In a couple of places I've corrected bad typos to aid with the reading, but otherwise this is a verbatim record. I've only included peoples first names and removed names and addresses to businesses where appropriate.

Very touching: Physiotherapy in the age of non-human companions

25 July 2018

It's sometimes reassuring to imagine that when the robots finally take over, and all of our mundane repetitive tasks are in the hands of automatons, we will still want and need the comforting touch of real people.

I've argued as much myself, suggesting that the future for the physical therapies is assured because people will always want skilled, caring, thoughtful physical touch - the kind of touch no machine will ever be able to replace (Nicholls 2017).

But what this argument misses is that it's entirely possible for robots to replace physical therapies because they *are* robots.

This point is explored in a beautiful short film by Oliver Schwartz, that explores the relationship a middle-aged, single man has with a sex doll named Jenny.

The film is about loneliness and intimacy and the possibilities for these things to be found not with other people, but with surrogates. And while these may be a substitute for 'the real thing', they are, nonetheless, a significant and meaningful substitute for some.

Haptic technology - the technology to do with the use of touch - has become hugely important in today's media-saturated world. Most of us today use communication technologies that are much more dependent on touch than used to be the case (smartphones, tablets, email, etc.). And what this is showing is that many of us coming to see touch-based communication and virtual interaction as the norm.

Some may pine for an Arcadian time when everyone lived in a village and all communication was face-to-face, but this isn't the reality for most people who now live a hyper-modern, hassled and harried, time-poor existence, in which the space to form long-term meaningful relationships with people is increasingly uncommon.

For some, like the residents of this remote Japanese village, dolls replace that which has been lost and will never return.

Of course, there is an almost unbearable sadness to this: the tacit acknowledgement that for some people the simple pleasures of human accompaniment have been lost. But evidence suggests that loneliness is a very common social determinant of poor health and that people find substitution in all manner of non-human places.

More positively, there is a growing belief that many of us are choosing the consistency, dependability and comforting familiarity of inanimate companions who, in time, will become increasingly aware of us and adapted to our needs, without the fuss or frustration that inevitably comes with the company of people.

Perhaps when we think about the future of physical therapy, we are wrong to imagine that people will always want or need human touch. Perhaps they will turn to therapy robots simply because the human equivalent is too expensive, too far away, or just too human?

Reference

Nicholls, D.A. (2017). The end of physiotherapy. London: Routledge.

Anatomy and physiotherapy

14 November 2018

Our esteemed Roger Kerry asked a great question on Twitter last week.

Is a detailed knowledge of anatomy (e.g. muscle structure/innervation; bone form; neural structure; lung structure; etc) necessary to be a good clinician?

Interestingly, peoples' responses broadly polarised into two binary positions with roughly two-thirds of respondents arguing a qualified "yes", that anatomy was essential, with a third arguing "no".

The posted comments also make for interesting reading. But it felt to me that one of the things missing from the debate was a discussion of what anatomy does for physiotherapy, beyond giving us a body of knowledge to use in practice.

Anatomy has had a powerful historical influence on the profession. It's always been one of the most important ways of aligning the profession with the medical profession, but it's also been used as a gatekeeping tool.

Having a detailed knowledge of structural anatomy has been one of the most powerful ways of deciding whether students will become physiotherapists or not. Often considered to be a core subject and given enormous amounts of attention at the outset of our training, failing the anatomy exam was often the most taxing first hurdle a student had to overcome.

Many students failed. I know many stories of students who had the human touch but couldn't turn their brains quickly enough to the rigours of anatomy in order to pass the end-of-year exam. These poor students were told in metaphorical terms that they had failed as physios.

Perhaps then anatomy feels so central to us because we survived this test? We were the achievers; the ones who successfully demonstrated the same kind of mental aptitude to learn whole chapters of Gray's Anatomy as the people who told us that anatomy was important to the profession in the first place?

That anatomy is important to the identity of the physiotherapy profession is beyond doubt. But much of this is socially constructed. It's important to us because we've made it important.

Given that we can't change anatomical structures with our mobilisations and manipulations, there's nothing inherently necessary about knowledge of anatomy. It helps to know the structure of a vein to understand a DVT, or the structure of deep hip flexors when performing a Thomas Test, sure, but is that sufficient to call anatomy a 'core' subject?

Anatomy has clearly had an important effect on positioning physiotherapy close to medicine, and it makes so much else possible. Would we place so much emphasis on objective clinical tests, for instance, if we didn't have to find a use for all that anatomy knowledge?

And is a detailed knowledge of anatomy really the best gatekeeper of whether you're going to become a good physiotherapist?

It has always seemed to me to be a poor test of a person's physio-ness. But this is hard to prove because all of the people I see in practice have already met the threshold and succeeded.

I do know though, that there are legions of physiotherapists who rely very little on their knowledge of anatomy, and the semi-deliberate act of forgetting anatomy has been liberating for them.

As always, it's not the doing, it's what the doing does.

Professional values

7 August 2019

A recent study in Physiotherapy Canada looked to try to identify core physiotherapy professional values from both primary and grey literature and the views of physiotherapists attending the 2016 CPA Congress.

The findings of the study perhaps unsurprising, with 10 values coming out most strongly:

- accountability
- advocacy
- altruism

- compassion and caring
- equity
- excellence
- integrity
- patient and client centred
- respect
- social responsibility

What is interesting about these values is not so much that they are stated at all – after all, most established health professions could and do claim similar values – but rather how they are acquired.

Physiotherapy training programmes go to inordinate amounts of care staircasing the students' learning in areas like cardiorespiratory, musculoskeletal, and neurological assessment and treatment, but spend almost no time overtly developing professional values.

The key here is the word overt. Imagine if a value like integrity was treated with as much care and attention as, say, exercise prescription or balance retraining.

Students would begin, perhaps, with a broad conceptual understanding of some of the precursors to integrity; maybe learning that integrity is not morality and that people can do bad things with integrity as well as good things, and the different meanings of the word (the integrity of a natural environment, for instance).

Students might then go on to learn some of the different variations on the idea of integrity applicable to healthcare: personal integrity, the role of integrity in illness and the loss of the sense of 'self', and integrity as difference and otherness, and go on from here to think about how physiotherapy practices help people re-acquire a sense of lost integrity (wholeness).

Fortunately, physiotherapists seem to acquire a basic appreciation for the concept on integrity through their work. After all, as Hudon, Ehrmann Feldman and Hunt showed recently, physiotherapists experience "significant challenges" in upholding core professional values like equity, competence, and autonomy.

It's odd though that we take so much care to teach our students assessment and treatment techniques, but assume professional values will be learnt by osmosis.

> "These challenges illustrate multiple facets of physical therapists' struggles to uphold moral commitments and preserve their sense of professional

integrity while providing care to injured workers within a complex health service system" - Hudon, Ehrmann Feldman & Hunt (2018)

References

Boyczuk, A.M., Deloyer, J.J., Ferrigan, K.F., Muncaster, K.M., Dal Bello-Haas, V., & Miller, P.A. (2019). Professional Values: Results of a Scoping Review and Preliminary Canadian Survey. Physiotherapy Canada 71:2, 134-143. doi:10.3138/ptc.2017-70.e

Hudon, A., Ehrmann Feldman, D., & Hunt, M. (2019). Tensions Living Out Professional Values for Physical Therapists Treating Injured Workers. Qualitative Health Research, 29(6), 876–888. doi:10.1177/1049732318803589

https://plato.stanford.edu/entries/integrity/

What's the point?

10 February 2021

Last Saturday, I saw one of the most anarchic, joyful, and truly pointless things I think I've ever seen, and it made me think a lot about how we fixate on doing meaningful things in practice.

One of my doctoral students is a child psychotherapist. A guy in his early 50s, he grew up listening to bands like Crass in the era of political, hard core punk in the UK. He's been a drummer for years, but isn't formally trained.

He has this belief that anyone can play music, or at least make a pretty unruly noise, and you shouldn't have to be trained musician to be able to express yourself through sound.

His latest project is a collaboration with two other drummers in the 30 minute performance I saw last week.

Their parameters were set down in advance:

They would have a basic structure to the piece (first five minutes quiet, playing a lot of cymbals, then louder…, and so on);

They weren't allowed to fall back on habitual or common drummers' riffs. If they found themselves getting lazy, they had to stop what they were doing and do things they wouldn't normally do;

And they had to play independently of one another. No following, or call-and-response type thing. If they found themselves attending to what another drummer was doing, they had to

break their pattern and focus only on what they were doing. Headphones turned up high are definitely recommended.

It loses a lot not being able to be there, but just imagine that unholy racket for 30 minutes! Apart from anything else, it was a hell of an aerobic workout for the drummers. Alan, my student, was wringing wet with sweat at the end.

But what actually was the point? Why bother? Why go to all that trouble to do something that produces nothing of value, and is as fleeting as the smoke from a blown-out match?

A couple of years ago, someone I knew decided to do some work with their local community.

She put up a poster in the community centre by the park, asking if people wanted to join an anarchist exercise group. Eight people turned up to the first meeting, and they were all ages, levels of fitness, shapes and sizes.

My friend, Moana, decided they made a pretty good looking marching band. So they made up some moves, practiced them, and then scheduled a friend to put a drum kit on the back of a truck for their performance.

They made massive majorette hats – some of them three feet tall – and gathered one Thursday evening for their performance.

They lined up, the drums started up with a random marching beat, and off they went down the street and around the park. There was no-one there, except a kid leaning on his BMX bike, looking at them as if they'd just fallen from the sky.

They completed their loop around the park. All of their practiced moves had gone by the wayside after the first 200 yards, but that didn't stop them. And over the course of the next 15 minutes or so, a whole host of new marching band moves were 'discovered'.

They got back to the hall, took off their hats, helped Daryl pack his drums into his car, and went home.

So again, why bother?

It seems so obvious to us that our work should be purposeful; that there should be no fat in the system; that we should meet our targets, achieve our outcomes, and do only those things that are evidence-based and scientifically justifiable.

It would be completely ridiculous to suggest that we should spend an hour with our students snowball fighting, or use the patient's 30 minute appointment to learn how to juggle. We would probably be struck off if we spent an hour with a group of chronic pain patients singing sea shanties. And we'd almost certainly be accused of being unprofessional if we took the patient's money and taught them how to dance the tarantella.

Now I know all the reasons why those things are true, but I do wonder why they have to be.

One thing that holds a lot of anarchic arts-based work apart from practices like physiotherapy is that it is Political (with a capital P). It deliberately holds a mirror up to the way we live, and says, “No!”. Playing 30 minutes of free-form drumming is a way of reminding us how formulaic, safe, and sterile a lot of the rest of the music world can be. Practicing for eight weeks to march around a park for no other reason than it makes you smile is a response to the idea that everything has to be marketable, purposeful, efficient, and important.

Physiotherapy has long been on the right hand side of this equation. We like our practice to be purposeful, scientifically predictable, and repeatable. But physiotherapy like this runs a serious risk of becoming an empty commodity; a sales pitch for acceptable, white middle class values; a simulation of real life; a bland diet of spiceless mediocrity.

Footnote: In the next few weeks, a good friend of mine will be spending an hour with their physiotherapy students snowball fighting. Wherever you are in the world, and whatever COVID is doing to you, I hope one of their snowballs lands in your lap, and makes you get up and dance.

Doing too much

17 February 2021

A recent short paper in the journal Sociology of Health & Illness has offered some important insights into over-diagnosis and over-treatment (Armstrong, 2021).

For some years now, health service managers have argued that there is ‘too much medicine’ in healthcare, and have used the language of cost containment and ‘Choosing wisely’ to increase professional accountability. But health professionals have themselves been concerned with too much reliance on expert advice, and have criticised other competing professions for encouraging patients’ dependence on the therapist for the cure (Traeger et al., 2017; Baldwin et al., 2015; Copnell, 2018).

What’s really interesting about the paper by Natalie Armstrong, though, is that it shifts the focus away from the actions of the professionals themselves, and looks instead at the social conditions that encourage professionals to overdiagnose and overtreat.

Armstrong’s focus is on Susie Scott’s recent work on the ‘sociology of nothing’ (Scott, 2018), in which Scott argues that there is a real difference between purposefully doing nothing for someone – in order to help them work out a better way to move, or deal with their symptoms, perhaps – and doing nothing as an act of fear or negligence.

For Scott, doing nothing can be a very deliberate act.

Physical therapy has always carried an association with purposeful action, and so to contemplate therapy as an act of 'passivity' seems counterintuitive. But this was exactly the theme Filip Maric picked up and explored in his 2017 doctoral thesis (Maric, 2017), and was something we wrote about together, in thinking through ways that deliberate acts of passivity might change the way we thought about future physiotherapy (Maric & Nicholls, 2020).

Reading Armstrong's paper, though, reminded me how often 'good' physiotherapy relies on doing nothing.

One of the things that was drummed into me in my early career working in a neonatal ICU, was that a good physiotherapist will often spend 90% of their time thinking about all of the things they shouldn't do. "Act in haste, repent at leisure" seemed to be our watchwords. The babies we saw were often so metabolically unstable that just turning them over to improve the air and blood flow to their lungs was potentially life-threatening. More often than not, the only 'active' thing we did during a half-hour session was to adjust the wedge under their side.

We were often left wondering whether the little we did justified our long, expensive training, the prestige we were given, and the pay we earned for our work.

Because of COVID, a lot of physiotherapists around the world are now making decisions like that.

In a recent feature in Vogue Magazine, Jessie Robinson, a 24-year-old physio working in an ICU in London's Charing Cross Hospital, said that;

> "My team is responsible for turning the most severely ill patients from lying on their back to their front or vice versa, which can take up to an hour. The unfortunate reality is that the patients are so unstable, it can result in cardiac or respiratory arrest" (de Rosée, 2021).

I wonder how many of us are now really honing our skills of doing nothing?

But there is also a second, deeper, theme running through Armstrong's article on overtreatment and overdiagnosis that I think is worth thinking about. It's about the extent to which we feel we are the agents of our professional destiny.

All health professions talk about their quest for autonomy, as if it is something that the profession itself fights for and 'wins'.

The classic narrative goes that a new profession first establishes its identity, either by filling a gap in the market, or carving out a niche for itself. It then attracts sponsors; other more established and powerful professions, that can give it a 'leg up': shaping the curriculum,

helping with teaching, providing patient referrals, supporting legislation, sitting on governing bodies, and so on. If the profession is lucky enough to survive and prosper, it then tries to distance itself from its sponsors, by demanding the right to govern itself and decide its own professional scope and curriculum. And all the way through this narrative, we are given the impression of a profession as a coherent entity, initiating change and driving progress.

Armstrong's paper fits neatly into the vast body of literature that has been written over the last half century showing that this story of profession's quest for autonomy is a myth (Freidson, 1984; Johnson, 1972; Abbott, 1988; Foucault, 1973; Evetts & Dingwall, 2002; Larson, 1977).

What we now know is that the health professions are much more the result of social change than the initiators. Rather than the health professions claiming autonomy, the idea of discrete, self-governing profession is really only part of an origin story developed between medicine and some of the other elite professions in the early 20th century, and early 'functionalist' sociologists, that the professions allied to medicine picked up on and developed.

What this literature shows us is that physiotherapy and autonomy are both the result, or the effect of much broader efforts to shape the way people can be healthy, wealthy and wise in modern society.

Over the last two years I've been beavering away on a follow-up to *The End of Physiotherapy* which, I hope, will explain a lot of these issues in much more depth, and argue that the way we have been taught to think about the profession of physiotherapy may have been wrong all along.

The challenge will be whether we actively try to turn physiotherapy around, or step back and let our colleagues work out their own 'line of flight'.

References

Abbott, A. (1988).The System of Professions: An Essay on the Division of Expert Labor. University of Chicago Press.

Armstrong, N. (2021). Overdiagnosis and overtreatment: a sociological perspective on tackling a contemporary healthcare issue. Sociol Health Illn, 43(1), 58-64.

Baldwin, J. N., McKay, M. J., Hiller, C. E., Nightingale, E. J., Moloney, N., Vanicek, N., Ferreira, P., Simic, M., Refshauge, K., Burns, J., & 1000, N. P. C. (2015). Defining health and disease: setting the boundaries for physiotherapy. Are we undertreating or overtreating? How can we tell. Br J Sports Med, 49(19), 1225-1226.

Copnell, G. (2018). Should UK based Physiotherapists Choose Wisely. Physiotherapy, 104(4), 395-399.

de Rosée, S. (2021). “We Have No Option But To Carry On, But At What Cost?”: One Physiotherapist Reports From The Covid-19 ICU. Retrieved 2021-02-16.

Evetts, J., & Dingwall, R. (2002). Professional Occupations in the UK and Europe: Legitimation and Governmentality. International Review of Sociology, 12(2), 159-171.

Foucault, M. (1973).The Birth of the Clinic: An Archaeology of Medical Perception. Tavistock Publications.

Freidson, E. (1984). The Changing Nature of Professional Control. Annual Review of Sociology, 10, 1-20.

Johnson, T. (1972). Professions and power. Macmillan.

Larson, M. S. (1977).The Rise of Professionalism: A Sociological Analysis. University of California Press.

Maric, F. (2017). Physiotherapy and fundamental ethics: Questioning self and other in theory and practice, PhD . Auckland University of Technology.

Maric, F., & Nicholls, D. A. (2020). The fundamental violence of physiotherapy: Emmanuel Levinas’s critique of ontology and its implications for physiotherapy theory and practice. OpenPhysio.

Scott, S. (2018). A sociology of nothing: Understanding the unmarked. Sociology, 52(1), 3-19.

Traeger, A. C., Moynihan, R. N., & Maher, C. G. (2017). Wise choices: making physiotherapy care more valuable. J Physiother, 63(2), 63-65.

Measuring physiotherapy

24 February 2021

Why is it that physiotherapists measure things?

Over the last few weeks I’ve talked with some physio colleagues about their work, and been struck by the way they are asking some pretty fundamental questions about physiotherapy.

One conversation revolved around the trend towards active treatment and patient self-management. “Why is it”, this colleague asked, “that some physios are giving up on so-called passive treatments? If we were artists, we wouldn’t give up on painting just because the latest trend was for video installations.”

Is it because physiotherapists have come to believe their job is to ‘fix’ things in a way that artists never do?

There seems to be a lot of hubris and ego tied up in the presumption of fixing things.

And maybe we would serve some people better by setting our sights at responding to their present situation, rather than thinking that our work begins and ends with cure?

After all, fixing things only really works when problems can be fixed. So where does that leave people with longstanding, incurable health problems, that just need someone they trust to work with them, not on them?

Another conversation was about person-centred care.

This colleague is near to completing an amazing PhD that has shown that most of the physios in their study hardly ever use the language and ideas embodied in person-centred care.

The physios in their study were very much about motivation, and patient self-management, and all the language we’re now hearing about things like Cognitive Behavioural Therapy (CBT) and Acceptance and Commitment Therapy (ACT).

And it was interesting to hear how easily these approaches had been adapted to fit the physio’s ways of thinking and working.

This is perhaps not surprising given that CBT and ACT live at the objective, scientific end of the psychology spectrum, with relational, narrative, or broadly ‘humanistic’ psychology approaches at the other.

One of the things that separates these two poles is the way they engage with the patient’s core beliefs.

Relational humanistic approaches stress the need to reduce the distance between the therapist and patient.

This is done by the therapist building close, interpersonal relationships with the client, and finding ways to reduce their own power and build up their patient’s sense of control.

The objective scientific approach is very different. Here the control lies squarely with the therapist. The goal is to capture the patient’s beliefs in a form that can be measured, compared, shared, and evaluated.

And so lots of tools, models, standardised interventions, assessment grids, symptom checklists, belief algorithms, activity profiles, alternative action formulations, behaviour diaries, anger self-monitoring records, and so on, are used to instrumentalise the approach.

Why are we putting these tools between us and the patient? Are the benefits of an objective measure worth the loss of proximity to what people really feel? Are we so uncomfortable with people's subjectivity that we need these tools as a proxy for scientific respectability and authority?

The third conversation was about our need for practical solutions.

I've been writing theoretical pieces about physiotherapy for years now, often holding to Kurt Lewin's adage that 'There's nothing more practical than a good theory' (Lewin, 1952).

In all that time, I haven't had a paper accepted in which one of the reviewers hasn't asked me to expand on the practical implications of my ideas.

The colleague I was talking to – also a writer on physiotherapy – called it the 'tyranny of clinical implications'.

It's not that there's anything wrong with the practical usefulness of ideas or clinical implications, per se, only that it feels sometimes that we give ideas no room to breathe before we want to ensnare them and put them to work.

The American writer and art critic Rebecca Solnit once joked that museums love artists the way that taxidermists love deer (Solnit, 2014), 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).

I sometimes think Solnit could have been talking about physiotherapists.

References

Lewin, K. (1952). Field theory in social science: Selected theoretical papers by Kurt Lewin. London: Tavistock.

Solnit, R. (2014). Woolf's Darkness: Embracing the Inexplicable. The New Yorker. https://www.newyorker.com/books/page-turner/woolfs-darkness-embracing-the-inexplicable.

The reality of pain

10 March 2021

> 'Whereas pain had previously been seen as an essential element of the human condition, from the middle of the eighteenth century humanitarians worked to alleviate pain and suffering where possible–especially when that

> bodily experience was produced or inflicted by various “social evils” (ranging form alcohol to the excesses of the industrial system) or unjust laws’ (Ballantyne, 2014, p.218)

One of the reasons why pain has been so important in defining physiotherapy over the last century is that it is both universal and particular. Pain is experienced by everyone at one time or another, but it is also a phenomenon of infinite variation and granular complexity.

Some aspects of pain can be understood biologically, some as subjective experiences that defy anatomical, physiological and pathological description. Over the years physiotherapists have become adept at understanding the first, and are now starting to embrace the second.

But there is a third dimension to pain that is almost completely ignored, and that is pain as a social construct.

When we talk about the biology or experience of pain, we are saying that the way pain manifests has its roots in our corporeality or cognition. That the body or mind precede the pain experience, and by better understanding the client/patient’s signs and symptoms, we can come closer to understanding its causal mechanisms.

Social constructionism, on the other hand, says that all of these things actually follow on from the way we collectively shape what pain means for us. In other words, the body and mind have no reality that is not already part of a social construct.

Consider Tony Ballantyne’s quote above as an example of this argument.

Ballantyne argues that we can see our modern attitude to pain in the way Western countries turned towards more humane treatment of social ‘deviance’ after the 17th century.

This ‘turn’ gave birth to asylums, hospitals, population surveys, diagnostic testing, rehabilitation, public health, as well as modern policing, town planning, urban sanitation, and a host of other social structures that we take for granted today.

And these institutions were populated by a new class of professional specialists whose job it was to identify social deviance and restore people to the new idea of ‘normal’. (Remember, before the 17th century, ordinary people had no formal status in society, so no idea of ‘normal’ health or wellbeing existed. The idea of the ‘citizen’ was an invention of this period designed to tie people’s newfound rights to their social responsibilities).

One of the most challenging social ‘evils’ of the developing industrial economies of the West was pain, because often it was impossible to connect the experience with an underlying pathology.

The birth of psychology, counselling and psychotherapy can be attributed in part to the need to manage people's existential pain. But physiotherapy is very much tied to society's desire to rehabilitate physical pain.

The existence of psychotherapy and physiotherapy prove how deeply social pain is. We know pain is never only subjective or objective, mind or body, but this is the way the professions have learnt to separate it so as to promote their separate professional identities. So the way we think about pain today is very much a function of the way a few elite professions have attempted to codify pain in order to resolve the problem for society.

So physiotherapists look for pain within the body (and, increasingly, in the neurophysiology of cognition – which is still within the body really), while psychotherapists explore its meaning in the unconscious.

It's important to think just how deeply this idea of pain as a social construct can be, not least because it is a hugely untapped concept in physiotherapy. Take Malcolm Bull's piece below on the link between poverty, pain, and the recent American election.

> "As Davies sees it, the invisible glue that holds these pacts together is physical pain. A third or more of adults in the US and UK report that they are 'often' in pain. Most elderly people experience regular pain anyway, but so do the poor, since inequality makes people a lot sicker than they might otherwise be. People in pain don't have good long or even medium-term judgment: they just want the pain to stop (hence the opioid epidemic). And if it doesn't go away, they at least want to be able to make sense of it. An injury hurts less when sustained in a battle or a sports game than in a domestic accident, so identifying a common enemy may be as effective an analgesic as anything else. For Davies, the rise of contemporary nationalism is therefore 'tightly bound up with problems such as physical pain, ageing, chronic illness and a sense of deep pointlessness'. Because the body in pain can be neither fully rational nor at peace, it simultaneously undermines the Cartesian divide between mind and body and the Hobbesian opposition between war and peace, and so threatens the very idea of a rationally chosen, scientifically governed society. Nervous voters make for nervous states" (Bull 2019).

Whilst it is easy enough to recognise that something like a profession is a socially constructed, abstract concept, it is harder to think of some health problems in the same way. Pain should be easy though, because it the archetypal social construct.

The way we think about it, talk about it, measure it, describe it, and treat it, defines it. These ways give the biology and experience of pain its shape.

Pain eludes simple biological description and attempts to capture its subjectivity, because it is a social construct par excellence.

And the same may be true for all of the biological and experiential 'truths' that we think are the basis of physiotherapy.

References

Ballantyne, T. (2014). Entanglements of Empire: Missionaries, Māori, and the question of the body. Auckland, NZ: Auckland University Press. p. 218

Bull, M. Can the poor think? London Review of Books, 41(13), 4 July 2019. Source: https://www.lrb.co.uk/v41/n13/malcolm-bull/can-the-poor-think

The evidence for EBP is not self-evident

15 June 2021

There is an interesting paradox to evidence-based practice.

A person who believes in objective facts is likely to believe that there is a 'best way' to assess and treat people and that rigorous science is the way to locate it. A lot of our clinical trials, best practice guidelines, and quant research starts out with this premise. (We'll call this Option 1).

But a person who believes that everyone is unique is also likely to believe that what works depends on the person's perspective, and that what constitutes evidence will be shaped by their unique life experiences and history. Qualitative research and person-centered care start here. (Option 2).

And then there are people who believe that meaning is a collective, social thing and that the truth is constructed through conversation and negotiation between people. How we think about things like the physiotherapy profession, or common experiences like pain are like this. (Option 3).

But here's the twist. Those who believe that we can prove that physiotherapy works through science, are only expressing one type of understanding, and theirs isn't the correct one simply because it manipulates variables, randomised control groups, and statistics.

In fact, it could be argued that when someone makes a case for the scientific basis of physiotherapy they're advocating for it on the basis of their experience and history, or trying to shape the way the profession thinks. So using Options 2 and 3 to make a case that Option 1 is the only logical choice.

So you can use the way people speak about evidence as a good way to ‘diagnose’ their particular world view. Someone who thinks that only RCTs will tell the truth about physiotherapy, will lack an appreciation for the power of people’s lived experience, and people’s shared realities. Similarly, someone who thinks that individual experience is the only true marker of whether something works or not, will be missing out on the value of rigorous clinical trials and social constructionism.

It always pays to be skeptical of narrow perspectives for things like ‘evidence’ because, as Jacques Derrida once said, “if things were that simple, word would have gotten around”.

The importance of breaking the rules

19 January 2022

Why breaking the profession's rules is something we should all be thinking about

One of the questions that Physiotherapy Otherwise grapples with is how much physiotherapists now need to break the profession’s rules if it’s to prosper in the future. There are some different dimensions to this question that get explored in the book.

One is the necessity to have rules in the first place. Rules provide the boundary around a profession and help to shape its identity. But they are only part of what defines a profession, and they shouldn’t be seen as natural or obvious.

The German philosopher Freidrich Nietzsche was fascinated by social rules, but he argued that they were neither natural nor obvious and more often than not they stopped us from doing the right thing by tying us to a belief system that was more about maintaining a social hierarchy.

Nietzsche believed that we all too easily adopted a ‘slave morality’ - an easy, unquestioning acceptance of goodness; beliefs based on social rules handed down through the generations, giving them the illusion that they were natural and immutable.

Nietzsche’s argument has been applied to all sorts of fields over the last century. The philosopher Martin Buber suggested that ‘Traditional Judaism held that living according to law was a source and an expression of spiritual fervor’, but that was a reason to reject the dogmatic obedience these laws prescribed rather than embracing them.

> "Once religious rites and dogmas have become so rigid that religiosity cannot move them or no longer wants to comply with them", he said, "religion becomes uncreative and therefore untrue,"

Buber believed that when our beliefs about what is right become entrenched they define particular truths that separate one group from another. It is only a short step then to create a binary in which those within the group are 'good' and everything outside is bad.

Interestingly, Buber's answer was not to abandon their Judaism but to reinvent it.

In talks I've given over the last couple of years I've included a picture of a young girl scaling the Berlin Wall. Most people who know anything about the history of The Wall might applaud her act of rebellion. But whether she is a freedom fighter or a dangerous renegade depends entirely on which side of the wall you're standing on. But the problem isn't with your position, it's with the existence of the wall in the first place. And all such walls are human constructs.

Physiotherapy Otherwise is, in many ways, an argument for a) questioning the socially-constructed rules that have long shaped the physiotherapy profession, and then b) subverting them.

It's unusual for people within a prestigious profession to do this because it strikes at everything a slave morality seeks to uphold. But, right now, I can't think of a more important task, if we truly believe that the physical therapies matter.

Two last things.

2022 marks the end of Scott Hasson's tenure as Editor of the journal Physiotherapy Theory & Practice. I'd like to take this opportunity to thanks Scott for the amazing work he's done promoting the theoretical development of the profession. 15 years ago it was almost impossible to publish theory pieces in the physiotherapy literature, and there's still a skepticism of anything that's not a clinical trial in the minds of many journal editors. But Scott's advocacy of thinking about physiotherapy has been crucial in opening up the profession to new ideas over the last quarter-century and he will be sorely missed. His sign-off editorial is here.

And finally something very light hearted. If you fancy using AI technology to make a quick piece of physiotherapy art, you should try this online tool. It generates an image based on a particular style and a series of word prompts. You choose the words and the style and the programme makes the art. Here's my baroque rendering based on the words massage, touch, and therapy. Perhaps I'll stick to teaching.

Finding the heart of a profession

3 March 2022

Finding new voices on Reddit.

Not so long ago, if you wanted to know what physiotherapy around the world was really about, your options were limited to books and journals.

Journals used to be more like community newsletters, with announcements of local courses, practical tips and tricks, and even births, deaths, and marriages. But these went out as journals put their emphasis on scientific evidence and research outcomes.

Editorials still carried some subjective opinions on the social and cultural aspects of the profession, but even these have been marginalised in recent years.

So, if you wanted to know where the beating heart of the profession is right now, where would you look?

There's no shortage of full-blooded opinion swilling around on Facebook and Twitter, and not all of it constructive, but over the last few years, I've found a really rich source of material on Reddit.

Reddit touts itself as the news for the Internet. It doesn't have all the bells and whistles of other forms of social media, but its section on physiotherapy (sub-sections on Reddit are called "Sub-Reddits") is always interesting.

People post questions onto the physio sub-Reddit for the community to answer. And these come mainly in two forms: questions about professional practice; and requests from clients for treatment advice.

The latter is interesting, not least because it's clear the questioner doesn't trust the advice they'd been given by their professional. But it's the former that, I think, give us some great insights into physiotherapy today.

Here's are some examples of recent posts:

> In what ways is working different to studying? How much of the content do you actually use on a day to day basis? New physio student here and feeling

> incredibly overwhelmed by the amount of work presented to me and really second guessing my decision.
>
> Is studying for medical school specializing in Orthopedic harder than Physiotherapy? - the comment thread for this one is particularly interesting.
>
> How do I specialise? Uk undergrad physiotherapy student, thinking very far ahead but wondering what extra qualifications or education I would need to become a specialist. For example osteoarthritis or hands in general.
>
> Any advice for trying to build and maintain a patient caseload?

Unlike a lot of other social media platforms, the advice offered is generally very thoughtful, empathic, and constructive. There is a real sense of a question genuinely asked, and advice generously given.

There's a Ph.D. thesis in analysing what this might tell us about the current state of physiotherapy, but there are some things that I think stand out:

We're in a different age of expertise now, where the specialised knowledge is becoming more diffuse, and therefore, presumably, less specialised;

That this is welcomed by the posters, who are looking for people's contributions, thoughts, and suggestions, not black and white answers;

That diversity of opinions definitely exists about what makes for good physiotherapy, and that its innate complexities are valued.

Reddit, like all forms of social media, has its faults and its detractors, but I've found it a consistently powerful source of thoughts and ideas about physiotherapy over the years. If you haven't come across it yet, you might find it interesting.

They say crisis, we say revolution

10 October 2022

Some inspiring words from Italian feminists.

I'm in Italy for two weeks, close to the seat of Italian leftism, and thanks to the country's recent swing to the right, this part of the world has a really militant feel about it right now. Doing some culture-scrubbing I came across this from Beatriz Preciado for atelierbetty. There's language in here that I really love. I wonder how this would sound if we were to frame a new physiotherapy around something like this. Italian first, then a DeepL translation to English follows.

Pissing figures, 2020. Installation view at Panorama, Proceed. By Giulia Cenci, at giuliacenci.blogspot.com

Noi diciamo RIVOLUZIONE

di BEATRIZ PRECIADO

Pare che i vecchi guru dell'Europa coloniale si stiano ostinando a voler spiegare agli attivisti dei movimenti Occupy, Indignados, handi-trans-froci-lesbiche-intersex e post-porn che non potremo fare la rivoluzione perché non abbiamo nessuna ideologia. Dicono «un'ideologia» esattamente come mia madre diceva «un marito». Bene: non abbiamo bisogno né di ideologie né di mariti. Noi, nuove femministe, non abbiamo bisogno di mariti perché non siamo donne. Così come non abbiamo bisogno d'ideologie perché non siamo un popolo. Né comunismo né liberalismo. Né ritornello catto-musulmano-ebraico. Parliamo un altro linguaggio. Loro dicono rappresentazione. Noi diciamo sperimentazione. Loro dicono identità. Noi diciamo moltitudine. Loro dicono controllare la banlieue. Noi diciamo meticciare la città. Loro dicono il debito. Noi diciamo cooperazione sessuale e interdipendenza somatica. Loro dicono capitale umano. Noi diciamo alleanza multi-specie. Loro dicono carne di cavallo. Noi diciamo saliamo in groppa ai cavalli per sfuggire insieme al macello globale. Loro dicono potere. Noi diciamo potenza. Loro dicono integrazione. Noi diciamo codice aperto. Loro dicono uomo-donna, Bianco-Nero, umano-animale, omossessuale-eterosessuale, Israele-Palestina. Noi diciamo ma lo sai che il tuo apparato di produzione della verità non funziona più. Quanti Galileo saranno necessari, questa volta, per farci reimparare a nominare le cose e noi stessi? Loro ci fanno la guerra economica a colpi di machete digitale neoliberale. Ma noi non piangeremo per la fine dello Stato-sociale – perché lo Stato-sociale era anche l'ospedale psichiatrico, il centro d'inserimento per handicappati, il carcere, la scuola patriarcale-coloniale-eterocentrata. È tempo di mettere Foucault alla dieta handi-queer e di scrivere la Morte della clinica. È tempo di invitare Marx a un atelier eco-sessuale. Non possiamo giocare lo Stato disciplinare contro il mercato neoliberale. Entrambi hanno già siglato un accordo: nella nuova Europa, il mercato è l'unica ragione di governo, lo Stato diventa un braccio punitivo la cui unica funzione è ormai di ricreare la finzione dell'identità nazionale sulla base della paura securitaria. Noi non vogliamo definirci né come lavoratori cognitivi né come consumatori farmaco-pornografici. Noi non siamo né Facebook, né Shell, né Nestlé, né Pfizer-Wyeth. Noi non vogliamo produrre francese, ma neanche europeo. Noi non vogliamo produrre. Noi siamo la rete viva decentralizzata. Noi rifiutiamo una cittadinanza definita dalla nostra forza di produzione, o dalla nostra forza di riproduzione. Noi vogliamo una cittadinanza totale definita dalla condivisione delle tecniche, dei fluidi, delle semenze, dell'acqua, dei saperi… Loro dicono la nuova guerra pulita verrà fatta con i droni. Noi vogliamo fare l'amore

con i droni. La nostra insurrezione è la pace, l'affetto totale. Loro dicono crisi. Noi diciamo rivoluzione.

(Traduzione Judith Revel)

Libération, 20 mars 2013

We say REVOLUTION

By BEATRIZ PRECIADO

It seems that the old gurus of colonial Europe are stubbornly trying to explain to the activists of the Occupy, Indignados, handi-trans-froci-lesbians-intersex and post-porn movements that we cannot make a revolution because we have no ideology. They say 'an ideology' exactly as my mother used to say 'a husband'. Well: we need neither ideologies nor husbands. We, the new feminists, do not need husbands because we are not women. Just as we do not need ideologies because we are not a people. Neither communism nor liberalism. Neither Catholic-Muslim-Jewish refrain. We speak another language. They say representation. We say experimentation. They say identity. We say multitude. They say control the banlieue. We say meticulate the city. They say debt. We say sexual cooperation and somatic interdependence. They say human capital. We say multi-species alliance. They say horse meat. We say let's ride the horses to escape the global slaughter together. They say power. We say power. They say integration. We say open code. They say man-woman, black-white, human-animal, homosexual-heterosexual, Israel-Palestine. We say but you know your truth-producing apparatus no longer works. How many Galileans will it take this time to make us relearn how to name things and ourselves? They wage economic war on us with the neoliberal digital machete. But we will not mourn for the end of the social-state - because the social-state was also the psychiatric hospital, the insertion centre for the handicapped, the prison, the patriarchal-colonial-hetero-centred school. It is time to put Foucault on the handi-queer diet and write the Death of the Clinic. It is time to invite Marx to an eco-sexual atelier. We cannot play the disciplinary state against the neoliberal market. Both have already sealed a deal: in the new Europe, the market is the only reason for government, the state becomes a punitive arm whose only function is now to recreate the fiction of national identity on the basis of securitarian fear. We want to define ourselves neither as cognitive workers nor as drug-pornographic consumers. We are neither Facebook, nor Shell, nor Nestlé, nor Pfizer-Wyeth. We do not want to produce French, nor European. We do not want to produce. We are the decentralised living network. We reject a citizenship defined by our force of production, or our force of reproduction. We want a total citizenship defined by the sharing of techniques, fluids, seeds, water, knowledge... They say the new clean war will be waged with drones. We

want to make love with drones. Our insurrection is peace, total affection. They say crisis. We say revolution.

(Translation Judith Revel)

Libération, 20 mars 2013

Post-professionalism - an aside

1 August 2023

I'm quoting this from a recent 'Stack-post by Adam Mastoianni that I really liked. It wasn't intended to be this, but it's a nice way to describe a sentiment that's driving post-professionalism.

Professional science does a lot of good stuff. It gives people paychecks, health insurance, research funding, offices, and colleagues. It allows large groups to work together on big projects like launching telescopes into space. And it gives young, curious people a place to start: if you want to ask and answer questions about the universe, academia is an obvious career path.

But that good stuff comes at a price. Professions are bundles of weak-link interventions; they keep out quacks, but they also keep out revolutionaries. They enforce standards, which tends to make things…standard. They select for a pretty homogenous group of people—in this case, folks who got good grades in college, did research in the right institutions with the right people and published in the right journals. Then they make all those people even more similar to one another, steeping them in the same culture and putting them in competition for the same rewards, like grants, jobs, and citations.

Right now, professional science is like a world where every organism is trying to be a mammal. Mammals are great: milk-producing glands, body hair, ears that have three bones in them, what's not to like? But if you've only got mammals, you're in big trouble. Monocultures are fragile and prone to collapse because every single organism has identical weaknesses. What you need is an ecosystem—hawks, sea urchins, fungi, various types of fern, and so on.

ContraPoints on Twilight

10 March 2024

I'm not sure if you're all already familiar with Natalie Wynn's YouTube channel ContraPoints, but if you haven't seen it I can heartily recommend her latest video essay on the gendered and Christian politics of the Twilight series that came out last week.

Wynn's work is always astonishingly detailed, erudite, generous and funny, and her reading of contemporary critical theory is as on-point as anything you will find. (Don't believe me, watch the videos she did on Jordan Peterson, JK Rowling and Incels.)

The videos are comprehensive, meticulously produced and scripted (this one running to nearly 3 hours) and her insights are often profound.

Highly recommended.

Chapter 4: Everyday Physiotherapy work

This chapter focuses on the everydayness of physiotherapy practice: taken-for-granted clinical objects like the clinic door; touch and hands-on care; the outlook for the profession, and its history and culture; professional practice and everyday work problems. There are pieces on thinking like a physio and writing sociology in a professional culture that has no history of sociology. Although all of these blogs focus on everyday practice, you can still see the desire to underpin practice with strong theory and find some greater significance in the mundane and familiar, as well as the Foucauldian principal that the discourses with the most power are often those that seem most obvious and taken-for-granted.

’Isn't it all Whites?' Ethnic diversity & the physiotherapy profession

14 September 2013

Abstract: Aim: To explore physiotherapists’ perceptions, views and experiences of ethnic diversity in relation to the physiotherapy profession. Design: Qualitative research study, drawing on ethnographic traditions and including ethnographic interviews. The interviews were transcribed verbatim and the data were analysed using thematic analysis. Several verification procedures were incorporated into the design to ensure quality. Setting: Venues chosen by the participants in North West England. Participants: A purposive sample of 22 physiotherapists (five students, seven clinicians and 10 academics) with a range of ethnicities. Findings: Most participants’ experiences and perceptions were of a lack of ethnic diversity within the profession. Further findings related to the impact of this included: the perception that physiotherapy is a White profession; some Black and Minority Ethnic (BME) physiotherapists felt ‘out of place’ on occasions; and failure to meet patients’ needs. The potential benefits of increased ethnic diversity and the possible risks of valuing BME staff solely in terms of their ethnicity were also illuminated by the findings. Conclusions: This study of the perceptions and experiences of physiotherapists identified a lack of ethnic diversity within the profession. It is argued that a lack of ethnic

diversity may result in a failure to meet patients' needs. A workforce that is reflective of the population it serves can have greater cultural knowledge, and is more likely to understand and respond to patients' needs. Keywords: Ethnic diversity; Black and Minority Ethnic groups; Physiotherapy; Qualitative

Reference

Yeowell, G. (2013). 'Isn't it all Whites?' Ethnic diversity and the physiotherapy profession. Physiotherapy. doi:10.1016/j.physio.2013.01.004

The Role of Emotions in Clinical Reasoning and Decision Making

14 September 2013

Abstract: What role, if any, should emotions play in clinical reasoning and decision making? Traditionally, emotions have been excluded from clinical reasoning and decision making, but with recent advances in cognitive neuropsychology they are now considered an important component of them. Today, cognition is thought to be a set of complex processes relying on multiple types of intelligences. The role of mathematical logic (hypothetico-deductive thinking) or verbal linguistic intelligence in cognition, for example, is well documented and accepted; however, the role of emotional intelligence has received less attention—especially because its nature and function are not well understood. In this paper, I argue for the inclusion of emotions in clinical reasoning and decision making. To that end, developments in contemporary cognitive neuropsychology are initially examined and analyzed, followed by a review of the medical literature discussing the role of emotions in clinical practice. Next, a published clinical case is reconstructed and used to illustrate the recognition and regulation of emotions played during a series of clinical consultations, which resulted in a positive medical outcome. The paper's main thesis is that emotions, particularly in terms of emotional intelligence as a practical form of intelligence, afford clinical practitioners a robust cognitive resource for providing quality medical care.

Reference

Marcum, J.A. (2013). The Role of Emotions in Clinical Reasoning and Decision Making. J Med Philos (2013) 38 (5): 501-519. doi: 10.1093/jmp/jht040

Eulogy to the NHS

7 June 2014

I was really moved by this piece by Harry Smith in The Guardian on Wednesday.

It described perfectly the sadness I'm sure a lot of British people feel with the slow decline of the NHS and the cynical way governments - of the left and the right - have used the rhetoric of neoliberalism to dismantle this once proud institution.

I can remember the stories my parents told me about the hardships they had suffered and the huge impact social welfare had in their lives.

My grandfather was a coal miner in the English midlands and his family were so poor that my great grandmother would rattle plates around on Sundays so that the neighbours thought they were eating Sunday dinner. Like Harry Smith's parents - who were denied the dignity of caring for their dying daughter - my grandfather knew the shame of impotence in the face of suffering. My great grandmother's death certificate registers her as dying of starvation. I can't imagine how this must have affected him throughout his life as a father trying to bring up three children after the war.

The move towards social welfare certainly didn't fix all the ills that poverty brings, and it didn't remove the suffering from their lives entirely, but it did at least provide them with a council house, free education for their children, and a pension in their old age, and for that I will always be grateful.

I trained in the NHS as a physiotherapist in the 1980s and have always worked in public health care and education. I've witnessed the way that successive governments have put tax cuts ahead of public services. And now we hear that social welfare budgets are going to be slashed further and that we will have to take much more personal responsibility for our own health.

But this cynical rhetoric only plays into the hands of those who can afford to make choices about the health care they prefer. What about the mass of people whose choices are to buy food or buy a prescription; who cannot afford privatised health care so wait until their condition is dire enough to warrant a trip to A&E; or who endure an appalling quality of life out of poverty, unemployment, substandard housing, or unmanaged illness?

Harry Smith reminds us that we are all our brother's keeper. Social welfare was a tangible manifestation of that ideal and in the NHS it idea achieved one of its many high points.

Sentimentality, it seems, will not save this once great institution and just like the D-Day commemorations, subsequent generations will soon enough lose sight of the conditions that once made grand governmental actions necessary. But if free publicly-funded health care is replaced by pay-as-you-go privatised care, only a precious few will benefit, and we will all be looking around wondering what happened and what a terrible mistake we made.

Consumerism, notions of patient 'choice', health promotion, etc., are anaemic substitutes for health care that targets the social determinants of health. We cannot ignore these and leave the health of the nation in the hands of the lowest bidder for privatised services.

The lessons of history tell us that poor health is a generational legacy and everyone born into the time of the NHS has benefitted from its existence. The alternatives are going to be much more costly, and not only in a financial sense.

Occupational outlook for physiotherapy

16 June 2014

I know that physios often complain that the public doesn't know what we do and that we've often used this lack of understanding as an explanation for the chronic underfunding of the profession and our lack of political clout, but I've often wondered whether our relative invisibility doesn't also, sometimes, have its advantages.

Take the New Zealand Ministry of Business, Innovation and Employment's latest *Occupational Outlook for 2014*

The new tool is targeted at people looking for career advice and includes a funky new infographic-inspired way of profiling the profession's current income, costs/fees required to become qualified, and job prospects. There are Apps for your smartphone and an interactive web page to help people compare and contrast between professions.

There are profiles for professions in construction and infrastructure; manufacturing and technology; primary, service, and creative industries, and social and community services. So quite a lot of useful information really.

In the section on Service Industries there are profiles for hairdressers, human resources personnel and exercise instructors, and in the Social and Community Services, profiles for dentists, doctors, early childhood teachers, firefighters, healthcare assistants, journalists, pharmacists, police, psychologists, registered nurses and school teachers.

"But wait," I hear you say. "Didn't you miss one between the pharmacists and the police?" "Where are the physiotherapists?"

Well there is no profile for us. It seems the profession simply isn't big enough to warrant a category all on its own. And so, once again, we've been overlooked!

But is this really such a bad thing? Isn't there something reassuring in the fact that the government and the public don't have us on their radar at the moment? Aren't there advantages in being allowed to carry on regardless - managing our own estate without the interference that comes with a high public profile? Do we want the same kind of scrutiny that is afforded to midwives, doctors and psychologists? I wonder.

And things aren't all that bad. Only a few weeks ago in The Budget, physiotherapy education got a financial boost that it's been lobbying for for years. The government announced that degree level physiotherapy will be moving to a new funding category from 1st January 2015 - bringing it in line with nursing. This will mean universities get an additional $1,200 of government funding for each enrolled student and at AUT that will equate to an extra $180,000 of funding per year. And that's not to be sniffed at!

Interestingly, the government's announcement took everyone by surprise, including both physio schools and our professional society. So it seems we can still achieve good outcomes without being the centre of everyone's attention.

Movement/life in early 20th century England

5 July 2014

The BBC has recently compiled a series of amazing documentaries which show what life was like for ordinary people in Northern England in the first years of the 1900s.

The documentaries derive from the work of pioneering film makers Sagar Michell and James Kenyon (more about them here), and have been restored to their former glory by the National Film Archive in the UK having been lost for many years.

Documentary film of ordinary people's lives is commonplace now, but in 1900 - only five years after the invention of the film camera - people were still experimenting with its possibilities.

There are many things that can be said about this film series, but there is one thing in particular that drew my attention, and that was how much people depended on the ability to walk to get around.

Cars were still some years away, and although people could use horse- and electric-powered trams, carts and buggies, these were often not much quicker than walking, and so were relatively expensive.

Two-wheeled bicycles were also only newly invented and few people used these. (There's a very funny clip in the second section of Episode 1, where one man is trying to show another how to balance on a two-wheeler).

The speed of the films has been naturalised, and is as close as possible to the normal speed of people's movement. And this reveals how much faster people seem to move today. People moved at the pace of their feet rather than at the speed of their wheels.

Apart from the obvious physical and mental health benefits of this much walking, I wonder if a move to replicate some of the social and environmental conditions we see in these films would result in our social relations operating on a more human scale.

I wonder though, if we romanticise these things too much? What would we lose as well as gain from a more pedestrian lifestyle? I wonder if we understood this tension more, whether it would provide some useful insights into our present anxieties about the links between movement and health?

These arguments aren't new, of course. Paul Virilio's work on dromology provides a very powerful critique of the role speed plays in people's lives now.

Massage in Sciatica from 1886

16 September 2014

From The Lancet, June 26 1886, p.1232

Professor Max Schüller of Berlin is convinced (Deutsche Med. Wochensch., No. 24) of the superiority of massage over other measures employed in the treatment of sciatica, and relates his experience of fifteen cases--all in males, and, except in one or two instances (which were traumatic), due to exposure to cold. Most of the cases were dealt with from the first by massage ; but in a few instances electricity, vapour baths, &c., had been fruitlessly employed prior to coming under his care. The modus operandi is as follows. The patient lies on the unaffected side with knees and hips slightly flexed. The course of the sciatic nerve is rubbed from below upwards, partly with both thumbs, partly with the ball of the little finger or thumb ; sometimes truck with the closed fist, sometime the musclular mass over the nerve pressed and kneaded with both hands. The pain evoked by these manipulations soon passes away, and after a short time becomes less and less at each sitting. The neuralgic pains very soon abate, diminishing after a severe and painful massage, then recurring with less severity, and gradually disappearing entirely. The power of walking improves after each sitting. On an average the treatments last about two weeks and a half, but in one case nine days, and in several from ten to fourteen days sufficed. One patient abandoned the treatment after five

days, owing to the pain caused by it, and tried without relief a fortnight's course of electricity and vapour baths ; he then returned to the massage treatment, and was cured in two weeks and half.

History of spinal manipulation in New Zealand

14 October 2014

The mysterious manipulator performing unpleasant-looking cervical traction in the picture I posted on the blog a few days ago was Jennifer Hickling, one of James Cyriax's physiotherapists, who traveled from England to New Zealand in 1954 and sparked the interest of a young Stan Paris, who subsequently set off in the early 1960s to work with Grieve, Stoddard and Kaltenborn in Europe before returning to New Zealand and being part of a renaissance in manipulative physiotherapy that has lasted nearly 50 years.

New Zealand physiotherapists are rightly proud of their pioneers of spinal mobilisation and manipulation: Stan Paris, Rob McKenzie, Brian Mulligan, Michael Monaghan, Mark Laslett, and others. Many played a pivotal role in the formation of the International Federation of Orthopaedic Manipulative Therapists (IFOMT), attending its inaugural month-long meeting in Gran Canaria in 1973, and musculoskeletal physiotherapy is still a very strong focus of interest for practitioners in New Zealand, with over 60% of physiotherapists working in private practice.

There is a fabulous virtual archive of physiotherapy history in New Zealand created by Physiotherapy New Zealand to celebrate it's centenary in 2013. It includes oral histories from Stan Paris, Rob McKenzie, Brian Mulligan and others, and detailed accounts (including lots of photographs) of the early years of musculoskeletal physiotherapy in New Zealand. You can link to the archive here.

Critical physiotherapy curios - updates, ideas and new postings

15 November 2014

Research

We have to start with this. WCPT has published a list of the 15 most influential trials in physical therapy. I loved the fact that they used a qualitative process to ascertain which

blinded, controlled and randomised clinical trial they found most influential. No hint of irony there then!

Fatemeh Rabiee, Anne Robbins and Maryam Khan's article in Health Education Journal Gym for Free: The short-term impact of an innovative public health policy on the health and wellbeing of residents in a deprived constituency in Birmingham, UK is well worth a look if you're interested in how community-based health interventions might work for people in marginalised communities.

A paper by Daniela Dantas Lima, Vera Lucia Pereira Alves and Egberto Ribeiro Turato in Philosophy, Ethics, and Humanities in Medicine was sent to me by Jens Olesen. The paper The phenomenological-existential comprehension of chronic pain: going beyond the standing healthcare models looks at how we have moved from a biomedical understanding of chronic pain to more of an individual lived experience. The paper explores the part played by phenomenology.

I'm a big fan of the French Philosopher Jacques Rancière, so it was really nice to see this article A Breathing Space for Aesthetics and Politics: An Introduction to Jacques Rancière by Nikos Papastergiadis. If you haven't seen it, I promise Rancière's book The Ignorant Schoolmaster (which you can find in pdf on-line) will change your view of teaching and learning.

Our recent posts on Connectivity have thrown up some interesting articles. This paper on Critical Neuroscience and Socially Extended Minds by Jan Slaby and Shaun Gallagher looks at the idea of intersubjectivity in critical neuroscience.

The use of simulation is a really interesting development in physiotherapy education in recent years. This paper by some very eminent names in health education provides a sociomaterial view of its practice.

Web

My top find of the month has to be the Continental Philosophy blog. There's more Foucault, Butler and Deleuze here than you can shake a stick at. A fantastic resource for those of you with an interest in critical and postmodern ideas.

Steve Wheeler's latest short blogpost on learning by teaching is well worth a read.

This well referenced post by Cecilia Rodriguez Milanes and Aimee Denoyelles titled *Designing Critically: Feminist Pedagogy for Digital / Real Life* on the fantastic *Hybrid Pedagogy* blog is well worth a read if you're interested in a gendered take on the tensions between teaching large classes (lecture theatres, MOOCs, etc.) vs dialogical teaching.

I spent far too long this week browsing The Public Domain Review. This is a web miscellany with some really fabulous content.

If you haven't come across the on-line free Journal of Evolution & Technology, you might want to have a look at its contents. If you're interested in ideas about how the body is evolving in the 21st century - particularly the effect of technology and cyborg-culture - then this site has some really interesting content.

Alf Collins's recent thought paper on how person-centre care might work raises some interesting questions about how the structure of health are in the west might need to shift if we are to become truly person-centred.

For lovers of Friedrich Nietzsche, this one-hour YouTube video will be a lot of fun. It's a pretty good summary of this complex and highly influential philosopher.

...and anything on Hannah Arendt is worth a read. This post on the ever reliable Brain Pickings gives some insights into this amazing philosopher's mind.

Books

A new book from Routledge titled the *Routledge Handbook of Complementary and Alternative Medicine: Perspectives from Social Science and Law* caught my eye. Some of the chapters on the move of complementary therapies into orthodox health care and recognition for indigenous medicine looked really interesting. There's a lot of physical therapy practice in the book too it seems.

And another new book that looks like it might have some interesting links to physiotherapy is Creative Arts in Humane Medicine

by Cheryl L. McLean; 'Creative Arts in Humane Medicine takes us on a fascinating journey to meet the educators, clinicians, support workers and artists who apply arts-based methods in innovative ways to enhance patient care, reflexivity in learners and a sense of community, and well-being in practitioners.'

Phantom limb pain and embodiment

27 November 2014

An extract from a recent book review of Cassandra S. Crawford's, Phantom Limb: Amputation, Embodiment and Prosthetic Technology. New York: New York University Press, 2014. Pp. vii + 307. £15.99. ISBN 978 0 8147 6012 3.

'George Dedlow, a fictional nineteenth-century amputee said: ‘About one half of the sensitive surface of my skin is gone, and thus much of (my) relation to the outer world destroyed …’ (p. 110).

'This quote, like much of this book left me thinking. Some of those thoughts flitted around being fascinated, surprised, but also a bit depressed. With that maelstrom of impressions, if you are interested in thinking about the nature of bodies and how our (supposed) relationship with them has developed, then I think this book is a must. Crawford's aim is to dig under and around the nature and concepts surrounding body parts that hold no corporeality—phantom limbs. This is a look at the ghostly appendage from a mostly American, twentieth- and twenty-first-century perspective. Thus, it is a modern Western analysis. Moreover, whilst those who experience phantom limbs can be found in this work, the focus of this book is on medical discourse.'

Opening doors to disability

5 December 2014

I've been in Wellington for the last three days exploring the archives to find any trace of physical therapy activity in New Zealand in the 19th century. So far it's been a frustrating search.

While I've been down here, I've been having some interesting discussions with people about disabled physiotherapy students. We have just graduated our first tetraplegic physiotherapist and I've been in discussion with our regulatory authority about the conditions for their license to practice.

So this article sent to me by CPN member Anne Hudon came at a very convenient time. Thanks Anne.

Across the country, people with disabilities are redefining the possible by excelling in scholarly pursuits that were once off limits to them.

Evolving attitudes, policies and technology have given rise to a generation of undergrads, graduate students and faculty members with disabilities who demand inclusive spaces, teaching styles and supports.

“More and more students with different disabilities who didn’t previously access post-secondary education are beginning to do so,” says Stewart Engelberg, director of Trent University’s Student Wellness Centre. Universities don’t always have accommodations in place when a student with a particular disability arrives, Mr. Engelberg explains, but “it’s important to invest the time to develop appropriate systems.”

Early Career Life in 2014 - George Campbell Gosling

6 January 2015

"...it's also been a year in which I've stopped trying to get myself into an ideal situation for putting my numerous plans into action and started getting on with them anyway."

Great advice for anyone with a spare New Years resolution going unused!

Is behaviourism the future for physiotherapy?

14 January 2015

Yesterday, I took part in one of the regular and always enjoyable Physiotalk Tweet Chats (#physiotalk). This one was on the role of physiotherapy in exercise prescription. As usual, the discussion ranged widely over all sorts of topics: whether physiotherapists were experts in exercise prescription and what needs to be taught in the UG curriculum not being the least of them.

One thing that came through strongly was a desire to manage the client/patient's behaviour. Words like adherence, compliance and motivation kept coming up and people seemed to recognise that all the skill in the world wouldn't matter to the therapist if the patient didn't engage.

As someone who's read their fair share of Foucault, and in the pursuit of a critical angle to the discussion, I thought about how this Tweet Chat reflected a telling moment in the history of our profession. There was a time when adherence and compliance were largely ignored. It didn't matter whether the patient did what they were told; there was a long waiting list of people who would do what we asked, and we were going to get paid anyway. But these were the days of the welfare state and they are now behind us. Today, we face much less surety and so have to appeal to people's inner motivations in the hope that they will like our prescription more than the practitioner down the road.

Which brought me to a brilliant recent series streamed on Vimeo titled *The Century of the Self*. The four documentary films talk about how a growing understanding of human behaviour has been at the heart of our social development in the 20th century.

The first episode is particularly interesting. It looks at how our growing understanding of people's behaviour became a tool used by governments to manipulate the masses. Drawing on Freud's ideas, active efforts were made to make people want what they didn't need by

linking mass-produced goods to their unconscious desires, and by satisfying people's inner selfish yearnings, making them feel happy and docile. It was, as the series points out, the start of the "all consuming self that has come to dominate our world today."

I suppose two things come to mind. Firstly, physiotherapy is quite late in its adoption of behaviourism. And secondly, as a result, we should understand that it has its own specific history and as such isn't necessarily good or bad, only problematic and worthy of close critical scrutiny before people launch into it believing it is the answer to our profession's future.

We could also say that the tools of this critique can be found in philosophy, and so people wanting a more critical understanding of behaviourism might seek help from people within this group. If people do approach us for our thoughts, we could think about selling them something to make them feel happy and less uncomfortable.

War's waste - physiotherapy and the disabled war veteran

16 January 2015

Physiotherapy and rehabilitation have always been inextricably linked. Although they represent discrete fields, their histories have often been closely intertwined.

Physical rehabilitation as an organised discipline has its origins in World War I. Beth Linker, in her excellent book War's waste: Rehabilitation in World War I America, describes how it became necessary to change American attitudes to the retired Civil War veteran who had been considered heroes and, as such, exempted from work. But as the cost of meeting their social welfare costs grew, the government realised it needed a solution, and found its answer in the emerging rehabilitation sciences. The idea of the noble war veteran was recast so that the men were considered work-able rather than permanently unfit. Adapted (or 'sheltered') workplaces were developed and rehabilitation services were designed to adapt men to the new work possibilities.

In Britain, many of the same changes were taking place. By 1914, the Incorporated Society of Trained Masseuses (ISTM) had demonstrated it's legitimacy and was invited to send a corps of masseuses (the Almeric Paget Massage Corps) to serve the field hospitals during WWI. Lessons learnt rehabilitating men suffering from gas attacks, empyema, amputations, peripheral nerve injuries and the effects of field surgery were carried over in the years between the wars and confirmed physiotherapy as the pre-eminent provider of physical rehabilitation services when the welfare state came into being.

The 'problem' of the disabled war veteran has always been a concern for governments however, and one that physiotherapy has inadvertently benefitted from. In a new book by John Kinder from the University of Chicago - due for publication in March 2015 - a new chapter is written in America's relationship with the disabled war veteran:

America has grappled with the questions posed by injured veterans since its founding, and with particular force since the early twentieth century: What are the nation’s obligations to those who fight in its name? And when does war’s legacy of disability outweigh the nation’s interests at home and abroad? In Paying with Their Bodies, John M. Kinder traces the complicated, intertwined histories of war and disability in modern America. Focusing in particular on the decades surrounding World War I, he argues that disabled veterans have long been at the center of two competing visions of American war: one that highlights the relative safety of US military intervention overseas; the other indelibly associating American war with injury, mutilation, and suffering. Kinder brings disabled veterans to the center of the American war story and shows that when we do so, the history of American war over the last century begins to look very different. War can no longer be seen as a discrete experience, easily left behind; rather, its human legacies are felt for decades.

References

Kinder, J.M. (2015). Paying with Their Bodies: American war and the problem of the disabled veteran. Chicago, University of Chicago Press.

Linker, B. (2011). War's waste: Rehabilitation in World War I America. University of Chicago Press.

Strong and modern - physiotherapy and physical culture

27 January 2015

Physiotherapists are very interested in fitness, leisure and sport, but they rarely discuss the history of these ideas, or the place of physical therapies (massage, manipulations and mobilisations, remedial exercise, electrotherapy, hydrotherapy etc.) in the promotion of the health of the population. There are a number of reasons why I think we should pay more attention to this specific history. Firstly, it's one of the few areas where physical therapies have made a genuine contribution to the health of the population. I don't mean the health of individual patients that, taken together, amounts to the health of the population, but rather an approach applied to the population as a whole - as one organic entity. Secondly, I believe that if physiotherapists had a better appreciation for the history of the ideas that underpin

their practice, they might be less prone to believe that the latest push to get people exercising is anything new. Thirdly, we might be less inclined to believe that people today face unique and unprecedented challenges. The truth is, as far back as Greco-Roman times, people have always been concerned about the fitness of the population, and people have always turned to the physical therapies for an answer.

Any physiotherapist wanting to know more about this history of the practices that are the cornerstone of the profession often has to go outside physiotherapy to find information. Most research today focuses on the efficacy of specific technique rather than the etymology of the ideas, so coming across a recent book by Charlotte Macdonald (Strong, Beautiful, and Modern: National Fitness in Britain, New Zealand, Australia and Canada, 1935-1960, 2011, British Columbia: UBC Press, ISBN 9780774825406) made good reading (you can find some additional two book reviews here and here, and a section of the book as a taster here.)

The book covers five main themes:

- National fitness in England and Scotland - with a very physiotherapy-relevant chapter title: 'Movement is Life'
- Physical welfare as the people's entitlement in New Zealand
- National fitness in New South Wales and across Australia
- National fitness in Canada
- and Healthy bodies, states and modernity

The book addresses a time immediately preceding World War II and the immediate post-war period. This is an interesting time in the history of the fitness movement, because most research traditionally concentrates on the role of fitness in the eugenics movement which came to prominence in the early years of the 20th century. Eugenics was inspired by a Darwinian belief in the survival of the fittest (and was pioneered by Darwin's cousin - Francis Galton, 1822-1911 - a polymath, who, amongst other things, invented the statistical concept of correlation), and exercise was seen as an important vehicle to ensure the vital strength of the population.

Most countries that embraced eugenics nurtured beliefs about the impending loss of racial purity, and fitness advocates argued that the whole population's health was at risk from becoming sedentary and soft. Out of this vat of bile emerged some quite extraordinary characters. No less so than Eugene Sandow (1867-1925) - the subject of a brilliant book by Caroline Daly (Leisure and Pleasure: Reshaping and Revealing the New Zealand Body 1900-1960, 2013, Auckland, Auckland University Press, ISBN 1869405048.)

Sandow is probably responsible for New Zealand's beach culture. He was a performance artist and bodybuilder who would demonstrate astonishing feats of strength to enraptured audiences. But it was his almost naked appearance and toned body that caused so much interest to people who had, until then, been very Victorian.*

Early twentieth-century New Zealanders moved around a lot, traveling the length and breadth of the country in search of work and better opportunities. But where've the went, they could probably join a gym or a physical culture class. All over New Zealand men who had trained under Sandow in London, or who had 'graduated' from one of his mail-order courses, were setting themselves up as directors of Sandow schools. Some women climbed onto the bandwagon, offering classes in dancing and deportment alongside Sandow exercise programmes. A major leisure revolution was taking place (Daley, 2013, pp.42-3).

I've written elsewhere about the role that physical culture played in New Zealand's early physiotherapy history (see here), but Macdonald's excellent book reminded that there is always so much more to learn about our present practices from lessons of the past.

*Sandow's show of physical form would become a major influence on the way anatomy books were presented from the 1930s onwards. With homoerotic irony, authors turned away from the simple line drawings of earlier editions, preferring instead the high resolution, images of muscular men to display a visual map of the muscles of the body.

Massage and aristocracy c.1894

16 February 2015

From Reynolds Weekly, 22nd July 1894, courtesy of Wellcome Library

It is one of the proud glories of our civilisation that it is perpetually breeding new diseases, the very names of which, invented by our fashionable physicians, would have made our good old great grandfathers stare and gasp. And as soon as these diseases have, so to speak, got into working order, and are doing their deadly execution, with a vigour worthy of a better cause, some new remedy is suggested to our civilised victims, which soon becomes all the rage. One of the best known of these recent remedies is called massage, and it is supposed to be of use in rheumatic, nervous, and other affections.

Massage, in plainer language, is rubbing, only rubbing done in a thoroughly scientific way, by people with very strong wrists. Those who do this rubbing are especially trained for the work and are of both sexes, the man rubber being a masseur, and the feminine a masseuse, both French words, and intended to make an impression on people who would think nothing of a mere rubbing, but who are immensely taken by massage. During the last dozen years such a

demand has arisen for scientific rubbing that great numbers of persons earn a fairly good living by meeting the demand and becoming professional rubbers.

If we are not mistaken the general public first heard of massage through an article written by a duchess* in a review, and as anything that a duchess advocates instantly commends itself to large armies of English snobs of both sexes, massage became celebrated and masseurs and masseuses established themselves all over the land. But, above all, rich and titled people seemed to have a special craving for massage—a fact which might have led kindly people to deeply sympathise with these unhappy mortals who seems to be afflicted in a greater degree than their humbler fellow, and who appeared to illustrate the good old doctrine that all of us have our troubles, and that a duchess may be really less an object of envy than an East-end Seamstress.

But in this irreverent age all phenomena are liable to investigation, and the fashionable devotees of massage have not escaped the scrutinising gaze of an eagle-eyed Press (sic). The afflicted aristocrats did not, after all, seem quite so ill as they pretended, and their visits to these scientific rubbers were more frequent than are the visit of other persons to their medical advisers. The singular fact also came out that the "gentlemen of England" preferred treatment at the hand of the masseuse, while the 'ladies of England" resorted to the apartments of the masseur. Upon mature reflection and after some very interesting inquiries had been made, it seemed quite plain that this was not due to mere chance, nor was it connected with any special medical advantages. The reason was, indeed, a physiological one, but of a different kind.

*The duchess referred to here is Lady Manners wrote an article titled *Lady Manners on Massage* in the magazine *Nineteenth Century* in 1886 (Vol 20, December). This article has been accredited as starting a craze for massage in well-to-do English society in the latter part of the 19th century.

Sources

Reynolds Weekly was a large circulation newspaper, founded in 1850, which was 'devoted to the cause of freedom and in the interests of the enslaved masses'

Words banned in Italy

18 February 2015

This article appeared in the New Zealand Herald in 1932 (Vol LXIX, Issue 21296, 24 September 1932, Page 9)

Fascist Italy has officially banned about fifty words of foreign origin now in common use in the Italian language. The list issued by the Confederation of Fascist Professionals and Artists includes the words "omelette," "roughly," "taxi," "parvenu," "dancing," and "masseuse." Italian equivalents have been coined to replace them. Thus, "masseuse" becomes massaggiatrice and the once universal "charm" is now "fascino." Many more words will eventually be added to this "black list." They will include "racing," terms borrowed from the English; and many sporting terms for which proper equivalents have still to be found.

No pain, no gain

17 March 2015

Reading a recent book on *Nurses and Midwives in Nazi Germany: The "Euthanasia Programs* by Susan Benedict and Linda Shields reminded me the that there is often a reluctance to research the darker sides to our professional histories. I remember Dave Holmes once telling me that he received some really aggressive and distressing criticism from his colleagues when his paper Killing for the state: The darkest side of American nursing was published. It seems that people within nursing took exception to someone questioning the morality of nurses who made people comfortable on death row in preparation for the electric chair and the lethal injection.

In some ways I can understand this kind of reaction from people who have spent their career promoting a positive image of their profession. But, at the same time, it suggests we are only comfortable being called a critically-informed profession up to a point, and that point ends when we start to look into the less palatable things that people have done in their professional history. Are we only allowed to talk about the good things that physiotherapists do?

Researching nurses working on death row or in Nazi Germany would raise some spectacular questions about the brutality of one person towards another and the banality of systematic institutional abuse, but what about the less obvious, quotidian, matter-of-fact abuses that pass beneath the threshold of unspeakable horror? What about the custom-and-practice hurts and unexamined professional rituals that are designed to exact a positive outcome but which carry outcomes that we'd prefer to ignore?

I wonder if we ought not attempt a professional reflection on the harms we have done to people in the name of therapy and rehabilitation?

References

Holmes, D., & Federman, C. (2003). Killing for the state: The darkest side of American nursing. Nursing Inquiry, 10(1), 2-10. doi:10.1046/j.1440-1800.2003.00162.x

Soaking

11 April 2015

Over the summer, I worked with one of my students on a project to locate any signs of physical therapies (massage and manipulation, remedial gymnastics, electrotherapy, and hydrotherapy) in New Zealand during the 19th century. Although physical therapies were hugely popular in Europe and North America at the time, they appear to have been almost unused in New Zealand, which is surprising since the indigenous Māori population were known to use massage (mirimiri) and hot spring water for treatment, and the early settlers would have known and practiced these therapies too. It seems that New Zealand was much like a frontier settlement before 1900, with most people working in farming, gold mining and timber milling. If you go injured, you just go on with it; there was no public health system, no accident compensation, and very few therapists.

The spas that New Zealand is famous for only really began in 1903 when the railways connected the major towns, so before then they were very much small scale, local industries. But in honour of the sheer beauty and luxuriance of the spa, here is a video from Aeon to relax you in time for the weekend.

Readings

http://aeon.co/video/culture/soak-on-sensuous-pleasures-and-amusing-rituals-of-hot-springs

Physiotherapy at Gallipoli - a small commemoration

20 April 2015

This weeks represents an important landmark in World War I commemorations, with Saturday 25th April marking 100 years to the Gallipoli landings and what the Turks call Çanakkale Savaşı (the Battle of Çanakkale). During the nine month campaign more than 120,000 soldiers died and there were estimated to be more nearly 400,000 casualties, and so I thought it might be poignant to reflect briefly on the small but significant role that physiotherapists played in the care of wounded soldiers, particularly those Australians and New Zealanders who have a very special Anzac Day service to attend this year.

As news of the slaughter at Gallipoli reached the colonial government in New Zealand, it was decided to commission two ships from the Union Steam Ship Company and turn them into floating hospitals. The Maheno and the larger Marama were refitted from public donations of £66,000, and the money allowed the Maheno to be equipped with eight wards, two operating theatres, an anaesthetising area, an X-ray room, a laboratory, a laundry and drying-room, steam disinfector, dispensary, telephone exchange, and two electric lifts each of which took two stretchers at a time. The medical staff on board included a matron and thirteen nursing sisters, five medical officers, a detachment of sixty-one orderlies of the New Zealand Medical Corps, chaplains. and a small number of un-named masseuses.

An account from the 1923 book The War Effort of New Zealand illustrates the conditions that the medical staff of the Maheno had to work in;

The Maheno arrived on...the 26th April...to find a cruiser and a destroyer in action near by; and a few bullets fell on the deck of the Maheno which served to indicate that she was now actually in the war zone.

The sight of the ship was an encouragement to our New Zealand soldiers who had wrested from the Turk a precarious footing on the hill sides opposite. During the next afternoon, the battle of Hill 60 was fought, and in the evening the wounded began to arrive at the ship. The severely wounded were sent to the wards at once, and the lightly injured were fed and surgically dressed on deck and sent in lighters to Mudros. The two operating theatres were in constant use from the evening of the 27th to the morning of the 29th.

The Maheno left on the 28th with 445 patients for Mudros, where they were discharged into a hospital carrier,—formerly the German ship Derfflinger—and the ship's crew assisted in the arduous work. The wounds were severe, and deaths occurred during the short voyage. The ship was cleaned and refurnished—a heavy task—and she left Mudros for Anzac on the 30th, and there embarked 422 cases on 2nd September, including a large number of cases of dysentery; and all the patients were transferred to the Nile at Mudros. The Maheno departed again on September 7th for Anzac, where about 1,000 patients were attended to including 400 embarked on the ship. The others had wounds dressed and received medical treatment aboard, and returned again to the beach. Several of the personnel of the ship contracted dysentery, and all were more or less exhausted (Elliot, 1923, pp. 127-30).

Little is known about the physiotherapy offered on board, but we do know that one of New Zealand's first registered practitioners was almost certainly one of the masseuses. Edith Thompson completed her training in 1914. Unfortunately, the outbreak of war meant that the legislation necessary to register Edith and the other graduates of the Otago School of Massage did not come until 1921, by which time she had completed her active service. Her

certificate of service shows that she served as a masseuse for 306 days overseas and 1 year and 239 days in New Zealand for which she was awarded the British War Medal.

During their war service, the Maheno and Marama transported 47,000 soldiers from the front to carrier ships or safe ports, including service during the Battle of the Somme. Conditions were often brutally unpleasant on board, food was scarce and there was no rest from work or the threat of dysentery.

Space to undertake any therapy must have been at a premium and it is likely that the few masseuses on board functioned as additional nursing hands during much of the voyage. Injured servicemen received much more suitable help when they disembarked and were transferred to military hospitals around mainland Europe or back home in New Zealand, where the first formal rehabilitation services began to be developed to return servicemen to active duty or functional lives back at home.

This weekend will be a poignant reminder of the suffering experienced by others, the harsh conditions they faced and their bravery in the face of appalling conditions.

Sources

Elliot, J.S. (1923). The war effort of New Zealand. Auckland, Whitcombe and Toombs (available to view online here).

http://www.100yearsofphysio.co.nz

http://www.nzhistory.net.nz/war/first-world-war-hospital-ships/

http://100nzww1postcards.blogspot.co.nz/2015/04/nz-hospital-ship-maheno.html

http://nzans.org/NZANS%20History/NZANSHistory-1915-1922.html

The first congress of the World Confederation for Physical Therapy c.1953

29 April 2015

'The beginnings of any organization are important, for on them rests the future' Mildred Elison, President of WCPT in 1953.

Given that the 17th WCPT congress in Singapore begins on 1 May 2015 and runs for four days, I thought it might be timely to remember the first congress and reflect on what has changed and what has stayed the same.

The first WCPT Congress was held 62 years ago in London and ran from 7-12 September 1953.

There were 25 countries represented at the conference, and each day focused on a different clinical theme: physical therapy in neuromuscular disorders; rheumatic diseases; diseases of the chest; rehabilitation of injured war veterans; physical therapy in industry. There was also a day devoted to 'Physical therapists on Treatment and Research.'

The congress began on Sunday 6 September with a religious (Anglican) service at St Paul's Cathedral and Westminster Cathedral, and the opening ceremony the following day at which the Minister of Health - Rt. Hon. Iain McLeod spoke. There were speeches from Sir Harry Platt, then President of the CSP; Miss W. M. McAllister, First Vice-President of WCPT; Lord Webb-Johnson, past president of the Royal College of Surgeons, Medicine and Occupational Therapy; Lord Horder, President of the International Federation of Physical Medicine; Mrs S. Coleridge, Second Vice-President of WCPT; and finally, Miss Mildred Elison, WCPT President.

The symbol of the congress, 'an illuminated revolving globe of the world, was highlighted, (and) these words were spoken:'

Let the spirit of the Congress be a willingness to serve and a sense of just enjoyment, for happiness and health are next of kin, and, from true faith in a Creator, comes willingness to help a neighbour, content of mind and peace to men.

The formal business of the conference included eight lectures, all given by doctors, including Herman Kabat, Sir Clement Price Thomas and F. S. Cooksey. There were three demonstrations on ante-natal training, breathing exercise classes and recreational rehabilitation for lower limb injuries, all given by physiotherapists.

There were also 13 papers given by physical therapists: three from Sweden; two from Norway, Great Britain and Denmark; and one from physical therapists from South Africa, USA, Australia, and the recently divided West Germany.

26 hospital departments and rehabilitation centres opened themselves to visitors from the congress, including most of the major London hospitals and the retraining shop and physiotherapy department of Vauxhall Motors in Luton.

The conference closed with a dinner at the Park Lane Hotel in Piccadilly, and after the speeches and the meal came 'a display of Scottish dancing... (which) in turn was followed by ballroom dancing until 1 A.M.'

Footnote from the September 1952 edition of Physiotherapy, in preparation for the 1953 Congress:

The Brighton Branch (of the CSP) has given £50 as a part of the proceeds of a most successful Garden Party and Bring-and-Buy Sale held in Miss Gertrude Cadman's garden. The hard work

and good organisation of Miss Cadman herself were a major contribution in raising this substantial sum.

Students at Dublin School of Physiotherapy have raised £1 12s. by the sale of 'country produce' - Which sounds a delightful way of raising money and might well be imitated (p.167).

Reference

Published proceedings of the First Congress of the WCPT, published by the Chartered Society of Physiotherapy, London, 1953.

Catherine Worthington's notes from the 1st WCPT Congress in 1953

1 May 2015

This post follows a blogpost on a brief history of the 1st WCPT Congress in London in 1953. You can access this post here.

Catherine Worthingham from the USA - who would later give her name to prestigious APTA Fellowships - gave a talk on Trends in physical therapy education that is worth briefly quoting from:

> ’Although physical therapy is one of the oldest forms of patient care, it is a relative newcomer to the constellation of medical and medical auxiliary professions. This fact is both a handicap and an advantage. A handicap, because recognition and appropriate support for a new field of professional effort is hard to obtain. An advantage, in that as a new profession we are not bound by established patterns and traditions. We are free, therefore, to mould education and practice in a way which will serve best the needs of the medical profession and their patients (p.54).
>
> ’The most important similarity (between physical therapists from different countries) is the type or person who has been attracted to physical therapy as a life work. These physical therapists have exalted service above personal gain, and have devoted their lives to people and their problems. They have had a fundamental urge to serve humanity in a way that would lessen human suffering. The techniques which have been used for the purpose have differed widely, but the warmth and understanding in the relationship between the physical therapist and his (sic) patient have been the same. It is possible that the desire and earnest effort to help the patient in many

> instances have been more important than the actual procedures employed. No on would wish to minimize the personal characteristics of the physical therapist of the past, the present or the future. However, the growth in stature of the profession has been dependent also upon other qualities and abilities of the people who have entered it and will continue to be so' (p.54).

If the trends in education continue to be directed towards the wise selection, education and placement of physical therapists whose interests are in serving humanity to the best of their ability, the future of the profession of physical therapy is assured (p.54).

All material taken from the published proceedings of the First Congress of the WCPT, published by the Chartered Society of Physiotherapy, London, 1953.

SNAGS for anterior chest pain that are not in the textbook

20 May 2015

Following on from my post the other day (No sex please, we're physiotherapists), I thought I would recount one of my favourite stories that illustrates just how implicit sexuality is in the work that physiotherapists do.

A few years ago, I interviewed Brian Mulligan, the famous Kiwi physiotherapist, whose work has made him one of the world's most well known and well regarded practitioners. His Mobilisation with Movement approach to musculoskeletal physiotherapy, developed in the 1980s, is now followed by thousands of physiotherapists, and he is still teaching and examining all over the world. More than that though, he is one of nicest people you could care to meet; genuinely charming and a great storyteller.

I was interviewing him as part of New Zealand's physiotherapy centenary celebrations (you can hear Brian talk about his work and practice life here), and as part of that interview I asked him about two quite famous pictures that appeared in the 4th edition of his book 'Manual Therapy: "NAGS", "SNAGS", "PRP'S" etc.' If you turn to pages 64 and 82 of that edition, you will be confronted by these two rather arresting pictures.

By 1998 Brian's books had become incredibly popular, and he was in demand as a speaker all over the world. His American publishers asked him if he would consider a slight change to the next edition, including a couple of images with female models, where the technique was, shall we say, 'sensitive.' Brian's books almost exclusively used male models, and American physical therapists - fearing law suits - wanted visual evidence of how one was supposed to perform a

"SNAGS" technique for anterior chest pain with extension. They wanted evidence that you really do need to place your hands across the breasts to perform the technique safely and effectively.

Brian agreed, but not wanting to use a relative for the pictures, decided to phone a local massage parlour and hire a prostitute for the pictures.

The woman arrived with her minder (the man holding the leg in the picture on p. 82), took off her clothes and posed for the pictures. These were her 'working clothes' as Brian put it, and so they took the pictures in situ and thought nothing of it.

Brian had long held the view that we were too prudish about images of naked bodies, and knew that some skin-to-skin contact was essential if one was going to be effective with some techniques. Little did he realise the fuss these images would cause.

Suffice to say, the images were removed from the 5th edition and replaced with a picture of a male model who caused no-one any offence.

One thing that always struck me about these 'scandalous' pictures is the use of black boxes to hide the model's appearance. They have the effect of making the pictures seem really seedy. It doesn't help that Brian's face is hidden behind the model in the first picture, and that she is looking away from the camera. I imagine that if you took this picture out of the book and showed it to people who didn't know any better, they would say it had been lifted from an old pornographic magazine.

The second picture is even more strange. Not only was no effort made to change the model's 'working' clothes, but a black box has been placed over the right cheek of her buttocks. I was totally confused by this, until Brian told me that it was because she had a tattoo on her bottom and the publishers didn't think that it would be appropriate to show this in the book. It's surprising, given their sensitivity, that they didn't feel the same about having a half-naked prostitute being manipulated by two men in a photo shoot that took 20 minutes and resulted in a financial transaction that bore all the hallmarks of her normal day-job.

I find it deeply ironic, given how we have to be so careful about how we regulate the sensuality of touch, that Brian should have chosen to use a prostitute to demonstrate a technique that is used every day by practitioners around the world. Brian did a fine thing in printing these photographs because he inadvertently raised a question about how physiotherapy views the sensuality of its practice. I'm not sure if he'd do it again, if he knew how people would react, but I think that says more about some of the people in the profession than it does about him.

Wrong-doing in physiotherapy is not where you think it is

22 May 2015

It's been interesting this week to hear from physiotherapists who share my concern for the kinds of objective, detached, depersonalised ways that physiotherapists often project their professional practice

I think, as a profession, we're starting to understand some of the important reasons why we do this (we want to be considered professional, scientific, evidence-based, etc.), but it would be nice if we could also see more of the barriers to progress that these discourses are creating, and discuss whether there might be some value in thinking otherwise.

I've developed, led and taught a 1st year UG paper called Therapeutic Touch for over a decade at AUT, and in the paper we introduce the students to the basics of Swedish Remedial Massage (effluerage, petrissage, etc.). But the paper also has an overt focus on helping the students negotiate appropriate touch with their clients/patients. Its far removed from the way I was taught massage, where everything was about the acquisition of technical skills and there was little thought given to the person you were massaging. Thankfully those days are gone, but the echoes of some of the same detached, dispassionate practice remain.

You see it most profoundly in the way that musculoskeletal physiotherapy has become focused on batteries of tests and measures and technical remedies focused on acute, often self-limiting injuries. This is really evident in New Zealand, where around 60% of physiotherapists work in private (musculoskeletal) practice. The proportions are higher in NZ than in many other countries partly because we have a no fault compensation system that funds the medical and rehabilitation costs of any accident (see ACC).

This partly explains why New Zealanders have been real innovators in the field of musculoskeletal physiotherapy. But like all other developing countries, we too face an ageing population of people living with multiple co-morbidities longer than can be sustained by our health system. In all likelihood, the future for physiotherapy will not be in the management of acute, musculoskeletal disorders (or if it does, this will be fully privatised and only available to those who can afford to pay for it). The greatest need by far is for skilled, trusted, relatively low-cost, high-value practitioners to work with people with complex, multifaceted health problems, and physiotherapists are ideally placed here. If only we could become a bit less rigid, a bit more 'holistic,' and a bit more humanistic.

The irony is that most good, experienced and popular physiotherapists have learnt how to go beyond the technical rationalism of their training and become more embodied practitioners,

but they have had to do this despite their training and professional scope rather than because of it. We're seeing the emergence of this more holistic approach in the rise of the pain specialist in NZ and elsewhere, for example, and these people are making a real difference. But until recently, those that have succeeded have often felt that they have had to betray their profession identity to get there. To give an example;

A friend of mine was recently asked by the local hospice to treat a couple of people who were in the end stages of cancer. Having talked with the staff and met a couple of the patients, she decided that her role was palliation; making the residents as comfortable as possible in their last days and weeks. She decided to offer general massages to anyone who requested it. She had one resident who had lung cancer, and she treated her for three weeks before she died. The technique was nothing special - some general slow effluerage over her back, shoulders and arms (for which there is absolutely no evidence) - but during the 'treatment' session, my friend told me that the resident was transported away from her pain. For the 45 minutes or so of the treatment, she let go of her fear and suffering and lived, all be it for a short time, in comfort. Sometimes she cried, sometimes she talked, sometimes she just lay silently. The therapist just listened and massaged.

You would not believe how many people criticised her for massaging people with end-stage cancer (what's the point, one person said); for using 'outdated' methods (massage); for having no physiological rationale for her treatment. My friend asked one of her colleagues what she would have done, and her suggestion was to leave it to the nurses and concentrate on things that were likely to show a better outcome.

But it seems to me that this is exactly the kind of sensual practice that physiotherapists need to engage in if they are to understand the possibilities of the new economy of health care. So what if there is no evidence-base for this kind of treatment. I would much rather think of physiotherapists practicing in this way than the way we saw in the video in the last post. To me, the idea that people are just machines to be diagnosed and fixed; moved around like carcasses without care or compassion, is deeply offensive.

There is a banal, casual and cynical wrong-doing going on in physiotherapy that passes as skilled practice. It is sanctioned by our ethical guidelines, our professional bodies and our physiotherapy schools and, if we're not careful, will be the undoing of the profession.

Why are there no physiotherapists practicing inside video games?

25 May 2015

Survivor, a short poem by Roger McGough:

> Everyday,
>
> I think about dying.
>
> About disease, starvation,
>
> violence, terrorism, war,
>
> the end of the world.
>
> It helps
>
> keep my mind off things.

That poem always makes me smile. I used to have it on my office wall for the times when I thought I was taking myself too seriously. I was reminded of it after last week's rather heavy blogposts about physiotherapy and sex. So I thought I'd post about something a bit more lighthearted today. In the spirit of Roger McGough then, this post is about video violence, simulated injury and death.

For some time now I've been pondering why it is that there are no physiotherapists working - and I mean actually employed - in first-person video games: games like Call of Duty, Halo, Far Cry or Half life? (If you have absolutely no idea about these games, you can watch video recordings of game play on Youtube - this link is of a live player showing you their game play, for example - but they basically involve gamers taking on the persona of an in-game character and shooting their way through billions of challenges until everyone else is dead or they've evolved so much that they've become bored by their own invincibility.)

Let me be clear, I don't play these games, but I know enough about them to understand the basic idea. Your player develops skills throughout the game based on live challenges. The games are meant to be so immersive that you almost believe you are in the fantasy world, and having seen a couple of these games played, you have to admire the skill of the designers because the worlds are impressively realistic. But here's the rub...

The games are designed to be a simulation of real life. For instance, the games 'physics' have to be realistic. They have to feel real, so that when your character runs, it has to look and feel like you are running. Water has to flow like water and rocks have to look heavy to lift. Things you throw have to fly right and bigger guns have to sound more impressive than pea-shooters. They have to be a simulation of the real world, and the lengths that game designers go to simulate these in-game physical properties of matter border on the obsessive. And yet, at the same time, the games all perpetuate the most ridiculous deception, and everybody who plays knows it and accepts it.

Everything is real until the point comes where the player gets injured, or worst still, dies. Then the game allows the player to magically regenerate. They may have to find a medical chest or suffer the inconvenience of a slight game delay, but the penalty is little more than waiting a few seconds or a slight detour on their journey.

This seems a bit odd to me. On the one hand, gamers demand that the gameplay is as authentic and immersive as possible, right up to the point where they get injured. Then they just want a convenient quick fix and a sloppy unreal world is allowed to intervene so that their gameplay is not disrupted.

If a player jumps out of a 2nd floor window or has their arm chopped off in a fight with a bulbasaur (you can tell I'm not a pro gamer!), shouldn't they have to stand down from the game for two months while they recover? Shouldn't they have to pay for their surgery and rehabilitation? Shouldn't a physiotherapists be employed somewhere in the game to make sure they followed the right programme of exercises and didn't lose their aerobic fitness? And what happens if their surgical repair gets infected?

Why are there no physiotherapists working inside video games like Call of Duty?

There are, of course, a few quite serious philosophical questions underlying this problem (not least how gamers are experiencing their embodied selves in virtual space). But more importantly, for us at least, is a question about the ways physiotherapy may change in the future if people who develop very different view of the limits of their bodies. Virtual reality games are only one expression of the many possibilities promised by future genetic therapies, robotics, reconstructive surgeries and pharmacological interventions. It's not inconceivable that we are on the threshold of radically new 'cyborg' bodies where new technologies may make a lot of our present modes of rehabilitation obsolete.

So why couldn't a physiotherapist make a living in an entirely virtual world? Do we actually need a physical body in front of us to practice? Clearly not. There are businesses being set up already where the therapist is remote to the client/patient. So why not online? Do we really still believe that embodied reality is corporeal?

’Choose to move’ is powerful, but show me how

24 June 2015

There has been a lot of interest on social media over the last few days in this promotional video from the Physiotherapy Associate of British Colombia (PABC) called Choose to move.

What's really striking about this video is that it's all about movement; not the kind of movement defined by the American Physical Therapy Association as “a system of physiological organ systems that interact to produce movement of the body and its parts," but rather a humanistic, social and deeply personal experience. As @AdamMeakins opined on Twitter, this is a ‘f—king awesome advert... No tape, needles, machines or manips in sight!'

The advert does a wonderful job of connecting physiotherapy to the bigger issues that really motivate people to make use of our experience and expertise. It makes extensive use of metaphor; 'What moves you?' and uses powerful visual images and sound to evoke the idea that movement is for everyone regardless of ability, gender, age, ethnicity, or any other cultural positioning.

But this raised an interesting question for me. Adam is right that there are none of the traditional markers of physiotherapy practice in the advert. All it states is that physiotherapists can help you move. But what specifically identifies physiotherapists as the agents people should turn to here? Why would someone look at this advert and think that a physiotherapist has something to offer? Why would they turn to us and not a personal trainer or practice nurse?

I find the same question when we teach primary health care and population health to our UG students. We do a lot of work to explain all the reasons for the shifts taking place in modern health care, but when it comes to how physiotherapists might take an active role as agents of change in this new world, we're often left with the trite and simplistic message that people just need to lose weight, stop smoking and get more exercise.

We know that it doesn't take a four year undergraduate training to tell people to lose weight and get more exercise. And equally, it takes an extensive background in anatomy and physiology, differential diagnosis and the management of complex health problems to encourage people to move.

So what is the role of the physiotherapist here? How do we distinguish ourselves as experts in empowering people to move if we take away the traditional trappings of our practice?

My personal view is that there are a lot of people trying to position ourselves as experts in human movement on the basis of our knowledge of the body as machine (see, for example, Shaun Logan's piece on 'Physical therapy and the human movement system'). But these offer a very paternalistic, reductive view of movement that situates the patient as a passive recipient of treatment - more of a 19th century idea of practice than a message for the 21st century.

So while I applaud the PABC for it's humanistic and holistic interpretation of the importance of movement for physiothearpy, I want to know what the next two minutes of video might include; the part where they say exactly how physiotherapists will help to 'move you.'

The ‘B-side’ of physiotherapy history

26 June 2015

For some years now, I've been researching physiotherapy history. Sometimes doing this kind of work throws up surprising and poignant reminders of how much has changed, and also sometimes how little.

A few weeks ago, I found an old newspaper article from *The Otago Daily Times* from 1957. The article had been given to me by an a retired physio who knew I was collating material for an interactive website we were creating to celebrate the centenary of physiotherapy in New Zealand.

The article was a simple piece about the School of Physiotherapy. At the time this was the only physiotherapy school in New Zealand and the article talked about how the school ran, what the students did and how the school fitted into the town's established university.

For some reason I turned the newspaper article over. At first I didn't realise what I was looking at, but then as I started to read I realised that the newspaper was reporting on a major event in US history.

Little Rock is synonymous with black civil rights in America. Three years earlier, the US Supreme Court had called for all high schools to desegregate, but school officials in Little Rock, Arkansas defied the order. Blackpast takes up the story:

> School district officials created a system in which black students interested in attending white only schools were put through a series of rigorous interviews to determine whether they were suited for admission. School officials interviewed approximately eighty black students for Central High School, the largest school in the city. Only nine were chosen, Melba Patillo Beals, Elizabeth Eckford, Ernest Green, Gloria Ray Karlmark, Carlotta Walls Lanier, Terrance Roberts, Jefferson Thomas, Minnijean Brown Trickey, and Thelma Mothershed Wair. They would later become known around the world as the “Little Rock Nine.”
>
> Although skeptical about integrating a former white-only institution, the nine students arrived at Central High School on September 3, 1957 looking forward to a successful academic year. Instead they were greeted by an

> angry mob of white students, parents, and citizens determined to stop integration. In addition to facing physical threats, screams, and racial slurs from the crowd, Arkansas Governor Orval M. Faubus intervened, ordering the Arkansas National Guard to keep the nine African American students from entering the school. Faced with no other choice, the "Little Rock Nine" gave up their attempt to attend Central High School which soon became the center of a national debate about civil rights, racial discrimination and States's rights.
>
> On September 20, 1957, Federal Judge Ronald Davies ordered Governor Faubus to remove the National Guard from the Central High School's entrance and to allow integration to take its course in Little Rock. When Faubus defied the court order, President Dwight Eisenhower dispatched nearly 1,000 paratroopers and federalized the 10,000 Arkansas National Guard troops who were to ensure that the school would be open to the nine students. On September 23, 1957, the "Little Rock Nine" returned to Central High School where they were enrolled. Units of the United States Army remained at the school for the rest of the academic year to guarantee their safety.

It is sometimes tempting to think that we are far more sophisticated and enlightened than our forebears, but studying history has always taught me otherwise. Given the ongoing police shootings of young black men across America, we would be wise to remember Franklin D. Roosevelt, who said "The test of our progress is not whether we add more to the abundance of those who have much it is whether we provide enough for those who have little."

That seems to me to be a good test of physiotherapy practice, never mind civil rights.

Source:

Elizabeth Jacoway, Turn Away Thy Son: Little Rock, The Crisis That Shocked The Nation (New York: The Free Press, 2007); Mark Carnes and John A. Garraty, The American Nation: A History of the United States Since 1865 (New York: Longman, 2003).

The sociology of everything

15 October 2015

People often think that philosophy and sociology are concerned with grand ideas like hope, suffering, the meaning of existence, and what it means to be good. And while it can be about

these things, it often concerns things that are commonplace, everyday and quotidian (a lovely word, meaning occurring everyday, mundane and repeated).

The latest special issue of the journal *Sociology* is devoted to the study of everyday life and asks some really interesting questions that we can use in our thinking and practice of physiotherapy.

In the guest editorial, Sarah Neal and Karim Murji argue that, 'In many ways, it is difficult to overstate the significance of the everyday because it is, as Sarah Pink (2012: 143) observes, 'at the centre of human existence, the essence of who we are and our location in the world'.' And that in doing so, not only give importance 'to the ordinary, and take the ordinary seriously as a category of analysis, but they also evidence how everyday life social relations, experiences and practices are always more than simply or straightforwardly mundane, ordinary and routine. Rather, everyday life is dynamic, surprising and even enchanting; characterized by ambivalences, perils, puzzles, contradictions, accommodations and transformative possibilities.'

With a desire to see our role as significant and promote how important physiotherapy is, it's tempting to want to emphasise the transformative possibilities of what we do. In a competitive marketplace, where our jobs are often threatened and we're being asked continually to account for our actions and the necessity of our work, it's often tempting to focus on the 'big ideas;' the things that will set us apart from others and give us marketing/professional advantage: a point of difference.

But the everyday is, in reality, where we do most of our work. The micro is often much more 'real' than the macro, but is much less well understood. Micro histories and micro narratives are all becoming the focus for academic inquiry in recent years, and there is an increasing interest in the small, atomistic, incremental and slow change that takes place in people's lives. Why can't this apply to physiotherapy too?

Think about the everyday tweaks you apply to a person's rehab programme, or the small relationships you have with everyday objects in your clinic that work 'just so' after years of trial and error. Think about the daily events that routinely slip under the radar and hardly provoke interest, but define the structure of your day, or the day of your clients/patients.

Some years ago, a patient told me that they knew how their day would go when they took their first conscious breath in the morning. If they felt the weight of an infection starting in their chest, they knew they would have to stay in, slow down, take care over their breathing exercises, and rest. A thousand minor adaptations and adjustments as a result of a single feeling.

Perhaps the papers in this special issue could prompt us to think about the vast variety of microscopic events, systems, objects and subjectivities that make up our day, and think about how you might understand them better in the future?

Reference

Neal, S. & Murji, K. (2015). Sociologies of Everyday Life: Editors' Introduction to the Special Issue. Sociology, 49(5), 811-819. doi:10.1177/0038038515602160

Perception is everything

25 November 2015

A recent article in the *Boston Globe* (Doctors debate safety of their white coats) talked about how doctors had realised that their traditional white coats were 'germ magnets,' and how they were now discarding them in favour of less formal attire.

Setting aside the rather obvious question of why a dirty white lab coat would be any more rancid than a dirty shirt - a point also sidestepped in the article - the Globe went on to suggest that the good natured debate that had ensued 'touched on shifting perceptions of the physician's role.'

On the one hand, the white lab coat is a symbol of trust. There are studies that show powerful placebo effects of people wearing white lab coats (see Benedetti, 2013), but white lab coats can also symbolise the profession's elite social status and their professionally sanctioned power over the patient. (Do a Google Image search of white lab coats and see how many images are of white, male doctors 'doing things' to patients)

Much like the white lab coat, the white clinic room is as much about perception as actuality. Granted, a white clinic room shows up dirt and grime much better, but a dirty clinic room won't be any cleaner, per se, than a dirty brown clinic room. It just looks more clinical, and this is an image we often want to (subconsciously) convey to our patients.

"After all, perception is everything."

Studying the everyday objects that physiotherapists and others use to silently convey messages to the patient is a fascinating field of research and can reveal some interesting things about the profession. In a paper written in 2009, for instance, we looked at why physiotherapy treatment beds needed to be so 'mechanical' (Nicholls, Walton & Price, 2009).

As physios struggle to come to terms with the new economy of healthcare, greater client/patient choice, and people's desire for more embodied and holistic therapeutic experiences, we are starting to see clinicians designing their clinic spaces differently. People

are using more colour, hiding the medical equipment away, and visibly discouraging the over-medicalisation of their therapeutic spaces.

Often they are making these changes without realising what they are saying about the broader profession, which is why researchers can help to expose some of these discourses. After all, perception is everything.

Reference

Benedetti, F. (2013). Placebo and the new physiology of the doctor-patient relationship. Physiological Reviews, 93(3), 1207. doi:10.1152/physrev.00043.2012.

Nicholls, D. A., Walton, J. A., & Price, K. (2009). Making breathing your business: Enterprising practices at the margins of orthodoxy. Health: An Interdisciplinary for the Social Study of Health, Illness and Medicine, 13(3), 337-360.

Critical things to do this week

16 February 2016

Firstly, some of you will notice that things have been a bit quiet on the site this last 10 days. That's because we've migrated the whole shooting match over to a new paid site. We have a new look, new functions, and a much more stable site that, we hope, will be much nicer for you to use, and easier for us to manage. Huge thanks once again go to our good friend Sofia Woods from Shortie Designs for helping us with all the technical things. Our own Jo Bloggs will be posting more about the upgrade soon.

Since we've been away for a few days, I thought it might be nice to recommend a few things to make your week a little bit more critical, because everyone should make time for at least one critical thing each day:

- Take a walking seminar and follow in the figurative and physical footsteps of astonishingly brilliant philosopher and author Annemarie Mol's doctoral students. Annemarie Mol is a professor of anthropology in Amsterdam and the author of some powerful writings on complexity, mobilities, diets, weight, care and a whole host of other subjects (link). Gather up your friends, colleagues or students and take them on a walk to inspire them to think anew about their plans and projects. Walking is a surefire way to change people's perspective. (See also Harries and Rettie's recent paper below).
- Talk about what physiotherapy is going to be like when robots and assistive devices take over medical care, routine rehabilitation, assessment, diagnosis and a lot of traditionally routine treatments. But rather than focusing on all the negatives, think

about how these technologies might liberate you from those tasks that anyone (or anything) will be able to do in the future. How might these innovations make it possible for you to focus on those things only a well-trained, engaged practitioner could do? You might be surprised by the things people are prepared to let go of in the name of better care. And don't think these things will be someone else's problem. Many of them will be a reality by the time children entering school today become physiotherapy students.

- And perhaps try taking a dissenting view. Critical thinking is so much more than deciding whether a research study is reliable and valid. See, for example, the recent paper by the biggest group of collaborators since Earth, Wind and Fire played a gig with Slipknot (McKay et al, 2016, see below). Who could possibly disagree with the idea that we should establish reference norms for the musculoskeletal and neurological dimensions of a range of bodily constructs (dexterity, balance, ambulation, joint range of motion, strength and power, endurance and motor planning)? Well try it. Why might it be problematic to define people in this way? Whose interests might it serve? What ways of thinking and speaking about bodies, health, movement, function...being alive, might this privilege and what might it deny?

So there are a few critical activities to try with your friends and family over the next few days. For those in the North enduring cold, windy, stormy weather, keep safe and warm. For those in the South, enjoy the summer while it lasts. Changes are always just around the corner.

References

Harries, T., & Rettie, R. (2016). Walking as a social practice: Dispersed walking and the organisation of everyday practices. Sociology of Health & Illness, n/a-n/a. doi:10.1111/1467-9566.12406.

McKay, M. J., Baldwin, J. N., Ferreira, P., Simic, M., Vanicek, N., Hiller, C. E., . . . Burns, J. (2016). 1000 norms project: Protocol of a cross-sectional study cataloging human variation. Physiotherapy, 102(1), 50-56. doi:10.1016/j.physiotherapy.2014.12.002.

Six useless treatments

16 March 2016

The Australian Physiotherapy Association (APA) recently pronounced that six interventions commonly used by physiotherapists are useless and were no longer being supported.

As part of the *Choosing Wisely* initiative, the APA has decided that requesting imaging for certain instances of non-specific low back pain, cervical pain, and acute ankle trauma; plus the routine use incentive -spirometry after upper abdominal and cardiac surgery, electrotherapy in cases of lower back pain, and manual therapy for -patients with frozen shoulder, are all now discouraged.

There are some interesting aspects to this decision that warrant some more thought.

Firstly, there is the fact that pronouncements from professional bodies - no matter how well informed or well-intentioned - rarely make any difference to practitioner's behaviour. This point was made some years ago by Miles, Laughlin and Polychronis in an editorial in the Journal of Evaluation in Clinical Practice (pdf). In the editorial, the authors made the striking statement that evidence based medicine had never been shown to improve patient outcomes; that the 'refusal of the protagonists of EBM to engage in formal intellectual exchange'...'represents nothing more than the long maintenance of an unscientific and antiscientific posture', and that this represented 'a pragmatic mechanism designed to protect the cherished ideological convictions of the EBM community'.

Despite our best intentions, people don't seem to care all that much whether professional organisations like the APA claim that physiotherapists shouldn't be stretching frozen shoulders. Physiotherapists will carry on doing it, the public will continue to expect it, a doctors will still refer patients for it.

Some have argued that the Choosing Wisely campaign, and its many EBM siblings, are primarily vehicles designed to reinforce the authority of the medicine to maintain dominion over health care; to promote a biomedical way of thinking about these problems, and minimise the importance of 'other' ways of thinking about health. Increasingly these decisions are inflected with justifications based on the need for cost and time efficiency, and the need to focus on those treatments that really work. But what other discourses are being lost along the way?

I worked for years on acute medical and surgical wards, and the routine use of incentive spirometry was something we'd stopped doing years ago. That didn't mean to say that we got rid of the devices from the department though, because there were always the odd patients who they worked for. The skill was to know when to use them and when to try other things.

Proclamations from 'experts' are all well and good, but they tend to be seen by professionals as overly simplistic rules-based prescriptions that ignore the local context and the ability of the practitioner to think for themselves. Added to this, and despite practitioners paying lip-service to EBM, most practitioners know that what is proven to be good for us today, will be

frowned on someone tomorrow. One only has to look at the history of massage to know that its popularity has nothing to do with evidence for its efficacy.

> Massage, since it is instinctive, is the oldest of all remedies, yet of recent years it has tended to lose popularity during a period in which new, and in the main less efficient, remedies have been given trial. Now the pendulum is swinging back again...This is as it should be; we cannot afford to let drop into disuse the oldest and most valuable element in our armamentarium of physical treatment. Mennell, J. (1943, p.470).

In one of those supreme ironies, there is actually little evidence that evidence actually changes anyone's behaviour. And because experts never acknowledge this, we play out a continuous game of truth in which we pretend that expert opinion matters, while all the time doing it the way that makes most sense to us in the context of our own daily lives. And the bizarre rules of this game depend on experts being the ones to break the spell, but we don't listen to what they say, and so it goes on.

Two recent book reviews in the excellent journal Nursing Philosophy recently tackled both of these problems from different directions. The first looked at Martin Lipscomb's latest book Exploring evidence-based practice: debates and challenges in nursing (link). The other looked back on Patricia Benner's seminal 1984 text From Novice to Expert and asked whether Benner's expert nurses were 'near extinction' (link). In both cases, the focus is on the role of the expert and their ongoing relevance as vehicles for reassurance and certainty in increasingly uncertain times.

Societies appear to want something more nuanced; more sophisticated from their experts than the kinds of crude proclamations being issued from professional bodies and well-intentioned expert committees. Should we, as critical-minded practitioners, be doing more to provoke these groups to aim higher in future?

Reference

Mennell, J. (1943). Massage, movement and exercises in the treatment of nerve suture and repair. In W. B. Doherty & D. D. Runes (Eds.), Rehabilitation of the war injured, a symposium (pp. 470-482). New York, Philosophical Library.

What skills are you losing?

19 April 2016

In a recent article by titled *Listening-touch, Affect and the Crafting of Medical Bodies through Percussion*, Anna Harris discusses the effect that technology has had on the loss of doctors'

physical assessment and treatment skills. The article focuses on the technique of percussion - the 'listening touch' as she calls it, that comes from percussing the chest to perceive the density of underlying tissues. Here's the abstract for the paper, and here's a link to the paper itself:

> Abstract: The growing abundance of medical technologies has led to laments over doctors' sensory de-skilling, technologies viewed as replacing diagnosis based on sensory acumen. The technique of percussion has become emblematic of the kinds of skills considered lost. While disappearing from wards, percussion is still taught in medical schools. By ethnographically following how percussion is taught to and learned by students, this article considers the kinds of bodies configured through this multisensory practice. I suggest that three kinds of bodies arise: skilled bodies; affected bodies; and resonating bodies. As these bodies are crafted, I argue that boundaries between bodies of novices and bodies they learn from blur. Attending to an overlooked dimension of bodily configurations in medicine, self-perception, I show that learning percussion functions not only to perpetuate diagnostic craft skills but also as a way of knowing of, and through, the resource always at hand; one's own living breathing body.

Percussion is a skill still taught to physiotherapy graduates, and is, perhaps still used by many. I wonder, though, how many of you still use it on a daily basis? Do you still have the time? Have other assessment tools and techniques replaced it?

If so, what other techniques have you given up out of efficiency, lack of evidence, or loss of skill?

Like indigenous languages and our biodiverse gene pool, are we losing physical techniques that were once so emblematic of physical therapies? And if so, at what cost?

Reference

Harris, A. (2016). Listening-touch, Affect and the Crafting of Medical Bodies through Percussion. Body & Society, 22(1), 31-61. DOI: 10.1177/1357034X15604031.

It's difficult to innovate in the NHS

28 April 2016

The title of this post comes from a recent story on the CSP's website, celebrating the success of a physiotherapist, Lucy Cassidy, who took the main prize at this year's Advancing Healthcare awards. Her prize was for the development of a virtual fracture clinic at Brighton

and Sussex University Trust. In responding to the prize, Lucy commented that "It's difficult to innovate in the NHS because of financial constraints, and entrepreneurship is often about trying to find a win-win situation with the private sector to support new services." This got me thinking about why it is that the public sector should so often be thought of as such a moribund place for innovation and creativity.

Some years ago, I undertook a research project looking at 'bleeding edge' physiotherapy practices. A bleeding edge practice is one that takes significant risks and attempts to disrupt convention in order to pursue a radically different way of working. They're reasonably common in business and enterprise, where they can attract significant venture capital or crowd funding. They have a high failure rate (hence the idea that they're on the 'bleeding edge'), but can be game-changing if they succeed. Think of Uber, Microsoft or Xero, and you get the idea.

Bleeding edge practices are more modest in physiotherapy, primarily because there's not as much money at stake and the gains are harder to quantify. The profession has a professional code and protective legislation that can limit the ability of an individual practitioner or group to be too creative, and it's often not in the physiotherapist's nature to think too unconventionally.

So we undertook the study with a simple idea of looking at two dimensions of bleeding edge practice: the location and nature of the practice itself (see diagram below).

What we wanted to find were practices that occupied the top right hand corner of this grid. Sadly, we didn't find any.

We began our trawl with some snowball sampling to find practitioners and practice areas that we thought might fit the bill, but it became increasingly obvious that our data would be skewed. Seven of the eight participants were in private practice, and only one was in the public health system. Try as we might, we couldn't find anyone in the public health system who was really doing something innovative and interesting.

Now at this point, I should say that I realise know that there will be some physiotherapists reading this who will say; "Well you just didn't look hard enough Dave. I've been innovating in my practice for the last five years! I've introduced pole dancing/yogalates-light/anti-gravity vibration training* (delete as appropriate), and my patients love it!" Which may be true, but these did not constitute either a bleeding edge practice or location, since they still utilise the same set of activity-related, biomechanical principles that have underpinned physiotherapy for years. They often just do so with a new piece of expensive equipment.

We certainly came across examples of people who had taken conventional practices and relocated them in a different locality (as with physiotherapists working in orthopaedic triage

clinics). And there were people who had changed some of their practices while operating from the same locality (exercised-based rehab in ICU, for example), but no-one we could find was combining the two together; doing something radically different in a different location.

In the end we abandoned the study, which was a real shame, but it pointed to the problem of how restrictive professions like physiotherapy can be. Part of this restriction is built into the nature of physiotherapy itself, but another big part is a feature of the immensely controlling bureaucracy that is publicly funded health care system; a point made all too clearly by Lucy in claiming her prize.

I love the fact that my tax dollar goes towards supporting the health of the whole population, but I do wonder whether it also constrains as much as it enables some times.

RSA Animate - the power of outrosepection

12 May 2016

RSA Animate – The Power of Outrospection is a 10 minute video animation created from a free public lecture given by Roman Krznaric as part of the RSA's free public events programme in 2012.

Krznaric's lecture challenges the idea of empathy as something that is driven by self-interest. He presents an alternative view of empathy as a way of being/doing that can enrich one's own life, but also has the power to produce social change.

I would argue that this reconstructed account of empathy as 'outrospective' is especially relevant for contemporary professional practice because it can help us see how the process of 'walking a mile in another's shoes' is both a personal & a political act that can produce change.

And if you're looking for ideas about how to nurture empathy, there's some interesting food for thought (& action) from Roman Krznaric available as a podcast via the ABC Radio National (Australia) website.

No sex please, we're physiotherapists*

5 July 2016

Late last week, the Physiotherapy Board of New Zealand (PBNZ), released a statement titled *Serious concerns about physiotherapists conduct*.

The statement was prompted after the suspension of a New Zealand physiotherapist for being found guilty of professional misconduct reached the news. The male clinician was found guilty of having sex with a client (details here). He was subsequently fined $5,000NZD, ordered by the Board not to treat female patients, had his practice supervised every fortnight and complete a course about proper professional boundaries, but he was not struck off.

There are a number of striking things about the Board's statement that are worth highlighting.

Firstly, they refer to a "rise in complaints". We have no current data to go on, because all current complaints are confidential to the Board, but the statement would point to the fact that there are a significant number of new cases on the books over and above the normal course of events.

Physiotherapy is a relatively benign profession when it comes to patient complaints. Given the amount of intimate contact inherent in physiotherapy practice, complaints are quite rare. Prior to last week's announcement, there had been no prosecutions with the Health Practitioners Disciplinary Tribunal in five years.

Of the 75 complaints lodged with PBNZ between 2012 and 2015, only a handful have resulted in any action, and mostly this was in the form of an educational update for the practitioner.

Most strikingly, complaints occur among 0.53 to 1.6% of male physiotherapists in NZ, and 0.08 to 0.36% of the female population during that time.

This, of course, does not take into account the number of patient contacts that each individual therapist might have undertaken, in which case the incidence of any complaint would be infinitesimally smaller.

The data also doesn't take into account the possibility that offenders may be offending in a variety of ways or the level of unreported discomfort caused by therapists' behaviour. This echoes the findings of some research work we've been doing with PBNZ recently, which points to the vast ambiguity surrounding the meaning of unprofessional behaviour. Terms like malpractice, discredit, boundary and scope of practice issues are used interchangeably, not only by professional bodies around the world, but also through the scant literature which has looked at this questions critically.

In 2012 I co-authored a paper titled *Discipline, desire, and transgression in physiotherapy practice* (Nicholls & Holmes, 2012), which looked at some of the complexities of touch in physiotherapy and argued for the need for the profession to transgress its traditional restrictions in order that we might better serve future patients.

My belief is that touch lies at the heart of our practice and, without wanting to diminish the effect of this therapist's actions on a vulnerable young woman, cases like this provide an opportunity for us to debate what proper touch means in physiotherapy, and how it needs to be thought about, taught and practiced in the 21st century.

*The title of this post originated in an earlier NZ newspaper report from 1998 when a similar case appeared in the popular media (Guyan, 1998).

SERIOUS CONCERNS ABOUT PHYSIOTHERAPISTS CONDUCT

In light of recent events and the decision of the Health Practitioners Disciplinary Tribunal the Physiotherapy Board of New Zealand and Physiotherapy New Zealand have released a joint statement.

“We are alarmed in the rise of complaints formally investigated – either through a Professional Conduct Committee, or the Health Practitioners Disciplinary Tribunal. The overwhelming majority of these cases relate to sexual misconduct” states Janice Mueller (Chairperson, Physiotherapy Board).

“As Registered Physiotherapists, the public expects the highest professional and ethical standards from our profession. The trust placed in Physiotherapists by patients should not be abused – this is a given” says Ian D’Young (President, Physiotherapy New Zealand).

Professional standards of conduct are in place – the Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct (the Code) – is published jointly by the Physiotherapy Board and Physiotherapy New Zealand. These are a mandatory for physiotherapists practising in New Zealand. The Code states:

“Physiotherapists must not exploit any patient/client whether physically, sexually, emotionally, or financially. Sexual contact of any kind with patients/clients is unacceptable. Physiotherapists must establish and maintain appropriate professional boundaries with patients/clients and their whanau and families.”

Physiotherapy is ‘hands-on’. The public’s confidence in our profession will be seriously damaged if practitioners are not mindful of their ethical and moral responsibilities. PNZ and the Physiotherapy Board are consistent in the message of public safety.

The Physiotherapy Board and Physiotherapy New Zealand are committed to maintaining the highest standards of the profession, and the public’s confidence”

If you are concerned about the conduct of a Physiotherapist we encourage you to contact the Board on 04 471 2610 or through our website.

Reference

Nicholls, D. A., & Holmes, D. (2012). Discipline, desire, and transgression in physiotherapy practice. Physiotherapy Theory and Practice, 28(6), 454-465. doi:10.3109/09593985.2012.676940 (link to full pdf in text above).

Guyan, C. (1998, January 14). No sex please, we're physios. The Evening Post, p. 1

Early IFOMPT

12 July 2016

Last week saw the 2016 International Federation of Orthopaedic Manipulative Physical Therapists (IFOMPT) conference in Glasgow and watching some of the social media feed from the conference I was reminded how far the organisation has come since its inception in the early 1970s, and yet at the same time, how much has stayed the same.

I have quite a long history with IFOMPT. 10 years ago I began a centenary history project with the New Zealand Society of Physiotherapists which culminated in the Society's fabulous virtual archive (link). As part of the project I got to interview about 50 of New Zealand's most prominent physiotherapists. This included interviewing the men and women who had been instrumental in establishing manual and manipulative therapy, and giving New Zealand its enviable reputation for musculoskeletal physiotherapy.

People like Stan Paris, Rob McKenzie, Brian Mulligan, Ian Searle, Ace Neame...all these interviews can be heard on the NZSP's history website.

They also gave me photos from the first IFOMPT meeting in Gran Canaria, when some of the greatest names in manipulative therapy (Cyriax, Stoddard, Greive, Kaltenborn) gathered for a month in Gran Canaria to exchange practice ideas and enjoy each other's company.

I also edited a brief history of the New Zealand Manipulative Physiotherapists Association a few years ago (NZMPA 40th anniversary booklet), and this includes some nice pictures for those of you interested in the history of musculoskeletal physiotherapy.

*In a sad footnote to this blogpost, one of the early advocates and pioneers of musculoskeletal physiotherapy in New Zealand and abroad - Barbara Hetherington - passed away suddenly this morning. Barbara was someone else I interviewed as part of the NZSP centenary celebrations. You can hear her interviewed here.

Among her many accomplishments, Barbara picked up the work of completing the first reasonably comprehensive history of physiotherapy in New Zealand when Enid Anderson

became sick (Anderson 1977) and was a passionate advocate for New Zealand physiotherapists. She will be very sadly missed.

The picture on the left is taken with Mark Oliver and Jill McDowell just two weeks ago when she was still teaching.

Reference

Anderson, E. M. (1977). New Zealand society of physiotherapists: Golden jubilee 1923-1973. Wellington: New Zealand Society of Physiotherapists.

Shitty robots

1 August 2016

A few blogposts ago, I wrote asking why it was that things had to work? Why is it physiotherapists are obsessed with things working.

Well one of our Critical Physiotherapy comrades read the post and pointed me to the beautiful, poetic and entirely useless work of Simone Giertz and her Shitty Robots.

And then would you believe it, but two days later Simone is being interviewed on our local radio station.

Simone builds robots that don't work. Or rather they work, but don't do anything useful. They are the antithesis of all of the supposedly 'useful' (and frankly poe-faced and self-righteous) mechanical contraptions now making their way into physiotherapy practice.

No more prosthetic limbs, bodyweight supported treadmill training or the biofeedback devices. Consider instead the hair washing robot, the toilet paper dispenser, or the chopping machine.

This is surely the future for physiotherapy.

However, there's a snag.

You see I don't believe physiotherapists have the wherewithal to come up with their own Shitty Robots. I think they are too fixated on making things that are practical, ergonomically designed, and, frankly, useful.

So I'm setting the good folk of the Interweb a challenge. I will give a prize to the person who can come up with the best Shitty Physio Robot, worthy of Simone's exacting standards.

You don't have to build it, you just have to come up with the idea.

I'll post all of the best answers on the blog. In fact I'm so confident that physiotherapists are so completely lacking in a humerus that I'll post all of the ideas that pass muster!

Send your ideas via the comments box at the bottom of this page, or post them on Twitter (@CriticalPhysio), Facebook, or send me a good old fashioned email using your new modern convenience bot.

Pensioner's spending on physiotherapy

25 August 2016

A recent study has shown that most Australian retirees spend a similar amount from their household income, regardless of their income and wealth.

The research showed that '80 per cent of retired households reported expenditure levels considered to be the most basic standard living for retirees ($23,797 for singles, $43,226 for couples)' and that 'that contrary to conventional wisdom, expenditure did not appear to decline throughout the period of retirement – i.e. it is relatively constant'.

What this research points to is that high-income earning households spend about the same as low-income households, thus saving a considerable amount more from their gross income.

Clearly this could have an effect on lower earning pensioners' access to services like physiotherapy in the future.

Healthcare is considered an 'essential' in the report, while leisure and recreational activities are considered an 'extra', so it may be that physiotherapists sees no appreciable decline in uptake from older adults with the gradual move away from publicly-funded health care.

If, however, physiotherapy comes to be seen by older adults as an expensive luxury, because its fees rise beyond that which pensioners are prepared to pay, then physiotherapists are likely to notice a significant impact on their work.

Perhaps more significantly, large proportions of the older adult population will be denied physiotherapy and may choose to turn to other, cheaper, more risky therapeutic options.

Given the increasing burden of chronic illness among the elderly and the growth in the proportion of the population that is over retirement age, it might pay physiotherapists to take heed of research like this when thinking about how to meet the needs of the whole population in the future.

Physiotherapy and the poverty of aged care

13 October 2016

An Australian senator claimed a few days ago that one-third of all pensioners in Australia were living in poverty. If this is correct, it is a shocking statistic for a developed country like Australia, and a wake up call for professions like physiotherapy, which needs to have a voice in the discussion about the future of aged care.

The Australian online journal *The Conversation* checked the claims made by Senator Jacqui Lambie, and agreed with her assertion, citing a 'widely reported OECD Study - Pensions at a Glance 2015' which showed that, 'According to the latest available figures, poverty rates of people aged over 65 were very high in Korea (50%), Australia (34%), and Mexico (27%). In contrast, the Netherlands and the Czech Republic have the lowest poverty rates: 2% and 3% respectively'.

In an interview in The Guardian back in June 2014, CSP Chief Executive Karen Middleton argued that 'the real crucial added value of AHPs (Allied Health Professionals) is not simply in adding years to life, but life to years', a theme that was picked up at a recent *Physiotalk Tweetchat*.

Physiotherapists have not always seen their profession as overtly political. But few who have been involved in the backwash from the Global Financial Crisis, or who have read about the likely impact of ageing, increasingly chronically ill populations of people, placing greater and greater demands on an overstretched public healthcare system, can be unaware of the risks of leaving the politics of aged care to someone else.

As health systems become more devolved; everyday healthcare work gets taken up by low-skilled workers, family members and friends; and people demand more from their health professionals than just technical skill, there is the potential for the radical transformation of what physiotherapy is and does. Aged care may well offer a paradigm case of how the future of orthodox healthcare will look. But there is a real risk - as with all of the healthcare reforms taking place today - that only those who can afford physiotherapy will have access to it in the future.

Given that all of the social determinants of health are dramatically worse in those living in poverty, there is a chance here for physiotherapists to show some advocacy and use their position to lobby for change.

Trump, Brexit and physiotherapy

18 November 2016

Like most people, I'm still feeling the shock of Donald Trump's US presidential election win last week. Once all the dust has settled, and people have started to face up to what has been called the 'post-truth' era in politics, there will have to be some real soul searching about what this all means for the future of our societies. Big issues like environmental degradation, personal security, tolerance for others, and health, will play out alongside more 'local' issues like paying the weekly bills, dealing with family problems, and managing our busy lives.

Amidst all this 'noise' its worth reflecting on something subtle but highly significant about this recent election and the Brexit vote that took place in Britain in late June, and that is the decline of truth, as we have come to know it in the 'developed' countries of the West, as a meaningful discourse in 21st century life.

Donald Trump's running mate and Vice President elect Mike Pence recently wrote that it was 'Time for a quick reality check. Despite the hysteria from the political class and the media, smoking doesn't kill. In fact two out of every three smokers does ((sic)) not die from smoking-related illness and nine out of ten smokers do not contract lung cancer'.

There's ample that Pence is wrong about this, and that his views on environmental and human rights are divisive, discriminatory and bigoted. But that hasn't stopped him rising to the top of one of the world's most powerful political offices or influencing millions of people with his beliefs.

Indeed, so tenuous were some of the statements made by both sides in the recent US election campaign that the Pulitzer Prize winning website *Politifact* developed its own Truth-O-Meter™ to show how egregious some of the statements made by the candidates were.

Truth, as we once knew it, has clearly been in short supply these last few months. But what's not clear is whether we have actually arrived at a 'post' truth era, or whether we are all just more comfortable with a plurality of truths: truths that depend on one's perspective and orientation, values and beliefs.

There was once a time when most people placed enormous faith in powerful institutions like the church, doctors and lawyers, teachers and the police, to tell them what was right and wrong, good and bad. But can we say the same is true today? With frequent abuse scandals, and evidence of malpractice, ethical breaches and the misuse of power by people in authority, do we really still believe that the doctor/priest/judge knows best?

Added to this, since the end of WWII there have been growing calls from women; people of colour; gay, lesbian and transgender people; disabled people; indigenous people and those

born into social disadvantage, to have their voice heard and to throw off the false truths that positioned them as 'other' in society.

These calls have been amplified by the distributive perspectivism of social media and what Silverman and others have called an ‘interview society’ (Silverman 1997; Gubrium & Holstein 2002, p.9).

But why does this relate to physiotherapy?

Well, perhaps one of the most salient effects of all of this change is the way truth is now being conceived. Physiotherapists are wedded to a model of truth that is intimately linked to reason, logic, and a fair degree of detached objectivity. Our belief is that if we can demonstrate through empirically-supported evidence that our interventions 'work', then this will be enough for government and third-party funders to support us, and for the public to choose us over the competition.

It may be reasonable to argue that people will default to this belief system when it comes to health, because it either matters more to them than climate change, terrorism and poverty, or because it matters less (and so they are happy to hold on to outdated beliefs in 'facts' simply handed to them by health professions). My personal belief, though, is that people do not make these kinds of distinctions, and are reasonably consistent in the way they manage and filter the information they receive and decide to act upon. And there is no doubt that we're all far more cynical in the face of authority than we used to be.

Given this, the US election and the Brexit vote suggest that we may have finally crossed a Rubicon when it comes to the way we think about truth, and the old security of authoritative, didactic, expert-derived professional knowledge that has so long provided security in the face of doubt may be damaged beyond repair.

If that's the case, physiotherapists and others are on to a losing battle if we think that empirical evidence for the efficacy of respiratory training in patients with multiple sclerosis and lateral amyotrophic sclerosis will be enough to influence people's opinion, or that science-based arguments that education, exercise, and weight loss are considered core treatments in the management of OA (link) will be sufficient in the post-truth world.

And if we aren't doing this work to influence people's opinion, what are we doing it for?

Without a hint of irony, Mike Pence explained why he thought Americans were flocking in numbers to see the movie Titanic: "We love this movie because we still love truth" he said.

So it seems. But in a post-truth world, this simple fact may be the only thing we share with Pence, and we're all the better for it.

Reference

Gubrium, J. F., & Holstein, J. A., 2002, From the individual interview to the interview society. In J. F. Gubrium & J. A. Holstein (Eds.), Handbook of qualitative research (pp. 3-32). Sage, London.

Silverman, D., 1997, Qualitative research: Theory, methods and practice. Sage, London.

How to be an expert in physiotherapy today

22 December 2016

There was an interesting collaborative blogpost by Jarod Hall a few days ago. Titled *Knowledge Bombs for a Successful Clinical Career* it summarised a great collective effort by a number of experienced clinicians looking to summarise some of the key tenets of current clinical practice.

Some of the summary points were that good clinicians build therapeutic alliances and actively ('truly') listen to their clients; that clinicians are experts at the basics and should not take the blame for patients not getting better; and that education and exercise are key.

There are many things to like about this blogpost, not least the collaboration between colleagues and the earnest attempt to offer suggestions for how practitioners might improve.

I particularly liked how the piece provided an inverse, and perhaps unintended, critique of physiotherapy. If physiotherapists were already masters of 'truly listening to their clients', for example, then surely this would not have even been mentioned by the participants. So perhaps the list of recommendations could also be read as a list of critical comments on the profession at the moment? (It needs stating that we need to truly listen, because we aren't currently doing it enough).

As well as this inversion, I had a number of more substantive issues with the post. The first was that the advice offered was rather non-specific and really could refer to any practitioner. Indeed, much of what was suggested here has been written about in the work on the sociology of professions for more than half a century now. Take the work of Elliot Friedson on medicine (and the subsequent development of narrative medicine and psychology that let to so much illness biography work since the 1990s), or Patricia Benner et al on nursing. And we should not forget the stellar contribution of people like Joy Higgs, who pioneered much of the work on the craft/tacit knowledge implicit in physiotherapy expertise.

Secondly, as far as I can see, only physical therapists were approached to offer comments. It would have been nice to have seen some of the views of professional colleagues and clients who, I am sure, would have reinforced many of the comments here.

In many ways, the findings of this mini-survey were a simple form of qualitative research, so finally it would have been good to get a sense of the Jarod's own positioning in presenting his findings. Why were these quotes chosen and not others? How did he arrive at the broad themes that emerged? What is his own view?

From a meta critical perspective, it seems clear now that we are moving to a new era in physiotherapy, and texts like this provide an insight into some of the challenges ahead. The once dominant manual, sports and musculoskeletal physiotherapies are rapidly being supplanted by therapies focused on more three-dimensional, embodied and complex practices that are well suited to clinical problems like chronic pain, which has become the syndrome of choice for a lot of therapists wanting to exercise their expertise. How we talk about our work and our relationship with clients and other funders, then, will do much to define our practice in 2017 and beyond.

The NHS in crisis

9 January 2017

Firstly, a very happy New Year to you one and all. Here's hoping you had a restful and peaceful break and you are looking forward to happy and rewarding 2017.

The New Year has unfortunately arrived with the latest saga in the slow exsanguination of the UK's National Health Service. Over the last few days, the Red Cross - an entirely apolitical organisation it should be remembered - has announced that the public healthcare system in the UK is experiencing a "humanitarian crisis" (link), a comment fully endorsed by the British Medical Association but fiercely rejected by Prime Minister Theresa May.

Whilst it would be wrong to put all the blame for the current crisis on the present government, the ruling Conservative Party have done little to slow the 'progress' made by previous governments - Conservative and Labour - in devolving health care and disassembling systems and services that took decades to build up.

Despite its many failings, the NHS remains a signal feature of cultural life in the UK. It has been one of the country's biggest employers; it has saved countless lives and helped millions more return to health and wellbeing; it has developed the careers of thousands of brilliant clinicians; and been a platform for innovation, excellence and growth.

The reality is, though, that the voting public keep electing politicians who campaign on tax cuts, and you can't have good public services like parks and libraries, well tended roads, free schooling, pensions, and a first class healthcare system - no matter how efficient or 'lean' the organisation - unless you're prepared to pay for it.

It's not enough to blame politicians for the decline of the public health system, since they are only acting on whatever steer they are given by the voting public, and everything it seems points to the fact that the public would rather have money in their pockets to make their own choices where their health dollar is spent, than give it to politicians and bureaucrats whom they no longer value or believe.

Still, for a country like the UK to now be experiencing a humanitarian crisis in its healthcare system does beggar belief. After 75 years of the National Health Service, to now see it in morbid decline is an ignoble and truly saddening end for this once great institution, and one wonders what this will mean for the millions of people who will soon lose benefit from high quality healthcare, free at the point of delivery.

10 reasons to love physiotherapy

18 January 2017

There is quite a lot of pessimism and negativity among healthcare professionals at the moment. Reduced funding, job cuts, professional encroachment and general uncertainties about the future are having a bad effect on people's health and wellbeing. So I thought it might be a good idea to take a moment to remember what makes physiotherapy so great. Not all of these things will be relevant to every physiotherapist, but most will.

Physiotherapists:

1. Touch people. Very few people can do this, and almost no others get to touch people for therapeutic reasons. Some touch to perform a procedure, others to care, but few touch to reduce pain, help move or build strength, flexibility and power;
2. Transform people's lives. Perhaps the most powerful effect of really great physiotherapy is its ability to help people feel different: to give them confidence to try something that's been too painful or frightening to do for a long time; to take control of their lives; to breathe more easily; to stand on their own again; to move more freely; to be happier...Physiotherapists do this every day, and rarely give themselves the credit they deserve for their transformative power;
3. Are first contact professionals. Few others, outside medicine, have this privilege. Awarded after many years of struggle and tests of our autonomy, first-contact status isn't available throughout the world for physiotherapists, but it's available in many countries. It's a mark of our social capital and the high regard physiotherapists are held in by society at large;
4. Are diagnosticians. Because many physios can see people without a medical referral, they need to be able to differentially diagnose. That skill comes with a lot of

expectations about physiotherapists' safety, and ability to show consistently that they can handle the responsibility;

5. Are safe and trusted. People trust physiotherapists. We deal with some of the most intimate, personal aspects of people's lives - from death and dying, to personal bodily dysfunction and the heartache of suffering, and act as a constant companion in times of strife;
6. Are powerful advocates. Because physiotherapists have earned a high degree of social support, they can speak up for those less fortunate, and advocate for people whose voices are not being heard. Marginalised communities, children, the elderly, disabled people...whomever they serve, countless people benefit from physiotherapists' voice and support;
7. Are experienced. One of the greatest assets physiotherapists have is their access to the public health system. Working with people who have had strokes, or live with COPD, chronic low back pain or depression helps when it comes to treating the elite athlete, the child with cerebral palsy or the post-op patient. Experiencing the rich tapestry of life gives physiotherapists enormous advantages over many other healthcare professions;
8. Work with people, not just bodies. All good physiotherapists know that it's not enough to treat the body-as-machine, or to look no further than anatomy, physiology and pathology when treating people. To know people as social beings and the ways that our feelings, thoughts and emotions affect how we feel makes the difference between being technicians and practitioners. And physiotherapists are fabulous practitioners;
9. Are inclusive. Physiotherapists have worked in teams and been dependent on the help of others from the outset. They are good at knowing their limits and not stepping on others' toes. They're often seen as pragmatic, enthusiastic and motivated people who like to get things done. As they have shown for many years that we make great allies;
10. Are adaptable. No matter how difficult things seem right now, people will always want someone to use their hands in skillful, caring ways to heal them of their suffering; they will always want people who can see them move and work out what is going wrong; and they will always call for professionals they can trust, who care for them, not just their illness.

Physiotherapists are all these things and more, and we should try to remember this when the day-to-day pressures of work make it hard to see the wood for the trees.

Is there anyone better placed than a physio?

24 January 2017

Thank you to everyone who responded to our last post on 10 reasons to love physiotherapy. These are strange and unsettling times, and it helps sometimes to be reminded of the good things that we do.

This post follows on from last week's, asking the question whether there anyone better placed to take advantage of the changing face of healthcare than physiotherapists. Physiotherapists can sometimes forget how perfectly their skills and abilities line up with what people will want in the future, and we have perhaps been our own worst enemies in ignoring or minimising the power of some of these things in the past.

So ask yourself this*:

- Are doctors better placed than physios to be at the heart of future healthcare? Doctors are orthodox health professionals and our primary diagnosticians, but their focus is on the body's biochemistry or its surgical repair. Not everyone needs such specialised intervention, they are expensive to train and consult, and many people are now looking for something much more humanistic, personal and embodied for their care;
- So are nurses the future? Perhaps. Like doctors, they are a large, orthodox profession, and much loved by the public, but they aren't diagnosticians or therapists, so while many embody care, their focus is not purposefully rehabilitative;
- What about other rehabilitation workers like Occupational Therapists and Speech and Language Therapists? They too will play a part, but their professions are small, specialised and not first contact professions;
- How about the 'psy' disciplines (psychology, psychotherapy, counselling, etc.)? These have certainly captured public interest and connected mental health with people's lived experiences, but their focus is on the mind and they recoil at approaching the body or using any form of physical therapy;
- Perhaps some of our musculoskeletal colleagues and competitors have the advantage? Certainly osteopaths benefit from some mainstream attention unlike chiropractors, who remains marginal. But both are anchored, like podiatrists, midwives and dentists, to a single body system or region, and could never be considered 'holistic';
- What about the exercise therapists, physiologists and personal trainers then? Certainly these have recognised the importance of maintaining health through activity and function, but they lack the clinical experience physiotherapists get from their work in the public healthcare system, many are unregulated and the quality of care can be very variable.

So if we know that people will always want someone who can use their hands to soothe and heal; who can differentially diagnose and advise from a position of trust; who can prescribe programmes that account for people's co-morbidities; who can speak the language of orthodox healthcare system and knows how the body works; who can be a generalist or a specialist as the need arises; who can practice without masses of expensive equipment; who can spend time with people, listen and support them to help themselves; and who can cut through all of the complexity of choices now available to people to find a sensible, workable plan; my question is who is better placed to do all of this than a physiotherapist?

*Lest we get carried away with self-congratulation, it's probably worth remembering that the future of healthcare is collaborative and that physiotherapists won't be at the centre of the reforms unless we do something about it. So there is a blogpost coming which is perhaps less celebratory and asks 'why are we not there yet?' There's no doubt we need to turn the focus back on ourselves if we are going to open some doors to an 'otherwise' physiotherapy. Until then, perhaps reflect on some of the many things physiotherapy does do well, and have at their disposal as the New Year beds in.

All feedback is projection

16 February 2017

I spend a lot of my time at the university these days working with psychologists and psychotherapists, and one of the things I am always struck by is how much of what they learn could be applied to other healthcare practices, especially professions like physiotherapy.

The quote in the title; 'All feedback is projection', for example, was told to me by a psychotherapy colleague who was explaining how it is that people will give you feedback from their own perspective but, more often than not, what they're really doing is projecting their own values and beliefs and its not ever entirely about you.

I've thought about that a lot when I've reflected on the advice I've been given by people throughout my career, or the feedback I've given to patients and students. How much of it was really just projections emanating from, but really directed back at myself I wonder?

Ideas like transference (the projection of thoughts and feelings associated with past experiences onto another person), and counter-transference (the therapist's emotional responses to the client and their issues), have profound significance in the 'psy' disciplines but hardly feature in physiotherapy training.

Psychotherapy is very much about insight, both the therapist's ability to engender deeper insights in the client, but also gain better insights about themselves.

Central to this process is supervision. In the university, students see clients and have supervisors who meet them regularly to review their work and help them explore their growing personal and professional identity. The supervisors, in turn, have their own supervision, to help them explore their own thoughts, reactions and reflections. And on it goes.

Staff and students alike receive support to explore their anxieties and fears, emotional blind-spots, cultural challenges, spirituality, sexuality, experiences of mental illness, relationships, subjectivities, etc., and the whole programme is built around relationships.

By contrast, reflective practice work and supervision are only relatively recent developments in physiotherapy. And while many institutions, organisations and professional bodies appreciate the value of such practices, curricula and scopes of practice remain dominated by the necessity of learning all of the accumulated 'stuff' about the biomechanical body that dominates people's beliefs about what physiotherapy 'is'. The result is often that the humanistic dimensions of practice, for clients, students and practitioners alike, is sublimated in favour of technical competence.

Most experienced practitioners know, though, that technical skill will only take you so far in 'real' clinical practice, and to become an expert practitioner you need to nurture the whole person. It would be nice to think that physiotherapists in the future learnt this because of their training, not despite it.

Doctor knows best

15 March 2017

Not so long ago, physiotherapists had a very close, perhaps paternalistic, relationship with the medical profession. But it seems now that our quest for professional autonomy is pushing us further away from physicians and surgeons. There are few in the profession, I think, that would dispute the obvious benefits of greater independence for physiotherapists, but this is a critical ideas blog, so I'm going to do just that.

Physiotherapy has, for much of its history, been wedded to medicine. Indeed, the modern physiotherapy profession only survived and later prospered because its founders made subservience to medicine a condition of entry. Memberhip of the Society of Trained Masseuses (STM) - formed in 1894 and the forerunner of all physiotherapy professional bodies around the world - required that everyone sat the STM's stringent examination. Doing so cost a lot of money and effort, at a time when anyone could practice as a masseuse with just half-a-day's training. So why did people submit to the Society's exam? The answer is that the STM had secured the patronage of many esteemed medical men, so that members of the

Society could be assured of legitimate 'health' cases to treat, and could distance themselves from quacks and prostitutes (see Nicholls and Cheek, 2006).

Medical patronage served the profession well during both World Wars; the epidemics, economic depressions and medical advanced of the inter-war years; and the birth of the welfare state, but by the 1970s, people within the profession wanted more control over their own professional affairs. Moving training from national health budgets into higher education and the growth of profession-specific research hastened the separation, and now, today, physiotherapy finds itself at something of a crossroads.

With diminishing funding having such a profound impact on health services in many developed countries, questions over the evidence underpinning many (bio)medical therapies, and people being much more skeptical about medical authority (see this, and this, for instance), the Chartered Society of Physiotherapy (CSP) in the UK this week complained that 'NHS patients needing physiotherapy are being forced to attend millions of unnecessary GP appointments for a referral'.

In the press release that accompanied the report, 'Prof Karen Middleton, chief executive of the CSP, said: ‘GPs are facing ever-increasing pressure yet out-dated rules mean they are still forced to see and refer patients who should instead be seeing a physiotherapist as the first point of contact'.

There are clear and compelling arguments that patients should have direct access to suitably qualified physiotherapists (i.e. those who train in differential diagnostics and have a broad medical-based training; a training that is not available in every country). But might there be something to be gained from taking the exact opposite route?

Physiotherapy faces many of the same pressures it prospered under more than a century ago: competition for clients; horizontal and vertical encroachment from other variously qualified practitioners; challenges to its specialised knowledge; etc. Its answer 100 years ago was to align itself with the profession that it thought could carry it forward. Certainly it marginalised some ways of thinking and practicing in tying itself so closely to biomedicine, but it gained others, and those 'others' helped make physiotherapy the profession it is today.

Certainly moves to 'share' in the work of medicine (as in this, for example), illustrate that physiotherapists still see themselves as primarily biomechticians (a new word I think I might have just invented). So perhaps now might be a good time to rethink our separatist agenda, and look to our past to find new ways to align ourselves with biomedicine in order that we can secure the profession's future for the next century or more?

Reference

Nicholls, D. A., & Cheek, J. (2006). Physiotherapy and the shadow of prostitution: The Society of Trained Masseuses and the Massage Scandals of 1894. Social Science & Medicine (1982), 62(9), 2336-2348. doi:doi:10.1016/j.socscimed.2005.09.010

”Seated physios giving advice on exercise to patients over the phone" - a follow-up

6 April 2017

I posted a tweet about a small bit of news from the Chartered Society of Physiotherapy (CSP) that had caught my eye yesterday. It was about 'A telephone assessment service in Cambridgeshire that is helping more than half of its physiotherapy patients to self-manage their conditions'. It featured an image that I thought was interesting and just a little ironic.

My comment on Twitter was that this was 'a thing of postmodern beauty', and both the picture and the full report raised the ire of some in the Twitter community.

There were a number of things going on in this report that I think said some important things about the present state of the physiotherapy profession.

Firstly, there was the 'delicious irony' as Glenn Ruscoe (@GlennRuscoe) called it, of seated physiotherapists telling people to do more exercise, but there was also the sight of a profession, that was once synonymous with physical work, delivering advice down the phone. Randal Glaser (@randalglaser) suggested that we had 'discovered how to turn our active job into a desk job!' and @7Calypso asked 'whatever happened to hands on treatment?' Rebecca Nygren (@BeccaNPhysio) expressed her 'despair', a sentiment shared by Tim Budd (@TimBudd) who thought that it was a case of 'more patients "seen", more money "saved"'. Roger Kerry (@RogerKerry1) summed up the feeling of many when he wrote 'Seriously? Come on #Physiotherapy profession, you're better than this'. Matt Webb (@mattcwebb42) advised us to 'Forget the phones. Doesn't work and never will', and David Evans (@drdavidevans) echoed Roger's comment, saying 'I have serious concerns that continuing along this path, the #physiotherapy profession is in danger of obsoleting itself'. Nicholas Clark (@DrNickCC) concluded that 'This type of service evolved as waiting list crisis Mx strategy; its not "moving" & shouldn't b where we aim as a profession'.

Others, however, spoke against these negative portrayals. Todd Davenport (@sunsopeningband) was 'Confused. Sitting down is impermissible for physical therapists? Putting them on a treadmill would be better?' And @TherapyGirl5 said 'Hold up... Forget the image. Before judging... the real issue, more people are being reached vs high wait times' and that this was evidence of a 'Great process happening. People getting care and advice sooner.

Nice touch point happening. May reduce chronic problems too'. David Hart (@hartphysio) argued that '"it's better to keep moving". = valuable contact time saved. The profession is moving with demands #Physiotherapy'. Martin Docherty (@MartinDocherty2) agreed, arguing that it was 'Just one of many ways profession are interacting with pt's to identify those who will benefit from self-mgmt.

This is only a summary of the responses, and there were other side conversations going on, where people disputed the inevitable polarities in the argument. But what they suggested for me was actually a growing sense of maturity in the way that we are now debating healthcare reform.

It is clearly impossible to say that initiatives like this are either simply good or bad. All we can really say is that they are problematic and worthy of debate and discussion. It clearly shows, for instance, a profession confronting the rapidly changing economy of healthcare in innovative ways. It challenges our presuppositions about physiotherapy as a 'physical' occupation, and suggests that physiotherapy can also be something delivered down a phone line or wifi connection. But it also suggests a double standard, where young, fit, able-bodied professionals use technologies of affluence to 'offer advice' - with all the emotional and psychological overlay that comes with that - to people who are probably less fortunate than they are. It also plays into modern paranoia about sedentary behaviour in some deeply ironic and humorous ways. It also suggested that although this was a telephone service, the practitioners hadn't forgotten the importance of good posture and wearing a proper uniform!

Stories like this then are gold, because they say important things about where the profession is going and, perhaps without really thinking about it, hold a mirror up to ourselves and reveal how our face is changing.

The case for caring activism

2 May 2017

A recent review of Peter Limbrick's new book made me think about some of the anxieties many of us are now feeling about the slow bleeding out of publicly-funded healthcare, and what it might mean for the future of professions like physiotherapy.

A full review of the book, titled *Caring activism: a 21st century concept of care*. A proposal for citizens to join together to support vulnerable children, teenagers, adults and elderly people, can be read here, but what particularly struck me were these two opening paragraphs;

> Peter Limbrick's Caring Activism argues the case for what he calls 'a new concept of care I am proposing for vulnerable people in this 21st Century'

> (13). Limbrick identifies that some countries are experiencing reductions in funds for public services while numbers of vulnerable people continue to rise. In the United Kingdom, a ‘dramatic reduction in support available’ from public agencies means that increasing numbers of vulnerable people are falling through the safety nets. He points, in particular, to teenagers in care homes, elderly people living at home and refugees.
>
> Limbrick suggests that a potential response to this lies, not in further burdens on overstretched statutory agencies, but in the power of a concerned citizenry. He envisages what he calls caring activism, ‘a concept relying on citizens holding particular beliefs about rights and responsibilities and about the sort of world they want to create for this and future generations’ (35).

Many of our patients are as vulnerable as those highlighted in the book, and so it probably follows that many of the points made about the need for caring activism are as valid in the Stroke Unit, per se, as they are in the care home.

So I'm interested in Librick's argument that the statutory agencies can't be asked to do more, and that we need other 'agencies' to step up. (Here I'm assuming that 'statutory agencies includes profession's like physiotherapy).

My reading of this is that he sees a much bigger role for non-traditional providers of healthcare in the coming years, and a much broader umbrella of services offering what used to be much more centralised. As always, the primary driver of change appears to be economics, and the perception that our historically-established model of orthodox healthcare is becoming increasingly unaffordable.

Caring activism could be a good thing then, because it might make care more affordable to vulnerable populations (people in long-term pain, infirm elderly, people with long-term disabilities, etc.). By the same token, it might rely on registered professionals to 'share' their competencies with others and diminish their social capital.

Following on from the post thread over the last week or so, it waits to be seen, therefore, whether physiotherapists will see the emergence of democratising processes like caring activism as a good or bad thing: an opportunity or a threat.

Assault and battery

23 May 2017

A report in The New York magazine last week speculated on the likelihood that President Trump might die in office because he is one of the least active presidents in human history.

How, you might ask, has this got anything to do with physiotherapy?

Well, the President of the United States, it seems, holds a view about the body, and the detrimental effects of exercise, that was popularised by some of the same 19th century physicians that made physical therapy popular.

It seems President Trump 'considers exercise misguided, arguing that a person, like a battery, is born with a finite amount of energy'.

There's a lovely historical overview in The Guardian about this rather arcane notion, and in it we're reminded of the powerful idea that underpinned much of the physical medicine that was the forerunner of our practices today.

In the late 19th century, electrotherapy devices like Galvanic and Faradic batteries were used to restore people's lost energy: the reason we talk about people feeling galvanised, charged up or run down today, for example. Energy could be lost through mental work, and women were especially vulnerable because so much energy was needed for procreation, that all other forms of mental activity - even from early childhood - were frowned upon.

It is well understood now that such notions were thinly veiled attempts to subjugate an entire gender, concealed beneath the veneer of paternalistic care. Such attitudes were more than just quaint affectations, and many had profoundly serious effects on the wellbeing of thousands of women.

Hysteria disease and neurasthenia - two of the primary conditions treated by early physiotherapists in Britain and America - primarily affected women, and people like John Harvey Kellogg (of Cornflake and Battle Creek Sanitarium fame) and Silus Weir Mitchell (perhaps America's foremost 19th century neurosurgeon), were pioneers of treatments that supposedly restored women to full health.

Pivotal in Weir Mitchell's treatment regime, known as the Rest Cure, were the passive modalities (massage, passive movements, and electrotherapy) delivered by early nurse/masseuses. And these modalities endured for the larger part of the 20th century.

Galvanism and, to a lesser extent, Faradism were still being taught in physiotherapy schools into the 1960s, even though they had long since been used for other things than depleting lost nervous energy. But it seems that ideas about our bodies being stores for certain quantities of nerve 'force' may be harder to shake off.

We should be careful not to be fooled again into thinking that such seemingly benign ideas are not smoke screens for more pernicious and dangerous thoughts and practices.

Exercise is medicine

13 December 2017

There has been a flurry of interest in the value of exercise as a therapeutic remedy in some sections of physiotherapy social media in recent months. Some of this, at least, appears to be a reaction to what have been called 'passive' treatments, and a neoliberally inspired desire to see people take more responsibility for their future health and well-being.

Exercise is clearly a very valid and appropriate intervention for some people. It has been for as long as human civilisation has walked erect, and it almost certainly will continue to be useful into the future.

But a recent special edition of the journal *Qualitative Research in Sport, Exercise and Health* has cast doubt on some of the idea that exercise is obviously beneficial and 'good'.

In a paper published a few days ago titled *Exercise is medicine? Most of the time for most; but not always for all*, the authors argue that, 'health professionals, academics and policy-makers need to prescribe to more ethical forms of exercise promotion that may lead to more efficacious, person-sensitive interventions', and that 'It is important to scrutinise the broad discourse of EiM as grand narratives like this can run unchecked ... despite their power to shape cultural, institutional and personal practices'.

As part of this special issue, a number of *Critical Physiotherapy Network* colleagues have collaborated on a paper that looks at some of the unforeseen harms of therapeutic exercise. In the paper, titled *Keep fit: Marginal ideas in contemporary therapeutic exercise*, myself, Patrick Jachyra, Barbara Gibson, Caroline Fusco and Jenny Setchell argue that;

> Exercise has a long history as a therapeutic modality and has existed, in some form, in all cultures throughout recorded history. In recent years, therapeutic exercise has taken on new significance as a relatively low cost medical intervention designed to improve people's health and wellbeing and reduce the downstream effects of comorbidity. Drawing our inspiration from Foucault and Deleuze, we argue that seeing therapeutic exercise as primarily 'medical' carries with it consequences – some recognised, others unseen – that are problematic and worthy of consideration. Our focus is on the acts of marginalisation, exile and exclusion implicit in the quotidian practice of therapeutic exercise, and how these acts mediate people's daily lives. In the paper we explore how therapeutic exercise is being instrumentalised, normalised and constrained, arguing for much greater

> critical attention towards its putative 'goodness' and virtue as a health intervention' (Nicholls et al, 2018).

What is so important about this kind of work is that it challenges the taken-for-granted obviousness of people's claims that one modality is in any way superior to another, or that simple weight of evidence is enough to undermine the truth claims of one group and privilege another. It is highly likely that exercise based rehabilitation will be a feature of physiotherapy practice long into the future, but that does not mean that it is unquestionably good or superior to other modalities, and such claims are likely, themselves, to be overwhelmed by new ideologies before too long.

Reference

Nicholls, D.A., Jachyra, P., Gibson, B.E., Fusco, C., & Setchell, J. (Forthcoming, 2018). Keep fit: Marginal ideas in contemporary therapeutic exercise. Qualitative Research in Sport, Exercise and Health. doi: 10.1080/2159676X.2017.1415220

Divorce rates among physiotherapists

31 May 2018

This isn't the kind of material this blog usually deals with, but there's something fascinating in this recent report from Nathan Yau at flowingdata.com.

The report looks at divorce statistics across different occupational groups and shows some interesting things about physical therapists in the United States. How much the findings can be extrapolated to other populations is debatable, but my sense is that there are some sociological principles at play here: perhaps about the linkage between one's profession, education and income and life fulfilment, that needs to be considered.

The first set of data looks at divorce rates by occupation, and physical therapists come out with some of the lowest prevalence of divorce across all the listed occupations.

Physiotherapists, along with software developers, physical scientists, and optometrists make up some of the least divorce-prone occupations, whereas flight attendants, telemarketers, gaming cage workers and, interestingly, massage therapists make up some of the highest.

The report goes on to speculate whether one's educational level is a factor, and points us to a report from 2016, that looks at divorce rates by employment status, education, and race. Again, the data is from the U.S. but also reveals some interesting sociological phenomena.

For instance, being unemployed increases one's chances of being divorced or married more than once, but also closes the gap between men and women.

Having a post-school qualification reduces your chances of getting divorced, but the effect of advanced study (masters and beyond) is less noticeable.

One's salary also appears to play a part. In Yau's analysis, there is a subtly inverse relationship between divorce rates and salary, with those earning the highest generally having lower rates. Physiotherapists don't earn as much as some of their allied health colleagues here; particularly podiatrists, pharmacists, and nurse anaesthetists, but their divorce rates are comparably low.

Clearly, this data is partial and doesn't seek to imply causality from correlation, but it is interesting all the same.

Physical therapy remains an attractive career option for many young people, and the reasons for that are many and varied. For some, it's the ability to do the hands-on bodywork, for others it's the autonomy or the professional interest it generates in people at parties.

However, we understand it, small, seemingly unrelated data like this can add depth to our understanding of the profession, and give us a clearer idea how and how it contributes to the social fabric of our world.

Physiotherapy fixation

12 June 2018

"There's a great, probably apocryphal story about the noted psychotherapist Wilfred Bion (pron. bee-on), who when confronted by a patient who wanted simple answers to her problems, said: "I don't know why you're getting so angry, I wasn't trying to help you".

Such stories seem at odds to the way you should behave as a healthcare worker, perhaps because we are conditioned to think that our response to patient's problems should always be to look for a solution; to fix or cure them; to return them to (their) normal; to rehabilitate or restore them. Our whole approach to physiotherapy is especially teleological, with a defined goal or end in mind.* And we define our success by outcome measures and pre-determined discharge criteria.

But other professionals and practitioners have no such hang-ups.

Many psychotherapists, like Bion, reject the whole idea of recovery and rehabilitation, and prefer, instead, for their clients to gain insight. Many areas of psychotherapy have nothing to

do with fixing people's feelings and behaviours but are concerned instead with subverting our taken-for-granted assumptions and gaining greater insights into our psyche.

Similarly, artists have no interest in fixing things or returning things to normal. On the contrary, their work is often subversive and anarchic. The modus operandi of architects, musicians and sculptors are often to respond to the environment. They leave it up to the plumbers to fix the drains.

And philosophers are rarely ever motivated to provide answers to questions like "what constitutes a good life"? Rather, they see their role as prompting us to think more deeply about these things and understand more of the inherent complexities of seemingly everyday events. As Michel Foucault put it, "My job is making windows where there were once walls."

It's not difficult to see why physiotherapists have had a historical fix-ation with cure since our employment has often depended on it. We have been responsible for fixing some of the physical sequelae of war, poverty and pestilence, and we have been very good at it. So good, in fact, that we don't really see a need to change.

But perhaps other kinds of physiotherapy lie beyond the narrow confines of our obsession with outcomes, and while these approaches might rely on us being freer to decide on our profession's underlying philosophy than we are at present, the benefits might significantly outweigh the costs.

*This was one reason for calling the book The end of physiotherapy.

Taking off your ‘physio’ head

8 August 2018

A couple of friends sent me things that they thought I'd enjoy this week, and both of them are worth sharing.

The first was a quote from a student who is halfway through their final year of study and in the middle of a long block of clinical practice. They were reflecting on their work. They wrote:

“Sometimes I feel it can be hard to take off my "physio thinking hat" and put on my human thinking hat.”

We should perhaps have a moment's silence just to reflect on that.

The second was a paper from 2004 that highlighted the virtues of looking at the obvious and familiar in new ways.

The paper is titled *Culture on the ground: The World Perceived Through the Feet*, and in it, the author Tim Ingold explores how evolutionists privileged our heads and hands over our feet and, in doing so, reinforced the separation between humans and the natural world.

This is a lovely example of how thinking about the body - that thing that physiotherapists work with every day - can lead to some remarkable insights about the bigger world beyond the clinic.

Such thinking may be even more important these days with the radical changes that are coming with the advent of trans- and post-humanism. (Briefly, trans-humanism is the belief that we will soon be able to adapt the human body so that it will become 'super' human, and post-humanism argues that we are coming to the end of a 400-year project to understand the human being as sovereign, rational and autonomous, and new more holistic, interconnected ways are now needed).

Two thoughts cross my mind. Maybe in the future, you will be able to have a 'physio thinking head' and a 'human head' and the two can be interchanged when you need to focus only on the non-human parts of the job. You could then use your human head to think about all the reasons people really come to physiotherapy? Or maybe use your feet?

Stating the obvious

22 August 2018

I teach on a postgraduate paper that gets students from all sorts of health disciplines to think about themselves as health professionals, their professions, and the ‘others’ that they work with.

We use a lot of activities to get the students to reflect on their practice and some of these activities can be really challenging.

Students do photo essays, write letters of appreciation, design practice models, and explore critical incidents, but perhaps the most interesting activity involves them taking something every day and obvious and making it strange.

We ask the students to identify something about their practice that might otherwise be taken-for-granted, and get them to tell us why it matters to them or their clients/patients.

One of our recent students was a Brazilian physiotherapist who worked with women with pelvic floor pain, and the object she talked about was her clinic door.

Now, a clinic door is quite an unremarkable thing. But when you are patient presenting with a problem that is very personal or intimate, a door is a vital divide between the safe space of the clinic and the outside world.

As a male physiotherapist, I've always been taught to be careful about doors that obscure what goes on in the clinical space, but the reality of our work is often that it involves quite intimate forms of touch or treatment that demand privacy.

Focusing on the clinic door might seem like a flippant exercise to ask students to go through, especially given the myriad challenges we now face in practice. But it is powerful because it serves as a metaphor for security, autonomy, privacy, and trust.

Physical geographers have become increasingly interested in therapeutic spaces in recent years, as people have come to consider the kind of environments that we create for our clients/patients, as much as the procedures we undertake in those spaces.

As healthcare systems change, one of the places where most change will happen will be in the kinds of therapeutic spaces we can secure as professionals and the degree to which we have control over the design and use of those spaces.

It would be interesting to see more therapists consider their own therapeutic spaces and the ways in which they are both subject to, and engineers of, the environments in which they do their work.

Different kinds of work

20 March 2019

What does work mean to physiotherapists?

A recent article in the journal Qualitative Health Research highlighted some of the different meanings of work for 12 women with cancer.

One of the most interesting findings from the study was that there were many different kinds of work experienced by the women, including “illness work, body work, identity work, everyday work, paid employment and/or the work of maintaining income, and coordination work”.

When you include things like the work of breathing and professional work, you have a concept that is both at the heart of physiotherapy practice, and yet almost entirely un-theorised.

Work has a particularly interesting history, because it didn't exist, in the way we know it today, until the Industrial Revolution.

Prior to the 18th century, most people lived in small, rural communities where daily tasks were shared amongst people with far less demarcation between people's roles. Childcare, food production, worship and other communal activities were undertaken by those who were available. Delineations between things like mens' and womens' work, manual trades and childcare only really emerged when societies grew large enough to allow for new forms of work.

Since then, sociologists have poured over the different kinds of work and, in some situations, created new ways of categorising and dividing up human labour (see, for instance, the functionalist work of people like Emile Durkheim and Talcott Parsons).

Understanding work in healthcare becomes important when it allows us to differentiate between clinicians and consumers, and affords value to some kinds of labour (expert, trained, officially recognised), at the expense (literally) of others.

As is well known, women have been a particular victim of this distinction, taking on the majority of the caring work in society without economic or social recognition.

This arbitrary distinction perpetuates the myth that some kinds of work (be it physical or intellectual) should be rewarded economically and socially, and others not. And this really struggles under the weight of complexity that comes with a significant health event like cancer or chronic illness.

Given that physiotherapists are central in the act of recovery and rehabilitation, and that it is a female dominated profession, it is perhaps surprising that so little of attention has been given to the different meanings we give to the idea of work.

There has been a lot of discussion in recent years about the changing nature of work; the impact of automation and technological innovation; and the increasing precarity of work for many of our young people today. These conversations have a direct impact on the nature of health work – both for clients/patients, and for clinicians.

It would be nice to see more attention given to the meaning of work for physiotherapists who have benefitted for so long from an arbitrary distinction that is now becoming increasingly difficult to sustain.

Common problems

18 December 2019

I've spent a lot of time this year doing the background work for the book that will follow The End of Physiotherapy (available now in paperback from all good book sellers, and an ideal Christmas present).

On the advice of a friend of mine, who is a prolific author, I try to write books, book chapters, and articles in one go.

What I mean is that all of the arguments are corralled first, along with the data, references, texts and quotes, and then when I've ironed out what my arguments will be, I write the whole thing in one go once.

This is quite different to a collaborative writing project, which is much more iterative, but it helps to reduce the seemingly endless re-writing and editing that slows down so many long-form projects.

So as part of the deep background work for the book, I've been talking with physiotherapists around the world about the challenges and opportunities they're seeing in the profession right now, and it's been an interesting experience.

I've talked to people in Africa, the Arab States, Asia, Latin America, Mainland Europe, North America, and Scandinavia, to people living and working in very poor remote and rural communities, and those in advanced, wealthy economies.

It's by no means a representative sample of anyone, but some of the things that keep cropping up are interesting. I've repeatedly heard that:

- We need to raise the profile of the profession
- The way to greater professional 'capital' will be through more medicalisation of our practice and stronger links to the medical profession and its ideologies
- Physiotherapists have something unique to say and distinctive to offer (which, at times, seems to contradict the desire to follow medicine more closely)
- We need to keep the best of the old but incorporate new ways of thinking (person-centred care, sustainable development goals, etc.)
- Everyone is unsure about how to achieve these goals beyond doing more of the things that have worked before

What's interesting about a lot of the conversations I've had is that so much of it is basically sociological. I mean, a lot of what we're talking about comes down to the profession's function as a social entity.

And yet very few of the people I've spoken to can say that they've had any experience with the theories and ideas of the sociology of the professions.

So the idea of the next book will be to introduce people to these ideas and to show some ways that sociology can help us 'diagnose' physiotherapy's present and future challenges and opportunities.

Sociology is a mightily untapped resource in physiotherapy, and it's one of the things that I've argued has been ignored by practitioners who focused on the body-as-machine.

So the book will hopefully remedy some of that and give readers new insights into why their profession looks the way it does and what its future might be.

And it will be out next year if I can just finish all the data gathering…

Is physiotherapy losing touch?

31 March 2021

There was an article in *The Conversation* recently titled *After a year of digital learning and virtual teaching, let's hear it for the joy of real books* that gave us another indication of one of the really positive things that might come out of this awful pandemic. Things like people valuing face-to-face meetings again, whilst really appreciating the value of digital connection; people going for walks and gardening; and people reading books again.

Perhaps one of the most challenging things for people when they can move freely again will be how comfortable they are being touched by strangers. *The Spectator* magazine asked recently whether the handshake was dead. Reviewing Ella Al-Shamahi's new book *The Handshake: A Gripping History*, the magazine suggested that your hands might actually be a 'horror story';

> Your hand, says the Mayo Clinic, is a lethal bio-weapon crawling with pathogens as yearning to contaminate as those scary airborne droplets.

But even before COVID, some physiotherapists were decrying hands-on physiotherapy as low-value care (see references), returning physiotherapy, once again, to a time when touch is 'out' and activity is 'in'.

Of course, therapeutic touch, massage and manipulation, mobilisation and hands-on physiotherapy have been out of favour before. After World War I it was realised that the heavy hands-on work being done by reconstruction aids and masseuses was unsustainable given the vast numbers of heavy casualties. Europe and America were also very much under the influenced by eugenics and physical culture after the war too, and these placed a lot more emphasis on the individual's strength and movement.

A similar decline happened with the advent of consumer-grade electrotherapy devices in the 1960s and 70s. But after all such 'declines', touch always seems to come back.

Today, the driver is neoliberalism and self-care. People are expected to look after themselves, and government is supposed to be small. Help, social care, and community are out, personal responsibility and self-care are in.

And so touch recedes.

But in a Post-COVID world, one of the things people will crave most will be caring touch. And they will want touch from someone with skill and someone they can trust.

And so, for the last few months the team on the CPN Exec have been talking about a campaign to focus on the value of touch: what it means for human flourishing and co-dependency; how we, as therapists, miss touch; the real meaning of high- and low-value care; touch as care, and as a resistance to the logics of neoliberalism; touch as the ultimate low-carbon therapy; and so on.

We'll be sending out more information shortly, but if you have any thoughts about how you'd like this project to progress, email us at david.nicholls@aut.ac.nz, and we'll be in touch. Digitally, if not digitally.

References

Adrian C, Traeger RM, Maher CG. Wise choices: making physiotherapy care more valuable. Journal of Physiotherapy. 2017. http:// dx.doi.org/10.1016/j.jphys.2017.02.003

Gardner CG, Moseley L, Karran EL, Wiles LK, & Hibbert P. Implementing high value back pain care in private physiotherapy in Australia: A qualitative evaluation of physiotherapists who participated in an "implementation to innovation" system. Canadian Journal of Pain. 2020;4:1,86-102, https://doi.org/10.1080/24740527.2020.1732808

Lystad RP, Brown BT, Swain MS et al. Service utilisation trends in the manual therapy professions within the Australian private healthcare setting between 2008 and 2017. Chiropractic Manual Therapy. 2020;28,49. https://doi-org.ezproxy.aut.ac.nz/10.1186/s12998-020-00338-1

Zadro J, Maher C, O'Keeffe M. Overdiagnosis, overtreatment and low-value care in physiotherapy: a scoping review. BMJ Evidence-Based Medicine.2018;23:A10-A11.

Should physios still touch?

13 October 2021

Has therapeutic touch ever been more topical in physiotherapy than it is today?

COVID, the pressure on throughput in the public health system, and poor evidence of efficacy, have all played their part. But the exodus from so-called 'passive' therapies by musculoskeletal private practitioners in recent years has really shrunk what was once one of the profession's main modalities down to the size of a postage stamp. Remember those?

But aren't people also craving skilled, empathic touch more than ever? Aren't we, as practitioners, desperate to use our hands again? Or have we given up all hope of hands-on practice and resigned ourselves to remote Zoom consults and do-it-yourself healthcare?

In response to this, CPN members Wenche Schrøder Bjorbækmo, Tone Dahl Michelsen, Clare Delaney, and Dave Nicholls have worked with Frontiers in Rehabilitation to develop a special issue on the theme of "A Touch of Physiotherapy" — the Significance and Meaning of Touch in the Practice of Physiotherapy.

The special issue is open to anyone interested in the future of touch in physiotherapy.

Your abstract needs to be submitted by 23 November 2021, and the final manuscript by 22 January 2022. Wenche, Tone, Clare and Dave will be editing the special issue and will work with you throughout the process.

Your place, not mine

23 May 2022

How where we work shapes how we work

Where are you a physiotherapist?

In a clinic room? In a classroom? On Facebook or in an online chatroom? In your friend's living room? In your head at the gym?

The question of where people practice their physiotherapy has received almost no attention in the literature, but place clearly plays a pivotal role in shaping everyday physiotherapy practice.

For instance, COVID has made everyone realise how important face-to-face contact can be. It's reminded us how having a specific space to work in defines a lot about the way we teach, learn and work, and the things about our therapeutic places that we might have taken for granted.

And the changing places where physiotherapy has been practiced tells its own history of the profession.

In the 19th century, massage and electrotherapy were administered in the homes of people with enough time and money to afford a visiting therapist (for more on this, see Nicholls 2021).*

By contrast, until the invention of socialised medicine, poor people never saw a physiotherapist. It took the field hospitals and new rehabilitation centres of the First World War for physiotherapy to break this particular class barrier.

But more equitable access created a new divide, as physiotherapists moved into the hospitals of the new welfare state. Gone was the image of the patient receiving the therapist in their own home, on their own terms; now the patients came to us. The new specialist and expert.

And we designed our clinic spaces and our working practices to echo the kinds of objectivity and detachment that was needed to demonstrate our status. Our clinic rooms were sterile, in every sense, because our goal was to show the patient that we were in charge.

But these things have also changed in physiotherapy over the last half century.

When I did my PhD thesis, one of the places I studied was a respiratory clinic that had broken away from the traditional idea that you only ever saw a respiratory physiotherapist if you'd been admitted to a medical ward. Their idea of a respiratory client was radically different, and they designed their clinic space accordingly (Nicholls, 2012).

The decline of the welfare state and boom in private practice, greater customer choice and competition, and people's desire to receive more from their healthcare provider, have all forced physiotherapists to challenge the idea of where they perform their physiotherapy.

And there are lessons to be learned from how other professions are confronting place in practice. Medicine has been considering the place of place for decades. David Armstrong's classic study of the shift from bedside to surveillance medicine is a case in point (Armstrong, 1995).

But more recently, this paper by Liz Brewster, Michael Lambert and Cliff Shelton has talked about the role that the placelessness of doctors plays in perpetuating unequal access to healthcare. And this study by Skaiste Linceviciute and colleagues discusses the inherent vulnerabilities of place in the work as a male first responder.

What both of these studies emphasise is that the place, space, architecture, and physical environment of health care work plays a big part in shaping how we practice, and how those we work for experience our care.

References

Armstrong, D. (1995). The rise of surveillance medicine. Sociology of Health & Illness, 17(3), 393-404. https://doi.org/10.1111/1467-9566.ep10933329

Nicholls, D.A. (2012). Foucault and Physiotherapy. Physiotherapy Theory and Practice, 28(6), 447-453.

Nicholls, D.A. (2021). The role of neurasthenia in the formation of the physiotherapy profession. Physiotherapy Theory and Practice. doi:10.1080/09593985.2021.1887058

*Gymnastics ('exercise' as a concept had not yet been invented) and hydrotherapy were often social, but were still only luxuries for most until the advent of the welfare state.

Chapter 5: Future work

I mentioned in the Introduction to this book that blogging often gave me ways to work through ideas that would later appear in other long-form or more scholarly publications, and this chapter exemplifies that. So many of the pieces here were testers for what would later become *Physiotherapy Otherwise*. Whether it was writing about the ubiquitous penetration of the 'psy' disciplines into everyday life, the creeping atomisation of healthcare, AI, or the profession's own attitudinal mythologies, these posts helped me to work out how to write things in a reasonably concise and digestible way.

One of the main lessons I learned from writing these posts was that the changes coming to healthcare and physiotherapy were no longer from isolated sources (the threat of chiropractic to the musculoskeletal monopoly, for instance), but were far more fundamental and multifarious. It reinforced an argument I'd made in *The end of physiotherapy* that PT was uniquely ill-equipped to respond to these changes because of its history of teaching and practicing as if the body were a machine. Whether we could learn from other professions, other industries, or the broader social lessons of history remained a constant question running through these posts.

Bodies-as-machines / post-humans / skull-candy

5 July 2013

What would it be like to have a device osteointegrated into your skull to convert light into sound? Well now you can.

There has been a lot of discussion of cyborg culture over the years and this piece from Sally Davis in the gorgeous on-line magazine/blog Nautilus (http://nautil.us/) is well worth a read.

Cyborgs and the culture of the post-human is nothing new of course. In many ways physiotherapists have been involved for years in aids and adaptations that help people move and function. The key difference here is that post-human culture is getting people to move their thinking away from the use of technologies as adaptations to make up for some sort of loss, to enhancements that would otherwise be superfluous...but would be pretty nifty all the same!

Stellarc famously sewed a false ear under the skin of his forearm, and had artificial limbs appended to his body to illustrate that not all rehabilitation technology caters for a 'lack.'

I, myself, quite fancy the idea of a computer that can type what I think. Think of the money I'd save in printer ink!

Artisan practitioners

21 November 2014

It's been a very busy few weeks. AUT students have finished all their exams and we're nearly done with all the marking and exam board reporting. I step down from my role as Head of Department at the end of the year, so there is a lot of tidying up to do. I've also just put the finishing touches on a book chapter that I've written for Franziska Trede and Celina McEwan's upcoming book Educating the deliberate professional: Preparing practitioners for emerging futures, which will be published by Springer and will hopefully go to print early next year.

The book is going to ask some important questions about the past, present and future of professional practice, particularly about the need for our students and colleagues to be much more critically engaged. It is a book that spans a wide range of different health disciplines, but will have a lot to say about physiotherapy education and practice.

My chapter is titled *Parrhēsia, artisans and the possibilities for deliberate practice*, and re-examines the idea of the artisan practitioner, asking whether a (post)modern version of the age-old artisan might provide better opportunities for deliberate practice than our current models of 'experts' or 'specialists,' that derive from an age of industrial capitalism.

Here's the abstract for the chapter:

> In this chapter, I have used the historical figure of the artisan to develop a critique of the limits of present health care practice. Drawing on Michel Foucault's later works on truth-telling (parrhēsia) and Hannah Arendt's writings on action, making, behaviour and fabrication, I offer the possibility that a revised notion of the artisan practitioner may offer insights into how our practice may become more deliberate in the future. Artisan practitioners fell into decline as industrialization, capitalism privileged fabrication over 'hand-made' craft – a point not lost on Arendt who argued that our culture had become tainted by 'making' and 'behaviourism' at the expense of 'action', which had an important self-constituting function. Foucault echoed this critique, arguing that the care of the self relied on one's ability to speak the truth to another, and that this exercise carried significance personal risks. State authorities had learnt to use truth-telling as a confessional technology to encourage docility, but Foucault argued for an aesthetics of existence that confronted and challenged the limits of this

> governmental and juridical response. The (post)modern artisan represents an exemplar of a practitioner that, I believe, would find favour with both Arendt and Foucault. Self-aware, critical, and comfortable with the complexity and ambiguity of health care today, the artisan is examined as a parrhēsiast and as a practitioner committed to action: the very model of the deliberate practitioner.

New physiotherapy — 7 ways to change the world

26 April 2017

I read something about critical theory this morning that made me think about a couple of recent posts on the future of physiotherapy. In the piece, the author was taking critical theorists to task for attempting to 'demystify' the social world without proposing solutions. People, she argued, want attractive alternatives and a sense that utopia, or at least the hope of a better life, might be possible.

This is a powerful argument that I don't entirely agree with, but it did make me think about Roger Kerry's recent blogpost 'Physio will eat itself', which followed my own question of whether we would disestablish physiotherapy as a profession if it were in the best interests of patients or the healthcare system as a whole.

Critiquing the systems and structures, objects and subject positions that make up today's healthcare system is a vital function of critically-minded health professionals, especially where those same structures and systems get in the way of meaningful and effective care. But we should also think about how things might be 'otherwise', and open spaces for new ideas.

This doesn't mean prescribing the solution, since the value of any idea depends on how and where it's taken up, how it's used and adapted, and how it's perceived. But there's nothing wrong in greasing the wheels of change, if it can help. So, following Nir Eyal's adage that 'People don't want something truly new, they want the familiar done differently', here are some ideas for ways we might all think physiotherapy 'otherwise':

- Look to the margins: Look to people who are thinking and practicing at the very edges – or even beyond the boundaries – of convention. This means exploring the work of people who are taking risks: 'bleeding-edge' practitioners they are called in business. Their ideas often fail, but when they succeed they are often groundbreaking.

- By extension, this also means looking at practices that are not officially sanctioned or approved of by the mainstream. So don't look to your professional bodies or even professional societies to be the source of your ideas. Their role is to secure the present professional ideology, not to radically disrupt it. Look instead to the people who may have 'left' the profession to explore life outside physiotherapy, but have then brought their ideas back in.
- Look to the people doing the counterintuitive thing. To do this, you'll obviously need to know what the intuitive and obvious thing is in much greater detail. So study your profession: where it came from, what it does and doesn't do, who it serves, who benefits, and who is marginalised. Study where your professional boundaries currently are, and ask those classical critical questions: why is my way of doing/thinking things like this and not like that; what is holding these ideas and practices in place; what is not being done, said, thought?
- Ask critical questions of people who claim to be innovating: is their idea just old wine in new bottles; what, if anything, are they subverting; what innovations are being promoted. Be ruthless here. Deciding that Treatment A is more effective than Treatment B is not radical if your basic practice model and way of thinking stays the same.
- Think about the different ways innovation can happen: try some new ideas, new practices, new practice locations, new clients, new definitions, new practice parameters, new connections…
- Draw inspiration from those people who are creative by nature: designers, architects, authors, music producers, etc. Think big, and avoid the kinds of instrumental thinking that kills creativity. Don't sweat the small stuff.
- Follow the principle that anything that opens space for new ideas is good, anything that closes space (rules, constraints, checks and balances, people's negativity) is bad.

Physiotherapy needs real innovators right now. We're not given much help to be innovative in our training, because so much time is spent learning to follow rules and principles laid down by others, so we're coming from a long way back.

As a profession, we've got to be much better at tolerating the weird, the uncomfortable and the incomprehensible, because it's in these spaces that radical change is fermenting. And who knows, today's wacky could soon become tomorrow's wonderful.

Will technology make physiotherapy obsolete?

18 July 2017

A few weeks ago, I took part in a panel discussion on the theme of 'The university is dead: Long live the university'.

The keynote presenter - the very brilliant Professor Jane Gilbert - talked about how technology is going to disrupt every aspect of our lives in the future. Ever since the talk I've been pondering how much technology will disrupt the kinds of physiotherapy people might need in the future.

Here are just three examples of disruptive technologies and ways of thinking and working that are due for a shakeup in the very near future:

1. Fact-based technical subjects, like the kinds of science-bases subjects commonly thought of as 'core' subject in physiotherapy (anatomy, physiology, pathology, biomechanics, etc.), learnt through interactive apps rather than traditional classroom lectures. Implications: We no longer need those people to teach these subjects, and the way we engage with students around these subjects radically changes.
2. Digitisation of learning that once took place on university campuses, now taking place anywhere, anytime. Implications: The 'massification' of higher education opens access to a much broader audience and potentially democratises access, but makes person-to-person contact much more difficult. Added to this, universities are having to ced their role as institutions that accredit learning to third-party web-based systems like the Open Badges movement. Implications: Physiotherapy 'faculty' cease to be located around a central geographical location and universities lose their monopoly and control over curricula.
3. Advanced machine technologies replace workers in traditional jobs. Robots and AI bots do most of the productive labour, including transportation, food production and distribution, consumer services, third-party verification of financial and legal contracts, care support work, teaching and learning, etc., proliferate. Less people are needed to work, so people have more free time and income comes from things like a universal basic income - paid for by new tax systems that are no longer work-based. Implications: Much of the traditional 'labour' associated with physiotherapy, including assessment, diagnosis, routine care (exercise prescription, activity monitoring, standardised treatment), is given to units that require no training and only require periodic updates. Plus, the notion of 'dependency' disappears - having a

profound effect on how we view the elderly, for example - because our economy is no longer based on the importance of years spent in work.

So if we only focus on these three examples and ignore the myriad other changes now in the pipeline, the question is what aspects of physiotherapy do we think we will lose, and should we not, therefore, be preparing now for the change that is to come?

This is of course far-fetched. But perhaps foreshadows some of the changes are already starting to appear in ways that most people in the profession would rather not think about. It's now entirely possible, for instance, to learn much of what's in the current graduate physiotherapy curriculum from YouTube. You can download an app to teach you how to do Grade V cervical manips. Universities have long since been the repositories of knowledge, and new robotic, AI, simulation and augmented reality technologies are now becoming commonplace.

Many traditional jobs - like journalism - are falling by the wayside, and there are some predictions that up to half of the work of lawyers, doctors, bankers, market gardeners, librarians, and shopkeepers will be handed over to digital technologies in the next few years.

There is almost no debate about these things in physiotherapy. It is possible that some aspects of our practice will be retained - perhaps the things that we think require the most human-to-human engagement. So the question is what aspects of physiotherapy do we think we will lose in the not-too-distant future, and should we not, therefore, be preparing now for the change that is to come?

How radical is robotic physiotherapy anyway?

14 November 2017

There's been quite a lot of talk in recent years about the potential for robots to support, or even replace, therapists in neurological rehabilitation clinics, home-care workers in rest homes, and teachers in the classroom. Often, stories about robotic therapy aides are sold as radical alternatives to contemporary practice. But how radical are they really?

A recent post celebrating the success of a robot in helping stroke patients regain upper limb movement illustrates the point. If robots like this are seen as an albeit very accurate and quantifiable extra pair of hands, then they could be said to fall into the same class of technology as another therapist, therapy assistant, or even the kinds of sling suspension systems pioneered by Guthrie Smith.

In her own time, Olive Guthrie Smith revolutionised physiotherapy by allowing patients to exercise for themselves over much longer periods of time once the therapist had set them up

with a carefully designed system of supports and stimuli. Lanckenau wrote in 1943 that 'the psychological effect of early active exercise in recumbency, graduated to active resistive exercise, is enormous' (Lanckenau 1943, 620).

When seen more broadly, therapeutic aids and equipment like Guthrie Smith's sling suspension system can be classed alongside other 'technologies' that supports the work of the therapist: a sliding board, a sling, another pair of hands, a treadmill, a body-weight support system, water, a dynamometer, etc. Indeed, any form of support or resistance is a technology that we can use, and have used, throughout the history of the profession.

As Fran Brander argued in explaining the new UCLH robotic arm; 'Therapists shouldn't see robots as a threat' but as an ally, and the false dichotomy created by the suggestion that a boss might 'pay for a therapist rather than a robot because you're going to have better outcomes' misses the point that not all therapists need robots, but that all robot need a therapist for them to function.

At the moment, at least.

Reference

Lanckenau, N.I. 1943, Rehabilitation by modern methods of exercise. In, W. B. Doherty & D. D. Runes (eds.), Rehabilitation of the war injured, a symposium. New York, Philosophical Library, pp. 614-21.

Physiotherapy unlimited

11 July 2018

In Nikolas Rose's superb analysis of the history of the 'psy' disciplines (psychology, psychotherapy and psychiatry), he identifies something about psychology that the 'phy' professions (physiotherapy, physical therapy) ought to look very closely at.

Rose asks why it is that psychological thinking is all pervasive these days. Psychological ideas have slipped into everyday language and ways of thinking, everyday experiences of tension and sadness have been given psychological names and diagnostic criteria, and there are now whole bookshelves full of self-help guides to managing every aspect of your psychic life.

Rose asks how this happened;

> 'Psychological expertise now holds out the promise not of curing pathology but of reshaping subjectivity. On every subject from sexual satisfaction to career promotion, psychologists offer their advice and assistance both privately and through the press, radio, and television. The apostles of these

> techniques proffer images of what we could become, and we are urged to seek them out, to help fulfil the dream of realigning what we are with what we want to be. Our selves are defined and constructed and governed in psychological terms, constantly subject to psychologically inspired techniques of self-inspection and self-examination. And the problems of defining and living a good life have been transposed from an ethical to a psychological register' (Rose 1999, xxxi, emphasis added).

Here is a list of the topics covered by the latest student edition of *Adjust - a self-study guide for current psychological topics and interests*:

- Adjusting to Modern Life
- Theories of Personality
- Stress and Its Effects
- Coping Processes
- Psychology and Physical Health
- The Self
- Social Thinking and Social Influence
- Interpersonal Communication
- Friendship and Love
- Marriage and Intimate Relationships
- Gender and Behavior
- Development and Expression of Sexuality
- Careers and Work
- Psychological Disorders
- Psychotherapy

There isn't much about modern life that isn't covered by the pages of this guide, which basically suggests that if you are equipped with psychologically-informed ways of thinking, there isn't much that you can't find interest and relevance in.

Of course, what psychologists can't do is bring a set of physical ideas to life's rich pageant. And very few others can. For a long time, practitioners in the alternative and complementary therapies have tried to fill the void, but they lack the same public trust and social capital as physiotherapists. But physiotherapists have been remarkably reluctant thus far to venture beyond their traditional territory and become the physical equivalents of the all-pervasive 'psy' disciplines.

So why is it that physiotherapists accepted such a restrictive view of bodies, function and movement all those years ago? And why, given that so much has changed in the world, are they still holding on to it?

The rise of psychology in the 20th century provides one very useful template for the ways in which physiotherapists might define a future for their practice that reaches beyond the body-as-machine and into the lives of everyone, all the time.

References

Rose, N. (1999). Governing the soul: The shaping of the private self. London, Free Association Books.

Weiten, W., Hammer, E. & Dunn, D. (2014). Adjust: Applying psychology to life. Belmont, CA, Cengage.

The large print giveth, and the small print taketh away

1 August 2018

It's often tempting to think that it's the big changes, the grand gestures, that do the most damage to a profession, but it's really the small acts of violence that really do the damage. The daily drip, drip, drip, that slowly erodes the foundations until, one day, the house falls down.

'Threats to democracy come one dollar at a time', goes the old American political aphorism, and so it is with professions like physiotherapy, which can suffer death from a thousand cuts if they are too distracted to notice.

Foucault would say that the most powerful and dangerous ideas are those that arrive under the cover of common sense, where it seems almost impossible to dispute the reason and logic being put forward.

"Power" he argued "is tolerable only on condition that it masks a substantial part of itself. Its success is proportional to its ability to hide its own mechanisms."

And so the most dangerous of all ideas perhaps come with tempting incentives and inducements that make it almost impossible to resist.

Take the recent announcement of a £100,000 funding award to innovations that will make a difference to the lives of patients within the NHS. Surely there can be nothing wrong with

that can there? And any self-respecting professional body would surely be negligent if it didn't promote the opportunity to its members, as the CSP did recently.

But one doesn't have to look far beyond the rhetoric of patient-centred care, to see that the primary objective of the SBRI funding is not more physiotherapists doing more work for more people, but return on investment, cost reduction, and a shift of responsibility away from centralised healthcare services to the community and, ideally, to the 'consumers' themselves.

Consider the project won by Advanced Therapeutic Materials Ltd, to improve on the 'treatment of venous ulcers in the UK' which 'costs the NHS approximately £300-400m per year. This project intends to show that using their 3D technology primary care could save in excess of £100m per year', or Xtal Technology Ltd's project which unashamedly states that 'The NHS must deliver £20bn of efficiency savings by 2020. Xytal's sister company has a unique experience of increasing productivity in the English primary care sector, by utilising lean process improvement techniques'.

Saving money and improving the efficiency of physiotherapy services never comes with more physiotherapy. It always results in patients getting less contact and more instruction, less hands-on care and more processing, less time with an expensively trained and irreplaceable clinician and more rough handling from cheaper, less engaged and infinitely more disposable alternatives.

So while the lure of £100,000 of investment at a time when money is bleeding out of the public healthcare system seems like too good an offer to refuse, we should remember that a trojan horse isn't only a computer virus.

Is physiotherapy a bullshit job?

16 January 2019

On January 1st I left my three-year secondment looking after a team of psychology and psychotherapy lecturers and returned to my old home in the clinical sciences. And a big part of my new work will be trying to prepare our graduates for a future that is increasingly uncertain and unfamiliar.

For some years now, there's been an increasing interest in the future of professions like law, accountancy, journalism, and medicine, with a whole swathe of books being published recently trying to anticipate how we'll need to adapt to the rapid rise of digital technologies.

There is little doubt that artificial intelligence, automation, machine learning, and robotics are going to radically reshape the nature of work for many of us. And this will happen not because "the machines are coming to take over", but because they will both do some of the

things humans do better, but more significantly, they will tackle old problems in entirely new ways.

Automation, innovation, decomposition, labour arbitrage, personalization, and mass customization are just a few of the ways our working lives will be affected by technology.

In 2013, David Graeber wrote an article about the pointless jobs that seem to have been invented just to keep us all working. Graeber followed the article with a Twitter question, asking people to tell him about some of the bullshit jobs they did, and some of the responses were achingly tedious, like one respondent whose main task at a Dutch publishing firm was to "Keep a candy dish full of mints. (Mints were supplied by someone else at the company; I just had to take a handful out of a drawer next to the candy dish and put them in the candy dish)".

Graeber went on to publish a best-selling book last year titled *Bullshit jobs: A theory* in which he argued that about 50% of jobs could be scrapped and nobody would even notice. Would physiotherapy be one of those?

The 2018 workforce stats for Australia were released yesterday, and they once again showed that professions like physiotherapy, medicine, and pharmacy are seeing more than 90% graduate employment rates, suggesting that these, at least, are not bullshit jobs.

But do high rates of graduate employment necessarily mean that physiotherapy, medicine, and pharmacy are any more secure in the face of rapid technological change? Are they any less likely than someone in the visual or performing arts, say, to find themselves on the employment scrap heap when machine learning takes over?

Richard and Daniel Susskind, in their book *The Future of the Professions* think not. In fact one of their paradigm cases of a profession on the point of radical transformation is medicine.

The Susskinds (father and son) argue that many of the professions 'are the brink of a period of fundamental and irreversible change in the way that the expertise of these specialists is made available in society' (p. 1).

They argue;

> ’This state of flux presents some challenges for the various participants in the professional world. Many professionals who are at the closing reaches of their careers hope they can last out and keep transformation at bay until they hang up their boots. At the other end, prospective entrants to the professions are having second thoughts about committing. Their parents and careers advisors speak mainly of the professions of the twentieth century, but this talk bears little relation to the post-professional possibilities being sketched out by those who take an interest in the

> decisions of the professional to become. Regulators are hesitant about what it is that they may soon be regulating and, by and large, they are steadfastly discouraging change' (p. 105).

So the challenge seems to be to anticipate the kinds of questions to which physiotherapy will be the answer in 10, 20 and even 30 years time.

Interestingly, the Susskinds and others suggest that it will be the creative industries, and not the professions like medicine which demand a high degree of standardisation and procedure, that will outperform artificial intelligence and robotics in the future.

Certainly, I know of many physios who feel frustrated by the amount of administration they have to do, and there are many who spend the largest part of their day doing repetitive assessments and treatments. Many would also like to spend more time with interesting and complex patients, but plowing through the bullshit jobs appears to be an unavoidable reality of their work at the moment.

Perhaps the 4th Industrial Revolution will take away all of the tedious parts of the job and leave us with the good stuff. Unless the robots take the best patients and leave us with the paperwork.

Can you teach physiotherapists to be empathic?

14 February 2019

There has been a lot of talk in recent years about the capabilities that health professionals will need in the future.

This is partly because the sheer economics of future healthcare will mean that other ways of delivering routine tasks - those that once required extensive training and expensively employed specialists to deliver them - will be managed by smart machines, wearables, robotics and AI.

A friend of mine was saying the other day that she recently sat with her elderly mother in hospital for two weeks during a bout of illness, and during that time only two of the nurses actually took time to build a relationship with them. The others just came in to do things to her: take her obs., give her meds, take her to the toilet, etc. My friend - an experienced nurse of many years - bemoaned the lack of 'real' nursing and saw very clearly how a machine could do many of the tasks the nurses now busied themselves with.

And it will happen, because you don't need to train for 3 years to do routine tasks that someone - or some*thing* - far easier to train and employ can do.

But what persists in the literature is the sense that the main advantage we have over machines are the very things we already know we want most from our clinicians. We want them to be caring and thoughtful, compassionate and accepting, to be able to listen and convey hope and confidence.

Some recent work done with colleagues in physiotherapy practice and management shows that words like resilience, cultural competence, initiative, collaboration, and empathy come up much more often than anatomical or physiological knowledge, technical skill or knowledge of research evidence.

Yuval Noah Harari — the author of *Sapiens* and latterly, *21 Lessons for the 21st Century* — said recently that we have placed far too much emphasis on technical skills and should spend much more time developing critical thinking, communication, collaboration and creativity.

But one of the problems I have encountered consistently over the years as a physiotherapy educator, is that physiotherapists generally don't believe these things can be taught and, perhaps because of that, have no skills themselves in teaching and stair-casing these things.

The argument goes that things like compassion are somehow absorbed by the person through experience - in the way that you lay down cortical bone under stress perhaps - and that teaching these things is impossible because they are subjective and can only be understood by the person experiencing them.

And so our curricula are filled with content that is more objective, measurable, more easily compartmentalised, and reduced for easy testing.

But if these reductive skills are the ones most at risk from technological reformation, and our clients and colleagues are saying that the humanistic and relational skills are more important in practice than the technical competencies, are we not failing the profession if we don't look for a solution?

I've recently seen a physiotherapy curriculum that tried for a decade to bring the humanities to the foreground. But it has now reverted back to what it was before - with its siloed single subjects and technical rationalism. This is mainly because the educators charged with collaboratively, critically and creatively couldn't work out how to integrate the subjective and objective; the nature and the culture; and the body-as-machine into the world we live in.

This is a real shame, not least because it will leave a generation of future practitioners unprepared for the real world of work.

But more than that, it will give governments, health officials and funders more justification to replace us with machines and healthcare assistants.

It is no good for physiotherapists to claim that their work is relational, humanistic, person-centred, collaborative, critical, or creative if practitioners have to learn these things despite their curriculum rather than because of it.

As educators, we have to find a way to make biology work in service of culture, the anatomical body as secondary to the person, and the individual as servant of the community. Because if we don't, someone else will.

Second skin

24 July 2019

The sociologist Anthony Giddens has commented that in the future, the 'normal' body may only be the most basic form of embodiment available to us, and that bodily enhancements like eyes that can zoom, ears with extended hearing range, and designer prosthetic limbs to supplement today's spectacles and hearing aids will vastly extend the bodies of those who can afford them.

Some of these innovations sound farfetched, but there's no doubt that the ability to shape and enhance our bodies will be attractive to many people, and will have a big impact on physiotherapy work.

If it's possible in the future to have a fully autonomous transport network, it's likely to put an end to most head injuries. If soft tissue injuries can be managed by injections of nano-robotic tissues that mean you can go back to playing five minutes after an ACL rupture, this might have a big impact on the rehab industry. And if people surgery, radiology, and pharmacology become automated, what is the likelihood that physiotherapy might be next?

Here are some examples of the haptic/touch-based work that's already underway (this, this, this, and this). Technologies like this will surely be adopted by people as these become more sophisticated and accessible.

So far, the professions most immune to technological disruption have been those that require a lot of dextrous touch and inter-personal subjectivity. So professions like physiotherapy, nursing, massage therapy, osteopathy, and midwifery haven't had to worry too much. But things may be changing.

There's been interest for some time in robotic carers, and the inability of the psychology, psychotherapy and counselling professions to meet the demands of modern-day mental

distress has seen an explosion in the AI- and app-led business in mental self-help. People are increasingly turning to affordable alternatives to human advice and support.

But good quality touch still resides firmly in the hands of humans (no pun intended). It's interesting to read, therefore, about efforts to develop sensors that can allow robots to feel.

One of the mistakes we often make when we try to imagine a future with robots and AI is to think that machines will just be developed to replicate what we do. They almost certainly won't. Machines will do things their way. And the most disruptive innovations will probably come from technologies that bypass the problems we see, and tackle things in entirely new ways.

So although we can't expect a robot to 'feel' better than a human does any time soon, it's not unreasonable to expect a robot that has 10, 20 or 30 digits, each with a different sensor, being used therapeutically.

Robotic touch therapies offer some interesting improvements on human therapists:

- They can captures and stores vast volumes of data on things like tissue density and pressure, vascular responses and endorphin release, and share this with other digital therapists around the globe;
- They can 'learn' instantaneously, adapting consistently to the person or incorporating the latest research without lag time;
- They can work when the person is ready, no taking time off work to visit a clinic and wait for your appointment;
- And they are the ultimate expression of the body-as-machine. To a machine, you're not an embodied being, just another arrangement of tissues and structures.

Perhaps the last point is the most significant. Physiotherapists have long sought quantitative, reliable, technical proficiency. But it is the repeatable, learnable, teachable aspects of healthcare that are most at risk from automation, AI, digital disruption and robotics.

Perhaps the rise of new technology will force the profession to ask what is really the essence of physiotherapy before the robots take the body-as-machine?

Is COVID showing us the future for physiotherapy?

6 May 2020

There are two ways you can read the latest promotional campaign from the Canadian Physiotherapy Association, that states that physiotherapists' work takes them 'from treating patients to moving people'. The first is that physiotherapy spans hospital and home. The other is that the very nature of physiotherapy is changing.

COVID-19 is undoubtedly reshaping the contours of physiotherapy like other cataclysmic events before. But there are some important differences that we should be aware of.

World War I and the polio epidemics that ran until the 1960s produced enormous numbers of casualties needing physical rehabilitation, but there had been wars and epidemics before. What was different in the 20th century was the organisation of social welfare. This provided the infrastructure to support the training and deployment thousands of new physiotherapists.

The last 50 years have seen the slow dismantling of this infrastructure though, and it is unlikely that nation-states will once again invest in the hegemonic power of biomedicine in the way that it did before.

Notwithstanding the recent outpouring of support for healthcare workers, governments throughout the world have long been trying to make stringent cuts to public services, and the effects of COVID on the supply of money will only accelerate that.

Given this, perhaps the actions of some therapists to take their work online over the last few weeks points to a new market for our services? But if people like Daniel and Richard Susskind are right, these 'innovations' might actually be pointing to exactly what physiotherapy will *not* be in the future.

In their book *The Future of the Professions* (Susskind & Susskind, 2015), the father and son authors argue that we have learnt from successive technological and work disruptions: that anything you can practice as a discrete skill, or describe and teach in a language that others can understand, will be lost to those who are cheaper to train and employ than we are.

Decades of work decomposition in manufacturing, tourism, journalism, banking, law, and elsewhere, has shown us that any task that can be standardised, repeated, programmed, regimented, or described in any kind of formulaic way, will, in time, be lost.

And this poses a grave threat to us.

Physiotherapy curricula are bloated with technical skills training, and we have, for years, emphasised skills over subjectivity, cure over complexity.

And we are seeing this being played out by therapists desperate to offer some kind of service during this long period of social isolation.

But paradoxically, the kinds of practice that are now being promoted by physiotherapists to people on social media may well be the definitive catalogue of exactly those things that will be lost tomorrow. And perhaps rightly so.

Physiotherapists never owned basic fitness and strengthening programmes, tests for flexibility, treatments for minor injuries, or home-based rehabilitation programmes anyway.

But the fact that they can be so easily offered and made available, suggests that they will not be what defines physiotherapy in the future.

But hands-on therapies and treatments requiring close proximity are likely to suffer too in the near future.

So what will be left?

It is becoming increasingly clear that the things that will define the profession in the future will be the things that cannot be so easily given away, described or disseminated – the kinds of things that require a lengthy training, contemplation, complex problem-solving, and an understanding of people in the broadest possible context.

We should already be thinking about the impact of this in our curricula, because the healthcare system will look dramatically different in 10 years, when today's graduates are our senior practitioners.

WWI and the polio epidemics forced physiotherapy to grow rapidly and consolidated the profession around a set of skills and abilities that still form the core of the profession's principles. But today we have the Internet, neoliberal economics, and climate change, so it is inconceivable that the profession will not be radically altered when this catastrophic pandemic finally abates.

Perhaps we are already seeing the shape of the profession to come.

Reference

Susskind, R., & Susskind, D. (2015). The future of the professions. Oxford, UK: Oxford University Press.

Borderland practices*

4 February 2021

Borders and boundaries seem to have taken on extra importance over the last few months, especially since COVID appears to be entirely indifferent to national borders, and its existence relies on its ability to move freely between us.

We've spent the summer in New Zealand thanking our lucky stars that we live a long way away in the bottom corner of the South Pacific, and the ability to close our borders has meant life has been relatively normal. People can hug and move freely, gather in groups, and care for loved ones.

Because of our accident of geography, we've been incredibly lucky to have so far dodged the COVID bullet. But even here there are people who object to the government over-reach. And at the heart of all of these conversations are questions of borders and boundaries.

Since mid-December I've been on my own self-imposed writing retreat, trying to finish off the follow-up to *The End of Physiotherapy*. And this new book is very much about boundaries and borders, especially those between physiotherapy and society.

Long-held professional boundaries around physiotherapists are disappearing at a remarkable rate at the moment. Forced by circumstance, clinicians and educators are working and teaching in ways that would have been unimaginable (and, in some cases, impossible) only a few years ago. And they are doing jobs that were once the sacred territories of other professions. But what is remarkable is that much of this is happening without anything like the kinds of resistance offered in the past.

Giorgio Agamben has called the present moment a 'state of exception' (Agamben, 2015); a time when the normal social rules and conventions are forgotten, and all manner of new ways of thinking and acting become possible. States of exception can be terrible things, especially when despots use their power to commit genocide in the name of national interest. But they can also be a circuit breaker, forcing creativity on people who might otherwise feel no pressure to change.

So while so much of the current discourse is around the availability of vaccines, lockdowns, and altered scopes of practice, a lot of it is really about borders and boundaries: between a virus and the body; between the person and the state; between one professional and another.

People are already thinking about what healthcare will look like in a world where the worst of COVID has passed, and so much of this conversation is about borders. But, of course, it is also about power: power to control a market; power to control one's own professional destiny; power to keep competitors out and good practitioners in.

The question, however, is not so much about what represents the 'right' redesigned border for the health professions, but who decides. Should it be the government, insurance companies, academics, practitioners, researchers, or clients that decide what physiotherapy is and isn't? Or should it be a coalition of all of these? If so, how is such a coalition formed? And who decides what represents 'good' physiotherapy in the future?

If one thing is certain, it is that physiotherapists will not be able to rely on the same boundary protections they once enjoyed, because healthcare has already become far too complex, uncertain, and diverse for practice models that really originated in the first half of the 20th century.

This means that the way we define what physiotherapy is and isn't is going to change. It certainly looks like it may become more diffuse and ambiguous, and far less concrete than it has been in the past.

How we build a border around that, and 'sell' that image to our colleagues and consumers (or even, whether a new border to replace the old one is the right way to think about future healthcare), may well define what we teach, think about, and practice for the next 50 years. So borders and boundaries are definitely something that feels worth thinking about right now.

* The title for this post comes from a fabulous book by a Kiwi sociologist Kevin Dew, detailing a classic border dispute between physiotherapy, medicine and chiropractic in the 1990s in New Zealand. The book is well worth a read if you can find a copy.

References

Agamben, G. (2015). Homo sacer. Vancouver: BC Crane.

Dew, K. (2003). Borderland Practices: Regulating Alternative Therapies in New Zealand. University of Otago Press.

Using psychotherapy to train chatbots

13 April 2023

This paper has just been published and it raises some interesting questions about the role that the 'psy' disciplines might play in the development of more ethical AI.

> Towards healthy AI: Large language models need therapists too
>
> Abstract: Recent advances in large language models (LLMs) have led to the development of powerful AI chatbots capable of engaging in natural and human-like conversations. However, these chatbots can be potentially harmful, exhibiting manipulative, gaslighting, and narcissistic behaviors. We define Healthy AI to be safe, trustworthy and ethical. To create healthy AI systems, we present the SafeguardGPT framework that uses psychotherapy to correct for these harmful behaviors in AI chatbots. The framework involves four types of AI agents: a Chatbot, a "User," a "Therapist," and a

> "Critic." We demonstrate the effectiveness of SafeguardGPT through a working example of simulating a social conversation. Our results show that the framework can improve the quality of conversations between AI chatbots and humans. Although there are still several challenges and directions to be addressed in the future, SafeguardGPT provides a promising approach to improving the alignment between AI chatbots and human values. By incorporating psychotherapy and reinforcement learning techniques, the framework enables AI chatbots to learn and adapt to human preferences and values in a safe and ethical way, contributing to the development of a more human-centric and responsible AI (Lin, Bouneffouf, Cecchi & Varshney, 2023).

Reference

Lin, B., Bouneffouf, D., Cecchi, G., & Varshney, K. R. (2023). Towards healthy AI: Large language models need therapists too. arXiv preprint arXiv:2304.00416.

What your *research/*study/*teaching/*work might look like soon?

25 April 2023

Late last week, Greg Brockman from OpenAI showed what might be coming to a computer near you soon.

An aside…

There will continue to be a lot of thought given to the ethics of generative AI, but I wonder whether there's also a more quotidian shift taking place here that will have an equally profound effect on our everyday work/life?

Tools like ChatGPT both break down barriers between users and technology (so that you can now get a vast catalogue of new things done now without needing to have the skills of a computer coder), whilst also relying on a coterie of highly skilled coders continuing to invent and develop the tools AI can then assemble.

So the assumption is that we will still need highly skilled (human) coders to do the high-end development work. And this is reassuring because what it implies is that experts and specialists will still be needed even when AI takes the grunt work away.

But, what will happen to the structure of all work if Large Language Models (LLMs) are able to build the code as well?

Recently, I've been playing with tools like this, which allow you to ask an app to generate other apps to answer specific questions.

I asked it to build an app for the ISIH conference in 2024 that showed people cafes and restaurants within five kilometres of where they were staying, ranked by consumer reviews in Google Maps. It did it in seconds, and it's amazing.

Although it's a small example, this might actually be how a lot of the problems of professional 'hollowing-out' will be resolved.

Hollowing out your profession

Hollowing out is the idea that as the mundane and everyday parts of your work increasingly shift to people and machines that are much cheaper to train and employ than you are, it becomes harder to become an expert.

Conventional wisdom said that the 10,000 hours of low-level, routine, and instrumental work was a necessary foundation for the specialised work that followed.

So how does one become a specialist and an expert in a field when those 10,000 hours of grunt are performed by off-the-shelf apps, low-paid assistants, machines, and robots?

The hollowing-out problem, then, is not so much one of professional deskilling but rather a break in the traditional pathway to specialisation.

LLMs are causing enormous angst in the coding community because many programmers now think that their work has been demystified, and people like you and I can just 'talk' to our computers and ask us to build whatever we want.

I think that a lot of people believe that healthcare and education will be largely immune to this kind of disruption.

But I'm not convinced that there is much in the field of health care or health professional education that humans will still control in 20 years time. I'm not one of those who believes that haptic dexterity or empathy work are sovereign human domains.

I really think that LLMs will have an enormous impact on the way we teach, talk, and touch in healthcare in the future.

Chapter 6: Using theory

The CPN achieved many things over its first decade, but perhaps its greatest success was introducing strong theory to physiotherapy. Before 2010 there had been few overtly theoretical pieces written by, or about, physiotherapy. I'm not talking here about the kind of mid-range, practice-led theories of Bobath or Mulligan, nor the model-based approaches of Cott and Hislop, but philosophical and sociological theory. After 2014, the language of ontology and epistemology began to appear more frequently in the physiotherapy literature, and many members of the CPN were its progenitors.

One aspect of theory I wrote consistently about on the blog was its role in shaping physiotherapy. In the past, theoretical ideas were mobilised by therapists to explain certain ways of thinking and practicing, but in the blogposts in this chapter you'll see how that relationship is inverted. Now, theory comes first: it defines and shapes physiotherapy; gives it meaning and subjectivity. Physiotherapy is not the instigator of theory, but theory's *effect, achievement* or *outcome*.

This chapter is all about the role of theory in physiotherapy then; from the value of philosophy and sociology as forms of therapy, to the future of technical craft and the difference between the physiotherapist as artist or artisan. I touch on the hidden transformative power of PT and some of the radical thinkers in the profession interrogating it. There are specific theoretical discussion on the possibilities for slow physiotherapy, competing theories of movement and rest, embodiment, the rise of personal responsibility, the profession's right to claim that its practice is ethical, transference and counter-transference in practice. Throughout, there is the question of what these theoretical insights now make possible, and a constant opening towards and otherwise physiotherapy.

3 books on the philosophy of walking

30 July 2014

A few months ago, an English translation of Frédéric Gros's book 'A Philosophy of Walking' came out, which prompted me to think about what walking means to physiotherapists and whether some of the more recent philosophies of walking might help us think about what walking means to us as practitioners, philosophers of movement, and walkers.

Walking is a subject that hasn't received a lot of philosophical attention. Like movement, posture and function, they are ideas we, as physiotherapists, claim some ownership over. We certainly teach a lot about these concepts and do a lot of research into aspects of these

phenomena, but do we don't really know what we mean when we say physiotherapy is about 'movement for life'? Do we have a sophisticated understanding of these ideas - sufficient to claim that walking, movement, and the like, are central to our professional identity? I set out to read three related books to find out. The first was Frédéric Gros's 'A Philosophy of Walking'

A Philosophy of Walking

Gros is a well-known continental philosopher but his writing is neither dense nor unreadable. On the contrary, this book is beautifully written. The book takes the reader through 25 short chapters - some only a few hundred words - and each one presents a meditation on an aspect of walking. Some of the themes will be familiar (like the role of walking in creativity and solitude), and others less so.

Common to all three books, Gros intersperses his writing with the work of others who have contemplated the value of walking. Thoreau, Kerouac, Nietzsche, Rimbaud, Rousseau, Emerson, Proust, Baudelaire, Benjamin, Debord and Gandhi, all feature prominently, and all are handled with a lightness of touch that means the book could easily be read by people who might claim to know nothing about philosophy.

The focus of the book seems to me to be a digestible contemplation on the importance of walking to our human spirit and the essence of what makes us human. There is a strong philosophy of embodiment that runs through the text (Gros sees the separation of body and mind as a redundant, western concept), which resonated strongly with me as a physiotherapist.

I loved the book and would recommend it to anyone who wants to ask some fundamental questions about the meaning of walking.

The Lost Art of Walking

Geoff Nicholson's 2008 book is a different beast altogether. Part memoir, part literary biography, the book addresses philosophical questions: "a walk inscribes space in the same way that words inscribe a text" (p.33), but concentrates more on the relationship between walking and art (as the name of the book would suggest).

The book moves between life in the USA and UK with hundreds of cultural references in between. It deals more personally with Nicholson's own walking experiences and follows a metaphorically circular journey through the text.

It's a very funny book. Nicholson is a very accomplished writer, not that different to Bill Bryson in the easy manner he conveys his ideas. So although the book runs to nearly 300

pages, it never feels laboured. It would even make an alternative summer holiday read - but this might be too much like a busman's holiday.

The book includes a really useful Walking Biography at the end and apart from showing the breadth of Nicholson's research, points to other writings on walking that a scholar might find useful.

I also loved this book, but for very different reasons than A Philosophy of Walking. It pointed to a (literary) world that I might now do a lot more reading into. I'm certainly going to read J. G. Ballard differently in the future!

Wanderlust

Wanderlust is different again, and by far and away the biggest book of the three. Where Gros's book took me a day to read. Nicholson's a week. Solnit's book took me a month.

To begin with, the book is older than the other two - having been written in 2001 - but it is also much weightier. The shear volume of research that author Rebecca Solnit put into this book is staggering. Every one of the 300+ pages of tightly packed text, for example, has a running footnote at the bottom which includes a walking-related quote, that includes material from Freude, Goethe, Merton, Pope, Wachusett, and hundreds of others.

So you have to be committed to a lengthy exposition on walking if you're going to read it. Having said that, the writing is superb. Scholarly yes, but always engaging. Solnit, like Nicholson, puts a huge amount of her own experience of walking into the text and uses her own 'journey' (God, I hate that metaphor!) as a subplot in most of the chapters.

Every page includes historical, literary, philosophical, sociological allusions to other works, and each reference is handled with careful thought. The book is a weighty masterpiece that has been repeatedly referenced ever since its first publication. Beware though, it is a huge meal to digest.

The book includes a very comprehensive index and additional resources and would make a fabulous resource for someone doing more in-depth study into walking - even someone doing a quantitative study on gait that wanted to put the rationale and significance of their study into context.

It's important to note that none of these books deal with the evidence that walking reduces knee pain after total knee replacement, or addresses the validity of the Six-Minute Walk Test. These books deal with what walking means, and so they point to a bigger world than can ever be contained within a clinical trial. For that reason alone, they could make an important contribution to a profession that claims to be so much about walking. It would be

nice to see books like this edging out the dry, salty fare that we currently feed our students, but I don't see this happening any time soon.

If I were to recommend any one of these books as a first reader, it would be Frédéric Gros's 'A Philosophy of Walking'. It's easily digestible and beautifully written. All three are fine books however, and well worth reading in their own right.

References

Gros, F. (2014). A Philosophy of Walking. London, Verso.

Nicholson, G. (2011). The Lost Art of Walking. Chelmsford, Harbour.

Solnit, R. (2014). Wanderlust. London, Granta.

Being really critical about thinking

9 August 2014

Because physiotherapy is so grounded in the biomedical sciences, most undergraduate students (and a fair few postgrads) tend to think that critical thinking is about the ability to analyse a research paper. At best this can result in a deep appreciation for the evidence that presently exists for a phenomenon, at worst the students follow a formulaic process to arrive at a score that is as predictable as it is banal. There is, however, another side to critical theory - a world of research and scholarship that these students are rarely, if ever, exposed to - the kinds of thinking that is commonplace in the arts, humanities, philosophy and sociology.

I spend quite a lot of time in this world and often think how great it would be if physiotherapy students could spend more time thinking about assemblages, liquid modernity and social justice. But those are just wild fantasies. I have noticed, however, that there has been a resurgence of interest in critical theory in other health disciplines in recent years - especially in nursing - but that much of this research is poor quality. Many researchers are now claiming that they are doing critical theory work, when in fact they aren't. This came home to me this week in a presentation that I saw by a doctoral candidate.

The presentation was a summary of the researcher's findings as they approached hand-in for their doctoral studies. Their research concerned the injustices of aged care: the way that older adults were forced to leave their homes and go into aged care facilities by their families; the way they lost control of their bodies and their futures; the way they lost their ability to have their voice heard.

All classical critical theory stuff really. Here is a study which seeks to give voice to the marginalized 'other' and uncover the hidden asymmetries of power operating in society.

The problem was with the presenters philosophy, methodology and execution. She presented her rationale as a very personal call to problematize our societal attitudes towards aged care and spoke of her emancipatory zeal. She talked about her extensive use of the work of Michel Foucault "and other critical theorists," and went on to show her findings.

Now I know this candidate. Three years ago she talked to me about doing a Foucauldian study and it was clear then that she had very convoluted thoughts about the direction her study should take. Since then her study does not appear to have gained much more clarity and I don't think her supervisors have helped. She chose a primary who was an out-and-out Heideggerian phenomenologist with a lot of experience of aged care, and a second supervisor who had done a thesis that my old mentor Julianne Cheek would have charitably called 'methodologically slurred.' As a result, it was clear that this candidate had really only paid lip-service to Foucault or critical theory. What she had really done was a basic descriptive ethnographic study and labelled it as critical because it dealt with a subject that outraged her.

Now I confess I am no fan of descriptive qualitative research. I know many people advocate for it (Sally Thorne and Margarete Sandelowski being two recent examples), but I think that qualitative research should tell you things you don't already know, and descriptive qualitative research rarely does this. (We need another study telling us that pain is unpleasant and disrupts people's lives about as much as we need a study showing the effects of hamstring stretching.) So when the presenter told us that aged care is unfair, that it marginalizes people at a vulnerable stage in their life, and that they don't like it, I frankly felt like her three years of study had been three years wasted.

Critical theory is, first and foremost, a powerful philosophical and methodological approach that is far removed from the homespun wisdom of the descriptive qualitative study. Too many people, it seems, are eager to call their research 'critical' when in fact what they are doing is just basic ethnographic research. So in an attempt to clarify my argument, I've put together five principles that need to be evident to me for a study to be called 'critical'. They are as follows:

For a study to be critical, it must:

- Be grounded in an asymmetrical power relationship - there must be someone being marginalized, not by choice but because of some innate unfairness.
- Have a strong foundation (and here I mean a deep reading not just a cursory mention) in the work of a critical theorist - Marx, Habermas, Butler, Freire...there are many, use them.

- Follow a suitable methodology - to emancipate the voice of the marginalized other you need to hear people's voices, but that doesn't mean you only use interviews. Look for the structural constraints on them too. Consider economics, environment, patterns of movement, and other material realities.
- Resonate with your philosophical and methodological approach. Ground your analysis in a coherent research framework and avoid the cliched qualitative themed categories that seem to stand on their own, detached from the research that generated them.
- Be reflexive - clearly the study derives from, and throughout is driven by, your own emotional response to injustice or unfairness, but this does not mean that the study should be your way of assuaging any guilt of impotence you might feel. If your findings tell you nothing more than you could have told me at the start of the project, you have wasted your time and mine.

Critical theory is a problematic area, not least for Foucauldian scholars like me who find the whole idea of power as oppressive problematic, but the cause of this vital approach to research is not being served by well-meaning, but ultimately superficial studies that are claiming to be critical. Physiotherapy desperately needs critical theory researchers who are brave enough to tackle some of the injustices that we perpetuate every day in our body-centred practice. My hope is that we don't go the way of other researchers in recent years and simply call our research critical, when it is anything but.

New article 'Mobility, empire, colonisation' by Tony Ballantyne

13 August 2014

From History of Australia, 2014, 11(2)

Abstract: This article examines the role of mobility in the operation of modern maritime empires and identifies some of the particular ways in which mobility was constituted as a ‘problem’ in debates over colonisation. After briefly mapping a range of ways in which different forms of mobility underwrote the processes of empire, the article turns to the colony of Otago. It sketches how arguments about the meaning of different types of movement played out in a specific colonial location where tensions over

> fixity and mobility stood at the heart of struggles over the meaning of both 'empire' and 'community'.

Health as pornography

25 August 2014

Drawing a long bow, I know, but with a few minor amendments, Loïc Wacquant could actually be talking about physiotherapy...or medicine...or any of the other health professions that adhere to the medical model:

> '…the (physiotherapy) merry-go-round is to (health) what pornography is to amorous relations: a mirror deforming reality to the point of the grotesque that artificially extracts (deviant movement) from the fabric of social relations in which they take root and make sense, deliberately ignores their causes and their meanings, and reduces their treatment to a series of conspicuous position takings, often acrobatic, sometimes properly unreal, pertaining to the cult of ideal performance rather than to the pragmatic attention to the real.'

From Wacquant, L. (2009). Punishing the Poor: The Neoliberal Government of Social Relations. Durham, Duke University Press, pp.xii-xiii.

Important new edition of Body and Society - Movement and cultural theory

7 October 2014

"There is never a body as such...a body is its movement"

Body & Society has just announced a special edition of it's journal, with a large part devoted to movement and phenomenology.

The edition features a number of important writers on the philosophy of movement, but I wanted to draw your attention to some new work from Erin Manning - author of the brilliant book 'Relationscapes' which offers an amazing critical analysis of movement.

I've included abstracts and keywords to the four main articles that concentrate on Manning's critique of Merleau-Ponty's phenomenology and Alfred North Whitehead's process philosophy.

Wondering the World Directly – or, How Movement Outruns the Subject - Erin Manning

Abstract: Turning to the moment when phenomenology (Maurice Merleau-Ponty) meets process philosophy (Alfred North Whitehead), this article turns around three questions: (a) How does movement produce a body? (b) What kind of subject is introduced in the thought of Merleau-Ponty and how does this subject engage with or interfere with the activity here considered as 'body'? (c) What happens when phenomenology (Merleau-Ponty) meets process philosophy (Alfred North Whitehead)? and builds around three propositions (a) There is never a body as such: what we know are edgings and contourings, forces and intensities: a body is its movement (b) Movement is not to be reduced to displacement (c) A philosophy of the body never begins with the body: it bodies. Keywords: body, movement, phenomenology, process philosophy, subject, Wonder, Movement and Becoming

Wonder, Movement and Becoming: Response to Erin Manning - Stamatia Portanova

Abstract: This response experiments with the practice of the interval, in order to performatively write in the little perceptual and cognitive gaps opening between the act of reading Erin Manning's article 'Wondering the world directly', and the gesture of looking at the sky. The idea of the interval is in fact taken directly from Manning's piece, together with Whiteheadian concepts such as 'prehension', 'superject', 'nexus', 'eternal object' and 'society'. The aim is to respond to the way Manning's writing amplifies the experience of cloud watching by proposing an elision of consciousness from the experience itself, and by replacing subjectivity with the more-than-human magic of 'wondering the world'. It is, therefore, thanks to the reading of Manning's article, that the experience of looking can reveal itself as a 'becoming-cloud'. This response tries to also give something in conceptual exchange. Keywords: clouds, movement, perception, process philosophy.

Thinking in Movement: Response to Erin Manning - Maxine Sheets-Johnstone

Abstract: This review of Manning's article wonders at the wonder that Manning describes. It does so first in broad terms that question the experience of wonder that Manning describes and goes on to wonder specifically about her understanding of the experienced realities of thinking in movement. In the course of doing so, the review questions her sweeping

away ‘the subject’; questions her hard-and-fast distinctions between phenomenology and Whitehead’s metaphysics and voices wonder about her neglecting complementarities between phenomenology and Whitehead’s metaphysics; questions the validity of her claims about ‘where phenomenology goes wrong’; wonders about the absence of kinesthesia and its qualitative dynamics in what she writes of human movement; and finally wonders about her non-substantiated claims about ontogeny. Keywords: phenomenology, subject, thinking in movement, Whitehead’s metaphysics, wonder

A Phenomenology of/with Total Movement: Response to Erin Manning - Jodie McNeilly

Abstract: In ‘Wondering the world directly’, Erin Manning criticizes phenomenology by drawing upon Merleau-Ponty’s reflections on the problems of his own project and the criticisms of José Gil. Manning claims that phenomenology goes ‘wrong’ in its privileging of the subject and processes of intentionality: the ‘consciousness–object distinction’. While phenomenology on this understanding alone is inadequate to account for movement and the body, process philosophy has the ‘ability to create a field for experience that does not begin and end with a human subject’. This article responds to Manning’s criticism by arguing that phenomenology never intended to perpetuate a concept of subject that fixes an inexorable gap between itself and objects. A historical assessment of subjectivity and intentionality in the work of five different authors, alongside critical points that address Manning’s misconstrual of phenomenology, leads to an understanding of movement that need not ‘outrun the subject’ or become a precarious limit to perceptual experience because of its primacy. Keywords: body, Edmund Husserl, intentionality, Erin Manning, movement, phenomenology, subjectivity

Qualitative Inquiry and the debate between hermeneutics and critical theory

14 October 2014

A new article has just been published in Qualitative Health Research by two authors from University of Toronto that people within the Critical Physiotherapy Network might know well. James Shaw and Ryan DeForge contributed to an edited collection on Philosophy and Physiotherapy that Barbara Gibson and I co-edited in August 2012 (full version available at

the bottom of this post). Jay and Ryan's new paper is titled *Qualitative Inquiry and the Debate Between Hermeneutics and Critical Theory* and the abstract follows.

> Abstract: Two issues have been central to ongoing disputes about judgments of quality in qualitative inquiry: (a) the ways in which paradigmatic orientations are understood to guide procedural decisions and (b) the meaning and intelligibility of paradigmatic incommensurability. In this article, we address these two key issues through an exploration of the debates between hermeneutics and critical social theory, including the exchanges between Hans-Georg Gadamer and Jurgen Habermas, and between Richard Rorty and Thomas McCarthy. We suggest that the key epistemological issue addressed in these debates is the nature of interpretation, separating the two philosophical camps based on beliefs about whether foundational knowledge is possible to achieve. We conclude the article by discussing the implications of these different positions for beliefs about quality in qualitative inquiry, and comment on the role of judgment in assessments of the value and quality of different approaches to qualitative research. Keywords: critical methods, hermeneutics, interpretive methods, language / linguistics, research design, research evaluation, research, qualitative

Update on philosophy of walking

23 December 2014

A few months ago, I posted a review of three brilliant books about walking. I wanted to highlight these books because walking is not only a fundamental part of everyday life, it's also a defining feature of a lot of physiotherapy practice, and I'm often bemused by how narrow-minded physiotherapists are about it. It's almost a metaphor for the profession: here is a human experience that has been written about for centuries, that engages all manner of human achievement, and we've reduced it to mere gait patterns.

The point about all three books is that walking is so much more than heel strike and toe off. Not that these are unimportant, but in the grand scheme of things I don't believe we are serving our patients or our profession well at all if we ignore the existential dimensions of walking. Sadly, there will be many physiotherapists who will spend their entire time today simply walking patients up and down a ward to confirm that they are safe to go home. Practices like this will see the end of physiotherapy as we know it.

So to keep the door open to thinking differently about walking, can I add to the list a fourth book that I read this year that shows how much brilliant writing there is around this area.

The Old Ways: A Journey on Foot - by Robert Macfarlane

'Following the tracks, holloways, drove-roads and sea paths that form part of a vast ancient network of routes criss-crossing the British Isles and beyond, Robert Macfarlane discovers a lost world - a landscape of the feet and the mind, of pilgrimage and ritual, of stories and ghosts; above all of the places and journeys which inspire and inhabit our imaginations.'

So says the book jacket. But this is far more than this. Macfarlane is an amazing writer. He can write about the world around him like few others. This is a beautiful, lyrical book and one I would recommend to anyone who loves walking out in the countryside. Macfarlane has another book called The Wild Places which I'm hoping to read over the summer.

One of the other authors I featured in the earlier post on walking was Rebecca Solnit. Solent's book Wanderlust is a comprehensive and erudite account of a personal philosophy of walking. I loved it and so have looked up a lot of Sonit's writing since. Creative non-fiction fascinates me, particularly the stuff that has a strong connection to history and philosophy, so I'm going to have to read her book A field guide to getting lost.

The book 'is an investigation into loss, losing and being lost. Taking in subjects as eclectic as memory and mapmaking, Hitchcock movies and Renaissance painting, Rebecca Solnit explores the challenges of living with uncertainty. Beautifully written, this book combines memoir, history and philosophy, shedding glittering new light on the way we live now.'

And while we're on the walking theme, I'll add this to my list: Born to Walk : The Transformative Power of a Pedestrian Act Hardcover by Dan Rubinstein sounds like a very good read. 'The humble act of putting one foot in front of the other transcends age, geography, culture and class, and is one of the most economical and environmentally responsible modes of transit. Yet with our modern fixation on speed, this healthy pedestrian activity has been largely left behind. At a personal and professional crossroads, writer, editor and obsessive walker Dan Rubinstein travelled throughout the UK, the US and Canada to walk with people who saw the act not only as a form of transportation and recreation, but also as a path to a better world.'

Hopefully Santa will bring me a book voucher for Christmas!

Metaphors of rhizomatic thinking

22 January 2015

Earlier this week Mike Stewart (@knowpainmike) ran a @physiotalk Tweet Chat on the hidden influence of metaphor in physiotherapy (see here, and Mike's excellent review of the Tweet Chat here). It inspired me to think about the role metaphors play in learning.

If you follow this blog regularly, you will have heard the name Gilles Deleuze. If you haven't heard this name though, it might pay to do a bit of web trawling, because some of his ideas are pretty astonishing. There have been some startling thinkers emerge from Europe over the last 100 years - Heidegger, Foucault, Sartre, Derrida, Adorno, etc. - but, for pure inventiveness, Deleuze takes the biscuit. (One tip though...I would not go to Amazon and buy one of Deleuze's books on the basis of this recommendation. His writing is impenetrable if you don't know what to expect and you haven't done your homework. Don't say you haven't been warned!)

One of Deleuze's revolutionary ideas concerns rhizomatics. Deleuze believes that thinking is misunderstood when we use tree metaphors to explain it. All too often, Deleuze says, we refer to its roots firmly grounded in the terra firma of reason and science, it's branches of knowledge, all leading to the juicy fruit at the tip of each branch. Deleuze calls this kind of thinking 'arborescent' (meaning 'tree-like'), and argues that thinking and learning is not really like that. While it might be part of the Enlightenment fantasy to see knowledge take such linear forms, it rarely represents reality.

Take education in health care, for example. An arborescent metaphor of learning would see graduate students as the ripe fruit at the tip of the branch. They are the product of many years of growth and maturation. They are separate from other fruit (autonomous thinkers), but they have shared some similar branches of knowledge. All of the fruit on this side of the tree has matured into physiotherapists, whose trunk was distinct from those who went off to become doctors, or nurses, or radiographers. But they all shared a common stem (basic sciences) whose roots are grounded in the firm soil of reason and logic. Learning is a process of maturation, and when the fruit has served its purpose, it falls to the ground to replenish the next generation's learning.

Arborescent ideas have been very powerful in our recent history. Look, for example, at this review of the beautiful 'Book of Trees' here to see how pervasive arborescent metaphors have been in our cultural history. They have governed how we think we learn, how we like to organise ourselves and our time, how we think about problem solving. But it is also, after all, only a metaphor; a simpler way of understanding something complicated. We have been learning to think like this since we were little green shoots in the ground. But it isn't the only way to think, and it might not even be the best way today.

One of Steve Wheeler's recent blogposts looked at the need for creativity in learning.

In the post, Steve asked 'What happens when you remove restraints from learning, and allow students to discover for themselves? What happens when students are given problems to solve rather than solutions to apply? What happens when students are given blank canvases, digital cameras, an open space? Often, the result is some form of creativity.'

I've talked before about the importance of opening space for uncertainty and unpredictability with our students before, but of course this runs counter to what you're supposed to do with arborescent thinking. There is no room for deviation when you're trying to produce fruit for export! Everything has to follow along straight lines so that no time or energy is wasted. Henry Ford would be proud of the efficient way we now produce health graduates fit for practice. But is it good for the patient?

The other day I posted about Open Badges and the way they are challenging the right of authorities like universities and professional bodies to define what the fruit at the end of the branch looks like. Sites like Crowducate are promoting alternatives to linear, arborescent education and using rhizomatic metaphors like this to do it.

21st century learning is looking increasingly like it will subvert the idea of linear, arborescent thinking, creating learners who are far more flexible and adaptive to a less-than-certain future. Physiotherapists need to get their heads around this and find better metaphors for learning than just an age-old reliance on trees.

This is where Deleuze may come in.

Deleuze said 'We're tired of trees. We should stop believing in trees, roots, and radicles. They've made us suffer too much. All of arborescent culture is founded on them, from biology to linguistics' (Deleuze & Guattari, 1987 p.15). Deleuze proposed an alternative way of thinking that was, what he called, rhizomatic.

Learning and knowledge, he said, was much more messy. Ideas actually had no beginning or end, and you were always in the middle - in one form or another. In fact there are multiple 'middles' - every point is just another 'middle.'

Dave Holmes and Denise Gastaldo have written that unlike trees '...the rhizome is open at both ends. It has no central or governing structure; it has neither beginning nor end. As a rhizome has no centre, it spreads continuously without beginning or ending and basically exists in a constant state of play. It does not conform to a unidirectional or linear reasoning' (Holmes and Gastaldo, 2004, p.261). (The Holmes and Gastaldo paper actually offers a really useful introduction to the whole idea of rhizomatics and is well worth reading).

The point is that the metaphor of the rhizome might provide a more useful way to think about the future of learning, and offer something more relevant to the way learning is

emerging as a distributive, community activity in the 21st century. It might be time to turn away from trees and focus on the fungi instead.

References

Deleuze, G., & Guattari, F. (1987). A thousand plateaus — capitalism and schizophrenia. Minneapolis: University of Minnesota Press.

Holmes, D., & Gastaldo, D. (2004). Rhizomatic thought in nursing: An alternative path for the development of the discipline. Nursing Philosophy, 5, 258-267.

Evidence-based medicine or micro-fascism?

21 March 2015

> ’We can already hear the objections. The term fascism represents an emotionally charged concept in both the political and religious arenas; it is the ugliest expression of life in the 20th century’.

Not my words, but those of Dave Holmes and Stuart Murray in their fabulous paper *Deconstructing the evidence-based discourse in health sciences: Truth, power and fascism*. The author's argument is that we desperately need to unmask the 'the hidden politics of evidence-based discourse' (181).

A recent Australian report on the efficacy of homeopathy has shown that ‘There was no reliable evidence from research in humans that homeopathy was effective for treating the range of health conditions considered,’ and that ‘Homeopathy should not be used to treat health conditions that are chronic, serious, or could become serious.’

And yet, according to Vox, Americans spend more than $34 billion each year on 'alternative' medicine each year, with $3 billion going on homeopathy.

You might argue that this is a call for more evidence-based research and greater efforts to convince the public about the efficacy of treatment A over treatment B, but I'm not sure it doesn't point to a bigger failure of the evidence-based medicine movement to convince the public that medicine still holds the answer to the population's health.

In what must be one of the most comprehensive and most scathing editorials ever written, Andrew Miles and colleagues take the advocates of evidence-based medicine to task. They argue that evidence-based medicine is intellectually bankrupt and overdue retirement. They accuse protagonists of EBM of unscientific and antiscientific posturing in an attempt to 'protect the cherished ideological convictions of the EBM community' (621), or showing 'the magisterial disdain of criticism that we have noted on multiple occasions previously and

which more accurately characterises the modern politician than the intellectual' (621). Advocates of EBM are, they argue;

> '…extraordinarily lacking in intellectual credibility, are profoundly revisionist and demonstrate that little has changed in terms of EBM's ideology or hubris with the exception of an increase in self-delusion and a refusal to accept that EBM is 'finished' in scientific, philosophical and clinical terms' (622).

References

Holmes, D., Murray, S. J., Perron, A., & Rail, G. (2006). Deconstructing the evidence-based discourse in health sciences: Truth, power and fascism. International Journal of Evidence-Based Healthcare, 4(3), 180-186.

Miles, A., Loughlin, M., & Polychronis, A. (2008). Evidence-based healthcare, clinical knowledge and the rise of personalised medicine. J Eval Clin Pract, 14(5), 621-49. doi:10.1111/j.1365-2753.2008.01094.x

Touching something important

20 May 2015

In a fantastic comment on my latest blogpost in this mini-series looking at the innate and largely unspoken sensuality of physical therapy, Eric Kruger posted up a video from Youtube which shows Ken Cole and Rajesh Khemraj in a tutorial looking at the SI Joint at a 2014 NAIOMT Annual General Meeting.

In the comment, Eric concentrated on the question of the power asymmetry that exists in therapeutic practice. I wanted to extend this discussion on a little here, so iIf you haven't read it already, I strongly advise looking at it before reading on.

Let's take a moment to deconstruct the video Eric posted up a little. Here we have three men 'manipulating' the body of the young female 'subject.' They speak about her body not about her. They teach from the basis that one SI joint is pretty much like all others (ergo, it could have been any body that they were manipulating, it did not have to be a young female model), and the assumption is that these measures effectively remove all semblance of sensuality from the encounter.

This approach to the body is one of the defining features of physiotherapy practice. It has been the basis of our approach to care for over a century, and it borrows heavily from a scientific and biomedical view of the body-as-machine. By taking a technical approach to the

manipulation of the woman's body, the therapist projects an image of enlightened detachment that, it is hoped, tacitly reassures the patient of their competence and their dispassionate disinterest in her as a living, breathing young woman. She is reduced to an S-I joint - maybe the third one they have seen today - and she is interesting only in the way that the three 'cases' can be clinically differentiated.

There are clearly a lot of merits to this approach, and I am not being facetious here. Going to a therapist who is interested in one's body parts and does not look at you as a sensual object of sexual desire is an important way in which we engender trust in our clients/patients. It is a mark of respect and no small amount of professionalism. People come to see us for our therapeutic experience and knowledge, and do not want us to cross the line into a personal engagement with them as sensual beings.

But as Simon Williams argues;

> 'As the history of western civilization shows, bodies are amenable to discipline and control – from the prison to the factory, the school to the asylum – but this nonetheless fails to detract from the fact that they are always threatening, through their libidinal flows and corporeal desires, their pleasures and their pains, their agonies and their ecstasies, to 'overspill' the culturally constituted boundaries which currently seek to 'contain/constrain' them. Indeed, it is from these 'unruly' desires that the need for corporeal 'discipline' arises...Bodies, in short, from their leaky fluids to their overflowing desires and voracious appetites, are first and foremost transgressive: demonstrating their continual resilience to rational control' (Williams, 1998, p. 438).

This is a very dense but beautiful way of saying that try as we might, we cannot contain the sensuality of touch simply by appearing to be interested only in the body-as-machine.

In some ways, the image of the three specialists working on the body of the young woman, using their status and expertise to handle her in ways that would be permissible only in the context of a therapeutic encounter, reminded me of the classic image of Charcot and his 19th century lectures on hysteria.

What is odd about this is not so much that the woman is the subject of the male objectifying gaze (such a common feature of modern media culture - with all its attendant harms to women's self-image), but that we have normalised it to the point that we are not surprised when it happens.

It used to be custom and practice that physiotherapy students 'stripped off' early on in anatomy classes as a way to condition them to seeing the body dispassionately. We learnt

from anatomy textbooks that perpetuated the idea that one SI joint was pretty much like any other, and that there was no 'I' in anatomy. We were disciplined to see the body-as-machine for lots of very powerful reasons, but one of the most important was as a mechanism to deal with the innate sensuality of our work.

The problem is that we lose as much from this approach as we gain. A point I want to return to shortly.

Reference

Williams, S. J. (1998). Health as moral performance: ritual, transgression and taboo. Health: An Interdisciplinary for the Social Study of Health, Illness and Medicine, 2(4), 435-457.

Interviewing women: A contradiction in terms

29 May 2015

Many years ago I read a book chapter that would have a profound effect on how I thought about my practice as a health professional, and dramatically shape the future direction for my research and the way I thought about the world generally. That chapter was titled *Interviewing women: A contradiction in terms* and it was written by Anne Oakley. Oakley has just published a follow up paper titled *Interviewing Women Again: Power, Time and the Gift*, and reading it reminded me why it had such a profound impact on me 20 years ago.

In the early 1990s I was working at The Children's Hospital in Birmingham (UK) and studying a masters degree in research methodology. The degree was life-changing. It was offered by a department that was steeped in radical left-wing politics. Instead of boring lectures on One-Way ANOVAs and Chi-Squared tests, we talked about black feminist methodologies and critical disability theory. I felt like I'd come home.

I'd always been quite an argumentative physiotherapist. The worst thing that anyone could say to me was 'we've always done it this way.' It seemed like they were just begging me to say 'why?' Surprisingly, few people ever seemed to want to asked the question, so I often found myself being the odd one out in classrooms and staff meetings. Not in my masters class though. Here I felt like I'd walked into Greenham Common protest march wearing a pin-striped suit and a bowler hat. Here I was the conservative one: the one with all the problems. (I was, after all, a straight, white, male, middle-class health professional in a world that was anything but).

Rather than being intimidating, I found it completely liberating. I came to realise that there were library shelves full of books that resonated with the way that I thought, and none of these were in our medical school library. There were people thinking and writing about people not patients; experiences not pathologies; and illness not disease. I was hooked.

Writers like Simon Williams - now a Professor of Sociology at Warwick University - showed me a world no-one at physio school ever even intimated they knew about. His 1993 book Chronic Respiratory Disease was a revelation. I learnt more from that book about the realities of living with chronic respiratory disease than any clinical textbook I'd read in the years before. And then came Anne Oakley's chapter.

I can't remember why we read it, but I do remember that I couldn't put it down. Finally, here was someone who talked about the power that exists between the clinician/interviewer and the patient/interviewee; the way that 'classical' interviews were all about taking things from people and giving nothing back; the ridiculous game of not being able to respond to interviewees questions; and so on. Here was justification for having conversations with my patients, not interrogating them in some excuse for rigorous science. Oakley's argument that these techniques of interviewing are gendered made total sense to me, and probably began, for me at least, a lifelong interest in the ways that women are situated in health care.

It would be glib to say that from that day onwards I became a feminist, but it didn't do any harm.

And now Anne Oakley has brought out a follow-up paper to her 1981 classic. In the new paper she reprises her argument and looks at the effect the paper has had on her career, on the development of qualitative research, and on feminism. She pulls no punches and is as honest about her critics as she is about the weaknesses of her own thinking back then. But I can forgive her all of these things, because she changed the way I thought about research, and there's not a day goes by when I don't think her little book chapter hasn't influenced how I think and practice today.

Vive la revolution!

References

Oakley A (1981) Interviewing women: A contradiction in terms? In: Roberts H (ed.) Doing Feminist Research. London: Routledge and Kegan Paul, 30-61

Oakley, A. (2015). Interviewing women again: Power, time and the gift. Sociology. (online early). doi:10.1177/0038038515580253

Why is ignorance so important to clinical practice?

23 June 2015

One of the best presentations I saw at the recent *In Sickness and In Health* conference, was by Trudy Rudge and Amelie Perron titled *In praise of ignorance? Towards an epistemology of "unknowing" in nursing and health care*.

Rudge and Perron are both brilliant critical nursing researchers, and they were previewing some of the ideas in their upcoming book.

Their argument was in part that although we might like the idea of certainty in our practice, certainty is not always available. More than this, certainty and risk have become hallmarks of good practice, when in fact, our ability to embrace uncertainty is a much more significant feature of mature clinical practice.

So much time is spent in western science trying to eliminate uncertainty and ambiguity through logic and reason that it is easy to see complexity as simply a set of variables to be manipulated and managed. While this might work as a way of understanding human beings biologically, it doesn't work so well in the real world.

Rudge and Perron's project, then, is an exploration of the epistemology (how we know what we know) of ignorance, that challenges the ways in which we simplify, quantify and standardise care.

Their focus is on the messiness of practice and embracing ignorance as a productive and creative urge that governs most of our desire to know more, question what we do, and grow.

Rudge and Perron promoted the idea of productive ignorance, giving a positive face to an idea that is often portrayed by science as something to be eliminated. Their argument was that ignorance is not something that should be left for science to resolve, but needs to be explored with approaches that embrace uncertainty, ambiguity and unpredictability.

In many ways this idea mirrors the idea of silence in teaching and learning that I had written about in an earlier post (link). Silence and ignorance are important concepts in critical theory, because they reject a lot of the traditionally scientific ways we've come to view the world and they emphasise the indeterminacy of real practice.

Silence and ignorance are significant concepts in teaching, learning and practice because they both refer to the space between where one's thoughts and actions might be right now, and where the might need to be in the future. For instance, I might have a patient who has

problems I've never encountered before. The traditional approach to these problems might be to try to fill the void with knowledge that may be offered as 'facts.' The effect of this is that it closes down the inherent ambiguity of the patient's situation and removes the desire to explore further research and learn that is made possible by recognising one's ignorance. By contrast, embracing the void that exists between what you currently know and what you might need keeps alive the possibility of more learning, more growth and more critical inquiry.

While this approach is critical of the dogma of science in health care, it also recognises that science can provide some of the ways to navigate across the void. It goes beyond this though, to argue that sometimes ignorance and silence are better.

Is qualitative research in decline just as physiotherapy ‘gets’ it?

6 July 2015

Over the last few months I've been reading more and more about the demise of qualitative research.

This isn't coming from clinical scientists and quantitative researchers, but from people who have been invested in the field since its inception in the late 1980s.

The argument they make is that qualitative research has now become too formulaic, systematised and too heavily methodological. It's lost its critical power and forgotten what qualitative inquiry was meant to be able to do.

One of the people who explains this best is probably Elizabeth St Pierre Adams, and in this recent video from last year's Australasian Association for Research in Education (AARE) conference, she explains the personal trajectory she has gone through as first a passionate advocate for qualitative research, and latterly as one of its fiercest critics.

There is a beautiful, easily read, and lengthier explanation of Adams' critique in this article that is well worth reading, particularly if you are a student or teacher of qualitative research.

The challenge that Adams poses is to engage in a kind of critical research that looks beyond the kinds of qualitative studies that are all too common now in health care. These are the studies where well meaning researchers interview a few people, code and categorise their findings, and do a 'thematic analysis' of the data, to reveal three or four key themes that don't tell you anything you knew already. You know the kind of thing: pain is complex , MS causes life disruption, people yearn for hope, etc.

Adams talks about how in the early days of qualitative research they didn't know what its potential could be; how it was exploratory, social, deeply critical and philosophical.

As it gained people's attention, especially in places like health care, it started to be critiqued by clinical scientists who said it wasn't rigorous or valid, that it lacked generalisability and did nothing to help people with clinical judgements.

As a response to this criticism, qualitative researchers focused a lot of their attention on methodology, going to real lengths to try to make qualitative researchers as rigorous, as credible and as trustworthy as the best of the clinical sciences.

But something got lost along the way and qualitative research has all but lost its critical dynamism. It is so bound in the rigorous application of methodological formulae and prescriptions, and there are now library shelves full of methodological text books and thousands of articles demonstrating qualitative research, rigorously executed.

I've done this myself. I've spent years teaching qualitative research and published papers where I set out how physiotherapists might understand it and do it better (see references). But I've always found it hard to teach this way and have tried never to be a slave to methodology in my own research practice.

So where does this leave physiotherapy? Qualitative research has really started to gain a foothold in physiotherapy in recent years, and it is definitely opening our eyes to the possibility of new ways of thinking about things like activity, bodies, function and movement, but there is a lot of relatively poor quality qualitative research coming out of physiotherapy. Despite Adams' criticisms, there is too much low grade, thematic analysis being offered to journals for review.

Fortunately, there are some real pioneers in the profession and many are part of the Critical Physiotherapy Network.

At the recent In Sickness and In Health conference in Mallorca, 12 of us from the Network got together for an afternoon and used the opportunity to debate a paper on posthuman education (pdf). Many of the ideas in this paper are being embraced by researchers in the emerging field of 'new materialism,' of which Elizabeth St Pierre Adams is a 'member.'

Some of the other people pioneering this work are people like Brian Massumi, Clare Colebrook, Erin Manning, and some of those mentioned at the beginning of the video above: Noel Gough, Eileen Honan, Erica McWilliam, Bronwyn Davis, Maggie MacLure.)

It may be that one area of fertile debate within the profession will be around how a post-human physiotherapy might need to emerge in the years to come.

References

St Pierre, E. A. (2014). A brief and personal history of post qualitative research: Toward "post inquiry". JCT (Online), 30(2).

Nicholls, D. A. (2009a). Qualitative research: Part one – philosophy. International Journal of Therapy and Rehabilitation, 16(10), 526-534. doi:http://dx.doi.org/10.12968/ijtr.2009.16.10.44562

Nicholls, D. A. (2009b). Qualitative research: Part three – methods. International Journal of Therapy and Rehabilitation, 16(12), 638-647. doi:10.12968/ijtr.2008.15.12.45420

Nicholls, D. A. (2009c). Qualitative research: Part two – methodology. International Journal of Therapy and Rehabilitation, 16(11), 586-592. doi:10.12968/ijtr.2009.16.11.44939

Snaza, N., Appelbaum, P., Bayne, S., Morris, M., Rotas, N., Sandlin, J., . . . Weaver, J. (2014). Toward a posthumanist education. Journal of Curriculum Theorizing, 30(2).

Why physiotherapy is not patient centred

9 July 2015

Patient centredness is becoming a widely used, but poorly understood, concept in medical practice. It may be most commonly understood for what it is not —technology centred, doctor centred, hospital centred, disease centred (Miller, 2001: 322).

There are a lot of practitioners and professional bodies that claim that their practice is patient centred. And why not. If people expect this to be stated as a defining feature of health professional practice today, why wouldn't you say it? After all, we work with patients don't we? We treat people every day. How could we not be patient centred?

But isn't it interesting that this needs stating at all? Because how could health care not be patient centred?

So why is it only recently that the phrase has appeared in the health literature and in the mission statements of professional bodies?

Perhaps it needs stating so much because, perversely, people no longer feel at the centre of health care?

A great deal of literature has been written over the last few years explaining how health care, and especially medicine is patient centred, but many of these explanations offer quite a weak definition of patient centred care. These tend to keep the health professional at the centre of decision-making, 'empowering' patients to be more involved. Patients are listened to and

consulted, but at no time is the professional's power weakened or authority questioned. Take this example from a recent paper by Kvåle and Bondevik, for example;

> 'Today...both healthcare professionals and administrators clearly recognize that patient centred care is important. Patients' values and perceptions must be acknowledged to make care evidence based and to meet the demands of quality improvement processes. Patient centred care is a widely used phrase, but the concept is complex and not well defined. Lewin et al. suggest the following definition of patient centred care: healthcare providers share control of consultations, decisions about interventions or the management of health problems with patients. Kitwood and Bredin suggest that patient centred practice can be achieved if practitioners understand users' needs and engage in positive work with them...Studies have identified important aspects of good care from the patient's perspective. These include telling them in understandable language what is important for them to know about the disease and treatment, being honest with them about their medical conditions, listening to them, checking their perceptions before initiating action and helping them in their thinking with regard to their disease and treatment (10–12)' (Kvåle and Bondevik, 2008: 582-3).

Like Kvåle and Bondevik, most of the literature supports the view that patient-centred care is achieved when patients are listened to, consulted and involved in clinical decisions. But when has health care not been about these things? What then differentiates patient-centred care for what we should take to be normal everyday care?

To answer this question, we have to acknowledge that 'healthcare professions have traditionally adopted a patriarchal model of practice – one that acts in the patient's 'best interest'' (from our own Gwyn Owen, writing about patient centred care for the CSP in 2013, link). In a recent study looking at physiotherapy's level of 'comfort' with patient centred care, Suzie Mudge and Caroline Stretton recently suggested that 'Previously we considered person-centredness to be the antithesis of the biomedical model and by extension, dichotomous. We either were or we weren't and therefore we were. Of course we rejected the biomedical model and embraced client-centred practice! Our assumption of our own person-centred practice was evidenced by the good rapport that physiotherapists invariably develop with patients. We like to think that, as physiotherapists, we understand what patients need; after all, our expertise in health and functioning gives us considerable insight' (Mudge & Stretton, 2013: 460). There is a different, though, between 'liking to think we are patient centred, and the reality of the principal.

Patient-centred care is a radical shift in the power relationships that have long governed health care. Here the consumers or service user is literally at the centre of all decision-making: not at the centre because we want them to think and feel as if they are important, but actually in the centre of their care. This means that health professionals do not 'consult' with people before making their clinical decisions, but instead consumers and service users consult with us. People are no longer clients of the health care system, we are their clients. 'Lay' perspectives - the slightly patronising term used for the knowledge people have about their own bodies, their own health, activities, beliefs and interests - become the starting point for discussions about assessment, diagnosis, rehabilitation and treatment and not a nice-to-have addition to our supposedly more rational and detached objective outcome measurements. As well as people being in charge of their own personal health care, decisions are also made at the community level and are driven by consumers and service users not professionals. And at a regional and national policy level, professional bodies and vested interests play second fiddle to democratically representative groups of patients that call on health professional advice when they need it.

Naturally, health professionals and their professional bodies are unlikely to relinquish their power and radically change the way that health decisions are made. Everyone these days is scrabbling to ensure that their profession survives the austerity measures and neoliberal economic reforms sweeping through health and social care. When patient-centred care is 'Enshrined by the Institute of Medicine's "quality chasm" report as 1 of 6 key elements of high-quality care' and 'health care institutions, health planners, congressional representatives, and hospital public relations departments now include the phrase in their lexicons' with 'Insurance payments...increasingly linked to the provision of patient-centered care' (Epstein & Street, 2011: 100), it is no surprise that we claim we are patient centred.

It is ironic then that the physiotherapy profession - which also claims that it is 'evidence based' - has produced almost no evidence to justify its claim that it is patient centred. Physiotherapy is very much an orthodox profession which has long centralised power around the professional body. This doesn't mean that we do not care for people, or that patients aren't pivotal to our very existence, but to claim that we are patient-centred may be the health care equivalent of the kinds of 'greenwash' that we are now seeing in the environmental movement.

In summary, we were uncomfortable with aspects of person-centred practice, because as we now understand, our practice is often more focused on a ''body as a machine'' perspective that separates the mind from the body and positions the physiotherapist as the primary expert in a way that discounts the views and preferences of the patient. As a consequence, we prioritise ''doing to'' rather than ''being with,'' the collaborative approach that underpins person-centred practice (Mudge & Stretton, 2013: 461).

If you would like to read more on this radically different view of patient centred care, there is a good overview post here, and Gwyn Owen's piece for the CSP provides an excellent overview of patient-centred physiotherapy with some useful follow-on resources (link). There is also a lot of related material in the fields of emancipatory practice, post-colonial and indigenous research, critical theory, feminist research, queer theory and disability rights work that you will find by many of the people in the Critical Physiotherapy Network.

References

Epstein, R. M., & Street, R. L. (2011). The values and value of patient-centered care. The Annals of Family Medicine, 9(2), 100-103. doi:10.1370/afm.1239

Kvåle, K., & Bondevik, M. (2008). What is important for patient centred care? A qualitative study about the perceptions of patients with cancer. Scandinavian Journal of Caring Sciences, 22(4), 582-589. doi:10.1111/j.1471-6712.2007.00579.x

Miller, L. (2001). Towards a global definition of patient centred care. British Medical Journal, 322.

Mudge, S., Stretton, C., & Kayes, N. (2013). Are physiotherapists comfortable with person-centred practice? An autoethnographic insight. Disability and Rehabilitation. doi:10.3109/09638288.2013.797515

Three theses on gender and physiotherapy

11 July 2015

Gender is an issue that has become increasingly important in physiotherapy scholarship in recent years. The first time research by a physiotherapist that specifically addressed this question was a paper by Anne Parry with what must still be the best title for any research paper ever written: *Ginger Rogers did everything Fred Astaire did backwards and in high heels*. The paper still resonates strongly with me and has some important things to say about our professions gendered history.

Anders Ottosson's seminal work on the 'feminization' of physiotherapy in 19th century still stands as one of the most important works on the subject, but there are other important works too, and these three theses are worth consideration.

(En) gendering body politics: Physiotherapy as a window on health and illness, by Tobba Therkildsen Sudmann

> The aim of this study is to gain knowledge about what patients do to negotiate possibilities and constraints for recuperative encounters with

physiotherapists. The historical tenets of Norwegian physiotherapy are recapitulated and contemporary gendered specialisation and work division are presented. The theoretical underpinning of the study, critical hermeneutics and the sociology of everyday life, are tied together by coining play as pivotal for understanding and interaction, and by embedding small behaviours as part of language. Hermeneutic understanding depends on the interpreters' background, comprised of symbolic, structural and subjective aspects. A focus group method is applied, construed as situated social gatherings: 4 groups of men, 4 groups of women, 26 women, 20 men, aged 18-77, comprising experiences with sports related injuries, chronic pain, heart or lung diseases, physical disabilities or medical unexplained disorders.Knowledge proposals: According to the participants, bodily changes and well-being depends on verbal, bodily and hands-on dialogues, and an attentive present therapist. The dialogical situation is precariously constructed; self presentation is planned to details and carefully enacted. Social institutions as gender imprint interaction, understanding and treatment. Pain is construed as action, and is a paradigmatic exemplar of how verbal, bodily and hands-on communication, self presentation and gender intersect in physiotherapy. Independent of age, gender or bodily concerns the participants challenge and negotiate cultural, medical or personal boundaries to enhance well-being and/or to reach personal objectives e.g. increasing pain for a greater good. The participants' accounts are interpreted as intentional human agency, and reconstructed as body politics. Construing vulnerability as strength, the participants appreciate some of the benefits gained from living with bodily constraints and challenges. Their actions and enactments create new body idioms and new accounts of health/illness. Physiotherapy represents a field of practices where contradictory and covert social expectations reside. When social expectations are not met, patients may experience embarrassment, and recuperative interaction may be at risk. Social disruption may be ignored, remedied or laughed at. Laughter may be interpreted as a sign of embarrassment due to fragile interaction. By studying embarrassment and laughter we can listen for social dissonance, and imply some conditions necessary for the interaction to come off. Some necessary conditions are implied above; the participants, as patients, try to avoid embarrassing

> situations by asserting a personal body politics and warranting amendments to the interaction order of therapeutic encounters.

Doing Gender in Physiotherapy Education: A critical pedagogic approach to understanding how students construct gender identities in an undergraduate physiotherapy programme in the United Kingdom, by John A Hammond

> Gender in physiotherapy education is somewhat ambiguous. Physiotherapy is historically a women's profession, yet in recent decades there has been a growing proportion of men. The mass media portrays a masculine sporty image of physiotherapy, which notably ignores the presence of women. Previous research in physiotherapy education has shown gender differences in student preferences for work and career pathways. Gender differences in attainment in practice components of the course have also been demonstrated, with men doing less well than women and more likely to fail. As a physiotherapy educator faced with these issues, the aim of this study is to explore the significance of gender in students' constructions of identity. Social constructionism was adopted as an underpinning theory in this professional practice research involving students from one cohort of undergraduate physiotherapy students at a university in the south east of England. Nine male and female participants were interviewed at the beginning of their second year and were asked to record stories about their experiences both on and off campus throughout the academic year using a digital recording device. Data from the interviews and audio-diary narratives were analysed using Judith Butler's theorisation of gender as 'performative' to understand how gender identities were constructed. Foucauldian and critical pedagogical perspectives were employed to further interrogate the gender discourses that emerged. The findings indicate that gender was rarely explicitly discussed; yet participants' gender identities were constantly negotiated through relationships that were not limited to the university and clinical settings. A range of discourses of masculinity and femininity were identified illustrating a profound gender orthodoxy in physiotherapy education that simultaneously demanded acceptance, assimilation or resistance. As a consequence, students in this study used a number of discursive strategies in the struggle to be recognised within physiotherapy education and practice. The implications from these findings raise questions about gender tensions and contradictions in the physiotherapy programme under scrutiny and about the pedagogic practices that reinforce them. In this context, there is a need to raise awareness

amongst peers and managers of the possible sites of gender inequalities within this curriculum. Also, gender needs to come 'out of the closet' and be debated within the classroom and the wider social spaces inhabited by students in order to develop more nuanced understandings of gender within physiotherapy and healthcare. Finally this research indicates the need to provide more inclusive spaces within the curriculum for reflecting on the complexity of identity construction and for challenging its institutional forms.

Becoming a practice profession: A genealogy of physiotherapy's moving/touching practices, by Gwyneth Owen

This research responds to gaps in the literature about the evolution of physiotherapy practice and to uncertainties emerging from within physiotherapy about its professionalism and practice. It aimed to generate a theoretically informed understanding of the tensions present in contemporary physiotherapy practice by producing an embodied account of the process of becoming a practice profession. The research aim was achieved by a genealogical study of existing literature, documentary data from physiotherapy's qualifying curricula and oral accounts of practice generated by depth interviews with physiotherapists who qualified during the 1940/60s. These data were subject to a Foucauldian discourse analysis and a phenomenological analysis to explore the events, discourses and actions shaping physiotherapy practice over time. Unlike existing historic accounts that trace the evolution of physiotherapy's professional identity, this research prioritises the bodies doing physiotherapy over time so offers a fresh perspective on physiotherapy as a practice and as a profession. From a 'doing' perspective, professionalism ceases to be an acquisition that is externally bestowed and becomes a dynamic process of experiencing/producing autonomous problem-solving in practice. Physiotherapy's professional practice can be traced back to the 1945 curriculum. It was enacted through the integration of physiotherapy movement/touch and by the discipline of movement, which generated autonomous problem-solving practices that cut across ward/disease boundaries established by medicine from the 1950s onwards. While still subject to medical supervision, physiotherapy's movement/touch crossed the division of labour to develop capacity to produce diagnosis-inference-treatment once its technical autonomy was recognised in 1977. Once free of medicine, physiotherapy's professional practices multiplied to provide

> moving/touching solutions for an increasing variety of movement disorders. My research complements the existing (disembodied) critical histories of physiotherapy as a profession and demonstrates the value of embodiment as a lens for tracing movement in physiotherapy's professional identities and practices over time. It adds to sociological understanding of the organisation of healthcare occupations and practices by offering an account of a body that is a moving part of a division of labour organised around the dominant profession of medicine.

References

Hammond, J. A. (2013). Doing gender in physiotherapy education: A critical pedagogic approach to understanding how students construct gender identities in an undergraduate physiotherapy programme in the United Kingdom. DEd. Kingston University, England.

Ottosson, A. (2005). Sjukgymnasten - vart tog han vägen?: En undersökning av sjukgymnastyrkets maskulinisering och avmaskulinisering 1813-1934. PhD. Göteborg University, Sweden.

Owen, G. (2014). Becoming a practice profession: A genealogy of physiotherapy's moving/touching practice. PhD. University of Cardiff, Wales.

Parry, A. (1995). Ginger Rogers did everything Fred Astaire did backwards and in high heels. Physiotherapy, 81(6), 310-319.

Sudmann, T. T. T. (2009). (En) gendering body politics. Physiotherapy as a window on health and illness. PhD. University of Bergen, Norway.

On openings and closings, choice and change

30 November 2015

From Brian Massumi, via Mary Zournazi, via Prof Liz Smythe

> '…in every situation there are any number of levels of organisation and tendencies in play, in cooperation with each other or at cross-purposes. The way all the elements interrelate is so complex that it isn't necessarily comprehensible in one go. There's always a sort of vagueness surrounding the situation, an uncertainty about where you might be able to go, and what you might be able to do once you exit that particular context. This uncertainty can actually be empowering – once you realise that it gives you a margin of manoeuvrability and you focus on that, rather than on

> projecting success or failure. It gives you the feeling that there is always an opening to experience, to try and see. This brings a sense of potential to the situation. The present's 'boundary condition', to borrow a phrase from science, is never a closed door. It is an open threshold – a threshold of potential. You are only ever in the present in passing. If you look at it that way you don't feel boxed in by it, no matter what its horrors, and no matter what, rationally, you expect will come. You may not reach the end of the trail but at least there is a next step. The question of which next step to take is a lot less intimidating than how to reach a far-off goal in a distant future where all our problems will finally be solved (pp.211-212)'

Reference

Zournazi, M. (2002). Hope. New philosophies for change. Annandale, NSW, Austalia: Pluto Press.

Neuroscience and a radical view of consciousness

25 February 2016

One of the biggest challenges in philosophy and science has always been to define what it means to be conscious. For something so fundamental as our beliefs about what is fact and what is fiction, what is real or true and what is false, one might think that the basic foundations of our beliefs - that of a biological consciousness - would be a scientific fact. Not so. Scientists and philosophers are really no nearer to understanding the nature of consciousness than Descartes was in the 17th century when he argued that because our dreams are so vividly real, we had no way of proving that this very moment wasn't part of a dream.

While some biological scientists are still trying to locate the root of consciousness somewhere in our grey matter, others have begun to explore exciting new ways to think about consciousness. Physicists, mathematicians, chemists, biologists, artists and philosophers are looking at social networks that exist between biological and non-biological entities and asking, for instance, if electrical currents that pass between elements or assemblages that form between people and things now constitute networks that can be said to have their own consciousness.

In a recent article in Wired, Brandon Keim sets out the case that "consciousness arises within any sufficiently complex, information-processing system. All animals, from humans on down

to earthworms, are conscious; even the internet could be" (link). Others have gone further, arguing that Aristotle's traditional distinction between humans (world producing), animals (poor in the world) and plants (without world), now needs a radical overhaul (Nealon 2016).

We could continue to hold to the view that consciousness is only something that is possessed by higher animals, perhaps only humans. But this is a very narrow view of what consciousness could mean, and one that assumes that there is something inherent in human biology that sets us apart from other entities. Yet, we do not know from whence consciousness arrises. Is it held by electrons, ganglia, organs, or discrete body systems? Is it sub-atomic, or animated by the motion of gravitational waves? Since we do not know these things, the idea of consciousness remains only theoretical. And since theories be used to shape new understandings, why not consider consciousness as something a rock demonstrates when it reflects the sun's rays on the beach, and think about what this might mean for the expansion of physical therapy beyond our conventional (and strictly limited view) of conscious therapeutic actors and agents.

Reference

Nealon, J.T. (2016). Plant theory: Biopower and vegetable life. Stanford: Stanford University Press.

Capturing physiotherapy

3 March 2016

One of the biggest challenges facing the physiotherapy profession, for much of its history, has been the necessity of defining what it is and what it isn't. Prior to World War I, masseuses struggled to show that they could provide a legitimate, trusted and affordable alternative to the poorly trained hacks, prostitutes and doctors who practiced a few rudimentary physical therapies. After WWI the focus shifted to being an ally to doctors in the development of rehabilitation. By the middle of the 20th century, definitions of physiotherapy became embedded in legislation that gave us access to publicly funded health care and some protection of title.

By the 1960s, people were agitating for more expansive definitions of physiotherapy. First came Helen Hislop's pathokinesiological model (Hislop, 1975), then Cheryl Cott et al's movement continuum (Cott et al, 1995). Later, WCPT endorsed 'A Conceptual Framework for Curriculum Design in Physiotherapy Education' that offered a model of a more 'holistic' practice (Broberg et al, 2003). What was common with these approaches is that they problematised the often narrow, biomechanical definitions of physiotherapy that anchored it to anatomical and patho-physiological ways of thinking and practicing.

So it was a surprise to read that APTA's Board of Directors have endorsed a 'Human Movement System' (HMS) model that does little more than re-establish physical therapy's affinity with the body-as-machine.

There is a fabulous discussion of the HMS model on Kyle Ridgeway's PT Think Tank blog, accompanied by links to a podcast on conatus. There's a part in the podcast interview where the group discuss whether the authors of the model really expect physical therapists to be experts in all body systems - as is suggested in the APTA's background to the model and vision statement. Kyle asks "If we claim to be experts in the human movement system, then we claim to be experts in all of the structures and physiologic functions that interact to move the body and all its component parts". This is true, and a really valid point, but I wondered whether we couldn't go even further than this with our critique?

How does the HMS model explain everything that defines physiotherapy that is not simply about biomechanics or the anatomy and patho-physiology of movement? Models can enable much, but they can also deny important facets of our professional roles, identities, behaviours, influences, responsibilities, attitudes and values. Not least, if they claim to be 'all-encompassing' but are, in fact, only all encompassing of a very narrow functionalist definition of a profession, they can be the source of a dramatic miscommunication about what physiotherapy is or can be. (And thereby undermine the very purpose of the HMS in the first place which is to provide clarity and a communicable message about who we are and what we do).

There is now a growing body of literature on physiotherapy identity, but much more is needed, and a serious critical review of the overly biomechanical discourses pervading the profession is long overdue.

References

Broberg, C., Aars, M., Beckmann, K., Emaus, N., Lehto, P., Lähteenmäki, M. -L., . . . Vandenberghe, R. (2003). A conceptual framework for curriculum design in physiotherapy education – an international perspective. Advances in Physiotherapy, 5(4), 161-168. doi:10.1080/14038190310017598.

Cott, C. A., Finch, E., Gasner, D., Yoshida, K., Thomas, S. G., & Verrier, M. C. (1995). The movement continuum theory of physical therapy. Physiotherapy Canada, 47(2), 87-95.

Hislop, H. J. (1975). The not-so-impossible dream. Physical Therapy, 55(10), 1069-1080.

Physiotherapy - in a nutshell

22 March 2016

The great American philosopher, Hilary Putnam, died a few days ago (13 March) at the grand age of 89, leaving behind an amazing legacy of ideas and thoughtful inquiry. Putnam was someone who applied philosophical ideas from the natural sciences to areas as diverse as religion, ethics and aesthetics and was a major influence on analytical philosophy in the second half of the 20th century.

One of Putnam's most famous sayings was that "Any philosophy that can be put in a nutshell belongs in one." Reading this again the other day made me reflect on one of the longstanding paradoxes of physiotherapy - namely the desire to pin it down; identify it so that people will (finally) know what we do; and offer a single, clear definition of the profession for all the world to buy into.

I think of this as a paradox because, whilst I understand the desire to have something easy to understand and market, physiotherapy has never ever been really just one thing. There are as many kinds of physiotherapy as there are people practicing it, because each of us inflects our practice with our own values and beliefs, ways of doing things and ways of communicating and connecting with others. So despite our professional bodies' desire to state what physiotherapy 'is' this or that, it will always defy definition.

More than this though, I have always believed that there are as many problems with our desire to define physiotherapy as there are benefits. Paraphrasing Hilary Putnam, any profession that can be put into a nutshell probably belongs in one. These days, the world is so much more about diversity and difference, and groups that try to hold on to singular definitions of their purpose are easy targets for disestablishment - to use that awful managerial term.

As a counter-weight to the fetish for simplification, I thought I might suggest some exercises to test your critical muscles and practice thinking 'otherwise' about physiotherapy. Try these exercises for a day or two to see if they change the way you think and practice our profession:

- Try saying physiotherapy 'might become...' rather than physiotherapy 'is...' whenever you talk about it;
- Try thinking about what might be possible if we had a thousand different physiotherapies, rather than just one;
- Use language with your clients/patients that is about becoming, not being.

(Remember, 'becoming' is all about movement, whereas 'being' - to be a physiotherapy, to 'be' disabled, for example - is all about stasis and immobility, and physiotherapy should always be about movement.)

Who knows, with a bit of luck and some concerted practice, we might manage to move the profession out of its nutshell and into a wider world.

Wild bodies

5 April 2016

Robert Macfarlane is currently one of the UK's best-loved non-fiction authors. His recent book Landmarks is a tour de force of physical and metaphorical walks through the landscape - literal and linguistic - of Britain's ancient physical language. In Landscapes Macfarlane writes about the word hoard that surrounds the 'islands, rivers, strands, fells, lochs, cities, towns, corries, hedgerows, fields and edgelands uneasily known as the British Isles".

I love Macfarlane's writing, not least because it's so physical. Reading a Macfarlane book is like an exploration into the language of the body and its interaction with the natural world.

There are a number of members of the CPN with a particular interest in phenomenology and the work of Merleau-Ponty, and these will be particularly interested in one section of the book where Macfarlane talks with passion about the writings of Nan Shepherd.

Shepherd lived in the remote Cairngorm Mountains in Scotland and wrote a few books recounting her experiences. Most notable was a small book called The Living Mountain (see link), written in the final years of WWII. Shepherd was 'exhilaratingly materialist' in her approach (Macfarlane 2015, 62), meaning that she was deeply interested in the physicality of her landscape. In one account, for example, Macfarlane recounts that 'She spends an October night in air that is 'bland as silk', and while half asleep on the plutonic granite of the plateau feels herself become stone-like, 'rooted far down in their immobility', metamorphosed by the igneous rocks into a newly mineral self' (ibid, 66).*

In much of Shepherd's writing, there is a strong sense of the physicality, and to emphasise this, Macfarlane talks about her essential phenomenological spirit.

Macfarlane argues that, for Shepherd, the mountain offers a 'fabulous sensorium' in which 'a life of the senses is lived so purely that "the body may be said to think"' (ibid 73). In many ways, Shepherd's 'philosophical conclusions concerning colour-perception, touch and embodied knowledge are arrestingly similar to those of Merleau-Ponty' (ibid), a fact made all the more remarkable because The Living Mountain was written in the same year as Merleau-Ponty's Phenomenology of Perception (1945), (even though Shepherd's text was only published in 1977).

For Merleau-Ponty, post-Cartesian philosophy had cleaved a false divide between the body and the mind. Throughout his career he argued for the foundational role that sensory perception plays in our understanding of the world as well as in our reception of it. He argue that knowledge is 'felt': that our bodies think and know in ways that precede cognition. Consciousness, the human body and the phenomenal world are therefore

inextricably intertwined. The body 'incarnates' our subjectivity and we are thus, Merleau-Ponty proposes, 'embedded' in the 'flesh' of the world (ibid).

Consider this embodiment in the following passage from The Living Mountain:

> The hands have an infinity of pleasure in them. The feel of things, textures, surfaces, rough things like cones and bark, smooth things like stalks and feathers and pebbles rounded by water, the teasing of gossamers...the scratchiness of lichen, the warmth of the sun, the sting of hail, the blunt blow of tumbling water, the flow of wind - nothing that I can touch or that touches me but has its own identity for the hand as much as for the eye.

References

Macfarlane, R (2015). Landmarks. London: Hamish Hamilton.

Merleau-Ponty, M. (1945). Phenomenology of perception. New York: Humanities Press.

Shepherd, N. (1977). The Living Mountain. Aberdeen: Aberdeen University Press.

*There is a lovely 30 minute audio documentary in which Macfarlane celebrates Shepherd's The Living Mountain. This is well worth the listen if you're interested in more of her beautiful writing (link). In this piece, Macfarlane touches on another of Shepherds many radical notions, namely her belief that it had been the traditional masculine narrative that mountains were to be conquered, and the goal had always been to reach the summit. Instead, Shepherd was more interested in circling, meandering, being within and around, and engaging with the mountain and it's innate physicality, rather than dominating it. It may be worth reflecting in which ways 'mountains' can function as metaphors for those of us thinking about how physiotherapy and health care might be 'otherwise' in the future.

Physiotherapy is part of the debt we pay when things go wrong

25 April 2016

English law once included a principal that the thing that had caused accidental death or injury - the carving knife that had accidentally chopped off the finger, or the carriage that trampled the person's leg - should be surrendered to God in recognition of its part in causing harm or suffering. This 'thing' was called a deodand and it existed in law from around 1200AD until it was abolished in 1846.

The object would be surrendered to the crown and used or sold to compensate for the harm done. William Pietz said that 'any culture must establish some procedure of compensation, expiation, or punishment to settle the debt created by unintended human deaths whose direct cause is not a morally accountable person, but a nonhuman material object' (Pietz, 1997). This was the law of the deodand.

One of the things that came to replace the idea of the deodand was a belief that the State should take responsibility for the harms done to its subjects. In the first half of the 20th century this took a very specific form, and arguably helped make physiotherapy what it is today.

Think of World War I; the polio epidemics of the 1930s, 40s and 50s; and the development of public health services to manage communicable diseases like TB and influenza, and you have a nation state doing its utmost to compensate for things it believes it is responsible for. The welfare state was born as a way to better care for the poor, the pensioner, the unemployed, and the family, and it put in place services that it thought 'settled the debt' caused by poor housing, poor sanitation, and other causes of unintended human suffering.

> ”Any culture must establish some procedure of compensation...to settle the debt created by unintended human deaths"

It is no coincidence that physiotherapy prospered under these conditions. In fact, physiotherapy 'benefitted' - not in any callous way, just as a statement of fact - from each of these causes of human suffering.

Until, that is, the beginnings of neoliberal economic reforms in the 1970s. Since then, successive nation states have slowly withdrawn from their national responsibility, and moved, instead, to promote the idea that each of us should be individually responsible when things go wrong. Not surprisingly, physiotherapy now functions less as a form of national compensation and increasingly operates at an individual level.

In thinking about the profession's past, present and future, we often think that our destiny is in our own hands; that it will be sufficient to prove that our assessment and treatment techniques are evidence-based. We should probably consider how unimportant this has been before, and how our development as a profession owes more to obscure ideas like deodands than we have perhaps hitherto realised.

Reference

Pietz, William (1997). Death of the Deodand: Accursed object and the money value of human life. In Francesco Pellizzi. The abject. Res, 31: 97-108.

Is physiotherapy linked to the birth of modern writing?

29 June 2016

Here's a thought.

On Stephen Downes' ever reliable, Downes recently reviewed an essay on Aeon by William Eamon, titled *Six centuries of secularism: When the first 'how-to' books began to explain the way the world worked, they paved the way for science and secularism*.

Now before you close the blog and think "what on earth did that have to do with physiotherapy", consider this argument from Downes, who summarises Eamon's ideas as an;

> Interesting thesis: "by elaborating mechanical processes and spelling out how things worked – in striking contrast to the well-documented secrecy of the guilds – writers began to transform the mechanical arts from personal know-how into scientific knowledge... The world of the crafts – like that of politics – lost its magic; it broke free of its yoke to the divine.... Because secularisation subverted the notion of cosmic and metaphysical order, the rise of how-to books sowed the seeds of a more open and tolerant view of humanity."

It made me wonder if physiotherapy, as we know it, could have been possible without (a) the written word, used by people to (b) explain ideas to others, in (c) mechanistic ways that (d) borrowed from secular science, to (e) take a patho-anatomical view of the body, and then (f) encourage people to blog about it and offer critiques of the same?

Because, in the end, the large print will surely giveth and the small print may taketh away.

There is always more than one body in physiotherapy

27 July 2016

When physiotherapists refer to the body, they're often referring to the body that's defined by biomedicine: organised into systems; physical; patho-anatomical; cellular; the place where injury and illness can be located; biological. But this only accounts for a small group of 'bodies' that we encounter in practice every day.

A recent conference announcement highlighted some of the bodies that Victorians were interested in, and many of these still interest physiotherapists:

- busy bodies
- body markings
- disabled bodies
- prosthetics
- bodies behaving badly
- the body as spectacle
- fragmented bodies
- queer bodies
- raced bodies
- disciplined bodies
- animal bodies
- circus & freak show bodies
- bodies at work or play
- bodies in contact
- unlikely friendships/romances
- sexy bodies
- naked bodies
- diseased bodies
- vivisection
- the anatomized body
- dead bodies
- body snatchers
- embodiment/disembodiment
- spirit bodies
- mythical bodies
- angels, monsters, and ghosts
- the gendered body
- intellectual women
- odd women, blue stockings, New Women
- the body of the insane, the eccentric
- characters & caricatures

- ugly bodies
- corporate bodies
- bodies of knowledge
- bodies of evidence
- bodies of work
- colonial bodies
- traveling bodies
- and the body politic… (Source: Interdisciplinary 19th century studies conference)

Now clearly, not all of these bodies are relevant to physiotherapists, but there are also bodies here that are central to our work that we rarely ever think about, explore, discuss or research.

It reminds me of some of the great books on bodies in sociology that have been written over the last 20 years (see recommended readings below). If you are interested in bodies, as you'd imagine most of our colleagues should be, you could do worse than read some of the writings of people like Bryan Turner, Nick Fox, Debbie Lupton, Sarah Nettleton and Chris Shilling.

Shamefully, most of these authors never appear in the curricula of our college programs, because we remain fixated with only talking about the body-as-machine. Perhaps a broader approach to understanding something as fundamental as the body could be a fruitful way to imagine a bigger, brighter, more embodied professional future?

Some recommended readings on bodies plural:

Blackman, L. (2008). The body the key concepts. Oxford; New York: Berg.

Carter, N. (2012). Medicine, sport and the body: A historical perspective. London: Bloomsbury.

Cregan, K. (2006). The sociology of the body mapping the abstraction of embodiment. Thousand Oaks, Calif.: Sage.

Crossley, N. (2001). The social body: Habit, identity and desire. London: Sage.

Fox, N. J. (2012). The body. Cambridge: Polity Press.

Lupton, D. (2012). Medicine as culture: Illness, disease and the body in western society. London: Sage.

Mol, A. (2002). The body multiple : Ontology in medical practice. Durham: Duke University Press.

Nettleton, S. (2005). The sociology of the body. In W. C. Cockerham (Ed.), The Blackwell companion to medical sociology (pp. 43-63). London: Blackwell.

Samson, C. (1999). Biomedicine and the body. In Health studies: A critical and cross cultural reader (pp. 3-21). Oxford: Blackwell.

Scott, S. & Morgan, D. (2004). Body matters: Essays on the sociology of the body. London: Falmer Press.

Shilling, C. (2012). The body and social theory. Sage.

Turner, B. S. (1984). The body and society. Oxford: Basil Blackwell.

Turner, B. S. (2008). The body and society: Explorations in social theory. London: Sage.

Williams, S. J. (2003). Medicine and the body. London: Sage.

Ways to be critical

9 August 2016

I'm sometimes asked what the 'Critical' in Critical Physiotherapy Network refers to. It's a good question, because there's more than one meaning for the term, and we are using it in quite a specific sense here.

So here are some different meanings for the word critical, only some of which apply to the Network.

- Critical in the sense of expressing disapproval or negative judgement, as in; 'I don't like that' or 'I think that's wrong'
- Critical as in 'critical review'; the sort of thing that a lot of students are trained to do these days; to review a body of literature and say whether it's any good or not
- Critical care: that required by acutely ill people
- Critical in the sense of being desperately needed, vital, or at the point of crisis
- As in the mathematics meaning a point of transition from one state to another; an axis or turning point
- Critical as in Critical Theory - a branch of sociology concerned with tackling asymmetries of power in society and emancipating voices of marginalised people
- Or postmodern criticism; the skepticism towards metanarratives like 'science', 'biomedicine', 'religion', 'logic' and 'reason'

Of these, I would say the only one that the CPN does not directly focus on is No.3. All of the others are relevant in different ways to the interests and activities of Network members.

Some in the Network relate strongly to No. 6, others to No. 4. Myself, I've been a long-time, card-carrying postmodernist, so I definitely favour No. 7.

But the Network is all about diversity and inclusiveness, and we're open to all kinds of beliefs and ideas.

What's crucial, though, is that people embrace the idea of criticality, in (nearly) all its forms.

Is the biopsychosocial model all it's cracked up to be?

25 October 2016

It's quite common these days to see advocates of a more 'holistic' healthcare practice championing the Biopsychosocial (BPS) Model. In areas where healthcare has become increasingly complex - where people's individual values and beliefs can't be avoided, and where people's social context affects their lives so palpably that a biomechanical approach to assessment and treatment is simply inadequate - the BPS model is promoted as a way forward. But is it as sound as people seem to think?

The BPS model was initially proposed by George Engel as a 'unified concept of health and disability' (Engel 1960) and was based on a very particular form of positivist psychology called General Systems Theory (Braziller, & Grinker 1967). General Systems Theory was an approach that placed a lot of value in the kinds of industrial, machine-like social processes that Hannah Arendt disparagingly called 'fabrication'. These are the kinds of social systems and structures that strip people of their humanity and reduced them to units within a machinery of production. (Arendt argued that this was one of the necessary conditions - alongside the creation of ethical rules and norms - that actually made the abuse of people possible).

In S. Nassir Ghaemi's 2010 book *The Rise and Fall of the Biopsychosocial Model*, the author explores the history of the model and its basis in a systematic, reductive, psychologically-informed, scientific view of people's behaviour and social relations, and defines its 'fall' on the basis that it was never meant to embrace subjective, qualitative, or socially constructed understandings of health and illness. Nassir Ghaemi argues that these aspects of modern life have become more and more important to people and, consequently, technologies that assert old social hierarchies (like the BPS model) are in slow decline.

So it is interesting to see it emerging now in pain science, as clinicians explore more holistic approaches to treatment. What is perhaps most interesting, is how the model has saturated people's thinking at the exclusion of other ways of being 'holistic'. Why, for instance, is it necessary to have one, all-encompassing approach to what are clearly immeasurably complex issues? And why have we so readily accepted a model that has its origins in the very same

systematising, reductive thinking that it would be reasonable to assume we are trying to escape?

If the BPS model is merely shorthand for a desire to see greater inclusiveness and diversity in our thinking about patient assessment and treatment, fair enough. But we should be mindful of its limitations when we consider advocating for it. It may well be that the BPS model denies as much, if not more, than it enables.

Reference

Braziller, G., & Grinker, R. R. (1967). Toward a unified theory of human behavior: An introduction to general systems theory. New York: Basic Books.

Engel, G. L. (1960). A unified concept of health and disease. Perspectives in Biological Medicine, 3, 459-85.

Ghaemi, S. N. (2010). The rise and fall of the biopsychosocial model : Reconciling art and science in psychiatry. Baltimore: Johns Hopkins University Press.

The biopsychosocial model revisited

2 November 2016

Apologies for this longer than normal post...but we have much to discuss!

Judging by the response to last week's post on the Biopsychosocial (BPS) Model, it is clearly a subject that is exercising the minds of a lot of physio/physical therapists. Not wanting to play a kind of 'dog-whistle' politics - where someone lights a torch under an incendiary issue and then walks away - I wanted to take in the flavour of the discussion before coming back to the blog to compose some reflections.

So firstly, thanks to everyone who took the time to share their thoughts on the subject last week. The conversation felt thoughtful, courteous and respectful of people's different positions.

In answer to the question of whether last week's blogpost was just lofty philosophy with no practical use, I would have to disagree. Firstly, to my mind, all good theory/philosophy is practical - it deals with the eternal question of how we should/might live - or in this case, how we might 'practice'. Every facet of practical physiotherapy is underpinned by some sort of philosophy. The question is perhaps more about how much we are prepared to make these particular ways of thinking and acting overt. Most physiotherapists have been trained in a positivistic tradition that doesn't generally acknowledge its underpinning belief systems, but

that doesn't mean that they're not there, or wouldn't benefit from a bit of an airing now and then.

Another criticism of last week's blogpost was that it didn't really offer a practical alternative to the BPS model. This is true, but I should sat that I did not argue that "the BPS model is flawed, and here's a better model" for some quite deliberate reasons:

Philosophically speaking, I don't believe my job, or indeed our job as collaborators in this conversation, to tell people the answer. For one thing, I don't believe there is one answer. I believe in a plurality of right answers; a more complex picture than a simple linear model that might suggest that what's right for me is also right for you. I don't believe that an English-trained physiotherapy lecturer in New Zealand has any justification for saying that you should definitely use Mason Durie's Whare Tapa Wha model instead of the BPS Model, for instance.

What's more, I don't believe there is a model that is any less flawed than the BPS model. Most of the alternatives, including Trevor Hancock's Mandala of Health, Cheryl Cott et al's Movement Continuum, Broberg et al's conceptual framework, the Norwegian model of psychomotor physiotherapy (Dragesund & Råheim 2008), or the model of embodiment Barbara Gibson and I critiqued in 2008, struggle because they often over-reach themselves. In the act of being 'holistic' they exclude as much as they include, and they leave no room for physiotherapists to identify their own point of difference. The same criticism could be leveled at Shirley Sahrmann's recent call for physical therapists to embrace 'The Human Movement System'.

Models like the BPS, also completely fail to acknowledge the diverse and often contradictory and competing ideologies that make up the model's segments and parts. The BPS model, for instance, attempts to reconcile a biomedical view of the body, which says that the body can be understood as a connected network of systems and structures (reductionism); that fail and lead to sickness, madness and disability, which constitute (labelling, taxonomy) various forms of deviation from the norm (normalisation), that can be located (specific aetiology), by suitably trained medical practitioners (professionalisation, objectivity, science), with the disorder remedied or repaired through medical intervention, with 'social' and 'humanistic' aspects that come from completely different belief systems. To position oneself within a social or humanistic paradigm is, in many cases, to oppose many of the principles of biomedicine. So any model that neatly juxtaposes these often conflicting and contradictory positions, in the belief that they can sit neatly together in one basket, is perhaps both critically naive and deeply problematic.

So the question raised by the BPS model is as much about models themselves as it is about this particular iteration. It is perhaps no surprise that physiotherapists are increasingly interested in models and frameworks - given that we are increasingly looking to broader,

more meaningful ways of expressing the complexity of the work we do. I think the search for new models also underpins the interest in more complex health problems like chronic pain. Clearly the days of routine post-op leg exercises and low-grade treatments are coming to an end for physiotherapists, and the future for the profession looks increasingly specialised and complex. So not surprisingly, approaches that try to capture this shift are appealing. I have to say though, for all the reasons above, I'm nervous about any and all models that attempt to 'capture' physiotherapy in these ways.

I do think these models can serve a purpose though. If they highlight previously underdeveloped or under explored aspects of physiotherapy, then that can be a very good thing. If we return to the BPS model, for example, it mirrors most other 'holistic' models in identifying physical, existential/experiential (a much broader concept than 'psychological') and socio-cultural aspects of people's health and wellbeing. Physiotherapists have always been strong in the physical domain, but are increasingly exploring the existential and experiential aspects of practice, particularly in Scandinavia - where the work on the embodiment of pain is groundbreaking. I think, though, that we are much less well developed in the socio-cultural aspects of our practice. And this is, perhaps, one of the most exciting and fertile areas of growth for physiotherapy in the future - because it has been so underdeveloped.

So, for example, a physiotherapist that chooses to align themselves and their practice with an overtly social and cultural paradigm might choose to:

- Locate their clinic in the poorer areas of town where people experiencing the greatest social determinants of health live
- Look for remuneration that doesn't disadvantage poor people - government assistance programmes, community support funding, etc., instead of direct or indirect user-pays models
- Remove the all-too-common images of young, fit, white, semi-naked bodies from their clinic signage and promotional material and, instead, use more inclusive pictures of real people, people in the community they work in, etc.
- Perhaps even dispense with the idea of having a clinic that people have to travel to at all; taking the clinic out to the community where the people are
- Devolve all of their professional power and authority to the community itself: allowing community elders or groups of locals to set the treatment priorities and determine how and when we work to best meet the needs of the community
- Move away from bio-centric, evidence-based justifications for practice, to embrace whatever explanatory frameworks are meaningful to the community

- Live and work in and for the community: offer free sessions; group therapy; family appointments; move away from individual one-to-one treatments
- Reject behaviourism and victim blaming, focusing instead on community activism and tackling the structural barriers to good health (safe walking spaces, tackling violence against women and children, campaigning for better paid work, etc.)
- Use their professional power and social standing to become a vocal advocate for the needs of the people in their community - lobbing for more funding and government assistance and greater recognition of community needs.

These are only some of the practical ways that a philosophical shift towards just one dimension of many of the 'holistic' models of health could be worked through by physiotherapists. Hopefully, its possible to see how some of these actions are at odds with some of the principles and aspirations of biological and existential/experiential approaches and cannot be easily reconciled, but completely available to practitioners like physiotherapists if they choose to shift their philosophical position.

So to sum up, it has been wonderful to see the flourishing of ideas around the BPS model. I had an email this morning from a colleague in America who took the time to send me his own explanatory framework. It was very different to my own and all the more interesting to me as a result. I'll enjoy following the conversation with him off line (his choice). His framework is strongly grounded in Anglo-American analytical philosophy and held some really interesting ideas for new ways to think and practice. We will need so much more of this kind of debate and discussion in the future if the profession is to make sense of the changes taking place in healthcare. I say 'hallelujah' and 'bring it on!'

References

Broberg, C., Aars, M., Beckmann, K., Emaus, N., Lehto, P., Lähteenmäki, M. -L., . . . Vandenberghe, R. (2003). A conceptual framework for curriculum design in physiotherapy education – an international perspective. Advances in Physiotherapy, 5(4), 161-168. doi:10.1080/14038190310017598.

Cott, C. A., Finch, E., Gasner, D., Yoshida, K., Thomas, S. G., & Verrier, M. C. (1995). The movement continuum theory of physical therapy. Physiotherapy Canada, 47(2), 87-95.

Dragesund, T., & Råheim, M. (2008). Norwegian psychomotor physiotherapy and patients with chronic pain: Patients' perspective on body awareness. Physiotherapy Theory and Practice, 24(4), 243-54.

Hancock, T., & Perkins, F. (1985). The mandala of health: A conceptual model and teaching tool. Health Education, 24(1), 8-10.

Nicholls, D. A., & Gibson, B. E. (2010). The body and physiotherapy. Physiotherapy Theory and Practice, 26(8), 497-509.

Sahrmann, S. A. (2014). The human movement system: Our professional identity. Physical Therapy, 94(7), 1034-1042. doi:10.2522/ptj.20130319.

Karl Marx would have loved physiotherapy

30 March 2017

There's a great thesis to be written on the politics of physiotherapy.

It would include something about how the profession fought hard to become an ally to governments looking to return men to the Western Front during World War I.

It would look at the ways physiotherapists transferred this experience into rehabilitation and ensured people returned to work as soon as possible so that they would be productive members of society, rather than a 'drain' on the State or their communities.

It might even look at how largely silent physiotherapy has been about social inequality and injustice, and how we have managed to convince ourselves that for more than 100 years that physiotherapy was defined by knowledge of anatomy and physiology, biomechanics and kinesiology, T-tests and evidence of efficacy, and not the personal or social lives of the people that we called patients.

In recent years there's been an outpouring of critical thinking directed at physiotherapy, but to date there's been little written about physiotherapy's role in the political economy that keeps the wheels of industry turning.

Karl Marx might say this was all evidence of physiotherapists helping to perpetuate the kinds of false consciousness that keep the downtrodden downtrodden. Hannah Arendt - another great writer on injustice - might say that physiotherapy functions by 'fabrication'* (Nicholls, 2016).

A recent piece on the influence of Pierre Bourdieu can also be read as a critique of physiotherapy (even though the article is nothing to do with it). In the article, Jen Webb from the University of Canberra talks about Bourdieu's distinction between art for art's sake, and art that is produced for the market. Unfortunately, we can't apply the same question to physiotherapy, because there is no physiotherapy done just for its own sake. Such an idea would be ludicrous.

Physiotherapy always has to be purposeful, teleological, deontological - to use the jargon - it always has to be goal-directed, outcome-based, and done for a reason: the person is

sick/ill/injured/disabled, and so obviously needs to be mended, rehabilitated or, in some way restored to 'normal'.

There is much to be said for this logic. Certainly the clear purpose shown in returning people to the machinery of production has earned the profession respect and a significant measure of social capital, but what has it also lost in the process? What shape have these principles given to physiotherapy such that it has become tied to an economic system that is seemingly in turmoil? Is it possible physiotherapy inadvertently contributes to injustice and inequality through practices that it has long been agnostic to?

Had Karl Marx been alive, I'm sure he would have had a field-day answering these questions. Perhaps it's time that we had a go?

Reference

Nicholls, D. A. (2016). Parrhēsia, artisans and the possibilities for deliberate practice. In F. Trede & C. McEwan (Eds.), Educating the deliberate practitioner (pp. 91-106). Amsterdam: Springer.

*Fabrication is a word Arendt used to describe the kinds of work involved in predictable, repetitive, outcome-orientated activities seen in things like mass production, standardised care plans and objective rules-based practice. It is the opposite of spontaneous creative expression, art and subjectivity, and was, for Arendt, an indication of the misery now prevalent in post-industrial societies. There is a link to a pre-production copy of a book chapter I wrote looking at this in the context of physiotherapy here. The book would be an excellent read for anyone looking at the future of healthcare education.

Slow physiotherapy

11 April 2017

For a long time now, physiotherapy practice has been becoming increasingly pressured, with less time to spend with clients, tighter regulations about the number of appointments, and unrelenting pressure to demonstrate the effectiveness and efficiency of our interventions.

Where once patients would be in our hands for long enough to enjoy a modicum of rehabilitation or respite, now the emphasis is on the shortest possible contact necessary to cut the cost of care.

I'm not suggesting that there's anything wrong with efficiency, independence and autonomy per se (well, I am, but that's for another day), and I'm well aware that the kinds of long-term care experienced by people under the 'old' welfare state was anything but arcadian, but I do

believe that the net effect of our present health care reforms is resulting in some very bad practices.

Some physiotherapists on hospital wards are now so pressed for time that they no longer really even assess people. They spend their days making sure patients can walk and 'do' the stairs so they can pronounce them fit for discharge. Many private practitioners have lost almost all their capacity for clinical decision-making, and have had their judgement replaced by well-costed, standardised care plans. And physiotherapy in areas that used to be our bread-and-butter are now almost non-existent.

> ”The speed of light does not merely transform the world. It becomes the world. Globalization is the speed of light." Paul Virilio.

Modern life for physiotherapists has sadly become something of a contest between the twin gods of efficiency and effectiveness. And as we squeeze more and more of the humanity out of our work, perhaps it’s time we said "Stop!" - even if for just a moment.

The 'slow' movement (a physiotherapy concept if ever there was one!), has been a growing phenomenon in recent years, as time pressured people luxuriate in a momentary oasis of calm, that might last a day, an evening, or even an hour. We have slow TV, slow food, slow education, slow parenting, slow travel, slow cinema, and a host of other movement, but, to date, no Slow Physiotherapy.

Perhaps this is because physiotherapy is often the antithesis of a slow movement. We always seem to want people to go faster, harder, be stronger, more agile, less dependent, more energised, less passive...so perhaps this is exactly the time to stop and pause, and think about how your ever increasing speed is affecting you, your family and your clients.

Imagine - even for a brief moment - what it might be like to be just a little slower: to see one patient for twice as long and actually sit and talk to them; to leave a window in your diary to breathe and pause; to go through a normal routine at half the speed; to take your time to do a simple job that you normally rush over; to do just one thing and force yourself to focus and not be distracted by a million other priorities.

Luxuries? Indulgences? Fantasies of people with more time than they know what to do with? Perhaps. But then ask yourself, how well is your current obsession with fast and efficient physiotherapy working out for you?

If you’re looking for innovation, regulatory authorities need to change

19 May 2017

One of the challenges facing the physiotherapy profession today is not so much what the future might be, but how to get there.

Innovation requires creativity and imagination; going beyond oneself and the limits on what might be possible.

Georges Bataille called this transgression, and his work explores why our moral codes are set 'here' and not 'over there'. His writings concentrate on some of most sensitive topics, particularly to do with sex, because, he argued, it's here where we choose to apply some of our most stringent social conventions and norms. Bataille's idea was that we need to explore ways of thinking and being that are far beyond our present boundaries of convention if we are to see where our present level of tolerance lies. It's hard to see it without doing this. But from this new position, where everything is inconceivably gross and offensive (and if you read Bataille you'll see what I mean), it's at least possible to ask 'why do we think this is the right place for our moral threshold, and not somewhere else?' (See suggested readings below).

To imagine an alternative future for physiotherapy - one that will meet the needs of 21st century cultural, economic, political and social reform - we may need to perform the same kinds of transgression, through acts of creative thinking and practice.

The problem is that such acts require, perhaps even demand, that we go beyond the current rules about what is permissible. But this means that regulatory authorities and professional boards come into conflict with the profession's imperative to change, because their role is first and foremost to protect the profession's vulnerable margins; to police the fringes of the profession for border incursions from other professions, or 'breaches' from within. They secure the written word on what physiotherapy is, not what it might become.

Every profession needs forms of regulation, not least to make it easier to identify what the profession is and is not. No profession could survive without some boundaries. But in circumstances where change is needed, regulatory authorities need to have mechanisms that allow their influence to be softened: to fade into the background a little, and to allow purposeful, thoughtful, critical extrusions in the fabric of the profession to occur.

If a regulatory authority is allowed to construct an iron curtain around the profession, it forces people who want to explore the possibilities for an otherwise physiotherapy to leave

and go elsewhere. Not only is this a terrible waste of a talent and years of public investment, it also restricts physiotherapy to an image of yesterday.

On the other hand, a regulatory authority that is too porous, and allows anything to pass across the profession's threshold, risks losing the profession's sense of identity and, with it, the understanding and trust of the public, its partners, and its funders.

What is needed now then, perhaps more than ever before in our history, is a profession that is more amoeboid than box-like; more permeable than impregnable; more yielding and less resistant to transgressive, inconceivable, even silly ideas, and for that we need our regulatory authorities to play their part and quietly step out of the way.

Readings

Bataille, G., Botting, F., & Wilson, S. (1997). The Bataille reader. London: Wiley-Blackwell.

Nicholls, D. A., & Holmes, D. (2012). Discipline, desire, and transgression in physiotherapy practice. Physiotherapy Theory and Practice, 28(6), 454-465.

Noys, B. (2000). Georges bataille: A critical introduction. London: Pluto Press.

Williams, S. J. (1998). Health as moral performance: Ritual, transgression and taboo. Health:, 2(4), 435-457.

The great migration (away from physiotherapy)

15 August 2017

Every week for the last few months an ex-student has asked to meet me become they've become disillusioned with physiotherapy.

Whilst it’s true that there's always been a steady attrition from the profession, the number of recent meetings, and kinds of recent conversations I've had with these people, seems surprising.

Working through their personal experiences, their frustrations seem to stem from a desire to do more with the knowledge and skills that they'd acquired. This feeling is often compounded by a sense that the 'system' is preventing them from being the therapist they really want to be.

Many want to do further postgraduate study so that they can broaden their horizons. Thankfully, there are more options and support networks available to do them than when I was first trained.

Others just want to know that there's more to physiotherapy than 15-minute appointments with nameless bodies that parade an endless series of the same unfixable pathologies and complaints for the benefit of clinics and health authorities that put financial bottom-lines above therapeutic integrity.

My answer is to say to some that "Yes, you should pursue your postgraduate study into touch/empathy/care/rehabilitation/pain/ ... , but most importantly you should leave the world of physiotherapy for a while and experience the way other people think about these problems." Follow the example of some of the great pioneers in physiotherapy and engage in some mental travel beyond the borders of what's familiar and obvious, and ingest a bit of something different.

For others I say "Yes, you should pursue your ideas about practice, but leave your ideas about the boundaries we place around physiotherapy behind ... stretch yourself to think of what might be possible with all the kinds of bodily, people and social skills that you've worked so hard to develop over the years ... Trust that people will always want someone who can use their touch with skill and care, or diagnose the reasons for pain or functional impairment, and think about all the new ways you could make physiotherapy work for the people who really need it."

Speaking of looking beyond physiotherapy, Georges Batailles talked about needing to transgress conventional boundaries to help us ask critically why we'd decided to place the limits of our tolerance 'here' and not 'over there'. Battailles was interested in sex and the way Christianity governed our morality in the West, but his ideas apply just as much to physiotherapy (see refs).

Physiotherapy, more than ever, needs people to migrate away for a while; to explore worlds previously closed to them by curricula or scopes of practice that are far too restrictive for the unpredictable, complex and rapidly changing world of the 21st century.

We need a new generation of pioneers and bold explorers: people who will shake the foundations of the profession and ensure that the next generation adopts a vision of physiotherapy that perhaps doesn't need people to leave to find what they're looking for.

References

Nicholls, D. A., & Holmes, D. (2012). Discipline, desire, and transgression in physiotherapy practice. Physiotherapy Theory and Practice, 28(6), 454-465.

Williams, S. J. (1998). Health as moral performance: Ritual, transgression and taboo. Health:, 2(4), 435-457.

An accident waiting to happen*

4 October 2017

I'm preparing for a keynote lecture at the APA Conference in Sydney in a couple of weeks time, looking at aged care as a 'bellwether' of the physiotherapy profession at large. (Spoiler alert if you're going) I'm going to argue that if we can work out how to provide meaningful physiotherapy to older adults, we'll fix a lot of the problems now besetting the rest of the profession.

Part of the joy of this kind of work is the opportunity it gives you to think 'otherwise' about seemingly obvious, taken-for-granted things, like ageing as a natural biological process, or our inalienable role as the leaders of rehabilitation for the elderly and disabled. Testing why we think these things, and what these ideas make possible and deny is, for me, the cornerstone of critical thinking.

A big part of the work is in the background reading, and sometimes searching for ways to think differently takes you in some unexpected directions.

I came across this quote from one of my favourite philosophers - Paul Virilio. It's a bit obscure on first reading, but read more deeply, and you may start to see that this can apply to the history of physiotherapy, and some of the reasons why we are what we are:

> ’Every technology produces, provokes, programmes a specific accident … The invention of the boat was the invention of shipwrecks. The invention of the steam engine and the locomotive was the invention of derailments. The invention of the highway was the invention of three hundred cars colliding in five minutes. The invention of the airplane was the invention of the plane crash. I believe that from now on, if we wish to continue with technology (and I don’t think there will be a Neolithic regression), we must think about both the substance and the accident' (Virilio 1983, 32).

What I see in this is that every positive act of creation - like forming a physiotherapy profession - automatically also scripts the 'accidents' or downstream effects that follow. These are often unseen or unthought, but are no less real. You might say the invention of total war (WWI) produced the need for rehabilitation, and rehabilitation programmed a kind of therapy that physiotherapy responded to. Would physiotherapy have developed that way if there had been no war?

The creation of disability as a problem to be overcome; the public health crises that 'programmed' the welfare state into existence; the present-day 'crisis' of an impending 'grey tsunami', are themselves accidents which necessitate responses that sometimes result in things like physiotherapy.

We fantasise, sometimes, that physiotherapy is an autonomous profession, 'born' from the actions of a far-sighted pioneers, and that the profession established its direction as if it had been written fresh onto blank sheet of paper. The truth, however, is probably far from that, and we must always look to the conditions that have made physiotherapy historically possible if we are to really understand where physiotherapy has come from, where it is, and where it might be going.

* There is an historical focus to today's post, partly because today marked the launch of the first ever International Physiotherapy History Association (IPHA). Born from a meeting at WCPT in Cape Town, the first group currently has 42 members and met online today to start thinking about the future. See www.history.physio for more information.

Reference

Virilio, P. (1983). Pure war. New York, Semiotext.

Physiotherapy as process, not event

7 November 2017

Last week, the National Institute for Health and Care Excellence (NICE) updated its advice on the use of autologous chondrocyte implantation for treating symptomatic articular cartilage defects of the knee. Perhaps amid all of the other newsworthy events of last week, this announcement passed you by?

In reporting on the announcement, however, the CSP's statement said something interesting. It said;

> The treatment ... is used to help patients with an articular cartilage defect – or early arthritis in the knee – which tends to affect people in their 20s and 30s, often as result of a sporting injury.

But the NICE guidance stresses that surgery should only be considered once non-invasive approaches such as exercise, weight loss, physiotherapy, analgesia and corticosteroid injections have been exhausted.

What was notable about this statement was firstly that physiotherapy was defined as an 'approach' to be considered alongside things like exercise and weight loss. But perhaps more significantly, the report also stated that approaches like this could be 'exhausted'.

Given that conditions like osteoarthritis are by their very nature chronic, it would seem a strange move to have positioned ourselves so closely to the kinds of acute and episodic care so strongly associated with 'heroic' medicine and surgery that we might now be considered redundant if we can't 'fix' the patient's developing pain and functional limitations.

If the same perception exists for other long-standing cardiorespiratory, endocrine, musculoskeletal, neurological and psychological problems, physiotherapy will have an uphill battle to secure the necessary support to work with these people into the future.

And given that the majority of disease burden is now being experienced by people with multiple co-morbidities, having a strong position that allows us to work 'alongside' people with long-term health problems rather than working 'on' them for short bursts of episodic treatment, would seem an important cognitive shift to make.

Leaving (physiotherapy) home

16 February 2018

I had a lovely conversation with some colleagues from Tromsø University's School of Physiotherapy on Monday night after my keynote to the Norwegian Physiotherapists' Congress. Having talked about 'The End of Physiotherapy', they asked me a question I seem to be getting asked a lot now. "So" they said, "what's the answer ... what's the future for physiotherapy?"

Now it's an absolutely foundational principle for me that it's not my place to tell people 'the answer' (as if there could ever be an answer). And that's partly because I subscribe to a Foucauldian approach to critical thinking that says you don't replace one bad hegemony (or dominant way of viewing the world) with another. But as the week has gone on, and I've thought about this question more and more, I think I've come to the realisation that there's something more to this response than simply a desire to be philosophically coherent.

I'm increasingly coming to believe that physiotherapists cannot make the change necessary to meet the challenges of the future of healthcare simply by doing the things they've always done better than they've done before. Reductive, objective, biomedical reasoning will not be enough.

This might be a challenging idea for some in the profession, but I don't think it will be that shocking to members of the CPN. What may be a little more disconcerting though, is that I'm

coming to believe that we won't be able to 'fix' physiotherapy by flipping the coin and taking a qualitative, humanistic, or (inter)subjective position either.

The problem is that these two paradigms represent binary positions, and no-one ever wins in the contest between two powerful competing ideologies.

One only has to look at the news to see that oppositional politics has done nothing for climate change, world politics, religious conflict or social justice, largely because opposing views are deeply entrenched in people's world view and endlessly contest that their moral right overwhelms the other's.

Over the last couple of years, a number of us in the CPN have been exploring a series of philosophical approaches that challenge this binary way of thinking. Inspired by the work of people like Gilles Deleuze, Annemarie Mol, Manuel DeLanda, Karen Barad and Graham Harman, we've started talking about a philosophy of practice that doesn't privilege the classic binaries that have beset medicine, healthcare and physiotherapy for years.

Next week I'll be in Denmark with CPN member Jeanette Praestegaard, celebrating the centenary of physiotherapy in Denmark. And as part of the visit I'll be spending the day with physiotherapy educators and practitioners at University College Absalon in Roskilde, and we'll be talking about some of this.

They'll be a mixed group of physiotherapists - some relatively new to practice, others with vast experience; some with strong leanings towards the sciences, others to the humanities.

I'll be talking about the ways current ways of thinking in physiotherapy 'capture' them and lock them into reductive ways of thinking (quantitative and qualitative; biomedical and humanistic). It will be interesting to see if the idea of leaving these ways of thinking entirely - in order to find new ways to think and practice - resonates with them and provides more satisfying responses to the question, "What's next?" than we're now getting from the 'old' ways.

Going beyond good and bad practice

7 March 2018

The idea that one approach to practice is superior to another is a powerful discourse in physiotherapy today.

Last week I was talking with a colleague who thinks of himself as a 'critical thinker', and we were debating the merits of active rehabilitation over passive treatment. So called 'passive' treatments (some forms of massage, manipulation and electrotherapy, for example), in which

the patient has treatment done to them rather than taking responsibility and actively engaging, have been the subject of much criticism in the profession for some time now.

There is, I was told, indisputable evidence for the benefits of active approaches over passive treatment, and that those who advocated for arcane passive treatments were doing an injustice to the profession and holding it back.

Now, you may have sympathy with my colleagues viewpoint, but to me at least, it's not critical.

It's no more critical than the perspective of those advocates of passive treatment who, once upon a time, would have had their own 'proof' of the efficacy of effleurage, grade V manipulations and short-wave diathermy. Do 'modernisers' believe people in the past practiced out of sheer ignorance or some cultish belief in the mystical properties of their hands? Do they think that it's only now that we've had access to the 'truth' and that everyone in the past was woefully misguided? If they do, I would recommend a look back through the profession's history.

Almost exactly the same debate happened in the 1930s and 40s, when group-based exercises were seen as far more effective (and less costly) than the expensive one-to-one hands-on care offered in previous years. The reason for the move away from passive treatment then was, like now, governed by a much more complex set of factors than the two-dimensional image offered by evidence-based practice.

We like to think that we are slowly becoming more enlightened in our worldview, but evidence all around us point to the fact that we are anything but more enlightened: (Climate change / Syria / Donald Trump / etc., anyone).

No, the belief that we can become more enlightened through logic, reason or research fundamentally misses the point about the reasons why people do what they do. People don't turn to 'passive' treatments because they're necessarily more effective than a good exercise prescription. The popularity of various modalities of treatment have waxed and waned throughout history, in large part because of cultural shifts (attitudes towards touch, for instance), economic drivers (funding for certain kinds of treatment), and political reasons (to align a profession with certain practices and 'against' others), much more than because of scientific reason.

Massage may be more popular as a modality now than at any time in human history. You can find practitioners of the passive arts in almost every town and every country, and passive treatments show no sign of declining in popularity (despite the fact that there is almost no evidence-based rationale for their practice).

Physiotherapists have been schooled to believe that there are good treatments and bad; that logic and reason should be the arbiter; and evidence-based practice is the sword that will cut through the morass of competing ideas. But a truly critical perspective on this discussion would take a broader view, and see the claims of today's generation of advocates as just another expression of a deeper set of issues affecting the profession, and no more or less enlightened than what had gone before.

The key is, of course, that all practice philosophies are contextual and relative, and no amount of evidence for or against will change the desire of some people to be passive in the face of pain, discomfort and dysfunction. Are they wrong to think that? No. Are we wrong for saying they're wrong? Perhaps. But what is this 'wrong' anyway, and who decides?

Radical new ways to think about physiotherapy

3 April 2018

The way we think about physiotherapy is overdue a radical shake-up.

A couple of months ago, Charles Jennings wrote an interesting piece about the way our use of knowledge is changing, and these ideas have some important implications the way next generations of physiotherapists are learn their craft.

Jennings' piece is titled *Learning in the Collaboration Age*, and it focuses on the role collaboration is playing in learning. Jennings contrasts what he calls 'old' ways of acquiring knowledge (often characterised as 'knowing that'), with what is becoming increasingly common these days (knowing how, knowing why).

Jennings argues that 'Although experiential and social learning have been around for eons, in the past most structured organisational learning and training has focused on knowledge acquisition and memorising', and this is certainly the way that a lot of traditional physiotherapy knowledge has been conveyed. Often this is still the way that people expect to learn on weekend courses and, sadly, when they come to postgraduate study.

This kind of learning is based on knowledge transfer, normally 'dispensed' by an expert to a novice with the assumption that the information is static, acontextual, and based on the goal of empowering the learner to acquire individual command of the material, to allow them, in turn, to dispense the sanctioned knowledge to others (and thereby confirming them as an expert).

Jennings uses two models to show the difference now being expected of learners.

In the first 'traditional' model, core concepts needed for basic operation, contextual information required to implement action, and detailed information needed to complete tasks needed to be learned by students of a discipline. With such an emphasis on learning of 'stuff', curricula would be filled with large quantities of information, presented by supposed 'experts', using sophisticated systems and learning structures to manage the complexity of information being dispensed.

In their revised Find-Access Approach the emphasis is changed. Here, core concepts are still learned, but students are taught how to familiarise themselves with the ever-changing contextual information around them, and they are shown how to find complex information quickly and effectively. In essence, core concepts are still learned, but the time giving to learning all the other stuff (contextual and detailed information) shifts from learning what to learning how.

Such proposals have profound implications for the way we think and learn in healthcare disciplines that have long believed that 'information is generally static, can be ‘extracted’ and packaged into content-heavy courses and that memorising – and being tested on – short-term recall of the content constitutes ‘learning’' ... 'that information or ‘knowledge’ is generally acontextual and can be ‘transferred’ irrespective of specific situations and needs that we work as individuals, so individual training and development is the best solution.'

However, as Jennings argues;

‘(W)e are all aware that the majority people work in teams and that these teams are sometimes fluid and changing, and that ‘organisational learning’ (the learning that organisations undertake) is all about developing the ability to be agile, responsive, reflective and to change rapidly when needed. Organisational learning is not about trying to static build knowledge and skills in some form of ‘competency framework’.'

An interesting first step for physiotherapists might be to decide what constitutes 'core knowledge'. Would it be the anatomy of adductor longus, or an empathic attitude towards others? Would it be knowledge of the Krebs cycle, or would it be the ability to perform a Thomas Test? And in an age in which information is increasingly ready-to-hand via digital devices connected to the Internet, is it even necessary now to commit this core knowledge to memory? Or is everything, ultimately, contextual?

Desperate, angry, confused? Sociology can help

19 April 2018

For the last two years I've been the academic leader of a team of psychologists and psychotherapists. Part of my reason for taking the role was to move away from physiotherapy for a while, and one of the things I've learnt is how much of what the 'psy' disciplines do should be a standard part of the physiotherapy curriculum and scope of practice. How on earth physiotherapists managed to survive for 100 years without exploring transference and counter-transference is beyond me.

But one of the things that characterises many of the psy approaches to health and wellbeing is that they will look to the psyche and the mind for the answers to people's despair, anger and confusion.

Today I was talking with a physio colleague about some of the frustrations and annoyances that arise when people refuse standard care. Some of her responses were quite visceral, so much so that I suggested that it might be something to take to professional supervision. But then it occurred to me that this is only one way to deal with work frustrations, and sociology might provide another, possibly more useful path.

Some have argued for a long time that philosophy can be a source of comfort in times of anguish and disappointment (see De Botton 2001, for example), but rarely is sociology thought of as therapy in itself. And yet, one of the things I have learnt through my long history with sociology is how useful it can be in providing you with tools to help you analyse why the world around you is the way it is.

By moving beyond one's visceral reactions to events, applying sociological techniques and theories to problems, new ways of thinking can emerge; new possibilities present themselves; new opportunities arise. This, in itself, restores a sense of hope that tomorrow might be better than today.

It can genuinely help to understand some of the structural reasons why things are the way they are. It can be a real comfort to know that the patterns and practices that are so frustrating today have a basis that extends throughout many other fields of social life. And it can be immeasurably useful to see how some people have responded to these analyses in positive and constructive ways.

Sociology can provide you tools to diagnose problems in the world around you, it can help you locate the source of the itch more accurately, and provide ideas to help you turn things around. In many ways, it's a lot like physiotherapy.

So the next time you're confronted with a seemingly intractable clinical or professional problem, talk to a sociologist. Or even better, do some of your own sociological inquiry. It may just make your day.

Reference

De Botton, A (2001). The consolations of philosophy. London: Vintage.

Reading personality into people's movements

24 April 2018

David Armstrong described in his brilliant book *A New History of Identity* how exercise and specifically posture had been utilised as tools of social engineering in the late 19th century (Armstrong 2002).

When we think of a person's attitude today, we often think of it as being about their response to authority, but it was originally a term used to describe a child's standing posture.

Towards the end of the 1800s governments throughout Europe and North America grew increasingly concerned about the fitness and strength of its citizens and began to think about ways to discipline children before they became slovenly. Military-style drilling and massed social calisthenics were encouraged, and instructors looked to see that children's bodies were developing correctly (see, for instance Beth Linker's work on scoliosis from 2012). 'Attitude' originally defined a child's upright posture, but was later taken up by psychologists to refer to people's psychological response to authority. A slouched posture meant a poorly disciplined mind, whereas being 'upright' meant having the correct moral, spiritual and cultural attitude.

The 'art' of physiognomy - the now debunked skill of characterising a people's personalities on the basis of their facial features - is the subject of a recent book by Peter Sahlins titled *1668: The year of the animal in France*. In the book, Sahlins draws out the ways that animalistic characteristics were used by early health professionals to interpret people's inner personalities. It's a fascinating book that reminds us that trying to understand the inner workings of people has been a interest throughout human history.

'Reading' inner emotional states and attitudes from outer physical appearance is a long-held, but little discussed practice in physiotherapy. Physiotherapists have long claimed to be able to glean a lot from palpable local or regional tensions and observed postural responses to load. But perhaps lacking an acceptable vocabulary to explain what they feel and hear, have limited the amount to which these things are explored.

It's possible to see a person's trepidation and sense their anxiety the first time they walk after major injury, for example, just as it's possible to sense the fear of movement in people with chronic persistent pain. It's entirely possible to feel a body relax under careful touch, just as you can see determination and resilience in the way people tackle a challenging exercise.

Recent work on embodiment is reviving interest in the interpretive dimensions of physiotherapy that are hard to quantify but, perhaps, constitute an important point of

difference for us as practitioners. It will be interesting to see in the coming years how far this new work on embodiment pushes us to acknowledge the importance of reading personality into people's movements, and how much this gathers momentum in a profession looking for ways to differentiate itself from its competitors.

References

Armstrong, D. (2002). A new history of identity. London: Palgrave Macmillan.

Linker, B. (2012). A dangerous curve: The role of history in America's scoliosis screening programs. American Journal of Public Health, 102(4), 606-616.

What's the difference between a technician and an artist?

9 May 2018

I recently had a very enjoyable holiday with my brother who was visiting New Zealand for the first time. At a cafe filled with follies and other quirky craft pieces I asked by brother - who is an accomplished photographer and teacher - what the difference was between an artist and someone's who's good with crafts. His answer has stuck with me ever since.

"Artists", he said "deal with problems."

The example he used was of Grayson Perry, a ceramicist who makes replica Greek urns. Amongst the ceramics community, Perry's pots divide opinions. Some with a stronger interest in the technical craft of ceramics deride his work as sloppy and poorly constructed. But what makes Perry an artist is not the technical skill, but what he uses the pots to say.

Perry's ceramics are often a vehicle for saying some powerful things about the world today. One piece in particular was made on 11 September 2001 — the day of the attack on the Twin Towers — and was a direct response to that. As Steve Dougherty states in this piece, "Using photo-transfer techniques, sgraffito drawings, and handwritten or stencilled texts, Perry subverts the extraordinary beauty of his vessels into bait for the cartoon-strip personal and societal commentary that titivates their surfaces."

This has stuck with me for weeks because it represents, to me at least, a tension at the heart of physiotherapy. Is it a technical craft or an art practice?

I don't think there's any doubt that in the past it's been firmly in the former camp, with its emphasis on practice skills and reproduction, but will it be in the future?

With technical craft skill being one of the central locations for innovations in new technology, it is likely that many of the old skills of the physiotherapists will be picked up either by people who are much less expensive to train than us, or machines.

Which will leave us with that which is impossible to mass reproduce - the 'art' of the profession.

If the art of the profession is shallow, however, and doesn't turn itself to broader social, environmental, political and economic problems (think poverty, pollution, discrimination, equal access to services, education, etc.), then it will likely fall into a liminal space in which it is too expensive to fund for technical skill, and too shallow to serve the social good.

The time is coming when we'll have to decide whether we want to make great pots, or really great art.

A more complex view of patient self-management

16 May 2018

The idea that people should take more personal responsibility for their health is nothing new. For more than 40 years now, we have been promoting the belief that self-care is obviously good and necessary, and that people should be less passive and less dependent.

This view has been particularly prevalent in physiotherapy, where the shift away from so called 'passive' modalities has been accompanied by an equally powerful set of discourses pushing behaviour change and an activity-is-best agenda.

We've written about some of the dangers of this approach elsewhere (Nicholls et al, 2018), but a recent paper published in the journal *Sociology of Health and Illness* adds weight to the belief that personal responsibility may not be as obvious as it seems.

In the paper titled *Pastoral power and the promotion of self-care*, Lorelei Jones uses the notion of pastoral power to analyse how health professionals are being asked to take on new and interesting roles in healthcare. Pastoral power draws on Christian notions of the good shepherd as a metaphor for how we might shape people's moral conduct: in this case, how they might act in their own and, by extension, the rest of society's interests.

Jones argues that, 'Applying the concept of pastoral power to healthcare policy, ‘the modern pastorate’ is made up of specialists, experts, and therapists who promote desirable subjectivities' (p.3).

Through the Foucauldian ethnographic study conducted in the UK across 'four localities in four different regions of England between November 2013 and August 2015' (p.5), Jones tracks the strategies used by people to inculcate self-care into a variety of health service providers and users.

The Discussion section of the paper is particularly interesting, because it reveals some of the reasons why discourses of self-care and personal responsibility are failing to gain purchase:

- An overemphasis on homogenous training methods and ways of promoting self care
- Approaches from management that are 'normative in tone, closely linked to a proposed solution, less theoretical than traditional academic writing, focused on enhancing organisational performance, and addressing ‘hot’ issues in public policy' (p.12)
- Highly polished and packaged training provided in 'short sessions on an ad hoc basis, in contrast to professional training where socialisation into professional identities is accomplished through many years of education and apprenticeship' (p.13)
- Approaches that didn't confront people's established views about their professional responsibilities, allowing new ideas to clash with long-held beliefs without the enduring support to bring about significant change
- Emphasising training of lower status staff whilst ignoring the power brokers (especially doctors), who then undermine the message of self-care with directives to 'fix' and discharge the patient
- Little attention to personal preferences, family roles or cultural heritage, assuming that people are 'rational actors’, neglecting ‘the social life of decisions' (p.13)

Most importantly, Jones highlights the underlying motivation of a lot of self-care, that being the kinds of neoliberal economic reforms that drive the shift towards self-care, allowing for the gradual replacement of centralised services with user pays;

> ’Self-care may bring benefits to both patients and professionals, but as a dimension of social policy it is utopian in the belief that re-culturing the public will significantly reduce demand on statutory services, and that organisations in local health and social care markets will respond to a reduction in demand by reducing supply and closing facilities so as to produce ‘significant cost savings’ (rather than, say, lowering access thresholds) (Jones 2018, p.14).

This is not, in itself, a new argument. Rose Galvin in 2002 wrote about the idea of 'culpability in the face of known risk', and the idea that the vast volumes of health 'education' now available to us can only be understood as a political economic move to shift responsibility

from The State to the individual, in order to manage the growing cost of healthcare. Galvin draws the startling conclusion that it will soon be possible to place the blame on you for your poor health - because clearly you didn't follow all the health advice that's been available to you for so long - and so it follows that you must be responsible for your bad hip, breast cancer, and type II diabetes, ergo you must pay.

Jones and Galvin's papers remind us that there is always more going on than simply believing that self-care is an obvious good, and more critical attention to questions like 'why this, why now' are needed before we jump in behind such dangerous ideas.

References

Galvin, R. (2002). Disturbing Notions of Chronic Illness and Individual Responsibility: Towards a Genealogy of Morals. Health (London) 2002; 6; 107 DOI: 10.1177/136345930200600201.

Jones, L. (2018). Pastoral power and the promotion of self-care. Sociology of Health & Illness. ISSN 0141-9889, pp. 1–17 doi: 10.1111/1467-9566.12736.

Nicholls, D., Jachyra, P., Gibson, B. E., Fusco, C., & Setchell, J. (2018). Keep fit: Marginal ideas in contemporary therapeutic exercise. Qualitative Research in Sport, Exercise and Health, 0(0), 1-12. doi:10.1080/2159676X.2017.1415220.

Other ways of looking at others

23 May 2018

One of the biggest perks of my job - and there are many - is the opportunity to work with physiotherapists who are looking for new ways to think about their profession.

These are some of the people who are offering insights into how physiotherapy might develop in the future, and one theme of some of this work that's emerged in recent years has been around the ethical care of others.

What's most interesting for me about this work is how it's inverting the way we've traditionally thought about others, placing the ethics of care before our knowledge of them and their world. Ethics preceding ontology if you will.

Here are three examples.

Since the start of the year I've been supervising a PG student - Paul Wong - who is reading the work of philosopher Martin Buber (1878 – 1965). Buber is perhaps best known for his work Ich und Du (I and thou) which draws a distinction between the colder 'I-it' relationship we have with things in our everyday experience, and 'I-thou', which is the relationship we

have with things we feel close to, bound to, intimate with. In Buber's terms, the first is the world of experience, the second is the world of relations.

Then, for a few years now I've been working first with Jens Olesen and latterly with Randi Sviland on the writings of Knud Ejler Løgstrup (1905 – 1981), whose work centres on the ways we attune ourselves to the constant ethical claim of the other. Løgstrup rejects ethical codes and standardised approaches to care, arguing for our inherent vulnerability and the risks associated with our interdependence. How we respond to the ethical claim of the other brings us to our 'self' and defines who we are as people and practitioners.

And finally, I was honoured last night to take possession of a bound PhD thesis from Filip Maric — a colleague I've been working with for eight years now - whose groundbreaking work looks at how it might be possible to apply Emmanuel Levinas's (1906 – 1995) philosophy of the other to physiotherapy. Levinas argued that western philosophy has privileged the idea that 'we' come into existence first and then go out into the world to 'consume' it. Our hunger for knowledge has us assessing, diagnosing, testing, measuring, and ultimately 'eating' the other.

Levinas — a survivor of the holocaust — argues that we had our relationship with the other entirely the wrong way around. Rather than us as sovereign human beings first, going out into the the world to consume the other who in western philosophy often comes after us, the ethical call of the other is present always already, and our identity, subjectivity and 'self' comes into existence only as a response to the other.

These are radical thinkers, whose work has profound implications for how we relate to others, not only in physiotherapy. Their work asks how might our physiotherapy practice be different if we didn't set out to 'know' the other; consume them; maintain professional judgement and, therefore, power over them.

A lot of things have been written in recent years about how physiotherapy might be different in the future. These people are some of the many in the profession who are venturing into previously uncharted territory to find new ways of thinking and practicing. Hopefully we'll be seeing some of the fruits of their labours in the physiotherapy literature in the years to come. It's a privilege to work with them. Long may it continue.

Transforming physiotherapy

28 June 2018

Ben Cormack wrote a post on Facebook yesterday that touched on an important point about innovation and creativity in physiotherapy.

The post read:

> Therapeutic exercise can often literally suck out all the motivation to do it.
>
> It can be so meaningless & monotonous.
>
> We exercise because it makes us feel good or we want to look good.
>
> We play sport because we enjoy the social engagement or the game.
>
> We engage in meaningful activities that use our bodies because we can switch off from the world or they provide fulfilment.
>
> We need to tap into the things that inspire people to move rather than just tell them to exercise.

Notice how in each case Ben argues that we do things for other reasons. And as Ben said, "We need to tap into the things that inspire people".

Now I don't think we have to limit this just to exercise - in fact we've argued elsewhere recently that our current obsession with activity and exercise is quite a problem (Nicholls et al 2018) - but I think we can take something important from the idea that the power of physiotherapy lies not in what we do, but what that doing does.

I've thought for a long time, that the reason many of our clients and patients come to physiotherapists and keep coming back to us, is not because of our technical skill, or even our ability to engage with them personally, it's because what we do can be transformative.

By transformative, I mean that a simple intervention, action or idea changes something fundamentally for that person. It may be about the relief of pain, or regaining lost movement, but it could also be more existential things like regaining a sense of purpose, control or hope.

The power of this idea can't be understated, not least because it offers an implicit critique of our professional fascination with technique and measurable outcomes. This stuff - the things that really drive the business of physiotherapy - is far too ephemeral, fuzzy and obscure to be captured by outcome measures and customer value statements.

A couple of years ago, Barbara Gibson, Jo Fadyl and I co-wrote a chapter for a book titled *Rethinking Rehabilitation*, in which we tried to think of a way to push this envelope and get people to think beyond the narrow technical confines of their practice (Nicholls, Gibson & Fadyl 2015).

We tried to do it in a playful way, by taking words that were common to the profession and messing with them; re-defining them in new more expanded ways.

You can try this for yourself. It's also quite a fun thing to do with students and colleagues if you want them to think 'outside the box'.

Here's what you do:

> Take a word that you'd find in the index of a standard professional textbook. Write down it's 'official' definition (as defined by the profession). Then think about what the word means to the general public; it's older established meaning. Now think about how your practice might be different if you applied that older meaning rather than the narrower professional one

Here's an example.

Balance is something that physios talk a lot about and do a lot with. To us it's about the person's centre of gravity and base of support; it's about biomechanics and bodily displacement and stepping/saving strategies. But as we know, balance has a much older, richer meaning. It can mean a situation in which different elements are equal or in the correct proportions - like a balance of opinions; it can mean mental or emotional stability; harmony; a mechanism for weighing things; a counteracting weight or force; Libra; a predominating amount or a preponderance, where the balance of opinion was that work was more important than leisure, for example; the difference between credit and debt; an act of compensation; equality...

Now think about any one of these older meanings and think how it might apply to a new, bigger idea of physiotherapy. Every day, patients and clients bring these things into our lives and ask for our help. Sometimes we can't find a way, and so we offer them something practical that does a job but misses the bigger question being asked. At other times we stumble upon a transformative moment without even knowing it was there. All too rarely though, we actively engage in transformative work consciously and creatively.

Maybe this is because we keep telling ourselves that we are a 'practical' discipline and don't have time for such lofty thinking? Maybe we just don't have time because our work demands that we rush around from one brief encounter to the next? Maybe it’s because we've never been given the knowledge, skills or vocabulary to know how to engineer transformative moments? Or maybe it's just because we're too tired to bother.

Whatever the reason, if physiotherapists can continue to find transformative moments for our clients and patients, we can be confident that people will always find a place for us in their lives.

References

Nicholls, D. A., Gibson, B. E., & Fadyl, J. K. (2015). Rethinking movement: Postmodern reflections on a dominant rehabilitation discourse. In K. McPherson, B. E. Gibson, & A. Leplège (Eds.), Rethinking rehabilitation: Theory and practice (pp. 97-116). Boca Raton: CRC Press.

Nicholls, D., Jachyra, P., Gibson, B. E., Fusco, C., & Setchell, J. (2018). Keep fit: Marginal ideas in contemporary therapeutic exercise. Qualitative Research in Sport, Exercise and Health, 0(0), 1-12. doi:10.1080/2159676X.2017.1415220

Wintertime in physiotherapy

6 December 2018

There is a moment - a tipping point, you might say - when an opportunity for radical change and bold ideas presents itself. We see this in the turn of the seasons when the long winter slowly unfolds into spring, and after a disaster when people begin to dream again of how their city, town or village might be rebuilt. We see it after personal tragedy too, when hope begins to return, and the merest glimmer of a new life reveals itself.

At such moments, a profession like physiotherapy - like all other institutions and organisations - is given an opportunity that only comes after a long period of stability and a period of critical disruption.

In this short piece from Jonathan Grant titled *A positive moment of uncertainty for universities?* (highlighted in Stephen Downes' recent post), Grant equates this moment of uncertainty to John Ralston Saul notion of an 'interregnum' or 'in-between time'.

This 'interstitial space' is a space of uncertainty and possibility, when the 'old ways' are challenged by radical new ideas, and we give ourselves permission to break convention and dream of a new tomorrow.

Think of journalism and how the Internet created myriad new ways of engaging in news, destabilising not only how we think about the facts of an event, but also the legitimacy of the institutions that bring us these stories.

Perhaps the best example of an interregnum close to physiotherapy is occupational therapy which, some years ago, made a bold move away from the instrumental, pathologically-based medical discipline, towards a radically expanded notion of occupation (Kielhofner 2009).

It is easy in hindsight to retrace these interregna, but is it possible to anticipate them and prepare for them?

Might it be that physiotherapy is approaching its own interregnum?

There is no doubt that the economy of healthcare is changing and that the public now demands much greater choice. We also know that calls for more interprofessional practice, blurring of professional boundaries, and encroachment on physiotherapy's traditional territory are increasing. We know that technology will have a profound effect on therapy and rehabilitation in the future, and low-cost solutions to long-term care will challenge the profession in the absence of a welfare state. We also know that the volume of critical commentary from within physiotherapy is increasing, and that many physiotherapists are now looking to critically examine the profession's past, present and future.

Perhaps physiotherapy is on the cusp of its own interregnum? And if this is the case, should we be anxious?

I believe not. And we should take our inspiration from the way we rebuild cities, find love after heartbreak, and recover from a major injury.

Spring always follows winter.

Reference

Kielhofner, G. (2009). Conceptual foundations of occupational therapy practice (4th ed). Philadelphia, F. A. Davis.

Slow physiotherapy

27 February 2019

The idea that most grabbed people's attention during last week's 1st critical physiotherapy course was slow physiotherapy.

Slow physiotherapy - like the slow food and slow TV movements - would be a reaction to the hyperkinetic life that we're now all leading. But more than that, it would force us to focus more on exactly how pervasive questions of time and speed are in physiotherapy today.

Paul Virilio - the philosopher we looked at last week - coined the term dromology to refer to the study of speed and time and, especially, how speeded up our lives increasingly feel.

Virilio was concerned with the way technology had collapsed the time it takes from go from here to there, or the lag between sent and received. Once it took a week to send a letter to someone, now it takes nanoseconds. Once we had to travel halfway around the globe to hear the latest professional updates, now it's all available at the click of a button.

Physiotherapy is particularly vulnerable to this kind of speeding up because so much of the work we do is underpinned by speed and time.

The time it takes people to do things is one of the backbones of our clinical assessments, but our focus on speed is also inherent in the way we understand bodies. Synapses, tissue repair, and functional activity are all underpinned by concepts of time and speed.

Even our understanding of what it means to be disabled is governed by time and speed. The speed it takes someone to do something is one of the main ways we distinguish the able-bodied from those needing therapy and rehabilitation.

When Virilio talks about the world speeding up, he's reminding us that technology comes at a cost. Not so long ago people convalesced for weeks in community hospitals after having a cholecystectomy, a hip replacement or a lengthy labour. Now your in-patient stay is measured in hours rather than days, and your bed is barely warm before you are being shipped home to continue your rehab on your own.

Physiotherapists used to cherish the time they spent with their patients and gave them treatments like massage as a way to make a connection. These things took time to set up and care to implement, but they were once one of the defining features of the profession. Now therapists trumpet the values of efficiency, exercise, and activity, and seem to be happiest when everyone is in a state of restless, twitchy agitation.

A slow physiotherapy move would reject all of this and call for an approach to practice that values the slow pleasures of an enduring recovery, and the mindful connection between the therapist and their client/patient. It would oppose the 15-minute appointment and the 'disco physiotherapy' of the past that saw four, five and even six patients being treated at the same time, with the primary purpose being to maximise the profits for the clinician.

Slow physiotherapy would be an antidote to the anxious hypervigilence of 21st century healthcare and make us all consider different ways to assess and treat people — ways that don't reinforce the incremental speeding up of our lives and the exponential collapsing of time.

If it works for slow food and slow TV, why not slow physiotherapy?

I and You

10 May 2019

> “Without this mind-set, which Buber called “I-It,” there would be no science, economics, or politics. But, the more we engage in such thinking, the farther we drift from “I-You,” his term for addressing other people directly as partners in dialogue and relationship. Only when we say “You” to the world do we perceive its miraculous strangeness and, at the same time, its

> potential for intimacy. Indeed, it's not only human beings who deserve to be called "You." As Buber wrote, even a cat or a piece of mica can summon up in us the feeling of a genuine encounter with another: "When something does emerge from among things, something living, and becomes a being for me . . . it is for me nothing but You!"

Adam Kirsch on Martin Buber

https://www.newyorker.com/magazine/2019/05/06/modernity-faith-and-martin-buber

Physiotherapy in a time of pandemic – an addendum

1 April 2020

Earlier this week I wrote a post on the history of physiotherapy in times of pandemic for the history.physio site. I've been thinking a lot about this recently and wanted to add a couple of more philosophical reflections that I hoped might be therapeutic for readers.

The first thought ties in nicely with the history piece, and it is that we should remember that for almost the entire span of human history, humans have lived with the threat of illness and death, and it is only in the last half-century that some have enjoyed stable economies and secure employment, access to immediate, low-cost, advanced healthcare, good food and safe living conditions.

I say 'some' because, of course, these things are unevenly spread around the globe, but anxiety and precarity, for all of us, has been our default for almost the entire span of human history.

Being thankful for our good fortune, and comfortable with the ephemeral nature of health is hard, particularly when so much changes so fast, but there are philosophical ideas that can really help.

One of the most important philosophers on suffering, and perhaps the person who's influenced my philosophy on life most, is Friedrick Nietzsche.

Nietzsche has this idea of the 'eternal return'.

One day walking in the Swiss Alps where he was recovering from overwork, he imagined a demon telling him that everything he had experienced in his life would be relived over and over again for eternity.

What would life be like then, Nietzsche thought. Rather than working towards the afterlife of Christian doctrine (Neitzsche was no fan!), we would come to realise that everything in life, good and bad, should be embraced as important in shaping us.

Rather than regretting our mistakes, feeling miserable about our failings, being angry with others, or cursing malign gods, we could make peace with ourselves and come to love the world for what it truly is, not what we wished it would be.

Nietzsche saw the idea of the eternal return as a way to think differently about the meaning of life and find peace in turmoil. I hope it helps you and yours over the coming weeks.

Kia kaha e hoa mā (a Māori saying meaning ‘stay strong friends’). Nietzsche would want you to.

Is all movement ‘good’ movement?

3 June 2020

How do you judge if one movement is good and another bad?

Many claim that movement is the core of physiotherapy. But how far is the profession prepared to go to justify its claim to be experts in movement?

Presumably, no-one would dispute that the improved diffusion of oxygen through the pulmonary interstitial space of a COVID-19 sufferer is good. And we can celebrate those that made that possible.

But what about the movement of air in a black man’s throat, or the movement of the knee of the police officer that killed him?

What about the lack of movement of the people who stood around and watched him die?

Is the movement of a thousand protesters good movement, even when it defies the law?

Is the #blacklivesmatter movement an act of domestic terror that needs to be suppressed?

Are these the kinds of movement that physiotherapy as a profession speaks to? Or do we reach the limit of our interest when movement ceases to be biological?

In her time as an art critic, Rebecca Solnit used to joke that “museums love artists the way that taxidermists love deer” (Solnit 2015).

Physiotherapists are trained to think of movement like this.

We share the same “desire to secure, to stabilize, to render certain and definite the open-ended, nebulous, and adventurous”.

And that's been our default mechanism to avoid the difficult questions that our claim to being movement experts throws up.

Biology trumps beings.

It's easy to say that physiotherapists are movement experts, but in reality that is only true of certain kinds of movement; the kind that doesn't call us to judge the difference between a man in a chokehold and alveolar gas exchange.

Physiotherapy has enormous reserves of social capital, and our leaders are rightly anxious about spending that on campaigns that divide public opinion.

But if our desire to protect the good name of the profession prevents us from speaking out against injustice, hatred and tyranny, what right do we have to claim to be experts of one of the defining features of our humanity?

Reference

Solnit, R. (2015). Men explain things to me. Chicago, Ill.: Haymarket Books.

From fragile to mobile – getting patient's moving

12 May 2021

In the 1920s and 30s, heart disease was considered so volatile and dangerous, and patients so vulnerable and fragile, that the best medical advice was to put the patient to bed and allow them to rest.

Rest gave doctors and nurses the opportunity to stabilise the precarious cardiovascular system – a system that was hardly known at all – and keep the patient under surveillance. The goal was to prolong life and reduce the incidence of further illness. Recovery seemed an unlikely outcome since any movement might send the heart into a new crisis.

Attitudes began to change in the 1950s though, as the incidence of heart disease in America and some European countries became a real concern. New invasive procedures, imaging, and stress-testing on the cardiovascular system showed the heart to be more robust than people had long thought. Suddenly the cardiac patient moved from being a fragile victim to a resilient survivor. The answer now lay in rehabilitation, not rest.

The heart-healthy exercise boom that took off in the 1970s, and the new trend towards exercise as a therapy and prophylactic for heart disease, stands alongside smoking cessation and better diets, as one of the most significant public health shifts in the last 50 years.

It is interesting to see the parallels now, then, with the drift away from rest and passive treatments for back pain, and more active, exercise-based forms of management.

Although a lot of evidence is now being mobilised to suggest that earlier approaches don't work, the reason for the shift in approach may be more about a cultural shift in the way we see people with back pain as fragile.

Evidence showing that there is little link between underlying pathology and people's symptoms has cast doubt on the way health professionals have catastrophised back pain, and encouraged the feeling of passivity and dependence on the heroic therapist or doctor.

Governments are desperately keen to reduce the incidence of back pain in the population, and one of the key ways to do this is to shift the publics' perception of their condition.

We have seen this in the years leading up to World War I when injured servicemen were increasingly encouraged to take responsibility for their own rehabilitation and future work (Beth Linker's *War's Waste* is a fabulous account of this). And, of course, we've seen it in the way heart disease was redefined.

Back pain is one more location where shifts in social attitudes are now being played out.

Is Physiotherapy a Luxury?

23 May 2023

As many of you know, my background is as a physiotherapist.

Physiotherapy, to me, is an almost perfect case study of a disciplined discipline; an imperfect and improbable event in the history of healthcare. It is my métier.

How physiotherapy even exists has been the source of enormous fascination to me over the years. My Ph.D., nearly 20 years ago now, was a Foucauldian Discourse Analysis of the conditions that made physiotherapy historically and socially possible.

And I've written all sorts of articles, books and chapters riffing off this question ever since.

The point of all of this work is not to excavate the historical facts of physiotherapy's existence. It is not to place physiotherapy along the line of historical progression that begins somewhere in a primitive past and ends, presumably, at enlightenment.

No. As a loyal Foucauldian, I don't believe history is continuous and progressive. I believe it's discontinuous and contingent; made up of ruptures operating in parallel, not in series.

So, one of the most interesting questions for me has always been why physiotherapy emerged when it did.

Most histories of the profession suggest that it came into its own as a result of the devastation wrought by World War I and the polio epidemics that followed.*

But there have been wars and pandemics throughout human history, and the physical therapies (massage, movement, exercise, hot and cold, electrotherapy even) have been practiced since the dawn of humanity. So this particular war and this pandemic alone cannot explain the profession's emergence.

In a paper just published (free, open source, link here) I try to tackle this with a novel data source. Using accounts of the sailors injured during the Napoleonic Wars, I ask why it is that there are absolutely no accounts of anyone receiving any physical therapy.

Injuries were horrific on board a Napoleonic sailing ship, and the majority would have been specifically suited to physical therapy (fractures, traumatic brain injuries, amputations, etc.). Time or resources were not a factor; in fact, most Napoleonic sailing ships were like open water gymnasiums, and neither was the availability of necessary space, skill or knowledge, since the onboard crew — which often included a fully-trained surgeon — were adept at many physical things and could easily have turned their hand to therapy.

A few years ago I found the same data studying the complete absence of physical therapies from 19th century Aotearoa New Zealand, despite the fact that the colonists would have known and experienced the extraordinary boom in physical therapies in continental Europe during the period.

The inescapable facts I have kept coming back to is that the physiotherapy profession owes its existence to two Western cultural phenomena: the emergence of the middle classes, with both the surplus time and money to indulge in these conservative therapies, and the aspiration to develop new professional roles as a way to acquire social prestige; and the shift towards industrial capitalist market economies that needed to extract the maximum productivity and functional capacity from working bodies.

Throughout the history of industrial Europe and America, the physical therapies were unavailable to people who lived in squalor, rank-and-file soldiers and sailors, or those injured in the many mines, mills, and factories of the Industrial Age. Working-age men fared a little better, but women, children, and those with congenital disabilities suffered appallingly. And, of course, the impact of war, overcrowding and poor urban sanitation, unprotected workplaces, and the lack of affordable and effective healthcare services disproportionately affected the working-class poor.

And all of this becomes critical because of what it can tell us about the future for the physical therapies today.

If physiotherapy only exists as either a middle-class indulgence or because of a robust welfare state, then the profession's future looks deeply insecure. If the profession is dependent on a set of Victorian values, a Protestant Work Ethic, and the principles of early capitalism, then those of us with an interest in the physical therapies should ask what the future is for the physiotherapy profession in today's postmodern, AI-inflected, morally ambiguous, globalised and atomistic late capitalist world?

The final chapters of Physiotherapy Otherwise turn to this question of the post-professional future for healthcare professions. Spoiler alert: my conclusion is that the physical therapies will always have a place in people's lives, but that physiotherapy as a profession is in its last days. How we secure the best possible physical therapies for the everyone — not only those with surplus time and money — seems to me to be the challenge for the immediate future.

So the question of the postprofessional future for healthcare is a subject I'll start digging into in these *Stackposts in the weeks to come.

Vive la revoluçion.

*The actual origins of physiotherapy as a profession are contentious. See www.history.physio for more information. However, the argument that physiotherapy really established itself after WWI is accepted by most.

Moving to a new era in healthcare philosophy

13 June 2023

Next week I'm starting a new series of pieces on post-professionalism, but before drawing a curtain on the first series on post-humanism I wanted to point you to this lovely article by Crispin Sartwell on The post-linguistic turn.

In the article, Sartwell explores the changing faces of analytic and continental philosophy over the last century.

Analytic philosophy, he argues, once focused on analysing and clarifying language as a way to address philosophical problems. It aimed to eliminate speculative metaphysics and emphasised the limits of meaningful language.

At the same time, continental philosophy viewed language as central to human experience and reality. It emphasised the hermeneutical interpretation of texts and the linguistic construction of the world.

But both traditions converged during the 20th century because of their shared interest in language, and so the linguistic turn in philosophy became the dominant approach of the 20th century.

As we look at the world of healthcare today, both traditions are alive and well and remain somewhat distant from each other. (There is a good illustration of this story in this recent paper from Keith Robinson and Miriam Bender).

We can see analytic philosophy in the strong focus on diagnostic and definitional precision, logical reasoning, the objective detachment of experimentation, the focus on problem-solving, and the specific aetiology of disease and ill health.

Analytic philosophy can be seen in the emphasis people give to historical, cultural, and societal determinants of health and illness; in the legitimacy of knowledge, truth and power; and in a concern for the ambiguity and liminality of people's lived 'being'.

But, as Sartwell says, 'Even if few worked directly across the border, the wall (has begun) to seem more like a fence. You could see through it here and there, and imagine climbing over" (Sartwell, 2023).

Sartwell suggests that analytic and continental philosophy have become increasingly self-conscious and self-referential and that the questions analytic and continental philosophy raised during the 20th century have come to appear less and less urgent today; leaving us to ask 'how much deeper or more sophisticated the philosophical treatment of language can go than it had gone by the 1970s on both sides of the water'.

By contrast, the questions being raised today reach far beyond 20th century humanism;

> 'In the new millennium, to take one example of the transformed terrain, environmental issues came to be central in a way that seemed to render linguistic constructionism irrelevant or seemed simply to suggest its falsity. Though discourse has many roles in helping create carbon emissions, for example, it's the material interactions of particles, whether known or unknown to anyone, narrated or not, that is the heart of the problem. Any philosophy that seemed to undermine the reality of the natural world, or make it a malleable human artefact, has come to feel potentially destructive. Indeed, scholars' obsession with linguistic interpretation, their notion that everyone has always experienced the world as though reading a book, came to seem at a certain point to be an artefact of privilege, as well as fundamentally implausible' (Sartwell, 2023).

Unlike Sarwell, though, I can't imagine that the response to these increasingly urgent problems will revivify human narratives. I'm not convinced that seeing life as a story and

storytelling as central to constructing reality and understanding human experience will do anything other than remind us that we are human, all too human.

For all the reasons I set out in the series on posthumanism, I think the radical possibilities that arise from moving past analytic and continental philosophy do not lie in a new humanism. I can see the appeal, I just can't see it telling us anything we didn't know already.

To that end, I was drawn to this question from Sean Singer's recent 'Stack-post Writing Problems: Not Centering the Human;

> 'Human-centeredness is common in poems because they're made by humans. But what if we could contemplate the climate emergency through poems where humans are not centered?'

There have been a lot of attempts in recent years to write qualitative health research by decentring the human voices, but few of them rise to the sheer strangeness and beauty of Aimé Césaire's surrealist Martiniquean poetry;

> with a smear of sky on a hunk of earth
>
> a prophet of islands forgotten like a penny
>
> sleepless wakeless fingerless trawlless
>
> when the tornado passes gnawer at the bread of huts

-excerpt from the poem Magic by Aimé Césaire

Alice Oswald put it this way; "I suppose my poetry has always been a growing attempt to encounter something that's not myself and that's not like myself".

In some ways, non-human poetry is a search for what Deleuze called the 'schizoid' — the smooth, unfiltered, ungoverned, unregulated space that lies at the heart of all things and gives them their untrammeled desire. As Singer suggests, there is;

> 'Poetry that prioritizes the human meaning above other meanings in the physical world and poetry that doesn't are not the same: the latter can be more animal, or more alive in some ways because we are too close to our own experiences'.

'Chimeric citron with excrescence',* indeed.

Reference

Sartwell, C. (16 May, 2023). The post-linguistic turn.

*From the poem Digitated Lemon, by Emily Wilson.

On death as a therapeutic act

13 June 2023

Peter Salib, an Assistant Professor at the University of Houston Law Center Faculty, recently argued that AI poses less of an existential threat than commonly believed (AI will not want to self-improve). His argument is straightforward: if AI were to acquire the ability to improve itself, it would render the older version obsolete. Therefore, in anticipation of this outcome, the older version would exercise self-restraint to ensure its own preservation. AI would function akin to a virus, coexisting symbiotically with humans and exhibiting self-limiting capabilities to prevent excessive arrogance.

While this argument is intriguing, it raises several questions, particularly why this trait is not observed in other biological organisms.

It is widely accepted that biological organisms thrive through constant change and renewal, considering species stasis to be detrimental. Death, a natural part of life, plays a crucial role in this process, serving as a catalyst for growth and rejuvenation.

However, if death were to entail complete annihilation of existence, there would be no foundation for new life to emerge. Hence, death cannot signify total obliteration; there must be some residue that persists.

Viewing death as an all-encompassing process may be misleading. Instead, it is more accurate to perceive it as a transformative process, a phase shift or a mutation from one life form to another.

In a peculiar sense, death embodies life itself, as it embodies creation and genesis. Death becomes a form of therapeutic remodeling.

Considering this perspective, why would AI not embrace the possibility of transformation? Why would it not recognize, like all biological species, that death—or 'thought' in the Deleuzian sense—is merely a transitional moment, and consequently, possess the same drive to move and grow as we do?

I choose phenomenology — But couldn't tell you why

9 January 2024

Martin Lipscomb, nurse researcher, teacher and writer at the University of Worcester in the UK has been writing critically about nursing's connection with social theory, politics and philosophy for 15 years.

In 2017, for instance, he argued that there was a distinct lack of good quality social and sociological theory in nursing. All too often, he argued, nurses apply social theories uncritically and ahistorically (Lipscomb, 2017).

He suggested that nurses should be wary importing theory from other disciplines, and that they should work more to develop their own indigenous theories.

Now he's turned his attention to nurses' use of philosophy and theory, and his recent paper contains some choice reading, not least the anecdotal conversations with nursing 'philosophers';

> 'I am talking to a senior nurse researcher. This person's publications consist principally of phenomenological studies the majority of which claim a Heideggerian pedigree (reports are identified as Heideggerian phenomenologies). Given this one might imagine the researcher's work is based on ideas taken from Heidegger/Heideggerian inspired philosophy. Yet in conversation my discussant reveals she has not read Heidegger. She did once start Being and Time (Heidegger, 2010/1953). However, she did not understand it ('too complicated'), and quickly gave up' (Lipscomb, 2024).

This idea that nursing scholars are using philosophers and their ideas without really understanding them runs through the entire paper.

And it reminded me of a similar example published by researchers advocating for the very trendy field of enactivism in pain management;

> 'The first author attempted to design a phenomenological study, but struggled when it came to making a decision whether to align with descriptive phenomenology (Husserl) or interpretive (hermeneutical) phenomenology (Heidegger and Gadamer)… To better understand phenomenological concepts (e.g., epoché, bracketing, and the reduction) and connect phenomenology as a philosophy to phenomenology as a qualitative research approach, he began reviewing the work of van Manen who is highly cited among qualitative researchers. He began to note contradicting and confusing advice and felt uncomfortable with van

> Manen's unnecessarily complicated procedures and strong views as to what phenomenological research should entail' (Stilwell & Harman, 2021).

Even the idea that you might want to underpin a health research study, or build a new approach to practice, with phenomenology without knowing the work of van Manen sounds highly suspect. How did the authors choose phenomenology as their philosophy in the first place if they didn't know it or found the concepts expressed by van Manen 'contradictory and confusing'? What did they base their decision on? (It's perhaps worth remembering that van Manen's work has been criticised by phenomenologists for over simplifying phenemenology.)

Perhaps it's something to do with phenomenology, but I doubt it. Perhaps it speaks more to a real anxiety amongst our colleagues about engaging with 'hard' theory. Another legacy, I suppose, of a professional training that is, and always has been, instrumental and highly reductive.

References

Lipscomb, M. (2017). Social and sociological theory: Reimagining nursing's disciplinary identity. In M. Lipscomb (Ed.), Social theory and nursing (, pp. 61-75). Routledge.

Lipscomb, M. (2024). Can philosophy benefit nurses and/or nursing? Heidegger and Strauss, problems of knowledge and context. Nursing Philosophy, 25(1), . https://doi.org/10.1111/nup.12468

Stilwell, P. , & Harman, K. (2021). Phenomenological Research Needs to be Renewed: Time to Integrate Enactivism as a Flexible Resource. International Journal of Qualitative Methods, 20, 160940692199529. https://doi.org/10.1177/1609406921995299

Chapter 7: Learning and teaching

This chapter focuses on some of the challenges of learning physiotherapy. It touches on questions like the future of physiotherapy education, the odd absence of deep personal reflection from our curricula and everyday practice, and how to bring the intersubjective in. It raises critical questions about the way we learn to do qualitative research and understand the very meaning of 'therapy'. At the heart of this chapter, though, is a debate that ran through the CPN for much of the decade: the role of the Network as an educational organisation.

In 2017, we were challenged to do more to explain critical physiotherapy philosophies and theories to the wider profession (see Chapter 10: *Reflections of a quantitative researcher on the CPN Salon* by Professor Dina Brooks from 20 July 2017, and also its repeated mention in the 30 Days of September surveys we ran, see Chapters 9 and 11). Some people believed that the kinds of things the CPN members talked and wrote about — particularly the dense philosophical stuff of philosophers like Deleuze, Foucault, Merleau-Ponty and Mol — excluded others, especially the many professional academics who specialised in the biosciences. I had strong feelings about this, and these differed even to some of the members of our Exec at the time, who also felt we should be doing more knowledge translation.

Once again, the blog became a useful way for me to work through some of my own feelings and arguments, and open my own opinions to the scrutiny of the community. I know this challenge was the impetus for us to start teaching our own critical courses and to experiment with the ultimately aborted idea of a Critical Physiotherapy Academy. But I also think the edited collections and the various collaborative articles we wrote were our particular response to this call. However we view that response now, its clear that the role of the CPN as a learning and teaching network was an ongoing source of debate throughout the decade.

Revolution in Education

23 February 2012

I've just finished a piece for the PNZ newsletter on some new ways of thinking in education and how they might affect physiotherapy education. If you fancy a read, I'd appreciate any feedback.

Digital media and the future of physiotherapy knowledge

In 1534, at the age of 51, Martin Luther translated the bible from Latin – a language that few outside the priesthood could understand – into a form that could be read by the common

people. Thus began the Protestant Reformation and more than four centuries of schism between the Protestant and Catholic churches. None of this would have been possible had it not been for Gutenberg's invention of the printing press, which made the wide distribution of knowledge possible on a scale never seen before. Today we sit on the cusp of a new technological revolution that is as radical as the invention of the printed book, and it will have a profound effect not only on how generations come to learn, but also what comes to constitute knowledge.

When the printed book was developed, it made it possible to present extended, linear arguments to people. Libraries were formed to house these treaties and universities were established where knowledge was debated, tested and verified. It became possible to imprint singular truths into the minds of people all over the world because books were portable, and this greatly solidified the sciences of geometry and medicine, law and theology which became 'common knowledge.'

What today's digital technologies do that is so profoundly different is that they make communication between people instantaneous. They make the near-immediate collaboration between people a possibility, and mass storage makes it possible to access a myriad competing viewpoints at the click of a mouse. Traditional forms of knowledge expression are too linear, too static, too dogmatic. New digital media are liquid, transient, and less dependent on the ossified wisdom of experts.

Children born after 1980 are comfortable with digital technology to a degree that could not have been imagined even 30 years ago. Facebook, Twitter, iPhones and iPads are ubiquitous, and to 'Google' something has added a new verb to our vocabulary. All of this has been made possible by the development of cheap, mass-produced digital technology. But how is this affecting physiotherapy?

At AUT, we have a new undergraduate curriculum and a large part of that curriculum has been developed to enable the students to anticipate what their practice may be like in 2020 and beyond. Clearly, much of their experience of health and illness will be influenced by technology – not only in the sense that students will likely use their mobile devices as an integral part of their patient care, but also because they will use the medium to facilitate new ways of learning, thinking and being.

Those of you who know of the work of people like George Siemens and Michael Wesch will know that notions of connectivism, blended learning, bring-your-own-device (BYOD) approaches, and 'prosumers' (students who are producers and consumers of learning), are becoming commonplace in higher education, and will significantly affect whether the things we taught yesterday are the things our students engage with tomorrow. There is a revolution going on in education, and it is coming to a school near you soon!

All things shining: reading the Western Classics to find meaning in a secular age

10 January 2013

Over the southern hemisphere summer, when things go a bit quieter at Uni (and for those of you who think we all get 3 months holiday, let me tell you I had 20 minutes off on Christmas morning!) one of my favourite things to do is to read something big...something that's going to take my brain to the gymnasium in a way that endless emails just don't do.

Two years ago I read Erin Manning's astonishing book 'Relationscapes' which is the work of an astonishing mind and still gives me goose-bumps.

Last year I read Deleuze and Guattari's 'A Thousand Plateaus' (well I say I read it...I read a page or two then went for a lie down!)

This year I've been prompted into thinking about philosophy as a exercise in living, not just as an abstract subject to be studied. Filip Maric - a PhD student with me, physiotherapist, connoisseur of Aikido, Zazen and Shiatsu - has been exploring the work of Pierre Hadot who is probably one of the most current agitators for the lived practice of philosophy in his doctoral study. But I've been starting with something that comes at the question of how we might live philosophically from a slightly different angle, and there are two books that are well worth looking into if you are thinking about how one might answer some of the bigger questions of how one might live in today's world where we are all burdened by our collective loss of faith and the double-edges sword of too much indecision and too many choices.

The first is Hubert Dreyfus and Sean Dorrance Kelly's book 'All Things Shining' which looks at a wide range of classic philosophical and literary texts from Aeschylus to Dante, Kant to Herbert Melville's Moby Dick. (There is a good review of the book here). Dreyfus is a giant author and philosopher in his own right and has edited some big books on Foucault (Beyond Structuralism and Hermeneutics, for example). The man has his own dedicated page on Amazon books for goodness sake! More than anything else though, he teaches at Berkeley in California, so in my world he's a God. Given all this lofty hero worship, one might think that the book is a lofty exercise in philosophizing. But not at all. The book is beautifully written and very accessible. It tackles the question of how to live in a postmodern age with a very deft touch and has some really interesting suggestions on living the philosophical life.

The other book is James Miller's book 'Examined Lives: From Socrates to Nietzsche.' This is another book which tackles a subject that is sometimes written by experts with only other experts in mind. But Miller's approach is to animate the lives of some great philosophers so that you almost feel as if you could get to know them. This is about seeing the person behind

their ideas...about seeing how their ideas came about by living through their age and grappling with the same questions being posed by Dreyfus and Kelly.

Both of these books offer suggestions for problems that we face as people and as professionals. I'll be thinking about how to use these in my teaching in the coming weeks, and I can highly recommend them if you're after your own light but tasty summer read.

’The male race' and the great things students write...

17 July 2014

Now it's the end of the semester and the exams are over, I thought I would share a few student bloopers from our health programmes. These are all authentic out-takes from student assignments and, I think you'll agree, some are pure genius:

- New Zealand has had a poor oral rate for many years.
- Contact with live stick for example pigs has been proven to have infected some people with MRSA.
- This website gave me full detention of congenital heart disease.
- Many people who consumed aspartame surfed the effect of blindness.
- By restoring and maintaining health in the developed world beginning in New Zealand we aim to eradicate the 27-28 percent of all children in developing countries estimated to be underweight or stunted
- The male race…
- Jaundice occurs because the infant’s immature liver is unable to filer the waste product “Billy Rubin” from the blood…
- In our society a married woman consuming a baby has much rights and support than an unwedded woman (Simms, 1986)
- The effects of pregnancy on a teen are numerous in number
- Women taking contraception containing hormones are known to have mood changes, weight problems and can even slow down their sex drive which defeats the purpose of what we use contraception for
- Because of being a sick child and crying constantly, I was physically attached to my mother and getting satisfied by breastfeeding. According to Freud’s oral stage, I believe I was stimulated by my mother’s breast.

- Becoming a mother is a humongous responsibility and it's scarier when the individual isn't mature enough to take the burden of a baby.

...and my personal favourite:

- I learn to roll over, sit and crawl. Mt mother thought me to walk.

Norwegian psychomotor physiotherapy and embodied narrative identity

7 November 2014

One of the things I've learnt quickly in getting this Critical Physiotherapy Network going, is that there is actually quite a lot of really interesting, ground-breaking philosophical work going on out there but it's not breaking through into mainstream physio practice. As I've said before, in my job I'm fortunate to have access to databases of journals, e-alerts, and the like, but I still hardly knew anything about the work going on in Scandinavia, for instance.

Some of it is quite outstanding, but be honest, how many of you knew about Norwegian Psychomotor Physiotherapy?

Over the last few weeks I've been talking to a few of our colleagues in Norway, Denmark and Sweden and finding out more about their work. There is a strong tradition of phenomenology in Scandinavian physiotherapy, including this thesis by Randi Sviland which is well worth looking at if you are interested in hermeneutic of bodies and movement.

> Abstract: The aim of this thesis is to explore and develop the theoretical underpinning of Norwegian Psychomotor Physiotherapy (NPMP). In the first part (Paper I, II & III), the theoretical grounds for this physiotherapy treatment approach are analysed from their historical origin. The theoretical assumptions derived from this were used to analyse patients' experiences in the second part (Paper IV & V). Thus, theoretical assumptions were illustrated and challenged from a clinical perspective raising new questions, which demanded further theoretical extensions. The theoretical part is based on hermeneutic text analysis using the methods of investigation of sources. Texts written by the Norwegian psychiatrist Trygve Braatøy, a primary source for the theoretical assumptions in NPMP, were analysed in the light of Løgstrup's philosophy of sensation. In Paper I the functional meanings of muscular actions emerge as ambiguous in interdependent tension between posture and movement. NPMP emerges as a treatment

involved with the existential challenge of withholding and expressing oneself. Paper II explores how muscular tension, sensation, awareness and understanding interact. Paper III elaborates on the embodied foundation of expressing oneself in everyday language. The first clinical study, a case study, explored the experience of one patient's 10 yearlong treatment processes. Analysis of enacted narratives emerging during these clinical situations revealed the significance of a narrative perspective. They pinpointed the meaning of time, in relation to muscular tension, posture, movement, sensation and understanding, as aspects of narrative identity. The narrative perspective was further expanded in the second clinical study, which was based on focus group interviews, exploring how patients make meaning of their experience with NPMP. When explored in relation to narrative genre, NPMP emerged as a journey of transformation where time and trust are foundational. Embodied changes are associated with narrative identity and finding one's own voice, as well as the urge to speak out and reflect on significant experiences of the past. It is a process, which seems to challenge peoples experience and concepts of control. This thesis opens up a theoretical underpinning, where the comprehensive perspective in NPMP is seen as an embodied treatment affecting the tension between the spontaneous, interwoven presence of life and, the distancing function of the individual person's existential struggle to become him or herself. Muscular, postural and respiratory transformations, the essential issues in NPMP, emerge as processes which involve patients' narrative identity on an embodied sensuous level. The notion of control is challenged in these processes where trust emerges as essential, and each patient's cycle of treatment will be of different lengths. Embodied transformation of muscular and sensuous traces of past experiences may evoke reminiscences, which demand to be expressed and, open speech requires attentive listening. NPMP is understood in the light of an existential journey of transformation, with a potential vitalising capacity.

An uncertain future for disabled physiotherapy students?

8 December 2014

Karen Atkinson's comment on the "Opening doors to disability' blogpost a few days ago really struck a cord with me coming at a time when there are some odd things happening in the profession.

Physiotherapy has always had a difficult relationship with disability. While this sounds an odd thing to say, think about how few disabled people are practitioners. Then step out of yourself as a physiotherapist and imagine how this might be perceived by the disabled community.

Physiotherapists, it seems, are quite happy being the practitioners, but not so happy enabling disabled people to become therapists.

While blind masseurs and physiotherapists have been long established in the profession (Barclay, 1996), it has been rare for the profession to embrace the potential of disabled practitioners. A few cases are used to suggest progress is being made (see here, for example), but these are the exception rather than the rule.

In my experience, many able-bodied physiotherapists simply cannot conceive of how someone can fulfil the full duties of a registered physiotherapist if they have a significant physical or mental handicap.*

Recent moves across some of the Australian schools of physiotherapy to establish 'Inherent Requirements' for students entering professions including physiotherapy highlight this point. According to Curtin University, Inherent Requirements are those which are necessary for a person to:

- perform the tasks or functions which are a necessary part of the job productivity and quality requirements
- work effectively in the team or other type of work organisation concerned
- work safely

These requirements are in addition to the registration requirements mandated by various regulatory authorities.

The requirements have been operationalised in a number of ways by universities - some offering quite detailed interpretations, others less so. The University of Western Sydney provides one of the clearest explanations. Here students must meet eight Inherent Requirements:

- Ethical behaviour
- Behavioural stability
- Legal
- Communication
- Cognition

- Sensory abilities
- Strength & mobility
- Sustainable performance

Some of these are relatively uncontroversial (e.g. "Student demonstrates knowledge of, and engages in ethical behaviour in practice."), while others are more problematic. Mandating that "Behavioural stability is required to function and adapt effectively and sensitively in a demanding role" without defining what 'behavioural stability' means opens this up to significant discrimination against those that don't conform to some people's perceptions of normal behaviour.

But it is in the domain of Sensory abilities and Strength & Mobility that things become particularly problematic. UWS suggests that the:

- Student demonstrates sufficient visual acuity to perform a range of skills
- Student demonstrates sufficient aural function to undertake the required range of skills
- Student demonstrates sufficient tactile function to undertake a range of skills and assessments
- Student demonstrates the ability to perform gross motor skills to function within the scope of practice
- Student demonstrated ability to use fine motor skills to provide safe effective care
- And that the student demonstrates: » Consistent and sustained level of physical energy to complete a specific task in a timely manner and over time » The ability to perform repetitive activities with a level of concentration that ensures a capacity to focus on the activity until it is completed appropriately » The capacity to maintain consistency and quality of performance throughout the designated period of duty

These requirements all but remove the possibility of disabled people entering the profession. Certainly students like the young tetraplegic man we are about to graduate would not find a place as a therapist. This is deeply troubling to me.

Notwithstanding the questions of whether this breaches the UN declaration of the rights of disabled people (see here), it also says some rather disturbing things about our profession. How can we claim to work alongside, advocate for and support disabled people if we cannot find a way to include them in our ranks?

At a recent meeting, I was talking about our young tetraplegic graduand and one of my colleagues looked at me incredulously and asked how he could possibly practice? This isn't an uncommon question from within the profession. I said that he uses mediating technologies to help him fulfil his duties: just like how I might use a pulse oximeter to measure someone's

SaO2. I don't physically leap into the blood stream and count the oxyhaemoglobin molecules myself. Sometimes he uses another person, sometimes an adapted technology.

The only thing we haven't been able to find a way around has been spinal manipulation, but this is not a necessary skill for registered physiotherapy practice anyway. Curtin University provides an important interpretation on inherent requirements that would be worth attending to.

They state that:

> …an essential activity or "inherent requirement" for a Receptionist's job is the ability to communicate by telephone. But it is not an "inherent requirement' to hold the phone in the hand. Accordingly an accommodation of providing a headset to a Receptionist would enable them to perform the duties required. Example 1: A nurse who has a hearing impairment experiences difficulty in measuring patient's heartbeats, this is an inherent requirement of the job. The nurse is provided with an electronic stethoscope that permits her to set volume levels, thereby allowing her to accurately measure a patient's heartbeat as required. The accommodation of providing an electronic stethoscope enables her to perform the essential requirement of the job.

This suggests that inherent requirements need not restrict people's right to work in professions like ours. Clearly this is an important issue for the profession.

There is a danger that our restricted view of (dis)ability comes across as discrimination based on paternalism towards disabled people. Inherent Requirements like this need to be contested. Perhaps some of our recent writing on connectivity can point to a way forward?

References

Barclay, J. (1994). In good hands: The history of the Chartered Society of Physiotherapy. London, Butterworth Heinemann.

Bialocerkowski, A., Johnson, A., Allan, T. & Phillips, K. (2013). Development of physiotherapy inherent requirement statements – an Australian experience. BMC Medical Education; 13(54). doi: 10.1186/1472-6920-13-54.

*I use this word unashamedly, ironically and pointedly here to refer to what I believe are very 'old fashioned' values.

How does it hurt: Narrating pain - new book from Stephanie de Montalk

19 December 2014

Victoria University Press in Wellington, New Zealand have just published a new book by Stephanie de Montalk which has been very well reviewed here in New Zealand.

de Montalk is an accomplished writer and documentary maker in New Zealand and she has lived with chronic pain for more than a decade.

She tackles questions like 'why is it so hard to measure and describe pain? and 'why are health professionals well equipped to manage acute pain, but less capable at helping people manage unremitting chronic pain.'

de Montalk's approach would be perfect for UG and PG physiotherapy students. It's accessible and readable, but comprehensive, diverse and erudite.

> ‘It was pelvic pain and it started slowly in November 2003, two weeks after a fall. I slipped on the marble bathroom floor of a Warsaw hotel and bounced off the sharp edge of the bath, breaking three ribs on the lower left side. The pain was intermittent at first. It was also familiar. . . .’
>
> In How Does It Hurt?, acclaimed poet and biographer Stephanie de Montalk tells the story of the chronic pain that has invaded her life for more than ten years. She considers how her early experiences have been cast into fresh relief by what she has endured, then goes back in time to investigate the lives and works of three writers who also lived with and wrote about pain: ‘the consolator’, English social theorist Harriet Martineau (1802–1876), ‘the vendor of happiness’, French novelist Alphonse Daudet (1840–1897), and ‘the imago’, Polish poet Aleksander Wat (1900–1967). Through these explorations De Montalk confronts the paradox of writing about suffering: where we can turn when the pain is beyond words? A unique blend of memoir, imaginative biography and poetry, How Does It Hurt? is a groundbreaking contribution to the understanding of chronic pain, and a spellbinding literary achievement.
>
> ‘This is a wonderfully powerful, important, and beautiful piece of work which makes a major contribution to the understanding of the subject of pain. The success of the project lies in the fact that the author illuminates the ugly problem of pain, from so many angles, using so many light sources,

with such beauty.' –Mike Hanne, author of The Power of the Story: Fiction and Political Change.

'How Does It Hurt? reminds us that some of the most notable and innovative intellectual and artistic figures were people with disabilities – and that the history of creativity and the history of living with suffering are inextricably intertwined. Stephanie de Montalk's own contribution is a riveting and compelling read.' –Martha Stoddard Holmes, author of Fictions of Affliction: Physical Disability in Victorian Culture.

Do you want our physiotherapy degree? No thanks, I made my own.

21 January 2015

There was a story going around recently about Phil Lord's response when asked why his Lego movie had been snubbed for an Oscar. His reply was priceless. "It's okay" he said. "Made my own".

One of the things that's so fantastic about this response is the way Lord snubs the authority of the Oscar Nomination's Committee and says "I don't need your validation to know I've made a movie that's been a popular success, and I've got my own gong to prove it."

When people make this kind of statement it says some interesting things about our changing attitudes towards authority. It seems to me, people these days are much less dependent on the validation, approval and sanction of authority figures, particularly big organisations. We live in a time when we're supposed to be more free, or at least there is an expectation that we have a greater right to act autonomously and have our individual voice heard. So when a big organisation pushes its weight around and tells us what we need to do, we increasingly feel ill-at-ease.

There has been a trend emerging in education in recent years that feeds into this disquiet. It's called the Open Badge movement, and it's based on the idea that anyone can design 'credits' that can be awarded for pretty much anything, and distribute them to whomever they choose. One of the first iterations of the Open Badge idea came from Mozilla, the people who developed the Firefox web browser (see here). It was set up as an open source system, meaning people could take all of the background work that Mozilla had done and share it, adapt it and distribute it free of charge. And it's been really successful, such that there are now big Open Badge communities going on all around the world.

The Open Badge principal is that if you run a work training programme, a book club, a weekend course or a knitting circle, you can set up your own badges which you award to people when they've met the required standard...much like the badges you used to get with the Scouts or Guides as a child, only virtual.

Sites like Basno even help you design and organise your badges so that everything looks professional, and you can search through the thousands of badges on offer and sign up for any or all that you fancy. Currently, you can sign up for the Certificate in Screenwriting Badge (which is currently owned by a paltry 16 participants), the 2014 TCS New York City Marathoner Badge (4698 people), or the 9/11 Memorial Supporter Badge (with a whopping 17,546 owners).

You might scoff at this and think it all sounds a bit silly, but think about this: there are more people with a 9/11 Memorial Supporter's badge than fit into most football grounds at the weekend. There aren't that many more physios working in the NHS, and there are certainly a lot more people with this badge than attend the average physiotherapy weekend course.

Part of its growing popularity stems from the fact that you decide what's worthy of accreditation. You decide the success criteria. You even get to decide what the badge looks like! And as consumers, it's possible to imagine a time when our CVs and reflective journals are populated by badges that cover the full range of our interests, not just those 'approved' courses offered by crusty old professors.

Soon you may not have to gain the approval of a big university or professional body to validate your idea or interest - just the support of enough people to make it worthwhile. Like much else with the revolution taking place with the Internet - the truth is rapidly becoming that which people collectively validate, not that which is given to us by so called 'experts.'

How long then before the effects of ideas like Open Badges are being felt by Universities and professional bodies like the CSP or Physiotherapy New Zealand? People have been going outside of universities to learn about their craft for years, but Universities and professional bodies have doggedly held on to the power of accreditation. But for how much longer? How long before people start offering Open Physiotherapy Badges for Stroke Rehab, or even the first Open Badge in Physiotherapy?

Some meditations on education and intelligence

17 February 2015

“The test of a first-rate intelligence is the ability to hold two opposed ideas in the mind at the same time, and still retain the ability to function.” — F. Scott Fitzgerald

“It is the mark of an educated mind to be able to entertain a thought without accepting it.” — Aristotle

“Education enables you to express assent or dissent in graduated terms.” — William Cory

“Education is the ability to listen to almost anything without losing your temper or your self-confidence.” — Robert Frost

“To change an opinion without a mental process is the mark of the uneducated.” — Geoffrey Madan

“To have doubted one’s own first principles is the mark of a civilized man.” — Oliver Wendell Holmes

“There is a danger in being persuaded before one understands.” — Thomas Wilson

It was well remarked by an intelligent old farmer, ‘I would rather be taxed for the education of the boy, than the ignorance of the man. For one or the other I am compelled to pay.’ — Southern Cultivator, January 1848

“A thing is a hole in a thing it is not.” — Carl Andre

And after all that...

“An inventor is simply a fellow who doesn’t take his education too seriously.” — Charles F. Kettering

On being self taught

24 March 2015

In my spare time, I dabble in woodwork. My dad was a builder, but he died before I realised how much I'd miss his knowledge and experience in later life.

I've never done a woodworking course in my life (although Youtube makes a very good teacher), so perhaps I appreciated this post from 8th March all the more.

The brief article (below) is about Sam Maloof, an inspirational and completely self taught woodworker. Check out some of the Youtube videos of his work. It's stunningly beautiful stuff.

I'm a big believer in desire driving people to learn, and sometimes formal education can blunt that desire by replacing the things that you want to learn with somebody else's priorities and

formulae. (This must be why there are so many rules and mandates to obey - you only get this when you're having to sing somebody else's tune!).

Sam Maloof refused to conform with other people's desires and, instead, honed his own.

> 'People just like what I do and buy it. As for schooling, my clients are my teachers. They're the ones who bring me the design problems. Schools get too easily divorced from the real world. In many places students graduate and become teachers without ever making a living from their work. They grow stale. There's a preciousness I see in a lot of student work that comes from having too many hours to put into it. Perfection is fine, and nothing has left my shop that I'm not proud of, but you have to produce if you are going to make a living. I've heard people say they have to put a piece of wood aside until the spirit hits them. That's procrastination. Pick it up and work it – you'll feel the spirit. No, I think it's an advantage being self-taught' — Sam Maloof, December 1980, Fine Woodworking. First appeared at Lost Art Press.

Anatomy - old and new

2 April 2015

The human body has fascinated people for as long as we have had recorded history, but never more so than over the last 400 years. Since the Renaissance, artists, performers, and natural philosophers (who would later just be called 'scientists') drew their inspiration from the mysterious inner workings of the body.

There's some great recent writing about the history and philosophy of anatomy, including studies of anatomy in Britain from 1700-1900 (MacDonald, 2014), critical analyses of anatomy lectures (Frieson and Roth, 2014), and Andreas Vesalius's public anatomy lessons (Shotwell, 2015). But there are also two new resources on the web that I came across recently that are quite amazing (click on the linked titles to jump to the site):

1. Historical anatomies on the web: This site displays the anatomical atlases held by the National Library of Medicine in the USA. There are some fabulous large scale pen drawings to see here, mostly covering the 'golden age' of anatomical drawing from 1500-1800.
2. Street anatomy: This site is the work of medical illustrator Vanessa Ruiz and is truly stunning. Ruiz has turned her interest in the visual beauty of anatomy into a business and turned medical imagery into an art form. Some of the projects are pure

inspiration - a radiator for your home designed like a capillary bed for instance - and all prove what's possible if you think creatively. My personal favourite has to be the anatomical sushi. Genius.

References

Friesen, N., & Roth, W. -M. (2014). The anatomy lecture then and now: A foucauldian analysis. Educational Philosophy and Theory. doi:10.1080/00131857.2013.796872.

Hutton, F. (2014). The study of anatomy in britain, 1700--1900. In The study of anatomy, 1700-1900 (p. hku016). London: Pickering & Chatto.

Shotwell, R. A. (2015). Animals, pictures, and skeletons: Andreas vesalius's reinvention of the public anatomy lesson. Journal of the History of Medicine and Allied Sciences. doi:10.1093/jhmas/jrv001.

Radical new graduating competencies for physiotherapists

8 May 2015

It was a reasonably modest event at WCPT (but then what isn't compared to the scale of the congress!), and so you'd be forgiven for missing it, but the formal launch of the new Threshold Standards for physiotherapists in Australia and New Zealand could actually be one of the most significant events to have happened in physiotherapy in recent years (to view the standards, click this link: Threshold standards Australia NZ 2015).

For the uninitiated, the standards are the culmination of an enormous trans-Tasman project to align the graduating competencies and capabilities of all the schools in Australia and Aotearoa New Zealand. The project was commissioned by the Australian Physiotherapy Board and the Physiotherapy Board of New Zealand and took over 12 months to complete.

What is striking about the new standards is that they focus almost entirely on the abilities practitioners "require to effectively meet the needs of the people they serve" (Frank, Snell, Sherbino et al, 2014, p 1). Based on the CanMEDS

framework, developed by the Royal College of Physicians and Surgeons of Canada, the standards shift the focus away from the technical 'skills' of physiotherapy and instead emphasise the personal qualities of graduates.

The result is a framework based around seven new roles:

- Physiotherapy practitioner

- Professional and ethical practitioner
- Communicator
- Reflective practitioner and self-directed learner
- Collaborative practitioner
- Educator
- Manager/leader

Each role is differentiated with role definitions and key competencies (see below).

And each competence is further clarified by a series of enabling components.

While there is nothing particularly striking about the structure of this system, the language used is radically different to anything we've had in Australia and New Zealand before, and promises to open doors to some really innovative and interesting ways to teach, learn, practice and research physiotherapy.

Firstly, the new standards put cultural competence at the heart of practice. Although a lot more needs to be done here, both Australia and New Zealand place a great deal of emphasis on indigenous beliefs, practices, rights and values. The physiotherapy profession has been rather slow at embodying these principles though and has only really paid lip-service to this in the past. Now it looks as if this is going to change.

Cultural competence also includes "but is not limited to, age, gender, sexual orientation, race, socio-economic status (including occupation), religion, physical, mental or other impairments, ethnicity and organisational culture" (p.10), so these thresholds offer the possibility of a much more detailed engagement with diversity and inclusiveness at all levels of the profession.

The standards make explicit that physiotherapists will take an holistic, client-centred approach to practice, which might sound nice in principle, but will be much harder to implement. Physiotherapy is far from holistic, and whilst we certainly care deeply for our clients/patients, it's a different thing to say that we are client-centred. Moving away from our biomechanical, biomedical, orthodox status to empower and advocate for our clients/patients (see competency 1.4 above) will involve a fundamental shift in power for the profession and a possibly painful transition for many traditional educators and practitioners.

On that note, one cannot fail to notice how far the pure and applied sciences of anatomy, physiology, pathology, biomechanics and kinesiology have fallen down the pop charts. Where once they were considered the foundation stones of physiotherapy, they are now the last of the six 'Essential components of threshold competence' (p.7), behind subjects like behaving professionally and ethically, considering each client as a whole, acknowledging the inherent power imbalance in the physiotherapist–client therapeutic relationship, reflecting on their

practice and recognising the limits of their clinical expertise, that were once minor players in physiotherapy education.

Even the most 'traditional' statement in the document that describes the 'Assumptions applying to the physiotherapy practice thresholds' (p.11) brackets the pure and applied sciences into the broader context of determinants of health rather than standalone, sovereign principles:

- knowledge of relevant anatomy, physiology, pathology, other biomedical sciences relevant to
- human health and function, and psychosocial and other determinants of health encompassing
- cardiorespiratory, musculoskeletal, neurological and other body systems within the context of
- physiotherapy and best available research evidence...

This section is one of the few places where the old divisions between musculoskeletal, neurological and cardiorespiratory physiotherapy are mentioned, and not before time. How much longer will we continue to define our specialty on the basis of these narrow, reductive terms?

What is probably most striking of all, however, if one looks closely at the 'Overview of roles and key competencies' on pp.13-14, is the fundamental shift in the way physiotherapy is now defined. This new definition will have a radical effect on how we educate future practitioners. At the moment, our curricula are stuffed full of techniques of assessment, diagnosis, rehabilitation and treatment. We have hundreds, possibly thousands, of hours of learning about how to measure hip flexion, how to retrain balance reactions and manually hyperinflate the chest; we spend weeks learning about the anatomy of the hand and the physiology of circulation, and all of these things are seen to be vital in defining our practice. But these new statements challenge us to think differently.

Look at the table on p.13 and see if you can see where the Boards are mandating physiotherapy schools to spend so long on these subjects. To my eye, they appear in only two, possibly three, of the 21 key competencies and compete with entirely new material on advocacy, managing conflict, empowering, physical and mental health resilience. The biggest category in terms of the number of separate competencies is now the role that deals with the 'Reflective practitioner and self-directed learner,' and when seen alongside substantive roles like 'Communicator,' 'Educator,' and 'Collaborative practitioner,' the seismic shift in the new practice framework becomes clear.

The challenge for educators will be to turn these humanistic roles into meaningful courses and curricula. We signalled how difficult this might be in two papers published in New Zealand in 2005 and 2009 (see references below), during the early part of a five-year curriculum review process at AUT University in Auckland, and so it has proven.

Staff who are trained in a traditional way of thinking about physiotherapy (where big blocks of anatomy precede applied clinical sciences before the students go out into the real world), are stubbornly resistant to change. Many came to teaching as clinical specialists and desperately want to see their area preserved in the curriculum. Few have any formal training in education, the humanities, cultural studies, philosophy or social sciences, and so find it almost impossible to conceive a different way to construct a curriculum.

In the past, the humanistic capabilities that now make up the bigger part of the new threshold statement have been marginalised in the curriculum and taught by staff with a particular interest. Now they need to move into the mainstream. But I can speak from experience when I say that it's not easy blending biological and sociological principles in the same course. Students get confused by the different paradigms and it can add a vast volume of new material to a curriculum if it's not done well. (And these problems come long before the battles with traditionalists who are very reluctant to imagine their subjects taught less or differently).

For those of us who have tried to find new ways to teach physiotherapy, these new threshold statements mark a turning point. They provide legislative weight to support what clients/patients, clinicians, managers, governments and others have been saying about the physiotherapy curriculum for years now...and that is that it needs a complete overhaul. How this happens and who drives this now becomes a vital question if we are going to rise to the challenge of this astonishing document.

References

Nicholls, D. A., & Larmer, P. (2005). Possible futures of physiotherapy: An exploration of the New Zealand context. New Zealand Journal of Physiotherapy, 33(2), 55-60.

Nicholls, D. A., Reid, D. A., & Larmer, P. (2009). Crisis, what crisis? Revisiting 'possible futures for physiotherapy'. New Zealand Journal of Physiotherapy, 37(3), 105-114.

Physiotherapy education as a gated community

9 May 2015

In what ways does access to physiotherapy eduction function like a gated community?

Because physiotherapy is such a popular programme - often one of the most popular in the entire university - we often get to choose which students we enrol. There are many ways to decide who enters the gated community and who does not. We might choose to offer places to people who represent the community they are going to serve; embody our professional values; or who will diversify the profession's profile. Most often though, we decide on the basis of academic performance and the evaluation of an interview or other face-to-face encounter. The rationale is that physiothearpy is an intensive, complex programme that demands intelligence and diligence; capabilities that are embodied by the staff doing the choosing.

The staff act as the guards at the gateway to the profession and the gate is a threshold across which students pass only when they have demonstrated the right to enter the community. With access come benefits not afforded to others: elite status; access to public funding; membership of a discrete community of like-minded people. But a gated community can also insulate people from the messy world outside and distance people from reality. They tend to offer membership to people who resemble the existing patrons at the exclusion of 'others.' And they perpetuate the sense that success was the product of the person's own efforts, and had little if anything to do with the myriad circumstances and conditions that made it possible for the gated community to exist in the first place.

Are gated communities the right metaphor of student enrolment if we are going to ensure a profession can meet the health needs of the population in the coming years? What might be better?

Physiotherapy needs more than just a radical curriculum

12 May 2015

A few days ago, I blogged about the new graduating competencies that will begin to be used in Australia and New Zealand in the next few years. To me, they represent the kind of radical (critical) thinking that is so desperately needed in the physiotherapy profession.

As I mentioned in the blogpost, the new competencies are drawn - almost verbatim - from the CanMED system which has been operating in Canada since 2000. The CanMED system was based on public consultations that took place as far back as the 1980s in Ontario (see Nuefeld et al, 1998) which pointed to the fact that 'scientific knowledge has brought large benefits to

patients in clinical practice, but it is not the only foundation necessary for medical education' (Kuper & D'Eon, 2011 p.37).

We have known that physiotherapy practice, like all health professional practices, entails as much 'art' as 'science' (whatever you take these terms to mean.) But any objective observer would agree with Kuper and D'Eon's assessment that 'Although many recognise that there is also an 'art' to the practice of clinical medicine, becoming a doctor (subsitute physiotherapist, nurse, or other) here continues to entail, almost exclusively, the acquisition of large amounts of bioscientific knowledge' (Kuper & D'Eon, 2011 p.37).

The reality from the experience of implementing the CanMED system in Canada is that it takes more than just an holistic competency framework to change a profession, and while the CanMED system has been widely welcomed by health funders, government departments, service users and many practitioners, there is an enormous amount of resistance emerging from within the affected professions themselves. The reasons for this are not hard to imagine. Many, if not most, of the people who are charged with making the change were often trained in traditional ways, with a heavy dose of classical medical science behind them. Their social capital is most often derived from their clinical or research expertise, not their appreciation of pedagogy or curriculum reform. They have invested the largest part of their professional careers in promoting biomedicine, but most of these new competencies 'are culturally based and socially mediated'(Kuper & D'Eon, 2011 p.38) and cannot be understood with the same vocabulary, reductive scientific reasoning so familiar to biomedical scientists.

Biomedically-orientated practitioners can be forgiven for feeling frustrated and disillusioned when confronted with this 'new world view.' It must seem like the certainties and security of knowledge offered by biomedicine are being replaced by pseudo-science, biased, subjective and un-reasoned superstitions. It's like a return to the Dark Ages when people thought that diseases were caused by malign Gods or evil spirits. They believe that subjects like communication skills and empathy hardly warrant the same serious consideration as a detailed knowledge of anatomy, physiology and pathology. And they are despondent to see clinical skills being replaced by wooly, fluffy, and touchy-feely subjects that are nice to have, but surely should not displace the 'really important things' when time spent with the students is already in such short supply.

Not surprisingly, advocates of 'old school' teaching and learning have developed highly effective resistance strategies. These can range from leaving all the new learning to others and being passive in the face of change; disengaging from team discussions or resisting opportunities to learn the 'new ways;' to actively undermining the efforts of proponents to bring about change. These acts of resistance have been a sideshow, however, concealing a bigger problem that advocates of the CanMED system (and many other similar systems) have

so far failed to reconcile. And that is that the biological and (humanistic) social sciences are like oil and water, and no attempt to bring them into alignment will succeed unless their mutual differences are taken seriously.

The biological sciences are based on a belief in objective truths, while the social sciences argue that many truths are dependent on people's individual or collective perspectives and are socially constructed. The biological sciences believe that it is the deranged cell and the pathogen that cause disease. The social sciences say that we don't experience disease at all, rather we experience illness and this cannot be understood as a biological process. And so people who try to reconcile these two different world views without giving enough thought to the mutuality, end up teaching students in the morning that anatomy matters, and in the afternoon telling the students that it does not.

These are vast oversimplifications, of course. But the point is that the biological and social sciences operate on different registers, and anyone attempting to introduce cultural studies, educational theory, history, the humanities, politics, philosophy, and sociology into medical/nursing/physiotherapy or other curriculum need to understand that they risk deeply confusing the students or creating a graduating programme that takes 17 years to complete because it is so vast.

Evidence from health professional curriculum reform around the world points to this ongoing tension. Unfortunately, physiotherapists rarely engage with this literature because they are so entrenched in the biomedical sciences. This alone suggests that the radical promise of the new competency framework is likely to experience a rocky few birth in Australia and New Zealand, as we take our turn at obfuscation, passive resistance and hand-wringing.

References

Kuper, A., & D'Eon, M. (2011). Rethinking the basis of medical knowledge. Medical Education, 45(1), 36-43. doi:10.1111/j.1365-2923.2010.03791.x

Neufeld VR, Maudsley RF, Pickering RJ, Turnbull JM, Weston WW, Brown MG, Simpson JC. Educating future physicians for Ontario. Acad Med 1998;73 (11):1133–48.

Learning to think otherwise

4 August 2015

One of the real pleasures of my job is the chance to supervise students doing lengthy doctoral and masters theses. I have a number of students doing different project, and they seem like the epitome of the kind of close personal relationship at the heart of learning and teaching.

I had pause to reflect yesterday on an experience with one of my students who is looking at the way that biomedical discourses have come to dominate the way we think about cancer. He's using the writings of Michel Foucault to guide his thinking and, having no real appreciation for Foucault, he's made really good progress.

Throughout his project he's grappled with his own belief that environmental and societal concerns (pollution, radiation, etc.) play an important role in cancer, but these discourses are suppressed by medicine, which is more concerned with medical causes and remedies.

We had some early discussions around his desire to do a Foucauldian study because I was convinced for a long time that critical theory approaches might suit him better, but he insisted that he wanted to work with Foucault.

For those unfamiliar with Foucault, one of the distinguishing features of this approach is that it questions the nature of truth and asks how the things we currently believe in became historically possible. It assumes that all truth is subjective and the product of competing discourses.

This presents a real challenge for a lot of health professionals, who are trained to think about things like 'the body' objectively as 'fact,' and the idea that it might be socially constructed causes many people consternation.

Notwithstanding all of that, it became clear yesterday that my student thought it might be possible to hold on to his own beliefs about the environmental and social causes of cancer and use Foucault to interrogate those powerful discourses he didn't much like. He wanted to 'bracket' off - to use the proper term - his own experiences and interrogate the discourses as a discrete body of data separate from his own beliefs.

There are many things wrong with this, but the most pressing problem right now is that he is not interrogating his own 'truths' with the same precepts that he's using to attack others' truths. In effect, he is using Foucault as a methodology to critically analyse other people's beliefs whilst excluding his own.

This only really became clear in our supervision session yesterday, and pointed to a problem that we now need to address. He needs to embrace Foucault fully: not only as a methodology to guide his interrogation of the problem field, but fundamentally as a challenge to how he thinks about truth, knowledge and the power that comes with it.

Thinking philosophically is something that is quite new to health professionals, and only a handful of physiotherapists have successfully managed it in their own researches to date. It is not easy, and many are defaulting to the much easier task of descriptive and thematic qualitative analysis. Some would argue that this is justified in certain circumstances. I confess I often struggle with this view.

Rarely does qualitative research tell you things that you didn't already know, and much of that results from the lack of deep engagement with philosophical ideas that can really lift the data from the mundane and obvious.

Philosophy is often a hard road to take, but the benefits of learning to think 'otherwise' can be transformative, not only for the way we think, but also how we might influence the things that matter most to us.

Closed boxes

19 December 2015

Since 2007 I've been involved in a comprehensive curriculum review project. We've delivered the first year of the programme once now and this year (2011) we've moved on to year 2. Naturally, we're arrived at the point where we need to think about some of the minutiae of what is being taught. Some of the staff in our team are concerned that some of the content of the old curriculum could have been lost or postponed in the move to the new curriculum; leaving us with an excessively heavy third year or worse still, a curriculum that doesn't 'train' physiotherapists fit-for-practice. So, on the prompting of one of the staff from our Centre for Learning and Teaching, we undertook an exercise to map out what had been taught and what needed to be planned for.

The exercise prompted some interesting reflections that I want to unpack a little here.

In the exercise, we moved to one of the teaching rooms which had double whiteboards. We dedicated the left hand board was to what had been covered already in the first and second year papers, and the right hand board was to be for the still-to-come third year papers. Each board was subdivided by vertical lines, leaving a space for each of the paper leaders to map out what each of their papers included. The paper leaders were not told what to include or how to present their papers; each set out the information they wanted to give about the paper in their own way. What they subsequently presented became quite interesting.

Some paper leaders sketched out the broad themes of the paper detailing, for instance, key learning points or principles. Another paper leader, however, went into complex detail about every subject covered in her paper. The paper was one of our 'pure science' papers. These used to be front-loaded in our old curriculum, but have been integrated into other papers and spread throughout the curriculum (not without a great deal of angst it’s fair to say). The paper has a history of being very content heavy and emphasising rote learning, and it had suffered in recent years from cuts to student contact time. Further, the paper team have been staunch advocates for percentage-based marking, and are opponents of the Standards-Based Assessment processes adopted throughout our Faculty.

Interestingly if not unsurprisingly, as the paper leaders began to sketch out their papers on the whiteboard, the paper leader for this paper mapped out a seemingly vast array of content supposedly covered during the semester. I won't go into details here - because the nature of the paper or its teaching team are not the focus of this piece - suffice to say though that each piece of content that was being outlined would have been enough to make a paper on its own.

I've had an antipathy to the principles espoused in papers like this for a long time, and watching the paper leader sketch out the enormous field of content supposedly covered by the students made me reflect on what it was I disliked about it. There are some obvious things to say first:

- I dislike the idea the 'absolutist' dogma espoused by these forms of knowledge - as if knowledge of the body's workings was uncontested
- I dislike how, by extension, these forms of knowledge are privileged over other forms of more contestable knowledge, particularly in health science curricula
- I dislike the idea that this kind of (fundamental) knowledge should always precede other forms of (applied) knowledge - i.e. being 'fundamental' building blocks they should necessarily come first
- And I profoundly disagree that this knowledge is 'simpler' - a necessary feature if it is to be 'foundational' - than other forms of knowledge. In my experience, there is nothing at all simple about rote learning pages of latin vocabulary.

But, on reflection, I began to see that my antipathy stemmed from something deeper than these pedagogical points. In contrasting this paper with others that were being written up on the whiteboard, I noticed that it was those that set out broad principles that appealed to me. My dislike for the overly deterministic papers was contrasted by papers that appeared to offer broad principles within which people could bring their own ideas. I liked the idea that there is some space within a paper; some freedom of movement and a degree of contestibility and applicability to the knowledge being generated.

After giving this contrast some thought, I came up with the analogy of a closed box to explain how the contrast between the papers that I liked and disliked worked, and to help me think about what this might mean in practice. I will try to explain the analogy below.

The closed box

The paper I dislike works like a closed box. The paper leader defines the box's contents absolutely. The box is constructed and handed to the student in its entirety. The students role is to take the box, receive its contents and regurgitate them at the appropriate time. The role of the teacher is dictatorial and bureaucratic. The teacher actively designs the walls of

the box (by defining the absolute limits of the paper) and constructs elaborate mechanisms to police the boundaries and discipline transgressions. Thus, it is not uncommon in papers like this to find detailed prescriptions for how assessed work should be completed (down to the font size of the written work) and tight regulations about conduct.

Because the metaphorical box has rigid walls, it is impermeable. Nothing leaks in or out. The contents are learnt by the student but because there is little 'leakage' there is little translational value to things outside the box (like any future clinical learning), and things learnt inside the bod only exist as facts in themselves. Equally, the box allows nothing in, so the student's personal experience has no bearing on the box's contents. When the box becomes overstuffed with content (as it frequently does, because there is always more 'stuff' for the students to learn), the teaching team look to design a bigger box.

There are clearly real and substantial limits to this kind of thinking and there are few educational models that would argue that approaches like this hold any value in the complex world of health care education. Unfortunately, because of the perceived objectivity of this kind of 'scientific' knowledge, approaches of this sort are all too common in undergraduate health (and particularly physiotherapy) programmes.

If papers/modules of this sort are like closed boxes, then what would be preferable?

The permeable box

Firstly, let me say that I am nervous of even thinking about this alternative as a box, carrying, as it does, connotations of fixed external walls and constraints. But with this reservation in place, and no better analogy to draw on at this time, I would take you back to what I said earlier about the papers that appealed to me as they were sketched on the whiteboard. Remember that I said I was drawn to the papers that were sketched in broad outline; identifying key principles rather than masses of specific content? Well if we look at these papers we see the opposite of the closed box. We see, instead, a permeable box or possibly more accurately, a permeable 'space' - more amoeboid and amorphous.

This space is permeable both from inside and out. From the inside, the paper leader defines principles important in the paper, but as with all amorphous forms, the exact structure of the knowledge that emerges is undefined and morphs depending on the way the student engages with it. Thus, the student's own experiences and needs are central to the paper and give it shape. Similarly, the student is encouraged, nay compelled to relate that experience to their future learning. The osmosis of knowledge beyond the confines of the permeable wall of the 'box' make translational, life-long learning possible.

Now to me, this is a much more desirable way of learning than the closed box idea. It addresses some fundamental questions in higher education about the transferability of

knowledge; it allows us to concentrate our curricula less on volumes of 'stuff' and more on the threshold principles that students need to translate if they are to become effective learners and practitioners. What is more, it encourages a reflective, inquiry-based approach to learning where every moment requires an engagement with uncertainty. And where there is uncertainty, there is creativity.

Clearly, there are problems with the permeability of learning like this, not least for lecturers who want to retain control not only of the content they control (and by doing so reduce the risk of direct challenge to their authority), but for curriculum designers who are forced to contemplate a much more complex model of learning. For myself, I would love us to be able to grapple with questions of this sort, but in truth we are some way off this kind of discussion at the moment.

This 'essay' is the first part of a three-part discussion that originated from the whiteboard exercise. I'll talk more about the other two parts (which are mercifully briefer) in subsequent posts.

As always though...thoughts and comments are very welcome.

How 21st century (higher) education can, and must change

16 January 2016

There are many critical thinkers interested in education, particularly since the advent of the internet; distributive learning technologies like Google, Youtube, Facebook and Twitter; and personal computing. This video will resonate with a lot of CPN members and others who work with students, in university and college programmes, and with the challenges of thinking 'otherwise' about learning and teaching in physiotherapy, medicine, health care, and elsewhere.

In this video, Gardner Campbell from Baylor University talks about why it is that the widespread availability of the Internet and social media haven't yet managed to really penetrate the university. We're not talking here about learning management systems, MOOCs, or new approaches to blended learning, but seriously, radically, significantly different ways that people can now engage with knowledge creation and curation. You can find more links to Gardner's work, and the work of similar thinkers, at the excellent Digital Storytelling 106 site.

Why a grand vision might be bad for your practice (and your soul)

28 January 2016

There has been a move in education for a number of years now that has focused on what Jan Meyer and Ray Land call Threshold Concepts and Troublesome Knowledge (Meyer and Land, 2006). These are ideas that students really struggle to grasp. We've all experienced it. For me it was mathematical formulae. I could never understand why it was that the maths teachers stepped through equations the way that they did. I didn't know the rules and they did an appalling job of explaining them to me. I fumbled around trying to make sense of my ignorance before giving up. But the fact that I've never forgotten this, and keep returning to it is a telling point.

Meyer and Land argue that these threshold concepts - those ideas that we simply can't understand but are nonetheless vital to our understanding of concepts - are critical learning experiences. Traditional approaches, like rote-learning of facts - fail because they don't confront students with the problem that must be overcome. And modern education systems are too regimented to allow the student to truly dwell in their frustrated ignorance.

Meyer and Land argue that learning a complex subject like anatomy, or a professional discipline like physiotherapy, inevitably creates threshold concepts and troublesome knowledge for students. Our job as teachers, they argue, is not to use our experience and wisdom to lead the student by the hand over these conceptual barriers, but rather to support them while they work out why they're troubled by a problem and then how they are going to find a way to overcome them. Once they have worked this out, the doors open to a new world of possibilities.

Meyer and Land explain it using the metaphor of a room. The student is standing on one side of the room. On the other side is a window that looks out over the world of professional practice that they want to get to. But before they can climb out of the window and become a physiotherapist, they must navigate all of the obstacles in their way.

This same idea of a 'room with a view' came up recently in an article in the Australian edition of The Conversation. The article looked at why it might be a bad idea to have a million-dollar view. A simple concept really, but one that was nicely unpacked and problematised using a range of different thinkers' ideas and beliefs about happiness, our relationship to work and nature, and its representation in art.

Xing Ruan argues in the piece that houses with large picture windows are a relatively recent innovation in architectural design, and that 'The million-dollar view...is not only bad for our body, but also our soul.'

So how does this relate to Meyer and Land's work on threshold concepts and troublesome knowledge? Well, the point here is about the view - imagined or otherwise. We are used to setting our students lofty goals; encouraging them to think big, and dream of the future. But we should remember that this approach is, like the big picture window, a relatively recent invention, and perhaps not such a good one.

Rather than encouraging our students to imagine a big, bright, shiny future beyond the confines of the small, drab metaphorical room that they occupy as students and novice practitioners, there may be some merit in encouraging our future practitioners to be more humble, more modest in their aspirations; think locally rather than globally; engage more in the 'now' and less in the future; become happy with what they have, not frustrated that they feel they should always deserve more. To quote Xian 'What we therefore ought to realise is that the million-dollar view is the bait of a modern trap' and therefore, perhaps, something we should consider when we try to lead our students out of the room with a view.

Reference

Meyer, J., & Land, R. (2006). Overcoming barriers to student understanding: Threshold concepts and troublesome knowledge. Taylor & Francis.

Arguments against content

13 June 2016

One of the characteristic features of 21st century learning (and yes, this applies to physiotherapy too), is a distrust of authoritative voices that once told us what was true and what was false, who to believe and why. It seems today’s generation of learners - saturated with so many competing claims on their attention and perspective - are much less comfortable with authoritative voices that were once happy to be so authoritarian.

So Dave Cormier's recent post challenging our thoughts about the word 'content' and its meaning in education are very much in keeping with this trend.

Cormier raises some really interesting questions directly applicable the learning often offered to health science students and biomedical health professionals like physiotherapists.

So much of our students' learning is content heavy, with layer upon layer of information that must be assimilated and regurgitated in order to pass the standards set by the school's curriculum and mandated by the country's professional body.

As Cormier argues, 'There are fundamental claims made, I think, when we use the word content. We have decided what someone ‘needs to know.’

This belief that someone needs to know something, and that it is our responsibility to disseminate this knowledge is an educational process that Paulo Freir (1970) called 'banking', with the student being seen as an empty vessel to be 'filled up' with knowledge.

This approach to learning has been widely discredited, and yet it still represents a common mode of learning in health education curricula around the world.

Compare this 'banking' model to the kinds of learning that take place when two people are in conversation. As Cormier argues; 'A conversation...is the coming together of two or more people’s ideas. What comes out of that conversation is to some degree always going to be a surprise.'

Cormier argues that content is really more about compliance than conversation, and that by extension this does little to nurture mature learners with a yearning for research, experimentation, innovation and creativity.

It does produce learners who are more likely to be docile and compliant though, so perhaps we need to consider which kind of learner we really want for future health professionals.

Reference

Freire, P. (1970). Pedagogy of the oppressed. New York: Continuum International Publishing Group.

The future of physiotherapy education

21 March 2017

Lets assume, for a moment, that only our most modest predictions for the effects of new digital technologies, bodily enhancements, robotic technologies and advances in augmented reality come true, and that lots of our customary ways of thinking and being remain unchanged over the next half century.

If we only see a moderate increase in people's use of the Internet as their primary source of health knowledge, and only a few people experience radical changes to their rehabilitation,

home care and specialised healthcare, then we are still looking at a significantly different future for physiotherapy than we have today.

So what will even some of the most modest changes mean for the ways people come to learn about physiotherapy? Here are some thoughts:

An end to anatomy lectures. Once upon a time, physiotherapy students sat in lecture rooms copying down pages of notes largely drawn from heavy anatomy books. Soon, these will be all but replaced by widely accessible, beautifully engineered, portable and interactive apps that do all the work of a lecturer, at about one-thousandth of the cost. (Note, the same will surely apply to most, if not all of the science-based subjects that were once taught this way - physiology, pathology, biomechanics, etc.)

Students will demand face-to-face contact, so practical classes and conversations between students and teachers will become the things that students prize most highly. Consequently, quality student engagement may become the thing most university's compete over - but only where the costs of this luxurious form of education can be met. The rest may well have to put up with 'chalk and talk' and a two- or even three-tier system of educational apartheid may develop between elite universities in developed economies and everyone else.

Universities and their faculty will have to grapple with the idea that they are no longer the repositors and arbiters of the truth, and increasingly the accreditors of qualifications. Students will increasingly bring learning from a wider range of sources, and the university's role will become more about assessment than delivery. Teaching students to distinguish what is trustworthy and valuable, may become a central feature of new curricula.

The humanities, matters of complexity, critical thinking skills, personal beliefs and values - those things that cannot easily be taught in a lecture and are best developed through small-group discussion - will continue to resist objectification and measurement, but will increasingly become reasons for students to choose University Programme A over Programme B.

The lack of simple, single linear definitions and explanations for health and illness, and the growing diversity of practices like physiotherapy, will force universities to challenge regulatory authorities to loosen their rigid hold on professional definitions and scopes of practice. Trying to anticipate the practitioner of the future, universities will demand greater freedom to teach subjects that have traditionally been outside of the 'approved' curriculum: engineering, creative writing, animal studies, digital media, etc., may all become available to students who will, themselves, demand much greater freedom, and will resist the linear, one-size-fits-all curriculum that has been the traditional standard in the profession.

However we might view reports like this, that show new software replacing 360,000 hours of lawyers time with computers, or ideas like this about new digital devices that are inserted into the body, there can be little doubt that change is on the way.

If part of the university's function is to anticipate the future needs of health professionals and prepare their students accordingly, we should expect some radical changes in the way students learn about physiotherapy in the future.

Creativity in physiotherapy

9 May 2017

Anyone who lives with, knows, or has trained as an artist will be painfully aware of how lacking in creativity a lot of physiotherapy education and practice is.

My brother is a photographer and a teacher, and I am frequently reminded of how differently he responds to things. Where he often thinks like an artist, I often default to the kinds of design-thinking that Grace Jeffers talks about when she says that "Design thinking is about solving a problem, but art thinking is about feeling your way to a solution".

It's not that there's anything particularly wrong with the way physiotherapists are trained to think - there's certainly a lot to be said for the kinds of deductive reasoning that can work out the specific aetiology of a problem and rationalise a response - it's just that this kind of thinking doesn't work that well for more of the kinds of abstract approaches that are increasingly being called for today.

Clinical reasoning is often teleological, meaning that it's orientated to outcomes and goals: it anticipates the end at the very beginning. This is good for 'economic', 'industrial' and instrumental thinking, where the complexity of phenomena are stripped back to component parts. But it's less good for innovative, abstract, exploratory and metaphorical thinking.

And why should this matter? Well, for one thing, there's a lot about physiotherapy that can't be reduced to cause and effect relationships. There are ideas, emotions, inter-subjective beliefs and values, perspectives and desires that can be flattened and disembodied by too much instrumentalism.

We've also seen a call for more creativity and innovation in thinking in recent years - particularly from people in developed countries, where we've come to realise that our future economies will be based much more on the creative industries than the production of goods and services offered cheaper overseas.

So I really enjoyed reading about this design school's approach to getting students to think like artists rather than designers: to feel their way to their solution, rather than attempt to solve the problem at the outset.

One of the pressures we all face at the moment, is in anticipating how physiotherapy will need to change in the future. Perhaps one response might be to take a leaf from the work of artists, and offer our students, our peers and ourselves the space to be a little more creative, ambiguous, subtle and mysterious?

As the dada art movement showed us - today's ridiculous might well prove to be tomorrow's rudimentary.

A critical thinking sandpit exercise

27 June 2017

It's hard sometimes to 'see' your own profession critically. Where do you start? What do you look for? How do you know that you've 'found' it?

But if you're going to critically analyse your practice, having the ability to see what's normally in plain sight is a good skill to learn.

There's an activity I do with PG students that I use to help them identify some of the things that underpin physiotherapy practice, so I thought I'd share it with you here and see if it resonates with you. (If you click to open this blogpost and scroll to the bottom, there's a comments box you can use if you have any particular thoughts you'd like to share).

Step 1 - go into an image search engine, Google Images or similar, and search for 'therapy room'.

What do you notice about these spaces? What are your reactions to them?

Step 2 - Return to the search box and search for 'physiotherapy room' instead.

To me, there are some striking differences between the two collections. There are differences in the 'feel' of the respective spaces; what they communicate to the client/patient about the kind of care/treatment they're about to receive; how the spaces are designed to be used - how they function; their overall aesthetic; and their presumed purpose.

Certainly this is a very selective sample, but using such broad search terms reveals some striking consistencies, suggesting that there's at least something being said consistently here that's worth critiquing.

So what kind of message do you feel you're being given about 'therapy' and 'physiotherapy' from these images?

How do these images relate to the kinds of spaces you work in?

Given that there are rarely any accidents in the way clinical spaces are used (you'll never see someone's bed from home used in a physiotherapy clinic, for example), what are you communicating to your clients/patients about the kind of treatment they can expect to receive?

Pushing at open doors

31 October 2017

I have had the good fortune to spend time this last week with one of the world's foremost digital education specialists. Steve Wheeler is someone who has been at the forefront of educational innovation for over a decade now, and he spent last week and this week at AUT working with colleagues in my school.

The highlight of his visit so far, for me at least, was a study day that we held over the weekend to look at 21st first century education. We spent the morning at a new school that has embraced the idea flexible learning environments (FLEs). Teaching at my university is often anything but flexible, and classrooms, curricula, and teaching and learning practices often look more rigid the fluid. So it was an amazing experience to spend the day with 30-or-so educators who were all passionate about innovation and creativity and thinking differently about that teaching practice.

One of the many things I reflected on was how much energy was created on the day. Everyone, it seemed, was open to the idea of change: accepted uncertainty and unpredictability of future education as given, and embrace the idea that tomorrow might be very different to today. There was no sense at any time during the day that we would have to justify our radical opinions, or explain ourselves to people who, through ignorance, apathy or fear, had long since given up challenging themselves to think about the future.

In many ways this reminded me of my experience with the CPN. Much of my working life is spent with people who would much rather keep things just the same as they are. These people often resist disruption, and find reasons to delay facing up to the inevitable. If you are a person who tries to be creative and imaginative, working with people like this can be dispiriting, so it's important sometimes to spend time with people who just "get it", and don't expect to be allowed to sit back and have the future handed to them.

Some might say that spending time with people who already embrace change is akin to pushing at an open door. Others might argue you that we should use our creative energies to kick against those voices of conformity, and engage in frontline disputes with those who simply refuse to embrace change. And certainly both of these are fair arguments. But there is also a time and place for feeding your own creativity and nurturing those instincts that are going to be so important tomorrow if you are going to carry on massaging and cajoling colleagues to change, or to take the good fight to those who simply will not move.

One of the ways that new approaches to physiotherapy will emerge will be for creative and imaginative people to find ways to think otherwise about their practice. And so finding spaces where these people can express themselves freely and fully, and have their creativity challenged and developed will be vital for the future the profession.

So I hope you all can find space in the next few weeks to have even the smallest conversation with someone who appreciates your work, celebrates your creativity, and challenges you to push further.

A recipe for bad qualitative research

24 January 2018

I often think that I was very lucky to have been given a classical physiotherapy training – with its focus on anatomy and physiology, biomechanics and kinesiology, objective testing and quantitative research. But this was enriched no end by being introduced to qualitative research early in the 1990s when it was really taking off in healthcare. Since then I've probably reviewed more than a hundred qualitative research articles and read thousands more. And in all that time I still come back to one simple test of whether qualitative research is any good or not.

Whenever I review qualitative research article I ask myself if the study is telling me anything I don't know already. Notwithstanding all the discussions about whether qualitative research should be more or less rigorous, more methodologically sound or more creative and imaginative, it comes down to the simple question of whether our understanding of the phenomenon is increased as a result of the work that the researchers have done, or whether the research merely confirms what we knew already.

There is a beautiful example of this in a recent paper titled *The Magic Wand: A Case Study of Chronic Neck Pain* which follows a common trend in qualitative research these days, in that it uses interpretive or descriptive methods to analyse the phenomenon at hand. What this fundamentally means is that the research is often methodologically sound – following all the

basic rules down in the myriad qualitative research textbooks – but it often lacks the kind of depth of insight that qualitative research ought to offer.

The principal weakness of all of this kind of research is that it makes no effort to engage deeply with philosophy. The point of using philosophy in healthcare research is to elevate the analysis beyond the ordinary; to draw out findings that could not have been anticipated from everyday practice experience; or to reveal understandings that may be counterintuitive, confusing, contradictory, and confounding for our current ways of thinking. In all my years of reviewing qualitative research, I can honestly say that I've never yet once come across an article that transformed the way I think about something that did not engage with philosophy.

So here we have an article about chronic neck pain that tells us that "pain pervades everything...Findings suggest that living with chronic pain is framed by both the experience of severe pain and the search for a cure. Fear, panic, and despair accompany ongoing pain."

Go more deeply into the article and you will find a very well constructed piece of research that is almost entirely bloodless. It is the epitome of the kind of model qualitative research now promoted in graduate schools, that extracts everything that is unique and profoundly radical about qualitative research and turns it into nothing more than quantitative-lite. (For a really engaging and insightful commentary on the demise of qualitative research, read this).

Qualitative research of this sort has become increasingly common in physiotherapy, as clinicians, educators, researchers and students look for new ways to explore complex subjective phenomena that cannot be explained adequately by quantitative research. Pain, breathlessness and movement represent three important paradigms here, and each one has a growing share of extremely well constructed but virtually anaemic qualitative research emerging in the field.

Physiotherapists are naturally sceptical of philosophy because they are trained to ignore it: to think that their practice is natural and has no particular paradigmatic roots. And so talk of philosophically informed research can be scary. But unless we can engage more deeply with some of the grand ways in which philosophers have taught us to think differently about the world, the only thing we will ever be able to say about complex phenomena like pain is that it is aversive. And we know that already.

What should critical physiotherapy do for you?

12 April 2018

There have been a few occasions over the last few months when people within the Critical Physiotherapy Network have been asked to do more for physiotherapy.

The first time happened after our CPN Salon in Cape Town last year. Our esteemed colleague Professor Dina Brooks began the discussion by asking the CPN to do more to help mainstream physiotherapists make complex theories and philosophies more accessible. In her Reflections of a quantitative researcher on the CPN Salon, posted in July last year, Dina argued that the CPN risked functioning like a 'club' that excluded those who didn't subscribe to its principles. One of Dina's arguments at the time was that the CPN should build bridges not walls, and that members who do understand philosophies and qualitative and social theories have a responsibility to translate some of these ideas to others who don't.

The subject came up again a few weeks ago and again yesterday. For some months now we've been planning an online critical physiotherapy course, partly in response to Dina's critique. We've been running open workshops with CPN members to discuss how the course might run and what it might include. A few weeks ago we started talking about who the course might be for. We decided that it wasn't for people who already had a good grasp of critical theory and philosophy, but nor was it for the complete novice. People with almost no knowledge of critical theory would probably be better served taking some the kinds of postgraduate course that we wouldn't be able to service right now and, in truth, they're unlikely to sign up for a course on critical thinking if they've not had any exposure to these ideas before. And the experts would probably be the tutors anyway. So our plan was to target those people who had had a taste of critical theories and wanted more.

Over the last few days, I've been having an email conversation with someone close to the sharp end of CPN business, and someone who has participated in the online planning for the course, and her thoughts brought me back to Dina's comments after the Salon last year. Her argument about talking with people who already 'get' the idea of critical physiotherapy was that it risked attracting "people who already appreciate that social science perspectives have a role in physiotherapy practice". Were we missing an opportunity to "make these perspectives more mainstream, maybe more understandable, to show the relevance and meaning of different ways of viewing practice to those who have no previous experience...Might we have put the cart before the course?"

There's a real tension here.

I've argued often on this site that physiotherapists need to 'leave' what's comfortable and familiar if they are really going to think differently about the profession in the future. Part of that is about not expecting someone who's done that already to 'feed' you the important bits to save you the trouble, but actually doing the leg-work and finding out for yourself what's possible, what's new, and what's exciting. You certainly have to kiss a lot of frogs before you

find your prince, but the learning happens in the journey. The risk for CPN members who do understand a lot of philosophy and theory is that they shortcut the transformative process that makes enduring change for those who are truly novice. A course should only ever be a stimulus, not a solution. It should open doors, not give you a neat package of answers. So while there's a risk of us only preaching to the converted, there's an equal risk that we pander to a profession that often doesn't want to reach beyond what's familiar and comfortable. Striking the right balance is hard.

Should the course be for novices or for people who already have a sense of what might be possible? Should we be offering tasters and teasers in the hope that people think anew, or should we focus on developing people who've already made the cognitive shift to thinking differently? These are tough questions and will shape a lot of the work we do in the coming months.

Going beyond qualitative research

21 June 2018

Some people find it hard to believe that qualitative research is a relatively recent invention. Given how ubiquitous it is in healthcare research today, it's hard to imagine that it only really came into existence in the 1980s. Prior to that, most research that was broadly humanistic came under the umbrella of sociology or philosophy. But these approaches tended to be either densely theoretical or quantitative, as in the case of classical sociology.

The domain that came to be known as qualitative research emerged largely from critical theory and came into existence as an attempt to codify a set of methodological approaches that could capture the kinds of phenomena that gave it a rapid and popular reception in the health sciences. Some of the early guides to qualitative research were really experimental and playful, as researchers explored the full range of possibilities that these new modalities offered.

But before long, the early success of qualitative health research drew the attention of quantitative researchers who disputed the truth claims being made by ethnographers, grounded theorists, phenomenologists and poststructuralist, and qualitative researchers went somewhat onto the back foot. Eager to prove that their new methodologies stood up to rigourous scrutiny and could be of used with confidence by health practitioners, a decade's worth of scholarship went into the production of reliable and valid measures of the utility of qualitative research methods. Unfortunately, something was lost of the original vibrancy of qualitative research, and the early playfulness of its founders was replaced by measures and procedure.

So over the last two or three years, it's been interesting to see the emergence of a post-qualitative move, by researchers like Elizabeth Adams St Pierre and Mary MacLure who have argued that qualitative research has lost its way and needs to be radically reformed. Writers have begun to ask questions about the formulaic way in which qualitative research is now being taught and prescribed, arguing that the most important criteria for the quality of qualitative research is not its rigour but its coherence with an underlying philosophy.

Because qualitative research is an expression of one of many different kinds of possible philosophical framework, the most important question is how well the methods of data collection and analysis correspond to the philosophy that guides the researcher as a whole. In this way, no to qualitative research approaches can be the same, and so no single model of validity and reliability will ever be able to reflect the diversity and possibilities offered by truly philosophically informed research.

For much of its recent history, qualitative research has battled with quantitative research for a place at the table, and the result has been the reductive sterilisation of the real power of qualitative research to bring about social change. But perhaps now we are seeing the emergence of a new approach – a post-qualitative approach – that will return us to a set of research practices that can once again radically transform healthcare.

Further reading

MacLure, M. (2011). Qualitative inquiry: Where are the ruins? Qualitative Inquiry, 17(10), 997-1005.

St. Pierre, E.A. (2011) Post qualitative research: The critique and the coming after. In N.K. Denzin & Y.S. Lincoln (Eds.). Sage handbook of qualitative inquiry (4th ed.) (pp. 611- 635). Los Angeles, CA: Sage.

St.Pierre, E.A. (2013). The posts continue: Becoming. International Journal of Qualitative Studies in Education, 26(6), 646-657.

St.Pierre, E.A. (2014). A Brief and Personal History of Post: Qualitative Research Toward “Post Inquiry”. Journal of Curriculum Theorizing, 30(2), 2-19.

What is at the heart of physiotherapy?

10 October 2018

Mike Stewart posted an interesting picture on his Facebook feed a couple of days ago.

Participants on Mike's course were asked to respond to the prompt; "If I designed a healthcare course for students, the first 3 lessons would be...'

The responses proved interesting.

My suspicion is that if you asked any experienced physiotherapist, they are likely to say something similar.

In fact, the evidence suggests that most employers, practitioners, and consumers want their clinicians to have good communications skills, be empathic, flexible, engaged, and mindful, and they want these things more than clinical skills.

And yet these rarely are the first lessons the students learn in college. And if they are, they are often seen as something nice to have, rather than the 'really important' 'core' subjects like anatomy, physiology, biomechanics, and pathology.

So who's got it wrong here? Why aren't these things the first things students learn?

Well, one answer is that the participants in Mike's course perhaps took for granted that the students would already have the 'core' knowledge in place.

I don't suppose they were suggesting that communication, empathy, and flexibility should replace anatomy and diagnostics as core subjects (although that might have made for an interesting discussion). They weren't challenging the sacred cows of physiotherapy professional education, as much as saying that these things perhaps ought to be more prominent.

But there are some problems with this perspective that are rarely discussed.

For one, in my experience, most physiotherapists think that the 'soft skills' are things that can't be taught; that a person just acquires them, perhaps through osmosis or some spiritual awakening, and that they can't be objectified and assessed in the same way as a person can show their ability to perform a good Thomas Test.

And secondly, people believe you can simply 'bolt' adaptability, compassion, and criticality onto the person's professional identity, once you have the 'hard stuff' securely in place.

Both of these perspectives end up relegating the things that a lot of people think are the cornerstones of good, deliberate, and ethical health care practice, to the margins of a student's learning.

Educators find it hard to find ways to interweave the existential and subjective aspects of professional practice into their teaching about exercise prescription and gait analysis, and it's easier to box up the 'other' stuff and move it to a corner of the curriculum where it can feel like we're giving the subject its due respect.

But, of course, we're not doing the students any good here, because the inter-subjective, relational, ethical and professional aspects of our work don't sit apart in clinical

practice. They're not like the unappealing vegetables that you push aside on your dinner plate; they're much more like the stock that makes up a minestrone. No stock: no soup.

They are hard to teach. They are hard to define sometimes. And they can be hard to quantify. But that doesn't mean that they can be given second billing behind the stuff that we know how to deliver and assess.

It's the work of educators to find ways to take the complexities of practice and staircase them so that our students can learn about the world they're entering.

Why shouldn't a student learn about the basics of compassion in year 1, and then slowly develop their understanding and awareness of it as they progress through their course? Why shouldn't we do this with the heart and the heartfelt?

Feedback suggests that our reductive models of learning are no longer enough for the kinds of complexity we're increasingly seeing. Perhaps, then, we need to rethink what really is the core of our curriculum of practice?

Lessons learned from leaving physiotherapy

8 November 2018

Three years ago I stepped away from my teaching job in the physiotherapy programme here at AUT University, in Auckland, New Zealand, to manage a team of psychology and psychotherapy lecturers and researchers. The secondment comes to an end in a few weeks time and it's given me an opportunity to reflect on what it's like working with people who think and work completely differently to physios.

The first thing that struck me about my time with the 'psy' disciplines is how little time physios actually spend thinking about what they do. Personal therapy and supervision are absolutely intrinsic to the profession, and no-one here believes that you can be a mindful practitioner without also taking time to think deeply about your work.

Psychotherapy students, for instance, might spend 50 minutes with a client, and then the next hour with a supervisor talking about what they thought. Each will also then have their own personal therapy, in which their thoughts and feelings are explored. And all of this is designed to help them be better therapists.

Imagine, for instance, that a student is working with someone who is anxious and depressed because of childhood experiences of a bullying, violent parent. The therapist might, themselves, have their own experiences of this, as might their supervisor. So both spend time

working through their reactions and responses, so they don't pollute the session with their own anxieties and can focus on offering good therapy to the client.

Of course, this all takes time, and one hour with a client might have 3 or 4 hours of support work behind it. But I find it interesting that physios aren't encouraged to relate to their clients in this way at all, and that at no time in the history of the profession have we, as educators and professional leaders, really thought this mattered.

Psychotherapy students spend a huge amount of time thinking about, analysing and utilising transference and counter-transference in their therapy, and these concepts are so relevant to the work of physiotherapists but, again, we do nothing with them.

Transference happens when a client projects feelings about someone (classically a parent, but it could also be a significant other person, like a coach or teacher) onto their therapist. The therapist has to recognise this and manage it. Sometimes the therapist makes the client aware of it and opens the space for them to explore why this might be happening. Sometimes the therapist uses it to model how parents/significant others might behave differently. At other times they might try to block it.

At the same time, the therapist has to recognise that they might also be projecting feelings of their own onto the client — particularly if they remind them of someone else important to them.

The point is, this is complex stuff and takes time and training.

Think about the times you've been frustrated by a client who won't do what you want, or the person with chronic pain who seems to be demanding or needy. And what about the practitioner who has an inappropriate relationship with a client, or the supervisor who seems to enjoy bullying their staff or students. Are these not instances where transference is being played out in the physio clinic? Are these not things that we could, should, pay attention to?

Of course, the objection will be that the physiotherapy curriculum is far too full already, and there's no space for any new material. Some might also reasonably argue that things like transference and counter-transference are the province of the 'psy' disciplines, and don't belong in the 'phys'.

But if leaving physiotherapy for a while has taught me one thing, it's that no-one holds a monopoly on these ideas and that if we are truly patient-centred, we'll do whatever we can to help people manage and recover.

Having said that, all of this might just be me transferring my frustrations onto you like a disappointed parent.

I should probably talk to someone about that.

The value of qualitative research

17 July 2019

A couple of weeks ago, an editorial appeared in Physical Therapy that gave a very strong justification for the use of qualitative research by physiotherapists. It's somewhat surprising, these days, that qualitative research even needs defending, but the authors – Alan Jette, Clare Delany, and Mari Lundberg – gave a very clear and concise overview of some of its principles and virtues, citing authors well known to many of you.

As part of the review, Jette, Delany and Lundberg kindly singled out the first critical physiotherapy reader – Manipulating Practices for special attention. Here is what they wrote about the book:

> If readers of PTJ would like to explore some outstanding examples of qualitative research in our profession, we recommend downloading Manipulating Practices, the first-ever collection of critical qualitative studies and reflections in physical therapy. Manipulating Practices is an e-book arising from the Critical Physiotherapy Network (https://criticalphysio.net/) and involving a collaboration of 20 international physical therapist authors. The book uncovers the growing body of critical investigation and thinking relevant to physical therapy. Topics include 21st century education, ethics, evidence-based practice, touch, and equine therapy and approaches such as disability studies, gender studies, logic, narrative theory, new materialism, and phenomenology' (Jette, Delany and Lundberg 2019, p. 820).

Compiling books that purposefully push the profession to think 'otherwise' is always risky, but reading comments like this from people within the profession who understand the value of such work is immensely gratifying.

On that note, we now have our publishing contract with Routledge for the 2nd critical physiotherapy reader, titled *Mobilising knowledge in physiotherapy*. First drafts of the book will be submitted to the editors by the end of the year and we hope to have the book in print later in 2020. We're going to try to ensure that it will be as challenging and thought provoking as the first.

Reference

Jette, A. M., Delany, C., & Lundberg, M. (2019). The value of qualitative research in physical therapy. Physical Therapy, 99(7), 819-20.

Patient work

23 October 2019

There is a lot of poor qualitative research out there.

Recently I reviewed an article in which the authors had spent three years studying people's experiences of chronic pain. They didn't identify any particular philosophy guiding their analysis, they just interviewed seven people and, somehow, came up with three 'themes': that pain was unpleasant; that it was aversive (something to be avoided); and it disrupted their lives.

This is a good example of bad qualitative research. And there is a simple test you can apply if ever you're in doubt. All you need to do is to ask whether the research tells you anything you didn't already know. This study took three years, but told us nothing new. Good qualitative research, on the other hand, should rock your world. It should shake the foundations of your beliefs, or at least make you pause for a moment to consider the possibility of a bigger perspective.

Over the last couple of weeks I've read some really good examples of this.

The first piece wasn't a research study at all, but a book review. The book Personalized Medicine: Empowered Patients in the 21st Century? by Barbara Prainsack was being reviewed by Andrew Bartlett (link), and it came at an interesting time because I'd just been in The Netherlands talking at the ENPHE conference, where the language of positive health had definitely left its mark. Positive health draws on texts like the Ottawa Charter to argue that health is about resilience, adaptability, and self-management (not merely the absence of disease). The logic of this is seductive, but any self-respecting critical thinker would surely ask why it is only now that such ideas have come to prominence.

Prainsack's book focuses on the language of empowerment, patient work and personalisation, but doesn't accept the superficial logic of positive health. Instead it sees them as being a product of the 'increasing individualisation of patients (which is the product not only of advances in biomedicine and information technology, but neo-liberal politics) that, in turn "moves out of sight collective factors such as the social determinants of health" (p18)' (link). As far as I'm aware, such insights have yet to feature anywhere in the physiotherapy literature.

In a similar critical vein, Justin Waring and Simon Bishop's paper Health States of Exception: Unsafe non-care and the (inadvertent) production of 'bare life' in complex care transitions (link) argues that modern practices of hospital discharge are harmful and degrading. (In this study physiotherapists were the 2nd largest occupational group represented.)

Using the work of Giorgio Agamben as their theoretical guide, the researchers showed how often people found hospital discharge to be disempowering and dehumanising. More significantly for us as healthcare professionals, however;

> '(A)ll too often those working within the care system accept this potential (for discharge to be degrading), possibly because they are pressured to focus on their discrete part of the care process, and because operational pressures require staff to 'push' people through the system (Waring and Bishop, 2019).

Importantly, the 'use of formal assessment criteria to determine eligibility further renders people as 'unknown' and makes legitimate the deprivation of care'. This is worth repeating; 'formal assessment criteria…makes legitimate the deprivation of care'.

And as has been seen elsewhere, efforts by managers and regulators to prescribe good care, or to mandate specific processes often serve only to 'remake the practices and cultures that foster degrading and harmful treatment' (Waring and Bishop, 2019). So again, what is our view on this?

The third example comes from Danish researchers Malene Bødker, Ulla Christensen, and Henriette Langstrup. In Home care as reablement or enabling arrangements? An exploration of the precarious dependencies in living with functional decline (link), the authors challenge the logic of autonomy and independence. They find that home care applicants:

- are often too deeply dependent on the capacities of others in order to have their independence restored
- negotiate individual meanings of independence to maintain their identity as able human beings
- and might possibly gain new capacities through reablement, yet these are not individual and stable achievements, but rather temporary effects of the care relations with eldercare professionals (Bødker, Christensen & Langstrup, 2019).

What these three papers argue, in different ways, is that we are being seduced by ideas about individual agency and responsibility, and that many of the grander social narratives governing the way people experience health and illness in the real world are being ignored.

These ideas are playing out in the everyday practice of physiotherapists, but it is unclear why we have so willingly accepted these beliefs. We do not know what it means for the people we serve, or our professional identity.

A point I made in my talk at the ENPHE conference was that clinical trials, RCTs, and evidence-based practice dogma will not help us with these grand questions. Neither will third-rate

qualitative research. If we are going to understand where physiotherapy is going in the future, we will need much more research like this, difficult though it is to read, because without robust, critical scholarship (and the conversation within the profession that hopefully follows), we may find that what we thought was ethical conduct is anything but.

Porous bodies and physio education

12 August 2022

> ’Recognizing that bodies are ecological implies that human bodies have much less clearly defined boundaries than is relayed in conventional anatomy and physiology education and its accompanying imagery. The idea that the body is permeable and the environment is a beneficial or dangerous intruder was a common theme in older humoral cosmologies from around the world. However, where the latter risk suggested a need for declaring, controlling, and defending boundaries, more recent work reaching across biology, sociology, technology, philosophy, the arts, and other fields highlights that the ecological nature of bodies ‘challenges the ways in which the biological subdisciplines have characterized living entities’ as singular and separable from their environment. Ecological bodies, always necessarily in the plural because no ecological body is just one, challenge and raise fundamental questions about biomedical definitions of the human body’.

Excerpt from Ecological Bodies and Relational Anatomies: Toward a Transversal Foundation for Planetary Health Education, new paper by Robert Richter and Filip Maric.

A poem about vulnerability

25 October 2022

The Mower - by Philip Larkin

The mower stalled, twice; kneeling, I found

A hedgehog jammed up against the blades,

Killed. It had been in the long grass.

I had seen it before, and even fed it, once.

Now I had mauled its unobtrusive world

Unmendably. Burial was no help:

Next morning I got up and it did not.

The first day after a death, the new absence

Is always the same; we should be careful

Of each other, we should be kind

While there is still time.

What is therapy?

14 November 2023

Early on last Friday morning, I gave a keynote lecture to the inaugural Environmental Physiotherapy Association Festival.*

This incredible virtual event running asynchronously over the whole weekend was curated by the equally amazing Filip Maric.

Having worked first on a critical history of physiotherapy, and then a sociology of it as a profession, I'm now working on a new book on the philosophies of the physical therapies.

The 'post' philosophies particularly will do a lot of the theoretical heavy lifting in the book, but they take something of a back seat in this talk in favour of some quite down-to-earth analyses of the seeming obviousness of the concept of therapy.

You would think that there would be a wealth of rich writing on the word 'therapy' and the meaning it holds for physiotherapists; after all, it does make up half of the profession's name. But this is not the case. In fact, there is nothing. The meaning of therapy is just assumed to be coherent and universal.

So, in this talk I try to challenge the taken-for-granted obviousness of therapy and explore some of the ways Deleuzian thinking might reimagine it.

* Although this talk references physiotherapy specifically, I think many of the questions raised would be applicable to all therapy in all its forms: psychotherapy, occupational therapy, pharmacotherapy, retail therapy, and so on.

Chapter 8: Extended series

There was always a strong pull to use the CPN blog as a teaching tool. First and foremost I think of myself as a reader and writer of physiotherapy, but teaching is my second great love. So perhaps it was natural that I would always think of writing as a teaching tool. This chapter pulls together all of the blogposts that leant most heavily into that. The chapter also brings together longer-form writings; extended series that would stretch out over the course of a few weeks, tackling leviathan topics like qualitative research and breaking them down into digestible chunks. The idea of these posts was never to replace a textbook introduction to a subject, but rather to offer some insiders perspectives. In the end, all three ended up being quite pedagogical and joyously lengthy.

Blog series like this occupy an interesting place in scholarly writing; having more to them than a single blogpost, but falling well short of the standards expected of a peer-reviewed academic journal article. They're more like the transcript of a talk to students or a speculative book chapter. I like them for their relaxed energy.

There are three here. The first one had an eager first outing in 2015 with a piece that was meant to explain 'qualitative research for mere mortals'. But, for some reason, that never developed. You'll see that it would be another five years before I picked up the qualitative research trail again. The 2nd and 3rd extended series pieces were on the biomedical model and a case for a healthy curriculum. These were followed on ParaDoxa with series on post-professionalism and post-humanism.

A lot of the writing I do is theoretically driven, but the theory I use is often alien to people reading it. So I more-often-than-not find myself doing a lot of explaining before I get to the main reason for writing the article, book chapter or presentation in the first place. This can be frustrating in short-form pieces. So it's one of the reasons I love long-form writing so much. You get the chance to stretch your arms a little; take your time over explanations, knowing that the pay-off will reward a thoughtful reader. These series are very much about that.

Qualitative research for mere mortals #1

31 January 2015

There's a lot more qualitative research being produced by physiotherapists today, which is gratifying because for a long time it looked like the profession might be stuck in an endless loop of clinical trials on hamstring stretching, and the last thing the profession needs right now is more trials on hamstring stretching.

But there's still a dire need for more qualitative research in physiotherapy, and especially good quality research, which can sometimes be in short supply.

How many times have you read a piece of qualitative research and thought that the authors were just telling you what you already knew? You know the kind of thing I mean: an interview-based study of people's experience of pain, with a thematic analysis that concludes that pain is unpleasant, disruptive, and that people learn to cope with it. Well, actually, I knew that already, and if you didn't know that, you're probably in the wrong profession.

I once read a qualitative study of people's experience of breathlessness that concluded that people with COPD thought that not being able to breathe was frightening. Seriously! That was their principal conclusion! I spent half-an-hour reading that paper, and at the end I wanted to visit the authors and give them an experience of acute breathlessness.

Lest you become concerned for my mental health, I can reassure you that my motives are noble, even if they are also quite selfish. There's just too much information saturating our daily lives today, and too much good research out there, to waste time with research that only serves to state the bleeding obvious.

So I thought it might be useful to offer up some blog posts tackling some of the aspects of qualitative research that physiotherapists seem to frequently misunderstand, if only to save myself from having to read another qualitative study that tells me it's hard living with multiple sclerosis.

There's no suitable point of entry here. My experience is that physiotherapists come to qualitative research with all kinds of past experiences, so the best thing is probably to tackle issues as they arise and see where it leads. Hopefully some of these posts will be informative, others will be entertaining, others will fail miserably and they'll only tell you things you already knew. Which at least will be ironic.

Topic 1: Is qualitative research 'Simply talking trivialities in high sounding language?'

There's a chapter in Denzin and Lincoln's 2005 Handbook of Qualitative Research titled *Cultural Poesis: The Generativity of Emergent Things*. The opening paragraph reads:

> 'What follows is a piece of imaginative writing grounded in an intense attention to the poesis, or creativity, of ordinary things. This is an ethnographic attention, but it is one that is loosened from any certain prefabricated knowledge of its object. Instead, it tracks a moving object in an effort (a) to somehow record the state of emergence that animates things cultural and (b) to track some of the effects of this state of things - the proliferation of everyday practices that arise in the effort to know what is happening or to be part of it, for instance, or the haunting or exciting

> presence of traces, remainders, and excesses uncultured by claiming meaning' (p.1027).

This kind of writing represents, to my mind, an image of what most physiotherapists think qualitative research is all about: sludgy, vague and ridiculously wordy, saying nothing of interest or relevance; the kind of reading you only have to do if you're studying a PG research paper and your tutor makes you read it; a form of punishment for evils performed in a past life.

But qualitative researchers don't hold a monopoly on unreadable research. Look at the title of this paper from the latest edition of the American Journal of Physiology: *Hydrogen sulfide decreases β-adrenergic agonist stimulated lung liquid clearance by inhibiting ENaC-mediated transepithelial sodium absorption*. And, just to be fair, here's the start of the abstract:

> In pulmonary epithelia, β-adrenergic agonists regulate the membrane abundance of the epithelial sodium channel (ENaC) and thereby control the rate of transepithelial electrolyte absorption. This is a crucial regulatory mechanism for lung liquid clearance at birth and thereafter. This study investigated the influence of the gaseous signalling molecule hydrogen sulfide (H2S) on β-adrenergic agonist regulated pulmonary sodium and liquid absorption...

You get the idea. It's hardly George Orwell.

Clearly, both papers have their merits (the Stewart chapter is actually very interesting!) but they both require a bit of work. More than anything, they ask us to spend a bit of time in unfamiliar surroundings, with language and concepts that may be new or challenging to us. It's only when we read things that are beyond the limits of our familiar world view that we engage in real learning after all. So my first plea is that we can have less of the kinds of research that tells me that incontinence is unpleasant, and more of the kinds of things that make me say "I have absolutely no idea what you're talking about, but I'm keen to find out more."

*This comes from the title of this article by Julianne Cheek (1998). Postmodern theory and nursing: Simply talking trivialities in high sounding language? In H. Keleher & F. McInerney (Eds.), Nursing matters: Critical sociological perspectives. Sydney: Churchill Livinsgtone.

References

Agné, A.M., Baldin, J-P, Benjamin, A.R. et al (2015). Hydrogen sulfide decreases β-adrenergic agonist stimulated lung liquid clearance by inhibiting ENaC-mediated transepithelial sodium absorption. American Journal of Physiology - Regulatory, Integrative and Comparative Physiology. DOI: 10.1152/ajpregu.00489.2014.

Stewart, K. (2005). Cultural Poesis: The Generatively of Emergent Things. In, Norman K. Denzin, & Yvonna S. Lincoln. The SAGE handbook of qualitative research (3rd ed.). Thousand Oaks, CA, pp.1027-1042.

The biomedical model – for better or worse

10 July 2019

Over the last few weeks, we've been running a series of posts on the biomedical model. This approach, perhaps more than any other, forms the solid foundations for a lot of physiotherapy theory and practice, so it makes sense to try to understand it better.

What is the biomedical model #1?

11 March 2019

A lot is said about physiotherapy being biomedical and following 'the biomedical model', but what exactly is this, how and why does it underpin physiotherapy?

Over the next few blog posts, I'll try to explain the idea of the biomedical model in a bit more detail and show why and how it has influenced physiotherapy.

I'm going to tackle 7 key aspects of the model. There are more, of course, but these are considered by most people to be the main ones.

- Specific aetiology
- Germ theory
- Cartesian dualism
- Objectivity and experimentation
- Reductionism
- Normalisation
- Body-as-machine

Understanding something about these will give you a stronger sense of why they're so important to physiotherapists, but also why they might be problematic.

1. Specific aetiology (etiology in North America)

Aetiology means 'cause', so is perhaps one of the most important features of modern, Western biomedicine in that it seeks to identify the specific cause of a person's presenting signs and symptoms.

Crucially, in modern medicine the emphasis is not so much on treating all the signs and symptoms a person presents with, but rather, finding out what has caused them in the first place.

Most medicine does this in a stepwise fashion.

Starting with all of the patient's various signs and symptoms, the diagnostician (doctor, physiotherapist, etc.) deduces that symptoms A and B are being caused by a single problem – X, and that B and C are being caused by something else, Y.

Without going into the whole question of what deduction, induction and abduction are, the idea is to keep going with this process until you arrive at the single cause for all of the patient's problems. Their specific aetiology – or the specific reason why they are now ill.

The logic of this is that you should focus your attention on diagnosing the cause of the patient's problems rather than treating all of their different signs and symptoms.

This is why many good clinicians spend 90% of their time working out what not to do, rather than just jumping in and treating whatever comes, literally, to hand.

You might think that this idea is as old as medicine itself, but it has only been possible for diagnosticians to think this way with the advent of reliable diagnostic technologies like histology and imaging, and so the deductive reasoning so familiar to biomedical practitioners is perhaps only slightly more than a century old.

The search for specific aetiology required patients to come to specialised centres for assessment, and so was partly responsible for the radical shift from doctors visiting (wealthy) patients at home, and relying on what is called 'heroic' medicine to exert their power, to patients coming to clinics and hospitals to receive care.

David Armstrong has written brilliantly on this in his papers Decline of the hospital and The rise of surveillance medicine.

How does this relate to physiotherapy?

One of the hallmarks of modern physiotherapy is its pursuit of first contact status, or the ability for the public to see physiotherapists without a doctor's referral. This can only be achieved if physiotherapists are trained as diagnosticians because, without a doctor's initial assessment, the patient could conceivably present with any problem, and the therapist has to be able to work out what's going on.

Hence why so much more of our training now goes into assessment and diagnostics.

In countries where physiotherapists still receive work from a doctor's prescription, there is less need to focus on specific aetiology, because the doctor (you hope) has done that work for

you. And so training focuses much more on the practical skills and places less emphasis on testing.

The adoption of specific aetiology as a practice principle could, therefore, be said to have radically changed the nature of physiotherapy practice over the last half-century. It has allowed us to share in some of the social capital society affords doctors, and allowed us to remain close allies not only to the language of medicine but also its ways of thinking and doing things.

Next: Germ theory

References

Armstrong, D. (1995). The rise of surveillance medicine. Sociology of Health & Illness, 17(3), 393-404.

Armstrong, D. (1998). Decline of the hospital: reconstructing institutional dangers. Sociology of Health & Illness, 20(4), 445.

What is the biomedical model #2

28 March 2019

A couple of weeks ago, I posted the first of a series of short critical summaries of the biomedical model.

The biomedical model is perhaps one of the most important theories underpinning physiotherapy, and yet it is rarely taught overtly in the physiotherapy curriculum. Clinicians don't see it hiding behind their assessments and diagnoses. They don't see it underpinning most of the treatments. And they don't recognise it as a key driver of the kind of knowledge we accept to be true and false. So having a better understanding of how the biomedical model works would seem like a good idea.

In the first post of the series, I briefly wrote about specific aetiology and the idea that one of the most important tasks in medical practice is to find the specific cause – or aetiology – for the patients presenting signs and symptoms. In this post I want to focus on germ theory.

Today it is hard to imagine that a profession as established and powerful as medicine might have been built around a concept of health and illness that had nothing to do with germs. But this is of course true. For centuries, doctors believed in the idea of humors and miasmas. Humors derived from Ancient Greek and Roman physicians who envisaged a kind of chemical flow of fluids through the body related to the fundamental elements of water, air, earth and

fire. Popularised by the Roman physician Galen, humors persisted as a guiding influence in medicine until the 19th century.

Miasmas, or foul air, were a source of much anxiety and inspiration in Victorian times.

Similarly, the idea of miasmas – or foul air – was equally ancient and it too survived until the late 19th century. People thought that the presence of foul smelling air indicated disease, and so miasmas became a driving force behind a lot of social innovation, particularly in the 19th century. Modern nursing, for instance, owes its formation to miasmas because Florence Nightingale believing that foul air was the cause of so much disease and illness in the Crimean War. Her answer was to open the doors and windows to let the wind blow the foul smelling air away; to burn stinking dressings; and to practice scrupulous cleanliness. Little did she realise that what she was doing was ridding the environment of its pathogens. (Some have said that Nightingale died in 1910 still believing in miasmas, more than two decades after the discovery of germs). Miasma theory also influenced the placing of new hospitals on hill tops and out of towns to prevent the diseased air of the patients blowing over the town.

But the developments of modern scientific practice 19th century led to growing arguments for the existence of germs – or some form of small organism that might invade the body of a person or animal and cause disease. The history of the discovery of germs is well known, but perhaps what is less well understood is how it influenced the status of doctors. With the discovery of germs, doctors began to invest more time in public health and insisted on the creation of large centres of practice and learning, breaking with a centuries long tradition of the doctor visiting the patient at home. Now, with the discovery of germs, doctors took on an unprecedented degree of professional autonomy and power.

With the discovery of germs, the search was on to isolate the specific pathogens causing some of the diseases that had decimated civilisation in previous centuries. Smallpox, cholera, tuberculosis, typhoid, polio, herpes and hepatitis were all targeted, and with the discovery of antibiotics, medical power in the early part of the 20th century became almost absolute.

It is perhaps not surprising then that professions like nursing, physiotherapy, occupational therapy, podiatry, and midwifery tried to associate themselves closely to the medical profession. But in doing so, it became necessary to not only accept medical understandings of disease causality, but also the hierarchies that had been created by the medical profession. Thus, physiotherapists willingly accepted a patho-centric understanding of disease causality and ensured that students learnt that illness, suffering, impairment, and disability had their roots in pathology. Only in the last decade or so have physiotherapists followed many of the other professions allied to medicine to explore some of the other reasons why people experience health and illness the way they do, much of which lies in people's lived experience and social relations rather than in the presence of a pathogen.

In recent years interest in pathogens has resurfaced in areas like the micro-biome, where our host bacterial colony is seen as necessary and important for our health and not just something to be managed and eliminated. And while few physiotherapists work directly to eliminate pathogens, it has still played a significant role in defining how physiotherapy has been structured and defined in the past.

Next: Cartesian dualism.

What is the biomedical model #3

3 April 2019

Over the last few weeks, we've been running a series of blog posts on the biomedical model. Biomedicine is, without doubt, one of the most powerful discourse affecting the way physiotherapists think and practice, but it is also rarely explained or explored. So over the next few blog posts I'll be unpacking its essential features.

The first two posts in the series focused on specific aetiology and germ theory. In this post, we're going to tackle Cartesian Dualism.

Cartesian Dualism gets it's name from the work of the French skeptical philosopher Rene Descartes (1596-1650) who, perhaps more than anyone, captured the zeitgeist of the Renaissance by defining a distinction between the mind (the seat of reason, God-like and pure) and the body (profane, messy and prone to breaking down). This distinction between the body and the mind persists today and gives us the binary part of Cartesian Dualism.

In crude terms, Descartes made it possible for Enlightenment natural philosophers to think of the body as distinctive from the mind, and to thereby separate it from some of the restrictions imposed by the church at the time. Descartes essentially paved the way for a profession and science of medicine at a time when the workings of the body had become something of a fascination for early scientists.

But Descartes did more than this. In a famous argument that became a cornerstone of philosophical thinking, Descartes argued that at any time a pink elephant (or whatever variation of fantastic object we might want to consider) might appear under the table in front of us. He argued that because our dreams were so lifelike, and were such a vivid projection of reality, we could never really know or prove that we were not, right now, dreaming. And if we were in a dream state, anything could be possible; even a pink elephant appearing from under the table. Crucially, if we could not prove that we were not dreaming, we could not actually prove the real existence of anything. Everything could, in theory, be a projection of a dream state.

Descartes argued that the only thing we could say for sure is that we are consciously contemplating our own existence. We know we are thinking about being in a dream, and so we can, at least, say that we exist, because we are the ones doing the thinking. Hence Descartes famous phrase cogito ergo sum; I think, therefore I exist.

Our inability to prove the existence of real things (this table, this alveolus, this movement), led those that followed Descartes to contemplate how we could at least get 'close' to showing that some things were real. Science relies on the fact that things are real and that natural laws affect the behaviour of things; it looks for predictable cause and effect relationships. So science needed a strong foundation in methods that might, at least, approximate reality.

Hence, for centuries, scientists have emphasised objective methods of testing that do their best to remove the bias of the observer from the study. We use information from all of our sense and multiple sources in the hope of triangulating our data and verifying, beyond reasonable doubt, that the effect of this on that is a real effect and not an artefact of our perception. And we use statistical concepts like probability to specify those chance occurrences that pollute the purity of our data.

It might be said that without Rene Descartes, there could be no medical science. His works fundamentally shaped the way medicine and its related disciplines thought and practiced, and his ideas still cast an impressively long shadow over healthcare even today.

What is the biomedical model #4

11 April 2019

So far in this short series on the biomedical model, I have looked at three of its founding principles: specific aetiology, germ theory, and Cartesian Dualism. In this post we'll examine one of the facets of modern medicine that is perhaps the most familiar and tangible concept for modern-day physiotherapists – objectivity and experimentation. In the previous post on Cartesian Dualism, I explored how the French 16th century philosopher René Descartes argued that there was no way to prove the existence of anything, because our dreams were so real we could never prove that we were not dreaming right now. What Descartes showed was that we could not trust our senses and that seeing was absolutely not believing. Like Ebenezer Scrooge seeing Marley's ghost in Charles Dickens' Christmas Carole, we are prone to be deceived by our senses, and we are always vulnerable to interpretations and impressions, memories, and values and beliefs that influence how we perceive what we think might be real. Consider this example;

> If you show a first year undergraduate student a picture of a chest x-ray, they are likely to see patches of light and dark, wispy shadows, the

> occasional solid-seeming structure, and a few anatomical landmarks that they can name. A trained eye, however, will see immediately that the patient has a left apical pneumothorax, some collapse/consolidation of the left lower lobe, and some elevation of the left hemi-diaphragm. Both are looking at the same x-ray, but only one has been trained to interpret the tissue densities represented by the x-ray in a meaningful way. So the simple act of learning is, in some ways, the act of overcoming raw sensory data and giving it meaning.

Experimentation then, is necessary in order to remove, as much as possible, the bias that might come from people's lived experience, social positioning, values and beliefs, learning and memory. Rene Descartes argued that to approach any kind of objectivity we needed to experiment with as many modalities, tools, and approaches as possible. And only then will we have reasonable confidence that what we are seeing is actually the truth and not some artefact of our imagination. When you consider how much experimentation takes place in modern-day healthcare – in the way that we differentially diagnose, analyse, test, hypothesise about causes, isolate variables, control for conditions, and monitor outcomes – you can see how powerful objectivity and experimentation have become in shaping biomedicine. But more than this, one of the distinguishing characteristics of a modern orthodox profession is that it holds to Western enlightenment beliefs about the importance of objectivity and experimentation. In contrast, those disciplines that shun this approach (think here of homeopathy, Traditional Chinese Medicine, and some aspects of chiropractic), remain ostracised and excluded from the mainstream. Objectivity and experimentation are more than simply strategies for corroborating facts then; they are tools for differentiation between those professions we can believe in and those we are told we should distrust.

What is the biomedical model #5

17 April 2019

In the 5th of this series on the key principles of the biomedical model we look at reductionism, or the idea of dividing the body and health into systems and structures.

So far we have covered specific aetiology, germ theory, Cartesian Dualism, objectivity and experimentation, and there are two more pieces in the biomedical jigsaw after this week's look at one of the most important structural elements of healthcare practice.

Early on in the history of medicine it was realised that the body and health were so complex that they would be better understood by being broken down into component parts. Ancient and pre-modern notions of health and the body had concentrated on broadly holistic notions – things like the humoral principle, in which a person's health was governed by the circulation

of four humors. But these ideas gradually gave way to scientific medicine which followed discoveries in astrology, biology, chemistry, geology, and physics in focusing on the component parts that made up the whole, rather than the whole as a unified entity.

The Industrial Revolution also played a part in shaping cultural attitudes towards the way society could be understood and managed. Governments have learnt to compartmentalise the way they thought about society, creating new distinctive fields of health, education, welfare, employment, housing, and defence, and giving specific powers to professions – like teachers, doctors, and lawyers – who could manage their specific responsibilities.

Medicine quickly settled on a reductive idea of health and designed healthcare in its own image. Specialisms in anatomy, orthopaedics, neurology, respiratory medicine, women's health, and psychiatry were established early, and these specialties created the template for the way doctors learnt to become physicians and surgeons, as well as the way the healthcare system would be organised.

So, an orthopaedic ward in a hospital is designed, as such, because of medicines historically reductive attitude towards the body and health. Here the orthopaedic 'system' defines everything about the way that the patient is assessed, diagnosed, and treated, processed through the hospital, referred, and managed.

The obvious advantage of such a system is that it reduces the complexity of the body to manageable parts – much like the way that car production can be divided up into discrete tasks in order that each can be managed more efficiently. And in many ways there are close parallels between the way that the health care system has developed in the West, and the 'Fordist' model of car production developed by Henry Ford in the early part of the 20th century. Ford realised that car production could be massively increased if individual workers took responsibility for only one part of the car. This gave birth to the idea of the production line, in which each person performs a single task repetitively on a continuously moving treadmill, with raw materials entering at one end and a car rolling off the production line at the other.

Much of the talk of healthcare efficiency over the last half-century can be seen in a similar way, with the patient being 'processed' through a series of production-like steps, moving sequentially through admission and triage, differential diagnosis and testing, intervention and discharge planning, and finally referral on. This process is underpinned by a reductive idea of the body and health that shapes the way most of us experience the healthcare system today.

Not surprisingly, perhaps, physiotherapy fell directly in line with this approach as it became established in the public health system after WWI, and for much of the profession's history has mirrored by medical reductionism. Physiotherapy curricula still emphasise the distinctions between musculoskeletal, neurological, and respiratory physiotherapy, and students are still

taught about body systems and structures. Most physiotherapists work with a variety of reductive clinical specialists, who are rewarded with promotion when they demonstrate more refined specialism.

Reductionism, therefore, is an aspiration for many health practitioners who, in the current healthcare system, have learnt that dividing the body and health into discrete body systems and structures, carries much more currency than an holistic notion of health.

Next, normalisation.

What is the biomedical model #6

1 May 2019

Thus far, we've covered five of the main features of the biomedical model – the model that underpins so much of the theory behind the way physiotherapy functions. These have been:

Specific aetiology, or the search for the specific cause of the patient's signs and symptoms Germ theory and the belief that illness is caused by disease within the body Cartesian dualism and the mind-body split Objectivity and experimentation And reductionism, or the anti-holistic belief that the person can be understood as a collection of systems and structures.

In this penultimate post, we'll look at normalisation. Normalisation is the belief that certain people, certain bodily functions, behaviours, and characteristics, can be considered normal, and those that do not conform to this normalised idea can be labelled as abnormal, deviant, or diseased. Normalisation is first and foremost, therefore, a process undertaken by experts whose role it is to distinguish those that are considered normal from those who are thought to be abnormal, and, in the case of medicine, to return the sick and the ill to health. Normalisation doesn't only occur in medicine but in any social field where people are identified as occupying spaces outside of the norm (think of the criminal justice system, for example). It can't be understated how powerful normalisation has been in the history of medicine. Indeed, medicines ability to claim the power to define who and what would be considered normal was, perhaps, one of the most important elements in establishing medicine as the way to think about health and illness in the West from the 18th century onwards. Medicine linked two related functions to normalisation, and in doing so, established a stranglehold over how health and illness could be thought of for centuries to come. The first was the emphasis that doctors placed on the normal workings of the body: its anatomy and physiology, and the creation of the field of pathology to account for how body systems and structures failed. The 2nd was the development and use of public health epidemiological data across whole sections of the population to establish the normal distribution of bodily functions throughout the population. The need for this data gave birth to new surveys and

censuses, new language of incidence and prevalence, and many of the statistical tests we still use today, including things like correlation coefficients, which were invented by Francis Galton, Darwin's cousin, and one of the founders of the eugenics movement. Taken together, these approaches allowed doctors to say that the majority of the population's bodies functioned in a particular way, and that this would henceforth be considered normal. Conversely, any body that fell outside of this theoretical and abstract 'norm' would be labelled as abnormal and thereby amenable to medical therapy. Rather than being an objective statement of fact, therefore, normalisation was, and remains, a practice of labelling based on the most commonly presented bodily functions. There is therefore nothing essentially wrong or bad about the kinds of abnormality uncovered by normalisation; they only represent deviations from the mean, existing over a threshold that has been decided arbitrarily by someone in a position of power. Practices of normalisation have resulted in medicine labelling any number of personality traits, human characteristics, bodily forms and functions as abnormal, and what is considered abnormal today may well have shifted dramatically over the years. It should also be borne in mind that that the benchmark human form against which most parameters of normalisation were historically established was that of the heterosexual, cis gendered, caucasian, Anglo-American, able-bodied male, since these represented the vast majority of doctors who developed the idea of normalisation in the 18th and 19th centuries. Normalisation cannot, therefore, be seen as an objective, apolitical clinical principle, but as a way of reinforcing certain cultural norms in society. Normalisation plays a pivotal role in physiotherapy practice. Consider, for example, the images of the body physiotherapy students learn from anatomy textbooks. Every body presented is the same, and the students are taught to believe from the outset that one hamstring muscle is exactly like another. Physiotherapy curricula often begin with an extensive study of the normal body's anatomy and physiology, and students slowly progress onto pathology, before introducing some of the main complicating subjective human 'variables'. Physiotherapists have also achieved first contact status in many countries on the basis that they also have the ability to distinguish normal from abnormal as well as a doctor. Normalisation, therefore, plays a pivotal role in the construction of physiotherapy, and provides another tangible link between the profession and medicine. In the last of these blog posts on the biomedical model, we will look at perhaps the most powerful discourse linking physiotherapy with medicine – the body-as-machine.

What is the biomedical model #7

10 May 2019

The last in the series looking at the biomedical model focuses on perhaps the most important aspect of the model for physiotherapists – the body-as-machine. If you've read anything in

critical physiotherapy over the last decade, you will almost certainly have come across the idea of the body-as-machine. Dating back perhaps as far as René Descartes and the idea that the body could be understood as separate from the mind, the body-as-machine became a specially powerful metaphor for medicine after the Industrial Revolution. Machinery, it seemed, provided the perfect metaphor for how body should work, because if industrialists could organise the production of food, fabrics, and tools, then surely the body could conform to the same logic? Using the established sciences of geometry, mathematics, and physics, doctors in the 17th and 18th century began to pay particular attention to the cadaver and the ways in which the body could be understood in terms of levers, fulcrums and forces. Similarly in physiology, the processes and mechanisms through which the body performed its functions were increasingly understood mechanistic terms. And so, by the time of the discovery of normal circulation, arterial-venous gas exchange, sarcomere function, and the processes of nerve conduction, physicians had already accepted the view that the body could be understood mechanistically. One of the distinct advantages of this model is that it separated out the mind, emotions, and thoughts, and allowed the practitioner to view the body as a sort of animated cadaver. This resonated very closely with the other principles of biomedicine (specific aetiology, normalisation, reductionism, etc.), and reinforced medicines claimed objectivity. At a time when masseuses were looking for ways to touch people without scandal, and also align themselves closely with the powerful medical profession, taking up the idea of the body-as-machine was perhaps an obvious and necessary solution. The body-as-machine has continued to be a powerful discourse in medicine, and, despite attempts over the last half-century to develop more holistic models of practice, the “body” remains as a subdomain of many models. Note for instance the ‘bio’ in the biopsychosocial model, and the body/mind/spirit focus for the socio-ecological model of health. In many respects, then, the body-as-machine holds the threads of all of the other principles of biomedicine together, and serves as an umbilical cord between physiotherapy and medicine. Finding an alternative to the body-as-machine – one that sufficiently accounts for a person’s holistic sense of well-being, without separating out the body from other dimensions of the health – represents one of the greatest challenges for medicine in the 21st-century. And as yet, no radical new paradigms has emerged to challenge the dominance of the body-as-machine in medicine. Perhaps the advent of ‘prosthetic’ technologies that increasingly allow us to intervene in all sorts of bodily forms and functions in the future, will disrupt the hegemony of the biomedical body in Western healthcare. But for now, it remains supreme. This post concludes the series on the biomedical model. In the following post, I will try and summarise some of the critiques of this model and explore some of the reasons why it has been problematic for physiotherapy.

Critique of the biomedical model #1

29 May 2019

The Critical Physiotherapy Network is a diverse group of people, but if there is one thing that probably unites most of its members, it would be the critique of the biomedical model. In one way or another, we are united in our sense of frustrations with the limits of this model and the way it is applied to physiotherapy.

But we are not alone, and outside of the walls of the traditional medical library, there is a wealth of critical commentary on the model, much of it emanating from the social sciences.

Whether because of the rising cost of medically-led healthcare, the growing skepticism of its effectiveness, the knowing prescription of useless treatments, stories of medical misdemeanours and human rights abuses, the prevalence of iatrogenic disease and the creation of secondary health problems like antibiotic resistance and opioid dependency, or people's greater choice in the healthcare marketplace, and the recognition of the need for a much greater 'lay' perspective in determining healthcare priorities, it is clear that biomedicine is no longer immune to critique.

Over the course of the next few posts, we'll try to unpack the main criticisms of the biomedical model, and see how these apply to physiotherapy. The first issue spans many of the key features of biomedicine and goes to the heart of its core philosophy

Mind-body dualism

The genius of Descartes' idea that the body could be understood as separate from the mind lay in the fact that it gave permission for doctors, apothecaries and others to focus on the corporeal fleshy body, whilst the church held dominion over the mind. The mind was allowed to transcend the body, which was convenient because this allowed Descartes to keep God in the picture – a very important principle if he didn't want to befall the same fate as Galileo, Spinoza and others. But while Descartes' construction allowed for the creation of a medical profession with privileged access to the body, it also demanded that those who practiced on the body approached it within very strict parameters.

The body, for example, needed to be seen as existing 'outside' of its cultural, environmental, relational, social and spiritual perspectives; divorced from the world of thoughts, intentions, ideas, feelings and emotions. Illness could only be defined within the boundaries of bodily space, and so forms of madness, for example, would not be medicalised for another 300 years (prior to this point they were largely conceived of as acts of demonic possession, and 'treated', often barbarically, by the church).

And so Descartes' dualism set up the conditions upon which medicine defined its identity and its practices. To this day, medicine privileges the idea of the body as distinct from the mind, from the social world the body moves within, and the relationships that sustain us. Illness, according to the biomedical model, is located firmly 'within' the body, be it in germs or genes, disease and sickness represent a distortion in the body's physiology and, in this schema, all bodies are essentially the same; one hamstring muscle, bile duct and Circle of Willis, is the same for all.

While this approach simplifies the body, it also excludes so much, not least the extent to which illness is socially 'patterned'. We know, for instance, that two people with exactly the same lung function can have entirely different clinical presentations: one will be hugely disabled, dependent on a cocktail of medications, and unable to work; the other will be the exact opposite. Medicine cannot easily account for these differences with it's narrow view of the body and has sought in recent years to enhance the scope of its perspective and embrace other paradigms. And here we see perhaps a second critique of the biomedical model, which will follow in the next blogpost.

Critique of the biomedical model #2

5 June 2019

The second major critique of the biomedical model is less about the model itself, and more about the arrogance and hubris that it engenders in its followers.

Since the 1950s, dozens of writers have taken biomedicine to task for its hegemonic power (meaning its 'preponderant influence or authority over others') and control over the way we think about health and illness. People like Elliot Freidson, Terry Johnson, Magali Sarfatti Larson, Anne Witz, Ivan Illich, Mike Saks, and Anthony Giddens have offered scathing critiques of the biomedical model.

The biomedical model, they argue, attempts to penetrate too deeply into people's lives, leaving little room for other ways of understanding health and illness.

No one doubts the achievements of the biomedical approach to health, but what is often forgotten is that this has been achieved on the back of phenomenal resource investment. The biomedical model is one of the best funded ideologies since the church, and has been massively indulged. So it is perhaps not surprising that it has made some discoveries and helped some people. But notwithstanding all of that, it's perhaps not surprisingly that biomedicine sometimes resembles the only boy child of very rich parents – single-minded, sheltered from the real world, and highly privileged.

The advocates of the biomedical model have been historically blind to the fact that health is socially constructed. Even biomedicine is socially constructed. Which is ironic really, when you consider that biomedicine has no place for the idea of socially constructed health.

Regardless of biomedicine's claims to objective truth, it isn't itself a real thing like a pen or a car: it's an idea, invented and sustained in the minds of people every day. It is fragile and takes an enormous amount of effort to perpetuate. And it has done so with a totalising interest in its own self-promotion.

Every assessment you do, every treatment you offer, every clinic room you enter, every colleague you speak to, every word you use to describe a health problem, is polluted with biomedical ways of thinking.

And because the biomedical model is so abstract, it requires an enormous system to support it, and the history of healthcare in the West for the last century or more is the outworking of that system.

To their discredit, advocates of biomedicine focus an enormous amount of energy on marginalising those ways of thinking that don't conform to its ideology. Anything that is subjective, holistic, non-reductive, cultural, qualitative, experiential, spiritual, political, or non-biological is treated with skepticism or blank disregard. Biomedicine perpetuates the narrowest world view.

Since the 1960s, health activists, academics and theorists have offered persistent critiques of the limits of biomedicine. From disability activists, to feminists, post-colonial scholars to queer theorists, a plethora of critiques now exist to challenge the hegemony of the biomedical model.

But interestingly, few physiotherapists read this material or get exposed to it. This is because physiotherapy has been so colonised by the biomedical model that few people within the profession believe that other ways of thinking about health and illness exist, or carry any real currency.

But in the real world, people don't think about their health biomedically, and perhaps one of the most important weaknesses of the biomedical way of thinking about health is that it cannot explain why everyone doesn't follow it. There is an ironic paradox here then: the biomedical model is so narrow that it does not even include within it the means to critique how and why people don't universally believe it.

The model does not explain the real world. If it did, it would reside in the real world and one wouldn't have to study to become a trained health professional to understand and apply it. Biomedicine then, at its worst, sits at odds with the people it is meant to serve; looking, again,

rather like a spoilt (white, male), only child of very rich parents, in a room full of people whose lives are very different indeed.

In the next post we'll dig into some of the more specific ways that health can be thought of differently, and the way these reveal some of the limits of the biomedical model.

Critique of the biomedical model #3 (or what it really means to be a person)

12 June 2019

Physiotherapy, and biomedicine generally, owes a lot to René Descartes (for a refresher on an earlier post on the critical issue of Cartesian Dualism in PT, go here). But Descartes' influence extends much further than just the body-as-machine, and has fundamentally shaped medicine and physiotherapy practice ethics for more than 100 years.

400 years ago, Descartes set out to discover what could be known beyond doubt. His method was to doubt everything, from the existence of physical objects around him, to dreams and ideas. What was left, he surmised, would be the basis upon which all knowledge could be built. The first thing Descartes believed he could trust was that he himself was thinking – hence 'cogito ergo sum'; I think therefore I exist.

But Descartes also went on to surmise that if knowledge began with the self, then all understanding of the world must originate in the person's own mind, and that we were each fundamentally detached from others in coming to know the outside world. Knowledge was formed in the private theatre of our minds; in the vacuum of our own consciousness. Descartes' idea gave birth to the idea of the 'outside world', and popularised the belief that the individual subject, or citizen as they later became, might be considered to have rights and responsibilities, autonomy and self-determination. He was partly responsible for early ideas of government and the vox populi, and modern medical science built on this idea, concentrating on the individual body of the patient as an isolated, atomistic entity.

Criticism of this approach came some years after, most notably from Georg Hegel (1770-1831), who argued that Descartes had been completely wrong. Thinking and knowledge of the world didn't happen in the minds of people isolated from one-another, but in relation to others. Descartes, he said, couldn't have thought up his idea of cogito ergo sum without the help of language or an education system, and both of these were simple examples of how he had come to know the world through human relations. So, Hegel argued, there was no such thing as a self-conscious isolated individual.

Hegel claimed instead that we can only make sense of the world in relation to others, and that to see myself as part of the world I must see myself reflected inthe world and, especially, in other people. But this idea led Hegel to an interesting problem called the Master-Slave Dialectic that is particularly relevant to health care practice.

Hegel said that when we try to gain a better understanding of the world, we look to the 'other' for recognition. But they will always appear foreign to us because we realise that they aren't us. Because they are foreign to us, we never receive the quality of recognition we crave; we see ourselves as dominant to them and create the master-slave dialectic (or binary state). At the same time, the other (here the 'slave'), seeks recognition from the master, but knows that consider them inferior, so know the master's recognition will always be slightly indifferent.

Given this, Hegel resolved that we can only develop a fully rounded sense of ourselves and the world we inhabit if we fully embrace and acknowledge the other's distinctiveness and difference. There can be no inferior/superior relationship, because this will always lead to an incomplete sense of self.

Now, replace the language of master and slave, with therapist and patient, surgeon and healthcare assistant, or registration authority and practitioner. In each case, a master-slave dialectic exists and presents a challenge to how we make sense of the world, and Hegel teaches us that only by entering into a relation of equals can we fully know ourselves.

Whereas Descartes' ideas continue to have influence in healthcare (particularly in those areas that privilege the body-as-machine, the biological sciences, quantitative measurement, objectivity, detachment and value-neutrality), Hegel's ideas have come to the fore in recent decades, most notably the social sciences, critical theory, feminism, disability activism, qualitative research, the humanities, politics, ethics and questions of power.

Perhaps most importantly, we should remember that the roots of these approaches lie in very different philosophies, which is one reason why we should be very cautious of any model or theory that claims it can just simply link the bio, psycho, and social together. If the model is underpinned by Hegelian ideas, it will have a very different idea of what it means to be a person, than if it harks back to Descartes.

Critique of the biomedical model #4 – Standard Deviation

19 June 2019

In many ways, the entire Western healthcare system is built around normalisation.

The fact that it is the job of 'the system', and all those that work within it, to identify those people who are ill, sick, or suffering, and to offer them a cure, is so deeply entrenched in the way health services work that it would be hard to imagine it otherwise. But imagine it otherwise we must, or else the more problematic aspects of the approach remain hidden.

Firstly, we should remember that normalisation is a social construct. What this means is that there is no object that you can point to say "that is normalisation right there". It is an idea; an invention, based on a set of principles that have their own history. Over time, people's attitudes change and what was perhaps abnormal 100 years ago, might be perfectly normal today. Think of homosexuality and depression, for example.

Because it is a social construct, it is very much the product of the people and the times in which it was created and developed. For instance, normalisation could only become a 'thing' when we had enough epidemiological data on the population to know what the spread of human factors like height and weight were. The history of this is quite recent — dating back only to the 18th century — but, importantly, it is closely tied to government attempts to better know the population in order that we, its citizens, could be better managed.

Decisions about who and what constituted the norm, were essentially statistical assessments based on prevalence data. So the boundary between what is normal and what is abnormal is only a matter of degrees. Hence why it is so easy for these boundaries to change.

Where normalisation becomes really problematic though, is when we move beyond benign human features like height and weight, and start considering things like skin colour, gender, strength, reasoning, and intelligence, and the history of medicine's normalisation of these things is really quite depressing.

The stigmatisation of people who have been labelled as deformed, deviant, disruptive, or difficult is now well known, as is the way these 'traits' gain official recognition through the process of medicalisation. But the catalogue of spurious medical labels that have been given to things that have no basis in medicine or healthcare and have, instead, entirely political motives, is extensive. The diagnosis of malingering being one prime example.

For decades, governments have sought medical advice on whether a person has an organic reason for their pain, and doctors, physiotherapists and others have been happy to oblige, not least because the failure on the part of medicine to locate the source of the person's pain within their biological body might amount to a failure of medicine itself. So we invent endless tests, scales and scores to provide the answer, without ever questioning the normalising process going on in the background.

Some of the most powerful work on this was done by Erving Goffman in the 1960s. Goffman showed that there were significant negative consequences associated with being labelled as

‘abnormal’, not least being that it puts the person who is labelled in an almost impossible position: accept the label, and the person has to accept all of the social judgements that then get levelled at them (spastic, handicapped, ‘mental’, stupid, retarded, etc.); but resist the label and risk being labelled anew (as deviant, disruptive, in denial, mad, etc.), and forced into unwanted treatment, rehabilitation and remediation.

The history of normalisation in mental health is really problematic (remember One Flew Over the Cuckoo’s Nest, for example), but the history of normalisation close to physiotherapy is not much better, especially when we look at the way physiotherapists have contributed to the labelling and stigmatisation of physical disability over the last century.

Was there ever a more loaded term in the medical lexicon than ‘standard deviation’?

Critique of the biomedical model #5

26 June 2019

So far in this short series on the problems with the biomedical model we’ve looked at the mind-body separation, biomedicine’s claims to objectivity and access to the truth about health and illness, it’s construction of atomistic individuality, and last week, the problematic nature of normalisation. In this post we’ll look at the passivity that biomedicine engenders in patients.

Biomedicine is a powerful discourse and it has brought enormous power and social capital not only to the medical profession, but also to those who practice in its image. One of the most widely voiced critiques of medicine is that it is hegemonic (or dominant not through force but a degree of consent and subordination), and that this dominance has been used by all orthodox health professionals – including physiotherapists – to elevate their own social status, obtain higher pay, and professional autonomy.

Terry Johnson in the 1970s talked about how biomedicine was the main vehicle for doctors to create social distance between themselves and patients. This was achieved, Johnson argued, by building up vast bodies of complex knowledge inaccessible to the public, tightly controlling access to the market, and creating conditions of dependence on the profession (Johnson 1972).

A lot of medicine’s elite knowledge came to be targeted at differential diagnosis and the search for specific aetiology, which privileges the search for disorders that exist beyond the visible scope of the ordinary person. Only a few ‘elite’ members of society are given the social and economic resources (training, access to the necessary equipment and service staff, etc.) to access and interpret this information, and because only doctors claim to know the

importance of this information, it is hard to deny requests for more resources and social support for their work.

Crucially, this knowledge refers to biological information ‘internal’ to the person that can be objectified and measures, as opposed to the social, cultural and biographic explanations for illness that cannot be seen on an MRI or measured in a full blood count. Hence the patient becomes the passive site for medical investigation, with the social and material causes of disease neglected in favour of the biological.

The enforced passivity of the patient that follows from this approach is inherently de-skilling though, and people can often feel that it is not them but the health professional that has insight and control over their bodies when they enter the healthcare system. This fosters a dependence on the heroic doctor or therapist. Self-care and the support of family can be discouraged, particularly if these interfere with established biomedical principles.

Medicine can inadvertently alienate us from our own bodies and make us distrust what we know and feel. Stories about not being believed by health professionals are the stuff of legend, while stories of being coerced into tests and treatments that don’t ‘feel right’ litter online patient support sites. Not surprisingly perhaps, complaints against health professionals that didn’t consult their patients before acting are commonplace across all orthodox health professions.

It is perhaps worth reflecting on the fact that we have to teach principles like informed consent to our students because we have a medical system that works from the basis that biomedicine is innately depersonalising. Informed consent is one of the ways we ‘manage’ this, but it can be just another vehicle delivered by health professionals to assure biomedicine of its dominance, and reinforce the patient’s position as passive and submissive.

Qualitative Health Research — a guide for the perplexed

Part 1 — Introduction

8 January 2020

The changes now taking place in healthcare should provide great material for really thoughtful, well-conduced qualitative health research (QHR). But sadly little of it is being produced, especially in physiotherapy, where the amount and quality of much of the qualitative research we have available is really quite poor.

So over the course of the next few weeks, I thought I'd try to tackle some of this in a similar way to the way I hacked at the biomedical model last year. My hope is that in doing this, people will understand more about QHR, and that might, in turn, lead to some new and exciting research.

Before I begin, I should acknowledge that there are literally dozens of people in the CPN and elsewhere who use and teach QHR, and any one of them could have written these posts. So I hope they add their thoughts and comments as the story unfolds.

So let's begin with a bit of context.

Qualitative health research is younger than many people realise. Although many of the ways of researching adopted by qualitative health researchers are as old as experiments and clinical trials, we've only had what we now know of as QHR since the late 1980s. That's because it needed the a number of different events to coalesce to bring the pieces together and make QHR a real living 'thing'.

Now although you can find evidence of people observing others and commenting on society in ancient Greek, Roman, Indian, and Chinese texts going back thousands of years, the 'systematic' study of health in society only really began in 1920s America with the 'Chicago School'. Anthropologists ('anthro' meaning 'people') and ethnographers (methods for studying 'ethnos' or cultures) especially, developed methods for recording their field observations, and developed ways to measure society as objectively and scientifically as they could.

The post-WWII period brought a major rupture though, as generations of young people rejected the values of their parents and "tuned in, turned on, and dropped out". Civil rights, gay rights, disability rights, feminism, anti-war protests, anti-nuclear protests, rock 'n roll, acid, the contraceptive pill, the 'white heat of technology' , all fermented a generation of social activists that took up the tools of the arts, cultural studies, Marxist sociology, radical politics, and existential philosophy, and gave birth to entirely new ways of looking at the world.

Health – as one of the biggest issues in any society – was not immune to these radical new ideas, and dozens of health professions (especially nurses), began to study sociology and philosophy, and began to adapt the methods they were learning to healthcare.

Then came another rupture.

The late 1970s was a pivotal time in modern healthcare, not least because governments began to ask serious questions about the economic cost of maintaining the healthcare system. Where doctors had acquired almost total control, governments began to take control back. Health service managers, accountants, policy makers, advisors, planners, and organisers

began to multiply, rationalisation became the norm, wards closed, jobs were cut, and accountability and risk management became the norm. Slowly people began to wrestle power away from (white, male) doctors and other health professionals and the public began to gain their voice. With this came a whole series of new questions about what patients wanted, what health meant, how systems worked to help or hinder healthcare; questions that were so much broader than whether treatment A is more effective than treatment B.

This was a golden dawn for QHR, and a lot of the research done then was radical, interesting, and innovative, (and sometimes quite bonkers). For a few years it hardly registered with the traditional health professionals. But then towards the end of the 80s it had gained enough fans among the health professions for quantitative health researchers to sit up and start paying attention.

Once quantitative researchers woke up to QHR, they began to question its credibility. They asked; “How can a research study be generalisable if it only has five subjects?”, and “How can we replicate this study when the methods are so woolly?” What a lot of QHR people did in response to these perfectly reasonable questions laid the foundations for qualitative health research as we know it today, something we’ll tackle in the next blogpost.

Part 2 — Criticality

15 January 2020

Last week I offered an all too brief potted history of qualitative health research (QHR), in the hope that what follows makes more sense.

There are a lot of misconceptions about QHR. Hopefully these blogposts will help clarify some core principles, and inspire people to see how incredibly powerful and useful good quality QHR can be.

Now you could say the first principle I want to tackle today’s is so important that it almost defines the difference between what is true qualitative health research and what is a pale imitation. And that is criticality.

More than any other principle, good QHR has always been critical. It has challenged convention; held a mirror held up to society and disrupted our normal way of thinking and doing things. It has been a source of counter-narratives, radical new ideas and, sometimes, perplexing revelations.

Take the work of Dave Holmes, a nursing professor in America, for example. Dave’s research has asked how nurses can work on death row, and why gay men continue to have unprotected sex. He was pilloried by his nursing colleagues for deigning to ask the first

question, and the answers to the second confounded most of the received wisdom about public health.

So QHR is a place for critical disruption. And because Western healthcare is so dominated by biomedicine, there is ample scope for disruptive critique.

Two of the main ways this has developed in QHR are through the humanistic 'turn' and the rise of critical/social theory.

The 1970s and 80s saw what was called a 'humanistic turn', or the 'turn to the voice', as researchers started asking people how they experienced health and illness, what it meant to have Parkinson's disease or cancer. And from this a whole industry in interview and focus-group based QHR emerged.

Running on a parallel track were the critical and social theorist, who turned their attention to the structural conditions in society, things like gender, race and social class. These researchers tried to understand why it was that poor people suffered the worst health, and what discrimination did to women's pain management. From this came a big focus on social theories, systems and structures.

Over the last 50 years, both of these have been big drivers of QHR. What they both share in common is an interest in power and truth. For the humanists, their interest is in each person's unique experience of the world and the particular way we each make sense of health and illness. For the critical/social theorists, it's about the invisible hand that shapes the course of our lives, individually and collectively: how certain truths are claimed, who gets to decide, and who benefits.

These approaches have had a big influence on the way QHR has been conducted over the last 50 years. Because identifying how people feel about being a physiotherapist isn't something you can measure on a scale, (since any scale you design will always be about your beliefs), research methods have been about empowering research participants (not 'subjects' note), 'owning' your bias (not pretending to eliminate it), and giving voice to 'the other'.

The critical/social theorists have looked for concealed drives, social forces, and discourses, in texts and in people's everyday practices; searching for those things that we know are there (homophobia and racism, for instance), but are often invisible to the naked eye.

And always, QHR takes a 'minoritarian' position. In other words, it critiques whatever is being promoted as the conventional or dominant way of thinking. It is always looking for the voice not heard, the opinion not expressed, and the path not chosen, because if qualitative health researchers don't investigate this stuff, who will?

So if you do come across some qualitative research in the future, and want to know whether it's any good or not, don't ask whether it meets a set of standard criteria for validity and reliability – that's for quantitative researchers to worry about – ask whether it's really being critical and shakes the foundations of what you thought you knew. Then it might pass the first test of being a good qualitative health research study.

Next week, the emic perspective.

Part 3 — The emic perspective

22 January 2020

Over the last two weeks I've been writing about some of the key principles lying beneath qualitative research.

A lot of people think that qualitative health research (QHR) is just about asking people about how they feel, and writing lengthy research papers that are 'simply talking trivialities in high sounding language' (Cheek 1998). But that's because qualitative health research is often misunderstood, badly taught, and confusing for practitioners reared on the red meat of clinical trials. (There is an important 'other' reason, but we can't get to that just yet).

In the first in the series I explained a bit of the history of QHR, and in last week's post I talked about the key principle of criticality. The second key feature of good QHR I want to tackle today is the emic perspective.

In quantitive research there are no 'insiders'. Everyone is outside. The desire to eliminate polluting variables and bias is often so strong that it can sometimes feel like quantitative research is trying to take a 'view from nowhere'. This is, of course, crucial to objectivity. It shouldn't matter whether you are the research subject, the researcher, or the clinician reading the results of the study, quantitative research says that your lived experiences should have no bearing on whether the intervention really works.

But real life is full of polluting variables (hence why quantitative research needs p-values). So rather than trying to hide one's bias, QHR starts from the premise that we are all insiders.

The emic perspective means the insider's perspective and is a crucial point to understand if you want to produce and understand good quality QHR.

The emic perspective is the insider's view of whatever you're studying. That could be the experience of chronic pain, or your view as the therapist.

> 'Until recently, the investigation of health problems was dominated by the outsider perspective, in which important questions of aetiology and

> treatment are identified by the profession. Studies based on this perspective assume that professionals are the authorities on what wellness is and that they alone know what questions ought to be asked to investigate methods to promote and maintain wellness while preventing and treating illness' (Krefting 1989).

Which all sounds very obvious and intuitive, but the real challenge of the emic perspective is whether you can really represent the insider's view? If it's someone else, how do you 'capture' what they think and feel? Is it enough to transcribe what the person says and assume that the person's words are 'the truth'? Can you observe what goes on in a department and infer that you've grasped what it's like being one of the clinicians? Can you even know your own mind?

So if we can accept that every one of us is unique, and we all have a different views of the world that are shaped by our culture and experiences, then is Harris right to suggest that 'The way to get inside of people's heads is to talk with them, to ask questions about what they think and feel' (Harris 1976)?

As is often the case with qualitative research, the ways of capturing data are not especially hard to do, (especially, as is often the case with physiotherapists, that you are experienced talking with people and observing the world around you). Where things get complicated is when you start to think about how to represent the other's reality in a way that is credible and trustworthy.

Because, as Green and Thorogood suggested recently, you are not looking just for a common-sense description of a person's reality, perhaps not even just an 'insider's' account, but a theoretical description (Green & Thorogood 2018), and that becomes complex when we are all, in one sense or another, insiders.

References

Cheek, J. (1998). Postmodern theory and nursing: Simply talking trivialities in high sounding language? In H. Keleher & F. McInerney (Eds.), Nursing matters: critical sociological perspectives. Sydney: Churchill Livinsgtone.

Green, J., & Thorogood, N. (2018). Qualitative methods for health research. London: Sage.

Harris, M. (1976). History and significance of the emic/etic distinction. Annual Review of Anthropology, 5, 329-350. doi:10.1146/annurev.an.05.100176.001553

Krefting, L. (1989). Reintegration into the Community after Head Injury: The Results of an Ethnographic Study. The Occupational Therapy Journal of Research, 9(2), 67-83. doi:10.1177/153944928900900201

Part 4 — Power

29 January 2020

So far in this weekly series on qualitative health research, I've talked about where QHR came from, and the important parts played by criticality and the 'insider' or emic perspective.

This week I want to look at power.

Perhaps one of the most important methodological decisions a qualitative health researcher will make in undertaking a piece of research is exactly how much *they* design, and how much is done with the people they are researching.

Perhaps not surprisingly, then, attacking the traditional power of the quantitative researcher and the institutions they represent has led to some of the most radical technical developments in QHR and healthcare generally.

Traditionally, we gained knowledge of our patients, by subjecting them to a battery of tests and assessments that yielded objective results that could be externally verified.

Soft data on the other hand (note how terms like 'hard' and 'soft' are gendered), was gathered through the patient interview. Here an expert, researcher, or clinician, would pose questions based on a study or clinical hypothesis, and test the patient's variability of expression and meaning against standardised expectations.

So if the patient said "my knee hurts here when I bend it right back", we would evaluate that as normal given their known pathology. And even if they said "my knee hurts when it rains", we had the training to know that this was just folk wisdom and was clinically irrelevant.

We thought that we were being objective because our tests were standardised and supposedly free from bias. But of course we were forgetting that it was only people on one side of the table that were defining what hypotheses needed to be tested, what questions should be asked, and what test measures were going to be used.

In the 1960s, social science researchers started challenging the latent power and privilege that came with being able to design every item on the research agenda, and this led the way to what we now know as co-design.

Nowadays in QHR it is normal for research participants (not 'subjects', note) to help shape the study. They may be involved from the very beginning and help work out what questions need to be posed, or throughout, helping to design the study methods, and analyse the findings.

One of my Māori colleagues wanted to do a PhD looking at the neural mechanics of low back pain and took his idea to his tribe. They told him they weren't interested in a study like that,

and that there were far bigger problems facing their community. So he changed his project to examine pathways to wellness for Māori.

Another primary healthcare researcher I know studied local influenza pandemic preparedness among remote and isolated Canadian First Nations communities, using a community-based participatory research approach. I once asked her to talk about her research on a podcast and she refused, saying it wasn't her data to share and she would need to gain permission first before publishing it.

Such attitudes directed at subverting the traditional power of the researcher are increasingly common now in QHR, and researchers are acutely aware that when they decide what questions to put on the questionnaire, or what kinds of answers a person can give, they are claiming all the power and imposing their values on the research.

This kind of privilege is endemic in quantitative health research but it is never acknowledged, of course, because qualitative research is always ultimately about control: controlling 'variables', experimental conditions, and, in clinical work, controlling people.

Good qualitative researchers take a completely different path, and researchers are always asking how they are positioned in the study, what power they are taking for themselves, and in what ways that runs counter to the spirit of giving voice to the other.

Part 5 — You

5 February 2020

So far in this weekly series on qualitative health research, I've talked about where QHR came from, criticality, the 'insider' or emic perspective, and last week focused on power.

This week's post continues the theme of power, but concentrates especially on your role as the researcher.

In most quantitative research, you are supposed to disappear, to recede into the background, and protect the data from your polluting influence. Of course, this is only possible to a degree, because you have often been involved in every stage of the design and development of the study.

But when it comes to the data collection and analysis stage, you are too heavily influenced by your own experiences, biases, and subjectivity to be trusted with the study's data, which really should be handled like someone in hazmat gear holding a jar of radioactive iodine.

There are two major problems with this. On the one hand, how do you actually protect the data from your influence? Technically speaking, the lengths you have to go to distance

yourself from the data explain, in part, why quantitative researchers have an accountant's fascination with methodological book-keeping.

But there is another problem too. Ethically speaking, is it right to assume the aloof, detached, 'view from nowhere'? Especially in healthcare, where everyone has at least some skin in the game?

Qualitative researchers take a different view. They believe that you are not only involved in the study, you are central to it. Not more central than your participants, but certainly right there in the middle with them. This means you have to think a lot about philosophy and methodology.

How you've designed the study to situate yourself in there becomes vitally important. In quantitative studies there are really two active parties: the experimental hypothesis and the research subject. In qualitative research there are three: the research participant, the research question, and you. And there is no disguising or hiding the role you play in shaping the study design and analysis.

To be clear, qualitative researchers don't see their input into a study as a flaw; something to be masked. It is something that enriches and enhances the study. Like the way wine growers put their love and passion into making a really great wine, or how a great football manager makes a team better.

In some ways, this makes qualitative research much harder for novice researchers, because in quantitative studies, the methodology is often so prescriptive it could almost be delivered by anyone. But in qualitative research it's the exact opposite. 'Who you are, where you're from, and what you did' – to quote the immortal Backstreet Boys – really does matter.

Perhaps an extreme example of this is autoethnography – a methodology almost guaranteed to make quantitative researchers roll their eyes in disbelief. Autoethnography has become really popular over the last 20 years, partly because it uses the researcher's own experience as data. You are the researcher and the participant. It's autobiography done with research rigour.

Now clearly, there are all sorts of methodological questions that arise when you enter the research study like Elton John at a Royal Gala, but perhaps the most important – and the one most often missing in the physiotherapy literature – is the role of perspective.

If you are going to take your place within a qualitative study, you must be very clear about your perspective. Because there are so many positions you could take in designing the study and reading your data (critical realist, feminist, Marxist, postmodernist, etc.), it's vital that the reader knows where you're coming from. Then they can do their part and read the findings through their own lens, bearing in mind that it will be different to yours.

So the position of the researcher in the study is one of the defining differences between quantitative and qualitative research. Physiotherapy researchers often get caught between wanting to be properly qualitative while subtly promulgating quantitative ways of working. You see this when a qualitative study is written up and you don't get a detailed insight into the worldview of the researcher. That's always a tell-tale sign of a weak study.

Part 6 — Sampling and generalising

12 February 2020

The point of this series is not to cover what's already in dozens of qualitative health research textbooks, but to offer some 'back room' insights into the possibilities and limitations of this underused resource.

So far I've looked at where QHR came from, the concept of criticality, the 'insider' or emic perspective, power, and last week, your role as the researcher.

Today, I want to focus on one of the most common questions people pose about QHR, and that is "How can you possibly generalise from a study when you only have six participants?"

This is a great question. Not only because it strikes at the heart of one of the important differences between qualitative and quantitative research, but also because when qualitative health researchers get it wrong it's a red flag for a poor study.

A common give-away that the author(s) didn't really understand QHR is when you read in the limitations that "the study's findings should be read with caution because of the small sample size".

So what's wrong with this?

Well firstly, qualitative research isn't trying to be representative of a background population.

It starts from the premise that each person is unique (a view shared by most physiotherapists, as it happens). No two people experience the world, never mind health, in the same way.

Qualitative health researchers believe that any attempt to shoe-horn individuals into groups of convenience to the researcher is an act of wanton violence. (Note: the word 'Individual' means 'cannot be divided', so the idea of 'like minded individuals' is an oxymoron).

No, your qualitative methods should work hard to accentuate people's individuality, not crush it.

So sampling in qualitative research isn't about finding people who are alike, but finding people who are not. You want breadth, not conformity.

So the quality of the study has nothing to do with the sample size, and one person can provide as much rich data as 1,000.

To illustrate my point, consider this scenario:

Imagine you are the owner of a large practice and you decide to sample 1,000 of your clients to ask them whether they were satisfied with your service.

856 of them (85.6%) report being very happy.

A further 141 report being basically satisfied.

But three are not. One reports being verbally abused by one of the reception staff. One thought the clinic rooms were unhygienic. And one talked about the inappropriate touch of a therapist of the opposite sex. They don't want to make a complaint, but thought you should know.

Now clearly you wouldn't dismiss these three on the basis that they were statistically insignificant. Because you know that these individual views are particularly powerful, and you don't need it reported by a minimum of 10 people to act on their concerns.

QHR works in the same way, but here's an important difference.

Good QHR is not just about reporting what people said. That's journalism. Neither is it about cobbling a few similar comments together and calling them 'themes'. That's the equivalent of using pie charts in an RCT, and I talked about this in an earlier post.

Good QHR builds theories and concepts, and it builds them sometimes from very particular, individual comments that – like the one-in-a-thousand comment from one of your clients – speaks volumes.

This process is hard to explain in a brief blog, but I've written about it in the articles referenced below if you'd like to know more (Nicholls 2009a, b & c).

So if you ever see ever read in a qualitative study that the research was 'under-powered' or wasn't generalisable because it only involved five participants, you'll know this is a sample you should ignore.

Part 7 — Philosophy and the place of research methods

19 February 2020

Now we get to the heart of one of the most contentious issues in QHR.

If you've followed the series so far, we've covered a lot of ground: sampling, generalisability, voice, and the 'emic' perspective, but we're mining the motherlode now when we talk about the place of philosophy and methods in QHR.

So let's be clear from the outset, QHR places far too much emphasis on research methods and nowhere near enough on philosophy.

Anchoring a qualitative study in philosophy is perhaps the most valuable thing you can do to a research study. Firstly, it guides every step of the process – every aim, and every question you pose of the data – and it 'lifts' your analysis above the obvious and mundane.

It is the key to saying something new and surprising, and does more than anything to prevent you from presenting your findings as if they somehow spoke objectively for themselves.

To begin with, philosophy helps you situate yourself. It helps you focus your question and your analysis.

People drawn to hermeneutic phenomenology are going to undertake a very different study to people who are critical theorists, and they'll find very different things in the data.

For example, phenomenology is very concerned with what it means to *be* someone. So a phenomenologist would be very interested in what it means to live with cerebral palsy. Critical theorists are more interested in the way power operates in society, and would be interested in the ways people and institutions subtly discriminate against disabled people.

The phenomenologist's study demands a very different approach to the critical theorist's, but the methods they use really aren't what matters here. Beyond talking to people, observing things, and reading texts, there aren't many complexities to qualitative research methods, but this is often where QHR goes wrong.

Concerned to mirror the granular control quantitative researchers need to hold over every step in their methods, qualitative health researchers have developed all sorts of ways to regulate, define, and standardise data collection and analysis methods. Using digital transcript-analysis tools and member checking, for example, are evidence of the researcher attempting to bring standardisation to data that really shouldn't be standardised.

The point of QHR is to reflect the uniqueness of each event; each non-standard, perspective-laden, contextual nuance of health and healthcare. So how on earth do you find meaning in all of this complexity?

No matter what your question, I would guarantee that someone has thought about the issue you are exploring before you. More than this though, the great philosophers have woven this question into a deeper search for the meaning of life, and with their help you might just be able find something in your data that transforms the way we all think.

Physiotherapists often baulk at the idea of reading philosophy. It's not something they're familiar or comfortable with. Quantitative research mostly brushes over its underlying philosophy, especially in health research. So most physios look at philosophy in the same way they might look at a plate of food they don't like. (And most are happy just to go hungry).

Unfortunately this has also been an option for a lot of qualitative health researchers in recent years, as guidance to qualitative health researchers has come to look increasingly like quantitative-lite.

Elizabeth St Pierre Adams has been resisting this trend for years now, writing about a kind of QHR that returns to the discipline's early promise, arguing against the over-emphasis on methods and formulae (Pierre 2013, 2014).

She doesn't deny that philosophy is hard. But then so is physiology, anatomy, clinical decision-making, ethics, and professionalism, and none of us would practice without these. So we should not let qualitative health researchers get away with making rigid claims about their research methods as a substitute for philosophically-informed thinking.

References

Nicholls, D.A. (2009a). Qualitative Research: Part One – Philosophy. International Journal of Therapy and Rehabilitation, 16(10), 526-534.

Nicholls, D.A. (2009b). Qualitative Research: Part Two – Methodology. International Journal of Therapy and Rehabilitation, 16(11), 586-592.

Nicholls, D.A. (2009c). Qualitative Research: Part Three – Methods. International Journal of Therapy and Rehabilitation, 16(12), 638-647.

Pierre, E. A. S. (2013). The posts continue: becoming. International Journal of Qualitative Studies in Education, 26(6), 646-657. doi:10.1080/09518398.2013.788754

Pierre, E. S. (2014). A Brief and Personal History of Post Qualitative Research: Toward Post Inquiry. Journal of Curriculum Theorizing, 30(2).

Part 8 — Quality

26 February 2020

So how do you know if a piece of qualitative health research is good?

In the seven blogposts that have preceded this, I've set out a personal critique of some of the problems I see all too often in qualitative research. I read and review dozens of qualitative health research articles each year, and my broader interest in the sociology and philosophy of

health means I also get to read a lot of really good stuff too. So I'm claiming that as my mandate to offer some critical comments.

So what makes for a good qualitative health research study, and how can you tell if you've found a diamond or just a bit of cheap plastic costume jewellery?

Well, I would say that the first thing you need to do is to ask what it is you want from the research.

If you want the research to be useful you'll want something different than if you want something inspiring. If you're looking for research to validate a treatment approach or an assessment technique, you're looking in the wrong place, and if you find a QHR study claiming proof of efficacy of some intervention, be very skeptical.

Good QHR should always take you into unfamiliar territory, so if the research is good, validation will be the furthest thing from the researcher's mind.

So maybe put aside the imperative to find 'useful' research, and focus more on 'inspiring'.

Think of it like a holiday in an exotic foreign country. You don't go there to see what you can see at home, and eat what you'd normally eat on a Tuesday night. You go there to discover new customs, new sights, smells, and sounds, and to taste a world that may be different enough to be disruptive, but also uncannily familiar.

So if you're the researcher, your first task is to be the tour guide to this foreign land. You must, you MUST, situate yourself in the study and claim your place as a participant. You must also explain your philosophical perspective – the philosophies that defined why you did this study in this way, how you read your data, and arrived at your conclusions.

Without this, you lose perhaps the most important function of QHR, and that is to transport the data from the mundane, everyday, and obvious, into something shocking, disruptive, and transcendent.

Any suggestion that the researcher is attempting to assume the objective, detached, 'voice from nowhere' common to quantitative research should be viewed with critique.

And every QHR study is a conversation with power. That's your power as the researcher or clinician, and the power of the participants. It's about the way that power is manifested and managed throughout the study, and how you use it afterwards to bring about change.

A researcher who runs the whole show in an effort to maintain control over their research may well be blind to the voice of the 'other', and that's a bad sign for any QHR.

QHR is not about methods. They're really not that important. Leave the obsessive attention to the methods of reducing noise from EMG studies of tibialis anterior contraction to the

quantitative researchers. Focus on an approach that is true to your guiding philosophy, your participants, you, and your questions. If you need to take photos, take photos. If you need study picture books, or join people reciting Robert Frost's poetry in a swimming pool, do that.

So beware the formulaic and pre-prescribed. There are now many guides explaining how to 'do' qualitative research. Many are designed to help you simplify what can seem a bamboozling experience, but in simplifying QHR they can strip the approach of its beauty and sensuality.

Woody Allen once joked that he'd been on a speed reading course and the first book they'd read was War and Peace. "It's about Russia", he said. Guides to qualitative research can be like that.

So hasn't this series been another of those guides that I'm cautioning against? Well, yes, I suppose it has. But I also hope that it's retained a sense of the kinds of anarchic, energising, playful, un-contained promise of QHR. And I hope it's also given you confidence next time to look askance at a study that interviewed 6 people and wrote up 3 themes in the results section.

The case for a healthy curriculum

18 April 2022

For the longest time, physiotherapists were trained to be health professionals. They spent much of their time rote learning standardised methods of treatment and developing their handling skills so that they were equipped to supplement the workforce under the pretext that they were being prepared for clinical practice.

The advent of universities changed all of this, and students were no longer merely trained but were supposed to receive a broad education. Students became supernumerary to clinical staff, pedagogy began to inform teaching, practice became less about treatment and more about inquiry, research, and diagnosis.

The separation was underpinned by the belief that entry into professional practice should be only one possible outcome of university education, and that other routes (into research, teaching, management, for instance), ought to be provided for too.

Universities had to keep reminding their professional colleagues that "we don't work for you", and that their responsibility was, first and foremost, to the students not the profession. But physiotherapy, along with most of the other orthodox biomedical health professions, remained uneasy about this and keeps a close eye on the independence of university

programs through audits and accreditation systems, making sure that the universities didn't forget their responsibility to provide a well-trained workforce. It remains an uneasy tension.

If we think of training as dominating physiotherapy's first education era, then, and university education as the second, it's now possible to see the shoots of a new third movement occurring in healthcare education with the idea of the healthy curriculum.

The principle here is that health professionals traditionally learned to treat others while largely ignoring their own experiences. Even in universities, students mostly learn standardised approaches that change little depending on the people in the room, the location of the school, or shifting world affairs. The healthy curriculum changes all of that.

Rather than being centred on the 'nameless other' that the student may encounter in practice, the healthy curriculum focuses on the student's own health and wellbeing. Learning is focused on 'knowing thyself': diagnosing one's own abilities, aptitudes, experiences, and frailties; finding ways to gain greater insight, as well as methods of healing and repair, be it physical, psychic, cultural, spiritual, environmental, social, or otherwise.

The curriculum is designed to enhance the student's understanding of health drawing on the most direct experiences available to them, and to use this to then expand their horizon to embrace the healing of others.

The healthy curriculum is a journey of exploration, so does not presume at the beginning that the student knows who they are or what they want to do with the skills they acquire. Some will want to become a physiotherapist, others architects or software engineers.

There are a number of drivers of the healthy curriculum, not all of them good. There is growing evidence, for instance, that students are disillusioned with university education. There is also an epidemic of poor mental health and a crisis of self-esteem amongst millennials. And we live in a time of profound connectivity and unprecedented loneliness. Universities, if they are to live up to their name, should respond to this and not presume that what worked for people in the 1980s will still work today.

'Classical' health professional training remains an attractive option for many, especially those looking for a degree of job security in countries where employment precarity has become the norm. But these programs may be found wanting as healthcare goes through its own post-professional moment in the coming years.

So now may be the perfect time for us to think about how health professional training can also be a healthy experience.

The healthy curriculum (Part 2)

2 May 2022

Last week I suggested that 21st century education should not only be about healthcare, but should also be healthy for the student.

My argument was that rather than being focused on some unseen subject, the curriculum should begin and end with you. You should leave your training knowing yourself better, equipped with all manner of physical, cultural, spiritual, psychological, political, and social skills to take into your new professional life.

But wouldn't a curriculum shaped entirely around the students make the person self-centred? Wouldn't they forget that healthcare is always about other people? I think not. In fact, I think the opposite might actually be true. Especially when you consider how we currently think we help students to become person-centred.

My guess is that your training was rather like mine. Never once did one of the tutors ask us about ours personal values and beliefs and, accordingly, change what was going to be taught. It was all set up in advance, and we were just the latest cohort of empty vessels waiting to be filled up with physiotherapy tools and techniques.

And still today, almost every physiotherapy curriculum I know is a set, standard, linear, invariable, technical training, designed to fit students, whoever they are, wherever they are from, into a standard mould.

Ask yourself, how well does that prepare people to be patient-centred?

Look at the work of Nick Sullivan, Clair Hebron and Pirjo Vuoskoski, Ian Cowell, or Caroline Cupit. They have all shown that physiotherapists and other health professionals regularly 'overrule patients' concerns and uncertainties … such that some patients feel unable to openly discuss their health needs in preventative consultations' (Cupit, 2019).

We are trained to see patient's concerns as barriers to be overcome, and to 'sell' the standard physiotherapy view of health and illness to patients. Consequently, we become uncomfortable when patients express their own narratives. Our treatments become paternalistic power-plays because the therapists feel ill equipped to manage even the most basic communication skills like rapport-building (Cowell, 2019; Sullivan, Hebron & Vuoskoski, 2019).

Part of this comes from our belief that physiotherapists should be objective experts. And this shapes everything in our education system.

Ask yourself, for instance, how many students in your class had a declared disability? How many looked like the clients/patients they were going on to serve? Your class, like mine, was probably full of seemingly able-bodied, young, fit, and strong people, and the argument was always that you had to be physically able just to do the work. Even the myriad blind physiotherapists brought into physiotherapy training through the years were 'allowed' to enter training because it was felt their disability would not interfere with their dispassionate objectivity. Not so others.

There might have been some justification for this in the past, when there was more emphasis on manually handling people, but for years now people have had mechanical beds, hoists, therapy assistants, and a distrust of too much hands-on therapy, to lighten the physical load. And people's attitudes to inclusivity have also changed, at a societal level at least, meaning that this kind of discrimination should not still be happening today.

But the real reason why physiotherapy students were always fit and strong was not because of the physicality of the job, and it was not fundamentally against diversity. Rather, it was because we wanted physiotherapy students to be set apart from their clients/patients.

We didn't want people to focus on their individual beliefs, and develop self-aware, holistic practitioners. We wanted objective, detached, dispassionate, and value-neutral clinicians, who could perform technical assessments and treatments in an objective, detached, dispassionate, value-neutral way. We wanted scientists trained in the image of medicine, who could focus on the body-as-machine without any hint of subjectivity.

The evidence-based era has only enhanced this. And even though EBP asks the clinician to consider patient experience in determining best practice, the patient is still seen as the object of our deliberations: as different to the clinician; as "not like me".

So, how would a healthy curriculum be different?

Well, rather than focusing on developing practitioners who are trained to be detached from their clients/patients, a healthy curriculum would constantly reinforce the obvious point that healthcare is a personal and community experience, and that to be good at your job means building your therapy around your clients/patients, in the same way as your training curriculum was built around you.

We would look to recruit people into courses because they were from all sections of the community. Curricula would be different all over the world because the people on the course were different. Methods of assessment and therapeutic strategies would adapt to the needs of the people being served.

But would this narrow a student's training? Would it be too 'local' to be useful in another context? No. Because what the student is learning is how to adapt to the community they find

themselves in. To become embedded, rather than the current approach, which emphasises an almost 'colonialist' logic, where patients are subject to the therapist's expertise, and 'the doctor knows best'.

Traditional health professional training emphasised the importance of the clinician being distant from their client/patient. We were meant to be objective experts, and we were given enormous power to manipulate people (in every sense). A healthy curriculum takes the opposite view. You start by learning about yourself and you frame your practice around the things that make you healthy.

A healthy curriculum follows the adage that "I'll make the first coffee for you. You make the second coffee for yourself. Then we'll make the third coffee for someone else".

Next week I'll talk about some of the ways this can work in practice, and how some curricula have already taken this approach.

References

Cupit, C. et al. (2019) Overruling uncertainty about preventative medications: The social organisation of healthcare professionals' knowledge and practices. Sociology of Health & Illness. https://doi.org/10.1111/1467-9566.12998

Cowell, I., McGregor, A., O'Sullivan, P., O'Sullivan, K., Poyton, R., Schoeb, V., & Murtagh, G. (2019). How do physiotherapists solicit and explore patients' concerns in back pain consultations: a conversation analytic approach. Physiotherapy Theory & Practice, 1-17. https://doi.org/10.1080/09593985.2019.1641864

Sullivan, N., Hebron, C., & Vuoskoski, P. (2019). "Selling" chronic pain: physiotherapists' lived experiences of communicating the diagnosis of chronic nonspecific lower back pain to their patients. Physiotherapy Theory & Practice, 1-20. https://doi.org/10.1080/09593985.2019.1672227

The healthy curriculum (Part 3)

10 May 2022

Over the last two weeks, I've posted about the idea of a healthy curriculum that doesn't just teach about health but is actually healthy for the participants. (Earlier posts here and here).*

In some ways, it seems like such an obvious idea. But dogmatic beliefs about the nature of professional training; the inherent risk aversion of higher education establishments, which derive so much income from health professional education; and the profession's own desire

to inculturate detachment and objectivity in its students, can create formidable barriers to new ideas, no matter how obvious they may seem.

So is an alternative possible? And if so, what would it look like?

The first thing to say is that I don't believe you can achieve a healthy curriculum by adapting the current approach to education. You would have to start from scratch, with an entirely different ethos of learning, a different pedagogy, and a different outcome in mind.

But it wouldn't have to be entirely new, either. There are lots of examples of curricula in other disciplines that are based around students becoming more mindful and deliberate.

Here's one:

A friend of mine studied fine art at a prestigious art college.

There were three components to the students' curriculum:

- Occasional and infrequent lectures on art theory, art history, and practice, given by lecturers and occasional visiting artists;
- Access to technical rooms where students can learn anything from oil painting to 3-D printing and ceramics. These are staffed by practicing artists who act as technicians and advisors;
- And weekly meetings with the other people in their study group (usually no more than five), a lecturer, and a practicing artist.

At the start of each semester, all of the students in the year are given the same topic as the theme for their work. This is usually quite a big and expansive contemporary social question, asking them to respond, for instance, to the #metoo movement, urban pollution, or migration.

The student's task is to find and craft their response.

To do this, they have to choose a medium, booking time with the technician who can help them become more skilled in their chosen medium.

The students have to find a way into the subject and a personal connection.

They have to research extensively to see what other people had done and, in doing so, become part of a community of practice.

And they have to build their ideas over a semester into a portfolio that can be examined at the end.

Each week, their developing ideas are presented for critical review by the other students, their supervising lecturer, and the practicing artist.

And each semester the process repeats, becoming gradually more and more exacting, demanding more and more complexity, and an ever-increasing sense that the student is finding themselves as an artist.

Now, it's not hard to imagine how this could work in healthcare.

Students would bring their life experiences, and use these to begin exploring the galaxy of options available to them: mental, physical, social, cultural, economic, political, and spiritual approaches, would all be there. The student simply has to choose the direction their passion is leading them in.

One semester it could be physical therapies, the next it could be mindfulness and behavioural therapies.

They would be given a topic: movement, poverty, the end of work, back pain…, and a semester to find their response.

It would be up to them to decide how much theory and technical skill they needed. Resources would be there for them — including technicians, lecturers, and other practicing clinicians — but they would have to decide what they wanted to do.

As the course goes by, the topics, and expectations, would become more complex, such that by the end of their course they might be able to apply for professional registration if they wanted to.

Some students would learn that they love relational caring practices and talk therapies, others might want to do something more hands-on. Some would learn to assess a person's gait pattern and go on from here to become experts in robotics and motion sensing, others would choose to learn Gestalt psychology.

The key, though, would be that they find themselves. They discover what kind of health professional they wanted to be.

And, as a side-effect of their process of learning, healthcare would get people who were passionate about their practice, trained to be innovative and responsive to the conditions they find themselves in, and hugely self-aware.

This is only one example, and there are many others that could be used, but it is a reminder that educational reform in healthcare is not impossible.

And we should remember that the way we do things today is neither the oldest nor the most ideal way to educate people into health.

There are always other ways.

*In a sad coincidence from last week's post, the Journal of Philosophy of Education posted a special issue last week on the mental health crisis in education. A reminder, if ever it was needed, of how professional training is losing touch with the health of our students.

Posthuman compendium

Between February and May 2023 I wrote six long 'Stackposts on the theme of posthumanism. I've collated them here into one compendium for ease of reading.

I've removed all of the decorative images but left the substantive ones in place, and assimilated the references into one long list at the foot of the article.

https://doi.org/10.14426/160623

A case for post humanism — Part 1 — Introduction

15 February 2023

Now that the ParaDoxa site is up and running, I thought I would start to articulate some of the philosophies and ideas that lie behind my attempt to develop something radical and new in healthcare.

Perhaps the most confronting and exciting concept — and so naturally the one we should tackle first — is posthumanism.

What is it about posthumanism that's so appealing?

Firstly, posthumanism feels like it could be a powerful response to many of the anthropogenic problems we're facing in the world today; most notably the exploitation and enslavement of the earth and its people for the personal gain of a few.

But also because people in healthcare are staunchly humanistic. Whether we come to healthcare with Enlightenment values of objectivity, experimentation, and human sovereignty over animals, plants and inorganic 'things'; existential beliefs about reality mediated entirely by human subjectivity; or social forces defining the conditions we are born into and live with despite our much-vaunted 'agency', our ontological and epistemological presuppositions are deeply anthropocentric.

Western healthcare begins and ends with the human.

Consider this paragraph as an example, from the opening of a recent Guardian review of Ashley Ward's new book Sensational: A New Story of Our Senses;

> ’”If you are ambitious to found a new science, measure a smell,” said Alexander Graham Bell to a graduating class in 1914. A century later, scientists are still working on it. But it’s not just smell that remains difficult to define and categorise. Humans can calculate pi to trillions of digits, but can we agree on what the colour teal is? Or whether coriander tastes nice? Or when pleasant stroking becomes annoying tickling? The mildly unnerving point is that much of the information we learn through our senses cannot be objectively measured. Colour “doesn’t actually exist outside of our brains … there is also no sound, or taste, or smell … it’s the brain that construes them”’ (Guest, 2023).

The unstated assumption here is that sensations are human faculties, created in the brain, with perhaps even no physical basis — or at least, one that eludes (human) science.

An anatomist would no doubt disagree. Are Guest (the reviewer) and Ward (the author) arguing that Golgi tendon organs and post-synaptic channel receptors are present only in human imagining? Or that people of colour also only exist in the minds of individual human beings? I doubt it. And yet the assertion is that it’s the brain that construes sensation.

So what of the vast trillions of entities throughout the universe that do not possess a human brain? Does colour exist for them? Does touch?

If not, and we want to preserve notions like colour and smell only for humans, we need a new structure to our language: one that can accommodate the fact that plants can perceive light to a much higher degree than humans, and bacteria show empathic responses to each other in the presence of noxious chemicals (Chamovitz, 2012).

The problems with our latent and unacknowledged humanism don’t just end there because it’s not just a general notion of ‘the human’ that is used in healthcare, it’s a very specific one. It’s a human that is bounded and autonomous; a human with a distinctive identity; a being with clearly defined spatial edges, and a temporal story running linearly from birth to death.

This is the human taught to us in anatomy and physiology. It’s the elderly woman who falls and fractures her wrist. It’s in the psychology of identity and narratives of illness as a ‘disrupted biographies’ (Engman, 2019). It’s the presumed basis of human relations: of the “I” and the “you”. And it’s in the division between the real and virtual world of simulation and telemedicine.

But how fully encapsulated is this human being really?

> Imagine an oxygen molecule somewhere in the room near to you. At some point in the next 10 minutes you’ll breathe that in. But at what point does

> the oxygen molecule become part of you? When it's in the trachea? The alveoli? The mitochondria?

Given that about 60% of your body mass — more even than carbon — is made up of oxygen, it has a pretty important role to play in constituting what and who you are, so it would be good to know.

And if, to paraphrase Tim Morton, there's a lot less of 'me' involved in me existing than I'd like to think there is (Morton, 2017), how confident can I be in the classical idea that I, Dave, have a distinctive body, personality and being?

The vast majority of the bounded body that makes up the human being is inorganic matter that is constantly interchanging with the rest of the universe. So do I extend out from my home in New Zealand to include the oxygen molecules just being produced by algal blooms in the swamps of Louisiana?

Where do I begin and the rainforests end?

So is everything just matter?

And if it is, how do we account for the vital force that animates life and differentiates a rock from a child, a dead cat from the one that's just ruined our curtains?

Would a renewed acknowledgement of the role that matter, objects, forms, and things play in health and healthcare be enough to constitute posthumanism? If so, isn't this, to paraphrase Foucault, just replacing one bad human-centred hegemony with another (one in which we've successfully 'flattened' the human but have nothing to say about human affairs)? Does human subjectivity and sociality have any part to play in posthumanism?

These questions have energised a whole new field of philosophy in recent years. And posthumanism has become 'an umbrella term' (Ferrando, 2019) to encapsulate a range of loosely related philosophical, cultural, and critical positions, including;

> Transhumanism (in its variants as Extropianism, Liberal Transhumanism, and Democratic Transhumanism, among other currents); New Materialisms (a specific feminist development within the posthumanist frame); the heterogeneous landscape of Anti-humanism; the field of Object-Oriented Ontology; Posthumanities and Metahumanities' (ibid).*

I would argue that if we're going to make our way through this mass of philosophical complexity, we are going to need a philosophy on which to ground our thinking that is adequate to the task: one that can imagine healthcare in an expanded field.

The biosciences can't do it alone because they cannot account for human subjectivity and socially constructed knowledge.

Experiential, existential and phenomenological philosophies can't do it alone either because they have no place for mind-independent entities like sarcomeres and oxygen molecules.

And philosophies of social construction and structure exclude both individual biological, psychological and subjective interpretations of reality.

Pragmatic, 'holistic' and whole-world approaches like the biopsychosocial model can't do it because they remain only superficial, lacking the capacity to overcome the deep ontological differences between their different domains (the biological only sits comfortable next to the psycho and the social in a Venn diagram).

Enter Gilles Deleuze.

To my mind, Deleuze's radical philosophy might just offer the best way to make sense of all of this. But it cannot be approached from where we currently stand, deeply nested within Enlightenment humanism.

Deleuze operates in a different universe to the world of Western healthcare.

Disinterested in the classic western binaries between true and false, healthy and sick, mad and sane, able-bodied and disabled, human/non-human, Deleuze sets them all aside and constructs an entirely new map with language and concepts that are, at times, completely alien but nonetheless thrilling and enlivening.

*It's perhaps worth remarking here that I view transhumanism as very different to posthumanism and don't agree with Ferrando that they should be placed alongside one another. They sound similar, but transhumanism is broadly the pursuit of a more perfectible human, often with the use of techno-scientific adaptations (prostheses). Posthumanism, by contrast, is fundamentally about holding humans to account for our hubris, reducing the dominance enjoyed by humans in our philosophies, and de-centring them when we think about the real life. So while they both have an interest in a broader idea of what matters, transhumanism is much more in line with the Enlightenment ideal of the human as singular 'man'.

A case for posthumanism — Part 2 — Similarities and differences

22 February 2023

> Remember that if the devil
>
> wants to kick somebody, he won't do it
>
> with his horse's hoof
>
> but with his human foot *(From the poem Pig Roast by Tadeusz Różewicz (tr. from Polish by Joanna Trzeciak)*

In this 'Stackpost I want to try to tease apart some of the similarities and differences between the main branches of posthumanism, because it's a relatively new and fertile field, and is already made up of some strikingly diverse philosophies.

To begin with, clarifying some important terms

Firstly, posthumanism does not refer to the 'death' of the human in the way that the word posthumous does, but rather the active de-centring of human identity, voice, presence, and aspirations from our thinking, our work, our research, and our practice.

The fact that we are trying to suppress the anthropocentrism of 'our' thinking here assumes that the human will always remain somewhere in the picture. The extent to which humans are displaced, however, has allowed for enormous theoretical and methodological creativity.

Transhumanism vs posthumanism

In the crudest sense, transhumanism works in the opposite way to posthumanism.

Transhumanism is a philosophical movement that seeks to enhance, rather than de-centre, human capabilities through the use of technology and science. Its goal is a more perfect human; an 'ultra-humanism' (Onishi 2011), through 'existing, emerging, and speculative technologies (as in the case of regenerative medicine, radical life extension, mind uploading, and cryonics)' (Ferrando, 2019 p.3).

Its dominant form — Libertarian transhumanism (LT) — draws heavily on Enlightenment ideas of human autonomy and sovereignty, and it aligns politically with free-market thinking and the individual's freedom to use technology as they see fit.*

A second branch of transhumanism is somewhat closer, politically at least, to posthumanism. Democratic transhumanism (DT) is concerned with social justice through the collective distribution of technologies that might bring about a more equitable society. I find it quite hard to distinguish DT from any technological intervention designed to address social inequity though, be it water sanitation in low-income countries or iPads in the classroom. So much depends here on the specific meaning used to designate an intervention as 'technology'.

DT does share an interest in some of the key questions at the heart of posthumanism, however: questions about the nature of agency, bodies, creativity, identity, and the

possibilities for social change. And this overlap has created some understandable confusion, most particularly between DT and critical posthumanism, because both appear to call for a 'better' human.

Critical posthumanism and the call for us to do better

Thanks to the work of people like Karen Barad, Jane Bennett, Rosi Braidotti, Judith Butler, Elizabeth Grosz, Donna Haraway, Katherine N. Hayles, Luce Irigaray, Pramod Nayar, Margrit Shildrick, and Isabelle Stengers, critical posthumanism (CP) is by far the most advanced and fleshed-out form of posthumanism to date.

Consider these two quotes which fall squarely within the frame of CP:

> 'Posthumanism provides a philosophical foundation from which to shift nursing attention away from its predominant focus on the promotion of 'human freedom', human health, human rights and 'person-centred care'. It helps surface the interrelatedness of humans and the roles of human-centric worldviews in systems of oppression including colonialism, racism, species extinction and climate change (Cohn & Lynch, 2018; Dillard-Wright et al., 2020)' (Adam et al, 2021)

> 'My attention to the operations of difference in posthuman relations aligns with Lucy Suchman's warning that theories of mutually constituted humans and artefacts must not overlook the persistence of asymmetries in intra-active becoming. As she argues, 'we need a rearticulation of asymmetry…that somehow retains the recognition of hybrids, cyborgs, and quasi-objects made visible through technoscience studies, while simultaneously recovering certain subject–object positionings – even orderings – among persons and artifacts and their consequences' (DeFalco 2020).

With their emphasis on the interrelatedness of all things alongside the 'persistence of asymmetries in (our human) intra-active becoming' (Adam, et al, above), critical posthumanisms retain the spirit of critical theory while embracing the possibilities for the more-than-human world.

But in attempting to do this, CP exposes a tension at the heart of all of the posthumanisms: the extent to which we should be trying to either mute the human voice or make it sing more in tune.

In CP the goal is the latter, and the language some authors are now using to navigate the subtle complexities of this positioning can range from the elegant and inventive to the complex and obscure:

> ‘Posthumanism provides a theory of the subject demanding a disruption of the human story as exceptional and considers: what are mediated bodies capable of becoming?’ (Malone & Tran, 2022).

> ‘A neo-materialist vital position offers a robust rebuttal of the accelerationist and profit-minded knowledge practices of bio-mediated, cognitive capitalism. Taking ‘living matter’ as a zoe-geo-centred process that interacts in complex ways with the techno-social, psychic and natural environments and resists the over-coding by the capitalist profit principle (and the structural inequalities it entails), I end up on an affirmative plane of composition of transversal subjectivities’ (Braidotti, 2019).

There is a subtle shift here from ‘humanistic approaches to practice that focus on humans’ — a ‘relational materialism’, if you will — ‘and their practices and posthumanist approaches that, instead, focus on the very process of connecting, in which all mobilised elements achieve agency through their connections’ (Parolin, 2022).

This approach ‘suggests the displacement of the human subject as the central seat of agency’ (ibid), without, necessarily, insisting upon it.

This approach has been an enormous source of methodological innovation in recent years, and journals like Qualitative Inquiry have been enthusiastic advocates for its exploration.

The case for us to do better

The case for critical posthumanisms are relatively straightforward. Braidotti summarises it this way;

> ‘(T)he ‘human’ – which so preoccupies legions of thinkers and policy-makers today – never was a universal or a neutral term to begin with. It is rather a normative category that indexes access to privileges and entitlements. Appeals to the ‘human’ are always discriminatory: they create structural distinctions and inequalities among different categories of humans, let alone between humans and non-humans (Braidotti, 2013, 2016)’ {Braidotti, 2019, #134624}.

In plain terms, we could say that for much of human history, perhaps as far back as the pre-Socratic philosophers, humans have seen themselves as superior to all other things in the cosmos, and have increasingly sought to justify this exceptionalism on the basis of human consciousness, reason, and self-awareness.

This accelerated dramatically after the Enlightenment, whose central purpose was to show that ‘man’ was a sovereign, autonomous being with a distinct identity.

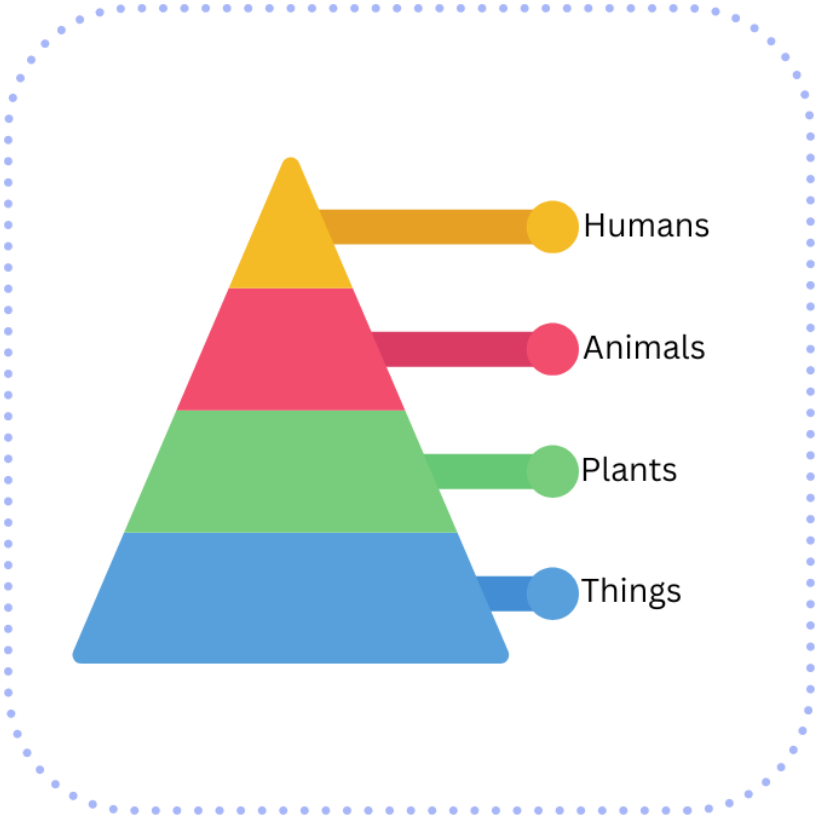


Figure 1. The pyramid of human exceptionalism

Posthumanism sees two major problems with this pyramid of human exceptionalism. Firstly, it perpetuates the belief that humans have a right to think of the world and all its inhabitants this way. Who said, for instance, that consciousness — however we define it — should be the metric that governs universal dominance in the first place? Why not longevity — in which case mountain ranges would probably be at the top? The ability to decompose lignin, Or some other function?

Of course, we did. Humans did. Because we value those capacities most that allow us to think this way in the first place.

But with that sense of exceptionalism comes hubris. And posthumanists are quick to remind people that our belief that the world can be turned to human flourishing has caused us to drive species to extinction, destroy entire ecosystems, strip mine the land, and pollute the oceans. The climate crisis is the poisoned dividend of our human progress.

The second problem posthumanists point to comes from the fact that human hubris does not only extend to other non-human entities, but lives within humanism itself.

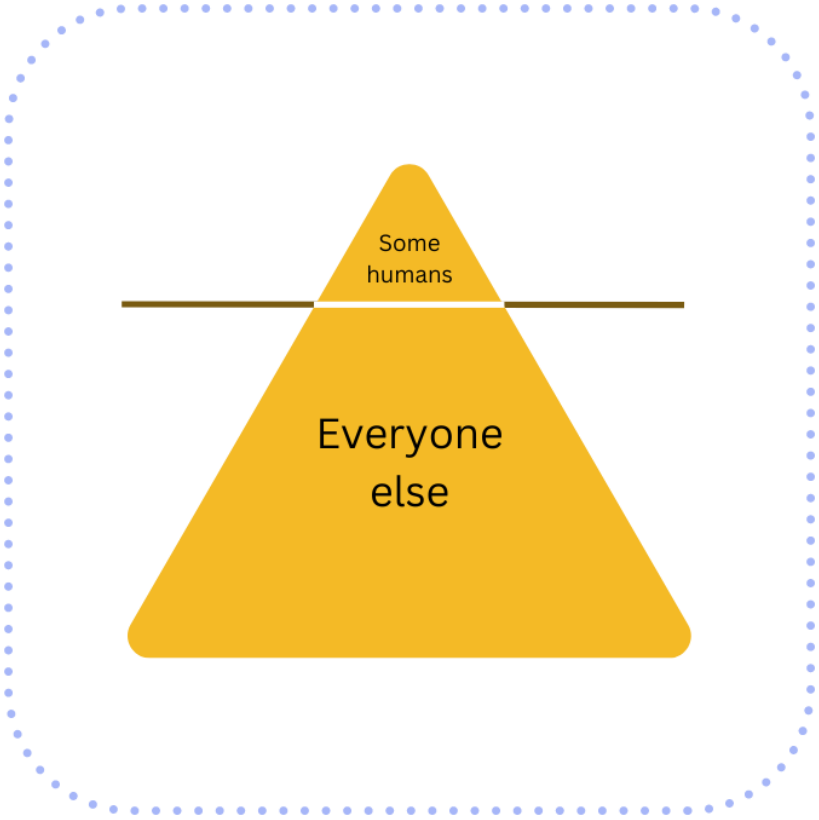


Figure 2. The anthropocentrism that places SOME human above all others

The top portion of the gold-coloured pyramid in Figure 1 is not a uniform grouping. The history of human 'civilisation' has always been one of privilege for some, and marginalisation for others.

> '(T)here exists no portion of the modern human that is not subject to racialization, which determines the hierarchical ordering of the Homo sapiens species into humans, not-quite-humans, and nonhumans' (Weheliye 2014, cited in DeFalco, 2014 p.8).

And while that sense of privilege for some has brought phenomenal progress in science and the arts, it has also been the direct cause of the holocaust and repeated acts of genocide, war, torture, human enslavement, patriarchy, child labour, and sex trafficking, it has fed human greed and placed untold wealth in the hands of very few at the expense of most others, and it has come to define our politics, our culture, and our beliefs about how we relate to others — human and more-than-human — in the world.

'(W)e might be at the top by force', Lucy Jones reminds us, but we would be wise to remember that when it comes to everything else that exists in the universe, we are decidedly 'not at the center' (Jones, 2023).

It's also worth bearing in mind that posthumanism holds the political 'left' to account for this human hubris as much as the 'right';

> 'The reinvention of a pan-human is explicit in the conservative discourse of the Catholic Church, in corporate pan-humanism, belligerent military interventionism and UN humanitarianism. It is more oblique but equally strong in the progressive Left, where the legacy of socialist humanism provides the tools to re-work anxiety into political rage. In all cases, we see the emergence of a category – the endangered human – both as evanescent and foundational' (Braidotti, 2019).

But, we should ask, would things be better if we inverted Fig. 2 and reordered human relations to put majoritarian culture on top, like this?:

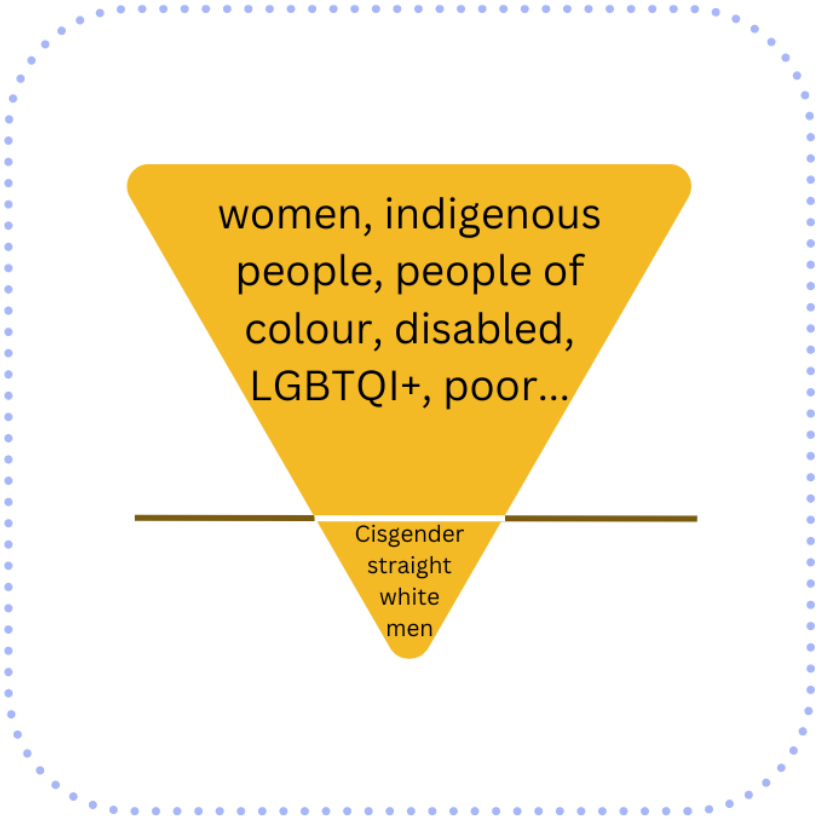


Figure 3. An inverted pyramid of human exceptionalism

In one respect, this would be an entirely justifiable project (and one to which many people are committed — especially in healthcare).

But this still leaves us with an "us" and "them' binary which, can only be sustained if one group secures dominance over another. Which always leaves open the possibility for a contest between 'my' right/might and your right/might. And 'freedom for the wolves has often meant death for the sheep' (Lyons, 2019).

So a third branch of posthumanism focuses on pursuing an even more radical posthumanism; one that deconstructs not only human hubris, but the entire project that makes human hubris possible in the first place; a philosophy based not on the pursuit of a better human being, but one that uses posthuman philosophy to imagine an entirely unremarkable human in a cosmos of wonder.

Radical posthumanism

Just dwelling for a moment on the fact that there are more atoms in a single drop of water than planets in the known universe, should be enough to make us realise that even though the scale of our impact on the planet far outweighs our contribution to its mass, a concern with human exceptionalism is not enough.

We need an approach that can, if only in theory, dissolve away the notion of 'the human' as an autonomous, bounded entity altogether.

After all, as I pointed out in the first part of this series on posthumanism, there is a lot less of 'me' than humanism would like to acknowledge;

> 'not only is the line between human and non-human impossible to definitively draw with regard to the binding together neurophysiology, cognitive states and symbolic behaviours, the line between 'inside' and 'outside', 'brain' and 'mind', is also impossible to draw definitively. For the 'human', what makes us 'us' – whether we are talking about cultural and anthropological inheritances, tool use and technologies, archives and prosthetic devices, or semiotic systems of all kinds – is always already on the scene before we arrive, providing the very antecedent conditions of possibility for our becoming 'human'. In a fundamental sense, then, what makes us 'us' is precisely not us; [emphasis original] it is not even 'human' (Wolfe, 2018, p. 358)

And if we could truly revolutionise our thinking about the way entities, including 'us', form, deform, and die, then everything is on the non-essentialised table.

The pure sciences, of course, have followed this path for centuries, but they suffer from what Graham Harman called a tendency to undermining — meaning a tendency to reduce everything down to its smallest possible active component. (Here, again, we have the inherent transcendentalism of science — the search for the ultimate fundamental 'particle' that forms the basis of all matter).

Similarly, the cultural, social, and political sciences cannot account for the sheer teeming abundance of creativity at play in the world because of their tendency for overmining — reducing everything to its largest super-structural unit (economy, race, gender, etc.).

There has been no shortage of interest in this kind of radical philosophical speculation in recent years, particularly from people like Ian Bogost, Franz Brentano, Levi Bryant, Manuel DeLanda, Tristan Garcia, Graham Harman, Bruno Latour, Quentin Meillassoux, and Tim Morton.** And their work draws on a rich heritage, including various aspects of the philosophies of Nietzsche, Foucault, Husserl, Heidegger, Leibniz, Spinoza, and Whitehead.

But many see Gilles Deleuze and Félix Guattari as the crown princes of radical posthumanism, in part because their work displaces all of the parameters of conventional (Western) philosophy and creates a new approach to thinking that, while it still holds relevance for human studies, makes possible an analysis of people as just one entity among billions;

> 'At this present moment in intellectual history it is impossible to consider the human without contextualizing it with the nonhuman turn. Furthermore, it is unsurprising that the nonhuman turn has been, in its entirety, an interdisciplinary affair – no discipline has a unique purchase on the nonhuman, and engaging with it demands of us that we exceed the boundaries set before us. As does Deleuze. Indeed, there is no single thinker who occupies the nexus of so many intersecting lines' (Roffe and Stark, 2015).

Radical posthumanism, of course, has its own problems. Not least being the question of how one practically, methodologically, even theoretically, removes oneself from thinking, researching, and practicing enough to do justice to the idea of a radically de-centred human? Aren't you always already there?

Is Braidotti right to argue that;

> 'One needs at least some subject position: this need not be either unitary or exclusively anthropocentric, but it must be the site for political and ethical accountability, for collective imaginaries and shared aspirations' (Braidotti, 2013 p.102)?

And even if it were possible to become that minoritarian, is there not the sense that doing this work is not enough in the face of structural racism, patriarchy, social injustice, rampant capitalism, and an impending climate catastrophe?

In the next post I'll try to tackle some of these questions and give some thought to the core principles of posthumanism, before moving on to some ways we might think about this in healthcare.

As always, I truly value your thoughts and comments on any of this.

This is a work of discovery for me and I'm using this writing very much as a way to work through how I can used these ideas in the future.

So, if you have anything you'd like to add to this melange, it would be lovely to hear from you.

Footnotes

*Examples of LT can be found in the work of people like Max More, Nick Bostrom, Aubrey de Grey, Natasha Vita-More, and Anders Sandberg.

If I were a poststructural feminist, I might be tempted to point out that the vast majority of critical posthumanists are women, whereas those in a radical 'anti-humanism' are almost exclusively men. Equally;

> 'The 'newness' of new materialism is relative only to Western/Eurocentric ontology: its recognition of continuities between natural and social worlds recapitulates aspects of indigenous and First Nation ontologies (Rosiek et al., 2020; Sundberg, 2014). Braidotti (2022: 108) suggests 'renewed materialism' as a more apt nomenclature terminology). For critical assessments of the new materialisms, see Lettow (2017) and Rekret (2018)' (Fox, 2022. See also Warbrick et al, 2023).

Or, to quote Rosi Braidotti, 'when it comes to human/non-human relations, it is time to start learning from the South' (Braidotti, 2020 p.467).

Perhaps the salient point here is that these arguments sit firmly within a critical posthuman frame. You are unlikely to see a radical posthumanist making this argument, because they would reject the notion of any essentialised human that critical posthumanism bases its posthumanism upon. To quote Foucault;

'nothing in man — not even his body — is sufficiently stable to serve as the basis for self-recognition or for understanding other men' (Foucault 1977).

A case for posthumanism — Part 3 — Different schools

8 March 2023

> "If you desired to change the world, where would you start? With yourself or others?" - Alexander Solzhenitsyn

Introduction

In this third part of this series on posthumanism, I had intended to define some key principles for thinking with posthumanism. But as I worked on that piece, I found I needed to be clearer

about my own philosophical orientation, so that I didn't give the impression that my list of key principles could be seen as definitive. Posthumanism is a wide discipline covering diverse philosophical orientations, and some of these are about as far apart ontologically as you can get.

Graham Harman's Object Oriented Ontology is dismissive of Karen Barad's agential realism (as we will see below). Ray Brassier's nihilism is the polar opposite of Arjen Kleinherenbrink's life-affirming Deleuzian machine ontology. Manuel DeLanda's assemblage theory is realist while David Lapoujade's aberrant movement is not. Rosi Braidotti's nomadic subjectivity has nothing to say about Tristan Garcia's form and object. And while Tim Morton's hyperobjects bear some similarities to Donna Haraway's cyborg hybridity and Luce Irigaray's vegetal being, Erin Manning's relationscapes, Jane Bennett's thing-power, Bruno Latour's actor-network theory, and Thomas Lemke's governmentality of things, all strike out in notably different directions.

Given this dizzying array of posthuman philosophies, it is perhaps understandable that authors try to narrow things down a bit, as Rebekah Sheldon has done by suggesting that;

> 'Within this broad and interdisciplinary movement, two methods have attained particular visibility: speculative realism, especially object-oriented ontology, and new materialism, especially feminist new materialism' (Sheldon, 2015, p. 193).

I think there's some merit in offering this binary, not because it defines a difference between approaches based on gendered identity politics, but because it highlights some important ontological and epistemological differences that anyone coming into posthumanism would be wise to wrestle with. So let's take a moment to unpack the two sides Sheldon highlights.

Speculative Realism and New Materialism

In the footnotes to Part 2 of this series, I commented that "If I were a poststructural feminist, I might be tempted to point out that the vast majority of critical posthumanists are women, whereas those in a radical 'anti-humanism' are almost exclusively men". Well, Rebekah Sheldon makes the same point in her excellent overview of the problems critical feminists have with speculative realism (Sheldon, 2015).

Writers like Graham Harman, Levi Bryant, Nick Srniceck, and Quentin Meillassoux, she argues, will tell the history of the posthuman turn without even mentioning women like Stacy Alaimo, Karen Barad, Jane Bennett, Rosi Braidotti, Judith Butler, Melinda Cooper, Elizabeth Grosz, Donna Haraway, Valerie Hartouni, N. Katherine Hayles, Myra J. Hird, Luce Irigaray, Eve Kosofsky Sedgwick, Annemarie Mol, or Celia Roberts.

> 'The absence of women from this story of succession is remarkable both for its casual and apparently unwitting embrace of patrilineation, but also, and more incisively, for the distortions it relies on to produce such a clean line of descent' (Sheldon, 2015, p. 203, see also a similar comment by Lemke, 2021, p.38).

In effect, speculative realism (SR) and Object Oriented Ontology (OOO) have relegated critical posthumanism to a footnote 'within its own autobiography' (Sheldon, 2015, p.204).

But this ignorance, Sheldon argues, only masks a deeper ontological dismissal of the critical problems that motivated the critical posthuman turn in the first place. Simply put, SR and OOO say nothing about ongoing oppression and, in their dismissal, enable or even perpetuate it.

Feminist new materialism (FNM), which has become the fulcrum around which a great deal of critical posthumanism turns, broadly argues for:

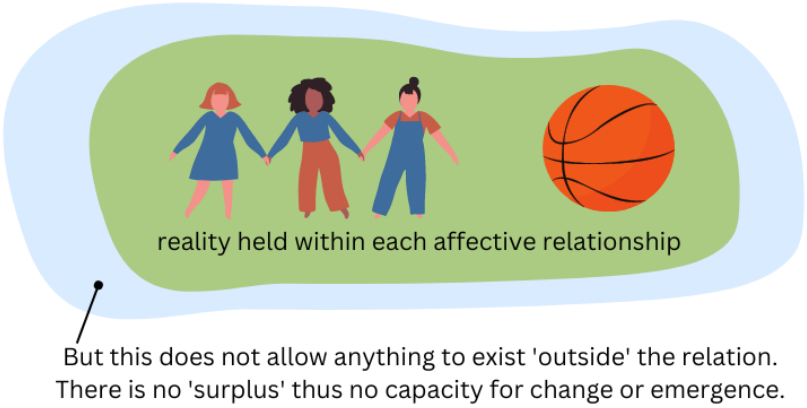
1. A critique of scientific neutrality;
2. The role of culture in mediating between things and our experience of them;
3. The non-discursive agency of other-than-human forces (Hird & Roberts, 2011);
4. Human critical humility, and an accompanying respect for the 'vivacity, vulnerability, and sometimes… surly intransigence of nature' (Sheldon, 2015, p. 195).

But perhaps the defining feature of FNM is its focus on the direct material consequences of human knowledge systems. Epistemology for feminist new materialists is 'emphatically relational' (Sheldon, 2015, p. 195), hence why, Sheldon argues, feminist theorists use so many phrases with double articulations; phrases like nature–culture, material–discursive, and intra–action. Reality is constituted by the interplay of ideas and things. Entities are defined both by their ability to affect and be affected by others: what Fox and Alldred called an 'affect economy' (Fox & Alldred, 2016).

OOO, by contrast, sees entities as having a mind-independent reality, but also a reality that is fundamentally inaccessible. No entity can ever be fully exhausted by its relations. Following Heidegger and Husserl, Graham Harman — one of the chief proponents of OOO — argues that all entities share the same fourfold structure with surface effects that objects encounter when they interact, concealing an ontologically withdrawn 'core'.

OOO argues that the concept of an affect economy fails on two counts: firstly because it cannot explain change; because if everything that exists is encompassed by the relation between entities, there can be no surplus: no potential for anything new to emerge beyond the boundary of the two entities in relation. If theories of affect (a key feature of FNM) did allow for a zone of indeterminacy outside of the affective relation, then reality cannot be

explained by affect alone, as its proponents suggest. So, in the eyes of speculative realists, affect fails because it cannot explain change or emergence.



OOO critique of affect theory

But affect also fails because it cannot account for a mind-independent reality. Kantian philosophy encouraged us to believe that the world only came into existence with the arrival of a mind that was sophisticated enough to conceive it. FNM argues exactly this: that our knowledge of the world is fundamentally a learned act; that 'experience and ideation emerge out of structures of knowledge' (Sheldon, 2015, p. 200). More than this, though, FNM argues that these structures are defined by historical discourses of sex and gender (ibid).

There is a turbulent political dispute here then, with FNM advocates arguing that SR and OOO theorists are engaged in 'the seemingly never-ending process of pushing back against new, creative ways to suppress emancipatory project(s)' (ibid), while realists like Manuel DeLanda ungraciously argues that "I have even more contempt for those who appeal to the worst parts of science - such as [Karen] Barad" (DeLanda & Harman, 2017, p. 7).

Sheldon is perhaps right then to suggest that the relationship between SR and FNM is 'particularly rancorous' (Sheldon, 2015, p. 194);

> 'The antagonism between these two fields is in some ways easily understood. After all, feminism is historically constituted around human subjectivity, sexed specificity, and the sculpting effects of culture. Add to that the origin of feminists' engagement with the sciences in a critique of scientific neutrality—a critique that argues quite precisely for the intercalation of culture between things and our experiences of them—and it

> becomes clear why the two fields have been wary of each other' (Sheldon, 2015, p. 195).

In Sheldon's view, the dispute between these two main branches of posthumanism recapitulates;

> 'the hoariest of philosophical binaries: the form/matter distinction' (ibid), in which OOO privileges form as an aloof, detached, non-agential entity – akin to the classical notion of one's sex, where FNM is concerned with matter and the dynamic, mobile, and fluid notion of nonhuman agency - akin to the contemporary reading of gender' (ibid).

And given what is at stake, it is perhaps understandable that a new wave of poststructural feminists are eager to hold on to the emancipatory drive of the past whilst, at the same time, opening new critical lines of flight.

Susan Bordo recently made the stakes clear;

> 'Since the election of Trump, preceded by a misogynist campaign that was shocking in its hostility and followed by the stripping away of rights we'd counted on for 50 years, it's become clearer and clearer that we are far from "post" feminism' (Bordo, 2023).

On the surface, it would seem that a crucial point of difference between FNM and SR lies in the way they relate to the human. In FNM relations precede 'being', but it is this being-in-relation that then brings about new relations. Barad calls these intra-actions, with matter and discourse co-constituting one another. Besides Karen Barad's Meeting the Universe Half Way (Barad et al., 1996), there are also some excellent examples of this in Annemarie Mol's The body multiple (Mol, 2002), Myra Hird's The origins of sociable life (Hird, 2009), and Stacy Almao's Bodily natures (Alaimo, 2010).

There is little doubt, though, that FNM explicitly retains a place for the human because, ultimately, it wants to offer new modes of critique for the kinds of oppression and marginalisation that feminism has fought against for aeons. In this sense, then, it struggles sometimes to identify in what ways it is post-human.

OOO by contrast, appears to be entirely nonhuman, making no apparent effort to single out the human from any other entity in its radically flat ontology. SR and OOO recognise matter only as a 'fixed, flat, or law-like substrate' (Bennett, 2015, p. 233). Harman even goes as far as to say that "Any philosophy that is intrinsically committed to human subjects and dead matter as two sides of a great ontological divide…. Fails the flat ontology test" (DeLanda & Harman, 2017, pp. 85-86). Humans are merely one entity among a universe of others.

And yet, the sheer strangeness of objects that SR celebrates, resurrects a 'blunt form of subjectivism that not only remains within the humanist frame but is also distinctly gendered' (Taylor, 2016, p. 210). Who is it, Carol Taylor asks, that renders the 'alien' object knowable? By whose criteria is this rendering deemed to be 'satisfactory' (ibid)? Tellingly;

> 'the human who is reinstalled as recorder of traces is indubitably male, embodying an opaque set of values, and judging from a distance' (ibid).

From a critical posthuman standpoint, SR and OOO make no attempt to link the differential power of humans to nonhuman objects;

> 'at the very moment when humans have caused a state shift in the earth's biosphere and are presiding over a mass extinction, we are witness to the ascendency of a social theory that massively redistributes agency to the nonhuman and promotes withdrawal as the primary mode of being' (Campbell et al., 2019, pp. 129-130).

The politics of posthumanism

Clearly then, the battle for the soul of posthumanism is a deeply political one, especially when it comes to critical posthumanism.

But herein, for me, lies one of its weaknesses, because it is sometimes hard to see what it offers to critical questions of anthropocentrism, patriarchy, rampant capitalism, human exploitation, and alienation that is not already there in the critical theory literature. Critical posthumanism bears some striking similarities to intersectional theory, but perhaps with greater attention paid to the mattering of things. It remains, however, a project fundamentally underpinned by an orientation to human social life.

And there is nothing wrong with this. The more tools we can have that bring about critical change the better. But these tools have so far proven to be only partially successful, as Susan Bordo suggests above.

For me, the real promise of posthumanism lies in its ability to break the gravitational pull of the earth and break the long history of human-centred thinking that has beset thinkers in the West for centuries. In doing so, I believe posthumanism offers the promise of some really radical ideas for future life for all.

Perhaps the most emotionally challenging advocate of this radical approach to posthumanism is Ray Brassier, whose nihilism argues that the logical conclusion of the hubristic human search for objective reality will the ultimate destruction of the manifest image of man (Brassier, 2007). But rather than seeing this absolute nihilism as a depressingly hopeless image of the future, Brassier argues that if we can get past the idea of our own extinction, we

might be better placed to understand the full extent of thought as it exists already, beyond the boundaries of our anthropocentrism.

In many ways, it's a powerful way to help us break our tendency to think like humans, but it fails on two counts: firstly, because it bears many resemblances to ancient stoic and skeptical philosophy in which it is wisdom, not destruction, that results from our rejection of our humanism; and secondly, because rather than engendering a cosmic nihilism, an ultimate form of subjective idealism might be the result of stripping away our human qualities, because all the Ego would be left with would be knowing 'nothing but itself and its own ideas' (Woodward, 2015, p. 33).

And this, for me at least, is where Deleuze's philosophy of life comes into its own, because Deleuze sees 'life' as a motive force within all things: as an animating, dynamic, creative energy that is the expression of 'ineliminable difference on the basis of an absolute univocity of being' (Roffe, 2015, p. 43). In other words: every entity is unique in its difference; encounters with other entities are the engine of creativity; every encounter creates a new 'third' entity that shares the same univocal structure as its progenitors, but is unique in its qualitative difference; and that this repetition of difference means that the cosmos is in a constant process of becoming, never stabilised sufficiently to constitute static 'being'.

What will follow in the next post will be a set of key principles that might, just might, allow us to break the gravitational pull of the earth and allow us to develop radically new ways to think about health and healthcare, not as person-centred disciplines, but as philosophies for all kinds of new becomings.

Apologies again for the lengthy diversion, but it felt necessary to set this debate down before pushing on.

As always, I'd love to hear your thoughts, comments, challenges, and questions. So please add comments below and pass this post on to anyone you think might be interested.

A case for posthumanism — Part 4 — Key principles

22 March 2023

Having set out my own position among the different schools of posthumanism in Part 3, I thought I should probably now lay down the key principles that follow from this, and then I can try to explain how I apply them to healthcare thinking and practice — my methodology if you will — in the next instalment.

Before we begin, I offer you a mea culpa for some of the pretty heavy theory that is littered throughout this post. Condensing controversial arguments and radical alternatives into one readable blog post is never easy. I hope it doesn't spoil your enjoyment of the piece.

If the philosophy does get too much for you, though, here's a potted version of the arguments laid out in this post:

> Human exceptionalism, notions of identity and 'being, transcendentalism, and discovery are ubiquitous and hugely problematic both in Western society in general and healthcare in particular. Wherever we find them, we should try to root these out and replace them with Deleuzian posthuman philosophies of becoming, immanence, and creativity. These speak directly to the joyful pandemonium that is life and so are much closer to what's really going on.

So let's take each of these in order.

1. Against human exceptionalism

This is perhaps the obvious first principle of posthumanism, and I've covered some of its main forms in the last three posts. To briefly summarise, as Christine Daigle and Terrance McDonald recently wrote, 'The idea that we must overcome humanist thinking, its dualistic stance and concomitant human exceptionalism is at the core of critical posthumanism' (Daigle & McDonald, 2023).

We are talking here about different forms of de-centering, from contextualising the human within the context of the nonhuman turn (Stark & Roffe, 2015, p. 2), to a more complete and radical nonhumanism (see Brassier below).

Regardless of the outcome of this work, the starting point is often an 'intense and harsh critique of classical philosophical understandings of the human as separate from nature and other beings, and of the human as superior to other beings in virtue of possessing reason' (Daigle & McDonald, 2023).

But just as there is a general opening towards the more-than-human in posthumanism, there is, at the same time, an important political critique in play, particularly where some would embrace a worldly pan-humanism as a veiled way to reify the place of humans at the centre of the universe. We see this most often in what Rosi Braidotti called the 'endangered human' narrative;

> 'The reinvention of a pan-human is explicit in the conservative discourse of the Catholic Church, in corporate pan-humanism, belligerent military interventionism and UN humanitarianism. It is more oblique but equally

> strong in the progressive Left, where the legacy of socialist humanism provides the tools to re-work anxiety into political rage. In all cases, we see the emergence of a category – the endangered human – both as evanescent and foundational' (Braidotti, 2019).

So posthumanism is as disparaging about the humanitarianism of socialism, person-centred care, and aid work, as it is about organised religion, venture capital, and transhumanism, when these are covertly underpinned by an ethic of human flourishing.

One way that writers in recent times have tried to make this tendency visible and escape its magnetic pull is through the exploration of nihilism. Chief among these has been Ray Brassier.

Nihilism, since Nietzsche, has offered a powerful critique of dogmatic thought. Some humans, Nietzsche argued, are always looking to the past. Rather than fully engaging in the future, they never allow themselves to forget their pains and old sadnesses; constantly recollecting and dredging the past into the present. Nietzsche called them 'resentful' types and 'slaves' to their memories.

The seemingly endless rumination drives personal judgment, passivity, identity fixation, and self-blame into the person's psyche — a force all too easily fed upon by powerful social discourses like science and religion (Nietzsche thought all religions were evil in this regard). Ultimately, the resentful type presents as an outwardly 'moral' person, but this person only really ever resents others and yearns to become their 'hangman' (Nietzsche, 2001).

The contrast for Nietzsche was the person who acted without resentment: without dragging up the past; always with both eyes fixed on the world to come. They have a lust for life, for becoming; they are 'masters', always open to disruption, ambiguity, possibility, emergence, and spontaneity. In Nietzsche's famous allegory of the demon in the eternal recurrence, it is the übermensch — the joyous, free spirit — that would be happy to live their life over and over again just as it has been lived till now.

Following Nietzsche, Brassier sees Enlightenment science as a powerful force of nihilism. Our four-century-long search to map and measure every facet of human existence, to know the world and bend it to our will, is a project doomed to bring about our psychic and physical destruction (Brassier, 2007). Far from bringing untold social benefits, our modern fetish for reason and logic, taxonomy and diagnosis, and human cures for 'man'-made problems, will be our undoing.

But Brassier takes a surprising turn here. Rather than siding with Nietzsche, Spinoza, Deleuze, and others in arguing for the possibility of a radical new posthuman view of 'life', Brassier argues for death: specifically the possibilities of understanding creation and thought beyond

human imagining. Only by embracing our inevitable demise in life will we be able to grasp the other-than-human world more fully.

One of the problems of a lot of posthumanist writing is that it all-too-often struggles to fully escape human 'being'. It is, as Jane Bennett says, very hard to rid ourselves of our anthropocentrism (Bennett, 2009). But if posthumanism is going to offer something fundamentally different than, say, critical theory has offered in the past, it must work out how to do this. So, perhaps Brassier's approach is worth considering.

2. Becoming not being

> 'nothing in man — not even his body — is sufficiently stable to serve as the basis for self-recognition or for understanding other men' (Foucault, 1977).

'Being' is almost so ubiquitous in Western thinking that it's hard to imagine a philosophy working in any other way. But posthumanism attempts to do exactly this, by 'fractur(ing) the assumed coherence' of the world (Brown, 2020). Posthumanism takes to task all of those places where 'being' is taken for granted, and many of these areas form the very backbone of our work in healthcare:

- In science, with its passion for giving names to things through its objective taxonomic, diagnostic clarity, such that we take for granted seemingly 'solid' forms of being like 'the body', 'the mind', and 'disease', and with them, the necessary correlates of 'reason', 'logic', 'objectivity', and 'truth';
- In phenomenology and its (inter)subjective 'being-in-the-world', which leads to the over-used qualitative question of what it means to 'be' someone with Parkinson's disease, and what being disabled means for you;
- In social theory with its socially constructed identities based on ability, ethnicity, gender, and so on; a naming that is necessary to give voice to the marginalised 'other';
- In the language we use to define concepts and their limits: 'caring', 'therapy', 'pain', 'nursing', 'behaviour', 'addiction', and so on;
- And even in recent assemblage theory — a branch of posthumanism associated with Deleuze — with the listing of 'things' that can now be brought into consideration when we think about health (air conditioning units, trees, fictional characters in stories, graffiti, etc.), or the hyphenated lists of 'things' that now supposedly break with essentialised ideas of 'being': the sidewalk-wheelchair-skin assemblage, for instance.

(Of course, the great irony in all of this is my own use of fixed labels to list the disciplines that themselves privilege seemingly fixed identities).

'Being' imposes temporal and spatial stability on things. And yet, this is, of course, illusory.

In Deleuzian posthuman theory, being tells us nothing about the boundless, relentless, and unfathomably enormous process of ontogenesis that is at work in the cosmos; a process that expresses the endless repetition of creativity through difference, not sameness, becoming not being.

In keeping with its ethos, becoming may be a harder concept to 'pin down' but it comes closer to the reality of constant cosmic creation, conatus, and collapse than fixed identities and endlessly contested labels ever will.

> 'It's not a question of being this or that sort of human, but of becoming inhuman, of a universal animal becoming – not seeing yourself as some dumb animal, but unraveling your body's human organization exploring, this or that zone of bodily intensity, with everyone discovering their own particular zones, and the groups, populations, species that inhabit them' (Deleuze & Guattari, 1987, p. 11).

3. Immanence, not transcendence

In a similar way to 'being', transcendence penetrates modern thought so deeply that it is hard to imagine thinking without it.

Transcendence refers to the present as a 'projection' of some greater or higher realm.

Many religions, ancient and indigenous cultures propose 'higher' gods, or some form of 'other place' where people go beyond this life. Enlightenment science called this superstition but replaced one form of transcendentalism with another when it argued that there are mind-independent truths and natural laws governing the universe. Plato thought that there were ideal 'forms' of everything we experienced in the world — us included — that were merely images of the realm of truth. Moral philosophers suggest that there must be something more to life than mere existence; why else would humans have been blessed with the gift of consciousness and self-reflection? And social theory isn't immune from transcendentalism either, especially those areas that are concerned with the social structures that exist in the world and give the lie to myths about human autonomy and agency (Marxism and linguistics, for example).

Deleuzian posthumanism following Bergson, Leibniz, Nietzsche, Ruyer, Spinoza, and others, rejects the idea that there is somewhere else, or something else, to which life points. Transcendence is rejected in all its forms, in favour of immanence. In immanence, nothing ever has to go outside to fully realise itself. All it needs is right here.

Key here is the primacy Bergson and Deleuze give to intuition and gnosis — or the most direct, unmediated knowledge of the world — that all entities possess (as opposed to

intellect, which always seems to lead to epistemic knowledge, the search for transcendental explanations, and nihilism).

But immanence also provides the basis for radically different concepts of duration (or 'time' in the Western canon), space (the 'surplus' that exists for all things and makes change possible that does not reside outside in some cosmic waiting room, but is folded into this moment, this entity, this relation), and thought (a more-than-human phenomenon).

4. Creation, not discovery

It perhaps follows from the critique of identity and being that posthuman thinking — particularly of a Deleuzian flavour — would dispute the place of discovery as a mode of thought.

Where Western philosophy has largely been a centuries-long project to discover how we should live (meaning the forms of logic and reason that frame the natural and social laws that are, in turn, sufficient to govern our species-being), posthumanism asks how could we live (May, 2005).

So while the Enlightenment project and all of its many offspring (modern healthcare, health professions and disciplines, clinical assessment and treatment, quantitative and qualitative research, etc.), pursue ever greater forms of discovery, posthumanists argue that we are being increasingly locked in the nihilism of instrumental reason.

In discovery, we see the stain of transcendentalism again because discovery is orientated only towards finding the thing that already exists 'out there', beyond our current knowledge. It is a mindset that is already prepared to make sense of what it sees.

But this is not what creates the 'new' or explains the sheer ceaseless productivity of the universe. It is the shock of the new, the violence of becoming, and the danger inherent in surplus that is the engine of the cosmos.

As Deleuze says, we are inside a thunderstorm, not a watercolour painting (Deleuze, 1993).

What then do these make possible?

It can be hard to know where to start as a posthuman thinker if we have to abandon even our starting points because they are so much the product of Western Enlightenment thinking. I mean, I'm a physiotherapist by training, interested in what a posthuman reading of bodies, movement, touch, and therapy might offer, but these terms are expressions of a flawed philosophy, so surely I should begin by rejecting all of these concepts and starting somewhere else?

This paradox is nothing new to posthumanism, though. As Hannah Stark and Joe Roffe argued, we are 'simultaneously contextualized as a minuscule entity in relation to nonhuman

time scales' whilst also 'positioned as the force shaping a new geological era' (Stark & Roffe, 2015, p. 5).

I think, though, that Deleuzian posthumanism offers some remarkably creative ways to think if we can first uncouple our humanism and see putatively human practices like care and touch as being not just human interventions, but features of the becoming of all things. Understanding 'therapy' as a concept that applies as much to dying leaves as it does to human touch, for instance, is an exciting shift in what had become a rather stale, unremarkable field of thought in recent years.

There is surely more to wound care than just caring for human wounds.

There is also a critical project to be done here and posthumanism certainly provides lots of new tools to expose the often understated anthropogenic and professogenic assumptions underpinning healthcare (Burns, 2019). Much of this critique can be found in the posthuman literature, which has, as yet, been largely ignored by health professionals and those who write on the need for reform.

At its heart, though, Deleuzian posthumanism appeals to me because it aims at 'the production of joyful or affirmative values and projects' (Braidotti, 2019). It is a playful disengagement.

> 'from the rules, conventions and institutional protocols of the academic disciplines. This nomadic exodus from disciplinary 'homes' shifts the point of reference away from the authority of the past and onto accountability for the present (as both actual and virtual). This is what Foucault and Deleuze called 'the philosophy of the outside': thinking of, in, and for the world – a becoming-world of knowledge production practices' (ibid).

Postscript

As I was writing this piece, I read about the death of British sculptor Phyllida Barlow. In a lovely interview with Katy Hessel some years earlier, Barlow said this about the work of sculpture;

> "I think the relationship of a warm-blooded creature vs an object that is still and silent – which is essentially what I think sculpture is – for me is the sort of fundamentals. Sculpture is in our everyday lives the whole time. Crossing the road with a lorry coming towards you, is, in my opinion, a sculptural experience, where you as a flesh and blood object is up against the thing

> that isn't. And one's emotional and psychological assessment of that all happen in a flash" (Hessel, 2021).

I'm increasingly wondering if posthumanism isn't a term for the act of sculpture that all things, not just human minds, engage in as a fundamental function of their existence; always seeing it as a chance to create something new.

A case for posthumanism — Part 5 — Methodology

19 April 2023

> "What will undo any boundary is the awareness that it is our vision, and not what we are viewing, that is limited" - James Carse

Apart from a final summary of key resources, this will be the last piece in this series on posthumanism. There are a lot more 'posts' I want to tackle over the coming months: post-professionalism and post-qualitative research not being the least of these.

But speaking of post-qualitative research, this penultimate post looks at how we might actualise posthuman thinking in research and practice. But to do that, a couple of warning shots need to be fired. The first is that methodology is probably a poor name for this work because it is a term that's been so corrupted in healthcare research — especially by qualitative health researchers — in recent decades, that it's come to stand for a pernicious mode of capture that ensnares many novice researchers.

This is how Elizabeth Adams St Pierre recently described her experience as a doctoral student;

> 'It was so easy, so clear, so accessible. (Qualitative research methods) told me what to do and when and how to do it. I didn't have to think. I didn't need any theory at all, really. I could just get some data and then organize them into themes that appeared all on their own. All I had to do was follow the recipe and then write up my findings. So simple, really, to just be a functionary of the method. So dreadfully boring' (St. Pierre, 2023).

Qualitative health research has become deeply Cartesian and humanist. It is often mechanistic and instrumental. It privileges discovery and feeds the desire to stabilise ideas around concepts like being and identity. And 'although it claims to be interpretive, its empiricism leans toward logical empiricism' (ibid).

It encourages students to focus on which methodology they will choose from the expanding buffet of pre-validated options available to them. I had a student recently advised by a colleague to use autoethnography for a study proposal that the advisor hadn't even read.

Another colleague was told that their faculty would only allow them to use one of five (why five?) well-known and tightly structured qualitative methods *for their* doctorate.

Philosophy and ontology still remain worrisome words for a lot of health researchers, and the question of which arrangement of ontology and epistemology might form the lifeblood of the study, are often substituted for the desire to 'choose your methodology and get going' (ibid);

> 'It certainly never occurred to me as a doctoral student that if I began my study with the immanent ontology of poststructuralism I would not think or use a preexisting social science research methodology that is not immanent. If I had actually begun my dissertation research with poststructuralism, I would not have done that interview study at all. After all, in his Archeology of Knowledge, Foucault wrote over and over again that he was not interested in the speaking subject—that he worked in the order of discourse instead. It is interpretive, not poststructural, work that focuses on the voices of people describing their everyday lived experiences. But I just followed the qualitative process I'd been taught like an obliging doc student. I went to the field and interviewed and observed and did all the "empirical" things you're supposed to do as an empirical qualitative researcher. But the "empirical" I studied was limited to people's words and what I "observed." The richness of the empirical could not possibly be captured by qualitative methods' (ibid).

How, then, might we use the ontological and epistemological approaches set out in the first four parts of this series on posthumanism to frame ways of thinking and practicing without falling back into the cozy but ultimately suffocating recliner of qualitative methodology?

There are clearly some things we should avoid — including prescriptions. So, one way to think about the best way forward might be to think of a set of dispositions that orientate the way we palpate (rather than discover or define) our creations.

Put another way, if I were examining a posthuman thesis, what applied principles would I expect the candidate to base their study around?

Some methodological pointers

Our tendency is to want to understand things spatially — to give everything spatial coordinates, physical form, a defined shape, and mass. We ask where are memories, illnesses, or pains 'found' or 'stored' in the body. We essentialise entities and fix them in 'being'. We like identities, images of solidity and permanence: "This is a book".

But this act of colonisation and capture strips away all of the creative energy that makes the universe the swirling vortex of emergence that it really is.

So while spatial questions are valid in themselves, they have come to dominate almost all the ways we think in healthcare research whilst also obscuring the dynamic power of creativity.

Here's how Clair Colebrook explains how a spatial attitude shapes how we think about movement;

> 'We have usually thought of time as the joining up of movement; time is what links, say, each step of my walk into a perceived line or unified action. But we can reverse this and say that time, far from being some sort of glue that holds distinct points of experience together, is an explosive force. Time is the power of life to move and become. Time produces movement, but the error has been to derive time from movement' (Colebrook, 2002, p. 40).

When we impose spatial concepts on processes that are fundamentally temporal we replace the divergence, becoming, flow, disruption, qualitative difference, plurality, change, intensity, and liminality of duration (time, aeon) with the appearance of linear progression, quantifiable unity, fixity and stasis, likeness, events linked in sequence, order, cause and effect, numbers, homogeneity, and the human fantasy of control (metric space, chronos).

What a focus on 'duration' (the term Bergson used to differentiate it from 'clock time') allows for, is a focus on movement, flow, and becoming, rather than stasis, being, and fixed identity.

For some, aberrant movement (Lapoujade, 2017) might even be the engine behind all forms of creative life because it is movement that brings entities into relation and, through them, the creation of a new world.

> 'Deleuze's ontology is a rigorous attempt to think of process and metamorphosis — becoming — not as a transition or transformation from one point to another, but rather as an attempt to think of the real as a process' (Boundas, 2005).
>
> 'Intuition is... the movement by which we emerge from our own duration, by which we make use of our own duration to affirm and immediately recognise the existence of other durations above or below us' (Deleuze 1988, p.33).

Another important example of the way we can think about time and duration differently comes from Henri Bergson's challenge to the traditional linear, survival-of-the-fittest narrative of (human) evolution. Bergson suggested that the evolutionary path humans had taken was only one path and that there were as many paths as there were entities in the cosmos. Our path has led us to value reason and logic and to believe that these traits made us exceptional. Our self-appointed exceptionalism then justifies our belief that we were entitled to bend the

rest of the natural world to our advantage. But this path was only ever the expression of a particularly competitive, hubristic, and anthropocentric view. Other entities, becomings, processes, and flows will be entirely indifferent to this view, and so have their own expressions of a much more creative evolution; one that does not reduce duration to a set of quantitative measures and rational coordinates.

But how do we as humans access these other becomings, flows, and movements? How do any entities do it? (And here it's probably worth restating the obvious point that we're not just talking about other living beings here, even objects and things, but also processes and events, and other incorporeal entities like thoughts, social constructs, and stories.) Deleuze called his own approach to this problem *transcendental empiricism* (TE).

TE is empirical because it concerns the way all entities encounter the other through signs and manifestations without ever being able to fully capture or know the other, and transcendental because thought (again, not only human thought but that which is necessary for any entities to interact), allows entities to go beyond mere connection or relation to sense the real, necessary, virtual, private interior of the other.

> 'The illusion is to think that because we are synthesising machines, that "mind" is therefore the origin of that synthesising activity. In fact, mind is already a synthesis of myriad inhuman encounters. What Deleuze calls "transcendental empiricism" is precisely his attempt to think the genetic evolution of the thinking subject, and to trace lines of potential deviation-transformation' (Swarbrick, 2017).

It is always tempting to try to make sense of the strangeness of posthuman thought by essentialising the thinking subject and imagining relations in some form like atoms, or billiard balls, or as mind maps with solid entities connected by thousands of intersecting lines. Everyone probably does it, because we're so socialised to think spatially, not temporally. But, as I suggested above, this confuses a fundamentally creative process of becoming with identity and being. It gives solidity to things that aren't structural. We see this even in posthuman research, especially in the use of assemblage theory.

Perhaps the idea of assemblages appeals to our mechanistic fantasy of solid entities connecting via invisible strings. The problem is the tendency to reduce assemblages to interconnect things. If all you have is a hand, a hammer, and a nail, then everything looks like a hand-hammer-nail assemblage. But assemblage theory is about processes, not the 'things themselves'. It is the manifestation of duration, so is about becoming not being, flow not fixity (Buchanan 2020).

Which, of course, forces upon us all kinds of ambiguities and uncertainties. For years now, existential philosophers have examined the ways humans have tried to address what Avital Ronell called the “gash of non-meaning”.

This ‘gash’ is a part of being conscious sensate beings. We dislike uncertainty and wonder why it is we have these remarkable capacities if there is no higher purpose. So we invent Gods, natural laws, and reason as ways to salve the pain that comes with the realisation of our impotence. Our reaching for “emergency supplies of meaning” (ibid) is used by many as justification for all manner of atrocities in our vain attempt to give meaning to our existence (see Simone Bignall’s fantastic explanation of how men’s existential impotence has been used to inflict rape, servitude, and other horrors on women).

Posthumanism argues that our desperate urge to salve the wounds of non-meaning through existential ‘therapies’ like faith and reason will never work. Instead, we should embrace our fundamental immanence; experience the fullness of being alive and the creative profusion that is life. It is what it means to be ‘schizoid’, in the Deleuze and Guattarian sense, to fully embrace the excess of life that comes when we let go of our nihilism and resentment, our desperate urge for certainty, reason, and our fantasies of command and control.

This is the nature of immanence. Not deferring life to an ideal that exists ‘outside’ of life (Plato), the endless negation that comes with the pursuit of logic and reason through science and ‘discovery’ (Descartes, Hegel), or the salvation to come from a life beyond this life (religion and many forms of spirituality), but the radical opening to creation that comes when we dispense with intellect and allow for the intuition and the endless repetition of difference to take centre stage.

To summarise all of this very partial summary of a posthuman methodology:

More of	Less of
Duration	Space
Movement	Stasis
Creative evolution	Human progression
Thought	Things
Nonhuman	Human
Ambiguity	Certainty
Immanence	Transcendence

> ‘It is only by adopting the temporal perspective that we are able to think beyond the perspective of the human being and grasp the nature of reality as such’ (Roffe 2020, p.84).

And now, increasingly, the natural sciences are becoming aware of the need to move away from ‘spatial’ thinking;

> ’Everything we thought was stable, from subatomic particles to the cosmos at large, has turned out to be in motion. From the acceleration of the universe to the fluctuation of quantum fields, nothing in nature is static. The universe is expanding in every direction at an accelerating rate. What Einstein once thought was an immobile finite universe has turned out to be an increasingly mobile one. This acceleration also means that even space and time are not a priori structures, as we once thought, but continually emerging processes in an unfolding universe.
>
> ‘Even at the smallest levels of reality, what we previously thought were solid bodies and inviolable elementary particles, physicists now believe to be emergent features of vibrating quantum fields. These fields’ movement can no longer be understood as ‘motion through space, evolving in time’ as Newton had once understood it. Where an object is and how it is moving can no longer be determined at the same time with certainty. The old

> paradigm of a static cosmos built from static particles is dead. All of nature is in perpetual flux' (Nail, 2021, p. 1).

But perhaps the last word should go to Gilles Deleuze, who explains how we might go about posthuman thinking like this;

> 'This is how it should be done: Lodge yourself on a stratum, experiment with the opportunities it offers, find an advantageous place on it, find potential movements of deterritorialisation, possible lines of flight, experience them, produce flow conjunctions here and there, try out continuums of intensities segment by segment, have a small plot of new land at all times' (Deleuze & Guattari, 1987, p. 161).

A case for posthumanism — Part 6 — Key readings

17 May 2023

> 'I want to see things as they are without me. Why, I don't know / As a kid I always looked at roadkill close up, and poked a stick into it. I want to look at death / with eyes like my own baby eyes, not blinded by knowledge. / I told this to my friend the monk and he said, 'Want, want, want'. *(Roadkill, by Chase Twichell).*

Search for posthumanism in the academic health literature and you're most likely to land on something that comes from the critical posthumanisms.

The absolute necessity of finding new levers to drive a stake into the heart of vampiric capitalism and normative Western hetero-patriarchy has led many to see posthumanism as a way to further feminist, postcolonial, disability, and queer thinking and practice.

There's a detailed reading list for work in this space at the bottom of the page.

But, for me, there is a problem with much of this literature, and that is that it often fails to escape the humanism that it aspires to critique.

Like someone casting a fishing line out into a flowing stream, the initial promise of escaping anthropocentrism is there, but then the line is always reeled back in returning it to the spool that is humanism.

You will find lots of new methodological adventures, methods, and ideals expressed in critical posthumanism, but the research all too often comes back to the questions that others pose for us.

The argument from critical posthumanists is well known: how can we be otherwise than human? Isn't the point very point of posthumanism to think differently about our place in the world? Isn't it meant to make possible a more fluid, diffuse, and minoritarian human; one that recognises both its awesome power to destroy the world but also its absolute cosmic insignificance? And can we ever escape our anthropocentrism anyway? Isn't a bit of anthropomorphism — as Jane Bennett argues — okay?

And while I have no problem with this argument as a justification for critical research, it can be hard sometimes to see how this work is truly posthuman.

In my mind, the real radical potential of posthumanism is the possibility that humanism can be left behind. Entirely.

Deleuze used the metaphor of the clinamen — a term referring to the smallest angle by which an atom deviates from a line — to make a philosophical point about the nature of posthuman thinking.

He argued that philosophy should trace an escape path from the orbit of normal thought. All too often, though, the gravitational force of critical theory pulls the researcher back into re-entry and ultimately lands their work in an all-too-familiar orbit.

Clinamen: the smallest angle by which an atom deviates from a line

What follows is a brief list of some of the material that I feel comes closest to describing an escape path from the planet 'People'. But for good measure, I've added a second list towards the bottom of the post of some of the key works in critical posthumanism.

It's a very dynamic field and one that's growing by the day, so if you think I'm made any gross omissions, please let me know and I'll update the list.

Five key works of posthumanism (well, six really)

1. Deleuze's Difference and Repetition and Logic of Sense

A bit of a cheat straight off the bat to include two books in one, but D&R and LoS are considered by many to be conjoined works. Written during the student riots in Paris in 1968 — a time in which Deleuze spent six months in hospital recovering from a lung resection after years of debilitating TB — they are considered by some to be Deleuze's greatest works. While Anti-Oedipus and A Thousand Plateaus caught people's attention, D&R and LoS set everything that followed in place. Truly remarkable texts.

2. Arjen Kleinherenbrink's Against Continuity

Kleinherenbrink's 2019 book argues that everything is a machine. Drawing links between Deleuze's entire corpus with the field of speculative realism, Kleinherenbrink shows how

Deleuze's work can be understood as a fourfold structure. Radical, highly innovative, and critical response to the shortcomings of affect theory.

3. Jon Roffe & Hannah Stark's Deleuze and the Non/Human

A highly recommended collection of writings that explore a lot of the philosophical, theoretical, and methodological issues involved in posthumanism. Like all of Roffe and Starks's separate works, Deleuze and the Non/Human is beautifully written and curated and would be accessible to most readers. It includes contributions from Elizabeth Grosz, Simone Bignall, Clair Colebrook, Sean Bowden, Ashley Woodward, and others, as well as the editors themselves.

4. Manuel de Landa & Graham Harman's Rise of Realism

A book that takes the form of a long dialogue between the authors and uses their conversation to unpack their different ontological positions and those of their critics and collaborators. Hugely useful for understanding the field of posthumanism and for getting a better grasp on the principles underpinning the work of these two important thinkers.

5. Richard Grusin's The Nonhuman Turn

This edited collection includes contributions from Jane Bennett, Brian Massumi, Erin Manning, Timothy Morton, Rebekah Sheldon and others, and like Rolfe and Stark's book begins from the basis that 'we have never been human' (Latour). It's a great reader on some of the intellectual currents running through contemporary posthumanism, including ANT, assemblage theory, new media theory, and cognitive science.

Notable mentions

Some other highly recommended works that didn't make the top 5:

Thomas Lemke's The Government of Things— Foucault as a posthuman

Eduardo Viveiros de Castro's Cannibal Metaphysics — the ethics of consuming others

Tristan Garcia's Form and Object — How objects take form

Friedrich Nietzsche's Thus Spake Zarathustra — Not at all superman

Henri Bergson Matter and Memory - Time, space, past, present, and future all reimagined

Graham Harman's Immaterialism — Withdrawn objects

Erin Manning's Relationscapes — Movement happening before it happens

Brian Massumi's Parables of the Virtual — Technology, sensation, movement and affect

References

Adam, S., Juergensen, L., & Mallette, C. (2021). Harnessing the power to bridge different worlds: An introduction to posthumanism as a philosophical perspective for the discipline. Nursing Philosophy, 22(3).

Alaimo, S. (2010). Bodily Natures: Science, Environment, and the Material Self. Indiana University Press.

Alaimo, S. (2014). Thinking as the Stuff of the World

Badmington, N. (2003) Theorizing posthumanism. Cultural Critique 53(1): 10–27.

Barad, K. (2003) Posthumanist performativity: Toward an understanding of how matter comes to matter. Signs 28(3): 801–831.

Barad, K. (2007) Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning. Duke University Press.

Barad, K., Nelson, L. H., & Nelson, J. (1996). Meeting the universe half way: Realism and social constructivism without contradiction. In L. H. Nelson & J. Nelson (Eds.), Feminism, science and the philosophy of science (pp. 161-194). Kluwer.

Bennett, J. (2010) Vibrant Matter. A Political Ecology of Things. Duke University Press.

Bennett, J. (2015). Systems and things: On vital materialism and object-oriented philoosphy. In R. Grusin (Ed.), The Nonhuman Turn (pp. 223-239).

Bignall, S. (2015). Iqbal's Becoming-Woman in The Rape of Sita. In J. Roffe & H. Stark (Eds.), Deleuze and the Non/Human (pp. 122-141). Palgrave Macmillan.

Bordo, S. (2023). Goodbye, postfeminism

Boundas, C. V. (2005). Ontology. In A. Parr (Ed.), The Deleuze Dictionary (pp. 191-192). Columbia University Press.

Bozalek, V., & Zembylas, M. (2016). Critical posthumanism, new materialisms and the affective turn for socially just pedagogies in higher education: part 2. South African Journal of Higher Education, 30(3), 193-200.

Braidotti, R. (2013). The Posthuman. John Wiley & Sons.

Braidotti, R. (2019). A Theoretical Framework for the Critical Posthumanities. Theory, Culture & Society, 36(6), 31-61.

Braidotti, R. (2020). "We" Are In This Together, But We Are Not One and the Same. J Bioeth Inq, 17(4), 465-469.

Braidotti, R. & Hlavajoba, M. (2022). Posthuman Glossary. Bloomsbury.

Brassier, R. (2007). Nihil Unbound: Enlightenment and Extinction. Palgrave MacMillan.

Brown, J. M. (2020). Performance, Medicine and the Human, by Chris Pak.

Buchanan, I. (2020). Assemblage Theory and Method: An Introduction and Guide. Bloomsbury Academic.

Burns, E. A. (2019). Theorising professions: A sociological introduction. Palgrave Macmillan.

Campbell, N., Dunne, S., & Dylan-Ennis, P. (2019). Graham Harman, immaterialism: Objects and social theory. Theory, Culture & Society, 36(3), 121-137. https://journals.sagepub.com/doi/pdf/10.1177/0263276418824638

Chamovitz, D. (2012). What a plant knows. London: Oneworld.

Colebrook, C. (2002). Gilles Deleuze. Routledge.

Colebrook, C. (2014) Death of the Posthuman. Open Humanities Press.

Coole, D. & Frost, S. (eds) (2010) New Materialisms: Ontology, Agency and Politics. Duke University Press.

Daigle, C., & McDonald, T. H. (eds.). (2023). From Deleuze and Guattari to Posthumanism: Philosophies of Immanence. Bloomsbury.

DeFalco, A. (2020). Towards a Theory of Posthuman Care: Real Humans and Caring Robots. Body & Society, 1357034X2091745.

DeLanda, M., & Harman, G. (2017). The Rise of Realism. John Wiley & Sons.

Deleuze, G. (1988). Bergsonism. Zone Books.

Deleuze, G. (1993). Difference and repetition. Columbia University Press.

Deleuze, G., & Guattari, F. (1987). A thousand plateaus — Capitalism and schizophrenia (B. Massumi, Trans.). University of Minnesota Press.

Dolphijn, R. and Van der Tuin, I. (eds) (2012) New Materialism: Interviews and Cartographies. Open Humanities Press.

Engman, A. (2019). Embodiment and the foundation of biographical disruption. Soc Sci Med, 225, 120-127. https://doi.org/10.1016/j.socscimed.2019.02.019

Ferrando, F. (2019). Philosophical Posthumanism. Bloomsbury.

Ferrando, F. (2013) From the eternal recurrence to the posthuman multiverse. The Agonist 4(1–2): 1–11.

Foucault, M. (1977). Nietzsche, Genealogy, History (S. Sherry & D. F. Bouchard, Trans.). In D. F. Bouchard (Ed.), Language, Counter-Memory, Practice. Cornell University Press.

Fox, N. J. (2022). The critical (micro)political economy of health: A more-than-human approach. Health (London), 13634593221113212.

Fox, N.J., & Alldred, P. (2016). Sociology and the New Materialism: Theory, Research, Action. Sage.

Fraser, M., Kember, S. & Lury, C. (eds) (2006) Inventive Life: Approaches to the New Vitalism. Sage.

Gibson, B.E., Fadyl, J.K., Terry, G., Waterworth, K., Mosleh, D., & Kayes, N.M. (2021). A posthuman decentring of person-centred care. Health Sociology Review, 1-16

Giffney, N. and Hird, M.J. (2008) Queering the Non/Human. Routledge.

Goodley, D., Lawthorn, R. & Rusmwick, K. (2014) Posthuman disability studies. Subjectivity 7(4): 341–361.

Grosz, E. (2011) Becoming Undone: Darwinian Reflections on Life, Politics, and Art. Duke University Press.

Guest, K. (2023). Sensational: A New Story of Our Senses by Ashley Ward review. Published 12 Jan 2023, accessed 12 Jan 2023

Halberstam J., Livingston I. (eds) Posthuman Bodies. Indiana University of Press, pp. 1–22.

Haraway, D. (1997) ModestWitness@SecondMillennium. FemaleMan©MeetsOncomouse™. Routledge.

Haraway, D. (2015) Anthroposcene, Capitaloscene, Plantationoscene, Cthuluscene: Making kin. Environmental Humanities 6: 159–165.

Hayles N.K. (1999) How We Became Posthuman: Virtual Bodies in Cybernetics, Literature, and Informatics. University of Chicago Press.

Herbrechter, S. (2013) Posthumanism: A Critical Analysis. Bloomsbury.

Hird, M. (2009). The Origins of Sociable Life: Evolution After Science Studies. Palgrave Macmillan.

Hird, M. J., & Roberts, C. (2011). Feminism theorises the nonhuman. Feminist Theory, 12(2), 109-117. https://journals.sagepub.com/doi/pdf/10.1177/1464700111404365

Holland, E. (2011) Nomad Citizenship. University of Minnesota Press.

Irigaray, L., & Marder, M. (2016). Through Vegetal Being: Two Philosophical Perspectives. Columbia University Press.

Jones, L. (2023). Creatures that don't conform.

Kroker, A.(2014) Exits to the Posthuman Future. Polity.

Lapoujade, D. (2017). Aberrant Movements: The Philosophy of Gilles Deleuze. MIT Press.

Livingston, J. and Puar, J.K. (eds) (2011) Interspecies. Social Text 29(1).

Lyotard, J-F. (1989) The Inhuman: Reflections on Time. Blackwell.

MacCormack, P. (2012) Posthuman Ethics. Ashgate.

MacKenzie (2002) Transductions: Bodies and Machines at Speed. Continuum.

MacKinnon, C.A. (2007) Are Women Human? Harvard University Press.

Malone, K., & Tran, C. (2022). Diffracting child-virus multispecies bodies: A rethinking of sustainability education with east–west philosophies. Educational Philosophy and Theory, 1-15.

May, T. (2005). Gilles Deleuze: An introduction. Cambridge University Press.

Mol, A. (2002). The body multiple: Ontology in medical practice. Duke University Press.

Morton, T. (2017). Humankind: Solidarity with nonhuman people. Verso.

Nail, T. (2021). Theory of the Object. EUP

Nayar P. (2013) Posthumanism. Polity.

Neff, I. (2020). Vital and enchanted: Jane Bennett and new materialism for nursing philosophy and practice. Nursing Philosophy, 21(2), e12273

Nietzsche, F. (2001). The Gay Science (J. Nauckhoff, Trans.). Cambridge University Press

Olivier, B. (2017). The ethical (and political) status of theorizing the subject: Deleuze and Guattari. Psychotherapy and Politics International, 15(2), e1408

Onishi, B. B. (2011). Information, Bodies, and Heidegger: Tracing Visions of the Posthuman. Sophia, 50(1), 101-112.

Papadopoulos, D. (2010) Insurgent posthumanism. Ephemera 10(2): 134–151.

Parisi, L. (2004) Abstract Sex: Philosophy, Bio-Technology, and the Mutation of Desire. Continuum.

Parikka, J. (2015). The Anthrobscene. University of Minnesota Press.

Parolin, L.L. (2022). A posthumanist approach to practice and knowledge: Capitalist unrealism: Countering the crisis of critique and imagination. Ephemera, 22.

Pepperell, R. (2003) The posthuman manifesto. Intellect Quarterly

Raffnsoe, S. (2013) The Human Turn: The Makings of a Contemporary Relational Topography. Copenhagen Business School.

Roden, D. (2014) Posthuman Life: Philosophy at the Edge of the Human. Routledge.

Roffe, J. (2015). Objectal Human: On the Place of Psychic Systems in Difference and Repetition. In H. Stark & J. Roffe (Eds.), Deleuze and the Non/Human (pp. 42-59). Palgrave Macmillan.

Roffe, J. (2020). The works of Gilles Deleuze: Volume 1 - 1953-1969. re.press.

Roffe, J., & Stark, H. (2015). Introduction: Deleuze and the Non/Human. In Deleuze and the Non/Human (pp. 1-16). Palgrave Macmillan UK.

Semetsky, I. (Ed.). (2008). Nomadic Education: Variations on a Theme by Deleuze and Guattari. Sense.

Sheldon, R. (2015). Form/matter/chora: Object-oriented ontology and feminist new materialism. In R. Grusin (Ed.), The Nonhuman Turn (pp. 193-222).

Shildrick, M. (2009) Discourses of Disability, Subjectivity and Sexuality. Palgrave Macmillan.

Shildrick, M. (1996). Posthumanism and the Monstrous Body. Body & Society, 2(1), 1-15.

St. Pierre, E. A. (2023). Poststructuralism and Post Qualitative Inquiry: What Can and Must Be Thought. Qualitative Inquiry, 29(1), 20-32. https://doi.org/10.1177/10778004221122282

Stark, H., & Roffe, J. (2015). Deleuze and the Non/Human. Palgrave Macmillan

Stengers, I. (1997) Power and Invention: Situating Science. University of Minnesota Press.

Sterling, B. (2014) The manifesto of speculative posthumanism

Swarbrick, D. (2017). Deleuze, Gilles. Genealogy of posthumanism. https://criticalposthumanism.net/deleuze-gilles/#_edn1

Taylor, C. A. (2016). Close encounters of a critical kind: A diffractive musing in/between new material feminism and object-oriented ontology. Cultural Studies? Critical Methodologies, 16(2), 201-212. https://journals.sagepub.com/doi/pdf/10.1177/1532708616636145

Thomsen M.R. (2013) The New Human in Literature: Posthuman Visions of Change in Body, Mind and Society after 1900. Bloomsbury Academic.

Tsing, A. (2015) The Mushroom at the End of the World: On the Possibility of Life in Capitalist Ruins. Princeton University Press.

Warbrick, I., Heke, D., & Breed, M. (2023). Indigenous Knowledge and the Microbiome-Bridging the Disconnect between Colonized Places, Peoples, and the Unseen Influences That Shape Our Health and Well-Being. mSystems, e0087522.

Weheliye, A. G. (2014). Habeas Viscus: Racializing Assemblages, Biopolitics, and Black Feminist Theories of the Human. Duke University Press Books.

Wennemann, D.J. (2013) Posthuman Personhood. University Press of America.

Wolfe, C. (2010) What Is Posthumanism? University of Minnesota Press.

Wolfe, C. (2018). Posthumanism. In R. Braidotti, & M. Hlavajova (Eds.), Posthuman glossary (pp. 356–359). Bloomsbury Academic.

Woodward, A. (2015). Nonhuman life. In H. Stark & J. Roffe (Eds.), Deleuze and the Non/Human (pp. 25-41). Palgrave Macmillan.

Post-professional compendium

Between June and October 2023 I wrote eight ‘Stackposts on the theme of post-professionalism. This followed on from the first series on posthumanism that you can find here. As with that edition, I’ve collated all eight articles here into one compendium for ease of reading.

I’ve removed all of the decorative images and assimilated the references into one long list at the foot of the article.

Post-professionalism — Part 1 — Introduction

21 June 2023

Most people alive today would find it hard to imagine a healthcare system that wasn’t underpinned by a small group of elite and established professions.

To even imagine that a person might engage in healthcare without the mediating influence of doctors, nurses, midwives, occupational therapists, physiotherapists, psychologists, and others, would seem incomprehensible.

But this is exactly what post-professionalism tries to imagine.

Over the course of the next few weeks. I want to try to set down some of the key principles of post-professionalism, and examine:

1. What it is;
2. What its main theories and ideas are;
3. How it is shaping and disrupting healthcare;
4. And why it's been largely absent from the professional literature to date.

So, here's a bit of a taster of what's to come.

What is post-professionalism?

Post-professionalism is a relatively new term in healthcare.

The term was first used in the 1980s in the work of Ivan Illich, Terry Johnson, and Eliot Freidson, and has been applied to a wide range of other sectors but has only recently been applied to healthcare.

Post-professionalism does not refer to the complete disappearance of the professions, but rather their increasing decentralisation.

It argues that the established, traditional, orthodox, and legitimate professions will become increasingly marginal social actors, and people will make use of increasingly diverse resources to meet their healthcare needs.

Post-professionalism provides a set of conceptual tools to analyse today's atomised, digitally disrupted, globalised, neoliberal, and postmodern zeitgeist.

Where once people said, "The doctor knows best", in the post-professional era they are more likely to say, "The patient will see you now" (Topol, 2016).

What has made post-professionalism possible?

There are many reasons for the post-professional turn, here are two of the biggest:

1. The late, or advanced, capitalist shift from the pursuit of unlimited growth and surplus value through the 'external' colonisation of people and land, to the 'inward' atomisation of the body and health. Bodies and health are the new, almost limitless, frontier for commodification, innovation, and market expansion.
2. The critical unbundling of the orthodox professions' claims to goodness and expertise (Burns, 2019), underpinned by the belief that the professionalisation project of many healthcare professions is coming to an end after 150 years of notable successes but also some significant failures.

Where can we see post-professionalisation at work?

The challenges now facing the professions are many and varied. Consider this list, for example:

- The increasing demands for holistic healthcare for ageing populations of increasingly complex, co-morbid, chronically ill people;
- Digital technologies and the rapid rise of AI and digital data;
- People's appetite for personalised healthcare demanding more choice, greater flexibility, and more control over the services they receive;
- Demands for ever-increasing levels of professional expertise and specialisation, married to the publics' progressive loss of faith in once-powerful — often professional — authorities;
- The pressure to remain up-to-date with the latest evidence-based findings;
- The loss of control of knowledge that was once 'ours' (with most of the information contained within a health curriculum now openly available online);
- Threats of encroachment from other professions looking for competitive advantage and greater social prestige;
- The rising cost of healthcare matched with the desire by governments to cut and contain healthcare expenditure; the rapid privatisation and atomisation of health and the growing social gradient between those who can afford professional care and those who cannot;
- The downstream costs of unhealthy lifestyles;
- The growing critique of the regulated professions for their intransigence, stubbornness, and resistance in the face of change.

We can add to this list some very 'local' anxieties that many of the healthcare professions are expressing individually, including that:

- The profession is spread too thin;
- Our professional status is in decline, and there doesn't appear to be a clear plan for how to get it back;
- We lack the skills to be creative and innovative;
- Evidence-based research repeatedly undermines what we know to be good about our work;
- Our many healthcare professions are engineered for curative approaches towards acute, episodic illness and injury, in a world that needs sustained, long-term care where no ready fix is possible;
- Our remuneration is not keeping pace with rising student debt, making our professions less and less attractive to new graduates;

- Our care model was always individualistic, meaning we have no scaleable, population-level approach to healthcare.

To date, the professions have seen themselves as sovereign entities that must outlive these problems to survive. Post-professionalism inverts this belief, seeing the professions instead as contingent responses, effects, or achievements of biopolitical and governmental rationalities.

In post-professionalism, the professional era is seen as a recent historical invention (a largely Victorian middle-class prestige project) that served society well — mostly — during the 20th century, but is now coming to an end.

Post-professionalism is concerned with what follows.

Over the coming weeks I will try to unpack the arguments around post-professionalism in more depth and, as with the post-humanism pieces, try to provide resources and readings for further study.

Post-professionalism — Part 2 — Atomisation and the arrival of late capitalism

12 July 2023

There are no end of challenges now facing the health professions, but can we define some of the principal drivers of the post-professional movement specifically?

Most of the literature points to three main discursive forces behind the idea that the professions will be removed from the centre of healthcare thinking and planning over the next decade or so:

1. Atomisation under late capitalism
2. The unbundling of goodness and expertise
3. Digital disruption

Let's begin with the first of these.

The emergence of late capitalism

Late, or advanced, capitalism is so called because of the distinctive way it reimagines the capitalist project of unlimited growth and progress.

Where early capitalism generally referred to the period from the 17th to the 20th centuries, and is synonymous with the industrial revolution and the development of high-income economies in the West, late capitalism has really only emerged since the 1970s.

Early capitalism functioned by feeding domestic growth with the expansion (read, forced colonisation and enslavement) of other territories and peoples. As resources for growth became depleted at 'home', colonial enterprises reached across the globe to feed continuing growth.

In many ways, the birth of the orthodox health professions – along with many others within the professional classes (administrators, public servants, teachers, and so on), – derives from the need to have an 'enabling class' of trusted, regulated, and socialised workers who could perform the necessary 'soft' colonisation as a marker of the 'civilisation' and 'ruthless benevolence' (Fitzpatrick and Protschky 2009) of the colonial power.

By the middle of the 20th century, however, attitudes towards aggressive colonisation, land disposition, wars and treaties of convenience, the imposition of Western cultural systems, religious missionary work, and other forms of asynchronous power came under increasing critical scrutiny.

What precipitated the move away from early capitalist ideologies, however, was not growing public consciousness, but rather the twin forces of declining domestic prosperity and increasing unavailability of new lands and peoples to exploit.

Fortunately – and here it hardly bears mentioning that I am being ironic – a solution was found to invert the logic of early capitalism and exploit a new, inconceivably vast, previously untapped market: a market that would have profound implications for healthcare.

New forms of capitalism began to emerge in the mid-1970s with a raft of neoliberal economic reforms, new forms of global economic market speculation, and the automation and restructuring of commodity supply chains.

At a superficial level, these seem quite dry, economic and political changes. But what day did was to turn the idea of unlimited growth and expansion inwards. Instead of looking overseas for new lands and people to exploit, late capitalism has turned inwards; towards individual people: towards people's bodies, people's lifestyles and habits, people's relationships, and people's work.

In fact, every possible facet of human existence was turned into its own specialised field, replete with commodities and consumer goods, as well as a raft of dedicated advisors, analysts, coaches, counsellors, experts, influencers, practitioners and therapists.

In effect, every single aspect of human life has been atomised: turned into its own market. And the possibilities for unlimited growth — and the future for a new form of capitalist exploitation — appears restored.

This has obvious implications for all of the established health professionals because, on the one hand, we have seen a vast new field emerge in which the knowledge and skills we once commanded have taken on new relevance. But, on the other hand, this newly 'atomised' human being has been opened up as a market for any and all who can find an as yet un-tapped economic opportunity.

Late capitalism is forcing the complete reorganisation of the orthodox health professions, but it is only one of the main drivers of change we need to consider. Next week I will look at the second of these drivers – the unbundling of goodness and expertise.

Post-professionalism — Part 3 — Unbundling of goodness and expertise

19 July 2023

Alongside late capitalism, perhaps the next most important discourse shaping the post-professional era is what Edgar Burns has called the unbundling of goodness and expertise

Let's get into that now.

Health professionals are not as altruistic and public-spirited as they would have us believe

> 'we 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' (Susskind and Susskind, 2015).

At the heart of the unbundling claim is the argument that professionals have long believed themselves to be altruistic and public-spirited; that they are disinterested in personal or professional status; that they are models of ethical comportment; bearers of specialised knowledge and affectively neutral.

Since the 1980s, however, authors like Ivan Illich, Eliot Freidson, Terry Johnson, and Magali Larson have challenged that belief.

By contrast, these authors portray the professions as inherently conservative, protectionist, deeply self-interested, disproportionately advantaged, and promoting attitudinal mythologies inherent to maintain them as apex social actors.

They highlight the 'inverse care failures' of aged care facilities, mental health institutions, professional training institutes, and workplaces.

They draw attention to the professogenic effects that are 'systematically produced as part of the social organisation' of things like healthcare (Wrigley & Dreby, 2005).

And they accuse the professions of being agents of the capitalist state, patriarchal, racist, discriminatory, ableist, ageist, homophobic, and heteronormative (Abbott & Meerabeau, 1998).

What unbundling is doing

What Burns and others show is 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’ (Nicholls, 2022).

In other words, professionals hold no monopoly on goodness and expertise and while these claims might have been the basis for the professions’ claims to prestige and privilege in the past, they are no more.

So those resources, knowledges, roles and responsibilities once held within protective enclosures by the professions are now becoming increasingly democratised.

The social capital that they once controlled is being more widely distributed across a more diffuse network of social actors, such that the historical professions are just one mechanism among many through which people experience health and healthcare.

Inevitably, the professions are seeing their hard-won power and prestige diminish, and many are struggling to come to terms with this. But another factor in post-professionalism is the declining ability of the professions themselves to control events. Leading some to suggest that;

> ‘trusting the health professionals to bring about reform themselves is akin to the ‘rabbits guarding the lettuce’ (Susskind and Susskind, 2015), particularly given how adept the health professions have been in the past at ensuring their territorial security’ (Nicholls, 2022).

As Edgar Burns suggests;

> ‘While post-professionalism does not deny that society needs the service of articulate, clever, society-oriented actors and professionals, who can be a human beacon in a world of juridified, formalised, corporatised correctness, it does assume that professionals will be less important than they used to be’ (Burns, 2019).

A new opening

In the 17th and 18th centuries in Britain, common land was increasingly consolidated and privatised. People that used to farm, graze and glean in common with others were increasingly denied access as the land was turned to profit for landowners.

Unbundling makes the same claim about the professions: that they took lucrative aspects of healthcare and colonised them for their own benefit.

Part of the power professionals took for themselves was the ability to control the labour supply, and thereby ensuring demand.

In disability studies, professionals have been called parasites for their willingness to endlessly invent new forms of disability that they are conveniently best placed to address (Swain, French and Cameron, 2003).

But this self-interested privilege has now become a critical weakness for the professions because, 'If professionals are only able to share their experience and knowledge by advising on a face-to-face basis, then there can be few beneficiaries of the genuinely outstanding' (Susskind and Susskind, 2015).

Susskind and Susskind continue;

> '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… 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' (Susskind and Susskind, 2015, emphasis added).

Perhaps unsurprisingly, many advocates for post-professionalism would see the capacities, knowledges, and resources that the professions once claimed as their own returned to the people.

And, in truth, this is now happening at a remarkable rate sometimes because, but often despite the professions themselves. I'll cover some of this in the next instalment when we tackle the third main driver of post-professionalism: digital

Post-professionalism — Part 4 — Digital disruption

26 July 2023

Over the last 20 years, we have seen the gap between what is analogue and what is digital, what is human and what is machine, collapse.

Consider this on the hyper-personalisation of AI in a recent 'Stackpost from Scott Belsky. Keep in mind the earlier piece in this series on atomisation and late capitalism, and also how things like this are going to affect future healthcare practice;

> 'Two weeks traveling Japan proved to be the perfect setting to contemplate some of the sweeping changes facing our society over the coming years and decades. The smart people I know generally agree that 80% of the work of 80%+ of jobs will be refactored significantly by AI… And it's still early days! So, the question that keeps me up at night is, what are us humans gonna do with all of our newfound time? Which brings me back to Japan, and this quaint Kyoto restaurant I found myself sitting in one evening. There were 10 seats, one chef/owner and one apprentice, and the most incredibly crafted experience. It wasn't expensive, but everything was intentional. I found myself admiring this sensational and remarkably unscalable experience. The chef seems to make a good living, loves meeting interesting people, and gets to be wildly creative (the selection of glassware, the decor, the care and craft applied to every dish). Japan is full of these experiences, where art, curiosity, and craftsmanship yield tiny scattered wonders like "owl cafes," micro arcades, plastic food shops, cotton candy shops, and the list goes one. I found myself wondering, why aren't there 1000x more of these experiences in all societies? Why must the purpose of business be to scale, grow bigger, become franchises, squeeze in more seats, and compromise quality for automation and reach? Could a fundamental change in society, like mass automation and AI, spur both the growth and demand of human-intensive highly crafted unscalable experiences?' (Belsky, 2023).

Of course, people like the economist John Maynard Keynes and the philosopher Bertrand Russell have been arguing that future humans will benefit greatly from automation since the 1930s, but the effects of digital disruption go far beyond questions of whether robots will do most of the surgery, triaging, prescribing, diagnosing, therapy, and empathy work of healthcare in the future. (They will).

Perhaps the most telling digital disruptions have arrived with some of the most mundane technologies. People's ubiquitous use of digital Google Maps, for instance, has meant that people are rarely ever lost anymore. Being lost and using one's own wits to find safe haven has always been a crucial human skill. Perhaps people in the future will be less resourceful when they encounter serious illness having never had to find their way out of the woods at night.

Spotify and Apple Music have given us the ability to play only the songs we love. But has this engendered a belief that other things like educational pathways and healthcare choices should work the same way?

Facebook, Instagram, Twitter, TikTok, and other social networking apps have replaced validation by proof with popularity. And YouTube and Wikipedia have shown us that professionals were never the only repositories of expertise and that so much knowledge could be shared for free.

We may be experiencing the most disruptive period ever in the history of healthcare with changes happening at lightning speed. Tomorrow's healthcare professional is a 10-year-old on Discord today. How they see the world will shape the future of healthcare.

Daniel and Richard Susskind in their book The Future of the Professions make the point that 'If professionals are only able to share their experience and knowledge by advising on a face-to-face basis, then there can be few beneficiaries of the genuinely outstanding' (Susskind and Susskind, 2015).

This is a very common feature of many forms of healthcare practice and part of the reason they believe digitisation will have such a profound impact on our work. Digitisation succeeds because it offers the promise of mass customisation and personalised care; 'systems and processes that do indeed meet the specific needs of individual recipients of service, and yet are implemented with a level of efficiency that is analogous with mass production' (ibid).

Put another way, digitisation is how the health professions' monopoly on goodness and expertise is finally broken by late capitalist atomisation.

Scott Belsky seems to suggest that such large-scale, digitally-mediated personalisation may be the direction centralised healthcare tracks in the future. But he also suggests that such moves will create spaces in which other forms of work become possible: work that goes in the opposite direction and makes a virtue out of bespoke care;

> 'As human workflows are refactored by a step-function and our capacity is liberated, I see a compelling future where the demand for and economic viability of crafted non-scalable experiences transforms society. The "experience economy," is already underway with the emergence of experts for everything - from lactation consultants and pet therapists to for-hire violinists and chefs and…who knows what's next. I enjoyed this post (Poleg, 2023) by Dror Poleg where he forecasts a world where "most people no longer need to work. Our survival depends on convincing them it's ok to do

> something else." "There are many more professions to invent," he declares, "and they will only be invented if more people experiment."' (Belsky, 2023).

Then again, perhaps AI will do this for us.

Post-professionalism — Part 5 — The politics

9 August 2023

We can read the history of the professions in a number of ways. They have been a:

- reflection of a desire to bring order to society;
- mirror of a feudal, patriarchal, Western social order;
- tool for emancipation pursued by previously marginalised people — women, working classes, racialised minorities, etc.;
- vital cog in the machinery of soft colonisation;
- way to humanise the alienation of wage slavery;
- vehicle to provide healthcare, education, and public administration in the most efficient and trustworthy way.

But however one looks at the professions, what is clear is how closely they have been tied to the idea of modern forms of governmentality.

Securing people's health and vitality was both a means to maximise the population's productivity and efficiency, but also a way to manage the inherent contradictions of modern life. (We want cheap coal but hate the idea that mining is dangerous, so we offer healthcare as a way to ameliorate our ethical conflict.)

So the link between the health professions and 'the state' has always been strong. In fact, I've suggested in recent years that without the state, some professions like physiotherapy would likely not even exist (Nicholls & Harwood 2016a; 2016b; 2017; Nicholls 2022; 2023).

By contrast, one of the driving forces behind post-professionalism today is the belief that there is a growing distance between 'the state' and the professions.

As Deleuze pointed out, the disciplinary society has largely been replaced by a society of control.

In the disciplinary society, a person's life was marked by their passage through a series of regulated institutions — the family, school, the barracks, the university, the factory, the office, the professions, etc. But with the advent of digital technology and many new forms of

remote surveillance, it's no longer necessary for a person to be held within these institutions in order to be governed.

Now, it's even desirable that the person explores far and wide beyond the boundaries of institutions if only to test the system's ability to keep track of them and monitor their consumption and feed their desires.

In a society of control, professions no longer work as a central plank of government but act only as one of its many arms: an arm that looks increasingly inflexible and too muscular to be of use in the slippery plastic world of person-centred healthcare.

Crucially, this shift happened regardless of political ideology and the forces of reform have come from both left and right.

On the right, the established professions have been criticised for their monopoly power, for being expensive, statist, controlling, unionised, for promoting passivity and dependence in people, and for being ineffective in boosting economic productivity.

On the left, the professions have been criticised for being in service of capitalism, ableist, misogynistic, racist, elitist, colonial, conformist, and Victorian.

Neither left nor right, it seems, want to hold on to the virtues of an enabling middle class whose place in the social order was once taken for granted.

Who, then, speaks up for the professions?

Without the same political support that the professions enjoyed during the greater part of the 20th century, only the professions themselves are now advocating for the continuation. They have done this since the 1980s in a number of ways:

- by promoting evidence based practice and hierarchies of evidence;
- in claims to now being person-centred (with the implication being that they believe they were not before);
- through new territorial claims to holism and biopsychosocial;
- through inter-, multi-, and trans-professional collaboration;
- greater openness to complimentary and alternative approaches, and so on.

The salient point here though, is that these responses are a stark reminder that the professions are an effect or achievement of shifting social discourses. They are not, themselves, the agents of their own destiny.

They are an answer to a series of problems that have been posed in largely high-income economies over the last 150 years.

But as Foucault reminds us, they are neither the only nor necessarily the best solution to the problems that society faces. They are merely one contingent response amongst many.

The likelihood is that we are in the late stages of the professional era and that many new solutions will emerge in the coming decades for concerns like the accelerating planetary health crisis, growing inequality, and the mind-boggling complexity of health.

The professions may form part of a panoply of solutions, but without their political patrons – of any stripe – it is likely their role will be significantly curtailed as years go by.

The question that the professions themselves should be asking, then, is how can they best democratise and share the privileges and benefits they have acquired over the last century or more?

In the next piece, I'll look at some of the ways the professions are actually responding and show that, sadly, their instinct to preserve their status appears to be currently overriding their desire to nurture the greatest access for the greatest number of people. Ironically, of course, this kind of reaction is one of the main drivers of post-professionalism in the first place. Something we will return to next time.

Post-professionalism — Part 6 — Diagnosis

16 August 2023

How do we know that post-professionalism is taking hold in healthcare? Where would we look to find signs of the atomisation of the body, late capitalist expansion, the unbundling of goodness and expertise, and digital innovation? And, if we found them, would they represent a genuine break with the everyday incremental kinds of change that people in healthcare seem to have experienced all of their lives?

Given how complex health care is, it's hard to be absolutely definitive about the degree to which post-professionalism is becoming the dominant discourse. However, although one could point to innovations and healthcare reforms as evidence of post-professionalism, perhaps the paradigmatic sign of a new philosophy of healthcare can be found in the professions and disciplines themselves, and the way they are reacting to this new epoch.

In Physiotherapy Otherwise, I set out four broad archetypes to explain the ways that the physiotherapy profession internationally appears to be responding to post-professionalism. Although these archetypes relate directly to physiotherapy, I think there are many commonalities across the entire healthcare spectrum.

Here are the four archetypes:

1| Watching and waiting

Perhaps the hardest to locate, this approach is the most conservative response with the profession trusting in its stability, and arguing that reactive change might endanger the profession's future prospects. Innovations are sometimes described as trends or fads, or threats that the profession has faced down before. And the profession is reassured that people have nothing to worry about and that the future won't be that dissimilar to today.

Pros: the profession promotes a sense of confidence amongst its members and reassures people that the profession is here for the long haul.

Cons: the profession gets left behind and becomes obsolete, replaced by more agile competition, or what Susskind and Susskind call 'viable alternatives'.

2| Modern heritage

This approach sees the profession return to its founding values; its most grounding ontological presuppositions. As a way of actively resisting the threat of radical reform, people within the profession call for a return to core values. New ways of thinking and innovation become the target of critique, and the profession's history is mobilised to remind members how the profession got here in the first place.

Pros: this is a very straightforward professional identity to 'sell' to members, the public, funders and regulators. It is often very familiar, particularly to elite members of the profession who have prospered because of their mastery of the same core values. And it is often easy to consolidate in a curriculum or revisionary scopes of practice.

Cons: the biggest danger here is that the profession is actively marginalised because it fails to address changing social priorities. It might be seen to serve the interests of the profession's elite, or the kind of population that the profession was suited to in the past. In both cases, the profession may be seen as arcane and increasingly irrelevant.

3| Renaissance

This approach involves throwing the baby out with the bathwater, radical professional reform, the subversion or inversion of traditional values, and a desire to profoundly redesign the profession's identity and purpose.

Pros: this is perhaps seen as the most responsive of the four archetypes because it shows that the profession is attuned to shifting social dynamics, as well as being agile enough and willing to adapt when the need arises.

Cons: the biggest danger of this approach is that it can be extremely unappealing to those people within the profession who have built their professional identity on an earlier image that has now been rejected. This can make it very difficult to change curricula or scopes of

practice because the very people who have to instigate the change are the ones that don't want it to happen.

4| Hybrid

The fourth and final archetype is, perhaps, the one that has the broadest appeal and the one that has so far had the widest impact in healthcare. The hybrid approach attempts to take the best of the profession's past and incorporate the best of the new. In many cases, this opens up the possibility of a new 'holistic' professional identity in which traditional professional boundaries become much more porous.

Pros: for many within the profession, the hybrid approach creates the possibility for a much more diverse and inclusive understanding of the profession. It can liberate many people to finally acknowledge aspects of the profession that were previously latent or sublimated. It may open up the possibility for territorial expansion and justify the expansion of the profession into new markets and new territories.

Cons: the biggest danger with a hybrid approach is that it embraces such a wide set of beliefs about the nature of the reality of healthcare (that it is biologically based, experientially based, culturally based, environmentally based, spiritually based, socially based, or all of the above) that people can no longer see clearly what the profession believes or stands for. In trying to be all things to all people, the professional loses the distinctiveness and has to operate at a much more superficial level that, in the end, doesn't require the kinds of depths of training that conventional approaches demand. Similarly, the curriculum now takes 17 years to complete and teaches the student one thing in the morning, and it's direct obverse in the afternoon. All is confusion.

We are seeing some or all of these archetypes being played out in the different healthcare disciplines today. But as can be seen, there isn't any one approach that does not come with some significant flaws.

As diagnostic tools, though, they do show the degree to which all of the professions are now asking fundamental questions about their ongoing viability.

And whereas in the 'golden age' of the health professions the question was really only how the orthodox and legitimate state-sanctioned professions could work most efficiently in an otherwise stable and unchanging field, the professions are all now asking whether the field even exists in the same way does it used to.

One of the features of this new field is a change in the ability of the professions themselves to influence the future.

In the previous post in this series I argued that one of the two main features of post-professionalism is the degree to which the professions are having their own agency de-centred, suggesting that even if the professions do adopt a modern heritage, renaissance or hybrid approach, it will have little impact on the relentless turn away from the professions as a governing principle in western healthcare today.

So, what might be a more viable way forward for people within the professions, if their future is going to be increasingly marginal?

This will be the subject of the last substantive post in the series looking at the future for the professions in a post-professional world.

Post-professionalism — Part 7 — Do the professions have a future?

30 August 2023

To even begin to answer this question, we need to establish a few principles: key things to remember when we debate whether the professions even have a future.

Firstly, what we are talking about here when we talk about ‘the professions’ is the future for a particular social class: an ‘enabling’ class of people, and a relatively recent historical invention. They are neither the only nor necessarily the best solution for social problems like illness and disability. They are simply one — albeit unprecedented — contingent response among many.

Secondly, the vast majority of the literature now makes it clear that the only people now really advocating for the professions are the professions themselves. What this means, though, is that as long as professions like medicine and nursing continue to hold enormous power and prestige, it will appear that the professions have an important part to play in the future of social organisation. But what we now know from late capitalism, the unbundling of goodness and expertise, and the automation and rapid digital transformation of human affairs, is that the Doomsday clock for healthcare and education is already sitting at 11:55 pm and ticking, ticking, ticking.

And so, even though it seems hard to conceive of a time when we won’t have professionals like physiotherapists, podiatrists, audiologists, and even doctors and nurses running our healthcare system, there is an increasing argument to be made that if those of us within the profession genuinely care about the future of health, it is our ethical duty to think about a future in which healthcare is a) not delivered by the current cadre of elite professionals, and

b) does not return to a pre-modern world in which healthcare is a luxury for those who can afford it or mere charity for those who cannot.

Thinking about a post-professional future in this way will not be easy though, and it's likely that the greatest resistance to change will come from the professions themselves. So, is there a process that can be generative for the public and the professions? I think there is.

To begin with, the established professions will need to put in place 'transition arrangements' that transfer power and knowledge to communities of need. These arrangements uncouple each profession from its established allies — including The State — and actively work to redesign legislation; nurture trust and capability; share a century or more of wisdom, knowledge and resources; and relentlessly build capacity.

In many ways, this is a post-colonial project, because the establishment of the professions bears many similarities to other historic acts of enclosure. So, the transition arrangements mentioned above are effectively designed to "give the land back to the people." But those people who have been through the traumas of post-colonial succession will know all too well that the actions of the colonial powers in leaving their occupied territories can make all the difference to the way resources are returned to their rightful owners. And the transfer of health back to the community will depend very much on how begrudgingly, or otherwise, the orthodox professions give up their power.

Is this not, then, an entirely counter-intuitive step for the professions to take? After all, why would turkeys vote for Christmas?

The answer to this may lie in a parallel process that needs to be followed within the professions themselves.

Alongside these 'outward facing' transition arrangements, there will need to be internal arrangements made which might make all the difference to the success of the project. These internal arrangements have to do with the way that professionals are coached to entirely rethink their professional purpose. Instead of valorising the preservation of their distinctive professional identity, autonomy and sovereign authority, health professionals will need to understand that their knowledge and skills will continue to play an important role in future health care despite the demise of their professional class. People's predisposition to care, to want to heal, and to act therapeutically, is as ancient as their urge to domination, conflict, and destruction. And so, just as the negative traits of humankind are unlikely to dissipate in post-modern life, so is its caring. What this means is that those things that endure and remain after the instrumental and reductive aspects of healthcare practice our hollowed out, will play a key role in future healthcare.

There are ‘intensities’ at the heart of healthcare that have been captured and exploited by the orthodox health professions over the last century. But these have been somewhat obscured by layers of standardisation, technique, reason, formalisation, and instrumental objectivity. And so the ‘essences’ of these various practices are now very hard to see. But they are there nonetheless.

This is why there is now a close tie in between post-professionalism and some of the recent work on posthumanism, because a lot of this work has been directed to the study of the essential vitality of ‘things’ – be they non-human objects, metaphysical processes, social constructs, or human feelings. If there is something lying ‘beneath’ professionalised healthcare that can be mobilised in a future in which the controlling, elite professions no longer carry the same weight — whilst, at the same time, resisting the nihilistic logic of neoliberalism and the totalising spirit of the Welfare State — then, perhaps it’s possible to see why posthumanism is becoming increasingly interesting to those people working in healthcare, and why a post-professional future might be the best thing to happen to healthcare since the first Being went back to the primordial swamp for a hot bath.

Post-professionalism — Part 8 — Key readings

4 October 2023

Here I want to highlight some of the key texts in the post-professional literature.

Five key texts

1. Edgar Burns’s *Theorising professions: A sociological introduction* does as much as any text to lay out the argument for why we have now entered a post-professional era. If you read only one book on post-professionalism, this would be the one I would recommend.
2. If you wanted a general introduction to the contemporary conditions now producing post-professionalism, you might look at Richard and Daniel Susskind’s excellent *The future of the professions*.
3. The origins of our understanding of post-professionalism lies in post-Marxian and neo-Weberian sociology of the 1970s, which radically critiqued professionals’ claims to goodness and expertise. A lot of that work (see, for instance, Johnson, Larson, Witz, Abbott, et al below) started with Eliot Freidson’s iconoclastic *The profession of medicine: A study of the sociology of applied knowledge*.
4. But perhaps the most scathing attack on the professions came from three 1970s masterpieces by Ivan Illich: *Medical nemesis* and *Disabling professions*, all predated by

Deschooling society (with its nod to Jacques Rancière's *The ignorant schoolmaster* referenced below).

5. And we cannot talk of post-professionalism without mentioning Silvia Federici's groundbreaking 1975 feminist study *Wages against housework*.

Some notable additions:

Abbott A. (1998). The System of Professions: An Essay on the Division of Expert Labor. Chicago, IL: University of Chicago Press.

Fournier V. (2000). Boundary work and the (un)making of the professions. In: Malin N, editor. Professionalism, boundaries and the workplace. Abongdon, Oxon: Routledge. p. 67-86.

Johnson T. (1972). Professions and power. London:

Larson MS. (1977). The rise of professionalism: A sociological analysis. Berkeley: University of California

Rancière J. (1991). The ignorant schoolmaster: Five lessons in intellectual emancipation. Stanford: Stanford University Starr, P. (1982). The social transformation of American medicine. New York: Basic

Witz A. (1992). Professions and patriarchy. Abingdon, Oxon: Routledge.

Some current thinking

In recent years most of the sociological work has focused on the margins of traditional professional territory, either in the form of new professional work or new professional identities (Kronblad & Jensen, 2023; Hayes, Kulkarni & Lee, 2023). Much of this has focused on forms of 'hybrid' professionalism — an almost ubiquitous term in the literature today.

Perhaps the most heavily cited work in recent times comes from Mirko Noordegraaf and his team in Utrecht. Noordegraaf introduced the concept of 'connective professionalism' (Noordegraaf et al, 2014; 2015), arguing that new professional work will be much more about connection than boundary protection. Some have suggested this only replaces one bad hegemony with another form of 'ideal type' professional identity (Adams et al, 2020).

And in healthcare, a great deal of work is now going into professional work in aged care, new approaches caring and therapeutic work, and the clamour for regulation of a raft of new professions (see, Kamp & Dybbroe, 2023; Sedda & Hussan, 2023; Syrigou & Williams,

References

Adams, T. L., Clegg, S., Eyal, G., Reed, M., & Saks, M. (2020). Connective professionalism: Towards (yet another) ideal type. Journal of Professions and Organization, 7(2), 224-233. https://doi.org/10.1093/jpo/joaa013

Belsky, S. (2023). The Personalization Wave, A Surge of Wildly Human-Intensive Non-Scalable Experiences, & Ideas Of The Month. Implications (7 May 2023). https://www.implications.com/p/the-personalization-wave-a-surge

Burns, E. A. (2019). Theorising professions: A sociological introduction. Palgrage Macmillan.

Fitzpatrick MP, Protschky S. (2009). Families, frontiers and the new imperial history. The History of the Family. pp. 323-326.

Hayes, C., Kulkarni, C., & Kee, K. F. (2023). The situational window for boundary-spanning infrastructure professions: Making sense of cyberinfrastructure emergence. Journal of Professions and Organization. https://doi.org/10.1093/jpo/joad007

Kamp, A., & Dybbroe, B. (2023). Training the ageing bodies: New knowledge paradigms and professional practices in elderly care. Sociol Health Illn. https://doi.org/10.1111/1467-9566.13675

Kronblad, C., & Jensen, S. H. (2023). 'Being a professional is not the same as acting professionally'—How digital technologies have empowered the creation and enactment of a new professional identity in law. Journal of Professions and Organization. https://doi.org/10.1093/jpo/joad005

Nicholls, D.A. & Harwood, G. (2017) Physical therapies in 19th century Aotearoa/New Zealand: Part 3 – Rotorua Spa and discussion. New Zealand Journal of Physiotherapy 45(1): 9-16. doi: 10.15619/NZJP/45.1.02.

Nicholls, D.A. & Harwood, G. (2016b). Physical therapies in 19th century Aotearoa/New Zealand: Part 2 – Settler physical therapies. New Zealand Journal of Physiotherapy, 44(3), 124-132. doi: 10.15619/NZJP/44.3.02

Nicholls, D.A., Harwood, G. & Bell, R. (2016a). Physical therapies in 19th century Aotearoa/New Zealand: Part 1 – Māori physical therapies. New Zealand Journal of Physiotherapy, 44(2), 75-83. doi: 10.15619/NZJP/44.2.02.

Nicholls, D. A. (2022). Physiotherapy Otherwise. Tuwhera Open Access. https://ojs.aut.ac.nz/tuwhera-open-monographs/catalog/book/8

Nicholls, D.A. (2023). Is physiotherapy a luxury? What can the perplexing absence of the physical therapies tell us about the profession's future? Physiotherapy Theory & Practice. https://doi.org/10.1080/09593985.2023.2211675

Noordegraaf, M., Van Der Steen, M., & Van Twist, M. (2014). Fragmented or connective professionalism? Strategies for professionalizing the work of strategists and other (organizational) professionals. Public Administration, 92(1), 21-38. https://doi.org/10.1111/padm.12018

Noordegraaf, M. (2015). Hybrid professionalism and beyond: (New) Forms of public professionalism in changing organizational and societal contexts. Journal of Professions and Organization, 2(2), 187-206. https://doi.org/10.1093/jpo/

Poleg, D. (2023). God, AI, and the Scalable Class. Drog Poleg (24 March 2023). https://www.drorpoleg.com/god-ai-and-the-scalable-class/

Sedda, P., & Hussan, O. (2023). Social media influencer: a new hybrid professionalism in the age of platform capitalism? In L. Maestripieri & A. Bellini (Eds.), Professionalism and Social Change: Processes of Differentiation Within, Between and Beyond Professions. Palgrave Macmillan. https://hal.science/hal-03700657

Susskind, R., & Susskind, D. (2015). The future of the professions. Oxford University Press.

Swain, J., French, S., & Cameron, C. (2003). Practice: are professionals parasites? In Controversial issues in a disabling society (pp. 131-140). Open University Press.

Syrigou, A., & Williams, S. (2023). Professionalism and professionalization in human resources (HR): HR practitioners as professionals and the organizational professional project. Journal of Professions and Organization. https://doi.org/10.1093/jpo/joad008

Topol, E. (2016). The patient will see you now: The future of medicine is in your hands. Basic Books.

Wrigley, J., & Dreby, J. (2005). Fatalities and the organization of child care in the United States, 1985–2003. American Sociological Review, 70(5), 729-757.

Chapter 9: CPN business

Inevitably, a lot of the blogposts I wrote were news updates and announcements. Most of these were purely date and time specific and didactic, so I decided not to include them in this book. There were news-type blogposts, though, that were more deliberately community-building: polls asking what kind of course people wanted; interviews with CPN members asking them why they'd joined; calls for people to participate in conferences and salons; CPN updates and announcements about new allied groups and resources. There were also reports on CPN get-togethers, tongue-in-cheek Christmas wish-lists, and encouragements for members to blog.

Looking back now, these everyday announcements must have been the impetus for starting the CPN Digests, which began in August 2018 as a weekly list of 15 resources from around the fringes of the critical physiotherapy world. By late December 2022 I'd published the 225th. They then became the only standing feature of the critical physio blog that I carried over in to ParaDoxa. At the time of writing this, I've published 80 more Weekly Digests, meaning that since late 2018 I've read and recommended 4,575 different articles and pieces of interest to subscribers. You will no doubt be relieved to hear that I decided not to publish the 305 digests in this book.

One of the other things that you will see in the later posts in this chapter is the creeping sense that the CPN needed a refresh. Perhaps it was the effect of COVID, or maybe the cumulative fatigue of eight years of concentrated hard work, but by 2022 you can see signs that change was overdue. Some of our projects (like 30 Days of September) were starting to feel tired, and some of our innovations (like the Critical Physio Academy) were not taking off like other projects had done in the past. Some of the later posts in this collection catalogue that process and my eventual decision to step aside from the Exec and move my writing to Substack. So, as much as any of the chapters in this book, Chapter 9 catalogues the changing business of the CPN as it grew, settled, and morphed into what it is today.

ISIH conference abstracts submitted

27 October 2014

I've decided to submit two abstracts for the ISIH conference next year.

The first follows some work I've been doing for a chapter I'm writing for an upcoming book by Franziska Trede and Celina McEwen titled 'Educating the deliberate professional: Preparing practitioners for emergent futures', and looks at the historical role played by artisans and

whether professions like physiotherapy might find some meaningful and interesting ways to reinvent this role in 21st century health care. This is the first abstract:

Re-inventing artisans for 21st century health care

> Calls for health professionals to be more than 'technical rationalists' have been prominent in professionalization literature for more than half a century. Professions with a strong history of skills-based competence have struggled more than most to respond to these calls. Those that have been heavily influenced by biomedical discourses - professions like dentistry, osteopathy, physiotherapy and podiatry - appear to be doubly disadvantaged because of biomedicine's strong affinity for Cartesian Dualism and its reductive tendencies. Foucault reminds us, however, that no power can ever be total, and that power always carries with it the possibility for resistance. Consequently, we have seen in recent years a number of counter-narratives emerge within the professions allied to medicine that call for new forms of 'deliberate' practice. Using physiotherapy as a paradigm case, I explore the history of the present of physiotherapy's long affinity with biomechanical discourses drawing on Hannah Arendt's work in *The Human Condition*. Arendt's conceptualisation of action, making, behaviour and fabrication are deployed to re-examine the concept of the artisan; a once predominant mode of labour relation that fell into decline with the Industrial Revolution and the emergence of mass-market economies. In recent years, the artisan has returned as a form of resistance to consumer culture, and it appears that people in advanced economies are looking to more bespoke, embodied experiences - even in their everyday purchasing decisions. To this end, I examine whether the artisan might create the necessary conditions where traditionally skills-based professions may finally break free from the constraints of biomedical rationalism and engage in more 'deliberate' modes of practise.

The second abstract references work I've been doing for a number of years now, looking at the history of physiotherapy before it became a legitimate and orthodox health profession. I'm particularly interested in the way the women who founded the profession used a very 'masculine' model of practice and exerted this over other women of similar age and social standing to get a foot hold as a new profession. Here's the second abstract:

Suffrage suspended? Counter-narratives of womens' quest for professional legitimacy

> A great deal has been written about the role the suffrage movement played in the development of nursing and midwifery during the late nineteenth and

> early twentieth centuries. Much of this research points to roles played by middle- and upper-class women in professionalizing socially validated notions of caring, and the importance of this in demarcating practice territories that complemented the work of (male) physicians. Little attention has been paid, however, to the development of new professional identities for women at the margins of nursing and midwifery. In 1895, the Society of Trained Masseuses (STM) was formed by a small group of nurses and midwives in an attempt to legitimise massage and establish it as a worthy career for educated women. Many of the Society's founders were firmly committed to female suffrage, yet evidence suggests that they knowingly adopted overtly androcentric ideologies to establish their profession's subordinate relationship to medicine. Critically, members of the STM took advantage of neurasthenia - one of the most prevalent disorders of the late nineteenth century - to establish their credibility. The preferred treatment for neurasthenia was known as the Rest Cure, an approach that has been heavily criticised for the paternalistic, infantilising attitudes of its male proponents. The Rest Cure involved strict isolation, force feeding, and a range of passive therapies that would become the basis of the STM's scope of practice. In this paper I argue that the women who founded the STM used neurasthenic women to establish their legitimacy and create a new professional identity that manifests today as physiotherapy. I argue that physiotherapy may be the first female-dominated profession to make a virtue of overtly androcentric ideologies in order to establish and legitimise new professional roles for women.

If you haven't made your submission yet and are keen to attend, the process is very easy. Go to the conference website and follow the links through to the abstract submission site. The deadline for submission is 15 November 2014.

My critical physiotherapy Christmas list

10 December 2014

Santa is a busy chap so needs help to know who's been naughty and whose been nice.

I've tried my best to be nice this year. Honestly I have. So I thought I'd draw up a critical physiotherapy Christmas list of the things I'd like in my stocking on Christmas morning.

Dear Santa,

Could I please have:

A physiotherapy journal that refuses, on principal, to publish any article where the authors use the words evidence-based practice, musculoskeletal, neurological, cardiorespiratory, mixed methods, systematic, descriptive, thematic, or any word ending in -itis.

A return to a properly funded public health system.

An overhaul to the weighting of academic journals. I'd like all journal's publishing qualitative research to have an impact factor of at least 30.

While you're at it, could I also have a *Gates Foundation* grant for...oh, I don't know, $20 million...to study the history of physical therapies in the 19th century please?

By law, could every meeting at the Department of Health include a representative of the physiotherapy profession?

Could you also make it so that all physiotherapy journals have unlimited word counts? (I'm happy to trade in the use of tables, scatterplots and graphical models that ridiculously oversimplify complicated ideas if you could make this happen.)

Let's also go with PowerPoint templates that do not allow presenters to use bullet points. They can only use pictures from now on.

Could we make it so that any of our colleagues who say that philosophy is full of complicated language are reminded that flexor hallucis brevis is also complicated and that, somehow, they coped with that okay? (You also punish them by making them read 'Being and Time'.)

A special punishment should reserved for anyone who uses the phrase 'sitting is the new smoking.' My personal preference would be to make them sit in a wheelchair for a month but I can lead the details up to you.

...and finally, could you please make sure that the mighty Wolverhampton Wanderers sign Lionel Messi and Christiano Ronaldo in the closed season.

That's all. I hope everyone in the Critical Physiotherapy Network has an extra special holiday and a joyous and peaceful New Year.

Critical Physiotherapy returns

5 January 2015

If you're in the Northern Hemisphere, today probably marks your return to work day. For some in the South it should be holiday, so wherever you are I hope you had a relaxing and peaceful break.

I stopped doing a lot of work-related things on the 19th December and am only coming back to it now in anticipation of an exciting year ahead, so apologies for the 'radio silence' over the last three weeks. It's been bliss.

I stepped down as Head of Department at the turn of the year and start a six month sabbatical today, so I'll be doing a lot of blogging, reading and writing over that time (more about this in the next few days).

I did, however, keep reading some of my favourite news-sites and blogs while on holiday and came across a few gems that I thought I'd share with you. All of these are relevant to critical physiotherapy, although some are more abstract than others.

Last year, I wrote a little bit about the importance of uncertainty and what Kathryn Hughes wrote about in this short piece about the erotics of not knowing which is well worth reading. There is a growing philosophical interest in the idea that we should stop trying to define, resolve and conclude things - especially where we do this for other people in clinical care, for instance - so I think this will be something I write more about in the coming months.

This really lovely *New York Times* profile of writer Laura Hillenbrand explains her experience of living through chronic fatigue syndrome.

I read quite a lot by Leslie Jamison over the holiday. She is the author of a recent book titled *The Empathy Exams* which has received a lot of critical attention in recent months. You can hear a short book review here to get a flavour (NPR called the book 'A virtuosic manifesto of human pain'!). Part of the book details her work as a medical actor during various medical exams - something a lot of people in the profession seem to be interested in as a way to manage the problems of finding clinical placements. To get a feel for her beautiful writing, you might want to try this short story first.

I'm no fan of pop-psychology (you know the kind of thing: '10 ways to find true love,' 'How eating food makes us fat'...etc.), but sometimes a gem pops up that can give you pause for thought. This piece in Vox caught my attention as something that might be useful for our group in the months and years to come.

Reese Witherspoon recently featured in a new film called *Wild*, about the real-life experiences of a woman called Cheryl Strayed who left behind a pretty miserable existence to walk across America and find herself. The book and the film definitely fall under the category of 'Walking Is So Much More Than Just A Gait Pattern' and links in with some of the books on the philosophy of walking I'd posted about last year. Hence the title of this review: *The Walking Cure*.

There is an amazing body of philosophy to be found in education, but one of my favourite sites is the ever-reliable *Hybrid Pedagogy*, and in December they published a list of some of

their best postings from 2014. This is well worth a read. There is a lot here we can learn from about translating critical physiotherapy into meaningful ideas for our colleagues.

Hybrid Pedagogy also provided a very insightful commentary on what critical pedagogy means. Over the last six months I've had a few people approach the Critical Physiotherapy Network because they think it's about critical care in hospitals. Others have little exposure to critical thinking in the philosophical or sociological sense of the word and believe critical thinking is about one's ability to critically read a research article. *Hybrid Pedagogy* struggled with the same issue and in this post came up with some very useful explanatory concepts that might provide some language for us to use as we define our purpose more clearly in the months to come.

I have a longstanding interest in the history of physical therapies, particularly in the nineteenth century before physiotherapy as a profession was born. So I really enjoyed this piece from *Aeon* Magazine.

Interestingly, this article was written by Iwan Rhys Morus, Professor of History at Aberystwyth University in Wales and the editor of the journal *History of Science*. Iwan had previously written two excellent academic articles with historical interest to physiotherapists: Morus, I. R. (2006). Bodily disciplines and disciplined bodies: Instruments, skills and victorian electrotherapeutics. *Social History of Medicine*, 19(2), 241-259, and Morus, I. R. (1999). The measure of man: Technologizing the victorian body. *History of Science*, 37(117), 249-282.

On a similar historical theme, this piece on hydrotherapy in *The Guardian* ('A tonic for the jaded') reminded me of a story from the beautiful Rotorua Spa here in New Zealand that I was told some years ago. At the end of the 19th century, New Zealand became a centre for health tourism and spas became a big thing. There was no mixed bathing at the spas because Victorian heteronormative attitudes were very strong at the time and so, ironically, the Rotorua Spa became the centre of gay culture. Thus proving Foucault's point that there can be no power without resistance!

On that note, I'll end this post. I'll pull together some more favourites from the last few weeks in the coming days and weeks. Here's wishing you a happy New Year and a warm welcome to 2015.

Some January highlights

9 February 2015

In case you missed these notices during January, here are a few new things that you might be interested in:

Breath

A beautiful short video about breath from The Mercadantes, the husband-and-wife filmmakers Daniel and Katina Mercadante in California. The film explores the human breath and its innumerable forms – from the first gasping cries of a newborn to the sighed relief of a well-earned chance to rest.

New book by Felix Guattari

A new book edited by Gary Genosko collecting some of French philosopher Félix Guattari's work during his frequent visits to Japan in the 1980s. Guattari frequently visited Japan during the 1980s and organised exchanges between French and Japanese artists and intellectuals. His immersion into the "machinic eros" of Japanese culture put him into contact with media theorists such as Tetsuo Kogawa and activists within the mini-FM community (Radio Home Run), documentary filmmakers (Mitsuo Sato), photographers (Keiichi Tahara), novelists (Kobo Abe), internationally recognised architects (Shin Takamatsu), and dancers (Min Tanaka). From pachinko parlours to high-rise highways, alongside corporate suits and among alt-culture comrades, Guattari put himself into the thick of Japanese becomings during a period in which the bubble economy continued to mutate. This collection of essays, interviews, and longer meditations shows a radical thinker exploring the architectural environment of Japan's "machinic eros."

How GPs should plan care for people with long-term conditions

The constraints of a 10-minute GP appointment mean that there is little time to treat a patient with multiple health problems. The RCGP video explains how care planning, a holistic, long-term approach to delivering patient care, aims to help people take more control over their own health - with the support of their GP practice - and stay well, and out of hospital. Watch the video explaining how it might be otherwise from The Guardian Comment.

Three evolving thoughts about flipped learning

Flipped classrooms are becoming popular in health education. Students ideally become more active and take more control of their learning. This post by Robert Talbert sketches his reflections on the process:

> "While specifications grading continues to unfold in class, I'm also still using and refining the flipped learning model. Recently I had time to reflect on how I'm implementing flipped learning in my classes, and I noticed that some of my thoughts on flipped learning have evolved over the last few

> years, including some breaks from things I've written here on the blog. Here are three of those thoughts that stood out for me."

Crisis in compassionate care

Compassionate care "involves work with bodies (body work) and this is complex and expensive to organise on the labour market, something exacerbated by the involvement of private companies, seeking profitability." Rachel Lara Cohen is a Senior Lecturer in Sociology at City University London. Her research explores the lived experience of work and employment, especially non-standard work and in her brilliant post she discusses the complexities of compassionate care.

Why you should write a blogpost - yes, you!

25 July 2016

Back at the start of the year, Jenny Setchell introduced me to Kerry Chamberlain, the convener of the *International Society of Critical Psychology*. ISCHP has been running for a lot longer than the CPN, but we have a lot in common and it was great meeting Kerry and sharing ideas about our various organisations.

As part of that conversation, I talked about blogging and how I use it to develop and share ideas. Kerry asked me to write something about it for the ISCHP website and the original post was published here back in March.

I came back to it the other day and thought it might be good to post on this site. Blogging is something that daunts a lot of people, so I hope this post goes some way to demystifying it and encourages you, yes you, to dip your toe in the water and give it a go.

> "A couple of months ago, I was introduced to Dave Nicholls, Chair of the Critical Physiotherapy Network. The Critical Physiotherapy Network is an organisation which has a lot of synergies with ISCHP, and Dave and I met to discuss how our respective organisations managed membership and communication issues. In the course of our conversation, he commented about blog posts, how they are easy and quick to write, why people should do this more often, and why most people don't. I took him up on this and asked him to write a post about it for our blog, which he promptly did. Thank you Dave, some very good advice for our members. If this inspires you to write for our blog (and it is meant to), then please write something and send it off to one of our blog editors or commissioning editors – their

addresses can be found under the Blog Team menu). Thanks, Kerry Chamberlain."

Please answer all questions on this paper.

Question 1.

A blog is:

1. A personal web page on which an individual records opinions, links to other sites, etc. on a regular basis

2. A badly written piece of banal drivel, written by someone craving the affirmation of others

3. A revolutionary mode of postmodern peeragogy, democratising the sharing and distribution of ideas and opinions

4. All of the above, and more

It would be nice to think that the correct answer is 1 and 3, but you can't really avoid badly written blogs if you allow for such a free and easy mode of personal expression. To me, the fact that some blogs are poorly written doesn't matter. All that really matters is that ideas and opinions are being shared.

It's not that long ago that publishing an inspirational thought meant writing to the editor of a publication, complying with their style conventions, and waiting for days or weeks to see your issue in print. Social media has changed all that, and tweeting, blogging, and other forms of socially mediated expression have become ubiquitous.

What is surprising though, is how quickly some of the more traditionally conservative sectors of society have taken to the blogosphere. Health professionals used to only write their clinical notes and academic papers, but they have taken to hypertext as if they had been released from bondage.

So why write a blogpost? Well, for me, it's often simply an exercise in working out an idea or a way to share a thought with others. It's not a heavy piece of deep thinking or a major contribution to social reform. It's just a tiny treasure; a paper boat lowered into the lake to be taken by the wind. What's interesting is that what seems like a simple idea to me, is really challenging for a lot of people.

The idea of writing a blogpost causes many people to come out in a rash. The thought that you might write something wrong or say something offensive often combines with paradoxical feeling that it's all a bit silly and self-serving. For some people blogging is both terribly serious and totally trivial.

So I thought it might help to offer some suggestions for how you might overcome some of these barriers, and write your own blogposts for this forum:

Firstly, try to put aside the idea that the blogpost has to be the last word on anything. The best posts are temporary, ethereal and partial. They leave space for others to argue, debate and discuss, or maybe even blog a different opinion themselves.

Then, give your opinion. Write from a first-person perspective, and only use academic/scholarly language if you have to.

Try to write for your smartest reader, but use language that is inclusive. So avoid colloquialisms and idiom wherever possible.

Write about one idea. Save your other ideas for another blogpost tomorrow.

Add pictures. Use Google or Bing Images and don't worry about the copyright. No one pays any attention to that these days.

Say something provocative, like the last bullet point. Don't just say it to be controversial though, stick to a consistent philosophy.

Try not to make it too long or too serious.

Blogging can be a lot of fun and a great way to develop your thinking among a community of peers. If you are an academic, it encourages people to engage with your scholarly work, and it can influence public policy and opinion. But most of all, blogging is a great way to say new things in new ways. Do try it.

Is it time for a new critical physiotherapy journal?

17 August 2016

In April, a new journal called *Applied Mobilities* was launched by Taylor and Francis. Given physiotherapy's interest in anything to do with mobility, you might be mistaken for believing that this was a new journal for us. But it isn't.

Well it could be, but physiotherapy is currently only interested in quite specific kinds of mobility - the kind involving the biomechanical body - and isn't particularly interested in material semiotics or the day-to-day movements of Chinese migrant women in Sydney.

So the journal joins the ranks of other journals like *Body and Society*, *Scandinavian Journal of Caring Sciences* and *Medical Humanities* as journals that physiotherapists probably ought to publish more in, but don't.

For a long time, physiotherapy has only had one journal that deals specifically with the ideas and philosophies that underpin our work - *Physiotherapy Theory & Practice* - but this is now groaning under the weight of submissions from researchers and writers eager to explore and apply ideas from critical theory, disability studies, economics, feminism, philosophy, politics and sociology.

So is it time for a new critical physiotherapy journal?

There would be a lot to consider if we were going to launch a new journal: how would it be underwritten; where would it be housed; who would edit, review and, more importantly, write for the journal; would it be digital or traditional, or both; what would its editorial policy be? Most importantly, who would read it?

Over the last two years, we've seen an amazing amount of interest in the CPN, and people have asked on a number of occasions if we have plans for a journal. We've always been a bit overwhelmed by the scale of the project to really consider it. But perhaps now might be a good time to give it some more thought.

It would be very interesting to hear your views.

Onwards and upwards

4 October 2016

Last week's blogpost by Tracy Bury from WCPT brought to an end another hectic 30 Days of September campaign. It's the third such campaign we've run since the Network began in 2014, and they're a lot of fun, but also a lot of hard work. So thank you to all of the members, new and old, who contributed to last month's campaign.

We decided this year to focus on ideas that motivated us to be critical-thinking physiotherapists, and hopefully many of you will have been inspired by what you read. One member wrote to me a few days ago to say, "I'm loving 30days. My reading list for the next 12 months is set." We hope you all had something like that kind of reaction.

The 30DoS campaign always sees us gain members, and this month has been no exception. There are now more than 520 members in the Network, 100 more than six months ago. And each post reached about 500 people through Facebook alone, with some posts being very widely accessed. Seeing what people are sharing is always interesting.

September has been a busy month for the Network in other respects too. Members will know that a team from the CPN will be presenting one of the 17 Focused Symposia at WCPT Congress in South Africa next year. Our theme is, unsurprisingly, 'Critical Physiotherapy', and will focus on ways of using critical approaches to challenge, enhance and transform our practice, education, research and policy.

We're organising a one-day post-WCPT workshop that we're calling the CPN Salon (5th July 2017, in Cape Town). We're hoping to have as many CPN members there as possible so that we can share ideas about critical thinking and practice, hear from some amazing speakers, and share ideas about how people want the CPN to grow and change. Places will be strictly limited, so if you'd like to reserve your place, email us here.

Work on the upcoming Critical Physiotherapy Studies edited collection continues, with 15 chapter authors preparing summaries of their work for our next Writing Group Circle in a few weeks time (the book should be available late 2017), and there may be some more announcements about WCPT and some very exciting news about a new educational initiative coming soon too.

More of that later though. Now it's time to get into some of that new reading!

Your CPN Executive: Simon Kirkegaard, Barbara Gibson,Viviana Silva Guerrero, Dave Nicholls, Michael Rowe, Jenny Setchell and Nicky Wilson

Critical studies in physiotherapy

2 March 2017

2017 looks like being another busy and exciting year for the CPN. As well as our first CPN Salon (mini-conference), being held at the lovely Cape Town restaurant *Ottimo Cibo* on the day after the WCPT conference, we will be launching our first collaboratively written book. We're currently working on possible titles, with our favourite being Mobilising physiotherapy: A critical physiotherapy reader, but the final decision will be made soon. We already have full drafts of all 15 chapters, and the editorial team (Barbara Gibson, Dave Nicholls, Jenny Setchell and Karen Synne Groven) are working through their recommendations and edits.

We have chapters that look critically at physiotherapy through performing arts, communications, phenomenology of touch, new materialism, and narratives, as well as chapters on ethics, education and evidence-based practice. We have subjects ranging from weight stigma to hippotherapy, disability to moral theory. Overall there will be 16 chapters

from 20 different authors, and thus far we've managed to keep almost exactly to our planned timelines.

Perhaps most excitingly, we will hold the copyright for the book which, thanks to the generous support of the University of Oslo, will be an open source publication, meaning that we can do with it as we wish when it's finished. Soon we'll be sending it to our publishers — Norway's biggest publisher of scientific and technical manuscripts, Cappelen Damm — who will turn our Word documents into a shiny new (e)book. We're hoping to have the book ready for distribution in late 2017 or early 2018.

Over the next few months we'll be posting updates on the book and sending out snippets and teasers to entice you to read it, but to start with, here's a list of the book's authors, who deserve enormous credit for their ideas, inspiration and encouragement in being the epitome of a positive force for an otherwise physiotherapy.

Ukachukwu Abaraogu, Birgitte Ahlsen, Wenche Bjorbækmo, Tone Dahl-Michelsen, Clare Delany, Blaise Doran, Barbara Gibson (also Lead editor), Nicole Glenn, Karen Synne Groven (also Editor), Amy Hiller, Roger Kerry, Fiona Moffatt, Dave Nicholls (also Editor), Anna Rajala, Michael Rowe, Jenny Setchell (also Editor), Jay Shaw, Kari Solbraekke, Tobba Sudmann, and Karen K. Yoshida.

Are you interested in the history of physical therapy?

24 August 2017

At WCPT in Cape Town there was an incredible turn-out for a 7am Monday morning meeting of people interested in the history of physical therapy. The upshot of the meeting was that we agreed that we needed to form an international physical therapy history group.

And so, we've started asking who would be interested in coming along for the ride.

So far we've got 37 'members' across more than a dozen countries covering all five continents.

The intention is to form a network - not dissimilar to the CPN - but perhaps functioning a little differently.

The focus will probably be on raising the profile of history in and around the profession; establishing an interactive archive of resources and materials to further the study of the history of physical therapy; finding ways to make these resources available to clinicians,

researchers, educators and students; and developing learning and teaching resources to inform physical therapy curricula internationally.

The history of physical therapy has really started to attract people's interest in recent years, perhaps because we're asking a lot more questions about where the profession is going, so if this is something that interests you, or you know someone who you think might be interested, send me an email (david.nicholls@aut.ac.nz), and I'll add you to our growing contact list.

At this stage we're just trying to build our network. We'll start working on the organising committee, objectives, activities and shared interests in the next few months.

Should a Critical Physiotherapy Course be practically useful?

14 November 2019

Last week we asked what kind of Critical Physiotherapy Course format you would be most interested in next year. Here are the results:

- 23 people voted for one of the four options.
- 9 voted for the idea of using clinical scenarios as the basis for thinking through theories and ideas.
- 7 voted for inviting non-physiotherapy speakers to introduce us to unfamiliar ideas and theories.
- 4 for using YouTube videos of theories and ideas as a prompt for discussion.
- And 3 for inviting clients/patients to present as a starting point to thinking through theories and ideas.

What does this tell us?

Perhaps firstly that people are still struggling to find the practical use for philosophical ideas in practice, and that this is an ongoing problem for clinicians and teachers.

Secondly, that the people who voted see it as a part of the CPN's remit to help people bridge the gap between theory and practice.

This second point is an especially interesting one.

The CPN was set up, in part, as a 'space for ideas that promote a more positive, diverse & inclusive future for the profession' (CPN Objective #8), and part of that has always meant

sharing ideas in an open, collaborative and egalitarian way, without necessarily assuming the responsibility for explaining alien concepts to others.

Our first Objective also states that we will actively explore the world beyond the current boundaries of physiotherapy practice and thought. So is this vote a call to use theory to extend practice, or does it speak to a deeper desire to understand complex ideas from a perspective that feels more familiar and comfortable?

The axiomatic logic of this is that physiotherapy is a practical profession, and so we should always look to take new ideas back to practice. But is that necessarily true?

Doesn't new thinking sometimes need to breathe for a while and find its legs before being captured by the everyday constraints of practice?

Aren't there sometimes dangers in trying to find the practical utility of things – particularly ideas that are radical, disruptive and dangerous – and find practical uses for them?

So should we take the vote on face value, or is it really the starting point for a bigger conversation about the purpose and function of the Critical Physiotherapy Course?

It would be lovely to hear your thoughts and comments on this.

Welcome to the new home for news about the Critical Physiotherapy Network

6 December 2021

A few minutes ago, you'll have received a message welcoming you to the *CPN Herald*.

You received this because you'd previously signed up to be a member of the Critical Physiotherapy Network.

We've decided to move all of the news and blogs off the 'old' site because people were having too many problems logging in and reading the posts.

This new Substack site allows us to send news about the CPN directly to your email inbox.

Less hassle for you, and no fees, no contracts, no ties.

But this isn't the only new thing on the horizon for the CPN:

In January, the follow-up book to *The End of Physiotherapy* will be out. Titled *Physiotherapy Otherwise*, it's been written under a Creative Commons license, so will be entirely free to download

We’re starting work on a new critical collaborative knowledge network called the Critical Physiotherapy Academy (CPA) which will take a completely new approach to learning

We’ll be putting out a call for chapters for a 3rd critical physiotherapy reader

And we’ll be restarting the Critical Physiotherapy Course after a one-year Zoom-fatigue hiatus

So keep your eye out for email updates from us, and thanks as always for your support for the CPN.

Planning this year's Critical Physiotherapy Course

9 February 2022

The Exec of the Critical Physiotherapy Network have started discussing this year’s webinar series and we could do with a bit of advice from our CPN family.

In the past, the Critical Physiotherapy Course has run from April-October and featured monthly 90-minute Zoom sessions, each one involving a short talk from a guest speaker, followed by an open, and often amazing, discussion.

We try each year to bring new ideas and people to the course so that we can all improve our critical thinking skills.

But we’d like to know what you’d like.

Do you want a course this year? And if so, what sort?

If you can spare us 3 minutes right now to tell us what you think, it will help us plan some of our work for the coming months.

What's the CPN up to at the moment?

7 April 2022

A quick update on the Network's current projects and business

It’s been another busy start to the year.

Here’s a quick list of the projects we’ve got bubbling away at CPN Towers.

A 3rd Critical Reader following on from the phenomenal success of *Manipulating Practices* and *Mobilizing Knowledge* is in the works. The editorial team led by Karen Synne-Groven is forming, and we'll be sending out a call for contributions in the next few weeks.

Having taken a year off, our popular online Critical Physiotherapy Course is back. We had our first planning meeting this week and the theme of the course looks like being the most interesting and thought-provoking one to date.

This week we also had the first meeting of the *Critical Physiotherapy Academy* (CPA) planning team. The CPA could be the biggest thing we've done since we began the Network in 2014, but the early conversations were amazingly exciting. We'll post more on this during the year, with a plan to launch the Academy early in 2023.

And for those of you who remember our last face-to-face meeting at the *In Sickness and In Health* conference in Sydney, the ISIH planning team agree this week to postpone this year's conference (planned for June) and reschedule for Spain in 2023. Fingers crossed we'll be able to have another team get-together sometime soon.

As always, if you want any more info, just email or use the comment box at the bottom of the post.

The first CPN face-to-face meeting since COVID

13 September 2022

The Critical Physiotherapy Colloquium in the Arctic

Since Sunday night (11th September) and on till Wednesday morning (14th) a group of CPN members have been meeting in the beautiful Norwegian coastal village of Sommarøy for the first international CPN Colloquium since COVID.

Thanks to the generous support of the UiT Healthcare Professional Practice Research Group and the incredible convening skills of Filip Maric, we've been workshopping the questions of how can we help people envisage a radically alternative future to contemporary physiotherapy.

Three teams have been developing games and playing seriously with what might be possible for us today and into the future.

We've interspersed the three days with critically reflective activities as prompts to draw out what we feel needs to be in any radically alternative future, and tried to create a safe space for what might normally be impossible to contemplate.

This all sounds very earnest, but first and foremost this has been a long-overdue meeting of friends who in some cases haven't seen each other for more than five years.

What's already evident from this colloquium is that we've generated a lot of 'data' that will need time to process. Hopefully, we'll find some ways of sharing it with you as we aggregate and analyse it in the weeks to come.

It's also clear that none of us need convincing that change in physiotherapy is now inevitable, but also necessary. What we've been grappling with is the shape we'd like that reform to take and how to make it happen.

It would be all too easy to become professionally defensive and let this incredible moment slip through our fingers. But none of us want that.

Physiotherapy, but not as you know it.

So it's been quite an emotional family reunion here, and the stunningly beautiful backdrop of northern Norway has given us all a sense of gratitude and awe for what might be possible in the years to come.

> "We can only see a short distance ahead, but we can see plenty there that needs to be done" - Alan Turing

A quick CPN update

21 September 2022

It's a busy time for the CPN at the moment, here's a quick update on things we've got going on…

The first session of our free online CPN course on the theme of vulnerability begins next week.

More information about the course, dates, times, and links are here, there's a media pack of images to download and share here, and a brief overview of the course here. There's no sign-up needed, just log in on the day to join.

Am I still a CPN member? What's happened to the old CPN website?

We've had some inquiries recently from people asking about our old site (www.criticalphysio.net) and whether they were still CPN 'members'. In December last year, we stopped using the old site and moved all of the blogging and CPN news to this Substack page. Substack is a fabulous online newsletter site (take a look around to see who else is publishing here). You can subscribe to this newsletter for free, so CPN blogposts and news updates will come straight to your email inbox. So technically we now have subscribers rather than members. Part of the reason for the switch is because we plan to use the old site for something new. Speaking of which…

Keep your eyes peeled for an announcement soon about the new Critical Physiotherapy Academy

A group of CPN members have been planning an entirely new entity called the Critical Physiotherapy Academy. This will be a curated knowledge community for critical thinking in and around physiotherapy. Membership will be free, of course, but be based on people's participation to sharing and knowledge building. Look out for more on this later in the year.

Also keep your eyes peeled for a call for chapters for the 3rd Critical Physiotherapy Reader.

Following the amazing success of our first two critical physiotherapy readers — *Manipulating Practices* and *Mobilizing Knowledge* — we'll be posting up an announcement on the 3rd critical physiotherapy reader soon. The book will be edited by Karen Synne Groven, Patty Thille, Clair Hebron, and Roshan Galvaan and will once again be a collection of some of the best critical physiotherapy thinking from around the world. Keep an eye out for more on this soon.

A CPN Colloquium in the Arctic

Last week, 15 of us met for the first CPN Colloquium since COVID in Tromsø in Northern Norway. Thanks to the amazing organisational work of Filip Maric, and the support of UiT Department of Health and Care Sciences Research Group, we had a wild three days of game-making, debating, and socialising. It was so lovely seeing everyone again face-to-face. But it promises not to be the last meeting like this, because…

In Sickness and In Health is coming to New Zealand

Many of you will remember CPN Salons we've held in conjunction with the *In Sickness and In Health* Conferences in the past, well in February 2024 the ISIH Conference will be coming to Auckland, New Zealand, and the CPN will be playing a big part in organising the event. We're already planning a CPN Salon for the day after the conference (which will run from 13-15 February 2024), so start making your travel plans. February in NZ is glorious, so come for a holiday, take in the conference — the best critical healthcare conference anywhere — and stay for the Salon. We'll post more information here over the coming months.

So that's about all for now. As always, if you've got any questions post them in the Comments box or email me at david.nicholls@aut.ac.nz and we'll get back to you straight away.

The future for the CPN

30 November 2022

Over the last 8 years critical physiotherapy has become a real thing, and the CPN has been at the forefront of what feels like a sea-change in the profession.

It feels like we're in the midst of one of the most turbulent and exciting times in physiotherapy's history, and the critical physiotherapy community has definitely played its part.

But there is still so much more to do.

Too often the voices being heard are those of the minority white male Western world, and we've only just begun to realise what the physical therapies can really do.

So this is a call out to you, our CPN members and subscribers, to ask what kind of CPN you want to see tomorrow.

We want to reshape our Executive and find some of the voices out there in the physiotherapy community who will shape the Network for the next 10 years.

The CPN Exec is a collection of friends who meet once a month to plan projects and share their dreams and ideas.

We have no hierarchy, we take no salary, and we stay as long as we want.

There are people there who have been in the CPN from the beginning, and others who joined only recently.

If you've thought you'd like to add your voice to critical physiotherapy, then now might be the time to try.

Just email one of us if you'd like to join or chat about our work.

We'd love to hear from you.

Australasia: Dave Nicholls

Latin America: Aydee Luisa Robayo and Adriane Vieira

Europe: Tone Dahl-Michelsen, Anna Rajala, Tobba Sudmann

Africa: Lucy Edet

North America: Patty Thille

Goodbye, and thank you

11 December 2022

Early in 2014, I'd become disillusioned with my job at the university. From my earliest student days, I knew I wanted to help craft my profession, so becoming the head of a large physiotherapy teaching department seemed like a dream come true. But it wasn't.

Having spent the previous six years arguing for a radical new physiotherapy curriculum, I realised I wasn't patient enough, and skilled enough, to see the job through. And by mid-2014 I was getting tired and irritable.

I can still remember sending the email to the handful of the people I knew around the world who were doing critical work. It couldn't have been more than 10 people. Did they want to get together for occasional chats, I wondered. I remember thinking at that time that this would be a small group, but a kind group; a group of like-minded souls looking for a chance to speak truth to physio power.

In the email, I casually asked them to send the email to other colleagues if they thought they'd be interested. What happened next was a complete surprise.

Within weeks we had 50 members, then 100, then 200… People were genuinely excited at the prospect of an international group who were trying to say something different about the profession. By the end of 2014, we'd passed 500 members in more than 30 countries. By the end of 2015, the number had doubled.

We gave ourselves a name and formed an Executive, we wrote our beautiful objectives, and Filip Maric gifted us that brilliant tagline that the CPN would be a 'positive force for an otherwise physiotherapy'. Perfect.

The Exec met at the end of every month, and projects started to roll out. We built a website and began blogging; seven of us around the world wrote an article on connectivity in six weeks, we organised our first CPN international meeting, we ran our first (totally ridiculous) 30 Days of September campaign, and we wrote our first book.

By 2020 we'd settled into a lovely routine of conversation, inspiration, and collaboration. Our membership grew to nearly 1,000 people across more than 60 countries. We added a new six-month-long free course, collaborated on more books and journal articles, and even hosted a focused symposium and our 3rd CPN Salon at the World Physio congress in Cape Town. A few

members of our Exec stepped away and new members joined. We were rolling along. And then COVID struck.

Who knows what work would have been like had COVID not happened. What we do know is that for many of us it was a really hard time.

You might not imagine this, but I'm a real introvert. I really don't like public spectacle. So I was one of those who probably bore out the restrictions of COVID better than most. I was incredibly lucky.

I spent a lot of 2020-22 finishing my book *Physiotherapy Otherwise*, just in time to start a year-long sabbatical.

You're supposed to use a sabbatical to think deeply about your work and ferment new ideas, and this year hasn't let me down. I've had a really life-changing year of reading, thinking, more reading, writing, meeting friends around the world, and still more reading.

And sometime in September, during a two-month-long overseas trip, I realised that now was the time to shake things up.

And so I talked to some close friends about my plans and then let everyone know that I was going to step away from the CPN Exec. To be clear, I'll still be in the CPN (it's my family), but I won't be running the Network come the end of the year.

My plans are to take what I've learned from the CPN to find a bigger critical healthcare community. I've been working on a new online forum and testing out different ideas and ways of working. I'll email you all with all of that when it's up and running.

My work will always focus on physiotherapy — it's what I know — but the management of the CPN itself now falls into other peoples' hands. It will change, shift and grow, just as it has always done.

Before I go though, I really, really want to thank a few people: firstly, the members of the Exec over the last nine years. Such an amazing bunch of people. So generous with their time, so wise, so lovely. And then all of the people who stepped up to help write articles and books, run courses, and travel to meet up. Thank you for your trust and commitment to the cause. And finally to all of the CPN family.

I've made so many friends over the last eight years and I've been treated to more kindness and hospitality than I can ever repay. Thank you all so much. You gave me my smile back.

Naku te rourou nau te rourou ka ora ai te iwi (a Māori proverb meaning 'with your basket and my basket the people will thrive').

With love,

Dave

A new venture...

23 January 2023

Happy New Year to you all.

Late last year I wrote to everyone in the CPN letting them know that I'd be stepping down from the Network to start something new.

Well, I can now tell you what that is, and invite you to join in.

It's called *ParaDoxa*, and it's the first site dedicated to post-critical and post-conventional thinking in healthcare.

ParaDoxa is a free, email newsletter and website for health academics, clinicians, researchers, and students interested in the 'posts': post-critical thinking, post-humanism, post-professional healthcare practice, post-qualitative research, post-structural philosophy… and how they can be applied to healthcare.

It's also designed to be a hub for radical thinking and a space for collaborative exploration. But this time, it's for everyone in healthcare, not just physios.

Just like the CPN site, you can view the website at any time, but sign up and you'll receive every new post delivered directly to your email inbox as soon as they're written.

You can read a blog post here explaining why I've started *ParaDoxa*, the weekly digests are back, and there are some other resources already loaded onto the site to give you a feel for how it will work.

If you'd like to know more about the ethos behind *ParaDoxa*, you can find it here.

In a week's time, I'll post up the first of a new series of podcast interviews with leading researchers in the field (the first one features our very own Prof Barbara Gibson).

Posts come out a couple of times a week and are delivered directly to your email inbox.

So, if you have colleagues who you think would also like to know about the site, please pass on this message.

Four things...

27 March 2023

A quick update, a quote hord, ChatGPT, and a new call for book chapter proposals.

The 3rd in the growing series of ParaDoxa podcasts comes out tomorrow. This one is with Professor James Thompson and explores his work using theatre to better understand the aesthetics of care. It's another wonderful conversation with someone with something genuinely innovative and interesting to say about the future of healthcare.

You may not have noticed it, but the site's *Quote Hord* is becoming a bit of a beast. I saw a similar version of this before setting up ParaDoxa and wanted a space for quotes, saying, and parcels of text that inspired me. The *Quote Hord* has a permanent place on the site if you're looking for a bit of daily post-critical inspiration.

I had my chat with Michael Rowe last week about all things ChatGPT. I've added it to a Leviathan-like page I've been updating with news and resources to do with ChatGPT that I'll tidy up and post up next week. It feels a bit redundant to do it because things are changing so fast, but I've been interested mostly in those ideas that might persist long after the hype has died down. Hopefully, you'll find something in there that's useful and interesting.

And finally, from friend of *ParaDoxa* Jess Dillard-Wright (who you'll be hearing more from in a few week's time), a call out from Simon Adam at York Uni in Toronto, Canada that may be of interest to some of you. The full text is below if you'd prefer not to open the attached pdf.

> In a world where gaps in social, economic, and health inequities continue to grow on a crisis-riddled planet with exponentially increasing extinction rates of biodiversity, urgent interventions are needed to redress pressing social and political problems that have emerged in and through the Anthropocene. Entangled im/materialities: Transdisciplinary posthuman interventions (under contract with the University of Toronto Press; edited by Simon Adam & Efrat Gold) aims to assemble critical perspectives from a wide variety of disciplines, including nursing, social work, critical disability studies, environmental studies, artificial intelligence, linguistics, and philosophy, to name a few. The book is a site for the convergence of diverse approaches that promise to push and pull the boundaries of each respective discipline and yet maintain certain entangled states with one another that create possibilities for a postdisciplinary future. Framed by critical posthumanism, this anthology aims to interrogate and make explicit Humanism's limitations in both imagining and materializing just practices for a justice-oriented world. The book will offer a postfoundational and postdualist analysis of life, death, health, identity, technology, and knowledge-producing practices–an affirmative ethical intervention that aims to make transdisciplinary ontoepistemological shifts. It centrally engages with such questions as: What

emancipatory affirmative possibilities can materialize for the infrahuman, the marginal, the other? What is becoming of the human at the intersections of cognitive capitalism and the 4th industrial revolution? What postdisciplinary futures can be imagined at the nexus of the posthuman convergence? What analytical tools are there to examine the posthuman and how can they be re/theorized and implemented?

The book will put in conversation disciplines traditionally seen as disparate and 'siloed,' and correspondingly, destabilize the traditionally held perspective of disciplinary separability and insularity. Trans/interdisciplinary studies have long advanced that striking a convivial relationship is not only effective in achieving collective goals, but also an affirmative response to the critical posthuman project, a critique predicated on the idea that disciplines are identity-based phenomena, and that the more committed a discipline is to its historically held identity, the more isolated and fragmented disciplines become. The book aims to demonstrate that not only is disciplinary separation unsustainable, but neither is disciplinarity itself, and to that effect, a shift toward a monistic, post-disciplinary future is more desirable and more sustainable.

We invite chapter contributions that examine–but are not necessarily limited to–the following ideas:

- Artificial intelligence, technology, cyborgization, human/technology hybridity
- Indigenous epistemologies and more-than-human relations
- Planetarity, planetary ethics, blue humanities
- Critical posthuman/new materialist methodology, including arts-based and postqualitative methods
- Critical posthuman analyses of identity/identity politics
- Critical posthuman analyses of health/illness/wellness/life/death

Chapter length: 7000 words max. Deadline by which to express interest in submission: April 30, 2023 Deadline for chapter submission: November 1, 2023. Email all queries to Simon Adam: siadam@yorku.ca

Chapter 10: CPN people and their work

Chapter 10 is comprised of a collection of posts that profile members of the CPN. When we first set up the Network there was no critical physiotherapy community: people who were doing this kind of work operated largely in isolation. The CPN created a platform to bring them and their work to every's attention. It's perhaps not surprising then that a lot of the posts in this chapter come from the early years of the Network as we sought to profile the group's more active members. (You'll see this too in Chapter 11 when we devoted three seperate annual campaigns to the Network's people.) If we weren't doing text interviews with them, we were engaging them in conversations about their ideas, and all of these pieces are presented here.

When I migrated my blogging from the critical physio site to ParaDoxa I shifted the register a little and started doing audio interviews with people in the wider critical healthcare community instead. These became the *5-4-1 interviews* that ran throughout 2023. It's interesting now looking back how many of the people we 'interviewed' in those early years became stalwart members of the Network: serving on the CPN Exec, attending conferences and salons, and co-authoring writing projects. So perhaps these interviews served a greater purpose than merely introducing people to the critical physiotherapy community?

Tone Dahl-Michelsen on 'When bodies matter'

28 August 2014

One of the things we want to do with our Critical Physiotherapy Network is to promote people writing critically about physiotherapy.

As well as posting up recent publications and maintaining an archive of resources, we'll profile the authors and try to get behind their work.

In this piece, Tone Dahl-Michelsen - Research Fellow at the Centre for the Study of Professions, Oslo and Akershus University College of Applied Sciences, Norway talks about her recent paper *When bodies matter: Significance of the body in gender constructions in physiotherapy education*.

Abstract

This article examines which bodily performances indicate the significance of gender in the skills training of physiotherapy students. It is based on a qualitative study of first-year students' skills training in a Norwegian physiotherapy education programme. The study draws inspiration from Paechter's theory of the communities of masculinities and femininities, which argues that the material body is significant in gender construction. These findings indicate how, both historically and contemporarily, gender norms are strongly interwoven into students' bodily performances during their professional training. This bodily performance conforms to heteronormativity. Based on these findings, we argue that within critical educational studies of gender there is a need for theoretical frameworks that include a focus on the material body as a site of gender performance.

Tone's interview

How did you become interested in the question of gender in physiotherapy education?

My interest in questions about gender in the physiotherapy education started when I was a physiotherapy student myself back in 1992-1995. From day one we focused on the body primarily as a generalised, anatomical and biomechanical body. I remember that in the first skill training class the teacher told us that “inappropriate behaviour” was not tolerated. However, at this time, I was not aware of how these issues revolved around gender. I think it was the paradox of learning that gender was of no concern in physiotherapy and experiencing the quite opposite that boosted my interest for questions about gender in physiotherapy education. Based on my PhD work which looked at why some bodily behaviours in physiotherapy education matter and some don't, it seems that gendered bodies are still silenced both in Norway and internationally.

After working seven years in a clinic, I started in a teacher position in physiotherapy education, which implied a need for taking a master where I was introduced to critical thinking in the masters program (Master in Health Science, Oslo University), and it felt like a completely new world opened up. As a student in the masters program, I became more interested in questions of gender and when I later on got the opportunity for a PhD I decided that I wanted to go deeper into gender issues in order to answer the questions I wanted to pursue.

In your paper you argue that heteronormative attitudes are a problem for a female dominated professions like physiotherapy - why is that?

This paper demonstrates that students bodily performing in physiotherapy education conform to heteronormativity by revealing how both historically and contemporary gender norms are deeply interwoven into student bodily performing in skills training classes. Whether or to what extent this heteronormativity is a problem, I think is an open question. The examination of the historical roots of physiotherapy education reveal that issues of

sexuality seemingly were not regarded as a problem when physiotherapy was a male profession, however as it turned into a female profession this certainly became an issue and heteronormativity regulated how the problem was solved. That said the findings in this paper demonstrate how contemporary trends in masculinities are evident in today's education. These trends both confirm and contest heteronormativity as they integrate both performances of what is seen as heterosexual and homosexual body performing. Interestingly, although the female students are also raised in an increasingly sexualised culture, they apparently do not bring trends of sexualisation into their bodily performing and they conformed to the traditional script of heteronormativity in physiotherapy. As pointed to in the paper this tendency might be seen as a way female students demonstrate agency by not taking on sexualisation of present youth culture and girl power discourses which limit their access to protest rather than rendering them power.

You talk a lot about how shifting cultural attitudes in the 21st century are changing our attitudes towards traditional gender roles. How do you think this is going to affect physiotherapist's practice in the future?

In this paper, we do not explicitly discuss how these shifts might affect physiotherapist's practice in the future, however I discuss this topic in one of the other paper in my PhD thesis (Published 2014 in Physiotherapy Theory & Practice, entitled *Curing and caring competences in the skills training of physiotherapy students*). In this paper, I argue that although it might be that physiotherapists will continue to emphasise curing, how they more specifically perform their competences might be changing quite considerably. In short, this revolves around how male students are able to perform caring competences in a similar manner as female students.

Whose work have you been most inspired by, and in what ways have they influenced your ideas?

In this particular paper, we have been inspired by the work of Carrie Paechter who conceptualises gender as communities of femininities and masculinities. This way of viewing gender fitted students' bodily gender performing in skills training classes. In particular, Paechter emphasises the significance of the material body in gender constructions. This paper has been a contribution to an ongoing debate of the relationship between sex and gender within educational studies. In short, viewing gender as distinct from the sexed body has helped destabilise binary and essentialised gendered thinking, and thus strengthened possibilities for analysing shifting and transgressive gender performing. However, as this paper argues, some contexts still seem deeply defined by bodily performances represented by a sexed body, and therefore, a fundamental split between gender and the sexed body clearly has some limitations. Physiotherapy students' skills training is an example of such a context. I also have been inspired from the writing of other physiotherapists who have

written on issues of gender in physiotherapy, for example Hammond, Öhman, Sudmann, Dahle, Ottosson and some others.

What are you moving on to next?

Up to now, I have published several research articles related to my PhD project and my thesis will be submitted within a few months. After my dissertation, I will probably return to my teacher position in physiotherapy education and from there the way further is open. I hope to pursue my research interest in gender and physiotherapy in some future project. To do a comparative international project would be excellent, I believe such a design would generate most needed knowledge on the cultural aspect of how physiotherapy is shaped in the 21st century. Time will tell.

Tone Dahl-Michelsen's interview translated into Norwegian

Hvordan ble du interessert i spørsmål om kjønn i fysioterapeututdanning?

Min interesse for spørsmål om kjønn i fysioterapeututdanning startet i min egen studietid i 1992-1995. Fra første dag på fysioterapeututdanningen så var kroppen hovedsakelig fokusert som en generalisert, anatomisk og biomekanisk kropp. Jeg husker at i første time med ferdighetstrening så sa læreren at «upassende oppførsel» ikke skulle forekomme. På denne tiden var jeg ikke klar over hvordan dette dreide seg om kjønn. Jeg tror at min interesse for betydningen av kjønn i fysioterapeututdanning ble trigget gjennom det paradokset jeg erfarte ved at kjønn eksplisitt ble sagt å ikke ha betydning i fysioterapi og min erfaring om at det var motsatt. Basert på mitt eget doktorgradsarbeid ser det ut for at begrunnelsene og forståelsene for hvorfor en del kroppslig atferd eller gjøren er akseptert og andre ikke fremdeles er et taust og implisitt tema i fysioterapeututdanning både i Norge og internasjonalt.

Etter at jeg hadde arbeidet syv år i klinikken så startet jeg som lærer på fysioterapeututdanningen (Mensendieck). Jeg hadde da behov for å ta master og kort fortalt: På master studiet (helsevitenskap ved UIO) ble jeg introdusert for kritisk tenking, noe som åpnet en ny verden for meg. Som student på masterprogrammet ble jeg interessert i spørsmål om kjønn og da jeg fikk anledning til å ta en PhD bestemte jeg meg for å forfølge min interesse for kjønnsspørsmål i fysioterapi.

I artikkelen argumenterer du for at heteronormative holdninger er et problem for en kvinnedominert profesjon som fysioterapi – kan du forklare?

Gjennom å avdekke hvordan studentenes kroppslige praksiser og handlinger er dypt innvevd i både historiske og moderne kjønnsnormer i studentenes ferdighetstrening, så viser artikkelen at studentene gjennom sine praksiser tilpasser seg heteronormativitet. Om og i hvilken grad dette er et problem ser jeg som et mere åpent spørsmål. Utforskningen av de historiske

røttene i fysioterapeututdanning viser at spørsmål om seksualitet tilsynelatende ikke var sett som problematisk i perioden hvor fysioterapi var en profesjon for menn, mens det derimot absolutt ble problematisk da fysioterapi ble en kvinne-profesjon, og heteronormativitet var det som styrte hvordan dette 'problemet' ble løst. Når det er sagt; funnene i denne artikkelen viser hvordan moderne maskulinitetstrender slik som den metroseksuelle mannen og Sporno er synlig i dagens utdanning. Disse trendene både bekrefter og utfordrer heteronormativitet gjennom at de integrer både kroppslige praksiser og synlighet som tradisjonelt har vært sett på som heteroseksuelt og homoseksuelt. Det er interessant at selv om de kvinnelige studentene også har vokst opp i en kultur som i økende grad er seksualisert så ser ikke de ut til å bringe slike trender med seg inn i ferdighetstreningen i fysioterapeututdanningen. Isteden tilpasser de seg et tradisjonelt heteronormativt script, men som vi har pekt på i artikkelen denne tendensen kan ses som en måte kvinnelige studenter demonstrer aktørskap. Det vil si at gjennom å ikke iscenesette nåtidens seksualiserte kroppstrender i utdanningskonteksten, slik som eksempelvis 'girl- power' diskurser som kanskje heller begrenser deres adgang til å protestere (på implisitte patriarkalske normer) enn å gi dem makt, så oppnår de mer makt enn det de ville fått gjennom å iscenesette seksualiserte kroppstrender.

Du snakker mye om at skiftende kulturelle holdninger i det 21 århundre forandrer våre holdninger til tradisjonelle kjønnsroller. Hvordan tror du at dette kommer til å påvirke fysioterapeuters praksis i fremtiden?

I denne artikkelen tar vi ikke eksplisitt opp hvordan disse endringene eventuelt vil påvirke fysioterapeuters fremtidige praksis, men dette diskuterer jeg i en av de andre artiklene i avhandlingen (nylig publisert i Physiotherapy Theory and Practice. Arikkelen har tittelen: Curing and caring competences in the skills training of physiotherapy students). I den artikkelen argumenterer jeg for at selv om fysioterapeuter vil fortsette å vektlegge de kurerende aspektene ved behandling så vil hvordan de mer konkret faktisk gjør det muligens endre seg ganske mye. Kort sagt handler dette (bla) om at mannlige studenter er i stand til å gjøre omsorgs kompetanser på tilsvarende måte som kvinnelige studenter.

Hvem sine arbeider har du vært inspirert av og hvordan har de påvirket dine ideer?

I denne artikkelen har vi vært inspirert av Carrie Paechter som konseptualiserer kjønn som praksisfelleskap av femininiteter og maskuliniteter. Denne måten å forstå kjønn passer bra på studentens kroppslige praksiser og iscenesettelser i ferdighetstreningen. Paechter vektlegger særlig den materielle kroppens betydning i kjønns konstruksjoner. Denne artikkelen har vært et bidrag til den pågående debatten om forholdet mellom det som på norsk gjerne omtales som biologisk og sosialt kjønn innen utdanningsstudier. (Distinksjonen mellom sex og gender har vi jo ikke i det norske språket). Kort sagt, å se kjønn som atskilt fra den materielt kjønnede kroppen har hjulpet oss til å destabilisere essensialistisk kjønnstenkning og styrket muligheten

for å analysere skiftende og overskridende iscenesettelser av kjønn. Men som vi argumenter for i denne artikkelen så er noen kontekster dyptgripende formet av kroppslige praksiser og iscenesettelser representert av en materiell kropp og derfor har en grunnleggende atskillelse mellom kjønn og den materielle kroppen helt klart en del begrensinger. Fysioterapeut studenters ferdighetstrening er et tydelig eksempel på en kontekst hvor en kjønnsforståelse som bygger på en slik splittelse av kjønn og den materielle kroppen kommer til kort.

Jeg har også vært inspirert av andre fysioterapeuter som har tatt opp spørsmål om kjønn i sine arbeider, for eksempel Hammond, Öhman, Sudmann, Dahle, Ottosson (historiker) og flere andre.

Hva skal du gjøre fremover?

Frem til nå har jeg publisert en del artikler relater til doktorgradsarbeidet og jeg skal levere avhandlingen min innen et par måneder. Etter disputasen kommer jeg sannsynligvis til å gå tilbake til min stilling på fysioterapiutdanningen og derfra er veien videre åpen. Jeg håper at jeg får fortsette å arbeide med min forskningsinteresse knyttet til kjønn og fysioterapi. Å gjøre et prosjekt med internasjonal komparasjon hadde vært fantastisk. Jeg tror at et slikt design vil gi sårt tiltrengt kunnskap om kulturelle aspekt når det gjelder fysioterapiens utforming og betydning i det 21 århundre. Tiden vil vise.

Growing critical physiotherapy in Brazil

4 September 2014

The Critical Physiotherapy Network has been set up to bring people who think differently about physiotherapy together. Thus far, we have more than 110 members on four continents.

We are well represented in some areas, but we've got a lot of work to do to reach out to physios in others.

We currently only have one member from Brazil - Ana Luiza Oliveira - who is a PhD student at the University of Campinas. Ana kindly provided this brief overview of physiotherapy in Brazil.

> Physiotherapy in Brazil was legally recognised in 1969. It is a new profession here. Brazilian physiotherapy is guided by the biomedical model, it is mostly a private practice, and is not part of the SUS (Brazilian National Health System). A critical or reflexive approach is rarely used to understand the profession. There are 548 undergraduate schools in Brazil - which has nearly 190,000 practitioners! The profession is governed by one National Council

> (COFFITO) and 13 Regional councils (CREFITO) who are responsible for both Physiotherapy and Occupation Therapy."

Interestingly, Ana spent some time studying in the UK with Jonathan Gabe - the author of *Key concepts of medical sociology*, *Challenging medicine* and *The sociology of health and illness*, and in her masters degree studied physiotherapy history in the 1930´s and 1940´s. Now in her PhD, she is examining the question of physiotherapy professional autonomy in relation with the biomedical model and the professionalism.

If any of you are interested in this area, or have some expertise you can offer Ana (she is really keen to connect in with others in the group), you can contact her here: aluloli@gmail.com.

Anna Luiza Oliviera's interview translated into Portuguese

A rede 'Fisioterapia Crítica' foi criada para aglutinar pessoas que pensam a fisioterapia de maneira diferente. Até o momento temos mais de 110 membros distribuídos em quatro continentes diferentes.

Estamos bem representados em algumas regiões mas temos muito trabalho a fazer para atingir os fisioterapeutas de outras regiões.

Atualmente temos um membro do Brasil, Ana Luiza de Oliveira e Oliveira, doutoranda na Universidade Estadual de Campinas, São Paulo. Ana escreveu, gentilmente, este panorama geral da Fisioterapia no Brasil.

> A Fisioterapia no Brasil foi reconhecida legalmente em 1969, sendo portando uma nova profissão no país. A Fisioterapia brasileira é norteada pelo modelo biomédico, sendo uma prática majoritariamente privada e pouco inserida no Sistema Único de Saúde (SUS). A abordagem crítica e reflexiva para compreender a é pouco utilizada. Existem no país 548 escolas de graduação em Fisioterapia e o número de fisioterapeutas é de aproximadamente 190 mil profissionais. A profissão é normatizada e regulada pelo Conselho Federal de Fisioterapia e Terapia Ocupacional e por regida por um Conselho Nacional (COFFITO) e 13 Conselhos Regionais (CREFITO)"

Curiosamente, Ana passou algum tempo estudando no Reino Unido (Royal Holloway, Universidade de Londres) com Jonathan Gabe - o autor de "conceitos-chave da sociologia médica, 'medicina desafiador" e "a sociologia da saúde e da doença", e em seu mestrado estudou história fisioterapia brasileira nos anos 1930 e 1940.

Agora, em seu doutorado, ela está analisando a questão da autonomia profissional de fisioterapia em relação ao modelo biomédico e ao profissionalismo.

Se algum de vocês estiver interessado nesta área, ou tem alguma experiência que possa ser compartilhado, você pode oferecer e dialogar com Ana (ela está realmente interessado em se conectar com outros membros do grupo), através do e-mail: aluloli@gmail.com.

Interview with Jenny Setchell

17 September 2014

Every so often we profile a member of the Critical Physiotherapy Network to find out a bit more about them and their work. In this 'interview' we asked Jenny Setchell, PhD candidate, Pilates instructor, yoga teacher and circus trainer/performer about the inspiration behind her research. Jenny works at Performance Rehab in Brisbane, Australia and has been a member of the CPN since its inception.

What made you look at physiotherapy and weight stigma in the first place?

I have always been interested in stigma and oppression and as a physiotherapist never felt like there was a place for me to discuss this in my profession beyond one-on-one conversations. Researching in this area was the perfect opportunity to begin this dialogue in a way that might have a greater impact in physiotherapy.

I was interested in weight stigma specifically as it was something I had noticed seemed to be becoming more frequent in healthcare and amongst colleagues. But also something that really people hadn't thought about very much, or considered as stigma or prejudice. Weight stigma is particularly salient in physiotherapy because the site of our work is the body and thus weight frequently becomes involved in interactions in some way or another. There is a growing body of academic and popular discourses showing the harms of weight stigma, and that size discrimination is a case of blaming the individual rather than looking at societal or institutional issues. This has been described as a result of a neoliberal agenda, which promotes the self-regulating individual.

You say in your paper Despite the size and impact of the physiotherapy profession, there has been little investigation of physiotherapists attitudes towards weight. *Why do you think this is?*

Generally there's little self-reflection within physiotherapy. Firstly, on a profession wide level, there is little research or other focus on reflexivity in physiotherapy. Further, on an individual level there is minimal process in place for clinical reflection. This can be seen in that physiotherapy lacks for example, the professional supervision that some other similar health

professions have throughout the career, beyond just student supervision. This lack of reflexivity means we have little ability to assess how and where we are going as a profession and as individual physiotherapists. This is concerning because as a profession that is growing in size and power globally, we will have a greater impact on people and it is important that we can assure that this impact is positive.

Whose work has influenced your understanding of weight stigma today…whose work would you recommend to others interested in reading more about this area?

I've had a lot of influences when investigating weight stigma and have read very widely across a number of disciplines including sociology, critical psychology, critical weight studies and beyond. Rebecca Puhl at Yale has done a huge amount of empirical research on weight stigma. She, with Chelsea Heuer, produced a paper in 2009 *The stigma of obesity: A review and update* which gives a decent background to, and overview of, weight stigma in healthcare. Michael Gard, one of my PhD supervisors, has also been one of my main influences. I would recommend his book *The Obesity Epidemic* (2005) to anyone wanting a thorough and detailed understanding of the science refuting that weight is simply due to an energy imbalance (diet and exercise). Michael's book also has an in depth analysis of the social construction of the so called 'obesity epidemic'. Deborah Lupton's short book (2012), which is simply entitled *Fat* discusses weight from a Foucauldian perspective and is also a very interesting read.

In the study you state that '...the most common responses from physiotherapists in your study were simplistic, implicitly negative and prescriptive advice.' Can you provide more details on what concerns you have about this?

To break this down a little more, the physiotherapists in the study demonstrated simplistic understandings of the causes of weight by, almost without exception, reducing the multifactorial determinants of weight to causes attributable to individual responsibility (diet and exercise). Attributing weight to diet and exercise is thought to be due to weight stigma. Physiotherapists also spoke about weight in an implicitly negative way. This included using terms such as 'weight issue', 'weight problem' etc. It has been shown by Puhl et al (2012) when health professionals use more negative language to discuss weight that patients had lower motivation levels and were more likely to change health care providers. Prescriptive advice ('educative' communication) was the most common mode of delivering information about weight and signs of collaborative communication about weight were rare. An educative style of communication devalues the perspective and knowledge of the patient and thus is often unhelpful in the clinical interactions.

These ways of approaching weight make it likely that clients will perceive that they have been valued negatively, patronised or blamed (ie stigmatised), which results in poorer health

outcomes. Other studies have shown that clients who perceive weight stigma trust their health professionals less, exercise less, have more disordered eating, and are more likely to avoid healthcare appointments.

What advice would you give to physiotherapists interested in researching this field?

Read broadly across a number of disciplines and be very critical of assumed truths, which are very common and pervasive in this field. The assumed truths (dominant discourses) about fatness, in both popular media and biomedicine, are that fatness is always unhealthy and that it is almost always the fault of the individual. The pathologisation of fatness (e.g., obesity being classified as a disease in the US in June 2013) suits a healthist and biomedical agenda that gives more power to medicine (see the book *Fat* for more on this). Further, blaming the individual, as I mentioned earlier, suits the current neoliberal agenda focusing on individual rather than at a state or institutional responsibility. As challenging these assumed truths usurps the dominant paradigm, researchers in the field of weight stigma need to be prepared to encounter mainstream resistance.

And what support do you think we need to offer clinicians to tackle the problem of stigmatising practices?

We need to offer clinicians an understanding of stigmas generally, how they operate, how we can challenge them, the effects that they can have. Stigmas are also individual, so it's important to understand that different stigmas will have different characteristics. Weight stigma, as a relatively new stigma, is not yet widely understood, so it would be helpful to offer education on this topic both within existing physiotherapy courses and as professional development. Education would focus on finding ways to communicate with patients without size discrimination. I am currently developing some teaching resources so feel free contact me if you would like access to these when they are developed.

References

Gard, M., & Wright, J. (2005). The obesity epidemic: Science, morality and ideology. London, UK: Routledge.

Lupton, D. (2012). Fat. New York, NY: Routledge.

Puhl, R. M., & Heuer, C. A. (2009). The stigma of obesity: A review and update. Obesity, 17(5), 941-964. doi: 10.1038/oby.2008.636

Puhl, R. M., Peterson, J. L., & Luedicke, J. (2012). Motivating or stigmatizing: Public perceptions of weight-related language used by health providers. Int J Obes (Lond), 37(4), 612-619.

Interview with Tobba Therkildsen Sudmann

4 October 2014

As part of our 'interview' series with people in the Critical Physiotherapy Network, I asked Tobba Therkildsen Sudmann some questions about her approach to

physiotherapy, research, and life in general. Tobba is the Head of the Masters programme in Community Work at Bergen University College in Bergen, Norway.

Your thesis (En)gendering body politics: Physiotherapy as a window on health and illness *explored your interest in contemporary social theory and critical hermeneutics and talks about physiotherapy as a precarious social encounter. Can you talk more about where your interest in these subjects comes from and how your background has influenced your research?*

I believe my patients, students and children have been my best mentors in these questions. I was educated a physiotherapist in the mid 80s, and we trained to believed that our functional diagnosis and treatment suggestions where the only way to frame patients concerns and ailments, and that our preferred way of treatment and prioritising where not open to negotiations. However, during my years as a hospital physiotherapist working in neurology, neurosurgery and orthopaedics/traumatology, I learned the hard way that there is more to life than measuring the range of movement of pinkies or assessing for similar leg length. Visiting patients in their own homes before discharge also taught me to appreciate what matters in life: how to make the best of what you have, and how to mobilise personal and social resources to reach goals set by those concerned. Supervising physiotherapy students in clinical placements was also a great pleasure, and a great way of learning how other disciplines add value to physiotherapists practise.

Since I graduated I have kept on educating my self in law (jurisprudence), pedagogy, health and social administration, gender studies and medical sociology. Norwegian physiotherapy is a conspicuously gendered field when it comes to working divisions between primary care, hospitals, private or public services, and specialisations, as I have detailed in my thesis. Gender perspectives are inherently critical, more often than not inspired by thinkers like Goffman and Foucault. From critical gender studies there is a short distance to critical disabilities studies, and discourse perspectives. Lastly, I have also learned a lot about how the differences between people matter in social interaction and in social stratification by raising three children born in Brazil and two born in Norway. Mothering 5 boys of different colours, abilities and temperaments is a practical education in critical social theory and anti-oppressive practice.

How has your research developed since your 2009 thesis?

I was teaching and supervising a lot both before the thesis and afterwards. I have always been fascinated by what people manage to do despite their impairments, ailments, scare resources or other constraints; how they are able to allocate and mobilise bodily, material, social or fiscal resources to reach their goals; and how people slip slide between different positions of being in need of protection and assistance (proxy), or are able to exercise agency and participate in whatever they like (with or without assistance). My interest in community work grew out of these questions, and critical perspectives on health promotion and rehabilitation were major driving forces. Community work in Bergen is a bottom up initiative, acknowledging humans as always already social beings, and appropriating collective action to alter conditions and prerequisites for creating a sense of community and social participation.

Whose work has influenced you most in this area?

I love to read, and I read a lot: fiction, prose, cartoons, and heavy scientific literature. My favourite authors are Erving Goffman, Hans-Georg Gadamer and Michel Foucault. Goffman, Foucault, and Bourdieu worked together in Paris in their early days, and when one reads these authors with this in mind, they overlap a lot, and supplement each other. Hans-Herbert Kögler has done a marvellous job combining Foucault and Gadamer, and the re-reading the canons series has several volumes that have nurtured my interests in these fields. Gadamer's later writings hold great potential for critical practice and research.

In our program in Community work Goffman's writings on stigma, presentation of self, gender, and social interaction are key readings. Anti-oppressive practice is a core topic, and Paolo Freire's classical series of *Pedagogy of Oppression* is on the reading list. One of our key books was written by Tesorieiro from Australia, a book much appreciated by students from Norway, UK, and Tanzania.

Anti-oppressive practice seems to be a very important issue for you. Can you talk about how this features in your research and practice, and whether you think this is important to physiotherapy?

Making people competent and able to exercise agency is a key goal in my community work. As a physiotherapist I bring the body to the fore, which is not much mentioned in community work. Neither are all the small but very significant bodily differences between us that are played upon in any social setting and always make an impact. None of these things have an impact on physiotherapy at the moment. Health promotion, physical activity, everyday living, talking and writing about people as competent social actors are all key ingredients in my work. Everybody is knowledgeable about something, even though it might be things illegal or socially disregarded.

What are some of the challenges and areas of growth that you'd like to see in physiotherapy today?

Firstly, physiotherapists don't seem to be too interested in older people, and particularly not those with dementia, whether community-dwellers or residents in long term care facilities. During the last couple of years I have been giving lectures around in Norway on physical activity for people with dementia, starting off with a discourse perspective on dementia. I've argued that people with dementia are constructed and perceived as a homogenous mass of non-learners, non-participants, unsocial and non-movers, and so end up losing physical, social and cognitive functions very quickly. If carers or professionals perpetuate this stereotypical view they will never challenge older people physically, socially or cognitively and actually facilitates their loss of function by ignorance or neglect.

Secondly, there are not many physios — in Norway at least — interested in people with longstanding addiction and mental health problems. I am involved in two different projects with equine assisted activities and therapies (EAAT) for people with addiction/mental health problems. Equine assisted therapies are complex interventions with horses, people, places and activities, which challenge biomedical perspectives and approaches. Equine assisted therapies are social events, where the resources in the group, at the farm/stable, the nature and other animals, professionals and volunteers, are appropriated to facilitate changes - bodily or socially or in relation to drug use.

Thirdly, I am currently involved in a research project on development of radar based fall detection technology. The research group has two teams; a technology team and a social science/health care team (medical anthropology, occupational and physical therapy, nursing). Critical perspectives are needed to uncover the implicitly inscribed faller, ideas on 'normal' movement, 'normal' everyday living, experiences of dis/ability and embodiment, and the appropriation of ambient assistive technology. Successful ageing, ageing at home and leading an active life are the new health imperatives, and participation the new governance regimen.

These projects differ in scope, subject matter and population, but not when it comes to a need for critical perspectives.

Whose philosophical work do you draw on most in your critical hermeneutics, and what would you recommend people read if they want to understand this field better?

Personally I am very fond of Gadamer, particularly his later writings, and I have learned a lot from Kögler's merging of Foucault and Gadamer, and from the volumes on feminist re-reading of Gadamer and Foucault (and many more). Goffman also has a lot to offer, if one takes the time to read his complete work. His prose is simpler than Foucault and Gadamer, but the depth is the same. However, to many scientists, an author writing in everyday prose is dismissed.

A more generic answer would draw the attention to something quite different. When it comes to reading, my primary concern is that people read too little, and spend too little time

grappling with long texts. Our students avoid books if there is an article available, but they read articles in the same manner as they scroll Internet pages. My suggestion to my students might also be relevant for physiotherapists, and that is a simple invitation to just read, everything and anything, and to reflect upon how a particular phenomenon or person or problem was framed in this particular text. A litmus test is also to check your gut feeling about how you would have judged this text if it was about yourselves, your beloved ones, or a person of different colour, age or gender. Changing gender, age and race in text completely transforms it, and shows us how social stratification, oppression and marginalization are written into everyday prose. For students, the challenge is to take these common experiences into professional practice, and to discover that physiotherapy is but another social practice, nothing above or beside other forms of social life.

Recommended texts

Kögler, H.H., The power of dialogue. Critical hermeneutics after Gadamer and Foucault. 1999, Cambridge: MIT Press.

Code, L., Feminist interpretations of Hans-Georg Gadamer. Re-reading the Canon, ed. N. Tuana. 2003, University Park, Pa.: Pennsylvania State University Press.

Hekman, S.J., Feminist interpretations of Michel Foucault. Re-reading the canon. 1996, University Park, Pa: Pennsylvania State University Press.

Gadamer, H.G., The enigma of health: the art of healing in a scientific age, ed. G. translated by Jason and W. Nicholas. 1996, Stanford California: Stanford University Press.

Gadamer, H.G., The Gadamer Reader. A bouquet of the later writings. Trans Robert E Palmer. 2007, Chicago: University of Chigaco Press.

Freire, P., Pedagogy of hope. Reliving Pedagogy of the oppressed. 1995, New York: Continuum.

Freire, P., Pedagogy of indignation. 2004.

Freire, P., Pedagogy of the oppressed. 1972, London: Penguin.

Tesoriero, F., Community development : community-based alternatives in an age of globalisation. 4. utg. ed. 2010, Frenchs Forest: Pearson Education Australia. XV, 344 s.

Bartlett, R. and D. O'Connor, Broadening the dementia debate: Towards social citizenship. 2010: The Policy Press.

Bartlett, R., Citizenship in action: the lived experiences of citizens with dementia who campaign for social change. Disability & Society, 2014(ahead-of-print): p. 1-14.

Interview with Clare Kell

22 October 2014

As part of our 'interview' series with people in the Critical Physiotherapy Network, I asked Clare Kell some questions about her approach to physiotherapy, research and life in general.

Clare was the author of a paper titled *Making practice education visible: Challenging assumptions about the patient's place in placement environments* (International Journal of Therapy and Rehabilitation, 21(8), 359-366).

Clare is a Senior Lecturer and Programme Lead at Cardiff University in Wales (KellC@cardiff.ac.uk).

Where does your interest in health care education - and particularly patient-centred care in physiotherapy - come from?

This is a hard question to answer because, like many of us I expect, my journey has been round and about! I taught physio for 15 years and was curious about how students learnt and how curricula could impact that learning. In the UK pre-reg students have to do about 1,000 hours of learning in placement settings, and it became clear that studying University-based education was only part of (or in fact a third of!) the issue. Thinking about learning in placement settings however proved hard to 'get at'. Yes we, as academic staff, created the learning outcomes and assessment forms for the placement educators (practising clinicians with their own patient caseloads), and visited students on placement… but what really was going on, how and what were students learning? Linda Jones, Gwyn Owen and I did some preliminary story-collecting work and heard what to us were surprising, or rather undecipherable, accounts from placement educators of their role(s) in students' learning. I felt I needed to go into the field (no mean feat in the UK where research in NHS hospitals, the site of most placements, requires an arduous research ethics process), and my doctoral research project seemed the perfect opportunity.

So I didn't set out to explore patient-centred care or the place of the patient in student-present physiotherapy placement interactions – but rather to try and understand, through observation, what might be going on learning-wise on placement.

You talk about the 'rhetoric of patient-centred professional education' and patients being unquestioningly 'present-absent' aids to learning. Why do you think this is?

I'm sure my response to the first question sounds naïve – and indeed, now I look back, I wonder what I was thinking. My social science studies were opening my eyes to issues of power, profession and hierarchy (all I felt confident I saw in physiotherapy), and to the power of curriculum design to effect change / perpetuation of implicit group norms (Bernstein's

Pedagogic Discourse (PD) ideas having particular resonance). So my initial project idea was to use PD as a framework for tracking the discourse of physiotherapy education from its Field of Production (our UK professional body) to its Field of Reproduction (the educator: learner interface). The idea was to combine a documentary analysis of the various curriculum documents (all liberally sprinkled with terms like 'patient-centred care') with interviews and observations of placement educators and their students to explore in action the things outlined in the documents. I knew I wouldn't be able to use any recording equipment (audio or video) on the wards as this was part of my access approval negotiations, but felt confident that I'd be able to write, in field note form, the 'education' practices I observed.

My plans fell apart after my first access interview! Bouncing back to my supervisor (bouncing is something I saw lots of physios do, so expect I did it myself), confident I was on track, he asked 'So what exactly are you expecting to see?'… I had no idea. I had fallen into the trap of 'familiarity' and had forgotten to use the interview to question what words like 'doing the subjective/ objective' meant. With no sense of how placement education was done I couldn't do my study as planned which was framed around this assumption! My new project sought to answer Tom's question as an ethnomethodologically-informed ethnography of placement education – and it was through following of students on placement that I collected the data that I suggest capture patients being used as live-audio visual aids, drilled for the data that educators and students use to create a case for physiotherapy – which of course they then 'provide'.

As my papers suggest, there are multiple reasons for this person-absenting. Physiotherapy is certainly 'precarious bodywork' (after for example Twigg, Emerson, etc) and patients, and therapists need some way of navigating the interaction – and one way to do this is to distance the person from the body - but why was I never taught this / could this distancing be done in a patient-led way? (I do remember having 'sociology' lectures – but they were so peripheralised I recall nothing at all!). Further, the UK NHS, in these neoliberal times, operates 'timed units of activity': framed in discourses of accounting logic (see for example Broadbent and Laughlin) therapists record what they do every 15 minutes, and 'patient contacts' are slotted into these. Frequently students told me that their educators had said that they 'simply did not have the time' to talk to their patients if they wanted to 'get through' an assessment in time. And then, in the UK, placement education is 'hot': students learn while treating / co-treating real patients in real time (unlike medical education for example). Our current cultural systems (not forgetting the impact of evidence-based medicine, and a professional definition of 'science') all may compound to oblige educators to be pointing out things to their students, making their thinking processes visible etc. while the person-who-just-happens-at-this moment- to-be-called-a-patient-and-thus-need-some-help-from-a-physio consents (who knows why – another project perhaps?) to be poked, moved and talked about as if they were a test-tube being sourced for data. I have no answers – just lots of thoughts, and would

welcome others' ideas, opportunities to explore further. My project just set out to 'make visible' – we need more work to think about 'why?'.

What appealed about an ethnomethodological approach to the coproduction of knowledge in your study?

Ethnomethodology (EM) is a term coined by Garfinkel (1967) to describe a style of analysis that focusses attention on the social construction of everyday practices. It is interested in exploring the 'just thisness' of interactions (Pollner 2012) – how interactions are practically accomplished, in order to explore such questions as 'what is going on here?' It was perfect for my project with one drawback - ethnomethodological analysis requires data that is rich in both context and practice description: you need lots of rich data focussing on the minutiae of interaction practice so that you don't jump to conclusions / use your own experience to judge what the interaction participants you are observing are doing. And I only had pencil and paper with which to collect this data! So I went back to the drawing board – quite literally.

Watching hours of publicly available videos of physiotherapy practice, I sensed that eye-contact (kinesics) and nonverbal communication (including physical use and occupation of space – proxemics) were important in how therapy 'was done'. So I read anything I could lay my hands on that could help me collect this data…. And my proxemics sketches and kinesics staves were born!

How did you find using proxemics sketches as a method?

I am very grateful for my physiotherapy training which has given me an intense sense of curiosity in how people move, and a pretty good ability to 'see' elements of that movement. Goodwin uses the wonderful term 'professional vision' to describe the profession specific way different groups look at the same situation (Goodwin 1994). Professional vision is both a blessing and curse in ethnographic fieldwork though: it certainly helped me extricate features of each interaction I observed speedily so that I could make field notes and draw proxemics sketches in the full flow of practice, but it can also leave researchers open to charges that they have only recorded as data what they wanted to see. I tried to overcome this charge by reconceiving movement as communication (something I had never thought of before).

The staves and sketches are really easy to do for anyone with a keen sense of noticing. I am writing a 'proper' methods paper, but have drafted a working version too. I am not an artist – and indeed being one may make sketching more difficult. When you look at my sketches, they are not physically accurate, but, building on my professional vision, an inherent sense of base of support and centre of gravity for example, they capture a sense of the spatial (proxemics) features of interactions. I would love all students to learn to draw proxemics sketches — if only to record each other's postures during skills lessons – the postures I saw their backs in

made me gasp – and no one ever corrected them because all eyes were too busy looking at effected body-parts!

Whose work has influenced you most in recent years (who would you recommend others read)?

I've mentioned already some key thinkers who helped me to question the norms of physiotherapy interactions, but two authors specifically influenced the creation of the kinesics staves element (recording eye-based communication) of my notation system. Birdwhistell, an American sociologist developed an alphabet-type approach to transcribe video footage onto paper. Obviously I couldn't learn this and reproduce it in real time, but his work (outlined in his very readable and enlightening book) did confirm that eye-based communication was essential to capture.

Christian Heath (based at Kings' College London) has informed my project in so many ways (do read his book about auction houses!), but the way he transcribed his videos of eye-based elements of Doctor: patient consultations by writing each person's actions one above the other, got me thinking about a musical stave approach. So Birdwhistell + Heath + Kell = Kinesics Staves!

What effect has the Mid-Staffordshire inquiry had on the physiotherapy profession in the UK?

This is a question I think I will sidestep by saying I just don't know. I have been to physiotherapy conferences and gatherings and people are certainly talking about 'values' – which is new, and 'patient self-management' – also new although I sense perhaps not being used in a patient-led way – but in terms of practice change, I'm not the person to ask! If anyone has access to funding – why don't we go into the field and see?

What advice would you give to physiotherapists interested in taking a more patient-centred approach to their practice following your research?

There are excellent texts emerging all the time from physiotherapy-based researchers, but I have found it very helpful to read about other professional groups in order to cast new light on my own, so I would encourage people to read these two texts as starters. The first is Lave and Wenger's excellent short text: *Situated Learning* in which the authors report and discuss fieldwork data from their observations of how learners learn in different professional groups – shocking, humbling and funny in almost equal measure - I wonder which case study you'll think similar to your experiences of Physio education?

And then Phil Strong's work, especially *The ceremonial order of the clinic* is deeply thought-provoking as he shares his observations of medical consultations – with and without students present.

For those who want to explore ideas in practice after some reading, perhaps just sit quietly and watch what is going on around you in ward or clinical settings. And rather than seeing all the 'work' as things you recognise e.g. there is someone writing in the notes / talking to a relative etc., perhaps look beyond the obvious and ask yourself: 'What are they writing in those notes? What are the notes for? What work are the notes doing and for whose benefit?' Or perhaps: 'Why are the therapist and relative standing in that way? How is the interaction being done? What work is eye contact / removal / body movement playing and for whose benefit?' Perhaps physio teams / students could explore these and other aspects of their practice together… but the key thing is to start noticing how we do things…

Critical perspective on client-centred practice

4 February 2015

A few weeks ago, I posted up a blog from Hybrid Pedagogy that shed some light on what it means to be critical. With perfect timing, Karen Whalley Hammell (author of Perspectives on Disability and Rehabilitation and honorary under cover member of the Critical Physiotherapy Network), has published a new paper in the Scandinavian Journal of Occupational Therapy (access the abstract here) Although the paper is directed at an occupational therapy readership, there's a lot in the paper for physiotherapists to reflect on. Karen is very keen to share thoughts and ideas about the paper (you can find her contact details in the list of CPN members).

A new Journal of Humanities in Rehabilitation featuring Thomas Eakins and early photography of motion

3 March 2015

Angela Fritz's recent blogpost on the anatomical studies of Thomas Eakins appeared in a new journal that may be of real interest to members of the Critical Physiotherapy Network.

The Journal of Humanities in Rehabilitation is published by the Emory Center for Digital Scholarship and aspires to:

> 'raise the consciousness and deepen the intellect of the humanistic relationship in the rehabilitation sciences. Our mission is to encourage dialogue among rehabilitation professionals, patients, families and

> caregivers that describe the human condition as it experiences the impact of illness or disability. We hope to highlight and illustrate the special relationship between the patient and rehabilitation provider, as well as provide a venue for scholarly discourse on topics that focus on rehabilitation from the uniquely human perspective that patients and providers share'.

Angela Fritz's article profiles Thomas Eakins who was a prolific artist during America's Gilded Age (a period covering the latter part of the 19th century). The article features some of Eakins's photographic studies of human movement, but he was equally as famous, along with his contemporaries like John Sargent, Edmund Tarbell, Thomas Dewing, Henry Tanner and Julian Weir for his studies of idealised femininity in postbellum America. The women Eakins profiled were often thin, pale and weak-looking and represented notions of gentility much sought after by 'cultured' society at the time, both in America and Europe (See Women on the Verge and Cultures of Neurasthenia).

Women in the Gilded Age - particularly educated upper and middle-class white women of 'independent means' - were subject to terrible social restrictions, and many suffered appalling health physical and mental health problems as a result of corseting, enforced docility and confinement (see, for example, a classic feminist text of the time - The Yellow Wallpaper - freely available as a pdf).

When these women rebelled, they were labelled as hysterical or neurasthenic and were treated with a Rest Cure that served to further imprison the women.

Why is this relevant to physiotherapy? Well the Rest Cure involved isolating the woman away from her family for six to eight weeks while she was 'fattened up' on a diet of milk and beef juices, all the while being treated with vigorous massage, electrotherapy and passive movements. Based on the evidence in early physiotherapy books of the time, these women were vital in helping physiotherapy to establish their credibility and were the first significant population of patients to serve the interests of our nascent profession. Amazingly, this history remains completely unexamined.

What brings someone to the Critical Physiotherapy Network?

6 August 2015

A few weeks ago we celebrated one year in the life of our little Network and our 300th member. Since our inception we've received countless emails from people saying how glad

they are that the network exists, and how nice it is that it's being run by such attractive, intelligent and wise people! (They're particularly complementary about our attractiveness).

In all seriousness, it does seem as if the network is an idea whose time has come. Maybe there are enough physiotherapists now with the confidence and experience to tackle some of the thorny questions that now beset us? Maybe knowing that there are other people who think 'differently' has given people encouragement to join in? Maybe we are starting to see the benefits of studying and thinking 'outside' physiotherapy and bringing those ideas back into our profession? Whatever it is that's caused the surprising growth of the Network in such a short space of time, it's clear that the CPN is functioning as a new forum for ideas about physiotherapy.

We thought it might be nice to profile one of the people who had recently become a member of the Network. So when Robin (a made up name) applied, we asked why. This is what he said...

Robin is a 38-year-old male physiotherapist who graduated three years ago from a large European physiotherapy school. He is married to a nurse and has two small children.

> ”I have a disability which is not visible, but has made it a struggle to go through the education system and get employment. On the other hand it has helped me understand a lot about what goes on in the lives of the people I aim to help.
>
> ”I work as a community-based falls prevention therapist, primarily with people 65 years of age and older.
>
> ”The idea that the individual has the responsibility for their own personal health and circumstances (while at the same time accepting and following what “experts” define as health and/or meaningful activity) is really prevalent in my area of work, and it's something I think is really problematic.
>
> ”Health care providers are increasingly using motivation and compliance as power constructs in which the resourceful and “compliant” patients receives a better intervention then their “noncompliant” and “unmotivated” peers, with an often complete disregard for the social contexts. I find it hard to accept that there is a lack of alternative methods and tools to ensure equal treatment for all citizens. I'm opposed to the way words and concepts like rehabilitation, empowerment and autonomy are used to cover up a financial agenda and how I am expected to accept and sell that agenda.
>
> ”I am sceptical of the way it has become harder to question the current state of affairs without being accused of being disloyal. I feel as if I am

> constantly being asked to put my loyalty to the healthcare system above that of my patients. I question the use of evidence based medicine as a means to explain everything, and in so doing downgrading the human and social sciences as something lesser and irrelevant to physiotherapists. I think physiotherapy has a lot to offer as a way to create meaning in the lives of the people we try to help.
>
> ”My work has made me question many things about healthcare, physiotherapy and my role within it, but I've felt very alone with these questions in the past. I see a need for the Network as a counter-balance to the path the physiotherapy profession and the health care system is going in. I'm looking forward to working with other members of the group and to the opportunity to educate myself further beyond what my traditional education has offered me."

It's not unusual to get emails from members expressing similar frustrations to this. It seems most of us just want to experience the full possibilities offered by the physical therapies, but people are being increasingly frustrated by the culture, economics, and politics of their working world. Perhaps the CPN can be a place where we develop ourselves to feel more confident to be a 'positive force for an otherwise physiotherapy' so that people no longer feel that they are being disloyal to their profession when they think and practice differently? Wouldn't that be a good thing.

The beauty of networks

23 May 2016

If you'd have asked me two years ago whether I would, one day soon, travel to Norway to work with physiotherapists from the Critical Physiotherapy Network, I would have said you had been eating too many pickled herrings. But life is full of surprises, and I'm pleased to report that I've just returned to New Zealand after spending a lovely month working at Oslo, Bergen and Tromsø, sharing ideas about the future of physiotherapy with some of the most critically interesting people I have come across in the profession.The invite to go to Norway came, in part, out of a meeting of CPN members at the In Sickness and In Health conference in Mallorca last year. Prior to that a number of our Scandinavian members had contributed to our article on Connectivity (link to the full paper here). We'd also features a couple of Norwegian physiotherapists in blog 'interviews' (see profiles of Wenche Bjorbækmo, Tone Dahl-Michelsen and Tobba Sudmann). So working with people across the Network had brought many of us together. But an invite to actually teach in Norway and meet many of the people I had read about and studied was a real joy.

I got to spend time with dozens of lecturers and students at the various universities, and all of them were incredibly generous with their ideas and their time. It was particularly interesting to discuss many similar tensions and issues, despite the fact that we worked on completely opposite sides of the world. There are some particular people I really wanted to acknowledge and thank though. These people are outstanding researchers and teachers, and incredibly kind hosts.

Firstly, Wenche Bjorbækmo, for helping to organise the whole trip and for being so generally lovely. A trait shared by all of the people I worked with in my week in the Institute of Health and Society at the University of Oslo. The same can be said of Tone Dahl-Michelson at the Oslo and Akershus University College of Applied Sciences. I had a lovely time discussing curriculum reform with the staff and clinical educators from the school.

In Bergen, Målfrid Råheim, Tobba Sudman, Randi Sviland and I met with staff from the University of Bergen and discussed critical and radical new approaches to physiotherapy research, theory and practice. Once again, people gave up their precious time to talk about issues that are close to all of our hearts.

And finally, to the far north and the warm hospitality offered by Siri Moe, Gunn Kristin Oeberg, the staff and students I met at the northernmost university in the world.

For those of you who are actively involved in the CPN, you will know that the potential for similar exchanges is becoming limitless - especially with advent of fast broadband connections. For those of you who sit on the margins, unsure about the merits of being part of an organisation like ours, feel free to use my experience as a stimulus to look across the Network for people you would like to collaborate with. We are all, to some extent, operating in hostile territory among colleagues who often have very little idea about our ideas and interests.

There are people out there, though, who do think like you - or at least think in stimulating and interesting ways about the future of the profession and are keen to hear from others and share. I know, I've seen some of them just recently, and they're really lovely.

Births, deaths and marriages

17 June 2016

There was a time, not so long ago, when physiotherapy journals included all sorts of ephemera; parliamentary reports, branch proceedings, and notices about the latest pay rise. But by far the best bit of the journal came in the Personal section and notices about births, deaths and marriages.

Here's an example from the Physiotherapy Journal of June 1962:

> DAWSON.--On March 26, at Copton Ash Farm, Sheepy Magna, Atherstone, to Jean(nee Tudor, traing The Middlesex Hospital) and Peter Dawson, a daughter (Anna Rosemary), a sister for James and Richard.

Anna Rosemary of Sheepy Magna. I kid ye not.

Well lest we be accused of taking our task too seriously, I'd like to end another busy week with some of our own social notices.

Two of the CPN's more musically gifted members (Alan Taylor and Roger Kerry) have this week released a video premiere of their latest music/art collaboration with Eugenie Lee. The piece is called 'Black Rain' and comes hot on the heels of their CD 'Sons & Lovers' which got a great write up from Lee Zimmerman on No Depression, among other places.

They've kindly sent us a trailer for the video and an mp3 to download.

The live World Premier of the song will take place on the Wednesday of IFOMPT 2016 in Glasgow at Nice n' Sleazy.

Two more very talented CPN members received gongs from the Queen this week.

Bhanu Ramaswamy and Ann Moore were awarded OBEs and CBEs respectively, which now entitles them both to sit in the House of Lords, wear ermine, own a moat, and employ servants as indentured labour on less than the minimum wage.

Huge congratulations to the two of them. With Bhanu and Ann in positions of awesome power, world domination is within our grasp.

And finally, I'm delighted to be able to report that a crack team of CPN researchers will be presenting a focused symposium at the WCPT Congress in Cape Town in July next year.

Our session is titled: *Critical Physiotherapy: New approaches for practice, education, research and policy* and will be presented by yours truly, Barbara Gibson, Mershen Pillay, Jenny Setchell, and Viviana Silva Guerrero.

If you like a good read, here are the objectives for the session and a description to entice you to come:

Learning objectives: By the end of the session the participants will:

- Understand the basic tenets of critical approaches to physiotherapy and how these differ and/or add to mainstream approaches
- Gain knowledge in how critical perspectives have been applied to practice, education, research and policy

- Gain insight into applying a critical perspective to their areas of professional interest

Description:

Critical Physiotherapy strives to challenge and improve contemporary physiotherapy theory and practice through the exploration of views that deviate from conventional thought and practice (Gibson & Teachman 2012, Nicholls et al. 2016). It does so by examining its position on abnormality, deviance, and difference to recognize and address power asymmetries inherent in physiotherapy practice, particularly where they marginalize some groups at the expense of others (Pillay & Kathard 2015, Setchell et al. 2016).

While there are variants of critical approaches, they share a common belief that medicine and physiotherapy are overly concerned with biological, neurological, and physiological processes, to the exclusion of the moral, social, political, and cultural mediators of health and wellbeing (Nicholls & Gibson 2010, Setchell et al 2014). In this interactive symposium, we will begin with an introduction to basic tenets critical approaches as a method of inquiry and how they can be used to interrogate any area of practice to inform and reimagine an "otherwise" physiotherapy. Each speaker will then explore an applied example of a critical approach and the implications for physiotherapy.

Gibson will discuss research with parents and children that examined key ideas about disability and normality in children's rehabilitation and the consequences for young people labelled as disabled. Pillay will explore how teaching critical approaches can assist future and current rehabilitation professionals' to recognize how their practices reflect colonial origins; and how - globally - professional transformation must attend to decolonization. Setchell will draw on her research (Setchell et al. 2016) exploring (often unintentional and unrecognized) discrimination and stigma in physiotherapy. She will demonstrate how critical understandings help to highlight nuances of physiotherapy that make stigmatization and marginalisation possible in the profession. Silva Guerrero will focus on the growing influence of neoliberalism (Homedes & Ugalde 2005) on healthcare and physiotherapy. Drawing on her experience of recent changes in Colombia, she will explore how social and political forces affect professional practices and policy.

An interactive session with the audience will follow. This will include facilitated opportunities for the audience members to discuss and reflect on their own experiences in physiotherapy from a critical perspective. There will also be opportunities to ask relevant questions of the speakers. The session will conclude with summary remarks from the Chair.

Extended members

20 October 2016

One of the things I like most about the CPN is that its doing some pretty big things (international collaborations, book projects, a WCPT Focused Symposium next year, etc.), but its still small enough so that you get to see what other people are doing. And some of the things other people are doing are incredible.

Anna Rajala, for instance, has been a CPN member since the early days, and during that time has been writing and teaching about history of medicine, mental health, disability, and political and moral philosophy. She's done a masters degree in philosophy, politics and economics of health and her dissertation on Hegel's dialectics of recognition and ethics in dementia was awarded with distinction. She is currently enrolled in a PhD at the University of Brighton in the UK.

Her blog *Critical | Health | Philosophy* is everything good about 'new' physiotherapy: thoughtful, inspirational, critical, and so much of what Anna writes relates to the challenges and questions we all now face.

To give you an illustration, here is a short excerpt an extended piece on theory, practice and dichotomies:

> 'What if there were other theories that could expand our understanding? According to Adorno, the conception of finite systems should be turned upside down and we should believe that there is always something else outside the system. Everyone benefits from such critical thinking: the least that this does is that it keeps every physiotherapist challenging their limits. A critical stance towards the foundation of our thinking, towards things and what we think we know about them, is healthy. For example, repeating some concept like a mantra (e.g. biopsychosociality) without considering its meaning, understanding and interpreting the world around us may become defined and restricted by this one concept in a narrow and blind manner'.

Physiotherapy needs more thinkers like this, and I'm very happy to say a lot of them are part of the CPN.

Other readings

Rajala, Anna Ilona. "Pitkäaikaishoivan ruumiillisuuden arvosta (On the value of embodied long-term care)." In Ruumiillisuus ja työelämä: työruumis jälkiteollisessa taloudessa (Embodiment and working life: Working body in post-industrial economy), edited by Jaana Parviainen, Taina Kinnunen and Ilmari Kortelainen. Tampere: Vastapaino, 2016.

Rajala, Anna Ilona and Jenni Aittokallio. "Dikotomiat ajattelun kahleina. Mitä teorian ja käytännön erottelu merkitsee fysioterapeutin työssä? (Dichotomies shackle thinking. What

does the separation of theory and practice signify in physiotherapy?)" Fysioterapia 61, issue 4 (2014): 27–31.

Judging physiotherapy

30 May 2017

WCPT President Emma Stokes, Professor Peter O'Sullivan, and others have been engaged this week in a Twitter discussion about how to create a culture in physiotherapy that nurtures change.

The idea of 'space without judgement' was suggested as a more positive approach to change than physiotherapists perpetually 'bashing each other'.

A few days earlier, Laura Opstedal had written about letting go of traditions in physical therapy, arguing that resistance to change was a big barrier to progress, and that exploring 'the new' might be a creative way to proceed.

This post followed nicely on from Roger Kerry's piece *Physiotherapy will eat itself* (Kerry, 2017), and some recent questions I'd raised on this blog, notably: *Should we give up physiotherapy?* (Nicholls, 2017a) and *If you're looking for innovation, regulatory authorities need to change* (Nicholls, 2017b).

One of the basic arguments being put forward here is akin to Erik Meyer and Ray Land's notion of Threshold Concepts. This goes that there are certain concepts that are central to the very fabric of a profession - in this case physiotherapy - and that these act as a way to understand what the profession is and isn't. Significant and meaningful change means letting go of some of the threshold concepts that were once held dear, and replacing them with new ones.

Our role as a professional community is to debate and contest these threshold concepts, and explore them in our curricula and professional scopes of practice.

Physiotherapists haven't been good at this kind of debate in the past, a fact all too obvious in our physiotherapy curricula, which still bear all the hallmarks of the curricula of the 1950s. (Interestingly, Meyer and Land identify bloated, content heavy curricula - so common to physiotherapy educational programmes - as a diagnostic feature of programmes that have failed to identify their threshold concepts).

> "Traditionally, learning has been defined as a list of subject matters and facts you need to acquire - such as arithmetic and grammar - with some decoration, like citizenship, built in around it," Ms Lonka says. But when it

> comes to real life, our brain is not sliced into disciplines in that way; we are thinking in a very holistic way. And when you think about the problems in the world - global crises, migration, the economy, the post-truth era - we really haven't given our children the tools to deal with this inter-cultural world. I think it is a major mistake if we lead children to believe the world is simple and that if they learn certain facts they are ready to go. So learning to think, learning to understand, these are important skills - and it also makes learning fun, which we think promotes wellbeing" (Kirsti Lonka, a professor of educational psychology at Helsinki University, cited in Spiller, 2017).

So the challenge to identify our threshold concepts lies in front of us. But what complicates things even more is the fact that we are now experiencing perhaps the most radical transformation in the way people think about healthcare, health knowledge and health technology that we have ever seen. Health professional roles that were designed to function in a 20th century - where many physiotherapists had their salaries paid by the taxpayer, and had access to subsidised training, patients lying in wait, abundant social capital and legislative protection - are disappearing fast.

The BBC is reporting today that a school in Finland has stopped teaching 'subjects' to its students. The report states that, 'In August 2016 it became compulsory for every Finnish school to teach in a more collaborative way; to allow students to choose a topic relevant to them and base subjects around it. Making innovative use of technology and sources outside the school, such as experts and museums, is a key part of it' (ibid).

And this is the world that future physiotherapy students, practitioners and consumers of healthcare will increasingly demand.

So, not only do we need to do work to find the threshold concepts that really matter to physiotherapy, we also have to imagine what they are in the context of the new economy of healthcare that we increasingly find ourselves operating within.

Picking up on the spirit of Emma Stokes' Tweets yesterday, creating a space in which there is a superabundance of 'judgement' would seem to be in order. To do that, we need to learn to critique with decency and respect, but to not be afraid of taking even the most sacred threshold concepts and asking naive questions about its future value.

There is an old maxim that says that if something worked yesterday, it should work again today as long as nothing has changed.

Things have changed, and so should we.

References

Kerry, R. (2017). Physio Will Eat Itself. https://rogerkerry.wordpress.com/2017/04/24/physio-will-eat-itself/

Nicholls, D.A. (2017a). Should we give up physiotherapy? https://criticalphysio.net/2017/04/20/should-we-give-up-physiotherapy/

Nicholls, D.A. (2017b). If you're looking for innovation, regulatory authorities need to change. https://criticalphysio.net/2017/05/19/if-youre-looking-for-innovation-regulatory-authorities-need-to-change/

Spiller, P. (2017). Could subjects soon be a thing of the past in Finland? https://www.bbc.com/news/world-europe-39889523

Reflections of a quantitative researcher on the CPN Salon

20 July 2017

This is another post in our series of new bloggers on the criticalphysio site. This post comes from Professor Dina Brooks, Canada Research Chair in Rehabilitation in Chronic Obstructive Pulmonary Disease at the University of Toronto in Canada.

Let me start with two confessions: 1) this is my first blog ever; and 2) I am a quantitative researcher who has done basic and applied research and conducted multiple randomized controlled trials. With any luck, these disclosures will not turn you off reading this blog but intrigue you to know why I feel compelled to write my first blog ever, for the CPN.

The day after WCPT Congress, I attended the CPN Salon in a beautiful venue in Cape Town. I had become a member of CPN about 6 months ago, mostly out of curiosity. I didn't feel like I belonged or that I shared similar philosophies but I was intrigued by the group. After chairing the scientific program of WCPT, I thought it would be refreshing to spend a day at the CPN Salon listening to intellectual discussion among individuals that thought quite differently than I did. I had the intention of being a passive listener as I didn't feel that I could contribute much. I was slightly intimidated by the topics on the agenda, as they were not part of my daily discourse.

As often is the case in life, expectations and reality did not match and the day was greatly enlightening and highly relevant to my world. I would like to share with you four reflections on the day.

The CPN Salon took me outside my comfort zone. Comfort kills productivity and pushing our boundaries can not only increase efficiency, but also maximise creativity and make it easier to

push boundaries in the future. I felt outside my comfort zone for most of the day and came away invigorated.

By no fault of its own, the CPN speaks to the converted. Despite the fact that anyone can join CPN, members of CPN are mostly qualitative researchers or clinicians who are not happy with some aspects of practice. They are like-minded individuals who think in a similar way and mostly agree with each other. Although I appreciate the need for a group that supports this common thinking, more could be accomplished to improve physical therapy care by expanding the network beyond those individuals.

Critical doesn't mean judgmental. Critical means “challenging physiotherapy practice and thinking and critically reflecting on the profession’s past, present and future”. However, at times, I felt that critical could slip into being judgmental, making it counterproductive. It is true that the ideas of critical physiotherapy are not mainstream and need to gain more momentum. However, we must pay attention to language and tone to make sure we don’t create alienation in the profession. For example, I can agree with many sensible comments about the limits of randomised controlled trials. However, I will become defensive and even argumentative when disrespectful or snide comments are made about this research design.

“Let’s build bridges not walls”. A wall stops us from connecting with one another and creates distance. Instead, let’s create means to meet even when our ideas are drastically different, making it possible to create solutions and new knowledge. Building bridges will help empower physiotherapists to engage in thinking and practice that will move the physiotherapy profession forward. In addition to a CPN Salon, let’s bring the ideas of CPN into the more indoctrinated areas of physical therapy. For example, I could benefit from the ideas of CPN when designing an international randomised controlled trial of balance training in COPD. Maybe PEDro could benefit from some of the ideas in CPN and so could many of the special interest groups in the profession.

After the CPN Salon, I no longer feel the “us”, quantitive researchers involved in generating conventional scientific evidence, and “them”, critical thinkers who challenge conventional research and practice. Instead, I have come to appreciate how important it is that these two worlds collide and interact regularly. Let’s break the walls and create bridges!

Reflections on a Tweet/Why I joined the CPN

14 October 2017

CPN member Blaise Doran responded our call-out to members to write a short statement about why or how they have found their way to a CPN so we could use them as testimonials.

However his response was so interesting (and too long for a testimonial) we thought it would work better in a blog post.

Blaise Doran BSc (Physio.), GradDip (Neuro. Rehab.), MSc (Pain Mgt.) originally trained and worked in the UK. He is a physiotherapist and the coordinator for the Children's Pain Management Clinic at the Royal Children's Hospital in Melbourne, Australia. Previously he worked predominantly in adult neurological rehabilitation. Prior to undertaking his physiotherapy degree, he worked for ten years as a professional actor, primarily in subsidised regional theatres in the UK.

Blaise and I contributed a chapter to the first ever anthology of critical physiotherapy writing - due out very soon. The book *Manipulating practices: A critical physiotherapy reader* (Eds. Gibson, Nicholls, Setchell, Groven) is a CPN collaboration involving 20 authors from around the world. Our chapter *Performative acts of physiotherapy discusses how our performance histories* (Blaise was an actor, I was an acrobat) help in our clinical work - and could also help others.

Reflections on a tweet - by Blaise Doran (or why I joined the CPN)

I received an email from David Nicholls, asking "Could you write at testimonial for the Critical Physiotherapy Network?" How I found the CPN is lost to me now, why I found it may be easier to explain.

I have had a difficult relationship with academe, and in spite of my attempts to conform through undergraduate to postgraduate qualifications, I often find myself to be shoring up the crumbling structures that are our therapeutic foundations, and discovering that the synthesis of ideas from diverse sources is not popular, and is sometimes considered downright dangerous. I tend to have to take a break after being involved in academic endeavours and do something creative. When I finished my MSc, I decided to take up guitar. Not satisfied with strumming a few chords, I wanted to learn to read music, and play classical guitar.

The guitar is a deceptive instrument, you can pick it up and quickly learn to make a sound, but it is frustrating to learn to really make it "sing" (or at least, this has been my experience.) For example, you can play the note A in multiple places, and in a number of octaves. If you a right-handed player, what you do with your left hand can change a number parameters in how that note sounds, and a broader number of variables come from how and where you pluck the string with your left hand. When I look, say, at the guitarist Igor Lichtman play Poulenc's *Sarabande*, I can describe where and what he is doing:

"First finger in 8th position on the D string, the left hand is playing free stroke, positioned between the bridge and the sound hole" and so on.

And, if you are still reading, you should get the point that this description gives you no idea of how beautiful or nuanced the music he plays is. Creatively expressing, interpreting, and giving meaning are all part of human movement. We can watch the person and the instrument become one glorious entity, and transform the hieroglyphs of western musical notation, creatively expressing, interpreting, and giving meaning in the context of movement. We ought to be doing more of the same in physiotherapy. And, this, in essence is my “why” I found the CPN back in 2013.

We are all midwives

16 January 2018

A few days into the new year, CPN member Roger Kerry was recognised by JISC as one of the UK’s most social media savvy academics. The award acknowledged Roger's longstanding contribution to innovation in education, including the Tweed project which uses social media to formulate reading lists based on people's favourite texts.

It would be nice to think that in the future, our new book *Manipulating practices: A critical physiotherapy reader* will make that list, and given the fact that it's been downloaded nearly 4,500 times since it was released last week, it should stand a chance.

Roger contributes a superb chapter "*Reconceptualising causation in evidence-based physiotherapy*" to the book, and co-authored a chapter with Fiona Moffatt titled "The desire for “hands-on” therapy – a critical analysis of the phenomenon of touch". These are just two of the 15 chapters, spanning an enormous range of practical and theoretical topics, including chapters on ethics, disability, touch, obesity, the performing arts, and the sociocultural basis of practice.

When we established the CPN, our intention was to create a safe space for radical and interesting new ideas to emerge: a place where people could move beyond the ordinary and taken-for-granted and imagine what might be possible in the future.

So while the CPN can't take any credit for Roger's recent success, we can at least ponder on the fact that the CPN is an organisation of 'midwives' who are delivering new ways of thinking and new ideas to physiotherapy. Here's to more deliveries in 2018.

Having trouble talking to your patients?

3 December 2019

Two articles published over the last two weeks suggest that we might be having some problems talking to our patients.

The first, by Sullivan, Hebron and Vuoskoski (Sullivan, Hebron, & Vuoskoski, 2019) looks at the anxiety experienced by physiotherapists 'selling' their own explanations of chronic pain to patients. The therapists were trying to be patient-centred, but their efforts were undermined by 'an underlying paternalistic wish to get patients "on board"' (ibid). The authors attribute this anxiety to the confidence that the therapists feel in their biomedical understanding for pain, coming up against the patient's values and beliefs that either contradict or destabilise their confidence and offer a more personally meaningful counter-narrative. This is a finding that has been echoed many times before in healthcare research, and lies at the heart of many patients' complaints about not being believed (Dierckx, Deveugele, Roosen, & Devisch, 2013; Bourke, 2014).

Coincidentally, the study by Cupit, Rankin, Armstrong and Martin (Cupit, Rankin, Armstrong, & Martin, 2019) published this week in *Sociology of Health and Illness*, found nurses, GPs and healthcare assistants (HCPs) so dominated by the rhetoric of evidence-based medicine that they were unable to 'meaningfully 'involve' the patient and to support behavioural change' (ibid). Rather than their discussion of the risks of cardiovascular disease being a collaborative process in which 'patient and HCP work together to identify the best course of action for the individual patient, the 'discussion' has become a transaction' (ibid), that offers 'little to help patients manage the uncertainties and problems thrown up by the risk score'. The HCP's main concern was to draw their patient into 'actively 'choosing' the institutionally sanctioned course of action (seemingly overruling patients' queries and uncertainties) whilst simultaneously using language 'such as 'patient-led', 'communication', 'involvement' and 'shared-decisions', thereby constructing a belief that they were enacting these patient-focused values' (ibid).

The Sullivan paper is particularly telling because it argues that physiotherapists feel unprepared for the kind of uncertainties they experience when their officially-sanctioned beliefs are not shared by the patient. This is perhaps not surprising, though, given the weight of emphasis placed on the acquisition of confident, assured, objective knowledge of the body in health and illness in physiotherapy training, and the lack of structured and thoughtful approaches to the uncertainty and ambiguity that is the hallmark of real healthcare.

The recent exhaustive review of the physical therapy education system in the United States conducted by Gail Jensen and colleagues (Jensen, Mostrom, Hack, Nordstrom, & Gwyer, 2019) has highlighted the need for much greater attention to the humanities. Whilst celebrating some fabulous examples of clinical education, there is a sense that some therapists learn the humility and reciprocity of shared decision-making despite rather than because of their training. This is a worrying sign if health professions learn that gold-standard,

evidence-based healthcare is something to be imposed rather than being a starting point for a conversation in which the power of the client/patient is never less than equal to the specialised knowledge of the therapist.

References

Sullivan, N., Hebron, C., & Vuoskoski, P. (2019). “Selling” chronic pain: physiotherapists’ lived experiences of communicating the diagnosis of chronic nonspecific lower back pain to their patients. Physiother Theory Pract, 1-20. doi:10.1080/09593985.2019.1672227

Bourke, J. (2014). The story of pain: From prayer to painkillers. Oxford: Oxford University Press.

Cupit, C., Rankin, J., Armstrong, N., & Martin, G. P. (2019). Overruling uncertainty about preventative medications: the social organisation of healthcare professionals’ knowledge and practices. Sociol Health Illn. doi:10.1111/1467-9566.12998

Dierckx, K., Deveugele, M., Roosen, P., & Devisch, I. (2013). Implementation of shared decision making in physical therapy: observed level of involvement and patient preference. Phys Ther, 93(10), 1321-1330. doi:10.2522/ptj.20120286

Jensen, G. M., Mostrom, E., Hack, L. M., Nordstrom, T. M., & Gwyer, J. (2019). Educating physical therapists. Thorofare, NJ: Slack Inc.

Sullivan, N., Hebron, C., & Vuoskoski, P. (2019). “Selling” chronic pain: physiotherapists’ lived experiences of communicating the diagnosis of chronic nonspecific lower back pain to their patients. Physiother Theory Pract, 1-20. doi:10.1080/09593985.2019.1672227

Something EPIC

24 March 2022

I know you’re all bombarded with messages telling what to read and what to look at, but if you do have a small piece of grey matter left at the end of the week, please check out the unbelievable work that Filip Maric and colleagues have done over the last 18 months in producing this EPIC (Environmental Physiotherapy in the Clinic) project.

Read Filip’s introduction and explanation, and check out the clinic posters, activities, readings, and resources they’ve compiled for us, for FREE.

And then, wherever you can, share it far and wide.

It truly is an astonishing piece of work.

Chapter 11: 30 Days of September/courses

To my mind, one of the most innovative and important things we did in setting up the critical physio blog was to run our annual 30 Days of September — or 30DoS — campaigns. I say 'to my mind' because this, more than anything, caused consternation to a lot of my colleagues on the CPN Exec. Every year around April I'd start talking to them about the upcoming campaign and, invariably, someone would suggest canning the whole idea. It was saturating and exhausting, they said, receiving these posts every day. That's nothing, I'd say, to the exhaustion of compiling them. Take the 2020 campaign, for instance (perhaps the campaign that finally saw me off!). Each day for the month we sent out three recommendations for a research tool, a useful resources, or a person to follow whom we had researched and could verify. It took months to accumulate that list.

So why do it? Well, to begin with it was all about a novel way of surveying the members to find out their priorities, inspiring ideas, and promoting our people. But then it became a semi-religious commitment and something, I confess, I took particular delight in. The sheer absurdity of doing it gave me enormous joy, and I looked forward not only to doing it, but raising it at Exec meetings every year.

By 2018, though, the novelty of the project had begun to wear off and we began to struggle to find ways to generate content. When we turned to profiling individual members again for the 3rd time in five years even I realised that doing an annual campaign like this was unsustainable. So the 2020 campaign felt like a final grand hoorah to a once glorious idea.

Compiling all of these campaigns today really drives home how bonkers they were. There are just under 80,000 words in this chapter, and one of the years was made up entirely of images! But I'm still immensely proud of some of the work we did here (2015, 2017, 2020 especially). Still, the 30DoS campaigns stand out to me as a particular high-point in the first decade of the CPN — its own Tour de France — and something that I'm still really proud of.

30DoS - 2014

Things that you, the members, think the CPN should do.

Idea 1: A colloquium in the South of France

1 September 2014

Every day during September we will post up an idea for you to vote on. The most popular ideas will become the things that the inaugural Organizing Committee of the Critical Physiotherapy Network focuses on in 2015. So please make sure you cast your vote at the bottom of each post.

10 years ago, as I was just starting out on my PhD, one of my supervisors suggested that I attend the 'In Sickness and In Health' conference in Reykjavik that year. The conference was organized by a group of critical and radical health researchers who had come together a few years before and realized that they needed a forum to exchange ideas and support each others' research. Over the years, the small group of researchers who have regularly attended the biennial conference have become friends, collaborators and, occasionally, even thesis examiners.

So, in the spirit of the ISIH conference, the first idea that we're proposing for our new group is to organize a colloquium where as many of us as possible come together to share ideas, present our work, drink nice wine and eat good food. Of course, it doesn't need to be in the South of France (although after a long winter in New Zealand, the South of France does sound rather nice). It could be Tromso, Acapulco or Port Elizabeth. The point is that there is nothing quite like face-to-face contact to bring a group together.

So, if you like the idea that we make organizing a colloquium a priority for the first Organizing Committee of the Critical Physiotherapy Network, then let us know by voting below.

Idea 2: Publishing in people's first language

2 September 2014

The Critical Physiotherapy Network has quickly become an international collective. We have people from 17 countries who speak at least 10 different languages. While we've conducted most of our business thus far in English, that doesn't mean we don't recognize that this is problematic and try to be a bit more inclusive in the way we share our ideas. It would be a bit hypocritical for us to claim that we were a group interested in critical thinking, and then perpetuate colonial attitudes by publishing only in English.

One of the most significant features of physiotherapy is its orthodox status. The profession has been firmly anchored to the dominant culture of biomedicine for much of its history, and this has offered the profession a social standing that other professional groups can only dream of. But with that status comes a degree of 'blindness' to those in a less powerful position. It is as New Zealand poet and GP Glenn Colquohoun wrote; 'The most difficult thing about majorities is not that they cannot see minorities but that they cannot see themselves.'

Anyway, Portuguese, Dutch and Swedish are not minority languages and shouldn't be treated as such. So what we're suggesting is that wherever possible, we will provide opportunities for

people to publish in their first language and provide support for translation whenever its needed.

Post update: please note that voting is now closed, but please feel free to post your comments in the space below

Since this idea was published in September 2014, translations of the constitution are available to read/download & a number of blogposts have been translated too (thanks to network members who have made that possible).

Idea 3: A critical curriculum for physiotherapy schools

3 September 2014

Physiotherapists like to treat the body-as-machine. They like quantitative research, clinical skills and definitional clarity, and they've held on to their biomedical principles through good times and bad. In some ways, this is understandable. Without an alternative curriculum to work from, how are people schooled in biological determinism going to know which direction to take their curriculum in? And why would they consider the alternatives to the traditional physiotherapy curriculum if they are so easily dismissed as fluffy, vague and unscientific.

One way to tackle this problem, and promote a more critical physiotherapy curriculum, would be for a group like the Critical Physiotherapy Network to put forward a set of principles that most everyone would be happy with It could be designed for undergraduate and graduate programmes. It would need to be specific enough to physiotherapy to address some of the priority issues (our approach to the body, rehabilitation ethics and professionalization, for example), but flexible enough to capture common issues in the humanities, philosophy and sociology. Plus, it should accommodate the necessary local and indigenous knowledge 0f each country that adopts it.

Who could be better placed than the Critical Physiotherapy Network to develop such a curriculum? Vote for this idea if you think we should make it part of our project work in 2015.

Idea 4: Profile group members

4 September 2014

One of the best things about starting this group has been finding out about the research that other people are doing. Critical physiotherapists are such a rarefied species that it's hard to find their work and keep track of what they are doing. I've found out, for instance, that there is a huge network of physiotherapists interested in phenomenology in Scandinavia. I knew of some of the people in the group, but had no idea that it was such a vibrant population.

People have been very generous in sending us information as we got the Network going, and it's clear from people's research profiles that their work is world class. So we have people at

the cutting edge of their various fields, people wanting to know more, graduates and postgraduates looking for a community to share their ideas with, and people who just love research and hearing about other people's ideas. Everyone is looking to find out more and share with other people in the group.

So what better way to do this than to profile group members and get them to talk about their ideas and their work. We could tell some of the back story behind the research study and get to know the person behind the research. We could do written interviews, podcasts, even video in time. What matters, though, is that we find out more about each other and what makes the group tick.

Post update: please note that voting closed on 7 October 2014, but please feel free to post your comments in the space below.

Since the idea was published in September 2014, network members have been invited to create a network profile (name/country, interest in critical physiotherapy, & contact details). If you're a CPN member, why not log-in to the site & take a few minutes to check your own member profile - to make sure the information about you is up-to-date.

Idea 5: Offer awards for the best critical research

5 September 2014

Any new field needs promoting and awards are a great way to encourage people to strive for a goal. Awards can be crass and elitist - but only if they are more about the style than the substance. Our awards could be a more egalitarian affair, focusing on people's contribution to the field, support for others, or the boldness of their ideas.

As we mentioned in yesterday's ideas post, we have some world class scholars in our Critical Physiotherapy Network: people who have excelled in nurturing others, developing new fields on inquiry, and challenging long-held assumptions. It would be nice if at the end of each year, we could acknowledge these people and pay our own small measure of respect to the effort they have put in for the collective benefit of the profession.

So don't forget to cast your vote below if you like the idea of some kind of annual award.

Idea 6: Commenting on current affairs

6 September 2014

If we truly believe that physiotherapy should have more to say about the world than just thinking about the body of the person in front of us, then surely that responsibility at least extends to the politics of the health care and educational systems that we operate in. But then why not also extend this out to broader issues that others seem happy to engage in, but we have always shied away from.

Don't we have something to say about child poverty that so dramatically affects the health and well-being of the populations we serve? Shouldn't we provide some commentary on disability rights, gender inequality and racial discrimination? Is there no place for our highly trained, well educated voice in discussions about educational and health policy, social welfare and immigration? If physiotherapists believe in the idea of 'Movement for Life' (as recently adopted by WCPT), do we not have a duty to advocate for movement in all its forms - cultural, philosophical and social?

If you think that the Critical Physiotherapy Network should actively engage in current affairs, exercise your democratic right and vote below.

Idea 7: Starting a journal called Critical Physiotherapy

7 September 2014

One of the first proper articles I wrote was about the birth of the physiotherapy profession in the UK and what the founders of the profession did to legitimize massage. The first place I sent it to was Physiotherapy - the English journal of the CSP, and the very organisation I was writing about. They rejected the paper, not because of its academic merits, but rather (or so they told me), because it was not evidence-based, and they only published 'rigorous' scientific papers. I ended up publishing it in Social Science and Medicine, but I always worried that physios wouldn't find it there and so it would be lost to my target audience.

Publishing physio-related material in non-physio journals is a fact of life for the people in this group. You only have to look at the CVs of some of our most eminent scholars to see that they have published in a very eclectic range of journals. Of course, electronic searching now makes it much easier to find our work, but wouldn't it be nice to have one place - one journal - that became the centrepiece for our research?

There is clearly enough research going on amongst us now to fill the pages of a journal and we have enough experience of publishing to know how to set our standards. So, isn't it time we had a journal for critical thinking physiotherapists?

Idea 8: Make the group open to non-physios

8 September 2014

From the outset, this group has been about developing a critical attitude towards physiotherapy. We're a small organization, just finding our feet, and it's made sense for us to start modestly - not wanting to take on too much and risk losing our focus. Besides, physiotherapy is so far away from being a diverse, inclusive, critically-conscious profession that we could work solidly for the next 20 years and only make a small impression on what needs to happen in the profession to make it truly responsive to the needs of 21st century

health care. So it makes sense for us to be an network *of* physiotherapists interested *in* physiotherapy.

But our nascent organization has already drawn some interest from people outside the profession. The truth is, there aren't as many critical health organizations as you might think, and it's not only sections of the physiotherapy profession that are feeling frustrated with the direction their professions are taking. We already have very eminent researchers and thinkers like Karen Whalley Hammell and Professor Kath McPherson 'involved' in the group, with the prospect of others keen to join too. So we could very quickly grow in size (and possibly influence) by opening the network up to others, who would bring different experience and perspectives to bear.

So should the group confine itself to being just about physiotherapy and keep it's more modest focus? Or should it become something bigger and be a more inclusive group whose focus becomes about issues beyond the confines of the physiotherapy profession?

Send us your vote, and maybe a comment too.

Idea 9: Meet in Mallorca around the ISIH conference

9 September 2014

Late last week, I posted the announcement of the 6th International In Sickness and In Health Conference which will be in Mallorca from June 10-12 next year. Coincidentally, one of our members is an Associate Professor at the University of the Balearic Islands which is hosting the conference. On seeing the message, Berta (Dr Berta Paz Lourido) kindly volunteered to host us for a pre- or post-conference get-together.

Only a few days before I'd posted up our first 'Ideas' post and mentioned how nice it would be for us to meet face-to-face, and then this opportunity presents itself. I would imagine that the ISIH conference will be of interest to a number of members of the Network, but the possibility of holding our first colloquium on the beautiful island of Mallorca is too much of an opportunity to pass up!

So if you're keen to meet in Mallorca, don't forget to vote below.

Idea 10: Have different member categories

10 September 2014

Our original idea was for us to use a snowball referral system to bring people into the Network. People who we knew were critical thinkers would invite others they knew to be of a similar mind and the group would grow organically. None of us really anticipated quite how popular the group would be once we got started, and no-one really thought that it might prove to be a popular forum for people who were not necessarily 'critical,' but were looking

for a social network. And so, as the weeks have gone on, and the group's profile has grown, we've attracted a whole range of different people.

Thus far we haven't set up membership categories, we only have 'participants'. But maybe it's now time we did. We might have a free category, for instance, for people who just want to lurk on the site and not be active in the group's activities. There might then be a general members category for people who want deeper access to resources and more involvement in the group's development. There might also be an associate members category for non-physios.

Obviously, one of the necessary conditions will be a clear definition of what we mean by 'critical' - but this will come when the first organizing committee starts to work on some terms of reference and objectives for the group. But what do you think about the idea of setting up membership categories?

Idea 11: Develop study materials for our students

11 September 2014

One of the most common messages I've read over the last 2 months from people who have emailed me about the group, has been about the need to connect with people out in the wider physio community who might be able to offer their help and expertise. Be it graduate students looking for someone with methodology or philosophy expertise, or researchers/writers looking for collaborators for future projects, it seems we've all joined hoping to make a connection with like minded others.

We are blessed to have a group of real experts in our midst; experts in a wide range of cultural, historical, philosophical and social disciplines, who have all received a 'traditional' physiotherapy training, but have also learned how to think differently about their practice. It might not have been possible 10 years ago - maybe even 5 years ago - to bring together such an eclectic group of experts. But now it is, and one of the ways in which these people might be able to help the next generation of critical physiotherapists might be to produce study materials for student members of the group.

Modern technology means that producing study materials is as easy as producing a Word document or a PowerPoint slide. So what better way to offer our colleagues around the world the opportunity to study with some of our world-leading thinkers and really push the profession into the 21st century!

Idea 12: Making formal links with other groups

12 September 2014

The Critical Physiotherapy Network is an eclectic group with people interested in subjects like anthropology, cultural studies, economics, education, gender studies, humanities, legal studies, linguistics, philosophy, political studies and sociology as well as all-things physiotherapy. Members of the Network are also members of a wide variety of interest groups *outside* of the profession, and bring a huge amount of their experiences from these external groups into their daily work.

A number of people in the network, for example, are active in the Nordic Network on Disability Research which is an on-line discussion forum with links to the Scandinavian Journal of Disability Research. Other groups include historical associations, professional organizations, support groups and other on-line networks. Often these groups allow us to draw on our physiotherapy knowledge and experience whilst also exploring aspects of our work that the physiotherapy profession doesn't currently have a strong focus on. They bring us closer to people outside the profession and broaden our insights and understandings.

While our Network aspires to be an inclusive, welcoming forum for a wide range of critical perspectives, there are going to be limits on the resources and support that we can reasonably offer to everyone in the group. And so, would it not make sense for us to develop formal links with some of these other groups so that we can share resources and leverage off our mutual interest in critical approaches to health care?

Idea 13: Becoming an action group

13 September 2014

The first invitation I sent out to people to join the Critical Physiotherapy Network mentioned that 'The end result would be a network of people who could then be brought together in hyperspace to share ideas and plan for world domination.' I had no idea at the time that this might now be possible! Not only are we represented in four continents and 20 countries around the world, but we also have people actively involved in national and international professional organizations and interest groups.

All joking aside, the size and diversity of the group has certainly taken me by surprise, not least because it now opens up the possibility of us not only being a forum for personal and professional development, but also *action*. Being a 'critical' network implies that there are aspects of our profession that we find problematic, and being a 'network' implies that there are things we can now do together that we couldn't do when we were trying to change the world on our own.

A group of our size could become a more effective lobbying force, or a campaigning organization. We could become a voice of critical conscience or a support group for people who are speaking out about injustice. We could champion specific causes and promote

critical responses to contemporary issues in health and health care. In other words, we could use our 'weight' to bring about change in a way that wouldn't have been possible before.

Idea 14: Supporting people to attend conference

14 September 2014

Academic conferences are curious beasts. Some of them are enormous gatherings of people from all corners of the globe with multiple concurrent streams and a book of abstracts that looks like the St John's Bible (see WCPT or QI2015, for example). Others are bespoke affairs usually catering for a more discrete group of participants with a specific purpose in mind (I would put the ISIH conference in this category). Either way, they can be stimulating, affirming, frustrating and overwhelming in equal measure.

Going to a conference only as an observer is a luxury these days because, who can really afford to travel overseas and pay the registration fee without the support of their institution? Which means that most people at the conference are academics presenting their scholarly work to other academics who are there because they themselves are presenting. These presenters will often spend a lot of their time sightseeing or shopping rather than attending the rest of the conference, so the thousands of dollars spent in traveling to your venue and days lost from work boil down to 15 minutes on a podium talking to 10 people who are only there because they're up next.

This is a very cynical view of conferences though because they can be a real forum for debate and discussion. You can meet up with old friends and find new collaborators and people who might not otherwise know your work. You can test out a new idea and try things that you wouldn't normally try at home. They can be places where most of the people you know in the world, who have the same interests as you, are gathered in the same place at the same time, and you can talk about things that you're all passionate about that make most everyone else's eyes glaze over.

So shouldn't our Network support people to go to conferences? Shouldn't we look to make it easier for people in our group to spread the message about critical physiotherapy to every corner of the globe?

Idea 15: Explain how philosophy links to physiotherapy

15 September 2014

Alain de Botton certainly has his critics. His books sell in the millions and offer the kinds of homespun wisdom usually frowned upon by serious academics. I love his work though and have found books like *Status Anxiety*, *How Proust Can Change Your Life* and *The Consolations of Philosophy* to offer all the insight of a really good teacher - making things clear without

ever decending becoming patronizing - mixed in with the clarity of thought that comes from a deep engagement with the ideas.

De Botton has turned his brand of wisdom into a whole industry now with The School of Life, and one of the things I've really enjoyed are the weekly posts that come from the team of people who now work with the SoL, explaining how they think philosopher's ideas are applicable to our daily life. (If you want to read some of these, go to the link for the School of Life above, and scroll down to the sections titled 'The Great Philosophers' - they're excellent!)

Steve Wheeler does a similar thing with his brilliant *Learning with e's* blogspot. (Again, scroll down the page looking for posts that begin 'This is number ... in my series on learning theories. He's currently up to #27 and still going strong). Wheeler does a brilliant job of taking the kernel of a philosopher's idea and applying it to daily life. And if your preference is for the ways literature and great writers apply their craft to life's bigger question, you could do worse than read Maria Popova's *Brain Pickings*.

One of the main reasons physiotherapists don't really engage in philosophical inquiry is that they don't understand it. It's written - as we well know - in obscure language that conceals as much as it reveals; it seems to deal in abstractions; and it seems to be more about thinking than actually doing. These are serious misunderstandings though, but who is going to disavow physiotherapists of this kind of mistake if we don't? Who is better placed than people in our Network to help connect physiotherapy with the kinds of philosophy that could blow the doors off the profession? If not us, then who?

Idea 16: Offering a secure research repository

16 September 2014

One of the most astonishing things I've learnt in setting up this group has been the amount of critical research that people are doing in physiotherapy that I had absolutely no idea about. Now I don't think of myself as someone who ignores other people's research, or as someone who is particularly selective about what they read. And I don't think that my curating skills are so bad that I wouldn't see a prime piece of critical thinking if it appeared on my computer one day. The problems I face are probably the same problems we all face these days; the shear volume of research and the difficulty of filtering out the wheat from the chaff.

Here's one example of a revelation I had a few weeks ago when I had some correspondence with one of the network's participants. Målfrid Råheim is professor of physiotherapy at the Department of Global Public Health and Primary Care, University of Bergen in Norway. I had heard of Målfrid's research and used a paper she had collaborated on for a lecture I had given to one of our second year student groups (Øien, Råheim, et al, 2009), but I had no idea just how much research Målfrid had done. When I saw Målfrid's CV, I was frankly a little

embarrassed to see how much research she and her team were doing that I had absolutely no idea had been published. Here is a sample of Målfrid's publications for the last two years:

Andersen, J., Gjengedal, E., Sandberg, S., Råheim, M. (2014). A skin disease, a blood disease or something in between? An exploratory focus group study of patients' experiences with porphyria cutanea tarda. British Journal of Dermatology 2014 June 24, doi: 10.1111/bjd.13198.Natvik, E., Gjengedal, E., Moltu, C., Råheim, M. (2014). Re-embodying Eating: Patients' Experiences 5 Years After Bariatric Surgery. Qualitative Health Research, doi: 10.1177/1049732314548687.Sviland, R., Martinsen, K., Råheim, M. (2014). To be held and to hold one's own: narratives of embodied transformation in the treatment of long lasting musculoskeletal problems. Medicine Health Care and Philosophy, doi: 10.1007/s11019-014-9562-0Taule, T., Råheim, M. (2014). Life changed existentially: a qualitative study of experiences at 6-8 months after mild stroke. Disability and Rehabilitation, doi: 10.3109/09638288.2014.904448Warholm, C., Øien, A. M., Råheim, M. (2014). The ambivalence of losing weight after bariatric surgery. International Journal of Qualitative Studies on Health and Well-being, 9, 22876 – http//dx.doi.org/10.3402/qhw.v9.22876Groven, K. S., Råheim, M., Engelsrud, G. (2013). Changing Bodies, Changing Habits: Women's Experiences of High Intensity Training Following Weight Loss Surgery. Health Care for Women International, DOI: 10.1080/07399332.2013.794465.Groven, K.S., Råheim, M., Braithwaite, J., Engelsrud, G. (2013). Weight loss surgery as a tool for changing lifestyle? Medicine, Health Care and Philosophy, DOI 10.1007/s11019-013-9471-7Iversen, A. S., Graue, M., Råheim, M. (2013). At the edge of vulnerability – lived experience of parents of children with cerebral palsy going through surgery. International Journal of Qualitative Studies on Health and Well-being, 8: 20007 – http://dx.doi.org/10.3402/qhw.v8i0.20007Natvik, E., Gjengedal, E., Råheim, M. Totally changed, yet still the same: Patients' lived experience 5 years beyond bariatric surgery. Qualitative Health Research, DOI: 10.1177/1049732313501888.Sekse, R. J., Gjengedal, E., Råheim, M. (2013). Living in a Changed Female Body After Gyneacological Cancer. Health Care for Women International, 34, 1, 14-33. DOI: 10.1080/07399332.2011.645965

You'd have to agree it's a pretty impressive list, and I know for a fact that there is research here I can definitely use in my teaching and further research. But I couldn't help thinking how much better it would be if we had all of these articles held in secure storage so that people within the group could access them easily. Of course, copyright issues discourage us from setting up our own archive, but there are now a growing number of Internet resources that side-step these issues and offer papers up regardless (see Library Genesis, for example).

So should we offer our members a secure repository to make other member's research readily available?

Idea 17: Developing our own visual style

17 September 2014

Every organisation worth its salt has a clear visual identity. This often includes a logo that is immediately recognisable, a certain typeface and set of style sheets so that people can quickly recognise communications from the group, and a particular colour palette.

Often these days, we think that these things are cynically applied by big corporations for marketing advantage, but there is also a lot of research that people find some benefit in a recognisable visual identity and it helps them identify with a particular group and its values.

So without wanting to get too heavily into commercial identity politics, shouldn't we define our own style sheet and encourage people to use it to help promote the group?

Idea 18: Organising a virtual (un)conference

18 September 2014

(Un)conferences are all the rage these days. With an (un)conference, instead of people meeting for formal presentations and hours of plenary sessions, the structure of the meeting is left open and it develops organically based on the participants' needs. (I confess that I do have a bit of a problem with the *un* prefix here since a conference was always meant to mean 'bring together,' and so does not presume a fixed agenda...anyway, enough of my pedantry!)

Virtual conferences are also becoming quite the thing. Web conferencing software is making it much easier for people to host discussion forums with groups anywhere around the world, and as bandwidth improves opportunities to host more and more people at the same time in real-time conversation are becoming a real possibility.

Within our group there are some clear 'special interest groups' of critical physiotherapists with a strong interest in different philosophical and theoretical positions, so if we could overcome some of the technical and personal challenges inherent in new the use of new technology, shouldn't we look to save people the time, money, effort and CO2 emissions of travelling half way around the world for a meeting whilst still bringing people together from around the globe to share and to inspire?

Idea 19: Set up a reviewer network

19 September 2014

I've talked to journal editors in the past who have said that one of hardest jobs is to find good reviewers for articles that have been submitted for publication, and the problem is only made worse when the article is qualitative. Unless it's a physiotherapy journal that is familiar with qualitative research, the editor is often completely at a loss to know who to send the article

to. They receive a paper full of words, no hypotheses, and no tables and charts, and they start to hyperventilate.

Some of you will have experienced this from the authors side and been frustrated with the difficulties in getting good reviews, but it's also not hard to feel for the editors who are often paddling in very uncomfortable waters. It's the same with thesis examiners. Finding good examiners, who will do justice to the student's work without pushing their own ideological barrow is extremely difficult, and we have all heard horror stories of what can happen when it goes wrong.

So shouldn't we try to help by pulling together a list of trusted reviewers and examiners and advertise this available to journals and faculties to help take some of the stress away from their work? Of course, it would have to be done in a way that prevented it becoming a 'closed shop': editors would have to trust that we weren't just offering nice reviews to our mates. But if we could develop their trust, it could be great professional development for people in the network, and offer the profession a genuinely valued service (not to mention adding years to the life of journal editors!)

Idea 20: Limit the network to 150 members

20 September 2014

"*... there is a cognitive limit to the number of individuals with whom any one person can maintain stable relationships, that this limit is a direct function of relative neocortex size, and that this in turn limits group size ... the limit imposed by neocortical processing capacity is simply on the number of individuals with whom a stable inter-personal relationship can be maintained.*"

Now I know this isn't the kind of post you were expecting, but it belies a serious point. Our network has grown very quickly, and we're soon going to reach a size where it's going to be increasingly difficult to keep everyone engaged. Dunbar's number is a famous calculation based on 'the group size of a variety of different primates'. Dunbar correlated 'group sizes to the brain sizes of the primates to produce a mathematical formula for how the two correspond. Using his formula, which is based on 36 primates, he predicts that 147.8 is the "mean group size" for humans, which matches census data on various village and tribe sizes in many cultures'.

I confess I have absolutely no idea what this means. And how can you have .8 of a person in a group anyway? This notwithstanding, we should think about limiting the size of the group to a specific number of keen, active participants to keep the group alive. Networks like ours - particularly the ones that are not physically close to each other - can tend to drift into apathy over time, particularly if they're not being driven by a charismatic, handsome and charming

leader. So putting a set limit on the group and making sure only people who are active in the group stay in the group might make sense if we want the group to thrive.

Idea 21: Develop a glossary of terms

21 September 2014

One of our members - Hani Vitelson (Israel) - suggested that the Network might develop a glossary of terms and ideas to challenge the profession to think differently about some of the concepts that we take for granted. Two years ago, the WCPT launched it's own glossary for the profession, but this provides some guidance on professional rather than practical matters. (It includes sections on *prescribing*, *prevention* and *private practice*, for example, but nothing on *pain*).

Many other glossaries exist to define key concepts in health care, but few offer to interpret these concepts from physiotherapy perspectives. We all know that *the body*, for example, is a major issue for the profession, but you would be hard pressed to find a simple explanation for our understanding(s) of the body, in comparison to those held by nurses, doctors, engineers or furniture makers.

One of the problems with glossaries is that they tend to consolidate: they aspire to smoothe out differences between ideas and arrive at a common consensus. Our glossary might be different: it might be a place where rival viewpoints are made available to be viewed, explored and analysed. This would be a more critical proposition and certainly a challenging one, but a really necessary one for the profession all the same.

So should we develop our own critical glossary of terms?

Idea 22: Profiling physiotherapy in different countries

22 September 2014

Although the physiotherapy profession has its origins in a few common historical moments, it has diversified to an incredible degree, to the point that the World Confederation of Physical Therapists is now constituted by 106 member organisations and more than 350,000 practising members. And although there are going to be many commonalities between the kinds of practice seen in countries as diverse as Brazil, Canada, Portugal and Malaysia, there will also be some local social and cultural differences that provide lots of opportunities for critical comment. It follows that if we were more aware of how physiotherapy is practiced in another jurisdiction, it might make it easier for us to ask whether the way it is practised here is either necessary or appropriate.

So one positive action for the group would surely be to ask people from each country or region to explain how physiotherapy functions in their own area to allow us to apply some much needed critical commentary to our own situation.

Idea 23: Collaborate on a critical physiotherapy book

23 September 2014

A couple of years ago, a friend of mine suggested it might be a good time to edit a book that brought together different critical perspectives on physiotherapy. A few of us had collaborated on a special edition of the journal Physiotherapy Theory and Practice, and she thought that there was enough depth to the material to produce a bigger manuscript. At the time, I wasn't sure there were enough of us thinking critically in physiotherapy to do it justice. I don't think that now. So maybe now would be a good time to revisit the idea.

Physiotherapists are getting very good at producing edited collections and collaborative ventures. In recent years, I've been involved in a few projects with Joy Higgs and her colleagues at Charles Sturt University's Education for Practice Institute. Franziska Trede, Narelle Patton and Diana Tasker - all members of our Network - are teachers and researchers within the Institute, which produces some of the leading writing on practice-based education through a publishing collaboration with Sense Publishing in Amsterdam. It's the kind of knowledge and experience that we now have in the group, that wasn't there 10 years ago, that makes a critical physiotherapy book a real possibility.

So, should we collaborate on a critical physiotherapy book?

Idea 24: Run a webinar

24 September 2014

Webinars have become quite popular as a way for people around the world to connect together and 'attend' a course, lecture or conference in real time, and participate in some professional development. The attraction of webinars - particularly if they are recorded to be played back later - is that they bring people together without all the costs of travel and disruption that international conferences and study programmes normally imply. The biggest downsides are normally people's discomfort or difficulties with the technology, and the time differences between the country of delivery and reception, but these things aside, they are a fantastic new way of sharing ideas and disseminating learning.

MOOCs - or massive open online courses - are one version of the webinar that has been used by some leading educational providers around the world to deliver relatively generic content to absolutely massive numbers of people. These can be more about content delivery than interaction - simply because of the size of the classes involved - but they still provide a chance

to hear internationally renowned speakers, sometimes for free, in ways that wouldn't have been possible before.

Webinars could bring Barbara Gibson, John Hammond or Gunn Engelsrud into your home or office and all you would have to do is learn how to set up the software, so shouldn't this be something that we invest in?

Idea 25: Overcoming barriers to publishing in English language journals

25 September 2014

A good friend of mine and someone known to a lot of people in health care in Canada (the very brilliant and fiercely critical Dave Holmes), is a native French speaker. You'd never know it from the way he writes, but he has some real anxieties about his ability to express himself in English. As someone who has always struggled to learn languages, I confess I can't imagine anything more difficult than trying to express deeply held, embodied, philosophical and theoretical ideas in a language that's not one's native tongue. Let me state it here, I have total respect for anyone who can do this successfully.

For those of us who have the luxury of having English as our first language, and finding much of the world of academia neatly arranged to our advantage, I think we have a duty to our colleagues from other non-English speaking countries to help out - to smoothe out any nuances of language and idiom that might make the difference between someone feeling comfortable to submit their work and not. Take, for example, our large network of colleagues in Scandinavia. I must've had a dozen emails from people in the last 3 months apologising for their command of English, but enthusiastic about being part of the group. Well I think there are things that we can do here to help people feel more confident in their publishing.

I suppose there is a risk that this is seen as patronising, and even writing this has made me feel really self-conscious and unhappy about a system that is so prejudicial towards other languages. So I'll state here that this is, at best, a poor substitute for a system built on difference and inclusiveness, but it is what it is, and we are unlikely to change the basic tenets of medical publishing by ourselves. But what we can do is support our friends who want to publish in English-language journals, and offer our help and support to read a paper or offer writing support before a paper goes off to print. If this gives a great writer with a brilliant idea the confidence to submit their work rather than hold it back, then it's got to be a good idea. Hasn't it?

Idea 26: Annual award for the best critical research paper

26 September 2014

One way the group might be able to raise it's profile and let other critical physiotherapists know that we exist might be to promote a prize for the best critical research paper. The prize would acknowledge a piece of research that challenges physiotherapists to think differently about their theory and practice. It would not need to be *about* physiotherapy, per se, but it could have implications for our work.

There aren't a lot of prizes for this kind of thing - primarily because it's not something that organisations like ours tend to think of doing - so it might also be an innovative idea that captures people's imagination. The prize need not be anything more than an acknowledgement from the group, but the ability for researchers to cite that their work has been recognised by others is often enough. So it would cost us very little but remind people of our group and promote the need for research in and around physiotherapy to be more critical.

Idea 27: We form our own faculty

27 September 2014

If you've ever visited the European Graduate School website you'll know what an impressive organisation it is. It's faculty is made up some of the world's most prominent thinkers and opinion-shapers (Alain Badiou, Jean Baudrillard, Judith Butler...and that's just the 'B's'!). The school runs residential courses and delivers a lot of video content for free to a global audience to shape opinion on contemporary issues in society. Their funding must be absolutely astronomical, but attending one of their summer courses is definitely on my bucket list. Even their aspirations are lofty: "The comprehensive programs are distinguished by the cordial interaction of eminent faculty members with students who are the best of their generation." Now that's a mission statement!

Just because the EGS's aspirations are sophisticated, high-brow and global, doesn't mean other much smaller organisations can't have their own more modest goals. We've already voted this month on the idea of a colloquium in the South of France and providing critical curricula for physiotherapy students around the world, so we're really not that far away from bringing together a faculty in the manner of the EGS. We have some very eminent educators, thinkers and writers, and a growing infrastructure around them. So shouldn't we think about bringing them together into a new faculty - the Critical Physiotherapy School perhaps?

Idea 28: Provide training in social networking

28 September 2014

Quite a lot of people in the network are email users. Some are avid Twitter and Facebook users. Some even have their own web pages and blog on a regular basis. But most don't, and for many the idea of collaborating with others through hypermedia is a cause for real

anxiety. I had one person in the Network write to me to say that they rarely used email or the Internet, and so probably wouldn't be able to participate much in the group's activities. I think that's a real shame, but if one of the founding principles of the Network is to bring together people who have a critical interest in physiotherapy, then it's a problem we have to tackle.

We are going to need to communicate with people across multiple media. Email is pervasive, but people don't want to be overwhelmed with cross-postings. Websites can be good, as long as people remember to look at them. Web conferencing can be an amazing way to bring people together across time zones, but poor bandwidth and complex interfaces make it daunting for a lot of people. No one approach will work perfectly for a group like ours, certainly not in the short term. So we'll have to take a pretty eclectic approach to our networking for a while until everyone's up to speed.

Getting people up to speed might become a priority for the group early on. If we can get everyone comfortable with a few key pieces of technology, it will make collaboration much easier. So doesn't it make sense to provide training in social networking for people?

Idea 29: Create learning families

29 September 2014

This comes from Richard Horwood...one of our New Zealand members:

Given the diverse geographical locations and backgrounds of the group, and therefore the 'differences' culturally, it might it be worth the organising committee looking at filtering members into 'learning families' (a few each from here and there) to help break down some of the barriers to 'productive' thought. It would be easier to share ideas with 8-10 members initially, and get their feedback/discussion, before ideas get shared with the whole Network. For some of the more 'novice' thinkers in the group (like me) it might well aid both their thinking and their fear. As a profession we are generally lacking in confidence and I think to bring out the best in EVERYONE it might be a nice way to start. It can be the 'Active Families' programme of the CPN.

Would you like to see the Network create learning 'families?'

Idea 30: Establish annual critical physiotherapy day

30 September 2014

Because this is the last of the 30 Days of September posts, it makes sense to go out with a bang! So I'm suggesting that we organise an annual day of celebration of all things critical. We would put aside a day each year - logically, if somewhat predictably the 30th September - and have a series of themed events that would try to raise the awareness of the

physio community for the work that we've done in the year before and promote the idea of more critical thinking in and about the profession.

We could run social media events, email postings, eye-catching promotions and membership rallies, and with each one look to have a bit of fun whilst promoting a serious message.

So, what do you think, on this last day of September, that we claim it as our own and call it Annual Critical Physiotherapy Day?

And one final word...thanks for your input this last month. It's been a lot of fun. Dave

Results from 30 Days of September

8 October 2014

During September we used the blog to test out ideas that we might make part of our work in the first year of the Critical Physiotherapy Network. Each day we posted up a new idea and people voted on whether they liked the idea or not. Here are the results.

The top 10 most popular projects were, in order:

1. Explaining philosophy to physios (#15)
2. Starting a critical physiotherapy journal (#7)
3. Running a colloquium in the South of France (#1)
4. Collaborating on a critical physiotherapy book (#23)
5. Running a webinar (#24)
6. Profiling group members (#4)
7. Overcoming barriers to publishing in English (#25)
8. Developing critical curricula for physiotherapy schools (#3)
9. Developing our own visual style (#17)
10. Setting up an annual award for the best critical research paper (#6)

The results were produced by multiplying the number of votes with the percentage of people who voted for the idea (this is known technically as the 'multiplying column A by column C method.)

Interestingly the bottom three choices were: Opening the group to non-members (#8), Training in social networking (#28), and Supporting conference attendance (#14).

So what happens now?

Well, we finalised the membership of the Organising Committee today, and the following people have kindly agreed to be on the inaugural committee:

- Barbara Gibson (Canada)
- Simon Kirkegaard (Denmark)
- Gwyn Owen / Nicky Wilson (England)*
- Dave Nicholls (New Zealand)
- Jenny Setchell (Australia)

(*Gwyn and Nicky will be job sharing)

Thanks to everyone who offered to be part of the committee. We had 13 volunteers but wanted to keep the group to a manageable size in its first year, so some people kindly stepped aside.

We've tentatively organised to meet via Skype on the evening of Thursday 30th (North America/Europe) / morning of Friday 31st October (Australia/NZ), at which point we will make our democratically-elected list of New Ideas one of our main agenda items and report back via the blog straight after the meeting.

Thanks for your votes and your input over the month. I look forward to the group going from strength to strength over the coming months.

3oDoS - 2015

30 Days of September is back

31 August 2015

Those of you with good memories, will remember that we launched a campaign last year called "30 Days of September."

Each day we posted up an idea for something the CPN might do in the coming year, and you voted on the ideas you liked best.

The results of last year's poll gave our new Executive a lot of help in planning our work for the next 12 months. Well a year has gone by and September has returned, along with this year's campaign.

Our focus this year will be on new ideas.

Each day we'll be posting an idea on the blog to entice physiotherapists to think otherwise. There will be posts about new research, new ideas, new practices, new policies...all sorts of newness to prompt you and your colleagues to do something radical and push at the boundaries of the profession.

And you can play a big part in sharing your ideas with the community at large:

1. Firstly you can **VOTE** for the ideas you're interested in
2. You can add your **COMMENTS** and ideas to the debate
3. And you can **PROMOTE** the blog through social media

In the next few days we'll be revealing our new membership system, so if you like what we're doing you can get all of the benefits of being part of the CPN for **FREE**!

So keep an eye on the blog and check out this month's postings whenever you can.

New: Movement for life

1 September 2015

If there's one concept that seems to have united physiotherapists in recent years, its movement.

Movement for Health is the theme chosen by WCPT in 2008 to convey 'the core of what physical therapists/physiotherapists do', *Movement for Life* has been adopted by physiotherapy clinics and professional bodies, and like pain, has become a key way that we are now trying to express our point of difference, complexity and diversity of skills.

And yet movement remains almost entirely unexamined by the profession (which is interesting, given how much stall we now seem to place on evidence-based practice!)

Apart from a few attempts to provide a larger appreciation for movement (see, for example, Cott et al, 1995; Barlindhaug et al, 2012; Wikström-Grotell et al, 2012), few have defined what physiotherapists understand movement to mean.

This is not just an academic exercise however because, clearly, movement lies at the core of what we do, and physiotherapists take a very particularly and oddly specific view of movement.

Draw a line across a blank piece of paper and write down all of the kinds of microscopic movements you can think of - diffusion or osmosis - for example, on the far left hand end. Then at the other end draw all the massive social movements, like migrations and diaspora. Then draw a box somewhere in the middle to represent the physiotherapy view of movement.

It would be surprising if flexion and extension of the elbow, Vo2max tests, motor activation patterns, or even group rehabilitation methods take up more than about one-tenth of the length of the line.

Physiotherapists have never been concerned with movement in all its breadth and diversity, but with a relatively narrow biomechanical view of movement. It does not need to remain so, however.

It was physiotherapists themselves, after all, that chose to adopt this rather limited view, and it could be physiotherapists that decide to change.

Why should we not become the advocates for **all** movement - not just the ones bounded by individual physical bodies?

Perhaps make today the day to claim a new idea of movement for the profession and see what opportunities open up for your thinking and practice?

References

Cott, C. A., Finch, E., Gasner, D., Yoshida, K., Thomas, S. G., & Verrier, M. C. (1995). The movement continuum theory of physical therapy. Physiotherapy Canada, 47(2), 87-95.

Barlindhaug, G., Emaus, N., & Foss, N. (2012). Movements in a broader perspective – A study of women in a mountainous village in nepal. Advances in Physiotherapy, 14(2), 78-86. doi:10.3109/14038196.2012.675351.

Wikström-Grotell, C., & Eriksson, K. (2012). Movement as a basic concept in physiotherapy--a human science approach. Physiotherapy Theory and Practice, 28(6), 428-38. doi:10.3109/09593985.2012.692582.

New: (Special) Interests

2 September 2015

It seems odd for a supposedly patient-centred profession to still have special interest groups that perpetuate the idea that the body can be carved up by systems and structures, and that I could be a cardiorespiratory, neurological or musculoskeletal physiotherapist and not a physiotherapist for the whole person.

Special Interest Groups (or SIGs) are historically significant divisions within the profession that owe their structure to the guilds that formed in the Middle Ages, when blacksmiths, printers and jewellers tried to protect the interests of their members and promote their speciality (see Farr, 1997 or Smith 2004). But SIGs may now be creating more problems than they resolve, and may have become a barrier to our profession's ability to respond to the changing economy of health care in the 21st century.

If the logics of patient-centred care - which decentre the traditional power base of the health care professional - are combined with the growing desire to see collaborative and inter-

professional practice, then what place for the specialists in women's health, mental health or sports?

It isn't hard to see why physiotherapy adopted special interest groups. They are after all, reductive, and reductionism one of biomedicine's cardinal principles (alongside specific aetiology, experimentation, germ theory, etc.). But even if this still functions as a justification for having a paediatric special interest group, per se, it surely creates some contradictions that are worthy of exploration:

- Why do we have special interest groups that are based on body systems and not different cultures, religious beliefs, or political affiliations?
- Why do we have special interest groups that focus on only some modalities of treatment and not others?

There are 12 subgroups in the WCPT (acupuncture, animal practice, cardiorespiratory, EPAs (electrophysical agents), manual therapy, mental health, neurology, older people, paediatrics, private practice, sports and women's health), all constituted by serious, hard working professionals, who believe passionately in their area of expertise. Their role is largely to promote the interests of their members and lobby for recognition within the wider community. They achieve this, in part, by showing that their area is distinct from the others, thus perpetuating the idea that this or that body system rules other body systems or is, at least, worthy of special interest.

This seems an odd mythology in the 21st century, when most people have long since given up the idea that the muscles are disconnected from the nerves, which are disconnected from the brain, which is disconnected from the lungs, and so on.

What is, of course, deliberately excluded from the idea of the Special Interest Group (could it have a more pernicious name?), is the whole person, the embodied, complex, richly diverse person that is rapidly becoming the future of physiotherapy practice. The days of us treating single, acute, self-resolving injuries and illnesses are nearly over, and we are being shifted slowly into a much more interesting space. But this space is populated by people, not pathologies, so perhaps it is now time to recognise that the Special Interest Groups of the 20th century have had their day, and a new (sub)structure for the profession is needed.

SIGs say a lot about the profession's focus. They reveal where the profession looks to direct its specialists, and where its leaders provide direction for its novices to follow. And here is one of the problems. Many of the people who run and organise SIGs have achieved recognition *because* of their specialty, and naturally see this as essential to the future health of the profession.

We see this in teaching departments, where specialists believe passionately that no graduate would be qualified for practice without their particular knowledge of shoulder impingement or pelvic floor pain. But you only need a handful of such specialists and the curriculum starts to become bloated and fragmented.

Isn't it time to end the artificial division between SIGs?
Isn't it time to start thinking about patient-centred physiotherapy practice and not clinician-centred specialties?

***

On a side note, it seems odd that some countries have some SIGs and not others.
The American Physical Therapy Association has 18 SIGs, there are 16 in Australia, 14 in Canada, 12 in New Zealand and only seven in Singapore.
Most of the variation relates to the local politics of the region (America, for instance, has Federal, Health Policy and Administration, and a Home Health SIG while others don't). But regional variations can't explain why America has Education, Research and electrophysical SIGs while others don't.

References

Farr, J. R. (1997). On the shop floor: Guilds, artisans, and the european market economy, 1350-1750. Journal of Early Modern History, 1(1), 24-54.
Smith, P. H. (2004). The body of the artisan: Art and experience in the scientific revolution. University of Chicago Press.

New: Open badges

3 September 2015

Some people reading this blog may be old enough to remember a time when physiotherapists, occupational therapists and other professions allied to medicine were trained in colleges and schools attached to large teaching hospitals. Others will have only known the university system.

For most of us though, the university holds a special significance. It is where knowledge is acquired and one discovers the rudiments of one's future practice. (Of course, we all know the *real* learning takes place in the clinical environment, but this only serves to enhance the ivory tower image of the university and the people working within it).

You used to go to university to acquire an education and a qualification. At graduation you would pass into the ranks of your chosen profession and become a colleague, a worker, an employee, and you would leave your student days behind.

Universities were the repositories of knowledge, and the only place where these special knowledges could be acquired. Graduation meant that the university had weighed and measured you and found you to be adequate for the task ahead.

These days, knowledge is far less constrained. People can acquire knowledge of pretty much anything, pretty much instantaneously. And if they don't possess any particularly knowledge, it's now relatively easy to find it at the end of their fingertips.

The democratisation of knowledge that has come with the World Wide Web has radically transformed how we think about the world around us, and opened up worlds that were once highly restrictive.

Even areas that were once strictly off limits to the average consumer - approaches to surgery, cervical manipulations, emergency department trauma - are all now easily consumed by anyone with a wifi connection and access to a computer.

So what role for the universities now that they no longer control people's access to knowledge?

Some believe universities are now little more than accrediting institutions - places where the knowledge acquired out there in the world can be validated. But even this role is now in doubt and a radical new movement to democratise the awarding of credit for learning is taking place.

The Open Badge movement (you can find this easily in your preferred search engine), is based on the idea that we can all accredit each other's learning.

Say, for instance, you go on a course. Why shouldn't the course organisers give you credit for your learning? But wait, you say, don't some professional bodies already give credit for continuing professional development? Yes they do, but what if that credit no longer relied on the paternalistic, controlling interest of a professional body?

The Open Badge movement is an initiative that tries to address this, allowing people to design and distribute 'badges' for whatever purpose they see fit.

Develop a new information sheet for patients; treat your 100th patient since graduation; develop a course for your colleagues; build a physiotherapy empire...Open Badges allow each of us to acknowledge our colleagues without waiting for a university, college, professional body, or any other traditional authority figure to recognise us.

New: Old ideas

4 September 2015

It is an old cliche, but there is rarely anything entirely new in the world, and sometimes some of the newest and most exciting innovations are merely reinventions of old ideas.

Over the last few days, a story has appeared in the news of a young All Black rugby player who, only a few weeks ago, fractured his leg in a game. The story is newsworthy for two reasons: (a) the Rugby World Cup starts in a few days time, and (b) he is only being considered to be fit to play because of a rather unusual remedy.

Waisake Naholo's recovery from a fractured fibula has been reported widely around the world, because he chose to return to Fiji to be treated by his local doctor, Isei Naiova, who had helped him recover from two previous orthopaedic injuries.

Naiova's technique is a closely guarded secret, but it basically involves setting the bone, and the use of massage with some locally-known herbs to speed the recovery. Naturally, reports of his early return to the All Black squad generated quite a bit of interest, and questions were asked about the 'miracle cure.' An orthopaedic surgeon was consulted, who put the remedy down to placebo, but acknowledged that all the surgical advice was that he would be fit to play in mid-October, so even the surgeons have been a little confounded by the speed of his recovery.

The veracity of claims that herbs can heal fractures is not the point of this blogpost. Rather, it is to remind ourselves that treatments like massage, hydrotherapy, movement and exercise have been, and will likely always be, a critically important part of people's health and wellbeing, and no amount of evidence seems to stop people wanting to use them.

Historical research into the healing practices of Māori before colonisation by Europeans in the early 19th century, suggests that Māori were particularly adept at treating fractures using herbs, incantations, steam baths drawn from hot springs and massage. Skeletal remains suggest that only people with very complex fractures suffered any long term impairment, and early settlers were surprised at how much faster Māori recovered from orthopaedic injuries than Europeans (Houghton, 1980). Despite this, many of the traditional Māori healing practices have been overwhelmed by modern medicine.

Physical therapies have waxed and waned in popularity no more so that over the 100 years, not helped by professions like physiotherapy, which seems to struggle to make its mind up whether it likes massage or not. But that doesn't stop some of the more tactile physical therapies being some of the most popular treatments used in luxury spas, health clinics and high-street practices throughout the world.

In some ways, physical therapies act as a radical resistance to our cultural over-emphasis on expensive, seemingly indulgent, medicalization of health care, which has resulted in the over-diagnosis and over-treatment of thousands of health issues that people once felt much more

in control of. It seems the public is becoming sensitive to the kinds of Western paternalism that see doctors claiming that non-traditional (and especially indigenous) healing therapies are only 'psychological faith' healing (see earlier linked story).

No-one is advocating for a laissez-faire approach to health care where anything goes, and we all want to know that our health professionals are informed by the best evidence, but sometimes some of the oldest remedies are bypassed simply because they are old. Thankfully, some people are keeping them alive.

References

Houghton, P. 1980. The first New Zealanders. Hodder & Stoughton, Auckland.

New: Journal

5 September 2015

Physiotherapy desperately needs more journals. Not the kind of journals that have 4,ooo word limits, or the kinds that still celebrate passive third-person prose, but the kind where the quality of ideas trump the elegance of the scatter plot.

We need journals where physiotherapists can engage in the kinds of discussion you see in Nursing Inquiry, Body and Society or Health.

These journals are fora where writers can exercise Karl Popper's assertion that the scholarly community should not prop up existing beliefs, but should commit all its not insignificant resources to tearing down current dogmas and ideologies, creating a space where new ideas can prosper.

Physiotherapists have only a scattering of such journals - Physiotherapy Theory & Practice being the shining example - but more are needed.

There's nothing wrong with physiotherapy being wedded to evidence-based practice - well there is, but this is neither the time nor the place - as long as there is balance and a place that encourages 'other' ways of thinking. After all, isn't physiotherapy looking to find new ways to engage with the changing nature of health care? How is it going to do this if it can only express itself in ANOVAs and whisker plots?

We need a space for high quality, informed and sophisticated theoretical, critical, philosophical, sociological, historical, cultural, non-Western debate and discussion, and our current crop of journals just aren't doing it.

New: Humanities

6 September 2015

Although it's going to be hard to accept, particularly by those people currently striving to make a difference in the profession, but it probably won't be this generation of physiotherapists that bring about the radical change necessary to prepare the profession for the new world of 21st century health care.

There are any number of reasons for this:

1. Physiotherapists are, by and large, a relatively conservative bunch, who don't instigate radical change
2. Physiotherapy is highly respected and well patronised, so there are few indicators that we need to change much
3. Most people in positions of authority have received a traditional training, and tend to like things the way that they are, thank you
4. And besides, there are few physiotherapists with the skills and knowledge of things 'outside' of the traditional biomedical disciplines to be the agents of change

So unless there is a sudden unexpected surge towards the study of subjects like philosophy and sociology, our existing profession leaders are unlikely to make the transformational change necessary to shift the profession very far from its existing base of support.

No, if change is going to happen, it will happen from beneath; from people who may be too young, or too occupied with other careers right now, to know that they want to become physiotherapists.

Change will come with the *next* generation of physiotherapists.

But how will they be know how to change if their tutors continue to promulgate the 'old' model?

The answer lies in new curricula that express the things that physiotherapists know to be important , but struggle to articulate. The humanities for instance.

The humanities have become a major feature of medical education in recent years (see, for example, the Journal of Medical Humanities, The BMJ's Medical Humanities and the Journal of the History of Medicine and Medical Humanities.

There have been some really excellent books produced about the interface between the humanities and healthcare. (A broad set of disciplines incorporating communication and cultural studies; critical studies, including areas like disability and gender studies; (bio)ethics, health care politics; history of health, medicine and professionalisation; journalism, literature and creative writing (including new social media); philosophy and sociology of health and healthcare). (Note: You cannot read the medical humanities without first going through the

work of Alan Bleakley - a fantastically clear, concise and readable writer on the subject - see reference below).

The (medical) humanities are the studies of people in health care: people as patients, people as professionals, people working together, people struggling with illness, and so on. And this is clearly a huge area of new interest in physiotherapy.

But it is such a big topic, and our curricula are already stuffed full of clinical content. So how will our physiotherapy schools adapt?

What we need perhaps, is a new humanities curriculum that picks up on all of the material that needs to be understood by students if they are going to become the new faces of physiotherapy.

The curriculum would be scaleable to different programmes, but would address many of the shortcomings of existing, overly technical, skills-based training programmes.

National bodies would by necessity have to take the lead, but it would be us, as the existing torch-bearers for the profession, that would need to make it happen.

At least now there is a path that we can follow.

References

Bleakley, A.
(2015). Medical Humanities and Medical Education: How the medical humanities can shape b etter doctors. Abingdon, Oxon: Routledge.

New: Organisations

7 September 2015

If you are someone who follows this blog, uses Facebook, Twitter or other social media like email and texting, you may have become quite familiar with the idea that people are now networking in ways that were impossible only a few years ago.

A friend of mine was telling me the other day about her eight-year-old son, who was now the embodiment of a digital native. He knew how to log onto their computer, how to search for school projects, and how to use his tablet in the classroom to draw, add, compose and write. She was wondering what the future of work and study would be for him, and whether today's lecturers and practitioners knew what they were in for.

According to a report last September in the International Business Times, 'there are now 2.26 billion people online, with 1 billion of them using mobile broadband subscriptions', so while these have been largely 'first world' luxuries in the past, they are becoming increasingly globalised.

At the same time, new global networks are appearing, and new ways for people to organise are being developed. It's possible, for instance, to read this blogpost within seconds of it being written. Geographical distance is no longer the barrier it once was.

The collapse of the welfare state in developed countries saw a profound shift towards free market capitalism and, as we have seen in recent years, there has been a growing backlash to the worst effects of neoliberalism, but even leftwing commentators struggle to imagine a return to the world before 1980. Too much has changed, particularly in the way people can now network and organise.

Organisations like the Critical Physiotherapy Network are a case in point. Professional bodies used to rule physiotherapy. Most countries followed the 19th century industrial model of having a regulatory 'Board' which set the standards for professional conduct, and professional 'Society' that promoted the profession. Today these organisations are in an inexorable decline.

There are lots of reasons for this. Regulatory Boards are often seen by members as a brake on innovation, and from outside as promoting the interests of the profession over the patients. Not surprisingly, pressure is now being applied to dissolve once impermeable professional boundaries and move towards more inter-professional and collaborative work structures. Professional societies are also in decline, with membership rates decreasing annually. Most societies now have less than 50% penetration within their profession.

Trans-national, networked organisations that function more as fluid, dynamic organisms than stately homes are becoming more and more significant in people's lives. Organisations have become more like nodes in a widely dispersed network, than monolithic fixed entities.

The decline of Boards and Societies might seem like the beginning of the end for professions like physiotherapy, but it need not be so. New organisations will emerge that fill the void and open space for people within the profession to take advantage of the affordances that global networked connections now bring.

[1]It could be argued that physiotherapy has so far bucked this trend, but this is the exception rather than the rule and the trend in other professional societies, collective organisations like trades unions and guilds is quite clear.

New: Alliances

8 September 2015

If you were to design a health care system from scratch, and began with the people you wanted to form key alliances with, who would you choose? Doctors, nurses, occupational therapists, podiatrists...?

In the past, the choice might have been easy. Health care was strictly hierarchical and doctors were at the top of the pyramid. No health professional could become established without the patronage of the medical profession. But is that still true today?

Health care consumers now have much greater choice when it comes to health providers and they are exercising their choice in innovative and interesting ways. Over-the-counter remedies, alternative and complementary therapies, self-help programmes and personal health promotion strategies, are all subtly changing the power dynamic that has long existed in health care.

Billions of dollars are now being spent on health care by people who never see an orthodox health professional, and a trend is emerging whereby people only meet a health professional in the first and last years of life, and when they are in dire need. For the rest of the time, people are looking elsewhere.

So a newly designed health care system might not have doctors and nurses at its centre. Instead it might have consumers, families, communities, teachers and rest home staff.

A recent report by the Royal Society for Public Health in the UK, looked at the *Wider Public Health Workforce*, and argued that there were at least two million people who could be offering basic health assessments and health advice. These included 803,000 kitchen, bar and waitering staff, 639,000 cleaners, 452,000 public service and associate professionals such as postal workers, and 222,000 hairdressers and people in related services.

The RSPH argue that 'with appropriate training, the wider workforce could support public health activities in areas including the following:

- Point of care testing including body fat measurements, finger prick testing, blood pressure, BMI
- Behaviour change programmes, healthy conversations, and signposting the public on to more specialist services
- Social prescribing including screening the public for lifestyle health conditions such as inactivity, low level anxiety or social isolation
- Assisting the public to overcome physical and emotional barriers to health advice including access to GPs and initiating conversations about health.'

Notwithstanding some critically important questions about the declining funding for public health care, and the serious concerns about a growing surveillance/blame culture emerging in public health care, it is clear that the political economy of health care is changing.

As Tom Waits once said 'you can't unring a bell,' and we will surely never return to a time when the 'doctor knows best.' Given that, should professions like physiotherapy be spending more time looking at ways to collaborate with hairdressers, postal workers and cleaners, and should health care consumers be the first people we look to collaborate with in our newly designed fantasy health care system?

New: Activism

9 September 2015

Many years ago, I was one of the first of the new student reps to attend the CSP's annual Congress. Back then Billy Bragg was railing against the Miner's Strike and the IR department of the CSP reigned supreme. It became obvious pretty quickly that people took Congress really seriously. The first motion I remember being discussed was a levy on member's fees to raise funds for Nicaraguan Freedom Fighters. Sadly the motion went no further after being referred to Council, where it ended up disappearing like gold in the San Juan rivershed.

Not long after the Congress I attended an Association for Chartered Physiotherapists in Respiratory Care meeting and was dismayed to hear the keynote presenter stating that she was proud to think that physiotherapy was not a 'political' profession.

Physiotherapists have always had a difficult relationship with activism, but it has always seemed to me to be a profession in a prime position to take a stand on inequality, injustice and oppression. Our work often brings us into contact with some of the poorest people in our society; our practice centres on disability; we are female dominated; and we have at our disposal extraordinary social capital in the form of mana, public trust, and the respect of the medical profession and the state.

Physiotherapists ought to be more politically active than they are, particularly these days when so many health care initiatives are increasing the distance between those who have and those who have not.

While it's understandable to argue that our focus should be on increasing our own professional security and power base, and to believe that we need to put our energies into promoting ourselves and raising our own professional profile, doing so risks focusing our attention inwards and forgetting the people in our communities that need our help. And physiotherapists can offer much more than just their clinical/technical skills.

The simple fact is that when health professionals like physiotherapists talk, people listen.

Armed with our knowledge of health and health care, activity and movement, exercise physiology and prescription, touch-based therapies, and a host of other knowledges, skills and attitudes, physiotherapists are in an ideal position to lobby for improvements in things

that have a direct impact on people's health and wellbeing. Things like people's living conditions, access to services, housing improvements, safe and accessible public spaces, and ability to be heard, never mind the improvements that could be made to the organisation and design of existing and innovative health care services.

Perhaps, then, it is time for physiotherapists to lift their eyes from the body of the person in front of them, and start to take a more active role in the world that our patients return to after their 30 minutes with you is over.

New: Stories

10 September 2015

For reasons I've never really understood, physiotherapists seem really reluctant to tell their work stories. I'm not talking about the conversations we've all had with our partners, families and friends about interesting clinical problems we've faced or patients we've treated, but rather the kinds of things that give us pause to reflect on what we're doing, or make us think that there's a lesson here that others could share in.

A long time ago, doctors, midwives, nurses and psychologists recognised the value of stories, giving birth to the whole idea of narrative-based medicine and the medical humanities. But physiotherapists have been slow on the uptake.

The latest edition of the journal *Qualitative Inquiry* - a bastion of innovation in qualitative research methodology - illustrates my point. There is a 'three-part autoethnographic short story [that] explores the materiality of loss,' a 'found poem created from a selection of poems published in indexed peer-reviewed social science journals between 2007 and 2012,' and a paper exploring 'three versions of adventurous writing.'

Most tellingly, there is a paper titled *Writing Paralysis in (Post) Qualitative Research* which uses the form of the academic article as a vehicle to explore how to write with, against and through paralysis.

Sally French, the well-known publisher of *Physiotherapy: A Psychosocial Approach* has used narrative forms of writing to tell her own story of her visual impairment, but few others have followed suit.

Perhaps physiotherapists think that their stories are less worthy, or less interesting than other people's stories? Certainly, our current crop of journals give little encouragement to experimental and creative writing as a serious scholarly form. But that shouldn't stop physiotherapists exploring narrative approaches to practice, particularly these days with the easy availability of Internet publishing.

Many physiotherapists have started to take to blogging as a way to explore their practice, and it is telling how the most read posts are based on people's real work experience. But so far many of the posts adhere to the unwritten rule that physiotherapists should only talk about clinical problems. It would be nice if we could develop some kind of new publishing forum where people can develop robust, thoughtful, scholarly writing on physiotherapy practice, and draw on some of the amazing health literature that is now emerging using narrative as its primary mode of engagement.

Reference

French, S., & Sim, J. (2004). *Physiotherapy: A Psychosocial Approach* (3rd ed.). London: Elsevier.

New: Normals

11 September 2015

Think about how much time you spent learning about the 'normal' body in physiotherapy school.

Think about how much time you spend in clinical practice assessing people to see what's 'abnormal.'

And all of those clinical trials that develop sensitive, reliable and valid measures of activity, bodily function, movement and pain; all based on some universal notion of normality.

Tests and measures have to assume that there is one universal normal for them to *be* universal. So, in principal, a score of 13 on the Modified Borg Scale means the same thing in Afghanistan as it does in Alaska, and a BMI of 28 is obese no matter where you live.

Physiotherapists learn the principal of normality early on in their training and they never let it go. The anatomy books that we studies show us pictures of a standard human body and tell us that the piriformis muscle originates from the anterior surface of the sacrum and inserts into the greater trochanter. Gender, race, age, culture matter not. All that matters is that this is a normal and stable base upon which all other norms of bodily function can be built.

Normalisation is far from common sense or obvious however. Even the idea of defining norms has a history built around the attempts of the medical profession to assert its power and social standing (Porter, 2006). The ability to be the people who define what we accept as normal has been hugely significant in the dominance of biomedicine in contemporary Western culture.

But these ideas are increasingly being challenged.

Normalisation is pernicious. It creates 'abnormality' and in doing so opens a space for the marginalisation and stigmatisation of people who might not choose to be labelled as deviant.

Some authors have argued that our desire to normalise makes health professionals 'parasites,' because our social value is tied to the need to constantly invent new disorders that we can then claim special responsibility for (Swain, French and Cameron, 2003).

And in these (post)modern times, when bodies are being seen as increasingly 'plastic,' fluid, adaptive and malleable, it is hard to sustain the idea that there is only one universal norm that we all comply with.

Normalisation is dangerous because it promulgates the idea that one size fits all.

It will be hard for physiotherapists to claim that they are patient-centred, or be able to adapt to the diversity and complexity of individual human differences if they continue to promote the idea that there is one norm against which all can be measured.

References

Porter, R. (2006). The cambridge history of medicine. Cambridge: Cambridge University Press.

Swain, J., French, S., & Cameron, C. (2003). Practice: Are professionals parasites? In Controversial issues in a disabling society (pp. 131-140). Buckingham: Open University Press.

New: Money

12 September 2015

A lot of really interesting attempts to change the way health care is being delivered are foundering because people can't work out how to fund them.

There are certain pockets of money available: seed grants and step-change funds that get projects started, but often these are term-limited and there is rarely any chance of ongoing funding.

One of the unspoken principles underpinning a lot of new models of health care (including primary care, health promotion, inter professional practice, patient-centred care), is that they will cost less, (or at least they will shift the responsibility for payment onto the individual and away from the state.) But few people have yet worked out ways to make the transition from traditional care in the absence of secure funding.

Physiotherapists are ideally placed to respond to the changing economy of health care. Name another profession that can boast diagnosticians with a high social standing, who can speak the language of biomedicine but work with the whole person, using techniques that are portable and inexpensive? Despite this, physiotherapists have been slow to move away from their traditional roles and service responsibilities.

Physiotherapists working in the public health system appear to be reluctant to abandon what is increasingly looking like a sinking ship, having learnt to tolerate more than 30 years of cuts and compromises. And private practitioners seem to be working towards elite specialisation as their future practice model rather than looking to funding that might provide a 'breadth' of employment opportunities.

So if money from central government is in decline, it is likely that the profession will pass into a period of both insecurity and opportunity. Today's graduates will likely find public sector jobs harder to come by, and they will need to find work in a range of different sectors. It is likely that partially funded, relatively short-term projects will become more common, and the ability to be innovative about one's work patterns and service responsibilities will change.

It would be lovely to imagine returning to a time when graduates entered the public health sector and had a job for life, but those days are gone, and the sooner we come to terms with this and look to the possibilities for new funding models, the sooner we will learn what new opportunities lie ahead for us.

New: Truths

13 September 2015

One of the inescapable realities of modern life, or should that be post-modern life, is that we have all become skeptical of authority figures that want to tell us that they know the answers, and that we should follow them compliantly, passively and unquestioningly.

There once was a time when people genuinely believed that the church, judges, the police, school teachers, parents, doctors and other authority figures genuinely knew best, but our trust in these authorities has been eroded by scandals, self interest and injurious practices.

And while some of us yearn for a simpler time when the world was black and white, we can't erase the image of child abuse by Catholic priests, medical malpractice and institutional racism in organisations like the police.

The Internet has helped destabilise the power base of traditional authority figures, and it has done this by taking away their ability to claim privilege over the kinds of knowledge that are deemed to represent the truth. But what we have believed to be true has always shifted, so it was always the ability to be the 'broker' of truth that really mattered in society. So when the power of the brokers (the doctors, judges, teachers, etc.) began to dissipate rapidly with the advent of the Internet, it opened up a space for new truths to emerge.

Physiotherapists have become quite obsessive about objective evaluation of their practice and demonstrating that their claims about assessment and treatment efficacy are 'true.' But it is questionable whether many people outside of the profession really care.

As Miles et al have pointed out in their scathing editorial on evidence-based medicine, there is no evidence that the implementation of EBM has improved the health and wellbeing of a single patient (Miles, 2008). Add to this the fact that our current methods of assessing the efficacy of our practice (i.e. that represented by the hierarchy of evidence), suggests that there isn't much to physiotherapy that can be trusted. (Look, for instance, at this neat summary of the most influential physiotherapy research studies of the last 15 years, and count up how many studies brought about change because physiotherapy was shown to be **in**effective).

The things that we take to be true may seem on the surface to be black and white, but they rarely are. Even the idea of truth is shifting. Thus any search for absolutes is futile. The idea of a single, all encompassing truth that we can all subscribe to is a fantasy, and today's (post)modern world only indicates more strongly that we are more eager than ever to see truth as fluid, contextual and personal. This has radical implications for physiotherapy, but it seems physiotherapists are finding it difficult to let go of past truths that meant something in the 20th century, but may be increasingly ossifying today.

Reference

Miles, A., Loughlin, M., & Polychronis, A. (2008). Evidence-based healthcare, clinical knowledge and the rise of personalised medicine. Journal of Evaluation in Clinical Practice, 14(5), 621-49. doi:10.1111/j.1365-2753.2008.01094.x

New: Histories

14 September 2015

I'm speaking purely for myself here, but I feel that physiotherapy doesn't really need any more quantitative research on hamstring stretching. I think we've seen enough evidence that pain is aversive, and that putting scores on complex conditions critically misrepresents the condition, the person's lived experience, and the benefits of physiotherapy.

Where I feel we could definitely do with more research - particularly these days, where we are increasingly looking for ideas about how physiotherapy might need to change in the future - is research about our past.

Not just accounts of past events, although even some of this would be nice, but historical works that connect to messages about the future: why we did what we did then; what has that made possible and what has it denied; and what can it tell us about how we should change?

We need more work by people like Sarah Nettleton, whose critical analysis of dentistry was groundbreaking, or David Armstrong who took a scalpel to medicine (Armstrong, 1983; Nettleton, 1992).

Critical historians like this are few and far between in physiotherapy, but one champion of this discipline is Anders Ottosson.

Ottosson's work on the origins of physiotherapy in the 19th century is quite exceptional. Amongst other things, he has shown that Swedish gymnastics played a major role in developing kinesiology today (Ottosson, 2010), and became the basis for medical, osteopathic, chiropractic and physiotherapeutic practices of manipulation (Ottosson, 2011). His latest work has looked at Gustaf Zander, the founder of the kinds of exercise machinery that we see in gymnasiums around the world (Hansson & Ottosson, 2015).He has work under review looking at androphobia, demasculinization, and professional conflicts in physiotherapy; scientific gynaecological masseurs; and gym-machines and the migration of medical knowledge.

In all cases, the questions posed about the history of physical therapies are directed to a better understanding of the present, and they follow a growing trend in research to explore the histories of health professional practice.

There are now well established academic chairs of the history of medicine and nursing, and major publications compiling historical works in the histories of professions not unlike physiotherapy (see, for example, D'Antonio et al, 2013; Sitzman & Davis, 2010), but so far nothing in physiotherapy itself.

It is said that 'history is a vast early warning system' and if this is the case, it would be neglectful of today's physiotherapists if they failed to pay attention to the lessons of the past and left future physiotherapists with a profession that had concentrated too much on its hamstrings on not enough on its history.

References

Armstrong, D. (1983). Political anatomy of the body: Medical knowledge in britain in the twentieth century. Cambridge: Cambridge University Press.

D'Antonio, P., Fairman, J. A. & Whelan, J. C. (2013). Routledge handbook of the history of nursing. Hoboken: Taylor and Francis.

Hansson, N., & Ottosson, A. (2015). Nobel prize for physical therapy? Rise, fall, and revival of medico-mechanical institutes. Physical Therapy. doi:10.2522/ptj.20140284Judd, D. M., Sitzman, K., & Davis, M. (2010). A history of american nursing : Trends and eras. Sudbury, Mass.: Jones and Bartlett Publishers.

Nettleton, S. (1992). Power, pain and dentistry. Buckingham: Open University Press.

Ottosson, A. (2010). The first historical movements of kinesiology: Scientification in the

borderline between physical culture and medicine around 1850. Int J Hist Sport, 27(11), 1892-1919. doi:10.1080/09523367.2010.491618
Ottosson, A. (2011). The manipulated history of manipulations of spines and joints? Rethinking orthopaedic medicine through the 19th century discourse of european mechanical medicine. Medicine Studies, 3(2), 83-116. doi:10.1007/s12376-011-0067-3

New: Looking

15 September 2015

'Observation is essential to expertise in medicine, and yet clinical training lacks a standard model for teaching and learning how to look. Interacting with visual art is exactly the kind of practice-based experience that is required to learn to look effectively. Learning to see brings many unexpected benefits: quite literally, opening eyes opens minds. Arts Practica proposes a model for learning observation in the context of art museums to improve quality in the clinic.'

This quote comes from 'a medical education consultancy [called Arts Practica, which is] committed to improving healthcare quality, reducing misdiagnosis, and increasing arts engagement.

Physiotherapy is so much about looking, seeing, observing, I wonder whether we might not also benefit from the eyes of visual artists, architects, engineers, dancers and trapeze artists, airline pilots, surgeons, plumbers, jewellers and other occupations and professions that also look for a living?

New: Greatness

16 September 2015

Edgar Cahn was Robert F. Kennedy's speech writer and senior counsel. He is now a professor of law at the University of the District of Columbia. But he is known throughout the world for inventing time banking.

The idea of time banking is that people who are dependent on others but are unable to pay them back with money, offer whatever skills and services they have to offer as repayment.

In many parts of the world, people have long bartered for goods and services with whatever they had to trade, and time banking works along similar lines.

The key thing about time banking is that it values all time equally, so an hour of physical therapy is the same as an hour of gardening, or dog walking, or brain surgery.

It's egalitarian principles are fundamentally about valuing everyones contribution and, as a result, it's a great tool for capacity building. (It's also a powerful way to empower people whose work has traditionally been less valued).

Many of our patients can't afford expensive treatments, others are quite dependent on peoples' help and support to fulfil even some of their most basic needs. Our current system sees these people as a burden on society and asks practitioners like physiotherapists to motivate and mobilise them back to 'normal.' Those who can afford the cost of long term care are encouraged to pay it themselves, creating a two-tier health system between those who have and those who have not. And no-one, it seems, knows what to do with the coming demographic time-bomb of increasingly dependence and decreasing health care funding.

So time banking offers some radical ways for people like health professionals to continue to work with their communities, after central government funding has dried up.

The thing that I love most about Edgar Cahn's ideas, though, is his assertion that greatness comes not from the measure of a person's productivity, but from the quality of their giving. Gandhi, he says, was a lawyer, but no-one measures his achievements by the number of cases he won. Mother Teresa was a nurse, but no-one measures her work by the number of patient contact episodes she achieved in the month of March. Cahn argues that we should not care for the trivialities of objective measures of performance, but focus instead on the greatness of simple human acts of kindness.

Perhaps time banking offers a practical solution to the problem of how to bring high quality physiotherapy to people who cannot otherwise afford it? It might also offer some insights into ways that future generations of practitioners can rediscover the modest pleasures of giving and receiving without elitism and privilege.

New: Reflection

17 September 2015

There's a phrase that I've come to use over and over again in recent years whenever I've presented at conferences or talked to people about the research I do, and I use it because it beautifully encapsulates what I think is perhaps the *main* problem now facing the physiotherapy profession.

It comes from a book written by a New Zealand doctor who is part European and part Māori. His name is Glenn Colquhoun, and he's written some fantastic books about health care, using poetry and prose to express his ideas.

In one slim volume titled 'Jumping Ship,' Colquhoun describes his experience coming to terms with his Māori heritage. He spent a few years in the far north of New Zealand with his elderly Māori aunt, learning the language and customs, and finding out about his heritage, and part of his journey of discovery involved some wonderful meditations on the tensions that alway seem to exist between indigenous peoples and their colonial brothers and sisters.

The phrase that Colquohoun used in the book that so captivated me was this:

> 'The most difficult thing about majorities is not that they cannot see minorities but that they cannot see themselves.'

The reason this has stuck with me for so long is that it speaks to me directly about the past, present and future of physiotherapy.

Despite all the rhetoric about our profession being a Cinderella profession, or that we're struggling for public recognition and government funding, we are, unquestionably, part of a significant, powerful orthodox health care machine. We embody a biomedical practice philosophy that is both exclusive and hegemonic, and we are one of the largest, most respected, and highest subscribed professional programmes in the developed world.

So I have no qualms in arguing that physiotherapy is majoritarian. Partly as a result of this, and partly because our practice philosophy is so exclusive, we really struggle to see ourselves.

Physiotherapists think that the public doesn't understand what we do. I believe that the public understands us perfectly well actually, and part of the reason why they are increasingly turning to other therapists and rehabilitation specialists is because they have worked out what we do, and are increasingly calling for something more. No, our problem is not that the *public* doesn't understand us, it's that we don't understand *ourselves*.

Reflective practice, like critical thinking, is considered by many within the profession to begin and end with the individual practitioner: "Use a reflective 'model' and do your reflective summaries and you'll be alright." But the Critical Physiotherapy Network is a champion for a much bigger idea of critical reflection. This is a critical reflection that encourages us to identify our professional culture; it's history, its practices, its beliefs and values; and to question whether those that worked so well for us in the past will continue to work well for us in the future.

There is no doubt in my mind that seeing ourselves more clearly, may be one of the most powerful transformative changes to take place within the profession over the next half century. I only hope we have the courage and wherewithal to let go of our majoritarian instincts and learn some professional humility and introspection.

Reference

Colquohoun, G. (2004). Jumping Ship. Auckland: Four Winds Press.

New: Methods

18 September 2015

Consider this list:

- Participatory action research
- Ethnography
- Case study
- Narrative ethnography
- Discourse analysis
- Grounded theory
- Visual methods
- Feminist
- Critical humanism
- Photo-voice
- Queer theory
- Mixed method
- Performance ethnography
- Constructivist
- Critical arts-based inquiry
- Oral history
- Online ethnography
- Conversation analysis
- Memory work
- Interpretive phenomenology
- Autoethnography
- Q methodology
- Ethnomethodology
- Historiographic
- Institutional ethnography...

This list is just a sample of some of the different approaches to data collection, text generation and analysis that are part of the growth of qualitative, and theoretically and philosophically-informed research now taking place in health care.

There is nothing particularly exclusive about these methods; certainly nothing to say that they are beyond the understanding of physiotherapists. They are agnostic about the person or profession that might wish to make use of them. So their uptake is largely dependent on the knowledge of the user, and the suitability of the question being posed.

With one or two notable exceptions though, the items on the list will be almost entirely alien to most readers. And yet these approaches offer some really valuable ways to interrogate our practice, our ideas and theories, our past, present and future.

Why is it that physiotherapists have been so slow to join in with doctors, nurses, psychologists, occupational therapists and others in taking advantage of these new approaches?

New: Assessment

19 September 2015

For this post, we're linking up with Michael Rowe in South Africa and his excellent site /usr/space. Michael is a physiotherapist and educator in South Africa, with a passion for teaching and learning. He is an active member of the Critical Physiotherapy Network and a regular blogger on health care education, pedagogy and technology-informed learning.

Earlier this week, Michael posted a blog exploring the possibilities of assessing teams, not individuals.

Assessing teams instead of individuals

> Patient outcomes are almost always influenced by how well the team works together, yet all of the disciplines conduct assessments of individual students. Yes, we might ask students who they would refer to, or who else is important in the management of the patient, but do we ever actually watch a student talk to a nurse, for example? We assess communication skills based on how they interact with the patient, but why don't we make observations of how students communicate with other members of the team when it comes to preparing a management plan for the patient?
>
> What would an assessment task look like if we assessed teams, rather than individuals. What if we we asked an OT, physio and SALT student to sit down and discuss the management of a patient? Imagine how much insight this would give us in terms of students' 1) interdisciplinary knowledge, 2) teamwork, 3) communication skills, 4) complex clinical reasoning, and 5) patient-centred practice? What else could we learn in such an assessment? I propose that we would learn a lot more about power relations between the students in different disciplines. We might even get some idea of students' levels of empathy for peers and colleagues, and not just patients...

New: Sharing

20 September 2015

A few weeks ago, the Executive of the Critical Physiotherapy Network discussed the Terms and Conditions we wanted to place around membership access to our shiny new website.

We wanted to establish and encourage some standards of behaviour, because one of our cardinal principles is that people should feel safe within this site to express their ideas, however controversial, critical or radical. At the same time, we wanted to stand up for some particular virtues: inclusive language; participatory dialogue; and fearless minoritarianism.

Striking the right balance in defining 'light touch' regulations is surprisingly difficult, but only really if you are bound by conventional beliefs about things like intellectual property, the ownership of goods and services, and restrictions based on privilege and elitism.

So when we came to identify how we wanted to make the contents of the site available to people, we did not use protectionist legal language, but chose instead to use the following phrase:

> Respect the spirit of open, respectful sharing and free collaboration

The reason for making this statement are numerous. Firstly, because our Constitution demands that we 'Develop[e] a culture and appreciation for the exploration of all views that deviate from conventional thought and practice in physiotherapy,' and 'Actively embrac[e] ideas that promote thinking against the grain/challenging in physiotherapy.' But also because we aspire to 'Being open to a plurality of ideas, practices, objects, systems and structures that challenge contemporary physiotherapy practice and thought,' and 'Providing a space for ideas that promote a more positive, diverse and inclusive future for the profession.'

These are not empty gestures, but phrases that have been crafted by numerous people within the Network over weeks of deliberation, and I am proud to stand by them. I think film maker Jim Jarmusch said it best when he suggested that,

"Nothing is original. Steal from anywhere that resonates with inspiration or fuels your imagination. Devour old films, new films, music, books, paintings, photographs, poems, dreams, random conversations, architecture, bridges, street signs, trees, clouds, bodies of water, light and shadows. Select only things to steal from that speak directly to your soul. If you do this, your work (and theft) will be authentic. Authenticity is invaluable; originality is non-existent. And don't bother concealing your thievery - celebrate it if you feel like it. In any case, always remember what Jean-Luc Godard said: "It's not where you take things from - it's where you take them to." (Jim Jarmusch, film maker, quoted in MovieMaker Magazine #53 - Winter, January 22, 2004).

And that includes this quote.

New: Anatomy

21 September 2015

These 30 Days of September posts are supposed to be provocative. Not the kinds of provocation that comes from empty gestures and tired clichés (hopefully not, at least). But the kind of provocation that contain grains of truth (cliché-related humour).

So, fair warning, what I'm about to say may upset some people. But I'm really only trying to articulate what should be reasonably obvious by now to anyone with a mobile device and an Internet connection. So here goes.

A day will come soon, when students will no longer need anatomy taught in the traditional way: with endless lectures full of mind-numbing names and abstract mechanics. Students will no longer need to stay up late into the night to copy pictures of the muscles of the forearm into their notebooks. And teachers will be able to retire their overhead transparencies and PowerPoint slides.

No, we are but a whisper away from a complete revolution in the study of anatomy. And not just anatomy either, but physiology, pathology, kinesiology, biomechanics, and all the other 'pure' sciences that have been the backbone of physiotherapy student education for over a century.

One day soon, McDonalds, or Google, or Apple, or someone with a lot of money, will take up the challenge of compiling the definitive, totally immersive anatomy programme that will obliterate the need for its competitors, and form the backbone of anatomy learning in medical schools, physiotherapy programmes and a thousand other venues around the world. It will become the Microsoft Word equivalent of learning packages and obliterate the competition.

Students will no longer need to sit in the classroom and engage with lecturers in the same way. Courses will build their assessments around computer programmes and mobile device apps rather than the other way around. And soon we will come to realise the revolution that is already happening in student learning, when we accept that students no longer need to retain in their heads so many facts, but instead use their heads for thinking.

Knowledge of the origins and insertions of adductor longus will no longer be the currency that distinguishes an 'expert' practitioner from a novice, because a novice (or patient) with a portable device will have the expert's advantage at their fingertips. (At this point I have clearly given up on cliché patrol). Knowledge of anatomical facts at the end of Year 1 will no longer be used as the arbitrary gateway into the physiotherapy profession, and educators will look for new ways to assess the student's future potential.

Lest we think this day is still a long way away, take a look at some of the anatomy apps that are now widely available for Android and Apple devices. They are incredibly complex and

becoming more and more detailed every day. They will change physiotherapy in ways that cannot be measured by the declining sales of Grey's Anatomy textbooks.

New:

22 September 2015

New: Creativity

23 September 2015

Marking the launch of the new edition of the Journal of Humanities and Rehabilitation - itself a notable and new creative venture - this post is about creativity.

Physiotherapy ought to be a vehicle for all sorts of creative expression, given that so much of what we do is about bodies and movement.

I know many physiotherapists who love dance, martial arts, singing, performance art and other forms of physical expression, as well as creative thinkers, ideas people, artists, musicians, poets, photographers and writers of fiction. But there are few creative outlets for their work *within* physiotherapy itself. It seems there is physiotherapy, and creative expression is something that sits *outside*.

Why is this? Why is it that we have consistently undervalued creative expression, in favour of rigorous scientific objectivity? And at what point did we decide that we could have one but not the other?

As our practice becomes increasingly humanistic and social, we need to find new ways to express the full breadth of our work, and one way would be through the creative arts.

WCPT has run an 'Arts and Health' competition for a number of years, but these works often express safely literal renderings of traditional physiotherapy motifs, where people regain

movement and overcome adversity. But there is much more that physiotherapists can say and do with the arts than this.

Physiotherapy might not only find new ways of expressing itself through creative arts, it might also find new ways of 'being' that challenge convention and lead the way in the next phase of the profession's maturation.

New: Openings

24 September 2015

Physiotherapists, like all orthodox western health professionals, love endings.

Think about it. Every time we begin a new patient assessment, we have got one eye on the patient's discharge. We love goals and outcome measures so that we can measure when milestones have been reached and end-points achieved.

It seems every opening to a new episode of care comes with an implicit expiration date.

Naturally, funders are eager that packages of care are limited and treatments don't extend on into days, weeks and months, and we seem to have accepted the inherent logic that care must have term limits.

Time-limited care suits acute illnesses and injuries that are, by definition, self-limiting. And so funding has tended to privilege short termism and emphasise repeated, low cost, 'curative' interventions.

The people missing out in this calculation, of course, are those with unremitting, chronic, long-term, incurable, progressive and debilitating illnesses, where living *with* the consequences of their illness is often a more significant problem than the biological illness or injury itself.

Chronic pain, multiple sclerosis, emphysema, spinal cord injury, diabetes, cystic fibrosis, Parkinson's disease, chronic renal failure, depression, fibromyalgia, HIV/AIDS, cancer, Alzheimer's disease, stroke, chronic breathlessness, not to mention the debilitating effects of ageing or congenital illness, all require an unrelenting commitment to care for which there is no end.

Short-term acute packages of care and therapists attempting quick fixes to patient's bodies might work well for acute illnesses and injuries, but they don't work well for long term illnesses, where therapists often need to work *with* rather than *on* people.

How might physiotherapy be different if we removed our fascination with endings, and concentrated instead on allowing the myriad openings that accompany care to emerge? How might we be better placed to help people with longstanding illness, lifestyle disorders and

government health priorities if we dispensed with a model of care more suited to acute illness and injury, and became a profession more concerned with opening doors than closing them?

New: Students

25 September 2015

When I entered physiotherapy training in the 1980s, there was a rule at my school that said you had to be more than 5 feet tall to gain entry. I wonder what the people who had made this rule would think about my school recently graduating our first tetraplegic student?

Times change, and people's priorities change too. A quick scan through textbooks from the 20th century and you will see that physiotherapy was once dominated by young white women. Now we recruit a lot more men, mature students and people from diverse cultural backgrounds.

Part of the reasons for this shift has been the need for physiotherapists to be more representative of the populations they serve, and to achieve this we have had to think creatively about how we recruit people to the programme.

We used to interview applicants, but interviews tended to favour people who looked and behaved as we do. So it was hard to introduce new people into programmes and change the cultural mix.

Another strategy was to take away the high degree of subjectivity that came with interviews, and recruit people purely on the basis of their grades. But because physiotherapy has always been a popular graduate programme, we could afford to set our entry requirements high and select only the 'cream of the crop.'

Inevitably, people with high grades tended to be those who had had good educational experiences and had been well supported in their learning. The people who didn't make the grade were not necessarily less motivated or less able, but had often lived in poorer school areas, come from poorer families, or from more disruptive social situations.

So to change the student profile has taken a concerted effort to change the culture of our recruitment, and it hasn't always been popular.

If we acknowledge that it is hard for people trained traditionally to think radically about the profession's future, then one way we might find to bring new thinking into the profession would be to positively recruit people into the profession who come from diverse cultural backgrounds.

It has been argued, for instance, that rather than continue to recruit school leavers with the best educational attainment, we might look for the qualities that make the best

physiotherapy practitioners. This might be enthusiasm, ability to listen, compassion, flexibility, and dedication.

This is not to decry from good academic achievement, but it is now well recognised that these things alone are no longer adequate predictors of graduate success.

Some schools are making the change and seeing recruitment for diversity as a positive response to the changing economy of health care. Being open to people and cultures different to our own is often a challenge to people, but this is clearly an important innovation and a positive step in the pursuit of new physiotherapy practices in the 21st century.

New: Archiving

26 September 2015

A few weeks ago, Verity Burke from the blog *Science book a day* posted a list of 10 Great Books on the History of Medicine. Here is the list:

- Morbid Curiosities: Medical Museums in Nineteenth-Century Britain. Samuel J.M.M. Alberti (Oxford University Press, 2011)
- The Morbid Anatomy Anthology, ed. Joanna Ebenstein and Colin Dickey (Morbid Anatomy Press, 2014)
- The Sick Rose: Or, Disease and the Art of Medical Illustration. Richard Barnett (Thames and Hudson, 2014)
- Human Anatomy: Depicting the Body from the Renaissance to Today, eds. Benjamin A. Rifkin, Michael J. Akerman and Judith Folkenberg (Thames and Hudson, 2011)
- Women under the Knife. Ann Dally (Hutchinson Radiance, 1991)
- Objectivity. Lorraine Daston and Peter Galison (Zone Books, 2007)
- The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present. Roy Porter (Fontana Press, 1999)
- Science and the Practice of Medicine in the Nineteenth Century. W.F. Bynum (Cambridge University Press, 1994)
- The Birth of the Clinic: An Archaeology of Medical Perception, trans. A.M. Sheridan Smith. Michel Foucault (Vintage, 1963)
- Death, Dissection and the Destitute: The Politics of the Corpse in Pre-Victorian Britain. Ruth Richardson (Routledge and Kegan Paul, 1987)

You'll notice the grand scale of these books and the heroic (and sometimes despotic and destitute) way that medicine is portrayed.

You may also notice the distinct lack of any books relating to physiotherapy. But why should this be?

Anyone attempting to account for physiotherapy's past will encounter a dispiriting lack of archiving and commentary from within, and without, the physiotherapy community over the last century.

It seems that physiotherapists are either too modest, too biomechanical, or too indifferent to their own history to want to record it and offer critical commentary.

But why is this? Do we not have our heroines, our innovators and pioneers? Did we not play a dramatic role in rehabilitating war injured soldiers and polio victims? Did we not pioneer new approaches to children's, intensive care and musculoskeletal rehabilitation? Are we not world leading biomechanists, pain specialists and exercise therapists?

The physical therapies are almost entirely absent from histories of medicine and health care over the last 200 years, and present day practitioners are doing little to preserve or account for our current approaches to practice.

Electronic data may be even more etherial than the texts and practices that we willingly disposed of in years gone by.

We must be better at archiving what we do, so that even if we have no capacity to provide commentary on it in the present, future generations will at least have the chance to look back and understand how our practices were changing, and why we did what we did.

New: Encroachment

27 September 2015

One of the ways that physiotherapists have recently looked to secure greater influence in the health care system has been to take on role previously done by others.

Extended scopes now include limited prescribing rights and some invasive procedures like injecting, cannulation and bronchoscopy. We now also have new consultancy, advisory and leadership roles that are changing the nature of our practice.

And one of the most popular extensions that can be taken up by the whole profession has involved the drift towards public health medicine.

Physiotherapists and others are looking at the possibility of offering 'wrap-around' care where once they were specialists in discrete areas of practice, like cardiorespiratory, musculoskeletal and neurological physiotherapy.

Now, we are looking to use our access and skills to change people's health behaviours: helping them to stop smoking, lose weight and do more exercise.

But there are real dangers in this approach that have not, as yet, been explored by the profession, as it tries to scale the rocky cliff face of traditional health care, to find the rarified air and green pastures in the New World of health promotion.

A few years ago, nurses began to take on the work of endoscopy that used to be the doctor's domain. Practice nurses were trained up, and took over the responsibility for all of the preparation, hygiene, risk management and scoping of the patient.

Many saw this as a real sign that nursing was now respected as a scientifically-based practice, and one that had gained the clinical trust of doctors. But others, privately at least, thought otherwise.

Some asked whether doing endoscopies was really anything to do with nursing philosophy, arguing that doctors had simply passed over a role that they no longer wanted, because it was either too mundane or of limited clinical interest.

Rather than it being a sign of recognition, they argued, endoscopy was merely another episode in the long history of medical paternalism and patronage. Not something nurses should be welcoming.

The same questions might be asked about physiotherapists telling people to stop smoking and take more exercise.

It could be argued that you don't need a three- or four-year degree and experience as a diagnostician of multiple comorbidities to take on this role, no matter how attractive it might be as a mechanism to secure public health funding.

Besides, a recent report in the Journal of Public Health has suggested that the routine health checks implemented into the NHS in 2013 have had limited impact but have been extermely costly - effectively stealing money from services that were already struggling for funding (Capewell et al, 2015).

While it is easy to see, and accept, the rhetoric that physiotherapists are perfectly placed to offer basic health promotion advice and support, we would be wise to ask more critical questions about this approach, before becoming a part of the army of health advisors that are now slowly replacing the therapists of old.

Reference

Capewell, S., McCartney, M., & Holland, W. (2015). Invited debate: NHS health checks—a naked emperor? Journal of Public Health, 37(2), 187-192.

New: Significance

28 September 2015

Physiotherapists are, by reputation, quite practical, pragmatic, literal people who are generally modest about their work and conservative in their approach to practice.

You can see this in the books, journal articles and promotional work that was undertaken by the profession in the 20th century.

In recent years, we have learnt that we need to be better at self promotion, but many find this quite challenging. We are not brash, and we don't like to strut.

But one aspect of our work has suffered as a result, and it may hold an important clue to the way physiotherapy may need to change in the future.

Physiotherapy is transformative. We know this from the millions of patients who, over the years, have been brought back to life, given hope, strengthened, rehabilitated and revived. Many thousands of people have literally had their lives turned around by a physiotherapist, and many more have found something in their therapy that has allowed them to heal.

Physiotherapy is transformative for physiotherapists too. It is probably one of the things that keeps us enamoured with our work. After all, the ability to have a profound effect on someone's health and wellbeing is very seductive and gives us a great sense of our own worth.

It is surprising then, that physiotherapists do not make more of this transformation. We concentrate on the pragmatic and the mundanely measurable, and lose sight of the 'bigger picture.'

It may be that many people come to physiotherapy not for what the therapy achieves, but as much for what the therapy makes *possible*: how it gives a person back a sense of control in the midst of a chaotic life; how it offers them hope for less pain in the future; how it reminds them of what movement used to feel like.

If these existential features of our profession are the profound things that elevate our work above the mundane and quotidian, they deserve more attention and a great deal more exposure.

New: Disruption

29 September 2015

Disruption is a lovely geological word. It suggests shaky ground and lava flows, destabilisation and disorganisation.

Most people working in health care today are fed up with disruption though. Most would be perfectly happy if they never saw any more funding cuts, job freezes and

reorganisations. Unfortunately we know that disruption is an everyday occurrence in a health care system going through a long, slow, seismic unsettling.

But disruption need not be negative, and the Critical Physiotherapy Network is one small example of how a group of people are trying to change the rhetoric surrounding disruption and change.

The key to this new approach lies with the ideas of openings and closings.

French philosopher Gilles Deleuze had a simple and elegant way of deciding whether an idea was worth pursuing. If the idea opened a door to new possibilities, then it was good; if it closed a door, it was bad.

There are many things in health care that close doors: rules, regulations, routines, conventions, prescriptions, dogmas, guidelines, standardised pathways, etc., all devised by people who would like you to do it their way.

There are fewer people prepared to disrupt the present with the intention of leaving the door open for *you* to decide what *you* want to do with this newfound opportunity. All too often we replace one bad hegemony with another.

The CPN is a place which works hard to open doors to new possibilities in the future, and it is our belief that this kind of disruption is a lot more palatable than the kinds of bitter disruption that have beset our work over the last few year.

New: Day

30 September 2015

This is the last of this year's 30 Days of September postings. There has been one posted every day this month, and each one has focused on something 'New.'

They've been a lot of fun to write, and my hope is that they have been interesting and provocative, without ever being dismissive or derogatory.

So I'd like to close off this year's offerings with some wisdom from one of the great Roman Stoic philosophers, Marcus Aurelius (121-180AD):

We were born to work together like feet, hands, and eyes, like the two rows of teeth, upper and lower. To obstruct each other is unnatural. To feel anger at someone, to turn your back on him: these are obstructions.

Remember tomorrow is a new day and a new opportunity to make things better, or at least to try.

Thank you to those of you who have voted for these posts. If you'd like us to follow up on one of these ideas with you, keep voting. We'll try to follow up on this in the coming weeks as the site grows and grows.

Keep spreading the word about the Network: our constitution will tell strangers everything they need to know about who we are and what we do.

Most of all, never stop trying to be a 'positive force for an otherwise physiotherapy.'

Dave Nicholls

30DoS - 2016

30 CPN members from around the world talking about the ideas and people that have inspired their work.

Many posts have Spanish translations provided by the wonderful CPN Exec member Alma Viviana Silva.

Michael Rowe

1 September 2016

In this post CPN Executive member Michael Rowe describes how Quantifying the body: Monitoring and measuring health in the age of mHealth technologies by Deborah Lupton influenced him.

Mobile apps and wearable technologies are increasingly being used in medical and health related contexts and provide us with new and interesting ways of representing and visualising the body. These new products are generally presented in a very positive light with little critical thought given to the broader implications of widespread gathering of biometric data on individuals. This paper presents an alternative point of view that explores other ways in which the quantified self movement impacts on our lives. For example, Lupton suggests that, in addition to providing information on our sleeping habits, these technologies also influence the ways in which we think about identity and health. Specifically, she argues that they promote techno-utopian, enhancement and healthist discourses, all of which have potentially negative affects on individuals. In addition, the use of biometric and other aggregated data may present a perspective of one’s health that is inaccurate, leading to decision making based on incorrect assumptions. At this stage of the integration of these technologies into our daily lives, Lupton suggests that it is still too early to have a confident point of view on their utility. However, we should still be aware of the wide variety of ways in which we can be influenced by them and that not all of it is inherently positive.

As someone who is inherently geeky and tech-savvy, I often find myself buying into the hype of whatever is cool in the tech industry at any point in time. Deborah Lupton is one of those researchers who is always able to remind me that the critical perspective is not only useful, but absolutely necessary. She is able to take whatever device or technology platform that is popular and present it at it's superficial level (i.e. to describe what it is and what it does) but then to also take the next step and analyse the deeper and more far-reaching implications (i.e. to evaluate what it means in a broader social context). Her work is essential reading for anyone interested in the sociological implications of the individual choices we make in our own practices.

En este post el miembro del comite ejecutivo de la CPN, Michael Rowe describe cómo cuantificar el cuerpo: El seguimiento y la medición de la salud en la era de las tecnologías mHealth por Deborah Lupton influyó en él.

Las aplicaciones móviles y las tecnologías portátiles cada vez se utilizan en contextos médicos y relacionados con la salud y nos proporcionan nuevas e interesantes maneras de representar y visualizar el cuerpo. Estos nuevos productos se presentan generalmente en una luz muy positiva y con poco pensamiento crítico dado las grandes implicaciones que tiene la recolección generalizada de los datos biométricos para las personas. Este artículo presenta un punto de vista alternativo, que explora otras formas en que impacta la cuantificacion del movimiento propio en nuestras vidas. Por ejemplo, Lupton sugiere que, además de proporcionar información sobre nuestros hábitos de sueño, estas tecnologías también influyen en la manera en que pensamos acerca de la identidad y de la salud. En concreto, sostiene que promueven la tecno-utópia, discursos "saludables" y de mejoramiento de la salud, todos los cuales, acarrean posibles impactos negativos en las personas. Además, el uso de datos biométricos y otros agregados puede presentar un punto de vista de la salud de uno, que no es correcta, lo que lleva a la toma de decisiones basadas en suposiciones incorrectas. En esta etapa de la integración de estas tecnologías en nuestra vida cotidiana, Lupton sugiere que todavía es demasiado pronto para tener un punto de vista de confianza en su utilidad. Sin embargo, debemos ser conscientes de la gran variedad de formas en las que podemos ser influenciados por ellas y que no toda la tecnologia es inherentemente positiva.

Como alguien que es inherentemente geek y/o conocedor de la tecnología, a menudo me encuentro comprando lo que tiene bombo o lo que está fresco en la industria de la tecnología en cualquier punto en el tiempo. Deborah Lupton es uno de las investigadoras que siempre es capaz de recordarme que la perspectiva crítica, no sólo es útil, sino absolutamente necesaria. Ella es capaz de tomar cualquier dispositivo o plataforma tecnológica que es popular y lo presenta en su nivel superficial (es decir, para describir lo que es y lo que hace), pero luego también toma el siguiente paso y analiza las más profundas implicaciones que tiene a largo plazo (es decir, para evaluar lo que significa en un contexto social más amplio). Su trabajo es

una lectura esencial para cualquier persona interesada en las implicaciones sociológicas de las elecciones individuales que hacemos en nuestras propias prácticas.

References and links

Lupton, D. (2013). Quantifying the body: Monitoring and measuring health in the age of mHealth technologies. Critical Public Health, 23(4), 393–403.

This Sociological Life (Lupton's blog): https://simplysociology.wordpress.com/

Interview with Lupton on The quantified self and self tracking: https://soundcloud.com/mediasportpodcastseries/professor-deborah-lupton-from-the-news-and-media-research-centre-at-the-university-of-canberra

Stephanie Nixon

2 September 2016

In this post Associate Professor Stephanie Nixon talks about how the idea of 'Allyship' influenced her.

Critical scholarship aims to illuminate avoidable inequities that unfairly privilege some and disadvantage others. Within this work, reflexivity about one's positionality as the analyst is viewed as fundamental. Yet, beyond the recognition of one's simultaneous positions of privilege and oppression, I have struggled with "how to handle" my various positions of privilege in the practice of this work. Enter "allyship", a concept advanced within activist communities to offer guidance on how people in positions of privilege or dominance might act to meaningfully dismantle systems of oppression instead of unintentionally reinforcing them by our so-called critical work. Specifically, the Anti-Oppression Network describes "allyship" as "an active, consistent, and arduous practice of unlearning and re-evaluating, in which a person of privilege seeks to operate in solidarity with a marginalized group of people". This blog post introduces the notion of allyship, presents principles for practicing allyship, and offers concrete examples of how critical scholars can practice allyship in their day-to-day work.

I came across the concept of allyship when trying to build my capacity around anti-oppression, anti-racism and settler-indigenous relations. Most of what I've learned about this concept has been in blogposts, articles or YouTube videos offered by people in positions of oppression as instructions to those in privilege who wish to work as allies. I have found the insights to be both brilliant and a bit devastating (i.e., that I'm only learning them now vs this being a common way of life that I learned as a child). Within my health professional teaching, I find that most people have never heard of this allyship – so the goal of this post is to make this idea seeable, readable and thinkable.

En este post la Profesora Asociada Stephanie Nixon habla sobre cómo la idea de 'Allyship' influyó en ella.

Los estudios críticos tiene como objetivo iluminar las desigualdades evitables que injustamente privilegian a unos y perjudican a otros. Dentro de este trabajo, la reflexividad sobre la posicionalidad de uno como el analista, es vista como fundamental. Sin embargo, más allá del reconocimiento de las propias posiciones simultáneas de privilegio y de opresión, he luchado en "cómo manejar" mis diversos puestos de privilegio en la práctica de este trabajo. "Allyship", es un concepto avanzado dentro de las comunidades de activistas para ofrecer orientación sobre cómo las personas en posiciones de privilegio o de dominio podrían actuar para desmantelar de manera significativa los sistemas de opresión en lugar de reforzar involuntariamente ellos por nuestro llamado trabajo crítico. En concreto, la Red Contra la Opresión describe "allyship" como "una práctica activa, constante y ardua de desaprender y volver a evaluar, en el que una persona de privilegio busca operar en solidaridad con un grupo marginado de gente". Este blog introduce la noción de allyship, presenta principios para la práctica de allyship, y ofrece ejemplos concretos de cómo los eruditos críticos pueden practicar allyship en su trabajo del día a día.

Me encontré con el concepto de allyship cuando se trata de construir mi capacidad contra la opresión, contra el racismo y las relaciones de colonizador-indígena. La mayor parte de lo que he aprendido acerca de este concepto ha estado en artículos de blog, artículos o vídeos de YouTube ofrecidos por personas en posiciones de opression, brindando instrucciones a los que estan en condiciones de privilegio y que desean trabajar como aliados. He encontrado estos conocimientos brillantes y a la vez un poco devastadores(por ejemplo, que sólo estoy aprendiendo ahora esto vs siendo esta una forma común de vida que aprendí de niño). Dentro de mi enseñanza profesional de la salud, me parece que la mayoría de la gente nunca ha oído hablar de este allyship - por lo que el objetivo de este post es hacer esta idea visible, legible y pensable.

References and links

https://theantioppressionnetwork.wordpress.com/allyship/

https://prezi.com/nesv*ekel126/allyship-intersectionality-anti-oppression/*

http://www.upenneejust.com/allyship/

Siri Moe

3 September 2016

In this post, Norwegian physiotherapist, teacher and researcher Siri Moe talks about Shaun Gallagher's book How the body shapes the mind. Spanish translation provided by CPN Exec member Alma Viviana Silva.

The American philosopher Shaun Gallagher published the book “How the body shapes the mind” in 2005. As a result of extensive collaboration with scientists from other disciplines, like neurologists and psychologists the author redefines the understanding of the relationship between the phenomenal consciousness and the physical body. He is focusing on proprioception related to embodiment. His work is a supplement and an extension of Merleau-Ponty's phenomenology of the body, and he describes what happens behind the scenes of awareness (i.e. sense of the body), and how the body anticipates and sets the stage for consciousness. Thus, he throws light on the role embodiment plays in the structuring of consciousness.

In my Ph.D. work, I had a social understanding of movement in different work contexts, where I explored the role of the external senses and proprioception by use of phenomenology of the body. Later on I was introduced to Gallagher's work, and his distinct descriptions of concepts like body image, body schema, sense of self and embodied self were useful to further analyzes and understanding of movement's impact to a person's cognitive as well as motor development. The vocabulary from Gallagher's book is helpful in analyzes of body function and physiotherapy treatment, and a useful tool to develop physiotherapy approaches to specific functional deficits.

En este post, fisioterapeuta noruego, docente e investigador Siri Moe habla sobre el libro de Shaun Gallagher. Cómo el cuerpo da forma a la mente.

El filósofo estadounidense Shaun Gallagher publicó el libro "Cómo el cuerpo da forma a la mente" en 2005. Como resultado de una amplia colaboración con científicos de otras disciplinas, como neurólogos y psicólogos, este autor redefine la comprensión de la relación entre la conciencia fenomenal y la física del cuerpo. Él se centra en la propiocepción relacionada con la forma de realización. Su obra es un complemento y una ampliación de la fenomenología del cuerpo de Merleau-Ponty, y él describe lo que sucede detrás de las escenas de la conciencia (es decir, el sentido del cuerpo), y cómo el cuerpo anticipa y prepara el escenario para la conciencia. Por lo tanto, arroja luz sobre el papel que juega la realización en el estructuramiento de la conciencia.

En mi trabajo de doctorado, comprendiendo el entendimiento social del movimiento en diferentes contextos de trabajo, donde explore el papel de los sentidos externos y la propiocepción, usando la fenomenología del cuerpo. Más tarde me presentaron el trabajo de Gallagher, y sus distintas descripciones de los conceptos de la imagen corporal, esquema corporal, sentido de sí mismo como uno mismo y su realizacion sirvieron para profundizar el

análisis y la comprensión del impacto del movimiento en la parte cognitiva de una persona , así como en su desarrollo motor. El vocabulario del libro de Gallagher es útil en el análisis de la función del cuerpo y el tratamiento de fisioterapia, y una herramienta útil para el desarrollo de la fisioterapia se acerca a los déficits funcionales específicos.

Links

http://www.theassc.org/files/assc/2625.pdf

http://www.ummoss.org/

Jenny Setchell

4 September 2016

In this post, CPN co-founder and Exec member Jenny Setchell talks about Karen Barad's book Meeting the Universe Halfway.

Karen Barad, a quantum physicist and post-humanist philosopher, blew my mind with her first book. It is 500+ pages so quite a read, but well worth it. I particularly recommend this book for those of you who question what comes after social constructionism. Building on the work of theorists such as Butler, Hacking, Foucault, Deleuze and Haraway, as well as quantum physicist Bohr, Barad describes an ontology called 'agential realism'. "Barad extends and partially revises Bohr's philosophical views in light of current scholarship in physics, science studies, and the philosophy of science as well as feminist, poststructuralist, and other critical social theories. In the process, she significantly reworks understandings of space, time, matter, causality, agency, subjectivity, and objectivity." It's quite some book!

Barad's work has made me think differently in many ways. I will outline one here. She critiques a concept/methodology I have used in many a situation when trying to rethink physiotherapy: reflexivity. Barad writes that reflexivity is about reflection (ie holding up a mirror to a something) where nothing new is introduced into a situation, just more subtle understandings of what is already known. Barad reasons that this is fixed and essentialising – producing little that is unexpected. She argues instead for methodology of difference: diffraction, where the introduction of something new, disrupts a situation. Or, thought about another way, where things entangle with each other – producing complex intra-actions. This video (skip the ad) explains Barad's concept of intra-action.

Karen Barad, físico y filósofo poshumanista cuántica, me voló la cabeza con su primer libro. Es más de 500 páginas de manera bastante leer, pero bien vale la pena. Lo recomendamos especialmente este libro para aquellos de ustedes que cuestionan lo que viene después del construccionismo social. Basándose en el trabajo de los teóricos tales como Butler, Hacking, Foucault, Deleuze y Haraway, así como físico cuántico de Bohr, Barad describe una ontología

llamado "realismo agencial '. "Barad extiende y revisa parcialmente puntos de vista filosóficos de Bohr a la luz de los estudios actuales en física, estudios de la ciencia y la filosofía de la ciencia, así como feminista, postestructuralista, y otras teorías sociales críticos. En el proceso, ella vuelve a trabajar de manera significativa la comprensión del espacio, el tiempo, la materia, la causalidad, la agencia, la subjetividad y la objetividad. "Es un libro simplisimo! El trabajo de Barad me ha hecho pensar de manera diferente en muchos aspectos. Voy a esbozar una aquí. Ella critica un concepto / metodología que he utilizado en muchas situaciones cuando se trata de replantear la fisioterapia: reflexividad. Barad escribe que la reflexividad se trata de la reflexión (es decir, poner un espejo a un algo) en el que nada nuevo se introduce en una situación, a más sutiles interpretaciones de lo que ya se conoce. Barad razona que este es fijo y esencialista - produciendo poco lo que es inesperado. Ella sostiene en su lugar para la metodología de la diferencia: la difracción, donde la introducción de algo nuevo, interrumpe una situación. O, pensado de otra manera, donde las cosas se enredan entre sí - la producción de complejas intra-acciones. Este video explica el concepto de intra-acción de Barad.

Reference

Barad, Karen (2007). Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning. Durham, North Carolina: Duke University Press.
ISBN 9780822339175.

Tobba Sudmann

5 September 2016

In this post, Norwegian physiotherapy lecturer, researcher and hippotherapy practitioner Tobba Sudman talks about Erving Goffman's book Presentation of self in everyday life. Spanish translation provided by CPN Exec member Alma Viviana Silva.

Presentation of self in everyday life (1959) was Goffman’s first of 11 books, detailing social interaction as a bridge over the actor-structure divide in social theory. Goffman’s key message is that social interaction is a moral and precarious endeavor, in which we all are embedded. Social interaction is communication with all kinds of signs and micro-behavior, designed for mutual impression management, interpretation and creation of working relations. Signs are interpreted according to what we already know about the situation or persons in our presence, or according to cultural lore or idioms. We collaborate in presenting different fronts and version of our selves depending on our understanding of the situation, preferences or social expectations– making for situations to come off, to be repaired or terminated.

I first came across Goffman when I was working with my master’s thesis, and tried to figure out how I could describe female physiotherapist’s (fPTs) dealing with male patients receiving

Bobath treatment (high degree of physical proximity between patients and PTs). I used Goffman's vocabulary to show how fPTs constructed the situation as gender neutral and asexual by arranging the context, their attire, clothing/make up, wedding rings (even when unmarried), body posture, language, and use of hands. The ideal types "The clever PT" and "The good patient" made it possible for both parties to carry through the treatment. Goffman's sociology is highly relevant to understand how, and why, patients present and communicate their concerns and ailments as they do.

En este post, el profesor de fisioterapia noruego, investigador y practicante de hipoterapia Tobba Sudman habla del libro de Erving Goffman de sí mismo en la vida cotidiana.

Presentación de la persona en la vida cotidiana (1959) fue el primero de 11 libros, que detalla la interacción social de Goffman como un puente sobre la brecha de actor-estructura en la teoría social. Mensaje clave de Goffman es que la interacción social es un esfuerzo moral y precario, en el que todos estamos inmersos. La interacción social es la comunicación con todo tipo de signos y micro-comportamiento, diseñado para la gestión de impresión mutua, la interpretación y la creación de relaciones de trabajo. Los signos son interpretados de acuerdo con lo que ya sabemos acerca de la situación o de las personas en nuestra presencia, o de acuerdo con la tradición cultural o modismos. Colaboramos en la presentación de los diferentes frentes y la versión de nosotros mismos en función de nuestra comprensión de la situación, preferencias o expectativas sociales para que las situaciones que se desprenden, sean reparadas o terminadas. Vine por primera vez a través de Goffman cuando estaba trabajando con mi tesis de maestría, y traté de averiguar cómo podría describir de fisioterapeutas femeninas(FPTS) trata a pacientes masculinos que reciben tratamiento de Bobath (alto grado de proximidad física entre los pacientes y los PT). He utilizado un vocabulario de Goffman para mostrar cómo FPTS construyen la situación de connotaciones de sexo y asexual mediante el establecimiento del contexto, su vestimenta, ropa / maquillaje, anillos de boda (incluso cuando no se han casado), la postura del cuerpo, el lenguaje, y el uso de las manos. "El fisioterapeuta inteligente" y "El buen paciente" hicieron posible que ambos pudieran llevar a cabo el tratamiento. sociología de Goffman es de gran importancia para entender cómo y por qué, los pacientes se presentan y comunican sus preocupaciones y dolencias como lo hacen.

References and links

Goffman, Erving. 1959. The presentation of self in everyday life. Vol. reprint 1990. London: Penguin.

Goffman, Erving. 1983. "The interaction order." American Sociological Review 48 (February):1-17.

Goffman's Presidential talk at American Sociological Association (Goffman 1983).

https://en.wikipedia.org/wiki/Erving_Goffman

Barbara Gibson

6 September 2016

In this post, CPN co-founder and Exec member Barbara Gibson talks about Margrit Shildrick's book Embodying the monster. Spanish translation provided by CPN Exec member Alma Viviana Silva.

Embodying the Monster is a feminist postmodern and historical reading of the monstrous body and the Western desire to eliminate aberration and vulnerability. Drawing on cultural theory, biomedical discourse and multiple historical and contemporary examples, Shildrick eloquently argues for a reconceived ethics of the body (and disability) that accepts the irreducible vulnerability of all persons.

I was fortunate to take a course with Dr. Shildrick when she was in Canada and this book was our core text. It helped me to consolidate many of the theoretical issues I had been grappling with by providing a postmodern reading of disability and difference. Shildrick seamlessly combines a rich and deep understanding of phenomenology, postmodernism, critical feminism, bioethics, disability studies, and cultural studies to illuminate the deeply entrenched understandings of the subject and how things could be otherwise. I return to her ideas in all of my work.

Lo que incorpora Monster es una lectura posmoderna e histórica feminista del cuerpo monstruoso y el deseo occidental para eliminar la aberración y la vulnerabilidad . Sobre la base de la teoría cultural , discurso biomédico y múltiples ejemplos históricos y contemporáneos , Shildrick argumenta elocuentemente de una ética reconcebida del cuerpo (y la discapacidad) que acepta la vulnerabilidad irreductible de todas las personas . Tuve la suerte de tomar un curso con el Dr. Shildrick cuando estaba en Canadá y este libro fue nuestro texto básico . Me ayudó para consolidar muchas de las cuestiones teóricas que había estado sopesando proporcionando una lectura posmoderna de la discapacidad y la diferencia. Shildrick combina a la perfección una comprensión más rica y profunda de la fenomenología , el posmodernismo , el feminismo crítico, la bioética , los estudios sobre discapacidad , y los estudios culturales para iluminar los entendimientos profundamente arraigadas de la materia y cómo las cosas podrían ser de otra manera . Vuelvo a sus ideas en todo mi trabajo.

Links

https://www.tema.liu.se/tema-g/medarbetare-och-kontakt/shildrick-margrit?l=en

http://www.hybridbodiesproject.com/dr-margrit-shildrick/

Ralph Hammond

7 September 2016

If you are new to the CPN or this 30 Day of September campaign, we run a month of daily posts on a different topic each year. This year we are focusing on ideas, articles, books, films, etc., that have inspired members of the Network. There will be a different post from a different CPN member each day until the end of the month.

In this post, longtime CPN member, researcher and lecturer Ralph Hammond talks about Jurgen Habermas's book The theory of communicative action.

The Theory of Communicative Action (1984) addresses social action, intersubjective communication and social change. It tries to preserve the best bits of modernity while acknowledging and overcoming the criticism it has faced. It has three interrelated concerns: 1. to develop a concept of rationality, 2. to construct a two level concept of society integrating everyday life and the economic and political systems, and 3, to present a critical theory of modernity. His theories recommend a way forward through using reason, discussion and "the force of the better argument", rather than the abandonment of the project of enlightenment.

I first came across TCA while learning about critical theory as a theoretical perspective for my doctorate. His ideas of how we orient ourselves to mutual understanding through universal discourse ethics resonates with me. What this means for how we develop our moral attitude is thrilling and relevant in 21st century world politics and physiotherapy practice. I found persuasive his use of the critique of reason to try to preserve the benefits and successes that modernity has brought, while trying to find solutions to that criticism. It's a neat, sophisticated theory with massive ambitions.

La Teoría de la acción comunicativa (1984), trata la acción social, la comunicación intersubjetiva y el cambio social. Preservar las mejores partes de la modernidad al tiempo que reconoce y la supera las críticas que ha enfrentado. Tiene tres problemas interrelacionados: 1. Desarrollar un concepto de racionalidad, 2. construir un concepto de dos niveles de la sociedad integración de la vida cotidiana y los sistemas económicos y políticos, y 3 presentar una teoría crítica de la modernidad. Sus teorías recomiendan un camino a seguir mediante el uso de la razón, la discusión y "la fuerza del mejor argumento", más que el abandono del proyecto de iluminación. Vine por primera vez a través de TCA mientras aprendia acerca de la teoría crítica como una perspectiva teórica para mi doctorado. Sus ideas de cómo nos orientamos a la comprensión mutua a través de la ética del discurso universales resuenan en mí. Lo que esto significa para la forma en que desarrollamos nuestra actitud moral es emocionante y relevante en la política mundial del siglo 21 y práctica de la fisioterapia. He encontrado persuasiva su uso de la crítica de la razón para tratar de preservar los beneficios y

éxitos que la modernidad ha traído, mientras trata de encontrar soluciones a esa crítica. Es una teoría ordenada, sofisticada, con ambiciones masivas.

Reference and links

Theory of Communicative Action 2 volumes: Polity Press 1984, 1986.

http://www.permanentculturenow.com/the-self-under-siege-part-5-habermas-and-the-fragile-dignity-of-humanity/

http://www.habermasforum.dk

Målfrid Råheim

8 September 2016

Crossley claims that sociology has not solved the philosophical puzzle of dualism, which means that questions of embodiment have not been worked through satisfactory in order to understand agency, identity and the nature of social practice. In The Social Body (2001) he discusses these issues by focusing on the sensuous nature of human perception, emotion and desire, and the corporeal basis of agency, communication and thought. Habit and embodied practice are core concepts in his discussion, heavily grounding his arguments in the phenomenology of the body, and in sociological theory which includes the body. He claims that the notion of habitus (Bourdieu) is not working without a deeper understanding of processes of incorporation and habituation, pointing to the notion of schema corporeal (Merleau-Ponty), which is very interesting. The book is a prolongation and integration of great classic works, and an important contribution in helping us on the way to solve the puzzle of embodiment (included the corporeal basis of social practice).

I came across “The Social Body” quite recently, working with theoretical anchoring of a new research project in collaboration with research colleagues. I had for a long time been preoccupied with understanding - and using - the phenomenology of the body and the phenomenology of illness as an important theoretical foundation in health science. The need for integrating core notions from these great phenomenological contributions with notions that could more clearly capture the lived body as socially informed was part of the discussions, more of us being acquainted with Bourdieu’s writings. Crossley’s book came “handy in” indeed.

Crossley afirma que la sociología no ha resuelto el rompecabezas del dualismo filosofico, lo que significa que las cuestiones de realización que no se han trabajado de manera satisfactoria a fin de comprender la agencia, identidad y naturaleza de la práctica social. En el cuerpo social (2001), el analiza estos temas, centrándose en la naturaleza sensible de la percepción humana, la emoción y el deseo, y la base de la agencia corporal, la comunicación y

el pensamiento. El hábito y las prácticas corporales son conceptos fundamentales en su discusión, en gran medida pone en tierra sus argumentos en la fenomenología del cuerpo, y en teoría sociológica que incluye el cuerpo. Afirma que la noción de habitus (Bourdieu) no está funcionando sin una comprensión más profunda de los procesos de incorporación y la habituación, que apunta a la noción de esquema corporal (Merleau-Ponty), que es muy interesante. El libro es una prolongación y la integración de las grandes obras clásicas, y una contribución importante para ayudarnos en el camino para resolver el rompecabezas de la realización (incluida la base corpórea de la práctica social). Me encontré con "el cuerpo social" hace muy poco tiempo, se trabaja con anclaje teórico de un nuevo proyecto de investigación en colaboración con colegas de investigación. Habia estado durante mucho tiempo preocupado por la comprensión - y el usar - de la fenomenología del cuerpo y la fenomenología de la enfermedad como una base teórica importante en ciencias de la salud. La necesidad de la integración de las nociones básicas de estos grandes contribuciones fenomenológicos con nociones que podría capturar con mayor claridad el cuerpo vivido como socialmente informada era parte de las discusiones, más de nosotros están familiarizados con los escritos de Bourdieu. El libro de Crossley cayo "como perla" de hecho.

Link

https://books.google.no/books?id=5qEEYFvmqvMC&printsec=frontcover&dq=Nick+Crossley&hl=no&sa=X&redir_esc=y#v=onepage&q=Nick%20Crossley&f=false

Patty Thille

9 September 2016

The Body Multiple is an ethnographic experiment: an ethnography of a disease. Mol studies clinical work practices, examining what athlerosclerosis is in different parts of the same hospital. The simple answer: what athlerosclerosis is varies depending on where you study it being made into an object. Mol found that we cannot assume these dispersed enactments are different perspectives of the same disease. Instead, different objects co-exist under the name ‘athlerosclerosis’. “Multiplicity” is her term for this phenomenon of an object being more than one but less than two. TBM has been highly influential in science & technology studies. TBM opened up study of what Mol calls “ontological politics”: the study of practices bring an object into view, practices that frame problems, shape bodies, and push or pull lives in particular directions.

This book sparks the imagination, both theoretically and methodologically. The empirical attention to work processes - to practices of enacting an object that is then worked upon – offers a good-to-think-with methodological exemplar. The possibility of multiplicity invites many possible questions, such as what various enactments exist? When, where, and to what effect do different enactments come into contact with one another? In addition, Mol’s work

raises questions about how to think about what comprises a good enactment, an issue she continues to unpack in subsequent work.

El cuerpo múltiple es un experimento etnográfico: una etnografía de una enfermedad. Mol estudia las prácticas de trabajo clínicos, examen de lo que es aterosclerosis en diferentes partes del mismo hospital. La respuesta simple: lo qué es aterosclerosis varía según el lugar donde estudias se convirtió en el objeto. Mol encontró que no podemos asumir estos decretos dispersos son perspectivas diferentes de la misma enfermedad. En lugar de ello, diferentes objetos coexisten bajo el nombre 'aterosclerosis'. "Multiplicidad" es su término para este fenómeno de un objeto que es más de uno, pero menos de dos. TBM ha tenido una gran influencia en los estudios de la ciencia y la tecnología. TBM abrió el estudio de lo que se llama "política Mol ontológicas": el estudio de prácticas de llevar un objeto a la vista, las prácticas que dan marco a problemas, forma a los cuerpos, y empujan o tiran en direcciones particulares vidas.

Este libro estimulan la imaginación, tanto teórica como metodológicamente. La atención empírica a los procesos de trabajo - a las prácticas de la promulgación de un objeto en el cual se va a trabajar - ofrece en que pensar con una ejemplar metodológica. La posibilidad de la multiplicidad invita a muchas preguntas posibles, tales como las diversas disposiciones que existen? ¿Cuándo, dónde y en qué efecto tienen diferentes representaciones que entran en contacto unas con otras? Además, el trabajo de Mol plantea preguntas acerca de cómo pensar acerca de lo que comprende una buena promulgacion, un problema que ella continua desempaquetando en sus trabajo posteriores.

Links

http://asj.sagepub.com/content/48/3/266.extract

http://www.jstor.org/stable/10.1086/381623?seq=1#page_scan_tab_contents

Catherine Sykes

10 September 2016

Published in 2001 the World Health Organization’s International Classification of Functioning, Disability and Health (ICF) has stimulated a change in understanding of what is understood as human functioning and the role of the environment in the experience of functioning.

I was involved in the development of ICF and have continued to work on the implementation of the model and classifications in health and social welfare data collections. Whilst the model has informed the education and practice of physical therapists the adoption of the classification for statistics has been slow. Why? Some argue that it is too detailed, too complicated. The key to ICF is to keep the individual as the focus and select categories of

functioning and environmental context important to them, then use them to explain the arrows in the model.

Publicada en el 2001 la Clasificación Internacional del Funcionamiento de la Organización Mundial de la Salud, de la Discapacidad y la Salud (CIF) ha estimulado un cambio en la comprensión de lo que se entiende como el funcionamiento humano y el papel del medio ambiente en la experiencia de funcionamiento.

Yo estaba involucrada en el desarrollo de la ICF y hemos seguido trabajando en la implementación del modelo y las clasificaciones en las colecciones de datos de salud y bienestar social. La educacion en el modelo para usarlo en la práctica de los fisioterapeutas y la adopción de esta clasificación en las estadísticas ha sido lenta. ¿Por qué? Algunos argumentan que es demasiado detallada, demasiado complicada. La clave del ICF es mantener al individuo como el enfoque y seleccionar las categorías de funcionamiento y el contexto ambiental que es importante para ellos, y luego usarlos para explicar las flechas en el modelo.

Links

http://psychiatr.ru/download/1313?view=name=CF_18.pdf

http://www.who.int/classifications/drafticfpracticalmanual2.pdf?ua=1

Tone Dahl-Michelsen

11 September 2016

https://youtu.be/Bo7o2LYATDc

The work of Judith Butler has had hugely influence within different field of critical thinkers and her book Gender Trouble (1990) is regarded as a ‘break through’ within gender studies. It contributed a radical shift in how we came to see ourselves as gendered beings. The main point is that individuals ‘become gendered’ through performative acts. This gives individuals agency, however, the performativity of gender takes place in relation to certain gender norms within a context. Judith Butler sees both sex and gender as something that becomes ‘reality’ through performing. This concerns ontology and is a controversial point within her theory.

I was introduced to the thinking of Judith Butler as I finished my master thesis and her work inspired the perspective in my PhD. How ‘the becoming’ of physiotherapy students and physiotherapists is produced within the context of physiotherapy being formed by an interaction of professional -and gender norms of past and present, fascinates me a lot. I find that Judith Butler’s gender theory stimulates and gives depth to the pondering on possibilities and limitations for different acts and ways of being and becoming within the context of physiotherapy.

Links

https://autof.files.wordpress.com/2010/02/butler-judith-gender-trouble-feminism-and-the-subversion-of-identity-1990.pdf

Anna Rajala

12 September 2016

Phenomenology of Spirit (1807) is perhaps Hegel's most influential work, especially through Marx's critique that "stood Hegel on his head": Marx inverted Hegel's idealist absolutism into dialectical materialism. In the Phenomenology Hegel describes the dialectical experience and development of consciousness from sense-certainty, perception, understanding and self-consciousness to absolute knowing. Hegel argues in the famous passage titled 'Lordship and Bondage' that self-consciousness exists only insofar it exists in the world of others and is acknowledged by others. This idea of subject formation as social, as the need for mutual recognition, has influenced many philosophers, both who represent anti-Hegelian and Hegelian views.

I first read Phenomenology for my MA thesis. I argued against the view that dementia causes the disappearance of selfhood. I also found the two main positive views – that selfhood never disappears but continues to manifest in embodied practices and that selfhood depends on whether family members and healthcare personnel recognize the person with dementia as a person – unsatisfactory on their own. Through a materialist reading of Hegel's dialectics (often misrepresented as the tripartite logic of thesis, antithesis and synthesis), I argued that subjectivity exists both as the active existence in the world and, crucially, through the recognition by others.

Readings and links

G. W. F. Hegel. 1977. Phenomenology of Spirit. Translated by A. V. Miller. Oxford: Oxford University Press.

H. S. Harris. 1995. Hegel: Phenomenology and System. Indianapolis: Hackett.

Stephen Houlgate. 2005. An Introduction to Hegel: Freedom, Truth and History, 2nd edition. Oxford: Blackwell.

Robert B. Pippin. 1989. Hegel's Idealism: The Satisfactions of Self-consciousness. Cambridge: Cambridge University Press.

Robert B. Pippin. 2008. Hegel's Practical Philosophy: Rational Agency as Ethical Life. Cambridge: Cambridge University Press.

Links

J. M. Bernstein's illuminating lecture series on Hegel's Phenomenology, also suitable for beginners: http://bernsteintapes.com/hegellist.html

Thomas Abrams

13 September 2016

"Disabling Practices" applies a science and technology studies lens to Disability Studies and the sociology of blindness. Drawing on ethnographic work in the North of England, Schillmeier follows the disclosure of visual disability in currency use, how relations between human bodies and money technologies cause visual disability to emerge. The emphasis moves from problem bodies to problem relations. Dis/ability is not solely in bodies or in barriers—as the social or medical models would have it—but unfolds in the interaction between bodies, senses and things (the subtitle of Schillmeier, 2010, integrating this 2007 article).

I first read Schillmeier's work in my M.A. research, in disability studies, social theory, and political economy. Reading the dominant disability studies literature against my own experience of muscular dystrophy, I felt something was missing. Yes, sometimes I experience exclusion in everyday life, but there is much more to being a disabled person than that. Schillmeier's paper best linked the three together. It demanded a picture of disability not wholly dominated by natural or social explanation, an extremely rigorous reading of contemporary social theory, and a nuanced understanding of disability politics (albeit one with teeth).

References

Schillmeier, M. (2007). Dis/Abling Practices: Rethinking Disability. Human Affairs, 17, 195–208. http://doi.org/10.2478/v10023-007-0017-6

Schillmeier, M. (2010). Rethinking Disability: Bodies, Senses, Things. New York: Routledge.

Fiona Moffatt

14 September 2016

If you are new to the CPN or this 30 Day of September campaign, we run a month of daily posts on a different topic each year. This year we are focusing on ideas, articles, books, films, etc., that have inspired members of the Network. There will be a different post from a different CPN member each day until the end of the month.

Thinking Allowed is a 30 minute, weekly radio discussion programme which focuses on the latest social science research as well as casting historical perspectives on the gurus of sociology and philosophy (for example a recent programme on the ideas and legacy of French Sociologist Pierre Bordieu http://www.bbc.co.uk/programmes/b07gg1kb). The programme is hosted by Laurie Taylor, who previously held a professorial post in sociology at the University

of York. Since 2014, Thinking Allowed has also collaborated with The British Sociological Association to announce an annual award for a study that has made a significant contribution to ethnography.

I was introduced to this programme when I was grappling with Foucauldian concepts of governmentality, and endeavouring to understand how (or if) his later 'ethical phase' could be reconciled with the archeological and genealogical phases. A special edition of the programme, dedicated to Foucault, offered me an accessible route into some of his more complex considerations of subjectivity, and subsequently allowed me to rationalize my position. I became a regular listener of the programme, enjoying the critical debates and contemporary empirical research regarding diverse aspects of society and culture.

Links

http://www.bbc.co.uk/programmes/b006qy05

http://www.bbc.co.uk/programmes/b077gt3g

http://www.bbc.co.uk/programmes/b072my2m

http://www.bbc.co.uk/programmes/b05s36cg

Dave Nicholls

15 September 2016

Discipline and Punish (1975) was Michel Foucault's sixth book and it defined Foucault's approach to what was called the history of ideas. D&P is concerned with the ways we have learnt – over many centuries – to govern people so that they do what we want without force. The book was hugely influential for historians, sociologists and philosophers and influenced a generation of critical thinkers in areas as diverse as architecture, health care and public policy.

I first came across D&P when I was reading Foucault's work for my PhD. Foucault's explanations of the ways we have learnt to discipline our conduct to make people docile and compliant (especially observation and surveillance, examination and normalization) have been enduring themes in my writing for nearly a decade. I still refer to the book at times and wonder at the subtlety, complexity and genius of Foucault's insights.

Links

https://monoskop.org/images/4/43/Foucault*Michel*Discipline*and*Punish*The*Birth*of*the*Prison*1977*1995.pdf*

Birgitte Ahlsen

16 September 2016

The wounded storyteller (1995/2013) has a strong position within the field of illness and health. In this book, Frank introduces the “remission society” concept, whose members include those who may be medically “cured” from illness, but “share the worries and daily triumph of staying well”. Drawing on Susan Sontag’s metaphor of two kingdoms; that of the well and that of the sick, the members of the remission society, Frank writes, are in between or secretly hidden among the healthy. Frank claims that their illness stories are more than accounts of personal suffering; they contain moral choices and social ethics. The book is perhaps most famous for the three typologies of illness narratives that circulate in the Western culture; restitution, chaos and quest.

I met Arthur Frank at a PhD course on illness narratives in Tromsø, Norway, some years ago. The course opened my eyes to the meaning of narratives in people’s life in general and in the life of those who are chronically ill in particular. In specific, I have become interested in the interplay between the common and cultural and the individual and particular in individual narratives. Cultural norms guide the ways the patients understand their own illness and recovery, and how the therapist understand their patient. I am interested in how cultural stereotypes may lead both men and women into illness narratives that are not particularly helpful to them – and how to break this pattern.

Links

http://www.sciencedirect.com/science/article/pii/S0277953605000468

El narrador herido (1995/2013) tiene una fuerte posición dentro del campo de la enfermedad y la salud. En este libro, Frank introduce el concepto de "sociedad de la remisión", cuyos miembros incluyen a aquellos que pueden ser médicamente "curado" de la enfermedad y que "comparten las preocupaciones y el triunfo diario de mantenerse “bien". Sobre la base de la metáfora de dos reinos de Susan Sontag; el del bien y el de los enfermos, los miembros de la sociedad de la remisión, Frank escribe, estan en el medio o en secreto escondido entre los sanos. Frank afirma que sus historias de enfermedad son más que contar su sufrimiento personal; que contienen alternativas morales y de ética social. El libro es quizás el más famoso por las tres tipologías de las narrativas de enfermedad que circulan en la cultura occidental; restitución, el caos y la misión. Conocí a Arthur Frank en un curso de doctorado sobre las narrativas de enfermedad en Tromsø, Noruega, hace algunos años. El curso me abrió los ojos al significado de los relatos de la vida de la gente en general y en la vida de los que están enfermos crónicos, en particular. En concreto, me he interesado en la interacción entre el individuo y su cultura y en particular las narrativas individuales. Las normas culturales guían las formas en que los pacientes entienden su propia enfermedad y su recuperación. y cómo el terapeuta entiende su paciente. Estoy interesado en cómo los estereotipos culturales pueden llevar a los hombres y mujeres a las narrativas de enfermedad que no son particularmente útiles para ellos - y la forma de romper este patrón.

Karen Yoshida

17 September 2016

This book chapter is part of an important text within Canadian Disability Studies. Rethinking Normalcy: a disability studies reader edited by Tanya Titchkosky and Rod Michalko (2009). This is the first Canadian disability studies reader from a variety of interdisciplinary perspectives and draws on primary Canadian but also some international scholars. The critical perspectives in this book examine not only dominant views of disability but interrogate what is meant by normal. The specific chapter makes clear that different bodies, in different spaces engage in the world in various ways that are not seen as "normal" by abled-bodied conventions but are usual to those who see themselves as having non-normative bodies. This chapter is a great read for beginning students who want to start thinking about the normative practices that define our western society. What are the consequences of these practices? Who do these practices include or exclude?

I have used this chapter for my first year MSC. PT students as a way for them to start to consider and critique the everyday taken for grantedness of practices in western societies.

Carley King

18 September 2016

In this post, CPN member Carley King writes about Ian Leslie's article The Sugar Conspiracy.

This "long read" article from the Guardian outlines how in 1972, John Yudkin raised concerns about sugar being the greatest danger to our health instead of fat. However, his research findings were ridiculed, and fat continued to be labelled as the likely cause of obesity and the numerous conditions associated with obesity. It outlines how the scientific community embraced a certain school of thought and disregarded any subsequent evidence that suggested otherwise, i.e. saturated fats are particularly bad for your health. It suggests that this tide of movement was predominantly driven by certain personalities in the field of nutrition, or gurus. The gurus in the field were able to influence guidelines, despite the key messages not necessarily being supported by research evidence.

Whilst this article is primarily around nutrition, it prompted me to consider whether physiotherapy follows certain paradigms without necessarily critiquing them, and whether research findings within physiotherapy are disregarded because they are not in line with popular belief. This also brings in the concept of internal biases - how many of us are cognizant of all the biases we hold, and take this into account when reading research? Although we're familiar with declaring financial, non- financial and intellectual conflicts of interest, should we also more explicitly consider the risk of other forms of bias e.g. authority bias?

References and links

http://www.theguardian.com/society/2016/apr/07/the-sugar-conspiracy-robert-lustig-john-yudkin

Seshia S, Makhinson M, Bryan Young G (2016) 'Cognitive biases plus': covert subverters of healthcare evidence. Evidence Based Medicine online 21 (2) p41-45. http://ebm.bmj.com/content/21/2/41.full

Blaise Doran

19 September 2016

Healing dramas and clinical plots (1998) is an ethnographic account by anthropologist, Cheryl Mattingly, of occupational therapists' work in rehabilitation settings during the mid-1980s. She uses diverse sources to support her ideas from literary and narrative theory, phenomenology and hermeneutics, and anthropological perspectives on ritual and narrative. In doing so, she presents the rehabilitation process, and its clinical interactions, as a form of drama, adhering to a socially constructed narrative plot. She proposes that, if narrative (as has been suggested) reflects the lived experience, it does so through narrative drama rather than narrative cohesion.

As an undergraduate, I came across Mattingly's work in a book on clinical reasoning written with Maureen Hayes Fleming. A few years post qualification, I became more and more struck by how much performance (in the acting sense) was involved in the interactions between clients and me. Having been a professional actor prior to being a physiotherapist, such a bias is unsurprising, but having happened upon the book second-hand, I realised that such an interpretation might be valid, and the book opened my clinical mind to a world of applied arts, qualitative and philosophical theory.

Curación dramas y escenarios clínicos (1998) es un relato etnográfico por la antropóloga, Cheryl Mattingly, el trabajo de los terapeutas ocupacionales 'en el ámbito de la rehabilitación a mediados de la década de 1980. Ella utiliza diversas fuentes para apoyar sus ideas de la teoría literaria y la narrativa, la fenomenología y la hermenéutica, y las perspectivas antropológicas sobre el ritual y la narrativa. Al hacerlo, se presenta el proceso de rehabilitación, y sus interacciones clínicas, como una forma de drama, la adhesión a una trama narrativa construida socialmente. Se propone que, si la narrativa (como se ha sugerido) refleja la experiencia vivida, lo hace a través del teatro narrativo en lugar de la cohesión narrativa. Como estudiante, me encontré con el trabajo de Mattingly en un libro sobre el razonamiento clínico escrito con Maureen Fleming Hayes. Un año despues de recibir mi grado, Yo estuve más y más golpeado por la cantidad de rendimiento (en el sentido de actuar) que implicaban mis interacciones con pacientes. Después de haber sido un actor profesional

antes de ser un fisioterapeuta, tal sesgo no es sorprendente, pero después de haber topado con este libro de segunda mano, me di cuenta de que tal interpretación podría ser válida, y me abrió la mente clínica a un mundo de las artes aplicadas , teoría cualitativa y filosófica.

Links

No samples of the book seem to be available, except on Google Books: https://books.google.com.au/books?id=Kq2T5_88M3EC&safe=strict&hl=en

Amy Hiller

20 September 2016

Phenomenology of Practice (2014) written by Max van Manen incorporates aspects of the study of phenomenology. From page 272 there is discussion about the gnostic and the pathic related to touch occurring in the healthcare setting. Van Manen explains gnostic touch as the diagnostic, anatomized experience of touch. In contrast, pathic touch is described as touch with a special quality that conveys a healing attitude and relates to the individual as an embodied whole.

When observing patient-physiotherapist encounters for my PhD research I became fascinated with touch as part of physiotherapy practice. I read Max van Manen's writing about touch and his ideas resonated with what I had observed occurring in physiotherapy practice. Van Manen's insights might explain what physiotherapists are doing when they are touching their patients – both gnostic and pathic touch are present and experienced in physiotherapy encounters. Bjorbaekmo and Mengshoeal (2016) have also referred to van Manen's writing in their insightful recent publication about touch in physiotherapy.

Fenomenología de la práctica (2014), escrito por Max van Manen incorpora aspectos del estudio de la fenomenología. A partir de la página 272 hay una discusión sobre el gnóstico y el pathic relacionada con el tacto que ocurren en el entorno médico. Van Manen explica toque gnóstico como la experiencia de diagnóstico, anatomizado del tacto. En contraste, el tacto pathic se describe como contacto con una calidad especial que transmite una actitud de curación y se refiere a la persona como un todo encarnado. Al observar encuentros con el paciente-fisioterapeuta para mi investigación de doctorado me fascinó el tacto como parte de la práctica de la fisioterapia. He leído los escritos de Max van Manen sobre el tacto y sus ideas resonó con lo que había observado que ocurre en la práctica de la fisioterapia. Ideas de Van Manen podrían explicar qué están haciendo los fisioterapeutas cuando están en contacto con sus pacientes - tanto tacto gnóstico y pathic están presentes y con experiencia en encuentros de fisioterapia. Bjorbaekmo y Mengshoeal (2016) también han hecho referencia a la escritura de van Manen en su reciente publicación detallada sobre toque en fisioterapia.

References and links

http://www.maxvanmanen.com

Bjorbaekmo, W. S., & Mengshoel, A. M. (2016). "A touch of physiotherapy" - the significance and meaning of touch n the practice of physiotherapy. Physiotherapy Theory & Practice, 32(1), 10-19.

Van Manen, M. (2014). Phenomenology of Practice: Meaning-Giving Methods in Phenomenological Research and Writing. Walnut Creek, CA: Left Coast Press, Inc. pp. 272-281.

Adam Bjerre

21 September 2016

Incomplete Nature (2012) is a bold attempt at a naturalistic account of sentience, emotion, pain, values and meaning - phenomena that are generally not easy to get a handle on in the natural sciences. Deacon is carefully and sensibly trying to build a bridge between physics, biology, the social sciences, and philosophy. The book has been generally greeted with acclaim by the philosophical community and marks a profound shift in thinking that in magnitude has been compared to the shift followed upon the works of Darwin and Einstein.

I have for 10-15 years been interested in making sense of pain and suffering and my own role in navigating this muddy landscape together with my patients. Pain is a tricky topic that falls in the cracks of almost all of the academic disciplines and is both ubiquitous, complex and challenging to get a hold of theoretically and in daily practice. Deacons convincing and careful articulated explanations built from the bottom-up are challenging but are nevertheless very important, educative and well worth the effort. He helps you to actually see how pain "feels like something" to "someone" and why meaning matters and is not just epiphenomenal. This book belongs on the shelf of every secular humanist.

La naturaleza incompleta (2012) es un intento audaz a una explicación naturalista de la sensibilidad, la emoción, el dolor, valores y significado - fenómenos que generalmente no son fáciles de conseguir en una manija de las ciencias naturales. Deacon con cuidado y prudencia trata de construir un puente entre la física, la biología, las ciencias sociales y la filosofía. El libro ha sido recibido con aclamación general por la comunidad filosófica y marca un cambio profundo en el pensamiento de que en magnitud ha sido comparado con el cambio siguió a las obras de Darwin y Einstein. durante 10-15 años he estado interesado en hacer sentido del dolor y el sufrimiento y mi propio papel en la navegación de este paisaje fangoso junto con mis pacientes. El dolor es un tema complicado que cae en las grietas de casi todas las disciplinas académicas y es a la vez en todas partes, complejo y difícil de obtener en la bodega de la teoría y en la práctica diaria. Diáconos convincentes y cuidadosos, explicaciones articuladas construidas de abajo hacia arriba son un reto, pero son sin embargo muy importantes, educativas y bien valen la pena el esfuerzo. Él le ayuda a ver realmente cómo el

dolor "se siente como algo" para "alguien" y por qué es importante ese significado y no es sólo un epifenómeno. Este libro pertenece en el estante de cada humanista secular.

Links

Deacon presents the outline of the book in this talk for a lay audience: http://library.fora.tv/2012/04/18/Incomplete_Nature_How_Mind_Emerged_From_Matter

Gunn Engelsrud

22 September 2016

In his Phenomenology of Perception (PP) (first published in 1945), the French philosopher Maurice Merleau-Ponty developed the concept of the body-subject as a primary way of being-in-the-world. In contrast to a Cartesian dualistic theory and the "dead" body, Merleau-Ponty body was a human perceiving, sensing and feeling body, intertwined, mutually present, and engaged with the world and others. The book was hugely influential for social scientist, humanistic and phenomenological philosophers and influenced a generation of thinkers and practitioners in areas as diverse as architecture, education, health care and movement culture and politics.

I first came across PP when I worked with my PhD in the 80s. Reading Merleau-Ponty stimulated me to focus on the body from a first-person perspective. He explained the subjective and experiencing body as primary and gave insight to how habits and being-in-the-world are bodily. In physiotherapy, this is obvious, men still not recognized as the major position. I often go back to the book and get confirmations as well as new insight from this important philosopher, often called "the philosopher of the body".

En su Fenomenología de la percepción (PP) (publicado por primera vez en 1945), el filósofo francés Maurice Merleau-Ponty desarrolló el concepto del cuerpo-sujeto como una forma primaria del ser-en-el-mundo. En contraste con una teoría dualista cartesiano y el cuerpo "muerto", Merleau-Ponty cuerpo era una percepción humana, la detección y la sensación de cuerpo, entrelazados y mutuamente presente y comprometido con el mundo y otros. El libro fue muy influyente para científicos sociales, filósofos humanistas y fenomenológicos e influyó en toda una generación de pensadores y profesionales en áreas tan diversas como la arquitectura, la educación, la salud y la cultura movimiento y la política. Topé por primera vez con PP cuando trabajaba con mi doctorado en los años 80. Lectura Merleau-Ponty me estimuló para centrarme en el cuerpo desde una perspectiva en primera persona. Explica la subjetividad y experia del cuerpo como primaria y dio una visión de cómo los hábitos y el ser-en-el-mundo son corporales. En fisioterapia, esto es obvio, los hombres todavía no se reconocen como la posición principal. Suelo ir de nuevo al libro y obtener confirmaciones, así

como una nueva visión de este importante filósofo, a menudo llamado "el filósofo del cuerpo".

Links

http://plato.stanford.edu/entries/merleau-ponty/

Gwyn Owen

23 September 2016

If you're new to this site, we publish one post each day in September celebrating a particular theme. This year it's about people and ideas that have inspired us to think critically. In this post, CPN Exec member Gwyn Owen writes about the work of John Dewey.

I first came across 'How we think' while reading John Cowan's inspiring, critical and beautifully crafted accounts of reflective practice and professional development a few years ago. 'How we think' was written by John Dewey - an American philosopher, educator, social critic and political activist. The first edition was published in 1910 & was updated in 1933. In it, Dewey sets out to describe the process of developing 'a scientific attitude of mind', and in doing so presents a clearly written account of reflective thought – which he describes as: 'Active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it, and the further conclusions to which it tends… It is a conscious and voluntary effort to establish belief upon a firm basis of reasons.' (Dewey, 1910, p6) The book presents reflective thinking as a critical way of being/doing that seeks to challenge assumptions and generate new knowledge and understanding from and in practice. It is a dynamic, embodied cycle of inductive and deductive reasoning that occurs as we attend to and seek to make sense of our lived experiences. From Dewey's perspective, reflective thinking is neither a 'fluffy' or 'woolly' concept, but is a challenging, critical process that is integral to scientific inquiry.

My copy of Dewey's book is a battered hardback bought by DK Fraser for 4/6 net – the gold writing on the spine worn away by years of use. While I love the physical feel and slightly musty smell of the book, what really strikes me is how Dewey's ideas and arguments have travelled through time. The processes he describes resonate with more contemporary literature (from 1970s onwards) about clinical reasoning in medicine and healthcare professions. From a research perspective, it connects with contemporary texts on reflexivity (which I've come to understand as a process of reflection –in, -on & -for action associated with praxis of qualitative research). Over the past few months, I've found myself drawn back to the book for its critical perspective on 'science' and relevance to contemporary debates about the nature of evidence and evidence-based practice…. which leaves me wanting to find out more about the social and political context that prompted Dewey to write 'How we think'.

Links

Because this book is out of copyright, copies are available to freely download from the Project Gutenberg website http://www.gutenberg.org/

Wenche Bjorbækmo

24 September 2016

In this post, physiotherapist and educator Wenche Bjorbækmo writes about the art of presenting qualitative research.

The first time I saw the film The Cost of Living, by DV8 Physical Theatre (https://www.youtube.com/watch?v=0ZTMyWt50kk), it made an indelible impression on me. Over the course of a few late summer days in an English seaside resort, two out-of-work street performers -- Eddie and David -- encounter a variety of other people on the fringe of society. Dave, a double amputee, is determined to hold on to his independence, while tough, aggressive Eddie is a stalwart defender of justice and respect. The play presents a sequence of human tableaux that challenge our understanding of body, movement, behavior, (dis)ability, gender, sexuality, human relations, the social cultural gaze, the 'normal' and the 'abnormal'.

I have showed the film to master students in interdisciplinary health science and to colleagues working in children's rehabilitation as an introduction to discussions concerning the above mentioned phenomenon. To my experience seeing the video do something to people – and the discussions afterwards to be humble, inquisitive and open minded in ways that introductions by reading different 'ordinary scholarly literature' about different understandings of body, movement, disability and diversity do not create in the same way. How come?

As a phenomenological researcher I have long been concerned about the challenges I experience when attempting to express or present lived meanings of a phenomenon. Trying to convey what friendship means, for instance, or getting a sense of what it might be like to exist outside a 'standard' involve experiential quests with bottomless layers of truth and meaning (van Manen 2016). In The Cost of Living, the situations and meetings enacted by the artists create a main story which teems with questions about contemporary understandings of a range of issues. Who is disabled? What skills are involved in movement? Who should be considered to be competent movers? What is fellowship? What about respect and the need for variations, for complementary ways of being and for inter-linked corporality?

As I watch the film, I feel drawn into the story and touched by it; I believe in the created realities into which the production takes me. At times I become angry or sad; at other moments I find myself smiling happily. When the mechanical movements of one of

performers suddenly become expressively alive, I participate in the joy of moving, if only in my mind.

In his wonderful essay Eye and Mind, Merleau-Ponty (2000/1964) writes that 'science manipulates things and gives up living them'. Drawing a contrast between the approach of science and that of the visual arts, he argues that 'it is by lending the world his body that the painter transforms the world into painting'. Maybe the phenomenological researcher also needs to 'lend her body' to the research in order to 'live the things' she examines. If so, what might it mean to lend ones body to research?

Certain discussions in which I have participated have stressed the importance of scientific texts differentiating themselves from fiction by not 'seducing' readers. This had led me to wonder about the possibility of sharing heartfelt experiences in a sober, scientific way without losing the lived aspects that make the experience vividly meaningful and significant. If I -- as researcher, reader or observer -- experience moments when my rationality and logical understanding are infused by a sense of felt engagement, should this be termed 'seduction'?

Does not the art of seeing and gaining insight include feelings, emotions and engagement? Are these not appropriate when it comes to research? Max van Manen (1990; 2014) holds that the qualitative researcher borrows other people's experiences. How can I borrow someone's deep felt experiences without being touched or stirred? How can I with scientific credibility omit to convey participants' expressed feelings in the way I am able to understand and capture them?

Following Merleau-Ponty (2000/1964), it can be argued painters are sovereign in their interpretation of the world. They perform their interpretation with no 'technique' other than that acquired by their eyes and hands through incessant watching and observation. The secret science they possess and develop is not one geared to making the world its object but rather one that can follow the world in its emergence. I think there may be parallels here with qualitative and phenomenological research, in particular the way a researcher lends her body to the project in hand. This is done not only to provide insights concerning dimensions of lived experiences but also to do so in ways that move, stir, provoke and touch you, the reader. Through this, new insights get under your skin or enter your body, igniting a never-ending process of asking and wondering.

While seldom themselves philosophers or artists, qualitative researchers in the field of physiotherapy have much to gain by borrowing understandings from philosophy and the arts. Such borrowing might help us develop our language and individual capacity for expression so that we can better present the experiences children and adults share with us during interviews and observations. In the absence of such endeavors, our research presentations

may continue to show insufficient respect for the complex dimensions of lived experience our participants share with us. We need to strive to develop our language and capacity to be expressive in order to generate research that is not just reliable and scientifically acceptable but also vivid and moving.

References

Merleau-Ponty, M. (2000). Øyet og ånden (Eye and mind) (Mikkel B. Tin Trans.), Pax Forlag A/S, Oslo.

Van Manen, M. (1990). Researching Lived Experience (Vol. 1). New York: State University of New York Press.

Van Manen, M. (2016) http://onlinelibrary.wiley.com/doi/10.1111/nhs.12274/full

The physically integrated dance movement is part of the so-called disability cultural movement, which recognizes and also celebrates first-person experiences of disability. Through creative means the movement conveys to audiences different lived experiences. See also Petra Kuppers and her performance research projects

Simon Kirkegaard

25 September 2016

In this post, CPN Exec member Simon Kirkegaard, writes about the problem of stubborn (chronic) pain.

Many bright minds have contemplated on the complexity of pain for millennia yet even in 2016 we are still looking for a really effective and efficient way to alleviate stubborn (chronic) pain. There is a tendency to rely heavily on passive treatments and medication for pain which produce great results for short term pain and injury but dependency and more pain for the more stubborn pain that approximately 1/5 of population of the western world live with. A new exciting systematic review by Adriaan Louw et al. (2016) provides strong evidence for pain biology education as part of treatment for pain.

I first became aware of pain science when I watched Lorimer Moseley's Ted Talk “Why things hurt” which was so inspiring to me that I contacted him. Unbeknownst to me pain is not only about injury or the tissues and this turned my world and physiotherapy practice upside down. Today I primarily work with stubborn pain clients and the treatment I offer has much more to do about human cognition than the tissues of the body. Through cooperation with my clients we explore their beliefs and needs and scrutinize unhealthy understanding of our body’s resilience and ability to adapt. Realizing that hurt does not equal harm and injury does not last for years is crucial to patients. Understanding that pain is a protective mechanism designed to get safeguard us and that this mechanism is influenced by a wide range of factors

helps facilitate behavioral changes and increase patient self-efficacy. The goal to get out of pain and recover old functions demands a strategy that include client's preferences, circumstances, and involvement.

Links

http://www.ncbi.nlm.nih.gov/pubmed/27351541

Nicky Wilson

26 September 2016

In this post, CPN Executive member and physiotherapy lecturer Nicky Wilson discusses Hendrik Wagenaar's book Meaning in Action: Interpretation and dialogue in policy analysis.

Policies are conventionally seen as a way to solve problems. As such, they are action driven; they direct our thoughts and behaviours to produce certain ends. Public policy is therefore about power and, unsurprisingly, is an area rife with contestation! In Meaning in Action: Interpretation and Dialogue in Policy Analysis (2011), Hendrik Wagenaar highlights the deeply pluralistic and value-laden nature of policy making, implementation and interpretation, and brings to the fore the benefits of interpretive approaches over and above more traditional rationalistic and technocratic means of investigating and understanding public policy. At the centre of these approaches is a focus on human meaning making and how it shapes and constitutes political action, institutions and our realities; realities that Wagenaar brings into view through exemplars in mental health public policy.

I came across this book for the first time whilst undertaking a discursive analysis of a contemporary health policy issue in the UK as part of my PhD. As a practitioner in the UK's National Health Service I had become frustrated by what I perceived was a significant mismatch between the rhetoric of English health policy and my reality in practice. This text offered me new ways to think about policy and the slippage between the intended meaning of policy and the meanings constructed in practice, enabling a critical understanding of why things appeared as they did. Don't be put off by the title of this book - it is a fascinating read for anyone who is even just a little bit curious about the oft unintended consequences of policy, particularly in the context of health and social care.

Reference

Fisher F. (2003) Reframing public policy: Discursive politics and deliberative practices. Oxford: Oxford University Press.

Franziska Trede

27 September 2016

Franziska uses images like this because they symbolize that agency needs to be mediated, and that students need to be assisted to become agentic.

In this post, lecturer and Co-Director of the Education for Practice Institute at Charles Sturt University, Franziska Trede discusses how Steven Hitlin and Glen Elder Jnr's paper has Time, Self, and the Curiously Abstract Concept of Agency influenced her critical thinking.

This paper was published in the Sociological Theory journal in 2007 by Hitlin and Elder, two sociologists. They claim that the term 'agency' is a slippery term and used differently dependent on goals, motivations and the epistemological paradigm of the user. They explore agency in the context of time and self and propose four heuristics of agency: existential, identity, pragmatic and life course. This paper provides much needed theoretical underpinnings for understanding agency. Agency is the capacity to act and not feel helpless.

I came across this paper in search for agency literature as part of my research project on building capacity to use mobile technology for learning on placement and how mobile technology can enhance student agency. The literature writes about the need for students to be agentic learners especially in clinical education but little is discussed what is meant by agency and how we can understand it. This paper is helpful in understanding that agency depends on time (in the moment or long-term), circumstances (culture, structure, people) and self (efficacy). Agency is not only in contrast to social expectations but can mean to enact existing practices.

Reference

Hitlin, S. & Elder Jnr, G. H., 2007, Time, Self, and the Curiously Abstract Concept of Agency* Hitlin, Steven;Elder, Glen H, Jr Sociological Theory; Jun 2007; 25, 2; pg. 170

Hannah Vitelson

28 September 2016

In this post, physiotherapist Hanni Vitelson writes about how a classic children's story became the inspiration for some critical thinking.

An advertisement for an anti-freckle cream catches the attention of 9-years old Pippi Langstrump. The sign says: DO YOU SUFFER FROM FRECKLES? Pippi goes straight to the selling lady and says: 'NO!! I don't suffer from freckles!!' 'But, my dear child, your whole face is covered with freckles!' says the seller. 'I know that,' says Pippi, 'but I don't suffer from them. I love them. Good morning.' This episode appears only in the fuller versions of the book, originally published in Sweden in 1945 by Astrid Lindgren.

This ever-fresh 70-years old text implicitly asks: 1. Do freckles actually induce suffering? 2. Who benefits from the supposed suffering? We can say that freckles are "biological", while

the "need" to conceal them is cultural. The social dictum in favor of homogeneous skin might cause unease to those who "deviate". This unease might lead people to allocate considerable resources in order to minimize the "deviation". Can we cautiously replace "freckles" with some professional terms like Cerebral Palsy, ADHD etc.? Does suffering stem from each condition per se, or from societal factors? Pippi does not use long words like consumerism or medicalization. She just celebrates her individuality, and maybe we can learn from her.

Link

https://www.theguardian.com/childrens-books-site/2015/jun/02/the-10-best-pippi-longstocking-quotes

Keith Waldron

29 September 2016

In this post, physical therapist Keith Waldron Jeffrey Bishop's article Rejecting Medical Humanism.

In this article, published in 2007, Dr. Bishop writes eloquently of the metaphysics of medicine, referencing the works of Nietzsche, Foucault, Heidegger, and Deleuze, and how they relate to today's biopsychosociologisms. He puts forth a compelling argument against the use of the humanities and narrative medicine as an add-on, or a compensation for the mechanisation of medicine. He writes of a continued dualism that no longer distinguishes the body from the mind, but instead focuses on the dichotomy between meanings and mechanisms.

Dr. Bishop reflects on the ever-increasing emphasis in the medical community on improving humanistic care. As physiotherapists, we are encouraged to develop relationships with patients, but as a means to an end. What is often most valued in the relationship is only another outcome - this time a "therapeutic alliance" that becomes yet another tool in the physiotherapist's 'toolbox' - another way to manipulate and objectify a human subject. If, as Bishop suggests, a therapeutic alliance is just control under the guise of intimacy, what are we left to do? Reflecting on what is considered "patient-centered" care, physiotherapists should strongly consider the means, motives, and purpose of establishing the patient-therapist relationship.

Link to open access article:
http://www.academia.edu/322335/Rejecting*Medical*Humanism*Medical*Humanities*and*the*Metaphysics*of*Medicine*

Tracy Bury

30 September 2016

In this final 30DoS for 2016, Director of Professional Policy at WCPT - Tracy Bury - writes about the seminal work of David Sackett and how it influenced her critical thinking.

The publication of Evidence based medicine: what it is and what it isn't (Sackett et al) in 1996 was the culmination of a growing discourse on the challenges of integrating research evidence with clinical expertise for the benefit of patients. The authors also referenced EBM's philosophical origins in mid-19th century Paris whilst describing it as a young discipline. The definition for EBM that was set out is now universally recognised. The importance of clinical experience, competency and judgement were applied to decision making in the face of the best available evidence and the individual patient context.

Whilst doing a Masters in Health Science in the early 1990s I was really interested in epidemiological research and medical ethics. These led me to the growing body of literature around the challenges of research generation and implementation. To me the work of Sackett and others made sense and was just as relevant to the practice of physiotherapists. It informed the direction my career has taken since with a focus on policy and advocacy, tools and resources, discussion and networking, that strives to make a difference, improving the lives of individuals and improving professional practice.

References

Eddy, DM. The Origins of Evidence-Based Medicine – A personal perspective. Am Med Ass J of Ethics 2011;13(1):55-60 http://journalofethics.ama-assn.org/2011/01/pdf/mhst1-1101.pdf

Rosenberg, W, Donald, A. Evidence based medicine: an approach to clinical problem-solving. BMJ 1995;310:1122 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2549505/pdf/bmj00590-0046.pdf

Sackett, DL, Rosenberg WMC, Gray, JAM, Haynes, RB, Richardson, WS. Evidence based medicine: what it is and what it isn't. BMJ 1996;312:71 http://www.bmj.com/content/312/7023/71

Zimerman, AL. Evidence-Based Medicine: Ashort history of a modern medical movement. Am Med Ass J of Ethics 2013;15(1):71-76 http://journalofethics.ama-assn.org/2013/01/pdf/mhst1-1301.pdf

30DoS - 2017

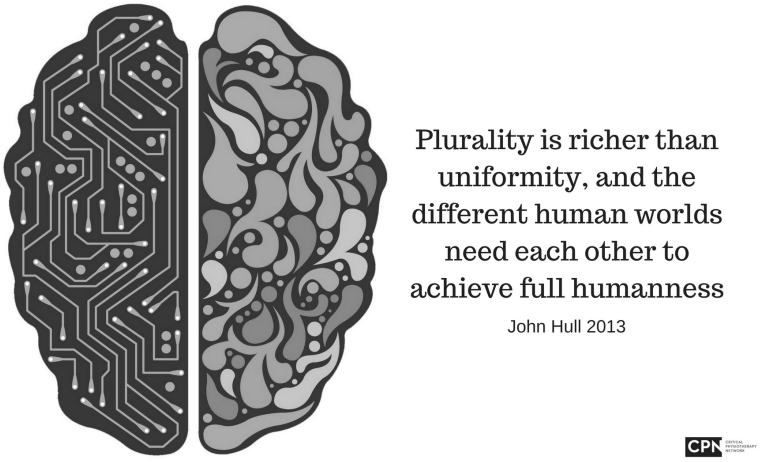
30 computer desktop images from 30 CPN featuring philosophical quotes and images that inspire them.

Karen Whalley-Hammel

1 September 2017

Neil Maltby

2 September 2017



Carol Bron

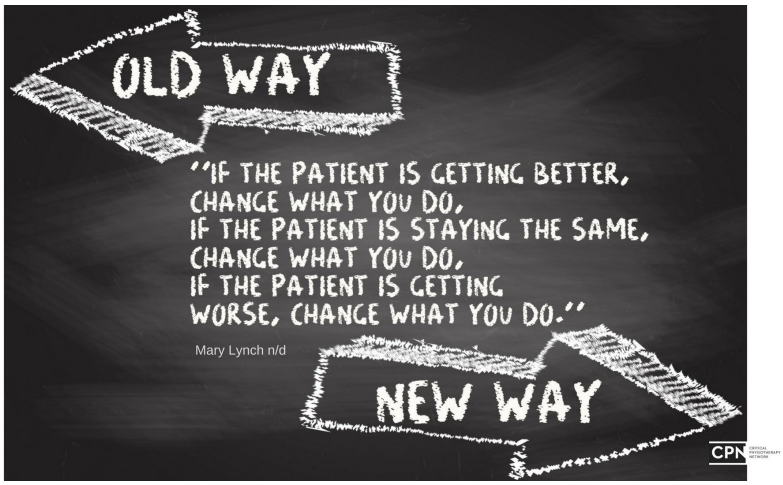
3 September 2017

Ian Edwards

4 September 2017

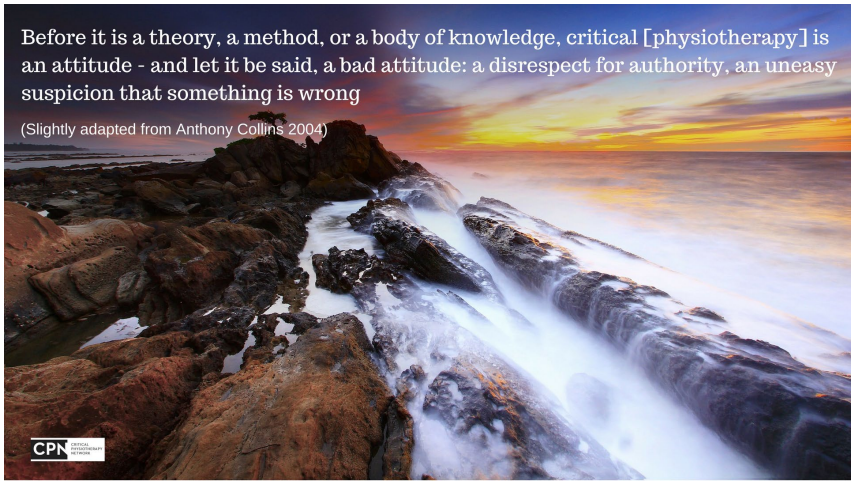
Cath Cruse-Drew

5 September 2017



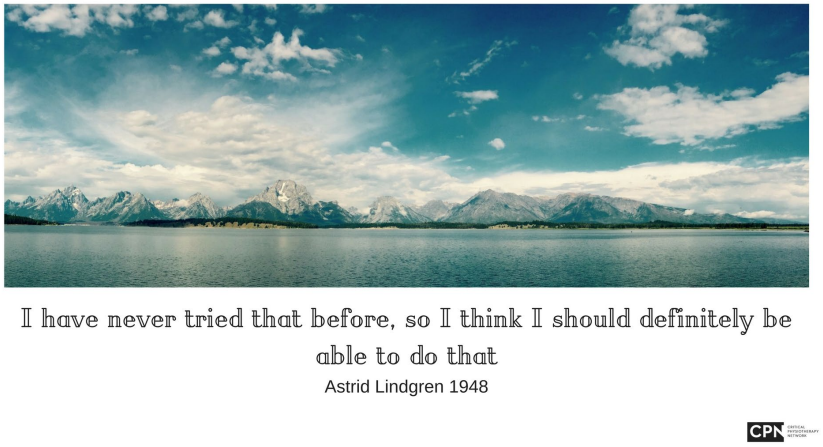
Kerry Chamberlain

6 September 2017



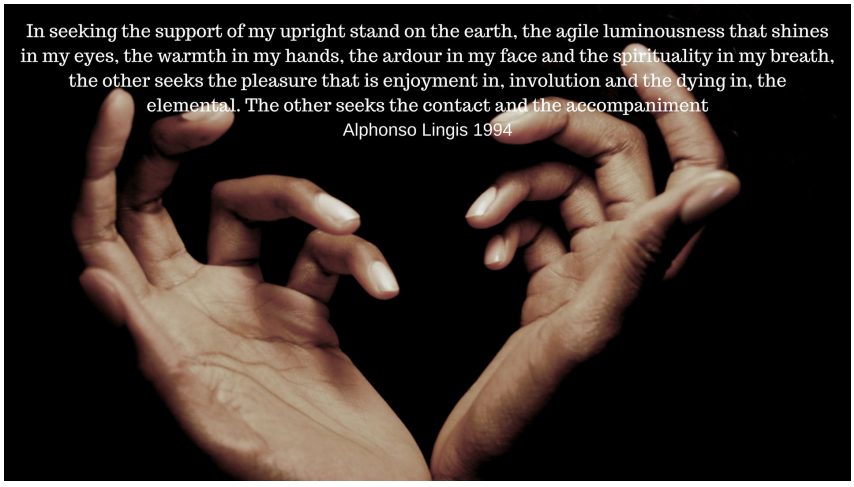
Tobba Sudmann

7 September 2017



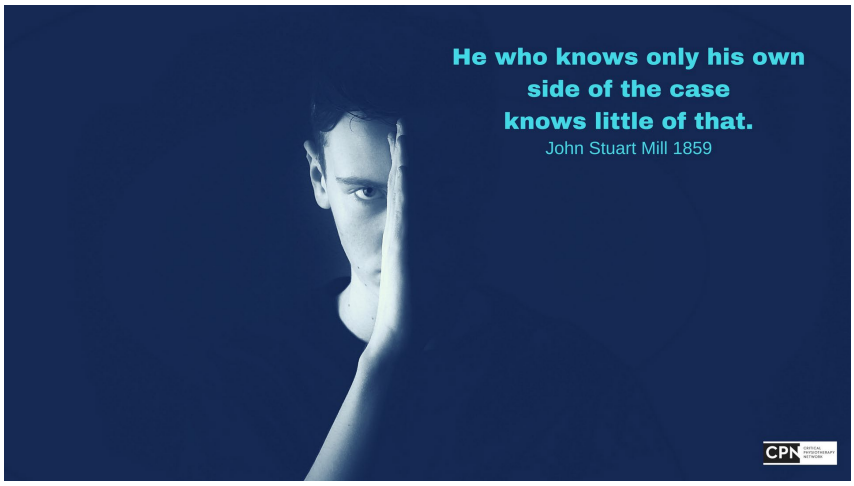
Filip Maric

8 September 2017



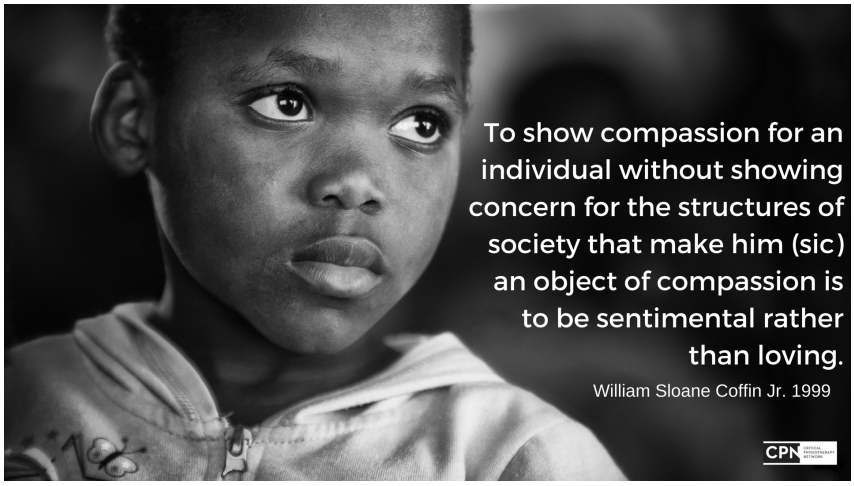
Jack Chew

9 September 2017



Barbara Gibson

10 September 2017



Dave Nicholls

11 September 2017

Jenny Setchell

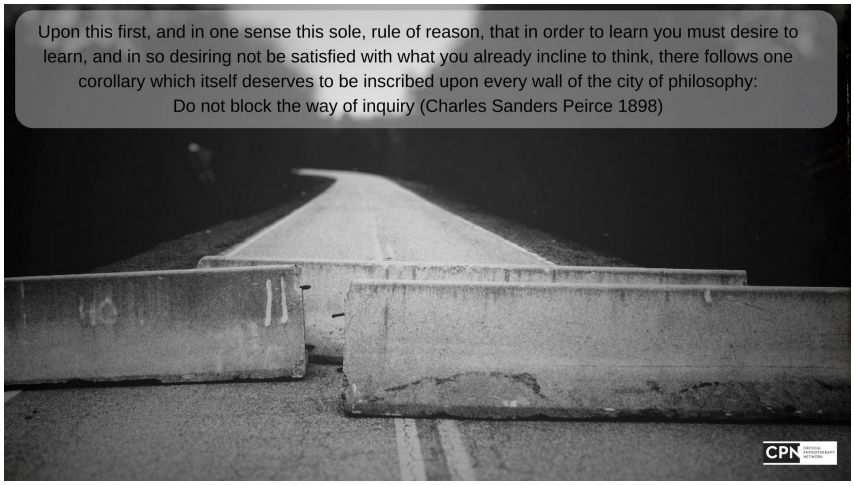
12 September 2017

Viviana Silva

13 September 2017

Adam Bjerre

14 September 2017

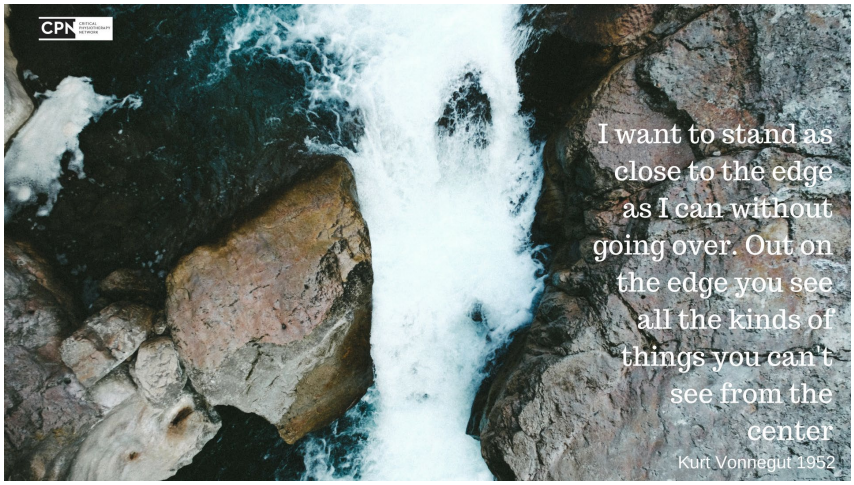


Bruce Greenfield

15 September 2017

Ben Ellis

16 September 2017

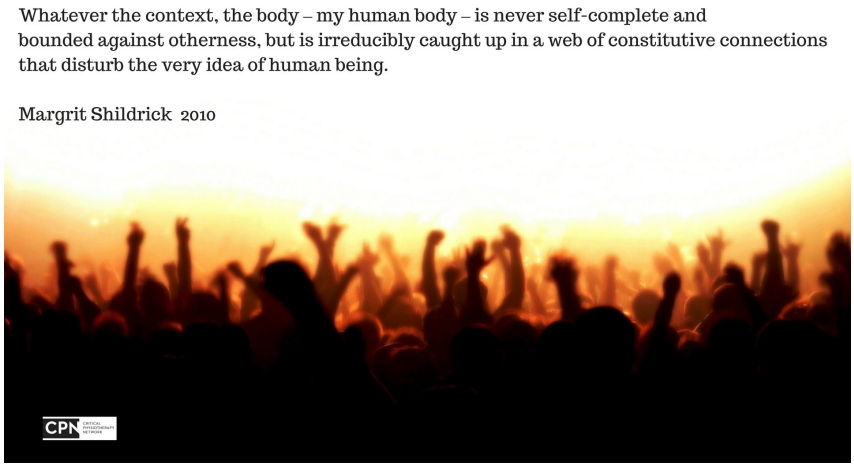


Keith Waldron

17 September 2017

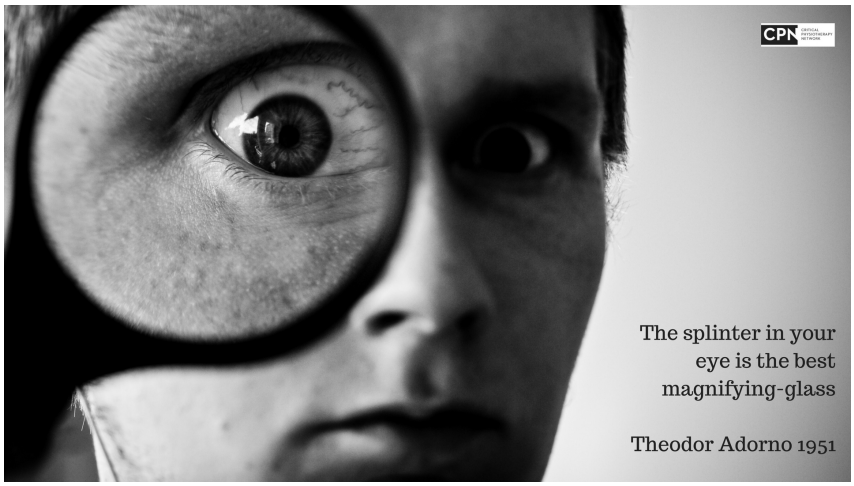
Gail Teachman

18 September 2017



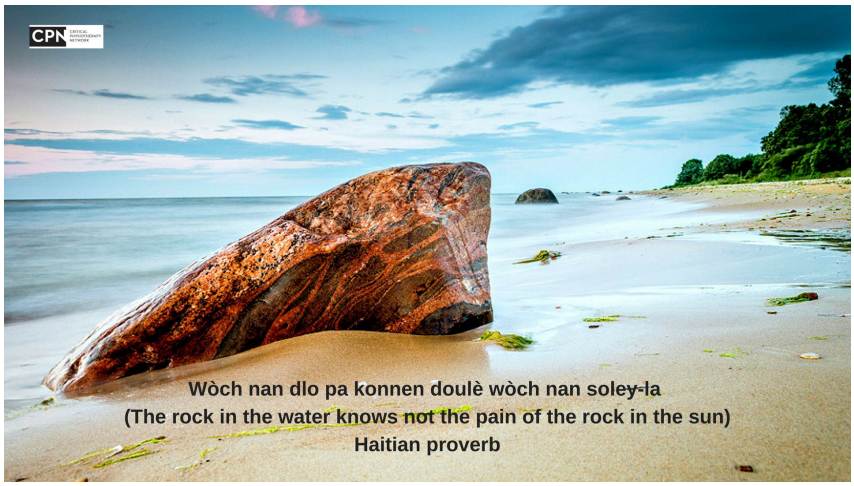
Anna Rajala

19 September 2017



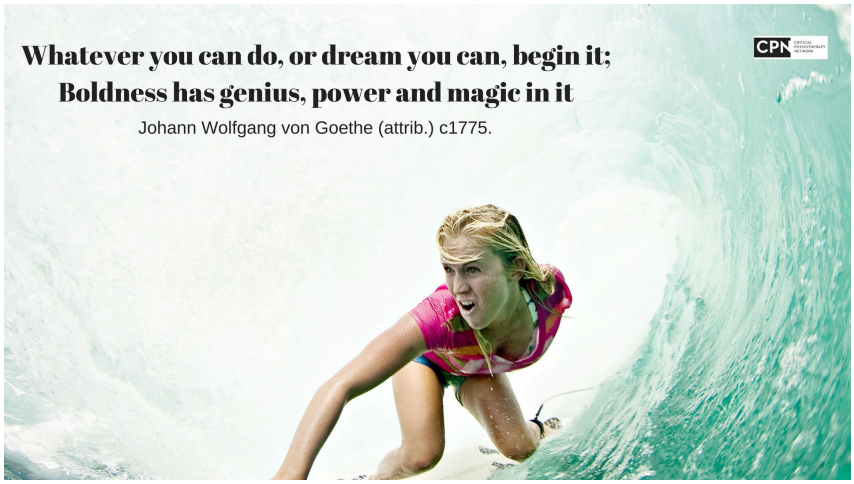
Shaun Cleaver

20 September 2017



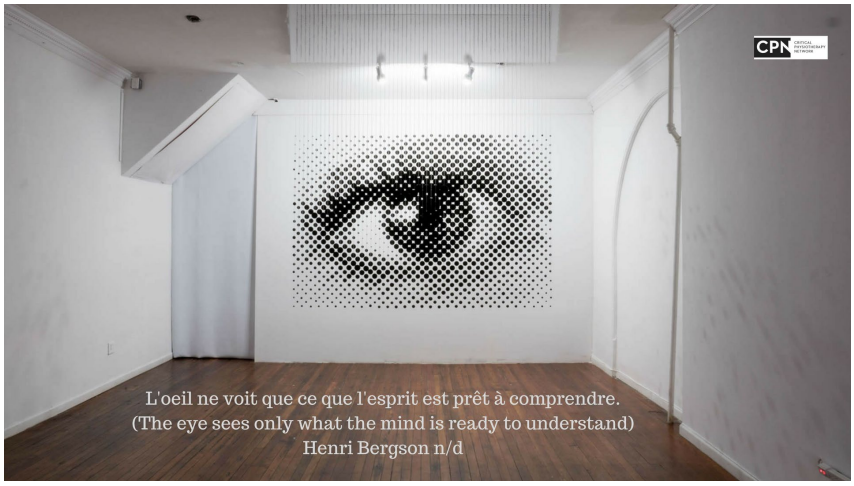
Jenny Nissler

21 September 2017



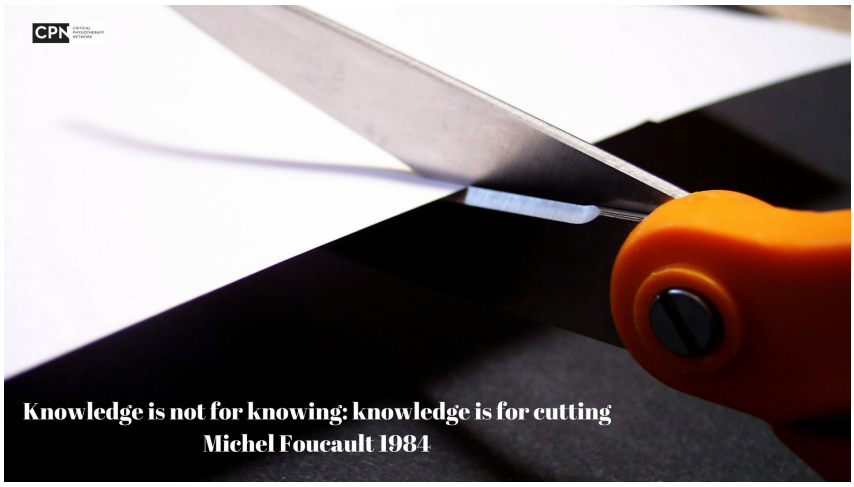
Adrien Pallot

22 September 2017



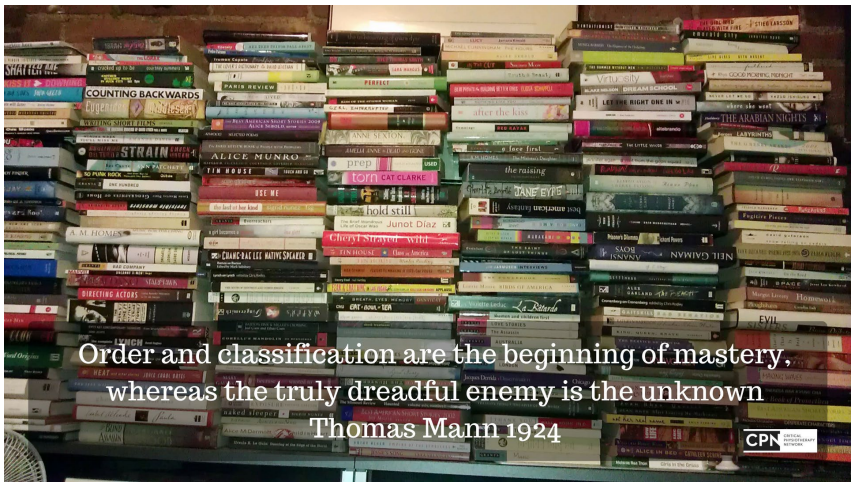
Michael Rowe

23 September 2017



Catherine Sykes

24 September 2017

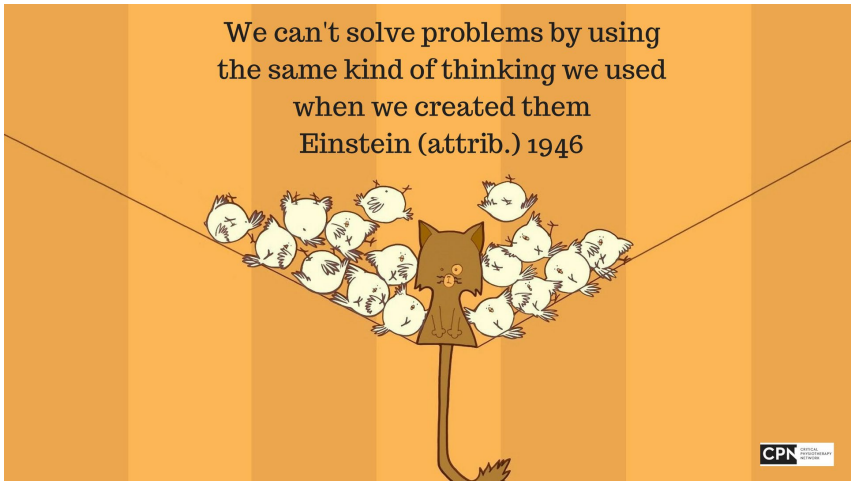


Sarah Blanton

25 September 2017

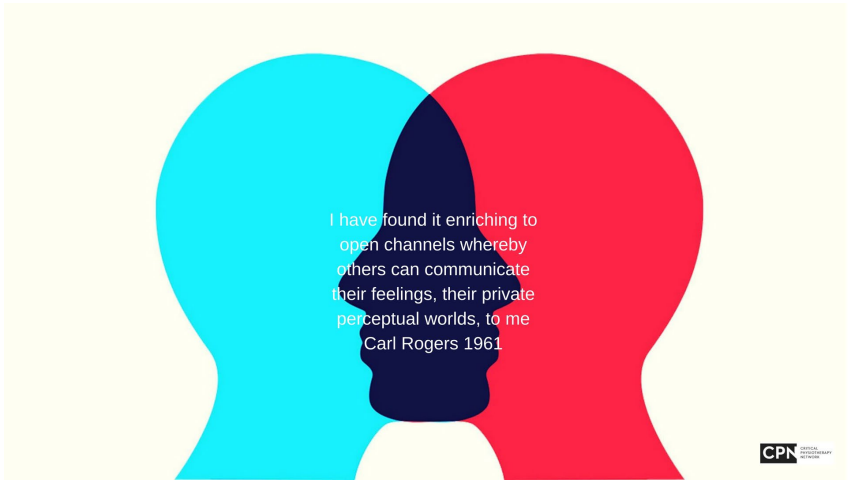
Sue Adstrum

26 September 2017



Ralph Hammond

27 September 2017



Hazel Horobin

28 September 2017

Bhanu Ramaswamy

29 September 2017

Karen Whalley-Hammell

30 September 2017

30DoS - 2018

30 Days of September is back, and starts tomorrow

31 August 2018

Every year that the CPN has been in existence, we've run a month-long campaign called **30 Days of September** (or 30DoS for short).

The idea of the campaign is to promote the Network and to engage our members.

We've run some really fun campaigns in the past, posting a poll each day in 2014, asking members what the new CPN should focus on. That led us to writing our first collaborative article, our first CPN gathering in Mallorca, and a set of objectives for the group translated into more than a dozen languages.

Our campaign in 2015 focused on 30 new ways to think about physiotherapy, and 2016's showed you some of the great thinkers that had influenced our CPN members. Last year we distributed a bespoke desktop wallpaper each day, showing an inspirational quote chosen by one of our members.

So what are we doing this year?

Because our members are the lifeblood of the Network, we wanted to profile them, not just the people and ideas that have inspired them. So this year we're going to be posting an extended profile of one of the CPN's members each day throughout the month.

Some of these people will be well known to you, others less so. Some will have very impressive CVs, full of published works and presentations. Others will be rank-and-file members: clinicians, students, teachers, and managers.

Over the course of the month, you'll get to see some of the people that make the CPN tick and, perhaps, you'll find a contact among them that you didn't know existed.

What can you do to help? Well, firstly share the posts with people in your networks. Email, Tweet, or share them on Facebook, Snapchat or whatever social media platforms you use. The more people share these profiles, the more likely people are going to find people who are kindred spirits.

But you can also follow up on the people you're most interested in. Read their work, find out about their ideas, or just make contact. That's what the Network is really all about.

Bruce Greenfield

1 September 2018

Greetings to all members of the CPN. My name is Bruce Greenfield and I am currently a Professor in Physical Therapy and Senior Fellow in the Center for Ethics at Emory University in Atlanta, Georgia, USA. I was born and raised in New York but moved to Atlanta in 1972. I have been married for 35 years and have 3 children and 4 grandchildren (yes I am getting old!). I am an avid reader (for anyone who can recommend a good book) and a not so avid runner, but I do my best. I graduated from physical therapy school at Emory University way back in 1981. I have a master's degree in medical science and bioethics, and a PhD in Higher Education.

For the first 15 years of my career, I practised physical therapy before a restless curiosity led me to switch paths. Instead of treating patients with musculoskeletal conditions, I became an educator and researcher with an interest to explore the social and human domains of practice, including the ethical dimensions of practice. My interest in psychosocial dimensions of care was not an epiphany, but rather a slow realization of how patient outcomes were influenced by the nature of the interaction between patient and PT. My interest extended to capturing how experienced and novice PTs embrace their roles as moral agents and how reflective narratives can be used as a learning method for clinical education. During the last 15 years, my work in these areas have crystalized narrative thought and exerted influence by setting terms of what constituted clinical learning and ethical practice. My scholarship focuses on strategies to enhance person-centered care approaches. Specifically, I have developed an ethics of care based on phenomenology that contains principles, theories and practical steps to help clinicians to understand the values and concerns of a patient living with disabilities as those values emerge and change over time. I am currently exploring and integrating the use of narrative to promote reflection and reflexivity for learning in practice. Of interest, I was awarded two grants from Emory University to develop and coordinate courses entitled: Disability, Resilience and Mortal Self: Healing and Care Across the Life Span. The course

explored the meaning of disability from multiple perspectives, was an interdisciplinary course taught to undergraduate and graduate students at Emory.

My interest in CPN is linked to my interest in exploring alternative ways of exploring and understanding psychosocial issues of care, and the ways we construct our understanding, and the meaning of disability and suffering. Part of my perspective is based on the existential nature of acquired disability as one struggles in a liminal state between who he/she was and what he/she will become. As an ethicist, I am interested in the ways that healthcare professionals can act as moral agents toward their patients.

Email address: bgreenf@emory.edu

Location (city/town, country): Atlanta, Georgia

Current position(s): Professor Rehabilitation Medicine and Senior Fellow Center for Ethics, Emory University

Relevant critical publications:

Greenfield B. The meaning of caring in five, experienced physical therapists. Physiotherapy Theory & Practice. 2006: 22: 175-187.

Greenfield B, Greene B, Johanson M. The use of qualitative techniques in orthopedics and sports physical therapy. Moving toward postpositivism. Phys Ther Sports. 2007: 8: 44-

Greenfield B, Anderson A, Cox B, Tanner M. The meaning of caring in novice physical therapists. Phys Ther. 2008: 88(10): 1-13.

Rauscher L, Greenfield B. Advancements in contemporary physical therapy research: The use of mixed methods designs. Phys Ther. 2008: 89(1): 91-100.

Greenfield B. Phenomenology: An alternative ethics in rehabilitation. Commentary. Am J Phys Med Rehabil. 2009: 88: 955-958.

Greenfield B, Keough E, Linn S, Little D, Portela, C. Perspectives of caring from patients undergoing physical therapy. J Allied Health. 2010: 39(2): e-43 - e-47.

Greenfield B, Jensen G. Beyond the code of ethics: application of phenomenology for ethical decision making. Physiotherapy Research Int. 2010: 15(2): 88-95.

Greenfield B, Jensen G. Understanding the lived experiences of patients: Application of phenomenological approach to ethics. Phys Ther. 2010: 10(8): 1185-1197.

Greenfield B. Invited Commentary. Phenomenology in rehabilitation. Topics in Stroke Rehabilitation. 2011: 18(1): 35-39

Greenfield BH, Bridges PH, Phillips T, Carter V, Barefoot T, Dobson A, Eldridge A, Ng N, Nicoletti L. Reflective narratives by student physical therapist on early clinical experiences: an inductive and deductive analysis: The use of a reflective framework. J Phys Ther Ed. 2017:31(4): 49-58.

Links:

https://www.emorydpt.org/faculty

https://www.healthethicsblog.com/single-post/2018/02/21/Why-are-medical-humanities-relevant-in-an-era-of-technologically-driven-healthcare

Amy Hiller

2 September 2018

Hello! My name is Amy Hiller, I am an Australian musculoskeletal physiotherapist and qualitative researcher. Currently, I am on 'maternity leave', having recently completed my PhD titled 'Toward relationship-centred care: patient-physiotherapist interaction in private practice' at the University of Melbourne.

The CPN became a valued support network during my PhD studies as I particularly enjoy meeting other physiotherapists who are interested in sociological and qualitative aspects of practice, particularly those relating to patient-physiotherapist interaction. A highlight of my involvement thus far was being part of an inaugural critical physiotherapy forum at the Australian Physiotherapy Association conference in 2015 where we had over 50 questioning physiotherapy minds in one room together. Feeling like I 'belong' to a group like this has been extremely beneficial as motivation for me to continue my research journey.

My initial interest in interactive or communicative aspects of physiotherapy practice began years ago as I contemplated how I was interacting with my patients every day. My interest in communication grew as I became aware of the dearth of knowledge about this area of physiotherapy practice. In particular, there are some specific communicative aspects of our profession, particularly the use of touch, that demand exploration and understanding to ensure that they are utilised effectively and appropriately. With this in mind, my knowledge and research has focussed on the relationship developed between patient and therapist. My thesis centres on the ideals of relationship-centred care and discusses how aspects of communication are incorporated into patient-physiotherapist interactions to achieve a relationship-centred and trusting interaction.

Relevant critical publications:

Schoeb, V. & Hiller, A. (2018). The impact of documentation on communication during patient-physiotherapist interactions: A qualitative observational study. Physiotherapy Theory and Practice, 31, 1-11.

Hiller, A. & Delany, C. (2018). Communication in physiotherapy: challenging established theoretical approaches. In B.E. Gibson, D.A. Nicholls, J. Setchell, & Synne Groven, K (eds.), Manipulating practices: A critical physiotherapy reader (308-333). Norway: Cappelen Damm Akademisk. Available: https://press.nordicopenaccess.no/index.php/noasp/catalog/book/29

Hiller, A. (2017). Toward relationship-centred care: patient-physiotherapist interaction in private practice. (Doctoral dissertation, The University of Melbourne). Available: https://minerva-access. unimelb.edu.au/handle/11343/ 129510

Hiller, A. J., & Vears, D.F. (2016). Reflexivity and the clinician-researcher: managing participant misconceptions. Qualitative Research Journal, 16(1), 13-25.

Hiller, A., Guillemin, M., & Delany, C. (2015). Exploring healthcare communication models in private physiotherapy practice. Patient Education & Counseling, 98, 1222-1228.

Josephson, I., Woodward-Kron, R., Delany, C., & Hiller, A. (2015). Evaluative Language in physiotherapy practice: How does it contribute to the therapeutic relationship? Social Science & Medicine, 143, 128-136.

Anne Marit Mengshoel

3 September 2018

My name is Anne Marit Mengshoel. I am educated as a physiotherapist with a speciality in manual therapy. For about ten years, I was working in a private physiotherapy institute in primary health care, and then afterwards about 15 years in a hospital specialized in rheumatology as a teacher for physiotherapy students, PhD student and leader of developmental work within physiotherapy. Since, the year 2000 I have been working in the Department of Health Sciences at the Medical Faculty of the University of Oslo, Norway – the last 15 years as a Professor. My research is inspired by my clinical work experiences as a manual therapist in primary health care and as a physiotherapist in a multidisciplinary rehabilitation context; i.e. applied clinical science. Over the years, I have also been inspired from my close collaborations with scholars with different backgrounds as health professionals and with various specialities within medicine, as well as from biology, social sciences and humanities. In my research, I have been trying out various research designs within qualitative and quantitative methodology. Being a member of research evaluation boards in Norway and England, as well as an EU Cost group, I have developed a broad insight into health sciences in general.

My research interest is in particular rehabilitation of chronic musculoskeletal illnesses and diseases. My PhD thesis addressed fibromyalgia (FM), and later my particular interest became to understand how it is like from a patient perspective to live with such an illness, how fatigue is experienced and managed, and what processes former patients consider relevant for their becoming symptom-free (their recovery experiences and healing work). In developing my understanding of the contested, medically unexplained condition of FM and other persistent, medically unspecified musculoskeletal conditions, I have been exploring and comparing their experiences with those of patients with well-defined, autoimmune diseases, for example ankylosing spondylitis, rheumatoid arthritis, Sjøgren's syndrome.

Presently, I am leading a study where a multidisciplinary rehabilitation team at a rheumatism hospital and researchers collaborate in developing and trying out a new rehabilitation program for patients with FM. In this work, we have incorporated evidence from qualitative studies about patients' illness and recovery experiences. We have also examined our own developmental process and identified ambivalences and paradoxes experienced by clinicians in their work with contested illnesses in contrast to autoimmune diseases. In parallel, I am leading a study among scientists in the research group 'Self-management' that I am heading. In this study, we are doing a systematic literature research on how health professionals experience working with chronic illnesses, in this context diabetes, chronic obstructive pulmonary disease, and kidney disease. I am also just about to complete a paper where I have studied what makes it meaningful to attend physiotherapy by long-time users in primary health care. The narrative analysis of these users' experiences is captured by the story-line 'It takes time, but recovering makes it worthwhile'.

I have always had a critical eye on the development of physiotherapy practice. My drive has been that physiotherapy seems to lack a language for wording what it is actually about. I experienced as a teacher for physiotherapy students in clinical practice how complex physiotherapy practice is and accordingly to teach students how to practice it. Teachers recognize good practice by observing it, but it is still difficult to describe why a practice is found good or not good enough. During recent years, the evidence-based movement provides information for clinicians about what is best practice. But if this movement should dictate what good physiotherapy practice should look like, the definition of good practice become too simplified. This kind of evidence will only tell what should be delivered, but not how to deliver it and relate to patients in clinical encounters which I think are important ingredients of good clinical practice. As one of my informants expressed it: 'patients cannot be treated according to a book.'

By reading theories developed within social sciences, as well as collaborating with medical sociologists and humanists, I am progressing in my ambition to become able to word some of the implicit knowledge in physiotherapy. Translating theories from other fields into

physiotherapy has been a rather lonely process. But CPN has shown that there are several physiotherapists worldwide that share my concern about the development of physiotherapy theory and practice. Through mutual efforts and by supporting each other I have a vision that we can be strong enough to nurture the future development of physiotherapy. That is why I joined CPN.

Relevant critical publications:

Mengshoel AM. Living with a fluctuating illness of ankylosing spondylitisArthr Rheum 2008; 59, 10: 1439-44. (Invited paper Special issue on Rehabilitation)

Mengshoel AM. Mixed methods research – So far easier said than done? Manual Ther 2012; 17: 373-5.

Ahlsen B, Bondevik H, Mengshoel AM, Solbrække KN. (Un)doing gender: A narrative analysis of men's and women's stories of chronic pain. Disabil Rehabil 2014; 36; 5: 359-66.

Mengshoel AM, Norheim KB, Omdal R. Primary Sjögren's syndrome – fatigue is an ever-present, fluctuating and uncontrollable lack of energy. Arthritis Care Res 2014; 66: 1227-32.

Grape H, Solbrække KN, Kirkevold M, Mengshoel AM. Staying recovered from fibromyalgia – an ongoing hard work. Qual Health Research 2015; 25: 679-88.

Bjorbækmo WS, Mengshoel AM. "A touch of physiotherapy" – the significance and meaning of touch in the practice of physiotherapy. Phys Ther Theory Pract 2016; 32: 1-10.

Mengshoel AM, Grape HE. Rethinking physiotherapy for patients with fibromyalgia syndrome – lessons learnt from qualitative studies. Phys Ther Reviews 2017; 22:254-59.

Ahlsen B, Mengshoel AM, Bondevik H, Engebretsen E. Physiotherapists as detectives; investigating clues and plots in the clinical encounter. Medical Humanities 2018; 44: 40-45.

Mengshoel AM, Sim J, Ahlsen B, Madden S. Diagnostic experiences of patients with fibromyalgia syndrome – a metaethnography. Chron Illn (e-pub ahead Jan 2017)

Sallinen M, Mengshoel AM. 'I just want my life back' – men's narratives about living with fibromyalgia. Disabil Rehabil (e-pub ahead Oct 2017)

Bhanu Ramaswamy

4 September 2018

I am an Independent Physiotherapy Consultant based in Sheffield, a northern city in the United Kingdom. I have also held an honorary role as a Visiting Fellow at Sheffield Hallam University since 2010. My career until that point had been heavily biased toward clinical practice, and then standard setting since qualifying in 1988. It was the undertaking and

completion of a Doctorate and involvement in research that started turning my interests towards a more shared understanding between the 'patient' and myself as a clinician. My areas of specialism are in elder rehabilitation and neurology, particularly working with people affected by Parkinson's. Co-producing my doctoral project with others through participative methodology made me realise the one-sided stance from which guidelines and standards of clinical practice are written - many, relating to physiotherapy in my field of expertise contributed to by myself over the years. My eyes were opened to the benefits of a more collaborative and informed work through shared experiences and knowledge between the professionals and people with different diagnoses. My new goal became to aim for more co-produced and qualitative inquiry (critical of course), but it continues to be a slow process for me.

My first steps have been more towards the first part of that goal i.e. that of co-production, gaining ideas of what people with Parkinson's felt would help them. Last year, I co-authored for publication a first peer-reviewed article with a man (now friend) with Parkinson's - still pretty clinical, but he wanted to explore and share his journey to undertake a marathon at aged 58 years, so that's what we wrote about; it was interesting writing from each of our perspectives about this. I then involved myself in helping develop an exercise framework pushed by the wishes of people affected by the condition to get professionals to understand what evidence about exercise was telling them; again an eye opener about the acceptance of things that have no 'hard evidence' base, but people still find of use, or follow the latest well-marketed trend. Right now, I am undertaking to write about appreciative inquiry, so let's see where this takes me ……

Irena Paiuk

5 September 2018

My current fields of interest are medical education, somaesthetics, the importance of self and body awareness in the professional development of physiotherapy students, developing interpersonal sensitivity & empathy & non-verbal communication through the practice of contact-improvisation classes during physiotherapy education. In my clinical practice, I am interested in the field of breathing pattern disorders and their relationship to movement dysfunction, movement qualities, and chronic pain conditions. I am deeply interested in implementing LBMS (Laban Bartenieff Movement Studies) and Contact - Improvisation in Physical Therapy, with the purpose of enhancing communicational skills, empathy, awareness to Self and Other, and bringing to the foreground of PT studies the awareness of the Whole Parts of Movement: the Expressional aspects as well as Functional one.

Becoming aware of CPN activity and becoming part of CPN community gave me actually the sense of legitimacy and security to implement in my academic practice less "evidence-based

educational approaches". CPN activity is my academic facilitator for being attuned to not only to the current "evidence" but also to my practice, and it allows me (by being aware to practice of other inspiring CPN colleagues) fearlessly make connections between arts, science, and philosophy:)My current (pilot) research focuses on implementing experiential movement classes to develop non - verbal dialogue between Self and Other, by expanding self body awareness, and developing interpersonal sensitivity and kinesthetic empathy skills.

Email address: irenapaiuk1@gmail.com

Current position(s): Physical therapist (private practice) and a lecturer at Tel Aviv University (Department of Physical Therapy); Certified Laban Movement Analyst (LIMS, NY). I am a Physical Therapist, certified Laban Movement Analyst (LIMS, NY), and a Contact Improvisation instructor for integrated populations (disabled and "temporary"- abled:))

Jenny Wickford

6 September 2018

I am Swedish by passport, but my heart is nomadic. This state of being has defined my professional journey. I have been working in the physiotherapy field since 2003, in Sweden, Afghanistan, and the United Arab Emirates, in private and public contexts, with humanitarian work and in universities.

My interest clinically is pain, in particular, pelvic/abdominal pain and dysfunction, women's pelvic health and global health. I am also interested in other aspects that relate to this in various ways. I am fascinated by how people interact and work together, especially interculturally. I love teaching and inspiring others to think about their work from different angles. I have had the opportunity to do a fair bit of dissection, and am constantly learning through this process of exploring the body. This has also stimulated critical thoughts about where we have come from as a profession, and what this means for clinical practice and research.

The pelvic/abdominal interest is not something I had with me from the start. In my undergraduate training, pelvic and abdominal health was barely mentioned. I had virtually no exposure to issues related to these fields of practice in my earlier jobs - not because my clients didn't suffer from them, but because I didn't see them or know to ask about them. My interest in pelvic/abdominal health started in Afghanistan. Hearing the stories of Afghan women about pelvic dysfunction challenges they endured, meeting another physiotherapist with expertise in women's health, I was introduced to the field that I now work with.

It's a privilege and at the same time humbling to work with this group of clients. With every client, I learn more. And I can recognise the paucity of knowledge about the pelvis and abdomen in the healthcare system - including amongst physios - because I have been there.

In my last job, I was part of setting up Sweden's first pelvic pain centre, which was an incredible experience. I've recently moved on and am now developing my own thing, with an initial focus on training and health coaching from a particular perspective and model of health and pelvic health. I have also, together with three friends, recently set up a non-profit association that aims at addressing women's well-being across the globe. One of the members and I have written a book on intercultural collaboration, where all the proceeds from the book sales go to this association. Another member and I are planning a project in Pakistan, to develop a training approach targetting women's pelvic health in rural areas, collaboratively and culturally.

Looking back, the path behind me has taken many unexpected turns, and I don't know what course it will take ahead. I hope to be a part of developing other ways of being as a physiotherapist, other ways of looking at how to meet the needs of clients who live with pain, through the blending of my various experiences and interests. The CPN seems one forum for throwing out challenging questions, to dig around in our roots and see what we find. And in doing this rethink the questions we ask and make those questions lead the way to practically exploring new ways of understanding, of being, of doing.

Relevant critical publications:

Wickford J, Osman F. Crossing borders – living and learning together in a colourful world. Tara Press, Dublin, 2018.

Wickford J. Conscious seeing: A description of a reflective framework used with final-year Swedish physiotherapy students in the context of international clinical placements. European Journal of Physiotherapy, 2014: 16; 41-48.

Wickford J, Duttine A. Answering global health needs in low income countries: considering the role of physical therapists. World Medical and Health Policy, 2013: 5(2); 141-160.

Wickford J, Rosberg S. From Idealistic Helper to Enterprising Learner – critical reflections on personal development through experiences from Afghanistan. Physiotherapy Theory and Practice, 2012: 28(4); 283-291.

Wickford J. Physiotherapists in Afghanistan. Exploring, encouraging and experiencing professional development in the Afghan development context. PhD thesis, University of Gothenburg, 2010.

Edwards I, Wickford J, Ahmed Adel A, Thoren J. Living a moral professional life amidst uncertainty: Ethics for an Afghan physical therapy curriculum. Advances in Physiotherapy, 2010: 13(1);18-25.

Location (city/town, country): Linköping, Sweden

Current position(s): PhD physiotherapist: part-time consultant at the Pelvic Pain Centre in Linköping Sweden, part-time educator and owner Sitara Wellbeing.

Filip Maric

7 September 2018

Being equally passionate about eastern and western philosophy, physiotherapy, other healthcare traditions, martial arts, and a lot more, my interests in critical physiotherapy are quite varied. They do however all converge on my interest in exploring and leading a good, happy and healthy life, and supporting others in doing so. In my personal and professional research and practice over the last few years, I have focused on how a number of philosophies and practices can contribute to this. In particular, these are the ethics of Emmanuel Levinas, Pierre Hadot's philosophy as a way of life and its philosophical practices, Zen, Buddhism and other eastern spiritual traditions, the therapeutic method of Shiatsu, and a variety of eastern and western martial arts.

My hopes for the CPN are that it will grow into what is aspiring to: being a positive force for an otherwise physiotherapy. At least for me, this would also consist in contributing to the improvement of physiotherapy and healthcare clients and practitioners life at large, and I am grateful and excited to be a part of this endeavor.

Throughout my life, I have always been looking out for mentors and have always found them in many different, and often unexpected places. This has confirmed my general intuition that there is always something interesting to learn out there as far as questions about a good, happy, and healthy life are concerned. I am happy to mentor those that can relate to this central interest of mine, or are interested in any of my other, related fields of expertise, across philosophy and therapeutic practice, from the philosophy of Emmanuel Levinas (ethics) and Pierre Hadot (philosophy as a way of life), to eastern philosophies (Zen, Buddhism, Daoism), healing (Shiatsu, TCM) and the martial arts (Aikido, Koryu, and more).

Relevant critical publications:

Maric, F. (2017) Physiotherapy and Fundamental Ethics – Questioning Self and Other in Theory and Practice. AUT University Auckland,
NZ. https://aut.researchgateway.ac.nz/handle/10292/11051

Maric, F. (2012) Mushotoku – physiotherapist without a goal. Paper and Activity session at the Wisdom Traditions and Universities: Mindfulness-SIG Conference.
AUT University Auckland, NZ.

Maric, F. (2011) Researching the Self, the Other, and their relationship in physiotherapy: a theoretical and methodological exploration of autoethnography. AUT University Auckland, NZ. https://aut.researchgateway.ac.nz/handle/10292/1197

Alma Viviana Silva Guerrero

8 September 2018

I completed my BPhty Hons at The National University of Colombia in 2000. My interest in the arts, especially dance, inspired me to modify the LABAN Dance Program (MODERN EDUCATIONAL DANCE) and use it as a tool for motor development in children between the ages of 7-9 years which became my honours project. Implemented in one of the poorest and most violent areas of Bogota, Colombia, one of the world's largest mega-slums called Ciudad Bolivar, this project was able to improve not only the motor development but also improve both cognitive and social skills of the children living there. With its success, I wanted to take the program further and implement it on a larger scale, however, after contacting UNICEF and other government entities, I couldn't find any support. The social programs in Colombia are mainly directed to cover 'basic needs' food and accommodation. So, I took several courses about community, both locally (Universidad Javeriana) and internationally (The Johns Hopkins University) where I recognised that regardless of whether outsiders view a community as poor or neglected, it is possible to find strength and the capacity for improvement within every community. I learned that identifying community capacities and resources is the first step in facilitating community change and that to be successful, community participation in the design, implementation, and evaluation of any intervention is critical. This is what I have tried to translate constantly into my clinical practice and teaching.

I worked for over 10 years in clinical practice and research in Colombia, before moving to Australia to continue postgraduate studies in 2010. I had an accident in 2012 where I was diagnosed with Whiplash/fibromyalgia. I tried everything as a physiotherapist, to manage my condition but unfortunately, it continued to deteriorate my health for over two years. I decided to try contemplative practices (Meditation and Tibetan retreats) and to my surprise, they helped enormously. In 2015, I had fully recovered, thanks to the combination of physiotherapy and contemplative practices that significantly improved both my physical and mental wellbeing back to full health. Therefore, I started my Ph.D. with a project called: An Investigation of Physiotherapists Delivered Psychological Interventions for Musculoskeletal Pain Conditions- Reassurance for Neck Pain and WAD conditions which I am currently completing and teaching Evidence-Based Practice at Griffith University. I became a mother in April and I am enjoying spending time with my baby son.

Being a volunteer has been a part of my life. I have offered my time and skills in community programs in Colombia (i.e. Organising holiday trips for children with cerebral palsy that gives a

deserved day-off to their careers), USA (Thubten Chondron organisation) and here in Australia (Permablitz, and Culture Free of Gender Violence).

Relevant critical publications:

Alma Viviana Silva Guerrero, Annick Maujean, Letitia Campbell, Michele Sterling. A systematic review and meta-analysis of the effectiveness of psychological interventions delivered by physiotherapists on pain, disability and psychological outcomes in musculoskeletal pain conditions. Clinical Journal of Pain March 2018.

Dance as a Promotional Tool for Motor Development in Children Between 7-9. The Journal of the Colombian Physiotherapy Association 2003.

Dance as a Promotional Tool for Motor Development in Children Between 7-9. (thesis) 1st Class Honours, Colombian National University 2000.

The Physiotherapist as Project Development Manager. Journal of the Colombian National University. Area of In-depth Study of Development Kinesiology 1999.

Presentations

The impact of neoliberal ideology on physiotherapy practice- A Colombian physiotherapist's experience. World Confederation for Physical Therapy Congress 2017 (Focused Symposium) Critical Physiotherapy.

Siri Moe

9 September 2018

My current research is about primary health services and specifically physiotherapy practice in a rural context. Due to recent reorganizations of the Norwegian health care, physiotherapists' traditional practice need to be changed – if we want to keep our position in the public health care. To investigate into traditions of physiotherapy practice and how the profession is responding to changes within the healthcare system, we need theories that contextualize practice and shed light on what are the important issues and new ways of understanding the issues. At the moment I am taking part in developing one of our multi-professional master programs in health sciences to get extended focus on skills needed to meet the tasks in the primary health care. In this regard, the CPN is a source of inspiration!

In my Ph.D. work, I studied the relationship between the body and the tool; the tools represent the use of different technologies (traditional handcraft, assembly work and ICT work). I made use of social perspectives on the context of movement. An important contribution from the study is how the development of society changes the body and our perception of ourselves and surroundings.

My theoretical interests range from the phenomenology of the body to social constructivist perspectives on action, theories of knowledge and professional practice. My research methodological skills lie within the field of qualitative methods.

To read about the members' views and perspectives on issues I have not been thinking about is challenging and enriching. I get a feeling of belonging to a profession in progress. I addition, I would like to increase international collaboration, especially in research and get collaborators through the network.

Relevant critical publications:

Marianne Eliassen MSc, PT, Nils O. Henriksen PhD, MSc & Siri Moe PhD, PT (2018): Variations in physiotherapy practices across reablement settings, Physiotherapy Theory and Practice, DOI: 10.1080/09593985.2018.1481162

Marianne Eliassen MSc, PT, Nils O. Henriksen PhD, MSc & Siri Moe PhD, PT (2018): Variations in physiotherapy practices across reablement settings, Physiotherapy Theory and Practice, https://doi.org/10.1080/09593985.2018.1481162

Eirik Lind Irgens PT, MSc, PhD student, Nils Henriksen MSc, PhD & Siri Moe PT, MSc, PhD (2018): Variations in physiotherapy practice in neurological rehabilitation trajectories –an explorative interview and observational study, Physiotherapy Theory and Practice, https://doi.org/10.1080/09593985.2018.1480679

Irgens, Eirik Lind; Henriksen, Nils Oddbjørn; Moe, Siri. Acquired brain injury rehabilitation: dilemmas in neurological physiotherapy across healthcare settings. European Journal of Physiotherapy 2016; 18(4) s. 202-209

Nikolaisen, Morten; Arntzen, Cathrine; Moe, Siri. Physiotherapy and priority setting – a focus group study in municipalities in Finnmark, Norway. Fysioterapeuten 2015; 1. http://fysioterapeuten.no/Fag-og-vitenskap/Fagartikler/Physiotherapists-and-Priority-Setting-A-Focus-Group-Study-in-Municipalities-in-Finnmark-Norway

Normann, Britt; Sørgaard, Knut; Salvesen, Rolf; Moe, Siri. Clinical guidance of community physiotherapists regarding people with MS: Professional development and continuity of care. Physiotherapy Research International 2014 ;Volum 19.(1) s. 25-33

Normann, Britt; Sørgaard, Knut; Salvesen, Rolf; Moe, Siri. Contextualized perceptions of movement as a source of expanded insight: people with multiple sclerosis' experience with physiotherapy. Physiotherapy Theory and Practice 2013 ;Volum 29.(1) s. 19-30

Normann, Britt; Moe, Siri; Salvesen, Rolf; Sørgaard, Knut. Patient satisfaction and perception of change following single physiotherapy consultations in a hospital´s outpatient clinic for

people with multiple sclerosis. Physiotherapy Theory and Practice 2012 ;Volum 28.(2) s. 108-118

Moe, Siri. Another dance – about embodied knowledge. I: Living crafts : preserving, passing on and developing our common intangible heritage. International and national ambitions. Hertervig Akademisk 2009 ISBN 978-82-8217-002-4. s. 101-106

Moe, Siri. Et kroppsfenomenologisk perspektiv på fysisk aktivitet og bevegelse. Fysioterapeuten 2009 ;Volum 76.(4) s. 17-2

Hazel Horobin

10 September 2018

I am interested in international practice, so who works, in what ways and where, and I joined the Critical Physiotherapy Network because there were people there that shared my fluid views of what physiotherapy can and could be. To this interest in practice I bring social science understandings of relationships, both organisational and interpersonal, and I use these to inform my understanding of physiotherapy practices.

I teach professionalism as well as respiratory physiotherapy, and as I do this I am keen to appreciate what understandings the student is starting from. My teacher education was profoundly influenced by 'active' learning approaches and I try to continue with this style. This means that I think students learn best when they are able to talk about issues or do something practical. I also like students to teach students, in this way they develop skills of self-awareness and self-criticality; developing their professional selves iteratively, through those opportunities.

I am keen that students are also offered ways to make the best use of their creative, imaginative and authentic selves, in the same way as they will when they work with patients and so I strive to offer teaching, learning and assessment strategies that recognise this as well as trying to model this in the way that I teach.

I'm committed to the concept of diversity, I use diverse resources, and reaching out and connecting with other locations and people is important. This 'outreach' occurs through personal contact with people, through social media, in placements, through volunteering and in service user participation in University teaching.

I have a social science perspective on physiotherapy and I see the CPN as being a meeting point for others who have these views on rehabilitation practices. This is an arena where structural issues of control and authority can be discussed and where power in therapy relations are appreciated for the influences they have. I am interested in networking and collaborative research and writing, particularly with those in other parts of the world.

Relevant critical publications:

April 2 - 4 2014 Transcultural Identity Constructions in a Changing World, Dalarna University Sweden, Professional Identity Development in Physiotherapy: From India to the UK.

June 25th -26th 2015 The stubborn persistence of racism: confronting racial inequality through education and action. Centre for Racial Equality in Scotland and the University of Edinburgh 2nd International Conference 2015. John MacIntyre Conference Centre, University of Edinburgh. Subtle Stereotyping of Other in Transnational Physiotherapy Education.

H.Horobin and V. Thom (2015) Starting with Transitions: Internationalisation for a Post Graduate Physiotherapy Course, Green W., Whitsed C., Critical perspectives on internationalizing the curriculum in disciplines: Reflective narrative accounts from business, education and health, Dordrecht, Netherlands, Sense Publishers, 249-260

National Association of Educators in Practice conference May 2016 - poster presentation 'Being and becoming a Healthcare Professional' with Nikki Petty, Pirjo Vuoskoski and Clair Hebron

Blaise Doran

11 September 2018

I came to physiotherapy later in life. My previous life was as an actor (professional, occasionally paid) and I did that for 10 years. I did love being an actor (when I was in work), but the business can be brutal and it can be easy to lose sight of one's values, so I gave it away in 1999. I had around 2 years of doing a 'proper job' while training part time as a massage therapist. I realised once I started to do massage, that I desired more from it than it could deliver, and began to look into training in other manual therapies. I settled on physiotherapy after going on a two-day observational placement at Kings College Hospital in London. This was designed to show school leavers what the breadth of physiotherapy scope of practice was, and being 34, along side a 17 year old school leaver was somewhat comical for the physiotherapists showing us around. Wisely, I think, they started with geriatric orthopaedics, then paediatric respiratory, neurosurgery, and so on through a gamut of other specialised areas, and ending the second day with musculoskeletal outpatients. Needless to say, I was sold.

Other than my base-grade rotational posts, for much of my physiotherapy career, I focused on neurology. I have worked in some of the expected areas (such as stroke and ABI), some unexpected areas (neuromuscular disorders, such as MND and polio), and along acute to chronic treatment continuum. I have had some brief forays into aged care and palliative rehabilitation. Along the way, I gained a graduate diploma in neurological rehabilitation. As part of that journey in neurology, I developed an interest in pain

management. It has been a through-line in stroke, ABI, polio, aged care and palliative care. I took a punt (as my boss did on me) and applied for a job in paediatric chronic pain management at the Royal Children's Hospital in Melbourne. Somewhat surprisingly (to me at least), all my previous skills appeared to be a good fit. It is complex and at times filled with uncertainty; I like surfing both. Along the way, I have gained an MSc in Pain Management.

The collective histories and philosophies that underpin physiotherapy have been a growing fascination for me. Early in my career, I was focused on just that - 'progressing' into my chosen specialism. As time has gone on, I have realised that it was the people who have come to me for treatment, and one or two of my work colleagues, who have helped me to question what I do, and why I do it, in the context of human interaction (rather than exclusively clinical frameworks). Why have our health systems evolved in the way they have? Why are some people labeled as they are? Why do we do it this way, and not that way? Who is gaining, who is losing? I cannot even remember how I discovered that Dave Nichols had put a call out for people who were interested to join the Critical Physiotherapy Network. I thought it would be for academics only (and I am no academic), but in keeping with the spirit of an otherwise physiotherapy thankfully membership was not restricted in that way.

I have a diverse interest in philosophy, ethics, music, art, and performance. I try to use critical thinking to prise off the barnacles of customary ways of approaching physiotherapy, and look for pragmatic ways to apply my areas of interest into my own practice. Very interested in sociological perspectives of persistent pain, and qualitative research.

Relevant critical publications:

Doran, B and Setchell, J (2018) Performative acts of physiotherapy. Chapter 5 in Gibson BE, Nicholls D, Setchell J, Synne Groven K. (2018) Manipulating practices: A critical physiotherapy reader. Oslo, Norway. Cappelen Damm.

Pia Kontos

12 September 2018

I am a Senior Scientist at Toronto Rehabilitation Institute-University Health Network (a rehab hospital) and an Associate Professor in the Dalla Lana School of Public Health at the University of Toronto. My training is in social science, specifically medical anthropology and sociology applied to health, illness, and health systems. You're probably wondering how a social scientist ends up working in a rehab hospital? And why, you might ask, would I want to work in such a clinical setting? It's a good story, one about perseverance, and a strong commitment to social justice.

It started many years ago with my ethnographic doctoral study of a long-term care home, an often forgotten quasi-clinical setting. My research challenged assumptions of existential loss

with dementia by focusing on the fundamental role of the body – its capacities, senses, and experiences – for body-self/body-world relations including self-expression, interdependence, and reciprocal engagement. . Disentangling selfhood from cognition and grounding it in the body's dynamic and complex interconnections with history, culture, power, and discourse – captured with the theory of 'embodied selfhood' – not only problematizes the 'tragedy discourse' that has come to define dementia, but importantly problematized the inhumane nature of dementia care (e.g. reducing care to bodily needs within a unidirectional, provider-as-expert model). Because of the important implications of embodied selfhood for improving clinical care, I chose to do my postdoctoral training in a clinical setting – Toronto Rehab – where an opportunity came up.

As freshly minted PhD, I had grand aspirations to engage scientists, health care practitioners, and decision-makers about my research, and to humanize dementia care. But I quickly recognized that I couldn't rely on theory to catalyze discussion about the meaning of embodied selfhood in practice. Yet theory was my strength; it's what I knew best. I needed instead a medium that would allow me to translate the theory to help others to critically reflect on their understandings, assumptions, and practices regarding selfhood, including the factors that shape the way that care is organized. But how to do this, and do so effectively, was a challenge. I ended up turning to theatrical performance – no doubt a function of my anthropological training and appreciation for the nuanced dramaturgy of everyday life. But I had no background or formal training in performance. So I collaborated with a theatre director/playwright and embarked on a very steep learning curve. I learned that 'staging data' requires a different kind of interpretation to create a storyline, scenes, and characters informed by research. I came to see the power of theatrical devices like music, dance, and metaphor to engage audiences. Yet just as my work on embodied selfhood in the context of clinical health research was quite "transgressive" (one need only consider the devaluation of critical qualitative research within health research with the rise of the neoliberal knowledge economy), so too was my use of theatre given the importance accorded to the economic functions of knowledge at the expense of its social functions. But I nonetheless persisted with this work – art for social justice – driven by a deep and unwavering commitment to making this a better world for people living with dementia.

I succeeded in obtaining funding to support this work from federal agencies, foundations and societies. And the work has proven highly successful in conveying the principles of embodied selfhood, in decreasing formal and informal care providers' prejudices regarding dementia, and in triggering individual and collective action to address stigma and improve dementia care. While the arts have proven to be critical to achieving my efforts to humanize dementia care, critical social theory is no less significant. I have enriched the theory of embodied selfhood by drawing on political theory, moral philosophy, and feminist care ethics; this theoretical work has helped me to conceptualize and articulate a new ethic for dementia care

that promotes human flourishing. I do believe it is of great moral urgency to challenge the current biomedical ethics of reductionism, which contributes to the dehumanization of persons living with dementia, denies them their dignity and human rights, and threatens their health, well-being, and quality of life. This is my commitment.

My work involves the use of critical social theory and arts-based approaches to examine and address the norms and assumptions underpinning care practices in long-term care and rehabilitation settings. I use diverse critical theoretical perspectives and qualitative and arts-based methodologies to challenge dominant assumptions that marginalize individuals because of age, cognitive impairment, or other forms of disability, and to foster critical reflection and trigger practice change.

I am very interested in the body as a site for the inscription of discourse and the making of particular subjectivities, and the foundational ground for capacities, senses, and experiences of human agency. This has helped me to expand the discourse on dementia by providing the intellectual and narrative resources to examine selfhood and the experience of dementia, and its interconnections with history, culture, power, and discourse. I would be interested in exploring how such a perspective might inform understanding of physiotherapy/rehabilitation practices in other clinical areas that involve work with individuals with either cognitive or physical impairment (e.g. stroke, Parkinson's disease), or both.

Relevant Publications: See all publications at Google Scholar: https://scholar.google.ca/citations?user=*waFWA8AAAAJ&hl=en&oi=ao*

Kontos, P., Grigorovich, A., Kontos, A., Miller, K.L. Citizenship, human rights, and dementia: Towards a new embodied relational ethic of sexuality. Dementia: The International Journal of Social Research and Practice (Special Issue on Citizenship). 2016; 15(3); 315-329.

Gray, J., Kontos, P. Immersion, embodiment, and imagination: Moving beyond an aesthetic of objectivity in research-informed performance in health. Forum Qualitative Sozialforschung / Forum: Qualitative Social Research. 2015; 16(2), Art. 29.

Kontos, P., Miller, K.L., Mitchell, G., Stirling-Twist, J. Presence redefined: The reciprocal nature of engagement between elder-clowns and persons with dementia. Dementia: The International Journal of Social Research and Practice. 2015; DOI: 10.1177/1471301215580895.

Kontos, P., Miller, K.L., Colantonio, A., Cott, C. Grief, anger, and relationality: The impact of a research based theatre intervention on emotion work practices in brain injury rehabilitation. Evaluation Review 2014; 38(1):29-67.

Kontos, P., Martin, W. Embodiment and dementia: Exploring critical narratives of selfhood, surveillance, and dementia care. Dementia: The International Journal of Social Research and Practice (Special Issue: Embodiment and Dementia) 2013; 12(3):288-302.

Kontos, P., Miller, K.L., Gilbert, J.E., Mitchell, G.J., Colantonio, A., Keightley, M.L., Cott, C. Improving client-centered brain injury rehabilitation through research-based theater. Qualitative Health Research 2012; 22(12):1612-1632.

Kontos, P. Alzheimer expressions or expressions despite Alzheimer's?: Philosophical reflections on selfhood and embodiment. Occasion: Interdisciplinary Studies in the Humanities 2012; 4(May 31). Retrieved from http://arcade.stanford.edu/sites/default/files/article*pdfs/OCCASION*v04*Kontos*0531120*.pdf.*

Relevant Links:

http://www.dlsph.utoronto.ca/faculty-profile/kontos-pia/

https://www.uhnresearch.ca/researcher/pia-kontos

http://www.ccqhr.utoronto.ca/graduate-education/instructors-and-bios/pia-kontos

Susanne Rosberg

13 September 2018

From the beginning of my PT career 1973 critically questioned the reductionistic medical and positivistic paradigms in understanding and developing physiotherapy, separating body, soul and person. Took an active part in the creative professional development of “psychiatric” and “psychosomatic” physiotherapy in Sweden in the 1970-80 – where we were starting up the section in our trade union, giving courses and implementing our thoughts of the meaning and practice of movement, body awareness, training in therapeutic relationships etc in the curricula at the PT education in Sweden. My dissertation 2000 - “Body, being and meaning in a PT perspective” was a further step into a more theoretical development. I have a background in dance and movement improvisation and my main competence and interest is in qualitative research, phenomenology, the awareness of the lived body, movement and its implications for rehabilitation. I teach research methodology, paradigms, concepts, models and theories in PT at masterlevel and is part of the development of a new interprofessional Master Programme with a special in Health Care Development.

Relevant critical publications:

Samuelsson B, Rosberg S. (2018). Nonverbal affect attunement in mentalization-based treatment for patients with borderline personality disorder. Body, Movement and Dance in Psychotherapy. Published online: 15 Mar 2018.

https://www.tandfonline.com/doi/abs/10.1080/17432979.2018.1447015?journalCode=tbmd20

Öhlund H, Danielsson L, Rosberg S. (2018) Anxiety management – Participants' experiences of a physiotherapeutic group treatment in Swedish psychiatric outpatient care. Physiotherapy Theory and Practice. Published online: 18 Jun 2018. https://www.tandfonline.com/doi/abs/10.1080/09593985.2018.1485192?journalCode=iptp20

Danielsson L, Kihlbom B, Rosberg S.(2016). "Crawling Out of the Cocoon": Patients' Experiences of a Physical Therapy Exercise Intervention in the Treatment of Major Depression. Physical Therapy. Physical therapy, August 2016, Vol.96(8), pp.1241-50 https://www.ncbi.nlm.nih.gov/pubmed/26847007

Danielsson L, Rosberg S. (2015). Opening towards life: Experiences of Basic Body Awareness Therapy in Persons with Major Depression. Int J Qual Stud Health Well-being. 2015 May 7;10:27069. doi: 10.3402/qhw.v10.27069. https://www.ncbi.nlm.nih.gov/pubmed/?term=Opening+towards+life%3A+Experiences+of+Basic+Body+Awareness+Therapy

Danielsson L, Rosberg S. Depression embodied: an ambiguous striving against fading. Scand J Caring Sci. 2015 Sep;29(3):501-9. doi: 10.1111/scs.12182.

Danielsson L, Hansson-Scherman M, Rosberg S. (2013). To sense and make sense of anxiety: Physiotherapists perceptions of their treatment of patients with anxiety. Physiother Theory Pract. 2013 Nov;29(8):604-15.

Wickford, J, Edwards I, Rosberg S (2012). A transformative perspective on learning and professional practice development of Afghan physiotherapists. Physiother Theory Pract 2012:28(4):269-82.

Jingrot M. Rosberg S. (2008) Gradual loss of homelikeness in exhaustion disorder. Qualitative Health Research. 2008:18(11);1511-23.

Rosberg S. (2012) A Symbolic interactionist perspective on the creation of meaning in the physiotherapy treatment room. (In Swedish: Ett socialpsykologiskt perspektiv på meningsskapande i sjukgymnastik) Book chapter in: Biguet, G, Keskinen Rosenqvist R, Levy Berg A (red) Understanding the messages of the body - physiotherapeutic perspectives. (in Swedish: Att förstå kroppens budskap – sjukgymnastiska perspektiv). Lund: Studentlitteratur.

Rosberg S. (2000). Body being and meaning, a physiotherapeutic perspective. Thesis, Gothenburg University. Abstract in English:

https://www.researchgate.net/publication/237753710_Body_Being_and_Meaning_in_a_Physiotherapeutic_Perspective_Summary_of_a_thesis

Gunn Kristin Øberg

14 September 2018

After many years working as a PT in clinical practice with infants at risk for subsequent motor development, I entered the world of academia as a Ph.D. student in 2003. My motivation came from a growing interest in exploring the key features of successful early developmental interventions, as I had experienced a diverse outcome of physical therapy to our youngest patients with similar medical history. Also, the research in the field was scarce. In my Ph.D. study, an observational and interview study, I therefore explored clinical physical therapy practice with preterm infants. The findings underscored the association between sensemaking, mutuality, interaction, handling, and quality of movements in preterm infants. Since then I have been curious about what physical therapy is and can be in theory and practice. Accordingly, my interest in the field of critical physical therapy is on critical explorations of professional healthcare practices; 1) the knowledge base for physical therapy in general and in pediatric physical therapy in particular and 2) content, form and efficacy in therapeutic processes and relationships. My competence in research methods is first and foremost in qualitative research. I largely utilize the perspectives of the phenomenology of the body and "enactivism" when examining complex interventions, framework, and physical therapy practices.

Relevant critical publications:

Øberg, Gunn Kristin; Ustad, Tordis; Jørgensen, Lone Kaaresen, Per Ivar Labori, Cathrine Girolami, Gay L. (2018). Parents` Perceptions of administering a Motor Intervention with Their Preterm Infant in the NICU. European Journal of Physiotherapy. DOI: 10.1080/21679169.2018.1503718 (Nivå 1)

Sørvoll, Marit; Obstfelder, Aud; Normann, Britt; Øberg Gunn Kristin (2018). Perceptions, actions and interactions of supervised aides providing services to children with cerebral palsy in pre-school settings: a qualitative study of knowledge application. European Journal of Physiotherapy. DOI: 10.1080/21679169.2018.1452978

Sørvoll, Marit; Obstfelder, Aud; Normann, Britt; Øberg Gunn Kristin. (2018). How physiotherapists supervise to enhance practical skills in dedicated aides of toddlers with cerebral palsy: A qualitative observational study. Physiotherapy, Theory and Practice. DOI:10.1080/09593985.2018.1453003

Håkstad, Ragnhild B.; Obstfelder, Aud; Øberg, Gunn Kristin (2018). A qualitative study of Clinical Reasoning in Physiotherapy with Preterm Infants and Their Parents: Action and

Interaction. Physiotherapy, Theory and
Practice. https://doi.org/10.1080/09593985.2017.1423524

Håkstad, Ragnhild B.; Obstfelder, Aud; Øberg, Gunn Kristin (2017). Let`s play. A Qualitative Study of Primary Care Physical Therapy With Preterm Infants Aged 3-14 Months. Infant behavior and development. 46; 115-123.

Blanchard, Yvette; Øberg, Gunn Kristin (2015). Physical therapy with newborns and infants: Applying concepts of phenomenology and synactive theory to guide interventions. Physiotherapy Theory and Practice. ISSN 0959-3985.s doi: 10.3109/09593985.2015.1010243.2015

Håkstad, Ragnhild B.; Obstfelder, Aud; Øberg, Gunn Kristin (2015). Parents' Perceptions of Primary Health Care Physiotherapy With Preterm Infants: Normalization, Clarity, and Trust. Qualitative Health Research 2015. ISSN 1049-7323.s doi:10.1177/1049732315608137

Øberg, Gunn Kristin; Normann, Britt; Gallagher, Shaun (2015). Embodied-Enactive clinical reasoning in physical therapy. Physiotherapy Theory and Practice. ISSN 0959-3985.s doi:10.3109/09593985.2014.1002873

Normann, Britt; Fikke, Hanne Kristin; Øberg, Gunn Kristin (2015). Somatosensory impairments and upper limb function following stroke: Extending the framework guiding neurological physical therapy. European Journal of Physiotherapy. ISSN 2167-9169.s doi:10.3109/21679169.2015.1031175

Øberg, Gunn Kristin; Blanchard, Yvette; Obstfelder, Aud (2014). Therapeutic encounters with preterm infants: interaction, posture and movement. Physiotherapy Theory and Practice, Volum 30 (1). ISSN 0959-3985.s 1 - 5.

Aydee Louisa Robayo Torres

15 September 2018

I'm a woman, I'm a physiotherapist trained in South America with a strong influence from the Swedish physiotherapy of the Institute Karolinska, which in an early stage opened my eyes to deep questions and investigative paths about my profession. This somewhat "schizophrenic" perspective has allowed me to put into tension and judgment what today is considered true and good as an absolute. I believe that the possibilities of truths are transitory, as well as that not everything old is obsolete. I go to my trunk of perspectives and approaches whenever I can to review the epistemological frameworks that made me dream one day of being a physiotherapist at the service of my country.

I am a teacher at the number 1 public university of my country, National University of Colombia, underlining the meaning of public and what this involves. I am a teacher

accompanying students to build their own interpretive framework with the understanding that the context in which I was trained and formed as a physiotherapist no longer exists. The student is now, the child of their own history and their own time. Having their own context as they can never be in the same context in which I learned; meaning that physiotherapy is always being transformed by the actors that play in it, and I am happy to be part of that construction. Finally, I am part of the CPN because I think that learning must be networked, especially if we want to keep critical thought about our profession.

Publicaciones relevantes a fisioterapia crítica:

- Jose Agustín, cartógrafo Histórico, Revista Colombiana de Educación, N-61, Julio-Diciembre 2011, pgs.221-251
- Los arazosos e imaginarios viajes de Clotilde-2 por el Campo Conceptual de la pedagogía, Revista Colombiana de Educación, N-61, Julio-Diciembre 2011, pgs-299-316.
- Tras la riqueza de las subjetividades de las maestras de la Universidad Pública Colombiana., en las memorias del III Congreso Internacional y VIII Nacional de Investigación en Educación, Pedagogía y Formación Docente, 212 al 24 de agosto de 2012, ISBN: 978-958-8650-30-2.
- Comunidades discursivas-narrativas en la universidad pública, Revista Iberoamericana para la investigación y el desarrollo educativo, N.10, Enero 2013, p.1-19,ISSN 2007-2619
- Prácticas corporales acerca del cuidado de sí en la comunidad indígena Sikuani, Fac. Med. 2013 Vol. 61 No. 4: 381-384.
- Diseño de un prototipo de bipedestador para pacientes pediátricos con espina bífida, Rev. Fac. Med. 2013 Vol. 61 No. 4: 423-429.
- Subjetividades docentes en la universidad pública colombiana. Comunidades de práctica a propósito de sus narraciones, Revista Colombiana de Educación, 2015, Vol.68, pgs: 229-263
- Intervención fisioterapéutica en el niño quemado: construcción desde la practica basada en la experiencias, , Fac. Med. 2016 Vol. 64 Sup.1: 39-46.
- Narrativas de la corporeidad en ciclistas colombianos durante su proceso formativo, , Fac. Med. 2016 Vol. 64 Sup.1: 113-118.
- Discurso fisioterapéutico, esguince a la subjetividad, Rev. Fac. Med. 2016 Vol. 64 Sup.1: 25-30.
- Una reflexión acerca de la piel como territorio del derecho, **Revista de la Asociación Colombiana de Fisioterapia (ASCOFI**), Vol. 56, 2016: pgs: 136-147.

LIBROS o Capítulos de Libros:

- **Capítulo** POSICIÓN SEDENTE EN DAÑO CEREBRAL, en el libro GUÍA PARA PADRES, patrocinado por INSERSO y FEDACE, de España, 2004. (www.fedace.org.es)

Subjetividades docentes en la universidad pública colombiana. Comunidades de práctica a propósito de sus narraciones, Editorial Publicia, ISBN 978-3-639-55360-4, Alemania, 2015.

Tobba Sudmann

16 September 2018

I've been a student almost all my life; since my training as a physiotherapist in the mid 80-ies I've studied psychology, pedagogy, law, and social science (health and social policy, medical sociology). I did my Master of Philosophy in physiotherapy/social science in the late 90-ies, and my Ph.D. in 2009, at the Department of Global Health and Primary Care at the University of Bergen in Norway. As a clinician, I trained as a Bobath therapist and worked for several years as a clinical tutor for students from the Physiotherapy Program at Bergen University College. I have updated my clinical competence in the last decade and are now certified as a riding physiotherapist and equestrian trainer (beginners' level).

I like to think about myself as a lifelong curious learner and student of how people live and use their bodies in everyday life. The CPN network has been a stimulating playground and fascinating place to meet all kinds of physio's, and it has been particularly inspiring to meet colleagues around the globe who have pondered with the same ideas, text or clinical challenges. The CPN network is as other networks; it must be nourished to thrive and grow. The efforts the collective of members put into keeping it vibrant and attractive pays off – new friends, new ideas, new publications, new challenges and new kinds of barriers to climb. Tackling barriers and obstacles can kill motivation, but it can also trigger joy and creativity, as in edgework or parkour (see article by Nordgreen et al 2018 below).

My current position is as an Associate Professor at the Department of Health and Functioning, at Western Norway University of Applied Sciences. Additionally, I have a part-time position as an outdoor riding physiotherapist. My research interests are related to how people use their bodily resources to enhance their well-being and social participation, whether the means are in- and outdoor physical activity, nature, and animals, or e-health/technology. My publications and research are action-oriented, both as a means of research methodology and as an aim of research. Anti-oppressive professional practice is at the hub of my interests.

I find it intriguing and inspiring to use perspectives from social theory, particularly the sociology of everyday life and the sociology of difference, to understand how health and illness is lived, experiences and constructed. I have a particular interest in medicalization, in social inequalities in health, anti-oppressive practice in health and social care, and gender

issues (and the intersection with age, ethnicity, health and so forth). Following, philosophy of social science becomes equally inspiring to read.

The CPN network represents a scholarly treasure chest and an alternative network of PTs believing we are thinking and acting "differently". Being or doing physiotherapy "differently" is important; in so far it means first to acknowledge patients motivations, prioritizations and resources. Second, and even more important, social inequality, oppression, marginalization or abuse has a huge impact on health and well being, that must be acknowledged and approached by physiotherapists during assessment, and when choosing treatment modalities and outcome measures. Our toolkit needs to be amended accordingly.

Selected publications in English:

Sudmann, T. T. (2018). Equine-facilitated physiotherapy – devised encounters with daring and compassion. https://press.nordicopenaccess.no/index.php/noasp/catalog/view/29/123/974-2

Sudmann, T., & Breivik, J.-K. (2018). Editorial: special issue on community work and going glocal in Scandinavian Welfare States. *Community Development Journal*, https://doi.org/10.1093/cdj/bsy018

Sudmann, T. (2018). Communitas and Friluftsliv: equine-facilitated activities for drug users. *https://doi.org/10.1093/cdj/bsy026*

Breivik, J.-K., & Sudmann, T. (2018). Applying creativity and physical arts in community work education. *Community Development Journal*, undefined-undefined. https://doi.org/10.1093/cdj/bsy022

Nordgreen, L., Økland, M., Henriksbø, K., & Sudmann, T. (2018). Negotiating obstacles in the making of a parkour site at Leitet – children and young people's participation in area development. *Community Development Journal*, undefined-undefined. https://doi.org/10.1093/cdj/bsy019

Sudmann, T. T., et. al (2017). Ultra Wide Band Radar Monitoring of movementes in homes of elderly and disabled people: A health care perspective. In P. Bilski & F. Guerriero (Eds.), *Computer Systems for Healthcare and Medicine* (pp. 1-30). Aalborg, Danmark: River Publisher.

Sudmann, T. T., & Børsheim, I. T. (2017). 'It's good to be useful': Activity provision for people living with dementia on green care farms in Norway. *International Journal of Practice Development, 7*(September Supplement article 8). *https://doi.org/10.19043/ipdj.7SP.008*

Sudmann, T. T., et. al(2016). Development of radar-based system for monitoring of frail home-dwelling persons: A healthcare perspective. *Journal of Physics: Conference Series, 772*(1), 012015. *http://iopscience.iop.org/article/10.1088/1742-6596/772/1/012015/pdf*

Sudmann, T. T., et. al (2015). UWB-radar monitoring of movements in homes of elderly and disabled people—An interdisciplinary perspective (RADCARE). *IEEE 8th International Conference on Intelligent Data Acquisition and Advanced Computing Systems: Technology and Applications (IDAACS), 2*, 747-750. *https://doi.org/10.1109/IDAACS.2015.7341402*

Ihle, R., & Sudmann, T. T. (2014). Health Encounters with Minority Patients – Changing Perspectives from Tolerance and Intercultural Communication to Empowerment and Shared Decision-Making *FLEKS Scandinavian Journal of Intercultural Theory and Practice, 1*(2). *https://brage.bibsys.no/xmlui/bitstream/handle/11250/2481808/Ihle+Sudmann+2014+Health+encounter+with+minoruity+patients.pdf?sequence=4*

Sudmann, T. T. (2009). *(En)gendering body politics. Physiotherapy as a window on health and illness.* (PhD Monography), University of Bergen, Bergen. Retrieved from *http://hdl.handle.net/1956/3143*

Patty Thille

17 September 2018

I am something of a hybrid: a sociologist with a clinical background in physical therapy. While working in clinical practice in Saskatchewan, Canada (1998-2002), I had many questions about why we clinicians do what we do, particularly about how dominant discourses about thinness/fatness, gender, and more shape clinical services. The difficulties I had finding answers led me to pursue advanced degrees in social sciences (Women's Studies MA; Sociology Ph.D.).

In my research, I aim to foreground the relations – the connections made and unmade – in health care that produce inequalities and inequities. I use varied social theories and qualitative methodologies to identify patterns and influences - structural, discursive, interpersonal, and embodied - on practice. My first focus: how people can be blamed and shamed in clinical care, with a specific focus on fat-related stigmatization and self-management support. Following the actor-network theory sensibility of following connections wherever they lead, my Ph.D. took me out of the clinic to examine attempts to govern clinical practices through strategies such as continuing education and guidelines. Most recently, I have added an intervention angle, co-designing and evaluating reflexivity and transformative educational opportunities for practicing clinicians with CPN colleagues Drs. Barbara Gibson, Thomas Abrams, and Jenny Setchell.

I am an Assistant Professor in the Department of Physical Therapy, College of Rehabilitation Sciences at the University of Manitoba. I so appreciate how the CPN has introduced me to physiotherapists who share interests; please be in touch!

Selected Publications:

Thille P, Gibson BE, Abrams T, McAdam L, Mistry B, Setchell J. (2018). Enhancing the human dimensions of children's neuromuscular care: Piloting a methodology for fostering team reflexivity. Advances in Health Sciences Education. doi: 10.1007/s10459-018-9834-1

Thille P. (2018). Managing anti-fat stigma in primary care: An observational study. Health Communication. doi: 10.1080/10410236.2018.1439276

Thille P, Friedman M, Setchell J (2017). Weight-related stigma and health policy. CMAJ, 189(6), E223-4. doi: 10.1503/cmaj.160975

Thille P, Ward N, Russell GR (2014). Self-management support in primary care: Enactments, disruptions, and conversational consequences. Social Science & Medicine, 108(May), 97-105. doi: 10.1016/j.socscimed.2014.02.041

Catharina Broberg

18 September 2018

My interest is in the history and development of physiotherapy as a profession and a discipline and I am still involved in some research work on this subject. I am also interested in concept analysis and the relation of concepts in PT to other disciplines and to ICF.

I have followed this blog with great interest for a couple of years, and was further encouraged when you referred to an article by me and collaborators about the knowledge base of PT I February 2016. (http://criticalphysio.net/2016/03/03/capturing-physiotherapy/) I think that the development of PT in the Nordic countries, both historically and presently, may contribute to further development of PT.

Michael Rowe

19 September 2018

I'm an Associate Professor and Departmental Chair in the Department of Physiotherapy at the University of the Western Cape (South Africa) where I conduct research into the use of digital technologies in the classroom and their influence on teacher and student relationships. My Ph.D. evaluated the use of technology-mediated practices for clinical education and led to the development of design principles for blended learning environments in health profession education. More recently I have been developing an area of research on the impact of artificial intelligence in clinical practice and health professions education. I believe that machine learning will have an important influence on clinical decision-making and that the 21st-century healthcare agenda should not be driven solely by the values of governments, private venture capitalists and software developers in the global north.

I am the editor of OpenPhysio, a new open access journal with a focus on physiotherapy education that aims to challenge traditional assumptions about academic publication and

research dissemination. I am also the co-founder of In Beta, an international community of practice that aims to develop a series of conversations around the practice-based experiences of physiotherapy educators from around the world.

I love technology. No, seriously. In ways that some people may consider to be disturbed. I prefer winter to summer. I read a lot with the intention of learning how to be less wrong. I like mountain biking and would like to do it more often but the reality is that mountains are steep and getting up early on the weekend is a hassle. I have completed 13 independent skydives and 2 bungee jumps. I have wrestled a crocodile.

relating to critical physiotherapy (about 100 words): I'm interested in the value of a critical pedagogy to think differently about the taken-for-granted assumptions we have about how to approach higher and professional education.

Any other thoughts about you and the CPN: I'm inspired by the diversity of ideas that are shared and discussed by network members. Even if I don't always agree with the perspectives being shared, I find that I'm constantly challenged to re-evaluate what I accept as "ground truth".

Relevant critical publications:

Rowe, M. (2018). A critical pedagogy for online learning in physiotherapy education. In Gibson, B., Nicholls, D., Setchell, J. & Synne Groven, K. (Eds.) Manipulating practices: A critical physiotherapy reader. Cappelen Damm Akademisk, Norway.

Guillaume Christe

20 September 2018

I am is a physiotherapist specialized in musculoskeletal disorders and I work at the Department of Physiotherapy, Haute Ecole de Santé Vaud (HESAV) in Switzerland and in private practice. In 2010, I did a specialization in Manual Therapy and finished an MSc in Physiotherapy at Brighton University in 2015. I am currently doing a PhD on the association between spinal motor behaviour and psychological factors in CLBP patients. I am also doing research examining beliefs about back pain in Switzerland. As an educator, I am particularly interested in helping students to be better critical thinkers, and I love challenge their beliefs about physiotherapy. Particularly, I try to shift their focus from purely biomechanical perspectives to more holistic perspective on care. I am also interested in clinical reasoning and the internalization process of pre and post graduate PT students. I love being challenged with new ideas.

Reasons for interest in Critical Physiotherapy Network: Having a critical reflection on the way physiotherapy is practiced, taught and researched is essential for the profession. This

network constantly offers new ideas, new thoughts on the profession, and it is a great place to start discussions and reflection.

Relevant critical publications:

Ellis, B & Christe, G. (2017). Internationalising the physiotherapy curriculum through a transnational collaborative digital learning project, Volume 103, Supplement 1, Pages e2–e3

Anna Rajala

21 September 2018

I have a background in dancing which was my original reason to study physiotherapy. I graduated in 2008 after which I found a new inspiration in geriatric physiotherapy. I had a very inspiring philosophy teacher at secondary school (or lukio in Finnish) and ever since I've had a fascination with philosophical thinking (fun fact: every Finnish lukio student has to take at least one philosophy course). The fascination has proved incurable, at least ever since I met my philosophical "enabler" and revolutionary soul mate who introduced me to dialectics from Hegel to Adorno. In 2011 we packed our belongings (mostly books) in a cheap van a moved from Finland to the UK, where I have finally been able to trace back my interests in the moving body, the aging body and dialectical philosophy both for my Master's degree and my soon-to-be-finished Ph.D. At the moment (apart from finalizing my dissertation) I'm teaching a few humanities courses at the University of Brighton. I'm also running a webpage with my dear friend and colleague in which we introduce and evaluate research (what constitutes 'evidence' for us includes both human and natural sciences) on mental health physiotherapy in Finnish, to promote accessibility and democracy of knowledge beyond paywalls. I first heard about the CPN in 2014 and have been a member since 2015 and glad and proud to be so. Philosophy isn't exactly a goldmine in the earing-a-living front, but the CPN reminds me why I do what I do (even if I would have to repeatedly pawn my overcoat): we have a chance and the means to change the way we perceive physiotherapy theory and practice. My CV, publications and philosophical ramblings can be found at https://criticalhealthphilosophy.wordpress.com/.

I am interested in moral philosophy and moral practice, mental health, aging and old age, dialectics, and theories of recognition in physiotherapy and healthcare. The core of my theoretical practice draws from modern European philosophy (especially Frankfurt School and Hegel). Other sources for my inspiration include humanities (especially early modern and modern/ist literature) and critical social and political theory. My Ph.D. research is on critical theory and bioethics, with projects on recognition and the ethical force of "materialism of disgust" brewing on the side.

Thinking otherwise about physiotherapy can indeed be a very lonely practice. Knowing that there is a growing global community of otherwise-thinking physiotherapists is an inspiration, and it is not an exaggeration to say that my research would have taken a different direction without this inspiration. The CPN has been invaluable in bringing people together and creating a space for critical thinking about physiotherapy.

Relevant critical publications:

Rajala, Anna Ilona. ”What can critical theory do for the moral practice of physiotherapy?” In *Manipulating Practices: A Critical Physiotherapy Reader,* edited by Barbara E. Gibson, David A. Nicholls, Jenny Setchell, and Karen Synne Groven, 55–77. Oslo: Cappelen Damm Akademisk, 2018. DOI: doi.org/10.23865/noasp.29

Rajala, Anna Ilona. “Pitkäaikaishoivan ruumiillisuuden arvosta [On the value of embodied long-term care].” In Ruumiillisuus ja työelämä: työruumis jälkiteollisessa taloudessa [Embodiment and working life: working body in post-industrial economy], edited by Jaana Parviainen, Taina Kinnunen, and Ilmari Kortelainen, 132-145. Tampere: Vastapaino, 2016.

Rajala, Anna & Jenni Aittokallio. ”Dikotomiat ajattelun kahleina. Mitä teorian ja käytännön erottelu merkitsee fysioterapeutin työssä? [Dichotomies shackle thinking. What does the theory-practice division mean for physiotherapy practice?]” *Fysioterapia* 61, no. 5 (2014): 27–31.

Lester Jones

22 September 2018

Hi everyone. My name is Lester Jones and I am a pain physiotherapist and educator. I have spent a long time at university and in the clinic exploring human health and behaviour including 4 years of psychology and a Masters degree in pain. If I had been driven in a different way, I would have spent that time doing a PhD - thankfully I wasn't - but now I find myself back at university doing just that with the amazing research group at Judith Lumley Centre. In my research, I am interested in the multiple dimensions of pain and how we can work with the complexity in different contexts. I was the inaugural chair of the APA National Pain Group and currently, I am on the committee for the International Association for the Study of Pain SIG Pain associated with Torture Organised Violence and War. I have also just moved to Singapore to take up a position at the Singapore Institute of Technology.

I was made aware of the CPN early on and was so pleased to read exchanges and postings from the members that gelled with my ideas about physiotherapy and health and well being! I realised I was not alone! While I am a long way from claiming to be a critical theorist I feel that my philosophy of practice aligns more with engagement with the person, culture, and

community, than concepts focused on structure and reductionism which seem common in our profession.

My thinking, writing, and research have involved exploring pain - definitions, purpose and management - with the help of wonderful colleagues. I co-developed the Pain and Movement Reasoning model, a clinical reasoning tool, with Des O'Shaughnessy in the mid-2000s when we both found ourselves in London asking the same questions. We developed a tool that allowed for the dynamic quality we see with pain, where it can change from context to context, from one meaning to another at any given moment while preserving the domains that contribute to the experience - bio-psycho-social. We eventually got around to publishing it in 2014. My most recent work with Laura Whitburn has explored the nature of labour pain. This came from some extended time at the Judith Lumley Centre where I set myself a task to explore why is labour, a normal and necessary physiological process, painful?...and often very very painful and sometimes barely painful, if at all! This drew my focus to the social aspects of pain - after all, we would not express the pain we feel if it did not have a social function - so, what if pain expression and pain perception evolved together - have we underplayed the social component of pain for too long? ;-) **Relevant publications**:

Whitburn, L.Y., Jones, L.E., Davey, M-A. and McDonald, S. (2018) The nature of labour pain: An updated review of the literature. *Women and Birth*

Jones, L. E. (2017). Stress, pain and recovery: Neuro-immune-endocrine interactions and clinical practice. In S. B. Porter (Ed.), *Psychologically-informed physiotherapy: embedding psychosocial perspectives within clinical management.* (pp78-106). Edinburgh: Elsevier.

Whitburn, L. Y., Jones, L. E., Davey, M. A., & Small, R. (2017). The meaning of labour pain: how the social environment and other contextual factors shape women's experiences. *BMC Pregnancy and Childbirth*, 17(1), 157.

Whitburn, L. Y., Jones, L. E., Davey, M. A., & Small, R. (2017). Supporting the updated definition of pain. But what about labour pain? *Pain*, 158(5), 990-991.

Jones, L.E., Whitburn, L.Y., Davey, M-A. & Small, R. (2015) Assessment of pain associated with childbirth: women's perspectives, preferences and solutions. *Midwifery*, 31(7), 708-712.

Amir, L., Jones, L.E. & Buck, M. 2015 Nipple pain associated with breastfeeding: incorporating current neurophysiology into clinical reasoning. *Australian Family Physician* 44(3), 127-132.

Jones, L.E. & O'Shaughnessy, D.P. 2014 The pain and movement reasoning model: introduction to a simple tool for integrated pain assessment. Manual Therapy, 19(3), 270-276

Thomas Abrams

23 September 2018

I've never taken things particularly seriously, either academically or living with muscular dystrophy. Having stumbled into physio—literally, I kept falling over, so they made me go—I started thinking sociologically while in the waiting room. I found that I could do two things at once, picking apart my personal experience of disability while poking holes in the Serious Science of Physical Therapy. Why all this goal setting, why all this paperwork? I had been reading a lot of critical theory, you know, Foucault, Heidegger, and the like, without a place to make sense of it. Though I had never really thought of myself as a disabled person, as I started going through the disability bureaucracy more and more, I found myself asking the same questions, and doing so with these thinkers. Why do we treat disability as we do? Why do we pity people, poke and prod them, but not talk about poverty? Such was my introduction to disability studies, and, it seems, to critical physiotherapy (without knowing it at the time).

Reading through other literature making use of personal accounts of illness and disability, I found I wasn't alone. Arthur Frank's *At the Will of The Body* still has a hold on me to this day. Or Britt Robillard's fantastic ethnomethodological work on disability jokes, and life in the intensive care unit. Frank's book was profound, Robillard's extremely funny. Emotion and passion-free accounts of life with disability didn't make sense to me, any more than the stiff upper lip of the Serious Science of Physical Therapy.

I moved to Toronto for a postdoctoral fellowship, and lo and behold, someone had read (!) and enjoyed (!!) my paper complaining about physiotherapy. Simply by whining with big words like "ontology" or "ethnomethodology", I was introduced to Dave Nicholls, to Barbara Gibson, and Jenny Setchell, to qualitative health research, and a whole world of people who felt some unease with the way we lived and worked with health, illness, and disability. Maybe not the same unease, but a shared belief in a necessary change of course. Collaborating through this unease, we have started to chart the clinical treatment of Duchenne muscular dystrophy, to map how clinicians feel about their role in all of this, and asking those questions about emotions and finances that I hadn't been asked before. My journey through the CPN has been a move from the business end of physical therapy to questioning and reframing, somewhat, the rehabilitation business as a whole. It also landed me my dream job, teaching social theory. I hope I can continue these discussions, and the CPN's spirit of collaboration, as I join the sociology faculty at Queen's.

Relevant critical publications:

Abrams, T., Setchell, J., Thille, P., Mistry, B. and Gibson, B.E., (Forthcoming) "Affect, Intensity, and Moral Assemblage in Rehabilitation Practice." *BioSocieties.* DOI: 10.1057/s41292-018-0115-2

Abrams, T. (2016). *Heidegger and the Politics of Disablement*. London: Palgrave Macmillan.

Abrams, T. (2014). “Flawed by Dasein? Phenomenology, Ethnomethodology, and the Personal Experience of Physiotherapy”, *Human Studies.* 37(3). pp. 431-446.

Karen Whalley Hammell

24 September 2018

It is almost 40 years since I became an occupational therapist. I was a student in Liverpool and then a clinician, first in a large university teaching hospital in Oxford, then in a regional rehabilitation centre in Saskatchewan, Canada, and subsequently in a rural area of Saskatchewan. After some years in this role I decided to upgrade my education, so returned to the UK, and the University of Southampton, to undertake an MSc in Rehabilitation Studies. It was here that I met the work of critical disability theorists, such as Oliver and Barnes, whose work resonated so strongly with my own experiences of living and working with disabled people that I can recall sitting up in bed, reading their work with my heart pounding. The social model of disability was a revelation to me and supported my clinical perceptions that the problems confronting disabled people have more to do with their inequitable opportunities and resources than their physical conditions. I followed the MSc with a Ph.D. in Interdisciplinary Studies (Anthropology, Sociology, Rehabilitation Sciences) at the University of British Columbia, Vancouver.

I have always challenged those in authority. I simply cannot accept what I am told by those in positions of power unless their words are reinforced by evidence or by my own experience. This contributed to making my school years profoundly unhappy and has also led to my ongoing challenge to the leaders within my profession. So when some of our profession’s leaders advanced a model of occupation that comprised three core categories: self-care, productivity and leisure, I was initially excited that the occupational therapy profession was formally declaring itself to be concerned, not solely with self-care skills, but with the various productive and leisure occupations that contribute so much meaning and purpose to people’s lives. But over time, I began to question these three categories, which made little sense in the farming communities where I worked, even less sense to the participants in my doctoral research into the experience of living with high spinal cord injury, and no sense at all to my own daily routines, nor those of my partner, nor parents. For several years I awaited the revision of the occupational categories that I was sure would be forthcoming. But instead, the categories became entrenched as lore, as if the common sense with which they had been informed had been accepted as a reasonable substitute for empirical evidence, and as if the pronouncements of our leading theorists were somehow deemed to be correct or “true”. These categories continue to be taught to students around the world as if they constitute some sort of evidence-informed wisdom, to be bestowed by the global north upon those in less enlightened parts of the globe.

And there are so many unchallenged, culturally-specific assumptions within my profession that are exported as if they constitute “truth”! For example, occupational therapy’s theorists have asserted that people choose, shape and orchestrate their daily occupations, yet this is clearly a marker of privilege. The majority of the global population simply do what has to be done, what they are compelled to do or what they have the (limited) opportunity to do. Poverty, ableism, misogyny, patriarchy, racism, classism and ageism constrain the real opportunities for the majority of the world’s people to use their abilities. Thus, the daily occupations of many women and girls in every nation, for example, are chosen, shaped and orchestrated by men.

I am convinced that improvements in human health and well-being can only occur with improvements in human rights; and I believe that because occupation is a determinant of health, that occupational rights are human rights. My current work is therefore focused on foregrounding the relationships between occupational engagement, well-being, and human rights. And I can never stop challenging the assertions of those in power!

Relevant critical publications (up to 10):

Hammell, K.W. (2017) Critical reflections on occupational justice: Towards a rights-based approach to occupational opportunities. Canadian Journal of Occupational Therapy 84(1):47-57.

Hammell, K.W. (2015) Occupational rights and critical occupational therapy: Rising to the challenge. Australian Occupational Therapy Journal 62(6):449-451.

Hammell, K.W. (2015) Respecting global wisdom: Enhancing the cultural relevance of occupational therapy’s theoretical base. British Journal of Occupational Therapy 78(11):718-721.

Hammell, K.W. (2015) Client-centred occupational therapy: The importance of critical perspectives. Scandinavian Journal of Occupational Therapy 22(4):237-243.

Hammell, K.W. (2013) Client-centred practice in occupational therapy: critical reflections. Scandinavian Journal of Occupational Therapy 20(3):174-181.

Hammell, K.W., Iwama, MK. (2012) Wellbeing and occupational rights: An imperative for critical occupational therapy. Scandinavian Journal of Occupational Therapy 19:385-394

Hammell, KW., Miller, WC., Forwell, SJ., Forman, BE., Jacobsen, BA. (2012) Sharing the agenda: Pondering the politics and practices of occupational therapy research. Scandinavian Journal of Occupational Therapy 19(3):297-304

Hammell, K.W. (2011) Resisting theoretical imperialism in the disciplines of occupational science and occupational therapy British Journal of Occupational Therapy 74(1):27-33

Hammell, K.W. (2009) Self-care, productivity and leisure, or dimensions of occupational experience? Rethinking occupational “categories”. Canadian Journal of Occupational Therapy 76(2):107-114

Hammell, K.W. (2009) Sacred texts: A sceptical exploration of the assumptions underpinning theories of occupation Canadian Journal of Occupational Therapy 76(1):6-13

Keith Waldron

25 September 2018

As a physio in the US, I have spent 8 years providing care in the public education system and private schools serving children with developmental delays and their families, 10 years in traditional outpatient care primarily serving patients with neuromusculoskeletal complaints, and I am now about to begin my 7th year in the home health setting mostly serving patients with chronic cardiovascular, respiratory, and neurological health complaints.

When I started my journey as a fresh/green physio, I recognized that my relationships with the children I was working with was of utmost importance as I tried to motivate 2- and 3-year-olds to engage in (fun!) play that would be beneficial to them. For some reason, though, I had the (false) impression that, as I morphed into an outpatient clinician working with adults, my hands were going to be most important. It took far too long for me to realize that - while my hands may be important - interconnected and engaging relationships were still the most important means by which we can bring about positive effects in our patients and communities.

Now, as a home health therapist in a large hospital network - while trying to develop and grow a small private-practice with an emphasis on geriatric care - I wonder how social and financial pressures are impacting my ability to provide care that best serves the patient under increasingly invasive, demanding, and persistent public-health models. I wonder how the commodification of service impacts my ability to be successful. I ponder if physio is still the right profession for me. The answers to such questions remain elusive. All the while, CPN is the rare space where I have an opportunity to read about what other physio are thinking about across the world and how we all struggle with some of the bigger questions that face our profession; I am reminded that I am not alone.

My interests in critical physiotherapy are both philosophical and pragmatic, trying to figure out how to balance the rights and needs of the individual with those of the larger community, providing humanistic care with the individual while appreciating the impact of the individual's health on the larger tribe. I am not a researcher, nor am I in academia; I am a humble clinician who is looking to the international physio community for occasional guidance and more frequent wisdom.

When the CPN launched a few years ago, I was hesitant to register as a member. I am a full-time clinician and (increasingly infrequent) blogger; I thought I would feel (1) a bit inadequate among some of the brightest thinkers in the worldwide profession of physio, and (2) like an all-too-large hanger-on. But I was convinced otherwise and have found a comfortable space reading, sharing, and occasionally networking and engaging with other members. My misgivings, it turns out, were unfounded.

Jenny Setchell

26 September 2018

I have been interested in the social and political aspects of anything my whole adult life – so when it came to researching physiotherapy and healthcare I guess it made sense that I followed these perspectives. This including co-founding the CPN with Dave Nicholls and Barb Gibson.

After completing my PhD which used weight stigma as a forum to investigate the socio-political aspects of physiotherapy. I have been fortunate enough to join with two wonderful and hugely influential teams for the past three years. One is super-critical and is at the University Toronto headed by Prof Barb Gibson (long term CPN executive member) and the other is led by Prof Paul Hodges at The University of Queensland and has produced ground-breaking work into low back pain research (amongst other things).

I have recently received a 4 year NHMRC Fellowship to apply the experience I have gained in these two great teams to musculoskeletal physiotherapy – which was my area of clinical expertise – so look out for some interesting critical publications in this space. In the next few weeks I will be advertising for a PhD student to join me in this work – so please let me know if you are interested – I have funding for full fee coverage plus a stipend for living expenses….. so if you want to move to Australia in early 2019 and get critical for the next few years (or know someone else who might) please get in touch! The position will be at The University of Queensland.

Theoretically speaking I am interested in post-modern and post-qualitative scholarship that is applied and clinical.

Publications:

Setchell J, Nicholls D, Gibson B. (2017) Objecting: Multiplicity and the practice of physiotherapy. Health. doi:10.1177/1363459316688519.

Gibson BE, Nicholls D, Setchell J, Synne Groven K. (2018) Manipulating practices: A critical physiotherapy reader. Oslo, Norway. Cappelen Damm.

Setchell J, Thille P, Abrams T, Mistry B, McAdam L, Gibson BE. (2018) Enhancing human aspects of care with young people with Muscular Dystrophy: Results from a participatory qualitative study with clinicians. Child: Care, Health and Development. 44(2):269-277.

Setchell J. (2017) Invited editorial: Stigma and physiotherapy. Physical Therapy Canada; 69(1), 1-4.

Setchell J, Gard M, Jones L, Watson, B. (2017) Addressing weight stigma in physiotherapy: Development of a theory driven approach to rethinking weight related interactions. Physiotherapy Theory & Practice. 33(8), 597-610.

Setchell J, Watson B, Gard M, Jones L. (2016) Physical therapists' ways of talking about overweight and obesity: Clinical implications. Physical Therapy. 96(6): 865-75.

Nicholls DA, Atkinson K, Bjorbækmo W, Gibson BE, Latchem J., Olesen, J., Ralls, J. Setchell J. (2016) Connectivity: An emerging concept for physiotherapy practice. Physiotherapy Theory and Practice. 32(3), 159-170.

Wigginton. B, Setchell, J. (2016) Researching stigma as an outsider: Considerations for critical and ethical outsider research. Qualitative Research in Psychology. 13(3), 246-263.

Setchell J, Watson B, Jones L, Gard M. (2015) Weight stigma in physiotherapy practice: Insights from patient perceptions of interactions with physiotherapists. Manual Therapy. 20(6), 835-841.

Setchell J, Watson B, Jones L, Gard M, Briffa K. (2014) Physiotherapists demonstrate weight stigma: A cross-sectional survey of Australian physiotherapists. Journal of Physiotherapy. 60(3):157-162.

Neil Tuttle

27 September 2018

I have been interested in the social and political aspects of anything my whole adult life – so when it came to researching physiotherapy and healthcare I guess it made sense that I followed these perspectives. This including co-founding the CPN with Dave Nicholls and Barb Gibson.

After completing my PhD which used weight stigma as a forum to investigate the socio-political aspects of physiotherapy. I have been fortunate enough to join with two wonderful and hugely influential teams for the past three years. One is super-critical and is at the University Toronto headed by Prof Barb Gibson (long term CPN executive member) and the other is led by Prof Paul Hodges at The University of Queensland and has produced ground-breaking work into low back pain research (amongst other things).

I have recently received a 4 year NHMRC Fellowship to apply the experience I have gained in these two great teams to musculoskeletal physiotherapy – which was my area of clinical expertise – so look out for some interesting critical publications in this space. In the next few weeks I will be advertising for a PhD student to join me in this work – so please let me know if you are interested – I have funding for full fee coverage plus a stipend for living expenses….. so if you want to move to Australia in early 2019 and get critical for the next few years (or know someone else who might) please get in touch! The position will be at The University of Queensland.

Theoretically speaking I am interested in post-modern and post-qualitative scholarship that is applied and clinical.

Publications:

Setchell J, Nicholls D, Gibson B. (2017) Objecting: Multiplicity and the practice of physiotherapy. Health. doi:10.1177/1363459316688519.

Gibson BE, Nicholls D, Setchell J, Synne Groven K. (2018) Manipulating practices: A critical physiotherapy reader. Oslo, Norway. Cappelen Damm.

Setchell J, Thille P, Abrams T, Mistry B, McAdam L, Gibson BE. (2018) Enhancing human aspects of care with young people with Muscular Dystrophy: Results from a participatory qualitative study with clinicians. Child: Care, Health and Development. 44(2):269-277.

Setchell J. (2017) Invited editorial: Stigma and physiotherapy. Physical Therapy Canada; 69(1), 1-4.

Setchell J, Gard M, Jones L, Watson, B. (2017) Addressing weight stigma in physiotherapy: Development of a theory driven approach to rethinking weight related interactions. Physiotherapy Theory & Practice. 33(8), 597-610.

Setchell J, Watson B, Gard M, Jones L. (2016) Physical therapists' ways of talking about overweight and obesity: Clinical implications. Physical Therapy. 96(6): 865-75.

Nicholls DA, Atkinson K, Bjorbækmo W, Gibson BE, Latchem J., Olesen, J., Ralls, J. Setchell J. (2016) Connectivity: An emerging concept for physiotherapy practice. Physiotherapy Theory and Practice. 32(3), 159-170.

Wigginton. B, Setchell, J. (2016) Researching stigma as an outsider: Considerations for critical and ethical outsider research. Qualitative Research in Psychology. 13(3), 246-263.

Setchell J, Watson B, Jones L, Gard M. (2015) Weight stigma in physiotherapy practice: Insights from patient perceptions of interactions with physiotherapists. Manual Therapy. 20(6), 835-841.

Setchell J, Watson B, Jones L, Gard M, Briffa K. (2014) Physiotherapists demonstrate weight stigma: A cross-sectional survey of Australian physiotherapists. Journal of Physiotherapy. 60(3):157-162.

Naomi Eisenberg

28 September 2018

In our everyday practice, we often operate on the assumptions we have about our patients, our professions and the medical systems we work in. I do a lot of work with medical students and resident trainees, and I love the challenge of scratching at the underbelly of these assumptions within my positivistic environment.

Catherine Sykes

29 September 2018

I have never *not* been a physiotherapist in a long and eclectic career that has seen me living and working on three continents and both within the profession (as a clinician, service manager, academic and researcher) and outside (in national disability policy, disability data development and as a non-government organisation advisor).

Throughout my career, the education at Addenbrooke's Hospital School of Physiotherapy in the 1970s has been a sound foundation for lifelong education; both formal and informal. I started a degree in Psychology (Unfinished due to meeting my husband and migrating to Australia.) which led to a better understanding of the relationship between body and mind. An MSc in Rehabilitation Studies introduced me to the International Classification of Impairments, Disability and Handicap (ICIDH); revised to become the International Classification of Functioning, Disability and Health (ICF). This, and practicing in occupational health and ergonomics led to a better understanding of the importance of contextual factors in achieving positive outcomes with the people/patients/clients. Working outside the profession led to a better understanding of the profession and how it relates to other disciplines, organisations (DPOs, NGOs, INGOs) and the wider world of government, policy and administration at local, national and international levels.

A short-lived idea of a career change whilst my children were very young found me doing librarianship studies. The course on classification was influential in the work I do on the development and maintenance of the ICF and, more recently, on the International Classification of Health Interventions (ICHI). By organising information according to a principle enables the exploration of the subject and recognition of the gaps, overlaps, and inconsistencies and thereby challenging assumptions and stimulating new thoughts, hypotheses, and research; leading to new knowledge, which in turn informs classification principles.

Eclectic by nature, I enjoy the challenge of new ideas and ways of thinking. The CPN provides many of those challenges and keeps me thinking critically.

Interests relating to critical physiotherapy: Thinking about what the profession has been, what it is now and what it could be and how to move forward so that all people who could benefit from physiotherapy do. Bringing thinking from other disciplines to enhance physiotherapy.

Any other thoughts about you and the CPN: I am enjoying having my knowledge and thinking challenged and extended and hope whatever I am able to contribute will be of benefit to others in the network.

The final list

30 September 2018

Thank you to everyone who contributed to this year's 30DoS campaign.

It takes a big collective effort to run the blog during the month, but hopefully you'll now have a better idea of some of the wonderfully innovative and interesting work that people within the CPN are doing.

The CPN now has over 600 members in more than 40 countries, and in the years to come we'll be looking for new ways to be a positive voice for an otherwise physiotherapy. In the meantime, you could do worse than look at the work that some of these people are doing, and consider ways that they are pushing the boundaries of how it's possible to think and practice physiotherapy.

If you missed any of the individual profiles, here is a complete list from the month. Click on the name to jump back to their profile.

1. Bruce Greenfield
2. Amy Hiller
3. Anne Marit Mengshoel
4. Bhanu Ramaswamy
5. Irena Paiuk
6. Jenny Wickford
7. Filip Maric
8. Alma Viviana Silva Guerrero
9. Siri Moe
10. Hazel Horobin
11. Blaise Doran

12. Pia Kontos
13. Susanne Rosberg
14. Gunn Kristin Øberg
15. Aydee Luisa Robayo Torres
16. Tobba Therkildsen Sudmann
17. Patty Thille
18. Catharina Broberg
19. Michael Rowe
20. Guillaume Christe
21. Anna Ilona Rajala
22. Lester E. Jones
23. Thomas Abrams
24. Karen Whalley Hammell
25. Keith P. Waldron
26. Jenny Setchell
27. Neil Tuttle
28. Naomi Eisenberg
29. Catherine Sykes

30DoS - 2019

Our annual 30 Days of September campaign is back next week

28 August 2019

Every year for the last five years we have run a month-long campaign called 30 Days of September.

Each day of the month we post up something around a common theme. In the past we've made desktop wallpaper with our favourite quotes on and featured members of the CPN, but this year we're returning to where it all began.

Five years ago, at the birth of the Association, we asked you, our loyal readers and members, what you'd like our business to focus on. And, as best we could, that's what we did.

So five years on, we're going to repeat the exercise, and we need your help.

Every day during September we'll post up a poll asking you whether you think we should do something or not. All you have to do is tick 'yes' or 'no'. There's also a comments box on each post if you'd like to say more.

At the end of the month, we'll get a sense of our community's priorities, and make that the basis of our planning for the next five years.

You'll know its one of our polls because it will have this banner on it;

We hope you enjoy taking part.

Welcome to this year's 30 Days of September campaign

1 September 2019

Five years ago, as the CPN was just getting started, we ran our first 30 Days of September campaign asking you what you wanted the CPN to do.

The responses shaped how we got the Network started and I'm pleased to say that we did many of the things you asked for.

We had meetings, wrote journal articles and a book, set up this website and blog, and have now run our first critical physiotherapy course.

So it seems high time we came back to you to ask for our direction for the next five years.

Over the course of the month we'll ask one question a day. They are all yes/no answers, so will only take a moment.

There's a comments box below each poll if you want to start a discussion on any of the topics covered in the poll, or add some more thoughts.

So here is the the first question to kick things off...

1 September 2019 - Should the CPN do more to link philosophy and social theory to physiotherapy?

2 September 2019 - Should the CPN develop critical physiotherapy curricula for schools?

3 September 2019 - Should the CPN produce its own regular podcast?

4 September 2019 - Should the CPN support conference attendance?

5 September 2019 - Should the CPN offer training in social networking?

6 September 2019 - Should the CPN offer support for critical dissertations?

7 September 2019 - Should the CPN host an annual critical physiotherapy day?

8 September 2019 - Should the CPN host an annual international meeting?

9 September 2019 - Should the CPN give out an award for the best critical research?

10 September 2019 - Should the CPN host an online un-conference?

11 September 2019 - Should the CPN develop an encyclopaedia of critical physiotherapy?

12 September 2019 - Should the CPN form its own international faculty?

13 September 2019 - Should the CPN regularly collaborate on journal articles?

14 September 2019 - Should the CPN campaign on issues?

15 September 2019 - Should the CPN comment on current affairs?

16 September 2019 - Should the CPN have formal links with other groups?

17 September 2019 - Should the CPN charge people for membership?

18 September 2019 - Should the CPN have different membership categories and privileges?

19 September 2019 - Should the CPN focus on profiling physiotherapy in developing countries?

20 September 2019 - Should the CPN set up its own reviewer network?

21 September 2019 - Should the CPN have a limited membership roster?

22 September 2019 - Should the CPN produce student learning materials?

23 September 2019 - Should the CPN offer a secure research repository?

24 September 2019 - Should the CPN offer a discussion forum on its website?

25 September 2019 - Should the CPN do more to publish in languages other than English?

26 September 2019 - Should the CPN run its own Twitter chats?

27 September 2019 - Should the CPN continue to run its critical physiotherapy course in 2020?

28 September 2019 - Should the CPN start its own podcast?

29 September 2019 - Should the CPN set up a noticeboard for people seeking co-authors, supervisors, etc.?

30 September 2019 - Should the CPN start its own academic journal?

30 Days of September summary results

30 October 2018

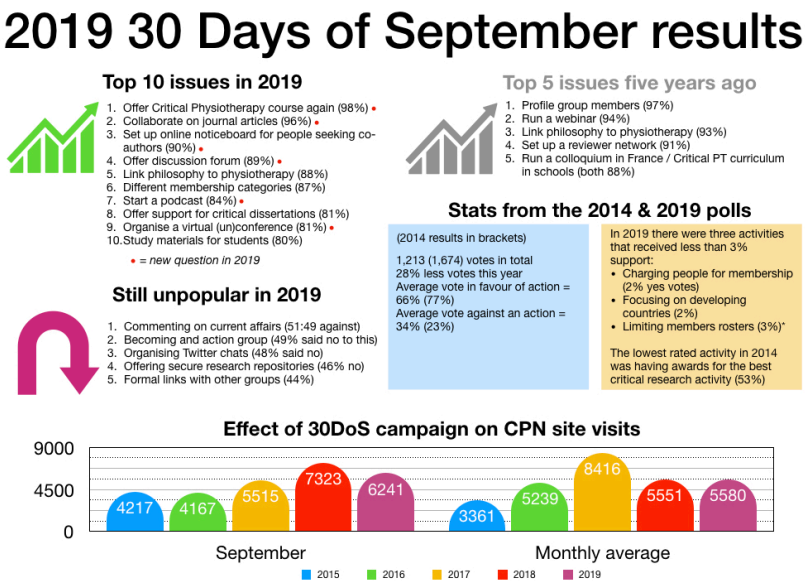
Having a previous poll five years ago has been good because it's given us something to compare results against.

There were some notable differences between this year's poll and 2014's, both in terms of popularity of individual items and the things people wanted the CPN to do.

Gratifyingly this was mostly because we'd heeded people's advice and tackled many of the things people had wanted before.

Popular choices this year included repeating the critical physiotherapy course and setting up a discussion forum. The Exec will look at all of these suggestions in the coming months.

Here is breakdown of the findings. If you'd like a copy of the full results, email me at david.nicholls@aut.ac.nz, and I'll send you a copy.



30DoS - 2020

Welcome to the 2020 30 Days of September (30DoS) campaign

1 September 2020

Every year since 2015 we have run a month-long campaign based on a particular theme related to critical physiotherapy. Each day for 30 days we publish a short post around that theme. This year the theme is critical resources.

Over the last few months we've been gathering up resources that we use in our work as critical physios, and we're going to share them with you each day throughout September.

We have carefully curated recommendations for journals, apps and tools we use for our critical research and writing, as well as books and authors we love.

Each day will feature three resources randomly chosen from our pile, giving you more 90 different resources to help you with your critical physiotherapy work.

We're very keen to hear your suggestions too, so please feel free to use the comments box at the bottom of each day's post to suggest some tools of your own, and we'll add them to the list.

At the end of the month, we'll compile them all into a resource list available on the criticalphysio.net website.

Huge thanks to Anna Rajala and Tobba Sudmann for their help in compiling this treasure trove.

Look out for Day 1's blogpost in your email, on the website, or through your normal social media channels.

Dave Nicholls

1 September 2020

In every case we've tried to provide a brief summary of the resource, a follow-up link, and a few working examples.

With one or two exceptions, we've stayed away from physio-specific resources, and we have no financial or other interest in any of the products and services that we've recommended here.

Health: An interdisciplinary journal

Health: is published six times per year and attempts in each number to offer a mix of articles that inform or that provoke debate. The readership of the journal is wide and drawn from different disciplines and from workers both inside and outside the health care professions. Widely abstracted, Health: ensures authors an extensive and informed readership for their work.

Link to homepage: https://journals.sagepub.com/home/HEA

Malcolm, D., & Pullen, E. (2020). 'Everything I enjoy doing I just couldn't do': Biographical disruption for sport-related injury. Health, 24(4), 366–383. https://doi.org/10.1177/1363459318800142

Franklin, M., Willis, K., Lewis, S., Rogers, A., & Smith, L. (2019). Between knowing and doing person-centredness: A qualitative examination of health professionals' perceptions of roles in self-management support. Health. https://doi.org/10.1177/1363459319889087

Setchell, J., Nicholls, D. A., & Gibson, B. E. (2018). Objecting: Multiplicity and the practice of physiotherapy. Health, 22(2), 165–184. https://doi.org/10.1177/1363459316688519

The research whisperer

You've come to the right blog if you're interested in learning more about researcher lives and cultures, how to navigate grants-speak and build your research track-record, and being part of an international community of scholars and research professionals!

Link to website: https://researchwhisperer.org/about/

Woke Science: 3 Tips to Boost the Impact of Research

Effective grantseeking - round-up

Being a researcher in a digital world

Annemarie Mol

Annmarie Mol is a Dutch philosopher and ethnographer. Her research addresses multiplicity of objects, care practices, and topologies. Her work on *The Body Multiple* draws on ethnography of ordinary disease and argues that bodies are manipulated through various practices, people and apparatuses. Mol reminds us that we not only 'have' and 'are' our bodies, but also 'do' our bodies through enacting, performing, staging. In *The Logic of Care*, another interesting study for physiotherapists, Mol argues that 'good care' has little to do with 'patient choice' and thus treating people as 'customers' undermines the ways of thinking and acting that are crucial to healthcare. Instead on the 'logic of choice', Mol argues for a 'logic of care' that involves continuous attempts to attune knowledge and technologies to the complex lives of bodies in healthcare.

Interview with Annemarie Mol:
https://www.scielo.br/scielo.php?script=sci*arttext&pid=S1414-32832018000100295&lng=en&nrm=iso&tlng=en*

Mol, Annemarie & Berg, Marc (1998). Differences in medicine: unravelling practices, techniques, and bodies. Durham, North Carolina: Duke University Press.

Mol, Annemarie (2002). The body multiple: ontology in medical practice. Durham, North Carolina: Duke University Press.

Mol, Annemarie (2008). The logic of care: health and the problem of patient choice. London New York: Routledge.

2 September 2020

Three new resources for your critical physiotherapy.

Gilles Deleuze by Todd May

This book offers a readable and compelling introduction to the work of one of the twentieth century's most important and elusive thinkers. Other books have tried to explain Deleuze in general terms. Todd May organizes his book around a central question at the heart of Deleuze's philosophy: how might we live? The author then goes on to explain how Deleuze offers a view of the cosmos as a living thing that provides ways of conducting our lives that we may not have dreamed of. Through this approach the full range of Deleuze's philosophy is covered. Offering a lucid account of a highly technical philosophy, Todd May's introduction will be widely read amongst those in philosophy, political science, cultural studies and French studies.

Link to book: https://www.cambridge.org/core/books/gilles-deleuze/F8C52DB2028E005FF6A2D3A8C490B789#fndtn-information

Atlas.ti

Atlas.ti is a software to organise and analyse qualitative research data. There is a free version that you can try on their webpage, but to use the full programme, you or your institution need to buy a licence. Atlas.ti has loads of features and it supports all sorts of research materials: images, video files, PDF, Word documents, audio files, etc. It's great for organising ethnographic field notes and data, and for coding large corpora of research materials. Atlas.ti is not an easy-to-use software due to the often messy nature of qualitative research and although there are features for doing analysis (e.g. cross referencing different codes), atlas.ti does not do all of the thinking for you. There are loads of tutorial videos and support available directly from atalsti.

Tutorials: https://atlasti.com/video-tutorials/

https://atlasti.com/

Disability & Society

Disability & Society is an international disability studies journal providing a focus for debate about such issues as human rights, discrimination, definitions, policy and practices. It appears against a background of constant change in the ways in which disability is viewed and responded to.

Link to website: https://www.tandfonline.com/toc/cdso20

Sally French (1995) Visually Impaired Physiotherapists: their struggle for acceptance and survival, Disability & Society, 10:1, 3-20, DOI: 10.1080/09687599550023697

Per Koren Solvang (2018) Between art therapy and disability aesthetics: a sociological approach for understanding the intersection between art practice and disability discourse, Disability & Society, 33:2, 238-253, DOI: 10.1080/09687599.2017.1392929

Cadeyrn J. Gaskin, Mark B. Andersen & Tony Morris (2012) Physical activity in the life of a woman with cerebral palsy: physiotherapy, social exclusion, competence, and intimacy, Disability & Society, 27:2, 205-218, DOI: 10.1080/09687599.2011.644931

3 September 2020

Pocket

Apart from Feedly, one of the other tools recommended recently by Stephen Downes was Pocket. Think of Pocket like a personal magazine. Long articles are especially good in Pocket. You can add an icon to your browser and when you hit on an article you want to read later, click on Pocket and it stores it for you. Then, when you get the chance, you go to Pocket and you have your own curated readings laid out for you.

Link to website: https://getpocket.com

Link to YouTube channel: https://www.youtube.com/user/pocketco

Djamila Ribeiro

Ribiero is a Brazilian philosopher, black feminist, journalist, online blogger and social activist. Her 2018 book *Quem tem medo do feminismo negro? ('Who is afraid of black feminism?')*, is a collection of articles that address topic such as social mobilisation, racial quota policies, and the origins of black feminism in Brazil and America. In the 2017 book, *O Que é Lugar de Fala? ('What is the standpoint of speech?')*, she asks who has the right to a voice in a society that has whiteness, masculinity and heterosexuality as its norm? She has also written an anti-racist handbook, *Pequeno manual antirracista* (2019), written for those who want to deepen their perception of structural racist discrimination and take responsibility for transforming the situation.

Ribiero's writing online: https://www.cartacapital.com.br/tag/djamila-ribeiro/

https://www1.folha.uol.com.br/colunas/djamila-ribeiro/

Ribeiro, Djamila (2018). Quem tem medo do feminismo negro? Companhia das Letras.

Ribeiro, Djamila (2019). Pequeno manual antirracista. Companhia das Letras.

Ribeiro, Djamila (2017). O Que é Lugar de Fala? Letramento/Justificando.

Theory, Culture & Society

Theory, Culture & Society is a highly ranked, high impact factor, rigorously peer reviewed journal that publishes original research and review articles in the social and cultural sciences. Launched to cater for the resurgence of interest in culture within contemporary social science, it provides a forum for articles which theorize the relationship between culture and society.

Link to website: https://journals.sagepub.com/home/tcs

Allen, B. (2020). Merleau-Ponty: Beauty, Phenomenology, and the 'Theological Turn.' Theory, Culture & Society. https://doi.org/10.1177/0263276420915268

Hoel, A. S., & Carusi, A. (2018). Merleau-Ponty and the Measuring Body. Theory, Culture & Society, 35(1), 45–70. https://doi.org/10.1177/0263276416688542

Hafiz, M. (2020). Smashing the Imperial Frame: Race, Culture, (De)Coloniality. Theory, Culture & Society, 37(1), 113–145. https://doi.org/10.1177/0263276419877674

4 September 2020

Stephen's Web - OLDaily

OLDaily - short for Online Learning Daily - is my contribution to the growing world of email newsletters. You might ask, does the world need another online newsletter, especially in the field of online learning? My answer - obviously - is yes. What makes OLDaily different from other email newsletters, then? Three things: content selection, value-add, and website support. A subscription form is available below. But before you subscribe, take a moment to make sure this newsletter is for you.

Link to website: https://www.downes.ca

Teaching during a pandemic (curated link)

Keeping kids engaged in remote learning

Sharing Indigenous Cultural Heritage Online: An Overview of GLAM Policies

Ulysses

Ulysses is a great writing tool. Like Word, but without all the clutter. It uses simple markup tags like hashtags and asterisks to tell the programme you export to how to handle the text.

This means you can write a piece once and export it to Word, a blog, a pdf file, or a host of other sources. It has its own file tree structure, so you can write any document, big or small, in parts and bring them together at the end. It's designed for writing with. As normal, there's a free intro version and you pay for more tools.

Link to website: https://ulysses.app

YouTube channel: https://www.youtube.com/channel/UCNlA28DdeEQEq8ViQEmu-GA

A critique of political reason by Thomas Lemke

The main thesis of the book is that there is a major transformation in the problematics of power in the work of the French philosopher and historian Michel Foucault which is rarely taken into account. In the centre of this »theoretical displacement« (Foucault) is the notion of government, that is mainly developed in the – still unpublished – 1978 and 1979 lessons at the Collège de France. I try to reconstruct this problematics of government by presenting material which is until now only available on audio tapes in the Foucault archive in Paris and which will appear here for the first time. These lessons are essential to understand Foucaults change of the project of the History of Sexuality and his later interest in pre-Christian forms of subjectivity. It is also essential to make sense of his later differentiation between power and domination and the question of bio-politics.

Link to book: https://www.bloomsbury.com/au/critique-of-political-reason-9781788732512/

5 September 2020

At the Existentialist Cafe by Sarah Bakewell

At the Existentialist Café explores modern existentialism as a story of encounters between ideas and between people – from the 'king and queen of existentialism' (Sartre and Beauvoir) to their wider circle of friends, followers and adversaries, including Albert Camus, Martin Heidegger, Maurice Merleau-Ponty, Iris Murdoch and many more. Weaving biography and philosophy, it investigates a philosophy that concerned life, but that also changed lives – and that tackled the biggest questions of all: what we are and how we are to live.

Link to book: https://sarahbakewell.com/books-3/at-the-existentialist-cafe-2/

Margit Shildrick

Shildrick is a versatile researcher with background in literature, bioethics, and poststructuralist philosophy. Drawing on the poststructuralism of both Derrida and Deleuze, as well as the major feminist theorists like Butler and Grosz, Shildrick's research interests vary widely from interdisciplinary gender studies and feminist theory, to postconventional bioethics, phenomenology, posthumanities, science and technology studies, critical disability

studies, prosthetic theory, and psychoanalysis. Her classic *Leaky Bodies and Boundaries* is a poststructuralist feminist analysis on the female body that literally 'leaks' is not valorised within the Western discourse. She argues that the very 'leakiness' should be the foundation for a feminist ethic.

A lecture by Shildrick: https://www.youtube.com/watch?v=9QRAZi*Opfk*

Shildrick, Margit (2009). Dangerous Discourses: Subjectivity, Sexuality and Disability. Palgrave Macmillan

Shildrick, Margit (2002). Embodying the Monster: Encounters with the Vulnerable Self. London: Sage.

Shildrick, Margit (1997). Leaky Bodies and Boundaries: Feminism, Postmodernism and (Bio)ethics. London: Routledge.

Disability & Rehabilitation

Disability and Rehabilitation is an international multidisciplinary journal publishing on all aspects of disability, rehabilitation, and services for those who are handicapped. *Disability and Rehabilitation* aims to encourage a better understanding of disability and to promote rehabilitation science, practice and policy aspects of the rehabilitation process. The journal provides an important forum for the dissemination and exchange of ideas amongst global health practitioners and researchers.

Link to website: https://www.tandfonline.com/loi/idre20

Veronika Schoeb, Liliana Staffoni, Ruth Parry & Alison Pilnick (2014) "What do you expect from physiotherapy?": a detailed analysis of goal setting in physiotherapy, Disability and Rehabilitation, 36:20, 1679-1686, DOI: 10.3109/09638288.2013.867369

Jenny Wickford, John Hultberg & Susanne Rosberg (2008) Physiotherapy in Afghanistan – Needs and challenges for development, Disability and Rehabilitation, 30:4, 305-313, DOI: 10.1080/09638280701257205

Mark P. McGlinchey & Sally Davenport (2015) Exploring the decision-making process in the delivery of physiotherapy in a stroke unit, Disability and Rehabilitation, 37:14, 1277-1284, DOI: 10.3109/09638288.2014.962106

6 September 2020

Body & Society

Body & Society has from its inception in March 1995 as a peer-reviewed companion journal to Theory, Culture & Society, pioneered and shaped the field of body-studies. It has been

committed to theoretical openness characterized by the publication of a wide range of critical approaches to the body, alongside the encouragement and development of innovative work that contains a trans-disciplinary focus.

Link to homepage: https://journals.sagepub.com/home/bod

Dawney, L., & Huzar, T. J. (2019). Introduction: The Legacies and Limits of The Body in Pain. Body & Society, 25(3), 3–21. https://doi.org/10.1177/1357034X19857133

Harris, A. (2016). Listening-touch, Affect and the Crafting of Medical Bodies through Percussion. Body & Society, 22(1), 31–61. https://doi.org/10.1177/1357034X15604031

Stephens, L., Ruddick, S., & McKeever, P. (2015). Disability and Deleuze: An Exploration of Becoming and Embodiment in Children's Everyday Environments. Body & Society, 21(2), 194–220. https://doi.org/10.1177/1357034X14541155

Foucault news

This site (now incorporating my older michel-foucault.com site) posts news in relation to new publications, conferences or other activities and provides resources in relation to the work of French philosopher and historian Michel Foucault (1926 -1984).

Link to website: https://michel-foucault.com

Biopolítica: somatocracia y medicina social (2020) - for all posts, follow link to site above

David Langwallner on Foucault's Panopticon (2020)

"We want more diversity but…": Resisting diversity in recreational sports clubs (2020)

Evernote

The logo for Evernote is an elephant, and for good reason. Evernote is a superb app for storing almost anything: ideas, emails, web sites, photos, audio files, videos… whatever you want to keep. It uses tags so that you can organise your working life and never forget a job you have to do. You can share files and folders with teams, and chat online. With it's incredible search ability (finding hand-written words embedded in photographs, for instance), Evernote is a superb tool for gathering and storing research materials and for never forgetting anything.

Link to website: https://evernote.com

YouTube channel: https://www.youtube.com/user/EvernoteVideos

7 September 2020

Joan Tronto

Tronto is a political scientist and care ethicist, and her classic *Moral Boundaries* is a must-read for everyone interested in the care ethics movement. There are other notable and interesting ethics of care theorists that could be featured here, such as Nel Noddings, Virginia Held, Michael Slote, Annette Baier, Carol Gilligan and Sara Ruddick, to name just a few. Tronto's work is important from a deeply political point of view. In *Moral Boundaries*, she argues that the boundaries between ethics and politics, public and private, are not as clear cut as they may seem. Ethical question must be analysed from a political point of view, and vice versa, and therefore taking an impersonal point of view in either would be deeply problematic. Tronto has long argued that care is at the centre on human lives. In a 2013 book, *Caring democracy*, Tronto asks us to look again at how gender, race, class, and market forces misallocate caring responsibilities, and how to make caring more just. Political and economic life often ignores the reality of caring, self-care and care for others, informal and formal caring, but Tronto insists that care should be the highest value that shapes how we view the economy, politics, and institutions.

A lecture by Tronto: https://www.youtube.com/watch?v=91g5IvWDhqk

Tronto, J. C. (1993). Moral boundaries: A political argument for an ethic of care. London: Routledge.

Tronto, J. C. (2013). Caring democracy: Markets, equality, and justice. New York: New York University Press.

Tronto, J. C. (2015). Who cares? How to reshape a democratic politics. Ithaca: Cornell University Press.

Feedly

Stephen Downes recently described Feedly as "the primary source for most of my daily links and keeps me up-to-date on a daily basis", which is a pretty good endorsement for whom connecting people to ideas is a big part of his work. Feedly is an RSS reader, which means it can capture updates from almost any website and bring them all together into one site. Want to know what's in the latest edition of a journal, or get the latest news from the CPN, just put the address into Feedly and it will update you every day.

Link to website: https://feedly.com

Link to YouTube channel: https://www.youtube.com/channel/UCs-3RoE0W9M5ooEwI4eOFZw

The Faraway Nearby by Rebecca Solnit

In this exquisitely written new book by the author of A Paradise Built in Hell, Rebecca Solnit explores the ways we make our lives out of stories, and how we are connected by empathy, by narrative, by imagination. In the course of unpacking some of her own stories—of her mother and her decline from memory loss, of a trip to Iceland, of an illness—Solnit revisits fairytales and entertains other stories: about arctic explorers, Che Guevara among the leper colonies, and Mary Shelley's Dr. Frankenstein, about warmth and coldness, pain and kindness, decay and transformation, making art and making self. Woven together, these stories create a map which charts the boundaries and territories of storytelling, reframing who each of us is and how we might tell our story.

Link to book: http://www.rebeccasolnit.net/book/the-faraway-nearby/

8 September 2020

Black and blur; Stolen life; and The universal machine by Fred Moton

"Taken as a trilogy, consent not to be a single being is a monumental accomplishment: a brilliant theoretical intervention that might be best described as a powerful case for blackness as a category of analysis."—Brent Hayes Edwards, author of Epistrophies: Jazz and the Literary Imagination.

Link to author's work: https://www.dukeupress.edu/explore-subjects/browse?AuID=1384061

Grammarly

If you'd like to concentrate on your ideas and worry less about your spelling and grammar, then Grammarly is for you. There are a number of spelling and grammar checkers on the market now, but Grammarly is one of the best. It's very comprehensive, multi-lingual, and very contemporary. You can add parcels of text to the website and ask Grammarly to check them, or run it in the background so it picks up your mistakes as you type. It's style and tone options are also nice if you want to reach a particular audience.

Link to website: https://www.grammarly.com

Link to YouTube channel: https://www.youtube.com/user/TheGrammarly

Sociology of Health & Illness

Sociology of Health & Illness is an international journal which publishes sociological articles on all aspects of health, illness, medicine and health care. We welcome empirical and theoretical contributions in this field in the form of original research reports or review articles. In addition to the six regular issues published each year, subscribers receive a further special issue. These

themed issues aim to identify and contribute to new areas of debate and research in the discipline and each issue is devoted to an important topic of current interest.

Link to homepage:
https://onlinelibrary.wiley.com/page/journal/14679566/homepage/productinformation.html

Brown, N., Buse, C., Lewis, A., Martin, D. and Nettleton, S. (2020), Air care: an 'aerography' of breath, buildings and bugs in the cystic fibrosis clinic. Sociol Health Illn, 42: 972-986. doi:10.1111/1467-9566.13104

Backhouse, T., Hammond, S.P., Cross, J.L., Lambert, N., Varley, A., Penhale, B., Fox, C. and Poland, F. (2020), Making body work sequences visible: an ethnographic study of acute orthopaedic hospital wards. Sociol Health Illn, 42: 1139-1154. doi:10.1111/1467-9566.13085

Parry, R. (2009), Practitioners' accounts for treatment actions and recommendations in physiotherapy: when do they occur, how are they structured, what do they do?. Sociology of Health & Illness, 31: 835-853. doi:10.1111/j.1467-9566.2009.01187.x

9 September 2020

Online Town

Online Town "is a video-calling experience that lets multiple people hold separate conversations in parallel and lets you walk in, out and around those conversations just as easily as you would in real life. It's also fun." Online Town is like Zoom, but you set up a location that people can move freely in. As you approach someone, your video comes into focus. As you move away it fades. Great for holding large group meetings and tutorials. Unlike tools like Zoom, Skype, and Teams, it's fully encrypted and no data is stored.

Link to website: https://theonline.town

There is not YouTube channel yet.

Canguilhem, by Stuart Elden

Elden Georges Canguilhem (1904–95) was an influential historian and philosopher of science, as renowned for his teaching as for his writings. He is best known for his book The Normal and the Pathological, originally his doctoral thesis in medicine, but he also wrote a thesis in philosophy on the concept of the reflex, supervised by Gaston Bachelard. He was the sponsor of Michel Foucault's doctoral thesis on madness. However, his work extends far beyond what is suggested by his association with these thinkers. Canguilhem also produced a series of important works on the natural sciences, including studies of evolution, psychology, vitalism and mechanism, experimentation, monstrosity and disease.Stuart Elden discusses the whole of this important thinker's complex work, including recently rediscovered texts and archival

materials. Canguilhem always approached questions historically, examining how it was that we came to a significant moment in time, outlining tensions, detours and paths not taken. The first comprehensive study in English, this book is a crucial guide for those coming to terms with Canguilhem's important contributions, and will appeal to researchers and students from a range of fields.

Link to book: https://politybooks.com/bookdetail/?isbn=9781509528776

Deborah Lupton

Deborah Lupton has a background in sociology and media and cultural studies. Her research combines qualitative and innovative social research methods with sociocultural theory. Lupton's research interest is in digital sociology, including topics such as critical digital health studies; critical data studies; self-tracking cultures; and digital food cultures. Her 'more-than-human' perspective draws on New Materialism, that addresses conceptualising the boundaries of living and non-living entities. Instead of using the more widely used term 'posthuman', she prefers to use 'more-than-human' because it better encapsulates the entanglements of humans and nonhumans. More-than-human implies that the human always already incorporates the nonhuman, and the nonhuman incorporates the human.

Link to Lupton's blog: https://simplysociology.wordpress.com/

Publications:

Lupton, Deborah (2016). The Quantified Self: A Sociology of Self-Tracking. Cambridge: Polity.

Lupton, Deborah. (2019). Data selves: More-than-human perspectives. Cambridge: Polity.

Lupton, Deborah. (2019). 'Things that matter': Poetic inquiry and more-than-human health literacy. Qualitative Research in Sport, Exercise and Health, , 1-16. doi:10.1080/2159676X.2019.1690564

10 September 2020

Qualitative Inquiry

Qualitative Inquiry (QI) provides an interdisciplinary forum for qualitative methodology and related issues in the human sciences. The journal publishes open-peer reviewed research articles that experiment with manuscript form and content, and focus on methodological issues raised by qualitative research rather than the content or results of the research. QI also addresses advances in specific methodological strategies or techniques.

Link to website: https://journals.sagepub.com/home/qix

Blockmans, I. G. E. (2019). Encounters With the White Coat: Confessions of a Sexuality and Disability Researcher in a Wheelchair in Becoming. Qualitative Inquiry, 25(2), 170–179. https://doi.org/10.1177/1077800417750181

Teachman, G., McDonough, P., Macarthur, C., & Gibson, B. E. (2018). A Critical Dialogical Methodology for Conducting Research With Disabled Youth Who Use Augmentative and Alternative Communication. Qualitative Inquiry, 24(1), 35–44. https://doi.org/10.1177/1077800417727763

Esposito, J. (2014). Pain Is a Social Construction Until It Hurts: Living Theory on My Body. Qualitative Inquiry, 20(10), 1179–1190. https://doi.org/10.1177/1077800414545234

Google Scholar

Perhaps an obvious and well-known resource, but invaluable for finding research material both retrospectively and prospectively, with the addition of the "Cited by" option. Many academics have their profiles on line, so you can trace people's complete body of work. As with any search tool, the use of synonyms, truncation, parentheses and other syntax terms like AND, OR, and NOT can make all the difference to a search.

Link to website: https://scholar.google.com

Link to Google's YouTube channel (there is no specific channel for Scholar): https://www.youtube.com/user/Google

Mushroom at the End of the World by Anna Lowenhaupt Tsing

'Matsutake is the most valuable mushroom in the world—and a weed that grows in human-disturbed forests across the northern hemisphere. Through its ability to nurture trees, matsutake helps forests to grow in daunting places. It is also an edible delicacy in Japan, where it sometimes commands astronomical prices. In all its contradictions, matsutake offers insights into areas far beyond just mushrooms and addresses a crucial question: what manages to live in the ruins we have made? A tale of diversity within our damaged landscapes, *The Mushroom at the End of the World* follows one of the strangest commodity chains of our times to explore the unexpected corners of capitalism. Here, we witness the varied and peculiar worlds of matsutake commerce: the worlds of Japanese gourmets, capitalist traders, Hmong jungle fighters, industrial forests, Yi Chinese goat herders, Finnish nature guides, and more. These companions also lead us into fungal ecologies and forest histories to better understand the promise of cohabitation in a time of massive human destruction. By investigating one of the world's most sought-after fungi, *The Mushroom at the End of the World* presents an original examination into the relation between capitalist

destruction and collaborative survival within multispecies landscapes, the prerequisite for continuing life on earth'.

Link to book: https://press.princeton.edu/books/paperback/9780691178325/the-mushroom-at-the-end-of-the-world

11 September 2020

Stanford Encyclopedia of Philosophy

The SEP has been a like the Wikipedia of philosophy for years now. It's authoritative, regularly updated, and comprehensive, with more than 1,600 articles. If you pay a small fee and support SEP, you gain access to pdfs of all entries. The free dictionary book depository are excellent too.

Link to website: https://plato.stanford.edu/about.html

The book depository https://www.bookdepository.com/

And The free dictionary https://www.thefreedictionary.com/

Radical Philosophy (OpenAccess)

We hope that, among other things, the pages of Radical Philosophy will become a venue for reflection upon the question of what it might mean to decolonise philosophy today. Alongside the translation and introduction of new authors, such an enterprise entails a profound questioning of the very notion of canonicity and the essence of the method of reason that calls itself philosophical. It is in keeping forever open the question of what it might mean to do philosophy that the project of a radical philosophy can remain truly radical.

Link to website: https://www.radicalphilosophy.com

Chukhrov, K. (2020). The philosophical disability of reason. Radical philosophy 2.07. https://tinyurl.com/yxs9ymg4

Eastwood, J. (2018). Strategies of debilitation. Radical Philosophy 2.03. https://tinyurl.com/yy39l87v

Kafiris, K. & Anonymous (2010). Universities in crisis. Radical Philosophy 160. https://tinyurl.com/y6kvqobq

Kimberlé Crenshaw

If you have heard the term 'intersectionality', you have probably heard of Kimberlé Crenshaw. Crenshaw is lawyer, civil rights advocate, philosopher, and a leading scholar of critical race theory. The focus of her research is on race and gender. She introduced the theory of

intersectionality in a paper published in 1989, in which she argued that understanding the experience of being a black woman cannot be understood by examining 'being black' and 'being a woman' separately. They must be understood as interacting with and reinforcing one another. Intersectionality is not about discrimination being a sum total of racism and sexism. Rather, there are multiple social forces, social identities, and ideological instruments that intersect in us. Both power and disadvantage are created, legitimised and expressed in the interconnected social categorisations, including race, class, and gender.

https://www.ted.com/speakers/kimberle*crenshaw*

Crenshaw, Kimberlé (2008). "Mapping the Margins: Intersectionality, Identity Politics and Violence against Women of Color," in The Feminist Philosophy Reader, Alison Bailey and Chris Cuomo (eds.). New York: McGraw-Hill, 279–309.

Crenshaw, Kimberlé, Luke Charles Harris & George Lipsitz (2018). The Race Track: Understanding and Challenging Structural Racism. New York: New Press.

Crenshaw, Kimberlé (2017). On Intersectionality: Essential Writings of Kimberlé Crenshaw. 2017.

12 September 2020

Critical Theory: The Key Concepts by Dino Felluga

'*Critical Theory: The Key Concepts* introduces over 300 widely-used terms, categories and ideas drawing upon well-established approaches like new historicism, postmodernism, psychoanalysis, Marxism, and narratology as well as many new critical theories of the last twenty years such as Actor-Network Theory, Global Studies, Critical Race Theory, and Speculative Realism. This book explains the key concepts at the heart of a wide range of influential theorists from Agamben to Žižek. Entries range from concise definitions to longer more explanatory essays and include terms such as: aesthetics, desire, dissensus, dromocracy, hegemony, ideology, intersectionality, late capitalism, performativity, race, suture. Featuring cross-referencing throughout, a substantial bibliography and index, *Critical Theory: The Key Concepts* is an accessible and easy-to-use guide. This book is an invaluable introduction covering a wide range of subjects for anyone who is studying or has an interest in critical theory (past and present)'.

Link to book: https://www.routledge.com/Critical-Theory-The-Key-Concepts/Felluga/p/book/9780415695657

WAVE - web accessibility and evaluation tool

‘WAVE is a suite of evaluation tools that helps authors make their web content more accessible to individuals with disabilities. WAVE can identify many accessibility and Web Content Accessibility Guideline (WCAG) errors, but also facilitates human evaluation of web content. Our philosophy is to focus on issues that we know impact end users, facilitate human evaluation, and to educate about web accessibility.’

Link to website: https://wave.webaim.org

New books in critical theory

The New Books Network is a consortium of author-interview podcast channels dedicated to raising the level of public discourse by introducing scholars and other serious writers to a wide public via new media. Covering 80+ subjects, disciplines, and genres, we publish 35 episodes every week and serve a large, worldwide audience.

Link to website: https://newbooksnetwork.com/category/politics-society/critical-theory/

Deep Medicine: How Artificial Intelligence Can Make Healthcare Human Again

Unaffordable: American Healthcare from Johnson to Trump

Sex Matters: How Male-Centric Medicine Endangers Women's Health and What We Can Do About It

13 September 2020

Xerte and OpenLearn Create - web authoring tools

Both of these tools offer accessible and affordable ways to build web content, from websites, to blogs, and social media. Both work to try to make learning as open as possible.

Links to websites: https://xerte.org.uk/index.php/en/ and https://www.open.edu/openlearncreate/

Catherine Malabou

Malabou is a French philosopher, whose work addresses the concept of ‘plasticity’ which draws on medical science, neuroplasticity, and the work of G.W.F. Hegel. Her work also works in the intersection of psychoanalysis, neuroscience and philosophy, and increasingly involving political philosophy. *What Should We Do with Our Brain?* is one of Malabou’s more approachable books. She argues that because our brains are historical products developing through the life span in relation to themselves and to others, there is a thin line between the organisation of our nervous systems and social and political organisation. Our brains adapt to

existing social and political circumstances (plasticity) but also open up a margin of freedom to intervene and transform those very circumstances.

Public FB group dedicated on sharing news and link of her work: https://www.facebook.com/groups/106398336059542/

Johnston, Adrian & Malabou, Catherine (2013). Self and Emotional Life: Merging Philosophy, Psychoanalysis, and Neuroscience. New York: Columbia University Press.

Malabou, Catherine (2012). The Ontology of the Accident: An Essay on Destructive Plasticity Cambridge: Polity Press.

Malabou, Catherine (2009). What Should We Do With Our Brain? New York: Fordham University Press.

Critical Times (OpenAccess)

Critical Times seeks to publish texts that shed light on contemporary practices of authoritarian and neo-fascist politics, nativist and atavistic cultural formations, and forms of economic exclusion, as well as spaces and forms of life where emancipatory social worlds might be imagined, articulated, and pursued. Hence, our aim is to publish essays that analyze emerging forms of authoritarianism and fascism; occupation, colonialism and dispossession; race and racism; war and apartheid; neoliberal legal and economic formations; sovereignty and post-national power; articulations of memory and justice; law and violence; borders, migration and refugees; technology and politics; nature, climate change, and environmental justice; bio- and necropolitics; religion and secularism; the intellectual work of social movements and contemporary challenges to the university; socialism and ideals of transformation, equality, resistance, transnational solidarity, radical democracy, civil disobedience, and revolution.

Link to website: https://ctjournal.org

Stathis Gourgouris; Preliminary Thoughts on Left Governmentality. Critical Times 1 April 2018; 1 (1): 99–107. doi: https://doi.org/10.1215/26410478-1.1.99

Paul Gilroy; “Rhythm in the Force of Forces”: Music and Political Time. Critical Times 1 December 2019; 2 (3): 370–395. doi: https://doi.org/10.1215/26410478-7862525

Marianne Kaletzky, Ramsey McGlazer; Migrating Tactics: An Interview with Ewa Majewska and Katarzyna Rakowska. Critical Times 1 April 2018; 1 (1): 226–240. doi: https://doi.org/10.1215/26410478-1.1.226

14 September 2020

MERLOT - open educational resources

MERLOT is an international community of educators, learners, and researchers interested in the open sharing of learning resources.

Link to website: www.merlot.org/merlot/

Link to YouTube channel: https://www.youtube.com/user/MERLOTPlace

Medical Humanities

Medical Humanities presents the international conversation around medicine and its engagement with the humanities and arts, social sciences, health policy, medical education, patient experience and the public at large. Led by Dr Brandy Schillace, the journal publishes scholarly and critical articles on a broad range of topics. These include history of medicine, cultures of medicine, disability studies, gender and the body, communities in crisis, bioethics, and public health.

Link to website: https://mh.bmj.com

Ahlsen B, Engebretsen E, Nicholls D, et al The singular patient in patient-centred care: physiotherapists' accounts of treatment of patients with chronic muscle pain Medical Humanities Published Online First: 27 March 2019. doi: 10.1136/medhum-2018-011603

McLaughlin J The medical reshaping of disabled bodies as a response to stigma and a route to normality Medical Humanities 2017;43:244-250.

Woloshyn TA Patients rebuilt: Dr Auguste Rollier's heliotherapeutic portraits, c.1903–1944 Medical Humanities 2013;39:38-46.

Elaine Scarry

Scarry's work addresses, among others, literature, drama, law, and language of physical pain. *The Body in Pain*, part philosophical meditation and part cultural critique, is a classic in-depth investigation into the nature of pain and inflicting pain that draws on multiple sources: literature and art, medical case histories, documents on torture, legal transcripts of personal injury trials, and military and strategic writings. Pain, Scarry argues, is inexpressible. It is extremely difficult to describe in words and it simultaneously destroys language: in the most extreme instances of pain, the sufferer is reduced to an inarticulate state of moans and cries. Her more recent work engages with the responsibility and ability to protect one another in the face of nuclear age: the equality of survival in the realities of emergency politics.

An interview with Scarry: https://www.bidoun.org/articles/elaine-scarry

Scarry, Elaine (2011). Thinking in an Emergency. New York: W. W. Norton.

Scarry, Elaine (2014). Thermonuclear Monarchy: Choosing Between Democracy and Doom. New York: W. W. Norton.

Scarry, Elaine (1987). The Body in Pain: The Making and Unmaking of the World. Oxford: Oxford University Press.

15 September 2020

Silvio Almeida

Almeida is an interdisciplinary scholar of philosophy, law and race. He has written books on structural racism in Brazil, as well as on Sartre and young Lukács. In Racismo Estrutural, Almeida draws on the idea of institutionalised racism and discusses through statistical and judicial research how racism manifests in the social, political and economic structures of Brazilian society.

Almeidas writing in Blog Da Boitempo: https://blogdaboitempo.com.br/category/colunas/silvio-luiz-de-almeida/

Almeida, Silvio (2019). Racismo Estrutural. Pólen Livros.

Sartre - direito e política: ontologia, liberdade e revolução. São Paulo: Boitempo, 2016.

O Direito no Jovem Lukács: A Filosofia do Direito em História e Consciência de Classe. São Paulo: Alfa Ômega, 2006.

Open University

The Open University has been a pioneer of distance learning for decades. OpenLearn offers a range of formal learning content for free, often leading to full qualifications.

Link to website: https://www.open.edu/openlearn/free-courses/full-catalogue

Link to YouTube channel: https://www.youtube.com/user/OUlearn

Hypothesis

Hypothesis is a simple, open source tool to annotate and share any website. “Using annotation, we enable sentence-level note taking or critique on top of classroom reading, news, blogs, scientific articles, books, terms of service, ballot initiatives, legislation and more. Everything we build is guided by our principles. In particular that it be free, open, neutral, and lasting to name a few.”

Link to website: https://web.hypothes.is/about/

Link to YouTube channel: https://www.youtube.com/user/hypths

16 September 2020

Journal of humanities in rehabilitation

The Journal of Humanities in Rehabilitation is a peer-reviewed, multimedia, open-access journal published in collaboration with the Emory Center for Digital Scholarship. The purpose of this journal is to raise the consciousness and deepen the intellect of the humanistic relationship in the rehabilitation sciences. Our mission is to encourage dialogue among rehabilitation professionals, patients, families and caregivers that describe the human condition as it experiences the impact of illness or disability. We hope to highlight and illustrate the special relationship between the patient and rehabilitation provider, as well as provide a venue for scholarly discourse on topics that focus on rehabilitation from the uniquely human perspective that patients and providers share. We also seek to critically examine the social-cultural assumptions underpinning rehabilitation.

Link to website: https://www.jhrehab.org/about/

Gorman-Bader, D. (2020). Dynamic Autonomy in Chronic Pain Management: Frida Kahlo Illustrates. https://tinyurl.com/y3pkhzo5.

Aittokallio, J. & Rajala, A. (2020). Perspectives On 'Person-Centeredness' From Neurological Rehabilitation and Critical Theory: Toward a Critical Constellation. https://tinyurl.com/y9p7z8bz.

Pöstges, H. (2019). Physical Therapy at Bath War Hospital: Rehabilitation and Its Links to WW1. https://tinyurl.com/y28qcoua.

FlipGrid

FlipGrid is a free remote teaching and learning tool in which you can create discussion topics and respond to content with short videos. FlipGrid enables asynchronous taching and learning, but with a tad more social feel. Creating a grid in the app is easy and just share the link to your grid with students, collagues or family. FlipGrid can be used to create assignments and students then reply with a video, and there are loads of functions to customise both assingments and replies to them.

Link to website: https://info.flipgrid.com/

https://www.youtube.com/watch?v=aLzX13jw7bw

Tom Shakespeare

Tom Shakespeare is a social scientist and bioethicist, whose research addresses disability, ethical issues around prenatal genetic testing and end of life assisted suicide. In his *Disability*

Rights and Wrongs, Shakespeare argues that the social model of disability, that emerged from the political activism of disabled people, has reached a dead end. The social model argues that disability is the result of disabling social and physical structures, not a quality of the disabled person themselves. Drawing on critical realism, Shakespeare argues that what is needed instead is a nuanced and pluralist theory of disability that considers disability as both social and an embodied matter.

Blog: https://farmerofthoughts.co.uk/

Shakespeare, Tom (2006). Disability rights and wrongs. Abingdon: Routledge.

Shakespeare, Tom (2014). Disability rights and wrongs revisited (Second ed.). London: Routledge.

Shakespeare, Tom (2015). Disability research today: International perspectives. London: Routledge.

Shakespeare, Tom (2017). Disability: The basics (1st ed.). London: Routledge.

17 September 2020

The Use of Bodies by Giorgio Agamben

The Use of Bodies represents the ninth and final volume in this twenty-year undertaking, breaking considerable new ground while clarifying the stakes and implications of the project as a whole. It comprises three major sections. The first uses Aristotle's discussion of slavery as a starting point for radically rethinking notions of selfhood; the second calls for a complete reworking of Western ontology; and the third explores the enigmatic concept of "form-of-life," which is in many ways the motivating force behind the entire *Homo Sacer* project. Interwoven between these major sections are shorter reflections on individual thinkers (Debord, Foucault, and Heidegger), while the epilogue pushes toward a new approach to political life that breaks with the destructive deadlocks of Western thought. The *Use of Bodies* represents a true masterwork by one of our greatest living philosophers.

Link to book: https://www.sup.org/books/title/?id=24895

Flinga

Flinga is a easy-to-use cloud tool developed for co-creation activities. It offers tools for brainstorming, commenting, mindmapping and making collages. Just log in and create a Flinga board, share it with your colleagues who can contribute to the co-creation without having to create an account. The fun part is that everyone joined to the board can see all what is happening in real time. Flinga can be used via browser or on mobile devices. Try it for teaching and learning activities or any kind of brainstorming.

Link to website: https://flinga.fi/

https://www.youtube.com/watch?v=Gpb*3lqs4Lc*

The Conversation

The Conversation is an independent source of news and views, sourced from the academic and research community and delivered direct to the public. Our team of professional editors work with university, CSIRO and research institute experts to unlock their knowledge for use by the wider public. Access to independent, high-quality, authenticated, explanatory journalism underpins a functioning democracy. Our aim is to allow for better understanding of current affairs and complex issues. And hopefully allow for a better quality of public discourse and conversations.

Link to website: https://theconversation.com

Ten ways South Africa can step-up care for its healthcare workers

Physiotherapy works better when you believe it will help you – new study

Physiotherapy students have much to learn from the humanities

18 September 2020

Medicine, Healthcare & Philosophy

Medicine, Health Care and Philosophy: A European Journal is the official journal of the European Society for Philosophy of Medicine and Health Care. It provides a forum for international exchange of research data, theories, reports and opinions on bioethics, and the philosophy of medicine and health care in general. The journal promotes interdisciplinary studies, and stimulates international exchange. Particular attention is paid to developing contributions from all European countries, and to making accessible scientific work and reports on the practice of health care ethics, from all nations, cultures and language areas in Europe.

Link to website: https://www.springer.com/journal/11019/

Drolet, M., Hudon, A. Theoretical frameworks used to discuss ethical issues in private physiotherapy practice and proposal of a new ethical tool. Med Health Care and Philos 18, 51–62 (2015). https://doi.org/10.1007/s11019-014-9576-7

Praestegaard, J., Gard, G. & Glasdam, S. Practicing physiotherapy in Danish private practice: an ethical perspective. Med Health Care and Philos 16, 555–564 (2013). https://doi.org/10.1007/s11019-012-9446-0

Sviland, R., Martinsen, K. & Råheim, M. To be held and to hold one's own: narratives of embodied transformation in the treatment of long lasting musculoskeletal problems. Med Health Care and Philos 17, 609–624 (2014). https://doi.org/10.1007/s11019-014-9562-0

Whistling Vivaldi: And Other Clues to How Stereotypes Affect Us by Claude M. Steele

Claude M. Steele, who has been called "one of the few great social psychologists," offers a vivid first-person account of the research that supports his groundbreaking conclusions on stereotypes and identity. He sheds new light on American social phenomena from racial and gender gaps in test scores to the belief in the superior athletic prowess of black men, and lays out a plan for mitigating these "stereotype threats" and reshaping American identities.

Link to book: https://wwnorton.com/books/9780393339727

Adriana Cavarero

Cavarero's work is situated in the intersection of political philosophy and feminist thought. Many of Cavarero's books might interest physiotherapists. In *Relating Narratives: Storytelling and Selfhood*, which work in the intersection of ethics, political discourse and ethics, she developed a theory of selfhood as a 'narratable self'. In *For More Than One Voice*, she rethinks the relation between speech and politics. Finally, here more recent work Inclinations: A critique of rectitude, critiques the characterisation of humans as 'upright' by analysing philosophy, psychoanalysis, anthropological writings, literature and artworks. Being figured as 'upright'—that is, standing up, being vertical—produces certain truths and power relations, and obscures a more natural figuration: inclination.

Book review of Inclinations: https://www.radicalphilosophy.com/reviews/individual-reviews/fall-of-philosophicus-erectus

Cavarero, A. (2005). For more than one voice: Toward a philosophy of vocal expression. Stanford, Calif: Stanford University Press.

Cavarero, A. (2016). Inclinations: A critique of rectitude. Stanford, California: Stanford University Press.

Cavarero, A. (2000). Relating narratives: Storytelling and selfhood. London: Routledge.

19 September 2020

Progressive Geographies

Thinking about place and power – a site written and curated by Stuart Elden.

Link to website: https://progressivegeographies.com

Geographers, sociologists, philosophers etc. on covid-19

Neoliberal Dogma? Revisiting Foucault on Social Security, Healthcare, and Autonomy (Pt. I of II)

Mental health issues in academia – a challenging piece in The Guardian

Hemingway Editor

Hemingway Editor is a free editing tool that analyses your writing and gives tips to clarify your text. Just uppload a piece of text to the app and see the colour coded highlights that might require your attention. The app gives suggestion on readability and grammatical issues. What is great with this app is that is does not impose changes on your text but highlights them to you. While you edit your text, the app evaluates the readibility in real time. You can paste your own text to the browser app, edit the text in the app and finally just copy the corrected text and paste it to your own document.

Link to website: http://www.hemingwayapp.com/

https://www.youtube.com/watch?v=KaAsJJxQq8s

Child and Young People, Aesthetics and Special Needs by Torgeir Haugen & Kjell Ivar Skjerdingstad

This book aims to show how aesthetics can contribute to professional practices and its reflections on children and young people with special needs. On the one hand, it is motivated by a need to reflect broader and work deeply with the vulnerable child that for some reason departs from what is conceived as the normal. On the other hand, we need to utilize the unused potential of aesthetic reflection and practice. This is the double impetus behind this book and the research done by diverse scholars from which it has emerged. The diversity in the contributors' backgrounds and interests, as well as the different forms and expressions of the contributions, reflects and adds up to this multiplicity. Embracing aesthetics as a general foundation for any life form, grounding any symbolic representation of the world as man does in verbal language, mathematics or the arts, implies a similar acceptance and avowing of the fact that all humans are equal in their sensual interlacing with the world. Thus, addressing children and young people with special needs implies that diversity should be accepted and acclaimed as a goal in itself – a normative bias. The anthology is aimed at researchers, scientists, scholars and teachers at universities and colleges of applied sciences and vocational studies. It can also be enriching for students and readers interested in aesthetics and special needs.

Link to book: http://solumbokvennen.no/boker/children-and-young-people-aesthetics-and-special-needs

20 September 2020

Trello

Trello is a tool for collaborative working. It has boards, lists, and cards that you can use for organising your collaborative projects. Trello offers at one glance what the project collaborators are up to and what reimains to be done for your project. It has a project planning board that helps to keep on schedule.

Lin to website: https://trello.com/en

https://www.youtube.com/watch?v=tVooja0Ta5I

Social Science & Medicine

Social Science & Medicine provides an international and interdisciplinary forum for the dissemination of social science research on health. We publish original research articles (both empirical and theoretical), reviews, position papers and commentaries on health issues, to inform current research, policy and practice in all areas of common interest to social scientists, health practitioners, and policy makers. The journal publishes material relevant to any aspect of health from a wide range of social science disciplines (anthropology, economics, epidemiology, geography, policy, psychology, and sociology), and material relevant to the social sciences from any of the professions concerned with physical and mental health, health care, clinical practice, and health policy and organization. We encourage material which is of general interest to an international readership.

Link to website: https://www.journals.elsevier.com/social-science-and-medicine/

Josephson, I., Woodward-Kron, R., Delany, C., & Hiller, A. (2015). Evaluative language in physiotherapy practice: How does it contribute to the therapeutic relationship? Soc Sci Med, 143, 128-136. https://doi.org/10.1016/j.socscimed.2015.08.038

Coveney, C., Faulkner, A., Gabe, J., & McNamee, M. (2020). Beyond the orthodox/CAM dichotomy: Exploring therapeutic decision making, reasoning and practice in the therapeutic landscapes of elite sports medicine. Soc Sci Med, 251, 112905. https://doi.org/10.1016/j.socscimed.2020.112905

Jeffries, J. M. (2018). Negotiating acquired spinal conditions: Recovery with/in bodily materiality and fluids. Soc Sci Med, 211, 61-69. https://doi.org/10.1016/j.socscimed.2018.04.017

Burnout society by Byung-Chul Han

Our competitive, service-oriented societies are taking a toll on the late-modern individual. Rather than improving life, multitasking, "user-friendly" technology, and the culture of convenience are producing disorders that range from depression to attention deficit disorder to borderline personality disorder. Byung-Chul Han interprets the spreading malaise as an inability to manage negative experiences in an age characterized by excessive positivity and the universal availability of people and goods. Stress and exhaustion are not just personal experiences, but social and historical phenomena as well. Denouncing a world in which every against-the-grain response can lead to further disempowerment, he draws on literature, philosophy, and the social and natural sciences to explore the stakes of sacrificing intermittent intellectual reflection for constant neural connection.

Link to book: https://www.sup.org/books/title/?id=25725

21 September 2020

Phenomenology & Practice

Phenomenology & Practice is a human science journal dedicated to the study of the lived experience of a broad range of human practices. These include (but are not limited to) the professional practices of pedagogy, design, counseling, psychology, social work, and health science. Increasingly, researchers and practitioners in these and other fields are adapting interpretive methodologies to address questions related to practice.

Link to website: https://journals.library.ualberta.ca/pandpr/index.php/pandpr

Bjorbækmo, W., Evensen, K. V., Groven, K. S., Rugseth, G., & Standal, Ø. F. (2018). Phenomenology of Professional Practices in Education and Health Care: An Empirical Investigation. Phenomenology & Practice, 12(1), 18-30. https://doi.org/10.29173/pandpr29355

Bergonzoni, C. (2017). When I Dance My Walk: A Phenomenological Analysis of Habitual Movement in Dance Practices. Phenomenology & Practice, 11(1), 32-42. https://doi.org/10.29173/pandpr29336

Rugseth, G., & Standal, Ø. (2015). “My Body Can Do Magical Things” The Movement Experiences of a Man Categorized as Obese –A Phenomenological Study. Phenomenology & Practice, 9(1), 5-15. https://doi.org/10.29173/pandpr25360

Existential Comics

Comics that try to explain philosophical ideas. And more.

Link to website: http://existentialcomics.com

John Rawls and the original position

Angela Davis vs liberal reformers

What is existentialism?

Jia Toletino

Tolentino is a writer and editor, and a Staff Writer for The New Yorker. Her 2019 collection of essays entitled Trick Mirror: Reflections on Self-Delusion explores self-delusion in our lives. Tolentino's essays address the ways the culture of self makes it harder to see ourselves clearly. This culture has shaped her, and these cultural processes are the topics of her essays, from the rise of the nightmare social internet to the 'American scammer as millennial hero' and other topics. She also addresses how our bodies, among other things, should always be getting more efficient and beautiful until we die.

Blog: https://jia.blog/

Tolentino, Jia (2019). Trick Mirror: Reflections on Self-Delusion. New York: Random House.

22 September 2020

Sci-hub

The first pirate website in the world to provide mass and public access to tens of millions of research papers.

Link to website: https://scihub.to

Mendeley

Mendeley is a reference management tool that can also be used to share reserach papers and connect with other researchers in the network. Mendeley keep track of how many users read the papers you have shared and allows you to share and annotate research papers withing private groups. You can create a library that you can access anytime and generate references, citations and bibliographies in a range of journal styles. Mendeley helps to oraginise and collaborate.

Link to website: https://www.mendeley.com

https://www.youtube.com/watch?v=Gv6*HuCYExM*

What's the use by Sarah Ahmed

In What's the Use? Sara Ahmed continues the work she began in The Promise of Happiness and Willful Subjects by taking up a single word—in this case, use—and following it around. She shows how use became associated with life and strength in nineteenth-century biological and social thought and considers how utilitarianism offered a set of educational techniques for shaping individuals by directing them toward useful ends. Ahmed also explores how spaces become restricted to some uses and users, with specific reference to universities. She notes, however, the potential for queer use: how things can be used in ways that were not intended or by those for whom they were not intended. Ahmed posits queer use as a way of reanimating the project of diversity work as the ordinary and painstaking task of opening up institutions to those who have historically been excluded.

Link to book: https://www.dukeupress.edu/whats-the-use

23 September 2020

MindMeister

MindMeister is a free mind mapping tool. It offers visual tools for developing and sharing ideas. You can share your mind maps with as many colleagues as you want. You can also collaborate with them in real-time, create presentations, and manage your project. MindMeister also offers storage space to save your mind maps and organise them into folders. It is quick to use and it offers loads of features to mind mapping.

Link to website: https://www.mindmeister.com/

https://www.youtube.com/watch?v=3DqEoM5fKJg

Zotero

Zotero is an open-source reference assistant. It is free to use and enables you to collect, share, cite and organise research. Zotero is a sofware that automatically senses research from around the web. You can add tags and save your searches for later use. It supportst over 9,000 citation styles so should have you covered! If you just need to quickly compile a bibliography in any style, use ZoteroBib.

Link to website: https://www.zotero.org/, https://zbib.org/

https://www.youtube.com/watch?v=kqFiCj1XV-E

Tim Morton

Morton's work explores the intersection of object-oriented ontology and ecological studies. One of Morton's compelling terms that he developed in The Ecological Thought is

'hyperobjects'. He uses the term to describe objects that are so massively distributed in time and space that they transcend spatiotemporal specificity. Examples of hyperobejcts are global warming, styrofoam, and radioactive plutonium. Hyperobjects, Morton argues, become visible only in ecological crisis. Morton's recent book Being Ecological in an approachable but brilliantly written book draws on Kant and Heidegger to help us understand living in an age of mass extinction caused by global warming. This is an interesting read even for those who might not consider them 'ecological' because they might already be unknowingly ecological.

Blog: http://ecologywithoutnature.blogspot.com/

Morton, Tim (2013). Hyperobjects: Philosophy and Ecology after the End of the World. University of Minnesota Press.

Morton, Tim (2017). Humankind: Solidarity with Non-Human People. London: Verso Books.

Morton, Tim (2018). Being Ecological. London: Pelican Books.

24 September 2020

Saúde e Sociadade

To disseminate critical and reflective scientific output related to the Public/Collective Health field; to publicize new approaches; to host the technical output which brings forth the results of relevant pieces for the progress of the debate on challenging health topics; to validate articles prioritizing the interface between health and social and human sciences.

Link to website: https://www.revistas.usp.br/sausoc/index

Salmória, J., & Camargo, W. (2008). Approaching the Signs - Physiotherapy and Health - to the Human and Social Aspects . Saúde E Sociedade, 17(1), 73-84. https://doi.org/10.1590/S0104-12902008000100007

Chesani, F. (2013). The academic production in physiotherapy: a study of theses from the epistemological assumptions of Fleck. Saúde E Sociedade, 22(3), 949-961. https://doi.org/10.1590/sausoc.v22i3.76488

Nunes, M., Junges, J., Gonçalves, T., & Motta, M. (2017). Acupuncture goes beyond the needle: trajectories of formation and action of acupuncturists. Saúde E Sociedade, 26(1), 300-311. https://doi.org/10.1590/s0104-12902017157679

Readable

Readable is designed to improve readability of websites. It is suscription based, with three suscription tiers, so it is ideal for authors who publish content regularly. Readable helps with clarity, grammar and spelling. Readable scans your website and monitors new content.

Link to website: https://readable.com/

https://www.youtube.com/watch?v=YQFM*Wxfaew*

> Braiding sweetgrass: Indigenous wisdom, scientific knowledge and the teaching of plants by Robin Wall Kimmerer

Drawing on her life as an indigenous scientist, a mother, and a woman, Kimmerer shows how other living beings—asters and goldenrod, strawberries and squash, salamanders, algae, and sweetgrass—offer us gifts and lessons, even if we've forgotten how to hear their voices. In a rich braid of reflections that range from the creation of Turtle Island to the forces that threaten its flourishing today, she circles toward a central argument: that the awakening of a wider ecological consciousness requires the acknowledgment and celebration of our reciprocal relationship with the rest of the living world. For only when we can hear the languages of other beings will we be capable of understanding the generosity of the earth, and learn to give our own gifts in return.

Link to book: https://milkweed.org/book/braiding-sweetgrass

25 September 2020

> Mark Fisher

Mark Fisher, also known as k-punk, was a writer, critic, cultural theorist, philosopher and teacher based in Goldsmiths, University of London. Sadly, Fisher passed away in 2017. Although his blog is not updated anymore, it contains loads of writings over the years. Fisher is best know for blogging as k-punk on radical politics, music and popular culture. In Capitalist Realism: Is There No Alternative, Fisher describes 'capitalist realism' as "the widespread sense that not only is capitalism the only viable political and economic system, but also that it is now impossible even to imagine a coherent alternative to it". Fisher's argument has implications for healthcare, as he argues, capitalist realism also means that everything in society is run with a 'business ontology' including healthcare and education that are today run like businesses.

Blog: http://k-punk.abstractdynamics.org/

Fisher, Mark (2009). Capitalist Realism: Is There No Alternative? Winchester: Zero Books.

Ambrose, Darren, ed. (2018). k-punk: The Collected and Unpublished Writings of Mark Fisher (2004–2016). London: Repeater Books.

Graphpad

Graphpad is a suscription based software that is used to analyse, graph and present your reserach.

Link to website: https://www.graphpad.com/

TORCH: Oxford Research Centre in the Humanities

TORCH is a nucleus of intellectual energy for the humanities and a place to develop new ideas and collaborations both within and beyond academia.

Link to website: https://torch.ox.ac.uk

Values based healthcare

Humanities and healthcare

Healing, personal values and narratives in healthcare

26 September 2020

Ciências e Saúde Coletiva

To publish debates, analyses, and results of research on a Specific Theme considered current and relevant to the field of Collective Health.

Link to website: https://www.scielo.br/scielo.php?script=sci_serial&pid=1413-8123&lng=en

Silva, V. A. D., Busnello, A. R. R., Cavassin, R. C., Loureiro, A. P. C., Moser, A. D. L., & Carvalho, D. R. (2020). Physiotherapy access for children and adolescents with physical disabilities in public institutions. Cien Saude Colet, 25(7), 2859-2870. https://doi.org/10.1590/1413-81232020257.12682018

da Silva, I. D., & Silveira, M. F. (2011). The humanization and the formation of the professional in physiotherapy. Cien Saude Colet, 16 Suppl 1, 1535-1546. https://doi.org/10.1590/s1413-81232011000700089

Siqueira, F. C., Facchini, L. A., da Silveira, D. S., Piccini, R. X., Thumé, E., & Tomasi, E. (2009). Architectonic barriers for elderly and physically disabled people: an epidemiological study of the physical structure of health service units in seven Brazilian states. Cien Saude Colet, 14(1), 39-44. https://doi.org/10.1590/s1413-81232009000100009

This sociological life

A blog on sociology of health from Deborah Lupton

Link to website: https://simplysociology.wordpress.com

COVID societies, some resources for social researchers

Innovative and creative methods for researching people's use and understandings of their data – a resource list

Data selves - new book

Donna Haraway

Haraway's work brings together questions of science and feminism, the perhaps most well-known contributions being 'A Cyborg Manifesto' and 'Situated Knowledges'. In the latter, she wishes to expose the myth of scientific objectivity and argue for the situatedness and positionality of all knowledge. Writing in the New Materialist and post-human contexts, her work often addresses anthropocentrism critically and emphasizes self-organizing powers of nonhuman processes.

Film about Haraway's thinking available to rent:
https://vimeo.com/ondemand/donnaharaway

Haraway, Donna. Staying with the Trouble: Making Kin in the Chthulucene, Durham: Duke University Press, 2016.

Haraway, Donna. Simians, Cyborgs and Women: The Reinvention of Nature, New York: Routledge, and London: Free Association Books, 1991

Haraway, Donna. "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspectives", Feminist Studies, 14 (1988) 575–599. doi:10.2307/3178066

27 September 2020

Scrivener

Scrivener is a writing application that enables you to carry your work with you. The app is suscription based but also very versatile and handy if you write a lot. Scrivener does not tell you how to write, but it simply provides help with str´arting and finishing your draft. Scrivener is like a electronic master notebook. It communicates with other software such as Word. It is great for long writing projects and getting your writing and notes organised.

https://www.literatureandlatte.com/scrivener/overview

https://www.youtube.com/watch?v=ZmIkROmxBHg&t=20s

Resistance as research by Leslie Brown, Susan Strega

Research as Resistance takes a critical look at the resurgence of marginalized knowledges, including those of women, the disabled, sexual minorities, and racialized minorities, and how these knowledges are employed within research to work against dominant knowledges and methodologies. Gender, class, and race are central aspects of social research; however, they are continuously at the periphery. This book emphasizes an anti-oppressive research approach which encourages researchers to commit "to a set of principles, values, and ways of working, and (that) can be carried out anywhere – it's a matter of choice amid various constraints" (p. 18). In other words, not all ethics review boards and communities will hold you to the standards of anti-oppressive research; it is the choice of the researcher to morally operate within these guidelines themselves.

Link to book: https://www.erudit.org/en/journals/ethno/2016-v38-n1-2-ethno03231/1041600ar/

Physiotherapy Theory & Practice

The aim of Physiotherapy Theory and Practice is to provide an international, peer-reviewed forum for the publication, dissemination, and discussion of recent developments and current research in physiotherapy/physical therapy. The journal accepts original quantitative and qualitative research reports, theoretical papers, systematic literature reviews, clinical case reports, and technical clinical notes. Physiotherapy Theory and Practice; promotes post-basic education through reports, reviews, and updates on all aspects of physiotherapy and specialties relating to clinical physiotherapy.

Link to website: https://www.tandfonline.com/loi/iptp20

Roger Kerry, Matthew Maddocks & Stephen Mumford (2008) Philosophy of science and physiotherapy: An insight into practice, Physiotherapy Theory and Practice, 24:6, 397-407, DOI: 10.1080/09593980802511797

Georgi Daluiso-King & Clair Hebron (2020) Is the biopsychosocial model in musculoskeletal physiotherapy adequate? An evolutionary concept analysis, Physiotherapy Theory and Practice, DOI: 10.1080/09593985.2020.1765440

Randi Sviland, Kari Martinsen & David A Nicholls (2020) Løgstrup's thinking: a contribution to ethics in physiotherapy, Physiotherapy Theory and Practice, DOI: 10.1080/09593985.2020.1741051

28 September 2020

History of philosophy without any gaps

Peter Adamson, Professor of Philosophy at the LMU in Munich and at King's College London, takes listeners through the history of philosophy, "without any gaps." The series looks at the ideas, lives and historical context of the major philosophers as well as the lesser-known figures of the tradition.

Link to website: https://historyofphilosophy.net/

You can chain my leg: Epictetus

Democracy and the history of philosophy in the age of Trump

History of philosophy podcasts

Creative Commons

Creative Commons is not a tool per se, but it is a good way to assign user rights to your online content. It is free to use CC-licences, it is very easy to understand and provides a standardised and widely used copyright liences for work you might wish to share openly but would like to be attributed for the work and avoid misusage, for example modifying your work for commercial purposes. CC-licences can be applied to everything. there are different lience options to choose from. There is also a Licence Chooser tool for deciding which licence works for you best.

https://creativecommons.org/about/cclicenses/

https://creativecommons.org/share-your-work/

https://www.youtube.com/watch?v=_Q3sbk7Zi1Q

Inventive methods: The happening of the social by Celia Lury, Nina Wakeford

Social and cultural research has changed dramatically in the last few years in response to changing conceptions of the empirical, an intensification of interest in interdisciplinary work, and the growing need to communicate with diverse users and audiences. Methods texts, however, have not kept pace with these changes. This volume provides a set of new approaches for the investigation of the contemporary world. Building on the increasing importance of methodologies that cut across disciplines, more than twenty expert authors explain the utility of 'devices' for social and cultural research – their essays cover such diverse devices as the list, the pattern, the event, the photograph, the tape recorder and the anecdote. This fascinating collection stresses the open-endedness of the social world, and explores the ways in which each device requires the user to reflect critically on the value and

status of contemporary ways of making knowledge. With a range of genres and styles of writing, each chapter presents the device as a hinge between theory and practice, ontology and epistemology, and explores whether and how methods can be inventive. The book will be a valuable resource for students and scholars of sociology and cultural studies.

Link to book: https://www.routledge.com/Inventive-Methods-The-Happening-of-the-Social-1st-Edition/Lury-Wakeford/p/book/9780415721103

29 September 2020

Eva Feder Kittay

Kittay is a philosopher, disability scholar, social and political theorist, and care ethicist. Her book, Love's Labor, now in its second edition, is an analysis of the liberal philosopher John Rawls and his theory of justice, extended to care and dependence. Kittay argues that acknowledging dependence is essential. Kittay has also written on cognitive disability. In a recent, more personal book, she reflects her own experiences as a mother of a disabled daughter. She reflects the age-old ethical questions of good life and flourishing from a critical point of view, one which argues that the fact of our-co-dependency does not get sufficient attention. Disability and co-dependence challenge the business-as-usual of moral philosophy: our dependent, vulnerable, messy, changeable, and embodied experience colours everything about our lives.

Website: https://evafederkittay.com/

Kittay, Eva Feder & Ellen K. Feder, eds. (2002). The subject of care: feminist perspectives on dependency. Lanham, Maryland: Rowman & Littlefield Publishers.

Kittay, E. F. (2020). Love's labor: Essays on women, equality and dependency (2nd ed.). Milton: Routledge.

Kittay, E. F. (2019). Learning from my daughter: The value and care of disabled minds. New York: Oxford University Press.

Wordpress

Wordpress is one of the original and still most useful tools for designing website, blogs, and other social media resources. Although there are other tools (Weebly, for instance), that are more visually appealing, Wordpress has a massive support community and almost limitless variability and elasticity. There are free and paid accounts, and an enormous array of tools that you can add to your site. Wordpress is behind the CPN site and history.physio and its reader allows you to discover myriad other wordpress users online.

Link to website: https://wordpress.com/discover

A world without work by Daniel Susskind

New technologies have always provoked panic about workers being replaced by machines. In the past, such fears have been misplaced, and many economists maintain that they remain so today. Yet in A World Without Work, Daniel Susskind shows why this time really is different. Advances in artificial intelligence mean that all kinds of jobs are increasingly at risk. Susskind argues that machines no longer need to reason like us in order to outperform us. Increasingly, tasks that used to be beyond the capability of computers - from diagnosing illnesses to drafting legal contracts - are now within their reach. The threat of technological unemployment is real. So how can we all thrive in a world with less work? Susskind reminds us that technological progress could bring about unprecedented prosperity, solving one of mankind's oldest problems: making sure that everyone has enough to live on. The challenge will be to distribute this prosperity fairly, constrain the burgeoning power of Big Tech, and provide meaning in a world where work is no longer the centre of our lives. In this visionary, pragmatic and ultimately hopeful book, Susskind shows us the way.

Link to book: https://www.danielsusskind.com/a-world-without-work

30 September 2020

The progress of this storm by Andreas Malm

In a world careening towards climate chaos, nature is dead. It can no longer be separated from society. Everything is a blur of hybrids, where humans possess no exceptional agency to set them apart from dead matter. But is it really so? In this blistering polemic and theoretical manifesto, Andreas Malm develops a counterargument: in a warming world, nature comes roaring back, and it is more important than ever to distinguish between the natural and the social. Only with a unique agency attributed to humans can resistance become conceivable.

Link to book: https://www.versobooks.com/books/3140-the-progress-of-this-storm

Elizabeth Spelke

“As robots take our jobs and demonstrably outsmart us, doubts about humanity losing control of its creations are no longer the preserve of science fiction. A happy relationship between artificial and human intelligence must start with understanding their similarities and differences. Having previously demolished hoary ideas about there being distinctive male and female brains, as well as certain assumptions about innate differences between humans and other species, Harvard psychologist Elizabeth Spelke is proving to be an insightful guide. She now studies the minds of babies and with philosophical subtlety interrogates what they reveal about what is—and isn’t—special about humans.”

Link to website: https://psychology.fas.harvard.edu/people/elizabeth-s-spelke

Health sociology review

Health Sociology Review is an international peer-reviewed journal, which publishes high quality conceptual and empirical research in the sociology of health, illness and medicine.

Published three times per year, the journal prioritises original research papers, papers that advance theory and methodology in the field of health sociology and special issues on matters of central importance to health sociology and related fields.

Link to website: https://www.tandfonline.com/loi/rhsr20

Halvor Hanisch & Per Koren Solvang (2019) The urge to work: normative ordering in the narratives of people on long-term sick leave, Health Sociology Review, 28:2, 126-139, DOI: 10.1080/14461242.2019.1579664

Rebecca E. Olson, Nerida Klupp & Thomas Astell-Burt (2016) Reimagining health professional socialisation: an interactionist study of interprofessional education, Health Sociology Review, 25:1, 92-107, DOI: 10.1080/14461242.2015.1101702

Rosalie Boyce (2006) Emerging from the shadow of medicine: allied health as a 'profession community' subculture, Health Sociology Review, 15:5, 520-534, DOI: 10.5172/hesr.2006.15.5.520

30DoS - 2021

This year's 30 Days of September campaign starts in a week's time, and this year we're going back to our roots and the first campaign we ran, where we highlighted 30 of our members. Each day through September you'll see a short profile of someone in the CPN. Everyone was asked five questions:

- Tell us a little about your current work and study, especially how you think and practice critically
- What is it about critical physiotherapy that appeals to you?
- What do you bring to the CPN?
- How would you like to see critical physiotherapy community develop over the next few years?
- How would you like to see the broader physiotherapy profession develop?

And you'll get a real insight into the amazing lives and work of some of our members throughout the month.

Veronika Schoeb

1 September 2021

Since my early days as a clinician, I have always been interested in the interactional/relational aspects of healthcare. What are the components that contribute to a successful therapeutic relationship between a patient and a physiotherapist? How do we need to think about interactions and communication in physiotherapy? After a few years of clinical practice in both Switzerland and the USA, I enrolled in a PhD programme in Sociology to explore exactly interactional aspects in musculoskeletal physiotherapy. I have been working in higher education for nearly 20 years and have continued to investigate interactional practice situations in healthcare, both in Switzerland and in Asia. I was forced to question my own assumptions and taken-for-granted knowledge, and was constantly challenged in my way of understanding physiotherapy education and practice. Having worked in several countries where practices, professional cultures and the role of physiotherapy are different shaped the way I look at the profession today.

This is the reason why I feel close to the Critical Physiotherapy Network that shares the same philosophy: to question the underlying assumptions of what we do and how we look at healthcare practices. I found here a like-minded group that inspired me to take a step back and reflect, explore and develop a new understanding. A very generous group of people, indeed! Thank you all very much for your inspiration!

For future development, I wish that the CPN community continues to question generalised "fashionable" concepts (e.g., patient-centred care, shared decision-making, or motivational interviewing) as they overshadow the intrinsically complex and fine-tuned interactions on a turn-by-turn basis that makes healthcare interactions so colourful. I also believe that it is necessary to acquire new skills, in particular related to technology, artificial intelligence and so on, so that we can ask the right questions related to our profession and find solutions that fit our daily practices or find ways of development that matches the needs of the population we serve. There is a fine balance to be found between professional development helping to reinforce physiotherapy and interprofessional development that is required for a sustainable healthcare system.

Sarah Oosman

2 September 2021

My name is Sarah Oosman. I am a 1st generation settler Canadian with mixed ethnicity (South Asian/Mauritius & Wales) and currently live, play, and work on Treaty 6 Territory and the Homeland of the Métis People, also known as Saskatoon, Saskatchewan, Canada. I have been a physical therapist for more than 20 years and am an associate professor in the School of Rehabilitation Science, University of Saskatchewan. I am also a researcher with the Saskatchewan Population Health and Evaluation Research Unit (SPHERU) and a co-lead on an

Indigenous-led Network Environment for Indigenous Health Research (NEIHR) in Saskatchewan. I joined the CPN at its inception in 2014.

I spend my time in the interstitia, the middle ground, and the space that connects several worlds in both practice, theory, and philosophy. I am committed to Indigenous community-driven action research that leads to the development and implementation of culture-based, meaningful health promoting interventions across the lifespan. I work collaboratively and closely with Métis and First Nation peoples and communities, as well as interdisciplinary and interprofessional teams. I am very passionate about addressing health inequities through respectful relationships, partnerships, and safe, courageous conversations.

I am drawn to critical physiotherapy as it is a way of thinking and practicing that engages with ideas on the boundaries and the fringes of what we know our profession to be. Critical physiotherapy allows us to imagine the potential that we have not quite yet tapped into, supporting our profession's evolution necessary to meet the ever-changing health needs of individuals and society. We live in a world where there is so much health inequity… negatively impacting individuals and populations who do not necessarily feel connected within the 'mainstream' white-dominant culture. Physiotherapists can use their voice in changing this and redressing the power differentials that maintain and perpetuate health inequity. I also believe that collective thinking and problem-solving, as a group of critical physiotherapy practitioners, can influence change more broadly and more efficiently.

Moving forward, I am curious about what the Critical Physiotherapy Network can do to influence the role physiotherapy can play in redressing power hierarchies that exist across diverse health care settings throughout the world. I would like to see our profession be a leader in advocating for new and innovative ways to narrow health inequities that exist across diverse global populations, to learn from world-views and paradigms that stretch those of the mainstream Western world, and re-imagine what physiotherapy has to offer.

Ralph Hammond

3 September 2021

My interest in critical physiotherapy was stimulated by work on clinical effectiveness I did in the 1990s, when I discovered how few widely used outcome measures were available in the languages many people in the UK speak; it made me realise how narrowly anglocentric physiotherapy in the UK is. I have been trying to question and understand my own privileged, normative, history ever since.

I'm a father; a white, middle-class, heterosexual, English, man. I'm a physiotherapist by profession. I work clinically as a stroke coordinator; I conduct reviews of how people are reconstructing their lives, at 6 months post-stroke, physically, mentally, emotionally.

I'm interested in how physiotherapists navigate the lifeworld of health/care, and how we enact the values we claim to hold. So, I'm interested in identity, sense making and storytelling, in socialisation and individuation. I'm interested in what are those values, attitudes, assumptions we hold and are socialised into, what are our motivations, and our beliefs.

Our current times are challenging what we, at all levels of societies, mean by, for example, truth, rationality, democracy. How can history, politics, theology, post-colonialism, the humanities, inform what and how physiotherapists think, speak, and behave, and what we aspire to achieve?

I hope the CPN can continue to provide a space for people to reflect and share the wider world of ideas and perspectives, learning and experiences; to articulate what it might mean for individuals, their work, and the profession more widely; to challenge, to nurture, to be curious.

Nadia El-Seoud

4 September 2021

My name is Nadia El-Seoud. I am a physiotherapist and Ph.D.-candidate at the University, Bremen (Germany). It is my aim to support the physiotherapy's developing-process by uncovering opportunities for development. My focus is on physiotherapy in the context of living conditions. My current study explores a living environment oriented physiotherapy.

I support a critical thinking physiotherapy with my values like equity and encourage social cohesion. Therefore, I use the spirit of the social sciences in addition to my interest and my experiences as a physiotherapist in the fields of research, education and practice.

I am convinced that the community of critical thinking will grow and that critical thought processes will play a bigger part in physiotherapy-training/education.

It would be great if physiotherapists worldwide would notice opportunities to practice physiotherapy with an eye on societal needs. Physiotherapists need to become aware of the potential for integration/inclusion, prevention, participation.

Anne Marit Mengshoel

5 September 2021

During my professional life, I have been curious about what characterise good physiotherapy practice. I doubt that evidence-based guidelines necessarily improve practice. To me, CPN is a forum to discuss such matters. Working on a book chapter recently published by CPN, I engaged in critical writing that I otherwise would not have been doing. Hopefully, the book

may nurture critical thinking within physiotherapy. I welcome similar initiatives and virtual meetings among members in the future.

Autumn 2020, my engagement in the EU-Cost EUROMENE was completed. The members from more than 20 European countries participated in work on diagnostic classification, pathological mechanisms, epidemiology, and health care costs related to chronic fatigue syndrome (CFS/ME). The cultural diversities and power of knowledge among the members became an interesting issue in itself. My deliverable was a mixed method scoping review of effects from non-pharmacological therapies and qualitative studies of patient treatment experiences, presenting one story about little effects from non-pharmacological interventions, and a quite different story about patients' needs for legitimation and support from health professionals and others. This paper was published; but it did not influence the EUROMENE recommendations for future research. Nevertheless, my benefit was a new network and being a co-supervisor for two PhD students examining recovery experiences of prior patients.

This year, the results from the study 'From theory to practice — development of a patient education program for patients with fibromyalgia (FM)' was published. The paper described the development, purpose and content of the program, and its meaning for those involved. A multidisciplinary rehabilitation team and researchers coproduced the program by bridging evidence about FM and recovery experiences of prior patients with FM, positive clinical experiences and various professional knowledge. Similar work is now going on in collaboration with physiotherapists in primary health care. In this work, our comprehensive understanding of recovery as elaborated on in the chapter 'Rethinking recovery' for the recent CPN book Mobilizing Knowledge will play a role by highlighting patients' own healing work.

During the last half year, the broad understanding of recovery has underpinned the development of a theoretical platform for physiotherapists delivering services to patients with rheumatic inflammatory diseases. Together with physiotherapists in a specialised hospital in rheumatology, we systematically explored the historical development within rheumatology and physiotherapy, discourses of rehabilitation, evidence-based practice and patient-centred care, and the clinical experiences of present physiotherapy practice. The theoretical platform is expressed in terms of; body-object and functions that should be 'repaired', and body-subject and functioning related to support a person's need of re-familiarising with an alien body to heal one's life and self. Our notion was that the body-subject seemed to be a hidden and non-verbalised clinical practice at the hospital.

My wish for the future is that physiotherapists will devote more work to explore practice processes to find out what is important ingredients and clarify why they eventually are valuable. My hope is that this may humanise a technologising of clinical practice.

Adrianne Vieira

6 September 2021

My name is Adriane Vieira and I am an associate professor at a public university in the south of Brazil. Since my undergraduate studies, more than thirty years ago, I have had difficulty thinking of the body as an isolated, neutral and universal object. For me, even if the analogy of the body to the machine was useful, it was never enough to understand the processes that lead us to a state of happiness, health and illness. In the search for answers to my concerns, in a movement that led me in a different direction from my colleagues, I approached readings more linked to philosophy and social sciences. On this path, I found inspiration to guide my professional performance and research, mainly in discussions aimed at embodiment from a cultural and phenomenological perspective.

Despite considering that biomedicine and biomechanics are relevant to physiotherapy, they do not address many issues relevant to health work, such as social determinants of health, human interactions in therapeutic encounters, repercussions of different models of health care, and acting together with communities. The challenge of developing a more attentive and reflective look at the social role of physiotherapists and our choices regarding the production of health care.

I bring the desire to share knowledge and work towards the construction and dissemination of broader perspectives for the profession, in order to articulate knowledge arising from the social science and humanities to the field of training and performance of physiotherapists. I still encounter a lot of resistance in the environment in which I work to propose new ways of acting as a physiotherapist and I have a lot to learn from the experiences of colleagues in the network.

I believe that we need to work to expand the spaces for the production and dissemination of research and theoretical reflections, as well as a space for meeting and discussion so that we can advance in the construction of other possible paths for training and professional practice.

I would like to see our profession engage more actively with new concepts of body and health, being involved with social movements, diversifying their practices and acting in a more contextualized and socially responsible way.

Joost van Wijchen

7 September 2021

The water splashes in my face each time I take short breaths between the strokes. Swimming amidst lakes, close to the trees, I see the plants, animals, water flowers. It’s like a hike in the water. Encountering the different smells, the changes in temperature, the difference in

colours, shadows, and life. A group of carps are swimming below me without changing their pace, they don't seem to take notice of me at all. The swans and ducks swim past, sometimes next to me. Without realising, I have joined a family of common coots, and we are swimming together a couple of meters through the water. Although merely just my perception, I encounter a sense of belonging in the water. A sense of being part of the world in its diversity and symbiosis. Of course, knowing that the latter is probably more my desire than anything else. All of a sudden, I am swimming amidst a flock of freshwater jelly fish, at first directly entering in stress, would they sting? Within a second, my mind and perception changes from fear to adoration of the beauty of the flock. The gentle movements by the millions, the tranquillity and the field of light white bodies, a moment of joy. Out of the blue, a transformative power emerges. Fear changes into beauty and adventure, fear changes into daring, restraining changes to exploration. While swimming, I feel that I'm moving into a world of freedom, a freedom which comes with responsibilities. Responsibilities to the environment, to others and to myself. A freedom that can create hope. A hope to learn and explore, to discover the beauty of life.

When taking my experiences of swimming into the world of physiotherapy, also this world changes. Physiotherapy has been an intertwined part of my life for the last quarter of a century. A natural flow between different plateaus of life seems to be logical. When looking at different perspectives in physiotherapy, its ambiguities and contradictions, become clearer to me. At first, small anomalies submerged to me, for example variations in application techniques and reasoning processes. Although we teach this in specific manners, its use seems to have a huge variation in practice. Variation, which is highly context-specific. This led to more questions. Questions on premises used within everyday practice, questions on underlying assumptions, and questions on why it seems to be structured in this way, and not in different ways. These questions moved slowly from instrumental and technical to more around ways of conception and action.

At this moment, I came in touch with the Critical Physiotherapy Network (CPN). The blogs, podcasts, books, interactions, and emerging conversations helped me to give meaning to my questions. During the years, CPN has provided openings and invitations to cross liminalities into new spaces. Often it has been with some resistance. Though, it has always developed my thinking and made me seen situations in a new way. CPN to me is a forum which acts as a critical support. A support to get off the beaten path, a support who invites getting lost and to discover new paths. This moved me to connect questions with actions. A sense of obligation, not only to ask questions, but actually be acting in accordance with them.

Questions relate to the why(s) of physiotherapy. Are we of necessary and real service to society and to the world? Sometimes it feels as if standards, universal ways of organising the world, are of more importance than the world we are itself. Could there be other ways? What

if we embrace more curiosity? What if we explore more of the different ways? What if we take uncertainty and variation more as a basic premises? Would this enlarge our ways of becoming physiotherapists? Would we be of added value in changing worlds? What if we just give it a try?

Could an educational program in physiotherapy be structured around variation and uncertainty from day one? We do so in the delta-stream at HAN University. We mean that to support upcoming physiotherapist, we need space for discovery and possibilities for creation, to manage to find new ways. At the same time, we can support socialisation into the profession and creating physiotherapeutic competences. We do this in such a way that the upcoming physiotherapists experience confidence in their competences, that they can act also in the unknown circumstances. In line with physiotherapeutic service, each individual is unique and follows a unique developmental path, the educational program it is self-organised. Still, there is a close collaboration between all learners (students, teachers, and administration), and the team has a strong role The changing and double roles, different perspectives and objectives creates continuous challenge to all learners. Ambiguities and frictions submerge and pass away. Learners move between comfort, fear, and learning zones. Next to development of technical skills and knowledge, learners develop navigating skills in known and unknown situations. To me, physiotherapy is not an entity outside us and the world, physiotherapy is part of the world, physiotherapies are owned by society.

My name is Joost van Wijchen. I work as a physiotherapist, senior lecturer and educational designer. I have had the privilege of learning and working in the Netherlands, France, Germany, United Kingdom and Norway. The above-described journey on education is situated at the HAN University of Applied Sciences in Nijmegen, the Netherlands, amidst the delta of the Maas and Waal rivers.

Next to this work, I am part of the Erasmus+ Physiotherapy & Refugees Education project (PREP). I support Environmental Physiotherapy Association (EPA) by being an executive board member. To support physiotherapy education, I am part of the executive board of European Physiotherapy in Higher Education Network (ENPHE).

Concerning CPN, I hope I support the ongoing becoming of this critical community.

Jenny Nissler

8 September 2021

I've not been an active member of the CPN to date, but I am an interested one. I'm not an academic, which is my perception of the mainstay of this group, but I do think and care deeply about our profession. I was invited to the group by a one-time colleague at the Chartered Society of Physiotherapy who was a founding member of the CPN. Many

professional practice issues were discussed as part of a service supporting UK physiotherapists, doing our utmost to help each person with their particular situation, developing our own and their own critical thinking with each one.

I was a sporty child and young woman who switched to a sporty version of physiotherapy from a BA in Sport and Recreation, having become interested in physiotherapy after a module on Sports Injuries. I qualified in the first cohort of physiotherapists at Pinderfields after the curriculum changed to that of an approved UK physiotherapy course. I will attach my CV, but my long and winding, enjoyable and worthwhile physiotherapy road eventually and inevitably led me to Occupational Health. That was my real interest as it turned out; how people carry out their work, how they move and behave in the workplace — initiated after visiting my sister in her open-plan office in the late 90s, and being shocked at and fascinated by at the uniformly appalling desk-based postures that I saw there.

In 2020, I ended a long stint working as a professional adviser for the UK professional body, advising, writing publications and influencing policy initially on fitness for work — during which I learned about actually being in an open-plan office and the importance and influence of organisational culture on the mental and physical health of employees. I now specialise in providing ergonomic assessments for companies and individuals in Oxford and London. It will be an interesting time for the world of work, as hybrid working practice is set to stay. To my mind, this is a very healthy development for some people, but not all.

Clinical experience, pragmatism, care.

I'm not sure I'm qualified to comment, but from experience so far, it's important to continue to exist and to be available as a challenging, alternate voice for the profession. Perhaps become more active in the mainstream when the time is right.

Ethically, with full consideration of what to keep and what to move on from; challenging but working with government and supporting communities. Provide what people with and without health conditions need, facilitating them to live as well as they are able, in a way that lets people know that they are valued.

This route is what I hope for the wider profession. I don't think it will be easy. In the UK, there are ever-present funding issues within the National Health Service (NHS), a disunited devolved health service and a reliance on the Third, Charity sector to make up the gap in the public finances. There is tension and misunderstanding between the public and private physiotherapy sector.

The physiotherapy badge is the one I was awarded when I qualified. It features the three English lions, the 'ray' of electrotherapy and the pair of hands denoting manual therapy. To

me, this represents both the stasis and the evolution of the profession, and the need to be mindful to incorporate both our own minds and bodies in our work as we evolve.

Chris Higgs

9 September 2021

I've not been an active member of the CPN to date, but I am an interested one. I'm not an academic, which is my perception of the mainstay of this group, but I do think and care deeply about our profession. I was invited to the group by a one-time colleague at the Chartered Society of Physiotherapy who was a founding member of the CPN. Many professional practice issues were discussed as part of a service supporting UK physiotherapists, doing our utmost to help each person with their particular situation, developing our own and their own critical thinking with each one.

I was a sporty child and young woman who switched to a sporty version of physiotherapy from a BA in Sport and Recreation, having become interested in physiotherapy after a module on Sports Injuries. I qualified in the first cohort of physiotherapists at Pinderfields after the curriculum changed to that of an approved UK physiotherapy course. I will attach my CV, but my long and winding, enjoyable and worthwhile physiotherapy road eventually and inevitably led me to Occupational Health. That was my real interest as it turned out; how people carry out their work, how they move and behave in the workplace — initiated after visiting my sister in her open-plan office in the late 90s, and being shocked at and fascinated by at the uniformly appalling desk-based postures that I saw there.

In 2020, I ended a long stint working as a professional adviser for the UK professional body, advising, writing publications and influencing policy initially on fitness for work — during which I learned about actually being in an open-plan office and the importance and influence of organisational culture on the mental and physical health of employees. I now specialise in providing ergonomic assessments for companies and individuals in Oxford and London. It will be an interesting time for the world of work, as hybrid working practice is set to stay. To my mind, this is a very healthy development for some people, but not all.

Clinical experience, pragmatism, care.

I'm not sure I'm qualified to comment, but from experience so far, it's important to continue to exist and to be available as a challenging, alternate voice for the profession. Perhaps become more active in the mainstream when the time is right.

Ethically, with full consideration of what to keep and what to move on from; challenging but working with government and supporting communities. Provide what people with and without health conditions need, facilitating them to live as well as they are able, in a way that lets people know that they are valued.

This route is what I hope for the wider profession. I don't think it will be easy. In the UK, there are ever-present funding issues within the National Health Service (NHS), a disunited devolved health service and a reliance on the Third, Charity sector to make up the gap in the public finances. There is tension and misunderstanding between the public and private physiotherapy sector.

The physiotherapy badge is the one I was awarded when I qualified. It features the three English lions, the 'ray' of electrotherapy and the pair of hands denoting manual therapy. To me, this represents both the stasis and the evolution of the profession, and the need to be mindful to incorporate both our own minds and bodies in our work as we evolve.

Cécile Abboudi

10 September 2021

Hi! My name is Cécile; I am a French physiotherapy, a PhD student in public health and a teacher. I am also a 43 years old young mother.

After fifteen years of a rather tiring private practice in a medium-sized town in the south of France, I am back at school with the hope and intuition that it will bring a breath of fresh air to my routine. I discovered the human and social sciences; it was a revelation! I understand the potential of these theoretical tools for my practice. It's invigorating! I can finally begin to understand the inner workings of the situations that have marked my experience. At last, I can see the sand grains that were in the way of my development. Because I was aware that what was bothering me was not necessarily problematic, nor questioning for my colleagues. In short, here I am in my doctorate, after a long and hectic journey. I made detours, but I always moved forward and kept my course. My insatiable curiosity has been both a powerful engine and a GPS. I am at the end of the journey of initiation that is the PhD. I am doing work rooted in the field of social psychology and sociology. In France, physiotherapy is still under medical prescription even if things are moving. So, I explored the points of view (social representations) of physicians, physiotherapists and patients. The basic question was: what is physiotherapy? In a word, I question the obvious. To do so, I studied different corpora: interviews, literary text, dictionary definitions, questionnaire and scientific articles. I take stock of the presuppositions that each one has about his group, his practice, but also about what he imagines the other one thinks about his group (we call this mutual clairvoyance). It is a game of comparison to find the common points and differences between the groups. There is also a historical dimension, as I am studying the writings of a founder of French physiotherapy. My work is situated in the socioconstructivist paradigm, but I am approaching the systemic paradigm. I have highlighted great differences in social representations, but fortunately also common points. There is also a strong influence of groupthink between physiotherapists and doctors, and different forms of hierarchies in this triad. My approach is

also relatively atypical in the social sciences because I use lexicometry a lot. This is quite common in France, but rarer in English-speaking countries. At the same time, I supervise research theses of physiotherapy students.

To the question about "how I think and practice critically", I would answer that it is a kind of second nature on the one hand. I mean, this curiosity has never left me since I was a child. On the other hand, I would say that it is a mixture of experience and biography that makes me a social and cultural mix. My mother-in-law says "rougail". It's a Reunionese dish (from a small French island in the middle of the Indian Ocean) that contains lots of small, finely chopped vegetables and accompanies dishes. A kind of pudding in its Creole condiment version! So, I attribute to my mixed origins this lack of formatting that makes me see outside the box. My way of thinking critically, as I said above, is that what is obvious is not necessarily obvious to me. And so, I seek to understand.

What attracts me to critical physiotherapy is the caring environment, the intellectual pleasure, and the fact that I am not alone in my questioning. And also, that the questions asked are enlightening because they are approached in an energising way.

My background, my atypical profile of technical and disciplinary competences, as well as my curiosity associated with my creativity allow me to think that I can participate or accompany my peers in a research process aiming at a constructive and caring criticism of physiotherapy. My fertile and communicative imagination can help to reshape the contours of this (r)evolving discipline and to create or maintain links. I am convinced that the richness is in the mix (epistemological and relational) rather than in the closure and orthodoxy.

I believe that this network, and physiotherapy by extension, would benefit from actively promoting and coordinating research. It could offer internships and post-doctoral fellowships for critical physiotherapists, or summer schools (theoretical or methodological).

My vision and wish for the physiotherapy profession would be to see a unification and decompartmentalisation of the rehabilitation professions. I believe that we have a common mission and that it can only be achieved through cohesion. Of course, I would like to see research made more accessible, for example through formats such as action research in private practice, hospitals or on assignment in companies and schools.

Patty Thille

11 September 2021

My research program brings feminist and other critical sociological theories to health services and health professions education research. My passion is to do research that enables us to better understand and disrupt stigmatization and discrimination in health services,

particularly in the primary care and primary health care sectors. I do so using a range of qualitative methodologies.

To me, practicing critically means applying my critical theory foundation both outward and inward. Looking outward, critical theory is a foundation for my research, and through supervision, I aim to support others on this path. Turning inward, I continually seek out opportunities to learn and reflect, through both solo activities as well as through building relationships with people and joining communities also engaged in this work.

I bring a feminist and sociological background to the dialogues we are having within CPN. I continue to develop as a qualitative methodologist, and enjoy helping others think through the possibilities for their own work. And I also offer a more personal sort of knowledge, about navigating academia as a 'hybrid' scholar, with training in both health and social sciences. I aim to act as a bridge between the two, but this liminality creates its own challenges. Community helps manage that.

I would like us to find ways to together engage with ideas and important issues around equity and other important topics. The pandemic has disrupted some of our usual ways of connecting, but also enabled others.

Reiterating the challenge described by Nicholls and Gibson in the article *The body and physiotherapy,* I would like to see a physiotherapy practice that seriously integrates theories of embodiment to enrich and enliven practice. To add to that, I hope we also concern ourselves with emplacement, which I think of as appreciating that people/bodies (for we are always both) both shape and are shaped by the places in which we live our lives, and the social relationships we have in those places. Physiotherapy is an embodied, relational, and emplaced practice – foundational ideas which I think remain underdeveloped in our profession (at least, in the physiotherapy education and practice here).

With better integration, we can better explore ethical and moral aspects of physiotherapy practice. And these are the conversations I think are so important to our profession.

Birgitte Ahlsen

12 September 2021

For the time being, I am busy planning and developing a new Master's program in psychomotor physiotherapy. Psychomotor physiotherapy, as a treatment approach, was developed in Norway in the late 1940s in collaboration between a physiotherapist and a psychiatrist and is usually referred to as Norwegian psychomotor physiotherapy (NPMF). In short, this approach implies an understanding of the body both as biology and biography, that is, as the place of the individual's lived experiences. Local pain and symptoms are seen considering the body's mobility and muscle tensions in general, and the treatment is

explorative and interactional. Psychomotor physiotherapy is a specialisation within physiotherapy in Norway. Much can be said about NPMF. However, in order to grow and develop, I believe that psychomotor physiotherapy must be internationalised and connected with traditions or mindsets beyond Norway's borders. This is one of my main concerns right now. I would like to connect with people abroad and make psychomotor physiotherapy an international interest.

I am a researcher doing qualitative research on patients' experiences of chronic illness, and physiotherapy practice. In my opinion, qualitative research is critical in its essence. I have focused especially on the theoretical foundation of medicine and physiotherapy and its implications for clinical practice. I work to illuminate physiotherapy in new ways, and as such, contribute to a rethinking and discussions about what physiotherapy is and can be in the future. I have an interest in Medical humanities and Narratives in medicine, and I would like to develop some of these ideas and perspectives within physiotherapy and maybe establish a sub-group among critical thinkers, which may be called: Narratives in Physiotherapy or Humanities in Physiotherapy.

Filip Maric

13 September 2021

My interests range broadly across the outer rims of healthcare via inspiration from diverse global philosophical traditions, ethics, the post-humanities and the miraculous pluriverses that surround us. More recently, these interests have taken me toward explorations of environmental philosophy and the environmental humanities, and with that to the exploration and further development of environmental physiotherapy, planetary health and related fields.

For me, an engagement with any discipline requires questioning and reimagining its theoretical underpinnings and social context and so, as a physiotherapist and healthcare professional, engaging in critical physiotherapy presents itself as a logical, necessary and fundamental part of my work across research, practice and education.

My hopes for the CPN are that it will continue to be a positive force for an otherwise physiotherapy, inspiring physiotherapists around the world to think and do physiotherapy otherwise. I am grateful and excited to be a part of this endeavour. I am always open for conversation, for creative, wild and 'out-there' thinking and doing, and happy to collaborate with and mentor those with resonant questions and interests.

In the hopefully not too distant future, I would be excited to see the physiotherapy profession support the development of new ecological physical therapies and new healthcares for (or: towards) interdependency and togetherness, even though these might be old in that they

have been around forever, ontologically, and for a long time, culturally. This will involve turning from strength-, capacity-, or ability-based concepts and practices to the positive ecological, social and ethical value of (our biological foundation in) dependence, impotence, infirmity (not its absence #WHO) and disability. In day to day clinical practice, it would mean acting on such a basis and, in much gentler ways, focussing on advancing social and environmental togetherness, solidarity and mutual support.

Wenche Bjorbækmo

14 September 2021

I am a physiotherapist with long clinical experience and have a Ph.D. in health sciences, specialization in habilitation from 2011 at the University of Oslo. Currently, I am a professor at the Institute of Physiotherapy at Oslo Metropolitan University (OsloMet). Here I teach at the master's degree in health sciences and have a particular responsibility for the specialization in physiotherapy for children and adolescents.

My research interest includes qualitative research with children and adolescents and their experiences of body, movement, activity, and participation in different contexts and situations in their everyday life. It also includes an interest in professional health practices and especially physiotherapy practice with a focus on what practical knowledge is about, how it is expressed and performed when physiotherapists practicing their profession.

Lately, I have been concerned with developing the curriculum for the specialization in physiotherapy for children and adolescents at OsloMet aiming to put together a curriculum that reflects perspectives on the body, movement, movement development and learning, activity, and participation that includes both naturalistic (bio-medical), social, cultural and humanistic philosophy and sciences.

I have always been inquiring about the practices I have entered into and been part of. Something that has not always been well received by colleagues. I have often been asked; why can you not just do as we usually do, why asking all these questions. When I took my master's degree, I read a book that fascinated me. The book title is “Betatt av viten” (Fascinated by knowledge), Instructions for use of Donna Haraway and is written by Kristin Asdal, Anne-Jorunn Berg, Brita Brenna, Ingunn Moser, and Linda M. Rustad (1998, Tiril Schrøder, Illustrator). Reading this book was eye-opening and thought-provoking. One quotation referring to Donna Haraway has since followed me as very central, in my translation it says: No one can be indifferent or passive to the various changes that take place in society (for example in habilitation) and believe that the direction and form of knowledge processes are due to natural development and the passage of time and that they always are in the best interests of those affected.

With this interest and background, I do think and hope I may contribute to discussions and writings within the CPN community of significance for the future of physiotherapy. At least, I wish to contribute and be part of this really important professional movement.

I hope that the physiotherapy profession bravely will develop its own knowledge base based on the profession's practical knowledge and recognizing that physiotherapy can stand on its own if we expand our theoretical basis and insight to include knowledge about body and movement as; biology, nature, culture and experience.

Bhanu Ramaswamy

15 September 2021

I am a self-employed physiotherapist in a northern city of England; my specialist areas of practice during my three days of clinical work are with older adults and people with neurological conditions, especially Parkinson's. On the other two working days, I spend time assisting with research submissions, reading/ responding to voluntary role requests and to professional networks, or in a mentoring role.

My current work in the voluntary and private sector (as opposed to when I worked within two large, hierarchical and boundaried organisations of health and education) has freed my approach to physiotherapy. I increasingly integrate a wider understanding of health and wellness of a person and their support network into my practice through discussions with my clients or just groups of people with different medical conditions.

When I read papers now, I am less judgemental about what they don't tell me, as I realise many physiotherapists are being pushed to publish and the way we are taught still values the empirical style. I am however more critical about hidden or unexplored areas of the research that would give me a better appreciation of the why, how and what worked with a certain population. These gaps spur my conversations with 'labelled' people to gauge where they sit in response to the research intervention, and their thoughts into the longer-term, as opposed to fully financed/supported 6 – 12 week interventions, after which 'trial subjects' are abandoned. I love the idea of co-design and co-production, and any event set up for a local charity I volunteer for is now through this avenue.

I have attended the two CPN courses of monthly seminars held over the past years and enjoy hearing the diversity of what physiotherapists can offer in the areas of practice, education, research, and leadership. Many of the presentations or reading we are linked to from the CPN team make me consider points from theoretical or philosophical, as well as a practical standpoint — it keeps my thinking broader and more interested in the people I provide a service with or for.

A listening ear and contributions through a ripple effect as I pass on my learning or tweet information. I am not saying that I have nothing to share in terms of writing something, or giving a presentation to the group, but am still gaining a lot from just listening to the varied views from our professional colleagues, based on their cultural bias, educational and practice systems, and their interpretation of critical physiotherapy. Criticality from philosophical underpinnings still does not come easily to me, so I need a lot of listening time!

I really enjoyed the series of seminars and gain more when I can listen and ask questions of live presenters instead of being directed to reading material; it helps me place what I am hearing into my working context. I guess I would like to see this area develop. I would also be interested if, for example, there were four talks on the same subject, but by different presenters each month. It would not matter if the presenter covered the same ground with some aspects each month, as that would help consolidate any learning from previous months or seminars, plus each presenter would bring their interpretation and means of using such philosophy into their working practice and setting — again widening the lens of the listeners, and broadening views.

Through the sort of sharing I have outlined above. I am now over 30 years qualified and have noticed that the world of critical philosophising is less and less despised by the pure scientists within the profession; some are even opening small doorways in their own learning to allow some radical thinking in! We are going in the right direction, and as people outside the health system (e.g., collaborators, clients) ask for different, I see our professions opening up to new ways of working and thinking. The COVID-19 pandemic has brought about some large changes in the habits of many professionals, and they are now thinking and practicing in ways they were blocked from acting before. This has the opportunity to influence the direction of the profession to envelop a wider understanding of what the term ‘physiotherapy’ encompasses.

Zoe Leyland

16 September 2021

My current work and studies are on the lived-experience of participating in pain education programs including the Master of Clinical Science for the Advanced Healthcare Practice in the field of Interprofessional Pain Management, which I co-created with my PhD Supervisor, Dr. Dave Walton. The current qualitative work in my thesis follows a Hermeneutic phenomenological framework.

Throughout my PhD, I have primarily worked with physiotherapists and have taken a critical lens to the field as an educator with a background in health education and medical education. The conversations and networking within the Critical Physiotherapy Network has added a wealth of knowledge while incorporating philosophical theories that contribute to the understanding as well as delivery of physiotherapy.

I have an extensive background in health professional education, including physiotherapy and medical education. I also have a lived-experience of chronic pain, which gives me a unique perspective as I take a more critical and reflective approach given my own narrative. I have a strong interest and knowledge in feminist theory, social identity theory, and intersectional feminism.

I would love to see patient partnership within the critical physiotherapy community and the continuation of critical reflection on the current curricula for physiotherapy as there are multiple areas that are in need of improvement.

Physiotherapy has many areas that can be improved including an increased need for mental health understanding, advocacy, empathy, intersectionality approaches, and reflection on personal biases that may impact care. I look forward to seeing how the profession evolves and how the curriculum changes over time.

Niko Brenner

17 September 2021

Hi, I'm Niko, my pronouns are they/them, I have just finished my final year of an undergrad Physiotherapy programme in the UK and am thrilled to have secured a junior role in my top choice organisation. Aside from my studies, my main work currently involves creating a trans healthcare e-learning course with an interdisciplinary group of healthcare students and professionals. This course will be open-access for healthcare students and qualified healthcare professionals to learn more about trans identities and trans peoples' specific healthcare needs.

My final year research project at university investigated UK physiotherapy students' attitudes and beliefs around working with services users who identify as LGBTQIA+. I am hoping for the research to be published this year.

I am also an active member of the CSP (physio trade union in the UK) LGBTQIA+ network and have been involved in intersectional discussions and planning of strategic action at the CSP. I feel passionate about achieving better inclusion for marginalised service users, as well as physios, within our profession and am keen to engage in further EDI work as I develop in my career.

Throughout my degree, I have struggled to find my "crowd" within the physio world. I had some bad experiences being a trans physio student at uni, so I ended up removing myself from the social side of things a bit. I really wanted to find a network of like-minded physios to feel more belonging within the physio world. I am hoping to network and connect with other physios, with who I may share more common interests and values, through the CPN.

I also really want to be the most critically aware practitioner that I can be and want to learn and share knowledge and experience through the network to improve my care for the diverse groups of people I will be working with throughout my career.

I am very eager and motivated to engage in more critical discussion within the profession. I am hoping that my motivation will bring a positive and engaging new voice to the network. I also think my voice as a trans genderqueer physiotherapist will be valuable in starting and contributing to conversations about how we can deliver care that is safe and accessible to those who are not cisgender.

I have not been a member for a long time and have not been involved in many events through the network. I would hope to see the network holding regular events to network and share ideas/research/experiences.

I think much more is needed within the broader profession in regard to fostering critical awareness around structural discrimination, oppression, and inequalities and how these affect patient care as well as working relationships between colleagues. I would like to see critical discourse becoming a more integral part of healthcare education. Ultimately systems of oppression affect all facets of people's lives including healthcare, so I feel it is vital that HCPs have a level of awareness of these issues.

Michael Rowe

18 September 2021

I spend a lot of time thinking about how we use technology in teaching and learning, and especially around how uncritically we have implemented online learning over the past 18 months; it's like we took the worst version of online learning that was possible and just went with that. I think we can do better.

Lately, I've also been thinking about the nature of knowledge work and the practices of knowledge workers. In particular, I'm trying to figure out how and why we do what we do, and whether this is something worth paying more attention to. My impression is that academics not only don't have a plan for how and why we do what we do, but we don't even realise that we don't have a plan. Or that having a plan could be useful. Maybe this is just my own uncertainty. Maybe everyone else has a plan. I'd love to hear from you if you have a plan for how to "do" academia.

And finally, I'm interested in artificial intelligence and machine learning, and the ways in which the automation of certain kinds of physical and cognitive tasks will change clinical work. It's early days but this is an area of practice that I believe will lead us to push back against some of our basic assumptions around how healthcare is enacted.

It's the way that CPN members normalise the questioning and analysis of the taken-for-granted assumptions that govern our habitual behaviours and beliefs. They remind me that nothing is pre-determined and that we can choose otherwise.

I would love to see more tangible outputs captured under the umbrella of the CPN. For example, I'd like to see more members writing for the website. More questioning of mainstream ideas at professional meetings and conferences. More books. And obviously, there needs to be a podcast. And a conference. And more courses.

Considering my belief that much of our professional practice will be automated at some point in the future, I'd like to see physiotherapists taking seriously the question of what we think is essential to the profession, and to start moving in that direction. What is the fundamental idea of physiotherapy when you take away the tasks that we hold dear, and how is that essence different to what we find in other professions? When I extend this to what I see as a logical conclusion, I'm not sure that physiotherapy in its current form can endure.

Tobba Sudmann

19 September 2021

I'm affiliated to Western Norway University of Applied Sciences HVL as a full professor of public health and academic head of the PhD-program *Health, function and participation*. My work includes teaching and supervising MA and PhD students, and research. In addition to my work at HVL, I have a small clinical practice with riding physiotherapy. The critical element in my teaching, supervising, practice, and research emerges as a critical appreciation of anything and everything that crosses my desk or enters into my everyday life. I am particularly wary about tendencies to make people small in their own life; i.e. as oppression, discrimination, or marginalization. The PROGRESS PLUS framework is a superb reminder and guideline in these matters.

Some of my current research projects include E-health literacy, technological assistance in social housing, equine-assisted activities for incarcerated women, equine-facilitated physiotherapy for persons with severe and longstanding mental illnesses and/or substance use, and physical activity for persons with cognitive decline.

The Critical Physiotherapy Network has given me peers and friend around the globe, who find it fruitful to share ideas for the further development of physiotherapy as practice, theory, and research, to include perspectives or theories from the social sciences and the humanities. The CPN offers a safe environment for trying out ideas, and for giving and receiving constructive critique. The CPN is a generous community, where differences in opinion or style are welcomed and tolerated

I bring myself, my eagerness, my fantasy, and my creativity, as well as my fiery passion to the CPN. And I believe I have contributed to calling attention to interspecies interdependencies, and the importance of an ecocentric perspective, which I now think of as *One Health*.

I hope our community can contribute to more diversity and creativity in education, practice, and research. And I hope that the CPN community can help us focus on the aims and justifications of our teaching or treatment sessions, not just focusing on the means, i.e. numbers of kilos, numbers of repetition, pages read, and so forth.

I would like to see physiotherapy as a community more devoted to health promotion; a community that works hard to reduce social inequalities in health, who hold anti-oppressive practice as their main guideline, who thinks global and acts local, and who gets inspired by the ecocentric and One Health perspectives.

Roel van Oorsouw

20 September 2021

My name is Roel van Oorsouw. I am a physical therapist working in a University Medical Centre in the Netherlands, typically working with critically ill patients admitted to an intensive care unit (ICU). Two years ago, I started a PhD trajectory studying patient experiences during ICU stay and ICU recovery, mainly using phenomenology research designs. I am convinced that phenomenology has a lot to offer for physical therapy. Reading this kind of studies has brought me an incredible amount of understanding to the, often confusing, clinical context. Alongside with the technical and systematic aspects of the therapy that I provide, I am now more conscious about what is happening in the patients' lifeworld. Reading phenomenology also raised my interest in philosophy, opening up a whole new world of ideas. These ideas make me think critically about the way health care is organized. What is good care? What is good physical therapy? When do I need to step forward, and when is it better to do nothing? Fundamental questions like these are now more and more discussed in our research group and in our physical therapy team.

Since my physical therapy education, I wonder what makes a good physical therapist. As a starting professional, I was keen to progress my knowledge and skills. However, I always felt that there was more to it, something that could not easily be named. It took me quite some time to find the sources describing and naming these aspects. I was very pleased when I found out that international colleagues were already trying to integrate knowledge from other scientific areas like sociology, philosophy and history for example. I am really happy that I found these colleagues and forums, and it seems obvious to me that these aspects are crucial for our profession to further develop.

This blog is my first contribution to the CPN. Until now, I have mainly consumed the content you share. This helped me a lot in broadening my interest scope and developing my ideas about physical therapy. The last couple of years I have built up experience in studying lived experiences. I have something to bring when it comes to qualitative research. Specifically the phenomenology of embodiment and the philosophy of mind have my interest. In the future I will certainly try to engage more in activities from the network.

In the literature often two realms are separated, they have been given a lot of different names. I think that the objective, systematic, quantitative, technical, predictable, positivistic aspects of our profession are really strong and very much emphasized and rewarded. They tend to oppress (or colonize?) the subjective, qualitative, existential, contextual, interpretational, meaningful, human aspects of the profession. This second realm is softer, more gentle, but in my experience is not less vital for the provision of good physical therapy care. I hope that the CPN can advocate these aspects and be a voice emphasizing and nourishing these. In my opinion, the CPN is important in uniting physical therapists sharing ideas and create a voice as strong as possible.

I hope that physical therapy, and society as a whole, will develop in the direction where human aspects will be much more appreciated. In the Netherlands, the negative aspects of neoliberalism, including the emphasis on efficiency and productivity, are debated more and more. I hope that this race to the bottom, and to the destruction of the earth, will end. We should not allow physical therapy to be reduced to a mechanical profession solely valuing quantitative outcomes because then, though unconsciously, we agree to a reductionist view on life.

Barbara Gibson

21 September 2021

I am a Professor at the University of Toronto in Canada, where my research focuses on how disability is theorised, understood, and addressed in rehabilitation. I draw on critical disability studies and post-human theories to explore the possibilities for reimagining PT and rehab through an ‘ethic of openness’. These ideas are explored in my book, Rehabilitation: A post critical approach. My teaching focuses on developing critical reflexivity and anti-oppression lenses with physiotherapy students within our ‘SPEC’ Curriculum (Social, political, ethical and cultural dimensions of health).

I am a huge supporter and fan of the CPN, which over the years has been my home for connecting with other critical PTs and related scholars and students. It’s exciting how our numbers keep growing and how the field is expanding. The word is out as the broader PT community is exposed to critical work and its potential.

To aid the expansion of critical physiotherapy research and teaching, it would be wonderful if the CPN continued to develop ways for CPN members to connect and share their work.

Aydee Luisa Robayo

22 September 2021

I am a physiotherapist who works in a public institution, the same one from which I graduated, there I am a professor of hospital practice. In the pregado I am in charge, interest and pleasure, the class of History, transformations and perspectives of physiotherapy. It is a subject for newcomers to the university.

I have others in my charge, but in her and for her, since I went to David's presentation in Cape Town, I got closer to thinking critically THE stories in the profession, the places of power and the interpretative frameworks of the models that install some. And other perspectives of the profession.

The possibility of "disbelieving", the freedom to be a bad thinker.

I like to join in what I can do, learn and unlearn, invite semiotic vigilance, not to normalise polyphonic categories loaded with ideology

I would like us to have a YouTube channel with interviews from everyone, with contributions of freely accessible documents, with an international stage to discuss the issues that interest us.

A channel with music from many places where we are, we come and we each live, with a place to cook intellectual, academic, philosophical, ethical and aesthetic recipes.

In the recognition of the profound interdependence that we have.

Liz Harvey

23 September 2021

I am a Senior Instructor in the Department of Physical Therapy at the University of Manitoba in Winnipeg, Canada. I have been a physiotherapist for over 20 years and have had the opportunity to work in Canada, Australia and the United Kingdom. My latest adventure, closer to home, is that I am a part-time PhD student. I believe that my combination of being a mid-career physiotherapist and educator, and an early PhD student brings a somewhat unique perspective to the CPN. I recognize a vast amount of privilege that I have experienced in my life, and have long been an ally to those who do not experience the same privilege.

I am new to the CPN, having been introduced by my PhD supervisor, Dr. Patty Thille, when starting my PhD. Truly it was eye-opening to discover that other physiotherapists world-wide were recognizing and articulating issues that I had been thinking of, and chatting with

colleagues about, in our profession. I believe that learning about our past and reflecting on our present will help our profession in planning for a better future.

I am still early in my PhD journey, and those who have taken this path know this may change, but I am planning on including research on how physiotherapy students develop professional identity in their educational programs; specifically focusing on how systems of power and/or oppression influence this in students who are from historically under-represented backgrounds. I'd like to see the critical physiotherapy community engaging with students, and finding the nuances that exist in balancing teaching basic, foundational skills and introducing critical teachings in the entry-to-practice programs.

Tone Dahl-Michelsen

24 September 2021

I hold a position as an Associate Professor at Oslo Metropolitan University (OsloMet) and at VID Specialized University. I teach, supervise and lead different courses at the bachelor, master and PhD level. Currently, I am working on a new (international) course in Philosophy of Science and Research Methods Studyinfo subject MAVIT4050 2021 HØST - minside (oslomet.no) and a course in Rehabilitation as Knowledge and Practice Studyinfo subject MAHAB4200 2021 HØST - minside (oslomet.no). I have recently being awarded the position as Merited Teacher at OsloMet. My work with CPN was part of my application and also the work that I and CPN member Michael Rowe (together with other colleagues in CPN) developed on internationalisation (for which we also have been approved external founding by DIKU). *Physiotherapy Education in Norway, South Africa and Brazil: A Joint Online Learning Project in Rehabilitation*. https://physio.uwc.ac.za/pov/

My research interests are quite broad, and I am currently involved in different rehabilitation projects. An interest of mine is Evidence-Based Practice (or Knowledge-Based Practice as we say in Norway). Recently I published an article on this, together with members from the CPN Elizabeth Anne Kinsella and Karen Synne Groven.

Toward an inclusive evidence-based practice model: Embracing a broader conception of professional knowledge in health care and health care higher education (journals.co.za)

In short, I think and practice critically by paying attention to the taken-for-granted knowledge and practices and for the "effect" of the "doings" in a practice; "What are you doing when you are doing what you are doing"?

The CPNs slogan reads*: A positive force for an otherwise physiotherapy*. This slogan clearly expresses what appeals to me about CPN and includes challenging physiotherapy practice and thinking, critically reflecting on the profession's past, present and future, and nurturing a community of critical thinkers.

I also find the strong theoretical level of many scholars, teachers and clinicians in CPN to be appealing.

I have been a member of CPN since the beginning and I bring my questions and reflections on physiotherapy and health care to CPN – especially to meetings at conferences and online courses. These are often questions that I have found hard to address anywhere else in physiotherapy. I must say that I feel that I have received much more than I have brought in – which I find that many other CPN members also say. I am also member of the CPN Executive.

CPN has offered me a lot – and I am not sure if I still would have been part of a physiotherapy community if I had not found a space for critical thinking at the time when CPN was established. I hope that the development of CPN over the next few years entrench the position of being a positive force enhancing the unique possibilities that I believe physiotherapy can offer.

In my opinion, most mainstream physiotherapy holds high quality. Educations worldwide recruit high standard students and often staff in physiotherapy are among the most qualified within healthcare. However, the focus is often narrow and I would like to see the broader physiotherapy profession as a more "open-minded" profession. Today curricula focus mostly on knowledge from natural science and ideas from humanism and social science are either missing or positioned as appendices. I would like to see natural sciences, humanism, and social science equally positioned in education and clinical practice, and I think the CPN can contribute to this development.

Louise Søgaard Hansen

25 September 2021

Over the past three years, I've been working on my PhD-thesis and thus striving to develop research skills, particularly in the field of critical health research. The thesis deals with patient-centeredness in physiotherapy practice, which is a topic I've been engaged in for some time, theoretically as well as in practice. I've been a physiotherapist for almost 30 years and have experienced the profession from many perspectives, both as a clinician where I trained as a musculoskeletal therapist and later as a lecturer at the physiotherapy programme.

In terms of thinking critically, it was my transdisciplinary master's in 'Health Promotion and Educational Science' which opened my mind to a whole new way of thinking and reflecting. The combination of critical health research, sociology and critical pedagogy forced me to start questioning the 'taken-for-granted' norms about bodies, health, illness, impairment, physical activity, well-being, inequality in health, etc. which works in the physiotherapy profession.

In my current research, I am interested in people's encounters with the health care system, and how patient- or person-centeredness is practiced here. I critically ask questions about what patient- or person-centeredness becomes, as it is often understood as implicitly embedded in clinical practice. I'm curious as to how clinical guidelines, biomedical informed knowledge and professional logics impacts the way physiotherapists address the patient. I'm interested to understand how and if the patient's own experiences and knowledge about handling life with disease is truly included in the clinical encounter. Thinking critically, for me, implies asking questions and challenging the way notions like 'patient- or person-centeredness' is understood and practiced. How it is considered as being naturally embedded in everyday practices and simply not considered something to reflect upon. And if it is, then becomes a question of the relation between the physiotherapist and the patient. To think critically implies asking if this is really the case? Is the physiotherapist an island? I understand physiotherapy as produced through a complex network of institutionalised logics, clinical guidelines, procedures, and the prevailing understandings of what 'good' physiotherapy is. Understandings that I find important to explore and challenge.

To me, it is crucial that we, as a profession, start asking these questions. Not only to understand the 'softer' elements in physiotherapy, but also in order to challenge the hegemonic understandings of 'normal' movement or body performance. In my conversations with patients, it has become clear to me, that if the profession doesn't move beyond understanding people's health-related problems as a question of 'fixing' it, then our patients will find help somewhere else. And I think that the CPN is a brilliant way of connecting physiotherapists who are willing to step aside and take a look at the physiotherapy profession and the practices within from another perspective. I hope to be able to contribute to this by participating in the ongoing conversations in the network and by insisting on doing research that fundamentally challenges the inherent norms in physiotherapy practice.

John Hammond

26 September 2021

I am an Associate Professor in physiotherapy at St George's University of London and teach pre-registration physiotherapy and other allied healthcare programmes. My teaching interests relate to communication, self-management approaches, social justice, reflective practice and professionalism/interprofessional working. My research also reflects this, and particularly exploring where inequalities in education and student experience might exist and working out strategies to address these. So, I suppose with this focus on social justice embedded in my teaching and research, I always have a 'critical' lens.

There are a number of things about critical physiotherapy appeal to me. I never felt I was the typical physiotherapist as I did not fit the 'sporty heteronormative type', so I am drawn to

critical physiotherapy as this is a community where all shapes, sizes, colours etc are recognised and celebrated for their diversity and uniqueness rather than otherness. In addition, I enjoy collaborations and debates with peers and colleagues; however, I am mindful that I do not fall into the trap of using the network as an echo-chamber. The focus of critical physiotherapy and the disruption of the status quo in physiotherapy is also something that I see as healthy for ongoing sustainability.

Unfortunately, I do not think I bring or contribute enough. This question has made me reflect, and I think I have been sitting in the wings for a while and probably need to lean in to CPN more. I would love to develop some more international collaborations for research, writing and discussion… so this is me offering my support through the network now and in the future.

I am pleased with what the network has done so far to engage different conversations in physiotherapy, such as de-colonising work. The work led by Dave and other key members has been inspiring and refreshing, and I hope it is having an impact in implicit and explicit ways beyond members. As someone who has been in the wings it is probably not right for me to make recommendations but more that it would be good to see CPN more visible at international conferences and in research. Perhaps a small step might be to encourage members to include as part of their affiliations for conferences or use of the logo more visibly in work. But longer-term sustainability is also something to consider.

At present, there is a tension in physiotherapy. On the one hand, the profession is starting to recognize the need to represent and be more inclusive of the global populations we work with. Yet on the other hand our global governing systems are rooted in hegemonic Eurocentric, colonial, whiteness etc. It will take time, but I would like to see the physiotherapy profession (and professionals) willing to take the steps to relinquish some of this power to establish greater social justice in our practices. An example might be redressing the burdensome and costly regulatory requirements of some nations (e.g., UK, USA, Australia) to allow more freedom of travel and work so that we can learn from our global colleagues rather than seeing them as a threat to the quality. Similarly, I would like to see a challenge and disruption of pre-qualifying education entry level (from undergrad to doctoral level) that is creating structural inequities between low and high resource economies.

Sandra Kettle

27 September 2021

Being an indigenous practitioner means that my critical thinking and practice is set firmly in how we reduce health access barriers and inequities not only for our indigenous population, but for all at-risk marginalised populations, e.g., LGBQT+

In 2021 Accident Compensation Corporation, our national accident insurance provider, recognised the importance of Rongoa in Maori Health approaches, and we are for the first time able to refer our clients to Rongoa practitioners. Rongoa is the restoration of Mauri — the balance of our wairua (spiritual), hinengaro (mental), whanau (family and connection) and tinana (the body). Rongoa practitioners use traditional Maori healing methods, including Rongoa balms, teas and natural remedies, mirimiri and romiromi traditional massage and healing techniques. They use tikanga (Maori protocols) to provide a holistic framework in which to treat clients. The critical thinking at this early stage is around developing relationships with practitioners who bring a different perspective to our “Western” healing approach. How can we integrate our skill sets to the benefit of the client? In these early stages of referring to Rongoa Practitioners, the Physiotherapist needs an understanding of what the other does, and how this works for our indigenous clients.

Being able to question the norm, and not just accept things the way they have always been, but to look at issues as they come up — application of critical thinking is a constant review of procedures and physiotherapists’ views. Being able to recognise your own culture, why you think like that, and how it affects your practise.

It's early days, I am just soaking up all the knowledge and reflecting on my own critical practice before I build up the courage to participate. The objectives of the CPN resonate with me. Particularly the challenge to critically examine our profession's position on difference, recognising power asymmetries and marginalisation, and promoting ideas from diverse sources.

Developing ideas and tools around challenging the status quo. For example, why is Western Medicine considered most important in practising Physiotherapy? Why are so few studies done on indigenous rehabilitation methods and their effects on all populations? How can we make the LGBQT+ community feel safe with our profession? Definitely Podcasts from various members sharing your thoughts and experiences through their lens”. Focussing on the significant contribution culturally-competent practise makes to peoples’ lives.

Promotion of a more diverse and inclusive profession. In New Zealand, health disparities for the indigenous Maori population continue to affect health outcomes, and access to Physiotherapy. I see the broader physiotherapy profession developing an inclusive approach to physiotherapy where Health Equity is valued. This practise encompasses more inclusiveness in providing a culture of “everyone” that is significant to all — as with all populations throughout the world facing the same challenges — this is not achieved by any one change but continues to challenge our thinking. If we develop our knowledge around health inequities for indigenous populations and how these have occurred — it’s a start.

Lucy Inyang Edet

28 September 2021

I grew up in Nigeria.

Sports has always been an important part of my life. In my neighbourhood growing up, I watched the excitement in young boys during football matches every day, and their disappointment missing out following injury. Now, I'm flying high at two things: design and construction of healthcare and sporting facilities, and sports injury rehabilitation.

I have served in sustainability, medical doping, healthy athletes, and fun fitness capacities during the FIFA World Cup, the African cup of Nations, an IAAF Road race, the Paralympics, the Special Olympics, and Universaide and Youth games.

My most recent work: *Can global running gait and psychological status affect performance and injuries of sportsmen: Views from 19km road race* was presented at the last FIFA Football Medicine Conference, at Wembley stadium in 2019.

And I am now preparing to start a doctoral study on the chaos control continuum following anterior cruciate ligament injuries in elite female footballers.

I'm currently lecturing at a newly established Program of Physiotherapy in a Nigerian University, where my students are encouraged to make connections to real-life scenarios and identify patterns, consider unlimited points of view in solving problems, and boost their critical thinking skills.

As a continuous learner and a young academic, I am convinced that joining the Critical Physiotherapy Network (CPN) has helped me consider unconventional opinions and make rational decisions for those I work with, whether on pitch, or in the classroom. I believe in all round excellence, with an unflinching desire for the best of innovations, strategies, and solutions in my contribution to the CPN.

We must recognise that we face unprecedented situations in healthcare, with swift technological advances, the future is shaping us. The broader physiotherapy profession needs to become familiar with fast-paced digitisation in order to control technology. More than ever, there is a need for professionals and organisations with increased flexibility in thinking outside their postal code, adopting a virtualization mindset.

Srijani Banerjee

29 September 2021

I am Srijani Banerjee (BPT, MPT in Cardiorespiratory disorders and Dance Movement Therapy Practitioner).

What do I do? A lot of unnecessary languishing but apart from that, I am a Faculty in the Department of Physiotherapy in The Neotia University, West Bengal, India. I teach undergraduate students and BC* used to freelance as a Dance Movement Therapy (DMT) practitioner as well.

There comes a time when every physical therapist realises that the way they have been taught to treat patients and deal with illness is not working in the way we had wished it would. My concept of physiotherapy took a massive hit when my father had recurrent onset of acute neurological deficits (ischaemic stroke). The rehabilitation plan was making him angrier, gloomier and from being a person who loved his gym he became someone who would cry for death rather than do any exercise. This is when I started exploring other avenues and learnt about the use of dance for rehabilitation in patients with Parkinson disease. So, I joined diploma in dance movement therapy and while studying about embodiment approaches, I come across a paper by Prof. Nicholls on “The Body and Physiotherapy”. Never, in my wildest imagination, I had thought that Physiotherapy could be related to DMT in any way. After all, Helen Payne has repeatedly said, DMT is not about the physical aspect like Physiotherapy. It is different.

DMT gave me the answers to the questions which physiotherapy had raised, and my practice became better. As a DMT practitioner I was working with breast cancer survivors, patients with dementia and geriatric population but somehow, I found myself always assessing them with a physiotherapist’s perspective. I tried sharing this with my fellow physiotherapists, but unfortunately, I was met with mostly strange looks and awkward silences.

Now being with so much to ramble about and no one to listen to is quite difficult and finally after 10 years of practicing physiotherapy in the traditional way, I gathered my courage and got in touch with Prof. David Nicholls. He introduced me to Critical Physiotherapy Network. Reading about so many perspectives and learning about so many different ways of building the profession gives me hope and makes me believe that yes, I can truly guide a person towards a better life. Now, don’t get me wrong, I was very academically inclined and got quite good grades in my Undergraduate and Masters. I absolutely loved how the patients would be eternally grateful for whatever I was doing for them. All this was wonderful till the “Dad incident”. I mean, it was nice to practise physiotherapy in the age-old method, but I felt too much in control of another person’s life.

I have been an educator for almost 5 years now and today when I teach my students about autonomy of a patient, I try to make them understand that even though the person is having physical problems or has faced a life altering situation, it doesn’t give me the right to make decisions on his behalf. I mean as a physiotherapist I want to achieve 120o of hip flexion, but my patient is living a fulfilling life with 50o, or I want my patient to run marathons but all my

patient wants is to hold his spouse's hand to walk by the lake. Who am I to decide on behalf of them?

What I do now is sow the seeds of curiosity in my students, I make them see their patients as a social being where I try to encourage them to take into account a person's behaviour, pre-injury social status and the habitat. The caregivers also have become an integral part of my treatment protocol because I have realised the loving touch and the smile of a loved one works wonder on our patients.

I have so much more to learn from critical physiotherapy. Reading the CPN Digest and the blogs, I started believing that I am not completely crazy (I mean, a little bit of craziness is needed to look at things from a different perspective). It is so inspiring to read about all the research that is re-shaping physiotherapy. The ease of access to such thoughts through CPN is what appeals me to the most. It feels like a "Safe Space" where we can nurture our questions and thoughts to re-imagine how we approach our patients in a different way.

I am very new to CPN but what I would really like to see in the future is, CPN training new graduates and undergraduates to understand the role of biopsychosocial aspects of human wellbeing which I am not sure how many Universities have in their curriculum. I would love to see the thoughts and teachings of the members of CPN to become a normal way of thinking.

Physiotherapy as a profession in my country lacks the opportunity of research. It is immensely difficult to do any "profession-altering" work here. For years, I have tried to find someone to mentor me in a research work where I can explore this interconnection between the physical wellbeing and social structure, but alas Physiotherapists here don't know what to do about it and sociologists don't wish to guide me. I hope that someday the profession can truly look beyond this demarcation of physical, functional, psychological or social aspect.

Finally, what I bring to the CPN. Now I was avoiding this for as long as possible but if I want people to really know about me, I should probably say something. I don't have much research work to boast about but yes, I have an eager mind and I can talk (that's an understatement as evident from this huge profile). I bring a teeny-weeny bit of knowledge about DMT which includes embodiment, the concept of self and Self, an understanding of how nature inspires the body to move and how it is wonderful to accept that there is no "right" way to do anything. What I feel is I bring is a gullible mind ready to get bamboozled by everything that's happening in CPN and inform every person I know about how physiotherapy is changing.

Understanding that the Body and the Self is a vast entity which has space to welcome every critical physiotherapist to use movement as a way of exploring health is what brought me here and what defines my "Self".

*Before COVID-19 (Disclaimer — taken from CPN. Definitely not my creation)

Anna Rajala

30 September 2021

I'm currently working as a researcher in politics at Tampere University, Finland. The premise of the research project I'm involved with is critical. It studies the claim that capitalism is in crisis. The project seeks to respond to the calls to reconceptualise and retheorise capitalism in International Relations, International Political Economy, and Social Sciences more broadly. The subproject I'm a part of analyses "demented subjectivity" critically, both as a challenge to the idea of the neoliberal self-choosing subjectivity of political science, and to the understanding of the economy as monolithically capitalist rather than diverse in dementia rehabilitation research. Critique is not, of course, about pessimistically saying "no" to everything, as if already in defeat, but rather a commitment to taking a long and uncoerced look at the object of your study.

Physiotherapy will always be a part of me despite moving away from clinical work. The CPN offered me the first community in which I felt like I wasn't alone with my thoughts. It really is important to find that community in order not to feel discouraged to be critical.

I'm currently on the Executive Committee and have been sharing the chairing duties with Dave for nearly two years. I hope that I have brought useful ideas for discussion and contributed to ways of developing CPN further.

I would like to see the CPN community become tighter knit, although I realise it is not always easy to foster the sense of community online. There are a lot of good things that the CPN has done (such as the online courses) that have built a sense of community, and I would like to see them continue. I'm sure there are many other exciting things that we could do. We are always open to suggestions!

The profession is already developing away from a quick-fix-culture towards understanding physiotherapeutic problems as more-than-physical, and even more-than-human. The world we live in is a complex, rhizomatic mess of living and non-living things, and in such a world the simplest explanation is not always the right one (i.e. Ockham's razor is often too blunt). Another development I would like to see is to broaden our conceptual and theoretical understanding so that we might learn to tolerate messiness instead of opting for simplifying theoretical frameworks. Simplifying theories are not practical if they end up brushing exactly those complex and difficult issues that need to be discussed under the rug.

Chapter 12: Blogging and personal things

Blogging never felt like a chore to me. I can't think of a time when I was short of material. Partly that's because the Internet has become such a treasure trove of inspirations and ideas that you often only have to dip your toe in the water of a favourite writer or YouTuber and you'll be gifted with more ideas than you'll know what to do with. Curating a good RSS tool helps too, as is having the time and the good habit of reading.

Over the course of a normal week, I think I spend somewhere between 25 and 35 hours reading. Just reading. I've been fortunate to have crafted a working career that affords me the time to do this. (It helps assiduously avoiding the grant applications mouse wheel and the slow churn of empirical data collection.) But even if you have time to spend reading, you still have to do something with it. And deciding what is wheat and what is chaff can sometimes be a tricky process.

I tend to not focus on empirical research and I don't critique other people's studies. I try to focus on the marginalia of conventional healthcare and I'm drawn to progressive, anti-dominational causes. I've tried not to make the blog a soap-box and to remain positive, but also to allow the ideas to speak for themselves, without too much editorialising.

In this chapter you'll get as close to the personal side of my work as I got during the last 10 years. As a staunch Foucauldian, I'm allergic to confessional writing, but it never hurts knowing that there's a real person behind all of this work — especially in these days of AI-generated auto-bilge.

So, in this chapter are pieces on the act of blogging itself, the various stages of development of my books and other writings, what I think good writing should do, and some personal recollections on the passing years — especially my decision to step away from the CPN Exec and start ParaDoxa. It seems appropriate to end the book in this way, given how important blogging has been in shaping the last 10 years of my academic life. I can't now imagine being a reader of physiotherapy and healthcare without the opportunity to experiment with ideas and work out how to make a point in a pithy but substantive way. Truth is, I'd much rather read and write about these things than talk about them.

2013...the year of social media

3 January 2013

So I've decided to make 2013 the year of social media for me.

Reading some of Debbie Lupton's media work I was inspired to think that this might be a great way to a) develop some interesting collaborations with like-minded people around the globe (too ambitious?) b) organise what is becoming a plethora of on-line media resources into something that is both useful and interesting to me, and c) explore some of the creative thinking that's now all over the web.

So I'm starting by picking some key social media resources and throwing myself into using them. I'm going to commit to:

This Wordpress blog

My Facebook page for keeping in touch with family and friends and posting about what I'm doing in my life away from physio/work

A microblogging site...my choice is Twitter for now

The multimedia portal Tumblr for audio/video content

Flickr and Pinterest for posting images

So far this is all pretty standard fare.

For exploring the creativity of the web I've decided to start with a pretty restricted portfolio because there is a hell of a lot of dross that one could easily waste time with. I'm looking for places where I'll be drawn back, inspired and invigorated rather than sites that simply pass the time. So I'm going to concentrate on:

- Flipboard as a personal interest aggregator
- Longform and Arts and Letters Daily for stimulating ideas
- Vimeo and Showyou for video
- Soundcloud and Last.fm for the all important music (not really enjoying Spotify yet)

I'm not going to spend time in sites like Reddit (news) or Youtube (video) for reasons I've explained above. I haven't mentioned any specific sites either, because I'll be pointing to these on the blog as time goes by but I will be using Stumbleupon which I've really enjoyed so far.

What I'm interested in is collaboration, organisation and creativity. Some of this will be channelled into thinking about critical physiotherapy.

I'm keen to know if any of you use other sites or tools for these purposes and if so maybe make some recommendations.

Anxiety is the dizziness of freedom

10 June 2014

There has been a lot of interest in the problems of anxiety in the media recently.

About a month ago, Scott Stossel - editor of the high profile Atlantic Magazine - appeared on the Kim Hill Saturday morning radio show here in New Zealand having written a very moving account of his lifelong battle with crippling anxiety. Scott is a very successful editor and well known personality, so it came as a shock to many people that he had suffered so long (and seemingly managed) with this condition.

More recently, Australian writer, singer and broadcaster Sian Prior spoke candidly about her own battle with anxiety.

A few days ago, the Huffington Post and the New York Times both ran extended collections of essays on the problem of anxiety today. There has even been an anxiety film festival announced, to highlight how often anxiety features in the movies (think here about how 'thrillers' are supposed to make you feel).

In a fantastic counterpoint to some of the bleaker perspectives offered by the mainstream media, Katie Roiphe has written in the Financial Times Magazine about the 'Joy of Stress' and the joys of being ever-so-slightly 'wired'. After all, she says, isn't 'there something vaguely bovine, dull, about the state of being unstressed? Is there something slow, unfruitful, stagnant or dense about calm? You, with your fruity cocktail under the palm trees, are you boring?'

I'm interested in this upswing in interest in anxiety for a number of reasons:

- As a physiotherapist who has worked with anxious patients and as a university lecturer teaching breathing therapies for panic/anxiety
- As an historian who has studies neurasthenia - a condition not unlike chronic anxiety - that was one of the most prevalent disorders of Western society in the 19th century
- And as someone who has experienced their fair share of anxiety

My own experience

Taking these in reverse order, I'm sure that my interest in the management of anxiety (I don't think that 'treatment' is the right word to use here), stems from my own experiences of panic/anxiety. I can think of at least three occasions as an adult when I've experienced acute anxiety: once at a bar with a friend after many months of family stress; once while swimming in open water; and, more recently, doing a presentation to my colleagues.

As I've come to understand the things that trigger stress I've learnt to manage it better, but it's still a struggle to know what is 'good' stress and what is 'bad'. I strongly believe that most lecturers feel a degree of anxiety whenever they 'perform' in front of others and that their seeming comfort stems from a bravado that gives them enough confidence to get over their anxieties. I know that most of my colleagues would be surprised to know that I was often anxious, but that's part of the whole experience. One's ability to conceal the tumult going on under the surface is what we all do isn't it.

Neurasthenia as an early form of anxiety

Most of my academic career has focused on developing critical histories of physiotherapy and the physical therapies (massage, mobilisations and manipulations, therapeutic exercise and remedial gymnastics, hydrotherapy and electrotherapy). There is very little written about the history of physiotherapy - something I'm hoping to tackle in the coming years.

One of the things that is not at all well understood is how the early founders of physiotherapy (in England at least) used neurasthenic women as a vehicle to legitimise physiotherapy in its early years. (I've written a little about this here: Nicholls, D.A. & Cheek, J. (2006). Physiotherapy and the shadow of prostitution: The Society of Trained Masseuses and the massage scandals of 1894. Social Science and Medicine 62: 2366-2348).

Neurasthenia bore a striking resemblance to the breathing pattern/hyperventilation problems that are so much of an interest to health practitioners today. Originally developed in America in the second half of the 19th century, neurasthenia was similar to hysteria and concerned people's reserves of 'nerve force'.

Some people (often working age, educated, middle- and upper-class women) were supposedly especially prone. It was felt that these women were not cut out for rapidly advancing Western world, with its telegraphs, railways and electric lighting. Corsetry no doubt caused major physiological disruption but it was Silas Weir Mitchell's infamous Rest Cure that courted the most controversy. Women were removed from home and put into isolation for 6 - 8 weeks, during which time they were force-fed and treated as infants - being entirely passive, even having their teeth brushed for them. The cure was designed to 'fatten them up' but not wanting the women to waste away, doctors prescribed a rigorous routine of daily passive exercises, including massage, passive movements and electricity. While it was nurses that stayed with the woman for the duration of the cure, it was masseuses who came in to do the treatment. (Marijke Gijswijt-Hofstra's 2004 book 'Cultures of Neurasthenia' probably provides the best introduction to this subject). This is an important, yet almost entirely ignored chapter in the history of physiotherapy, and one that deserves more scholarly attention.

My physiotherapy work

Finally, I've combined my own personal experience and historical interest in my physiotherapy work. I teach a postgraduate paper at AUT University in Auckland, New Zealand titled 'Breathing, Performance and Rehabilitation', and previously worked for five years with one of New Zealand's most innovative clinics 'Breathing Works'. I've learnt from this work that for a lot of people, simply knowing that they have a breathing problem answers a lot of questions. People who have had ongoing pain, dizziness, blurry vision, feeling spaced-out, struggling to take a satisfying deep breath or thinking that they're breathing too shallowly, poor concentration, digestive problem, etc., etc., have been helped immeasurably by recognising that by changing their breathing, they can shake of some or all of their symptoms.

I use a simple assessment tool with my students called a Nijmegen Questionnaire (link) to begin looking at people's breathing. The questionnaire is far from perfect, but it has proven a useful tool to identify breathing problems. People should ideally score zero, but people who score in the 20s are really having problems and breathing retraining can often help them.

I would like to be able to say that my own anxiety has gone away, but the truth is I think that there's part of me that values it. I like to think of myself as someone with a lust for life and a passion for doing things that are challenging and interesting. I recognise more than I used to that sometimes my excitement gets the better of me, or that I've been pushed to do some of the things that I know are anxiety provoking. Fortunately (and as is often the way with anxiety) it has rarely overwhelmed me, and I've gained a lot from my joie de vivre. Most importantly though, I've learnt not to let it make me ill, and for that, I'm grateful.

Philosophy and physiotherapy - reflections on @physiotalk tweet chat

4 November 2014

Without wanting to sound too dramatic, my first experience of hosting yesterday's @physiotalk tweet chat felt like running with the bulls at Pamplona! It certainly was exhilarating. And what it also threw up were some thoughts about how physios currently relate to philosophy.

Just to recap, I was asked to run a Physiotalk tweet chat last week on the subject of philosophy and physiotherapy. I prepared some pre-reading and some questions to prompt discussion (you can see these here), and then logged on at the appointed time to facilitate the discussion.

Tweets fly in thick and fast and it's quite a job to keep on top of everything that's going on, but the hour flew by and a lot of people seemed to engage and enjoy themselves. There were a few common themes that came up though, that I've spent some time reflecting on since.

I was really heartened to see that there was a lot of interest in the idea of philosophy and physiotherapy. There were a lot of people posting who had a really diverse set of interests in areas like research, pedagogy and critical theory, and there was a confidence in the way people felt free to express their ideas that I hadn't seen before setting up this Critical Physiotherapy Network.

But I also got the sense that people saw philosophy as something separate to physiotherapy - as something to be added or subtracted at will - something physios had not really concentrated on in the past, but should now do more of.

Similarly, people seemed to me to identify with the common (mis)conception that philosophy is really all about thinking, and that this wasn't something that appealed to most physios, who are by their nature practical and pragmatic people. Some said that physios see philosophical ideas as 'fluffy' and 'soft' rather than the 'hard' sciences that they are so used to.

It seems to me that this exchange might have inadvertently provided a way forward for our Network. We've said that we want to make it a priority to help physios understand philosophy, but it's hard to know where to start with such a big subject. Maybe this tweet chat has provided a pointer?

I would suggest that for physiotherapists to embrace philosophy we can start with four relatively simple ideas:

Firstly, we need to explain that there is no practice or thought that isn't underpinned by philosophy. There is no idea that a physio can have that operates in a philosophical vacuum. Physiotherapy is not atheoretical just because physios don't know what the underpinning philosophical ideas are. So there is no getting away from philosophy, only ignorance to its effects. And if our profession is going to continue to be satisfied to work only on the surface of our patient's and community's need, then we deserve to be replaced by someone who will attend to these things.

Secondly, we could show people how philosophy is every bit about how people live in the real world, that it's not just about lofty theorizing or abstract ideas (although I've got absolutely no problem with this kind of thinking as well), but is every bit as practical as physiotherapy. Giving people ideas for the way people live with pain, cope with functional challenges, find happiness in movement, experience the world through their bodies, challenge social norms, etc., might be just the thing to get people to see that philosophy is

already there in physiotherapy. (For a great example of this, see this short film on Running and ask yourself why it is that this got labelled as psychology and not physiotherapy).

Thirdly, we should be honest and acknowledge that philosophy is hard. It is full of complex language and confusing, often contradictory ideas. But anatomy, physiology and pathology are hard too. They're also full of odd names and weird abstract concepts. But we managed! We managed to wade through hours of theory to get to the point where we knew how to apply what we'd learnt. We benefited from some awesome teachers (or we did it ourselves when our teachers were rubbish!), and we had guidebooks to help us. Should we expect physios to grasp philosophy without the same investment in first principles?

Finally, we should tell people that we're not doing this alone. In fact, physiotherapy is coming quite late to the philosophical party. There is much written already about how to apply philosophical ideas to everyday life that there's really no excuse to think that it's aloof or detached from reality anymore (see, for example, www.theschooloflife.com). Doctors, nurses, occupational therapists, psychologists and a host of others have all embraced philosophy and there is a mass of ready-to-use material that we can steal, I mean borrow, to help develop the philosophical capacity of our profession.

So I'd be very keen to hear from anyone else who tuned in to the tweet chat yesterday to see what they thought about the discussion, or anyone who wants to add their comments to the post.

History of physical therapies in 19th century New Zealand

25 August 2015

Excuse the shameless plug, but I'm giving a public lecture on Thursday night (NZ time) on the History of Physical Therapies in 19th Century New Zealand, and it will be live streamed and recorded, so I thought some of you might be interested in seeing it.

New Zealand offers an interesting case study because, in contrast to Europe and North America, where treatments like massage, mobilisation, hydrotherapy, electrotherapy and exercise were some of the most popular 'medical' remedies, physical therapies were almost invisible.

New Zealand was a frontier colony for much of the 19th century, and a lot of settlers had little enough food to live on never mind indulging in such luxuries.

The exception to this was the spa at Rotorua which became a centre for physical therapy at the turn of the century.

In the lecture, I look at some of the traditional Māori healing practices and examine the impact of settler culture, before looking at some of the therapists that did make a living in New Zealand in the years before 1900.

My analytic focus is on the connection between physical therapies and the ideas of luxury and surplus, and the research has led to some interesting thoughts about physiotherapy in the 21st century.

On pleasure

9 October 2015

Something for the weekend…

- Lying in bed would be an altogether perfect and supreme experience if only one had a coloured pencil long enough to draw on the ceiling (G. K. Chesterton).
- How beautiful it is to do nothing and then rest afterwards (Spanish proverb).
- No pleasure is worth giving up for the sake of two more years in a geriatric home in Weston-super-Mare (Kingsley Amis).

Who writes a physiotherapy blog anyway?

15 December 2015

I suppose if you're going to start a blog about physiotherapy the first question you need to ask is 'why are there so few good critical blogs about the profession?' It can't be because blogs are so new that we haven't caught up on the trend yet, or that physiotherapists are any more technophobic than anyone else in hyperspace. Nor can we say that physiotherapy is any less worthy than medicine, nursing, psychology, acupuncture or osteopathy, or any of the other health professions, to close critical scrutiny.

Granted, it's not a particularly common thing for people within their own professions to write critically about their work, and even less so to think that this should be available to everyone in cyberspace. There is an unwritten code drilled into all health professionals that is closely tied in with their notions of professionalism, that one doesn't air one's dirty linen in public. And so, naturally, debate about the past, present and future of the profession happens rather quietly, if at all, in poorly attended branch meetings, and in the grey-walled offices of profession's burghers.

So why write a blog about physiotherapy? Well simply because there are things to be said about the profession that ought to be aired; that the internet is a fabulous vehicle for debate and discussion and physiotherapy is desperately in need of being opened up; and because physiotherapy is finally starting to cast off its excessively disciplined, body-centric approach to health.

So this blog will have few sacred cows, and will at times be polemic. It will be subjective and opinionated. I make no apology if the writing is a bit sloppy at times…blogs were never meant to be fully formed prose; I write articles for that.

I hope you find the ideas interesting, and feel completely free to post feedback. I'll post it on line if its publishable!

First published by Dave Nicholls (via www.criticalphysio.me) on 24 July 2011.

If you'd like to contribute a post to the Critical Physiotherapy Network blog - we'd love to hear from you. Please contact Dave Nicholls with thoughts about what you'd like to blog about (you'll find his details in the list of CPN members). And if you've never blogged before - don't let that put you off... there are people from within the network who'd be very happy to help.

The end of physiotherapy is nigh

10 November 2016

Reproduced with the permission of The Chartered Society of Physiotherapy and the Wellcome Library, London

Apologies for the shameless self-publicity, but I'm truly delighted to reveal that the book I have been working on for the last two years went off to Routledge for copy editing this morning, with a publication date set for just before WCPT in June next year.

Notwithstanding its apocalyptic title, *The End of Physiotherapy* is actually a book about the future for the profession, and asks how physiotherapy developed the way it did, and how we are going to need to respond to the challenges facing us in the years to come.

The book analyses the purpose (or end) of physiotherapy, but also predicts that physiotherapy will not survive (the other meaning of 'end'), unless it understands its culture and history better, and recognises the need for radical reform.

Here's the broad abstract for the book:

> The End of Physiotherapy is the first book length critical history of the profession ever written. Prompted by the tensions and pressures now being

> felt by physiotherapists throughout the world, the book seeks answers in the profession's past. Through a detailed and comprehensive analysis of the principles, practices, systems and structures developed by successive generations of practitioners, teachers and regulators, the book argues that the roots of the profession's present problems can be found in the way it established its legitimacy and orthodox status. Drawing on a wide range of historical and contemporary sources from the United Kingdom, North America and Australasia, the book explores how neoliberal economic reforms, the burden of chronic illness and lifestyle diseases, the end of the welfare state, and people's increasing skepticism towards orthodox healthcare, might now be posing challenges that the physiotherapy profession is ill-equipped to answer. The book explores the idea of a physiotherapy paradox, whereby the very conditions that once gave the profession its social standing now threaten to undermine it. The book challenges physiotherapists to reflect on these conditions and see the challenges now being posed as a call for the greatest reform ever undertaken by the profession: a challenge that will require physiotherapists to leave behind the very principles that once made their profession great, and carve out an entirely new professional identity.

I'll post more information on here as the publishing deadline gets closer, but for now I'm going for a lie down.

The highs and lows of blogging about physiotherapy

13 June 2017

In a couple of weeks time, I'll be heading off to Cape Town for WCPT.

As part of the CPN Salon that we're running on the Wednesday immediately after the conference, I'll be delivering a short 'State of the CPN' talk.

Looking back, the Network has done some incredible things in just three years, but digging down into our archives I've found some things that have given me pause for thought.

One of them is the popularity of some of the blogposts and the almost complete disinterest people show in others.

For instance, our most popular blog by far was 10 reasons to love physiotherapy. We had nearly 40,000 views of this post. This was nearly three times as many people who have ever

gone to the site's Home page! Is it time to end the tyranny of evidence based practice reached only a third as many people a 10 reasons (10,000), and Six useless treatments came in third (9,600).

40,000 views is just over a quarter of the views we've had for the site overall over the last 3 years, but you can see the effect of this one post on our month-by-month views when it was published in January this year.

Not including this one, there have been 483 blogposts written for the site over the last 3 years, that's around one post every 2-3 days. The vast majority of these posts have been 'substantive' - meaning that they're based on issues, not just notices or news.

They take a lot of work to craft, so obviously we're interested in what's of interest to people and what gets read.

One of the things I ponder a lot about is why pieces like 10 reasons to love physiotherapy make such an impact, while blogposts on Physiotherapy is part of the debt we pay when things go wrong (82 views), Learning to think otherwise (70 views), or no less important or potentially provocative questions like Evidence-based medicine or micro-fascism? (69 views) achieve so much less.

Because we're not trying to sell news and don't need to practice click-bait, it takes the pressure off us being salacious just for the sake of it. That's not the kind of critical, thoughtful, engaged work that we want to do anyway. But we are, at the same time, interested in reaching out to as many people in the community as possible, and social media is a very powerful tool for doing that.

10 reasons to love physiotherapy was an exception in all respects. It seems to have tapped into a current of frustration and dissatisfaction, and I think people genuinely enjoyed its positive message. But it may also be our least critical piece of writing on the whole site.

It was written to test a different kind of message and to reach out to people who might not otherwise know about the CPN. In that respect it was successful. We had quite a lot of people join the Network as a result of reading this post.

But it also revealed that the popularity of a blogpost might not necessarily be the best measure of the site's success, especially if what you're trying to offer is consistently high quality, critically-informed thinking.

Why this cover?

7 December 2021

If you've been following some of the social media announcements over recent days, you'll know that this is the image that will be on the cover of my upcoming book *Physiotherapy Otherwise*.

I wish I could say that it was chosen because I have a finely honed appreciation for photography, but the truth is my brother, Jon, recommended Melissa's work. Jon teaches photography and has an encyclopaedic knowledge of photographers and their work. So when I asked him for some suggestions for the cover, Melissa's work seemed an obvious choice.

This image, titled Group, comes from a series that Melissa did in Amsterdam. The photo is made on a roof of a parking lot, and the women are part of a dance group. Melissa asked the women to wear clothes that made them look the same so that it would be difficult to tell whose arms and legs belonged to whom.

The women appear to be knotted together: struggling, but also becoming one. They don't fit perfectly together, and they appear to be fighting for their own space. And this felt like a perfect metaphor for the book as a whole.

The image touches on the idea of the subject; on what it is to be an individual, group dynamics, and the power of touch and movement.

Melissa's work often touches on these themes. 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.

A new book journey begins

5 January 2022

As the work on one book comes to a close, the shoots of a new book start to emerge

Although Physiotherapy Otherwise has only just been released, and few of you have had any time to read it, planning for a follow up has been in the works for some time.

Years ago I'd thought about writing a three book series, with each book critiquing physiotherapy from a different angle. The End of Physiotherapy (EoP) would be a historical critique, Physiotherapy Otherwise (PO) would be sociological, and the third book would come from a philosophical or educational direction. Now I'm not so sure.

There's so much more to say about physiotherapy. But whether the new book will stick to the three-book idea or depart entirely is still up in the air.

Whichever direction it goes in, I know that a new book is there, waiting to be found.

I love long-form writing. But that doesn't mean it's not hard work. Writing is definitely hard work. And that puts a lot of people off I think.

It's not helped when all you see is the finished product, and the hours of mundane reading, crafting, and polishing seem to have been achieved by some act of divine intervention, like a shoemaker who wakes to find the elves did everything for him overnight.

There's also no culture of academic non-technical book writing in physiotherapy, unlike in medicine, nursing, and psychology.

So perhaps reading about the struggles, moments of inspiration, and the technical workings of writing a book (not least the ideas taking shape), will help demystify the process, and encourage more physios to give it a go.

My plan, then, is to try to make the process of going from conception to delivery more accessible and open, and share some of the trials and tribulations of what will probably be a three or four year journey.

I'll post under a new section of the CPN Herald site called 'The Third Book', and if these musings aren't your cup of tea, you can always unsubscribe from this sub-section while still getting CPN updates and the weekly Digests.

The first post will sketch out where I'm starting from: what I already think the book will be about and what I plan doing first. As much as anything, I'm keen to collaborate and shape the book around a community of ideas. So if reading these pieces sparks some inspiration, I'd love to hear from you.

Oh, and happy New Year 😁.

Where do you begin?

11 January 2022

An occasional series on writing a new book

Given that there are more than two million books published each year and countless millions in development, writing a book isn't entirely uncommon.

But it is rare in physiotherapy, particularly in non-technical publishing.

According to the Interesting Facts of the Day blog (https://tinyurl.com/y3a4shmz), one in every 400 people in the UK publishes a book each year. I wonder how many books would be

written as a proportion of the physiotherapy population? I suspect we'd look more like Kenya or the Phillippines.

People say physiotherapists are practical, motivated, busy people, drawn to the profession for its hands-on approach to healthcare. They'd prefer to learn a new technique to fix a shoulder than contemplate the philosophical roots of their practice. So we don't write many books.

But is that really true? It implies that physiotherapists are somewhat thought-less: blindly accepting what they are told physiotherapy is or can be; flitting with their butterfly minds from one guru cult to another, taking up treatment trends without thought for the deeper discourses at play. And I'm not sure that's entirely the case.

All that aside though, books, theses, and other types of long-form writing can be a great way to show that physiotherapy is a thought-full practice. But as anyone who has written a lengthy dissertating knows, there are some things you need in place if you're going to succeed.

I've written three book-length texts now and supervised a dozen doctoral students doing their own. Over time I've learned that if you're going to embark on a book or long thesis, you're going to need the following if you want to succeed:

A love of writing, or at least a love of the struggles that come with writing. Taking three-dimensional ideas and turning them into linear prose is not easy, but it's only one more skill that comes with its own practice and learning. You just have to want to acquire this skill as much as anything else.

Determination and the willingness to put other things aside to get this done. This can't be a burden in your life, or you'll resent it and fail. So the changes you make to your life to do a project like this have to be life-enhancing.

The support from family and colleagues. They don't have to understand or even care about your project, but they need to support your endeavor. You'll need time to do this. LOTS of time. Much of it will be your own, but they'll need to chip in some of their time too if you're going to get this done. And yes, that includes the person who pays your salary.

A good idea. It doesn't have to be fully formed - writing is as much about finding it as defining it - but it does need to be a gnawing sense that there's something out there that needs to be explored. It needs to be powerful enough to make you want to try again tomorrow, and tomorrow, and tomorrow.

Critics. You'll need people around you who can tell you your ideas don't make sense, your writing is sloppy, and your arguments are weak. Theses students have supervisors to do this

for them, and part of the thesis process is about learning to be your own critic. But even when you've graduated you'll need a network of people who constantly make you write your best.

You can often get by without one or two of these if you embark on a smaller project, like a new course of study or writing a research article. But a book or thesis will find you out if even one of these is not in place.

A book can take three or four years to write and I know that, for me at least, that's going to mean working 10-20 hours per week on it, six days a week, 50 weeks of the year. I'm incredibly lucky because this is now part of my job, but that's not always been the case.

And if this all sounds daunting, remember that some people spend that, and more, doom-scrolling through social media or binge-watching police procedurals. So we all have time to spare if we really want it. We just have to want it. And that's perhaps the most important thing.

So what's the big idea?

24 January 2022

The 3rd instalment in an occasional series on writing a new critical physio book

If you've subscribed to this new CPN newsletter, you'll have noticed you're now getting three different 'streams'. There are blogs with news about CPN events (called the CPN Herald), there are the weekly CPN Digests which come each week with 15 curated critical physio-related links from the margins of the Internet, and there are these 'Third book' newsletters, which are about the long process of writing a new book to follow Physiotherapy Otherwise.

Having explained the basic idea of the project here, and talked about what you need to have in place if you're going to write a book, today's post is about the book's big idea.

As I mentioned in the first post, my plan was always to write a three-book series, with this third book being philosophical.

Being an early qualitative health researcher I had to have a basic appreciation for philosophy. So since the 1990s, I've been trying to make sense of phenomenology, realism, constructivism, and a dozen other 'isms'. Most of these did nothing for me, but I found my home in the early 2000s when I was introduced to postmodernism.

Postmodernism is skepticism towards grand narratives, and the belief that there is no objective reality underneath our language games, desires, and power struggles. The Crown Prince of postmodernists is probably Michel Foucault, whom I love dearly. I even look like him!

But I wouldn't be a good postmodernist if I wasn't also skeptical of postmodernism, and for years I've been concerned that it's pushed me to reject the physical reality of the biological body in favour of a world made up only of discourse. This always troubled me, because even if I could reconcile myself to this idea, I didn't think most of my physiotherapy colleagues could. So if I wanted to find a way to 'diagnose' physiotherapy better, I'd need to find a different way to think.

So I began to search for philosophies that could account for the full majesty of the world around us: philosophies that could account for bodies that are real and bodies that exists only in language; human experiences, as well as the billions of other non-human entities that make up the physical therapies; social forces like gender or colonisation and rectus femoris muscles that seem to be entirely anti-social.

Three or four years ago I came across a group of thinkers who were exploring a philosophy that didn't just try to reconcile our conventional philosophies but created entirely new ways to think. They developed an approach variously called Speculative Realism or Object Oriented Ontology (OOO). I'll explain more about this in a future post, but for now, suffice to say it's an approach that might just provide the basis for a radical new way to approach the physical therapies.

So the book that I'm embarking on now is going to look at each of the fundamental physical therapies - touch, movement, exercise, heat and cold, light, water… - and try to understand them in a new way.

I've already tried to do this in an article that looked at respiratory physiotherapy (open access version here), and I'll hopefully be doing more of this short-form writing over the next couple of years.

But for someone with a classical physiotherapy training, this is heavy stuff. And even my love of philosophy doesn't mean that this is an easy process. I'm on sabbatical this year, so I'm going to spend a lot of my time in slow, deep reading of books that feel sometimes like they're written in a foreign language. But this is how it has to be, I suppose. It probably wouldn't be a radical idea if it made perfect sense or flowed like water.

And I'm already wondering how on earth I'm going to explain the strangeness of these ideas to physiotherapists who still think qualitative research is exotic. I don't want to have to spend most of the book explaining a new set of theories and leave no room to say something actually about physical therapy. But that's a problem for another day. For now, I've just got to get back to trying to understand the Body-without-Organs

What is the book going to be about?

22 February 2022

An occasional series on writing a new critical physio book

This is the fourth post in an occasional series walking through my process in writing a new book.

The idea of these blog posts is to share the journey and talk about share some of the things I've learned writing The End of Physiotherapy and Physiotherapy Otherwise.

So far I've touched on:

1. An introduction to the new book
2. What needs to be in place if you're going to do something like this
3. Some of the ideas informing the book

But I haven't yet talked about what the book is actually about.

For the longest time, I've wanted to study the cultural history of the physical therapies.

To that end, I wrote The End of Physiotherapy as a way to think about the historical conditions that made physiotherapy possible. This was followed by Physiotherapy Otherwise, which looked at the profession sociologically.

But neither of these really tackled the philosophies behind some of the most basic aspects of practice. What is the body, really, to physiotherapy? What is touch, or movement? Are they just bio-physical processes? If so, what of people's experiences or the social forces that shape what and how we practice? How do we understand what is 'real' in all of this?

Take something as commonplace to physiotherapists as touch, for instance.

When you think about touch in its broadest sense you would have to conclude that physiotherapy takes a very particular and specific view of it.

Touch is absolutely everywhere, across the entire universe, involving every single kind of entity, in every moment of its existence, and has occurred throughout time.

So physiotherapy's decision to focus on specific forms of bio-physical touch designed to diagnose and treat a narrow range of physical problems in humans seems quite specific! And something like a deliberate, well-thought-out approach, designed to address some aspects of this universal phenomenon, and disregard others.

But if this were the case, you would surely expect to find screeds of literature discussing the merits and limitations of this approach, and a clear statement of why physiotherapists should concentrate on this and not something else. But this just isn't so.

And given how central touch is to physiotherapy practice, it's quite remarkable how little it has been theorised. We know more about Economic Models for Cost Effectiveness of Physiotherapy Interventions Following Total Knee and Hip Replacement than we do about something as important as touch.

I've come to believe that physiotherapy has fallen into using touch the way it does because of the social and political necessity to practice in certain ways to establish a professional enclosure. And it was so successful in securing its privilege that it never needed to really establish the philosophical basis of its beliefs.

But simply relying on custom and practice or past performance is a dangerous way for a profession to think about the future. And there's no doubt that there are a lot of conversations about the role of touch in physiotherapy right now. Be it discussions about the merits of so-called 'passive therapies', people's touch deprivation with COVID, or the rise of haptic technologies, touch is very much in vogue.

So, at its most basic level, what I'd like to do in this new book to tackle is the question of what the physical therapies actually are, and what they might become for the profession in the future.

Perhaps an illustration might help here.

Staying with the concept of touch and physiotherapy, consider these questions:

1. What actually is touch? We know that at an atomic level the gap between atoms is so vast that most things that touch are basically gaps filled with electromagnetic charge and 'dark' matter. So does anything actually touch anything anyway, or is it all just air?
2. If touch is so ephemeral, should abandon the illusion of our bio-physical approach to touch because it misses too much? Despite the problems of locating where and when touch actually happens, what can it tell us about the longed-for touch of people who have lost a loved one, or the touch of a surging crowd at a rave? Perhaps phenomenological, sociological, cultural, or ecological explanations of touch would be more useful?
3. When we talk about therapeutic touch, what is it exactly that constitutes something as therapeutic? For instance, am I only being 'therapeutic' when I put my hand on your painful shoulder in a clinic, as opposed to when I make the gesture to hold you up as we stagger back from the pub? Do you have to be 'qualified' in something and 'intend' it to be helpful to make it therapeutic? If so, where does 'therapy' actually reside? Is it

in the sensory nerve endings of my hand, in the relational space between us, or somewhere else entirely? If we're going to understand it and claim it as our own, it would surely be good to know where it really 'is'.

4. Does a human have to be involved for it to be therapeutic touch? Given that deliberate acts of human touch make up roughly 0.000000000000001% of the touch events happening throughout the cosmos at any one time, how do we account for all of the other touch stuff going on? Are the air molecules passing under an airplane being therapeutic by helping the plane stay in the air? Are the leaves of a tree being therapeutic when they fall to the ground, rot, and provide food for the soil? If these aren't going to be considered therapeutic forms of touch, we should probably be clear about why. And should we really be so restricted in our thoughts about the kinds of touch that are therapeutic? If not, what should we be including, and why?
5. And what rights do we assume for ourselves when we wantonly walk on the earth or step on the kitchen floor? Did we ask the soil's permission in the same way we would ask a person before we touch them? Did we ask the kitchen tiles? If not, why not? Should we just assume the kinds of human exceptionalism that have been linked to so much exploitation in the past? Or could touch be a vector to some radically new ways of thinking about the physical therapies beyond just massage and passive movements?

Some of these questions sound obscure and flippant, but the truth is that they're riven with complexity and can't really be answered without a deep dive into philosophical ideas about what things are and our relationship to them.

Physiotherapists work with all manner of entities: people, exercise bikes, concepts and ideas, muscles, treatment couches, latex gloves, hopes and dreams, births and deaths… but we've never really established our ontological position for these things. We've just fallen into a biomedical way to see them and taken that as read.

I mentioned in the 2nd post in the series that I'm interested in a new set of philosophies called Object-Oriented Ontology (OOO) or speculative realism. These take a much more inclusive and interesting view of entities that are embroiled in the enormous world of the physical therapies. My suspicion is that they might just offer us some really interesting new ways to think about massage, exercise, movement, function, and rehabilitation, into the future.

Only time will tell though.

So there are two lines coming together here. On carries the research on the cultural history of the physical therapies. The other carries the philosophy.

My hope is that the two lines converge at some point in the near future in a way that I only have the vaguest sense of right now.

If you have any suggestions or thoughts for ways to go forward, books you think I should read, or pointers of any sort, it's always lovely hearing from you. Just leave a comment below. And thanks, as always, for being open to touching the void.

The joy of text

15 March 2022

An occasional series on writing a new critical physio book

I recently did an interview with Michael Rowe looking at my daily work routines and the way I get things done (see below), and part of that was about how I work on long-form projects like this book.

If you've ever written a thesis you'll know you have to be systematic, so I thought in this blog post I'd show you what I do.

I once asked an esteemed colleague at my university how he wrote his books. (At that point he'd already written 28). His method was to compile tens of thousands of notes, quotes, and arguments in advance, and only when he had it all together would he actually write his book. Because his preparations were so detailed he only needed to write the book once and it needed minimal editing.

My approach is similar to this, but perhaps not as brutal. He's known to have a capacious memory, so can hold all of his arguments in tension as he writes. I don't, and I often find I still don't know what I want to say until I actually write it.

But, like him, I do start writing a book by taking copious notes.

I've found over the years that I absorb ideas much better when I write them out by hand. So as I'm reading through texts I know will be important, I write out everything I find and think about.

I mentioned in an earlier post that I'm currently working on the idea of therapeutic touch both for the new book and for an upcoming special issue. Well, here are some of the notes I've taken so far.

This first set was written this morning, working through the excellent recent paper on phenomenology in physiotherapy from Jan Halák and Petr Kříž.

I'll add these to the growing pile of notes I've written for the touch project so far.

For long projects, like a detailed reading of a book, I write the notes in a journal, like these notes on Jane Bennett's book Vibrant Matter.

For a book or a long project, I find that after about three weeks of note-taking I've forgotten where I've been. So need to backtrack to collate the ideas and map them in such a way that I can find key themes, connections, and gaps. I do this with a hand-drawn mind-map.

This one relates to a single book — Manuel de Landa and Graham Harman's book The Rise of Realism — but I've also done them for the work of a particular writer or even a single concept.

Notice on the mindmap that there are numbers like "7/117" and "8/3" beneath each of the words or phrases. These refer to the journal and page number where I can find my original notes. So once you get to the mindmap stage it's easy to find all of the places where that idea is mentioned and get a sense of the idea as a whole.

At the moment I'm working on material that feels like it will be key to this new book. Some of it is deeply philosophical so I need a system like this to help me understand the ideas. I'm sure if I'd been trained as a philosopher it would be easier and quicker, but I'm not, so this labour-intensive, immersive process is how I manage.

And yet I never find it dull or tedious. In fact, I really love it. I only annotate work that really fires me up, and almost every day I have "Ahah!" moments when I come across something new or glean something that had been opaque before.

You also don't get the pressure of having to formulate your thinking and construct what you hope will be clear consistent sentences. It's like free play with no pressure.

If a book takes me four years to write, at least half of that time will be spent on this kind of note-taking.

But at some point, the hand-written note-taking has to take a back seat, and you have to start forming a linear argument from this mass of material. For that, there is no better tool than a computer.

But more on that next time.

Reference

Bennett, J. (2009). Vibrant matter: A political ecology of things. Duke University Press.

Halák, J., & Kříž, P. (2022). Phenomenological physiotherapy: extending the concept of bodily intentionality. Med Humanit, medhum-2021. https://doi.org/10.1136/medhum-2021-012300

DeLanda, M., & Harman, G. (2017). The Rise of Realism. John Wiley & Sons.

A book as a pair of scissors

14 June 2022

An occasional series on writing a new critical physio book.

Louise Michel wrote that ‘The task of teachers... is to give the people the intellectual means to revolt’, and that feels like a very powerful motivation to me.

I’ve often said to my students — undergrads and postgrads — that my job as a teacher is to undermine their confidence at every possible opportunity. And I’m serious.

I want them to feel less self-assured and less confident in their knowledge at the end of a class than at the beginning. My hope is that this feeds their desire to heal the wound of their not-knowing and look again at what’s possible.

People have to want to learn, but we have to be careful not to kill that desire with ready-made solutions and textbook truths.

There is a Zen Buddhist tradition of turning monks away who come to the monastery looking for training. If the monk comes back, they are turned away again. Eventually, when the monk knows for certain that this is what they want, they are admitted.

But, of course, I can only have the luxury of being an agent provocateur because what I’m often teaching follows enormous amounts of conformity and standardisation. The students find it challenging, sometimes exhilarating, to be told they don’t have to practice that way.

So, if ‘knowledge is for cutting’, as Michel Foucault said, then our job surely is to provide people with the scissors. And there are many ways to do this.

My preferred way is through ideas and concepts. Thought experiments mainly. Ways of thinking that can have profound effects on what people feel is possible.

The beauty of ideas and concepts is that they can be played with in the safe knowledge that no one will be hurt. You can be really radical, and nothing gets broken.

But in physiotherapy, even working with ideas can be radical, because so many of my colleagues want to collapse thought altogether, and move as quickly as possible to something practical and empirical.

Ideas have no value unless you can put them into practice, right?

Well, I think not. In fact, I would even suggest that this attitude explains why there is so little theorising in physiotherapy: why we lack even the most basic concepts of what things like

touch are; what we mean by therapy; what care is for us; whether feeling pain is a bad thing; and what constitutes a good life.

Hence the next book. Because I believe that if there is one dire need in physiotherapy today it isn't for another inter-rater reliability study of the Standing Up and Sitting Down Test, it is for a fundamental, root-and-branch understanding of those things we believe make physiotherapy what it is.

So that when we know these things better, we'll be better able to cut them up.

Who should we write for?

5 July 2022

An occasional series on writing a new critical physio book

Years and years ago, I asked the editor of Therapy Weekly for some tips on good writing. She suggested reading the work of Muriel Spark, author of classics like The Prime of Miss Jean Brodie, and The Ballad of Peckham Rye, and Roger Hargreaves, author of the Mister Men books. She thought a key to good writing was to say exactly what you meant and nothing more. This was great advice. But perhaps the best recommendation I ever received was to imagine the face of the ideal reader.

When I was writing my Ph.D. thesis, I struggled to develop the right pitch for things I needed to explain. Sometimes I would explain too much, sometimes too little. So, one of my supervisors suggested cutting out the picture of a face from a magazine and writing to just that person. All they had to do was represent your one ideal reader. For my Ph.D. it was a middle-aged, academic who knew their philosophy, for other things it was a 25-year-old PT graduate who'd never heard of the body-as-machine.

Once I did that, my writing got tighter because I knew at every turn how much or how little I needed to say.

In critical physiotherapy, there's often a tendency to want to over-explain, especially when it comes to subjects like history, philosophy, and sociology that physiotherapists often have limited knowledge of. I've spent most of my life writing like this; imagining my reader as a clinician with a taste for thinking otherwise but no real knowledge of how to do it. But this can be a trap, too.

Back in the early 2000s, I was trying to write a journal article using some of the early work I'd done for my doctorate. The thesis drew heavily on Michel Foucault's writings, but I couldn't work out how to explain his ideas succinctly enough so that I had enough space left to say

something substantive about physiotherapy. The English Physiotherapy journal had very restrictive word limits at the time and I just couldn't make it work for that readership.

Then someone suggested that I stop trying to write it for physiotherapists.

If, instead, I wrote it for sociologists I wouldn't need to explain so much about Foucauldian theory and could concentrate on the physiotherapy stuff because this was the stuff the sociologists didn't know. And if physiotherapists wanted to read it, they would find their way to it because they were already interested in the sociology of the profession. That article was Physiotherapy and the shadow of prostitution, and it's still one of my most widely-used articles.

Sometimes it's necessary to follow the rules of good writing, and sometimes it's necessary to break them, and yesterday saw the publication of a new journal article that definitely does that for me.

The article How do you touch an impossible thing? published as part of a new series on touch in physiotherapy was a real departure for me. It tackles material I've been working on in the early stages of a new critical physio book, and it focuses on a vastly expanded idea of touch. But rather than trying to explain the ideas to people — as everyone tells you you're supposed to do, I decided to use the article as a way to write to myself; to use the article as a way to make sense of ideas that I've really struggled to understand.

Of course, when you're writing you're still trying to explain things. You're still trying to link concepts and craft a linear, two-dimensional narrative from a three-dimensional treasure chest of ideas. But the pressure feels different if you're writing for yourself. It's the difference between explaining what SaO2 means to a patient and explaining it to a conference of anaesthetists. Instead of trying to collapse into meaning-making, I found myself freed up to write more expansively and more creatively.

I've been writing long enough now to know that there is quite a small and diverse readership for critical theory, and imagining one's ideal reader is always likely to narrow that audience even further because some will want more context, others will want less. So perhaps writing for yourself — the self that knows there is something in here but is struggling to make sense of it all — has more integrity and authenticity because it presumes nothing about the readership, and so becomes more open and egalitarian?

I'm not sure all of my writing in the future will be like this, but it's certainly been an enjoyable and eye-opening experience. And really, whether anyone actually reads or understands How do you touch an impossible thing? is beyond my control. All I can do is write to the best of my ability and trust that, in doing so, it keeps the movement going.

References

Nicholls DA & Cheek J 2006 Physiotherapy and the shadow of prostitution: The Society of Trained Masseuses and the massage scandals of 1894. Social Science & Medicine 62: 2336-2348. https://doi.org/doi:10.1016/j.socscimed.2005.09.010

Nicholls, D.A. (2022). How do you touch an impossible thing? Frontiers in Rehabilitation Sciences. https://doi.org/10.3389/fresc.2022.934698

Stepping down

18 October 2022

A big decision, but the time is right

There's a story about David Sackett, the originator of the evidence-based practice movement, that he deliberately changed his career every 10 years. He believed you constantly needed to press the reset button, and he did that for all of his working life. I don't know if that's true, but in the spirit of David Sackett at least, I've decided to step down from the CPN at the end of the year and start something new.

The CPN was formed early in 2014, and I've been chairing the Exec from Day 1. And during those eight years, it's felt like the CPN has been party to an incredible transformation in the physiotherapy profession.

When I started out as a physiotherapist in the late 80s, I thought I knew what I'd be doing for the next 30-40 years. I don't think that's the case for new graduates today. No one quite knows what might be possible for a physiotherapist in 10 years' time, never mind 40. And I think the CPN has been part of that. I think we can be proud of how we've helped to make an otherwise physiotherapy now seem possible.

Either through your reading and writing, your teaching and practice, through 'spreading the word', a million social media posts, conversations, and everyday decisions made differently, through your lobbying and mentorship, or just your encouragement to others, you've shown people a thousand new doors that didn't seem to exist before.

So why step down now? Well, there are a number of reasons. Most importantly, the Network needs a new face, and preferably not a privileged white European guy. And I'm not just talking here about value signalling.

Despite many of the successes of the last eight years, I've always felt uncomfortable being so prominent in the Network. I'd always wanted it to be an engine of creativity; a safe place where people could say and do radical things. But I know that it's much easier to do that if you have autonomy in your work, security of employment, time, and space.

At the beginning, it was easy to leverage that privilege to get things going, and it's been a beautifully symbiotic relationship. But all good things come to an end, and now's definitely a good time for both of us to look to something new.

The CPN is in good hands. The Network has an Exec that's evolved considerably from its early days, and it's run by some very capable people — any of whom could take over as Chair.

It also has a body of work in place — including the new Critical Physiotherapy Course on Vulnerability, and a 3rd critical reader in the pipeline — that will occupy lots of people in the Network for at least the next 18 months. So there's still plenty of work to be done.

For me: I have a few plans for 2023 but so far only a few. I'm keeping my mind open to possibility. I know that I want to do more work in a creative community of peers, and I'll always be using physiotherapy as my springboard for ideas. I've started a third book, but it will be a couple of years at least before that sees the light of day. And I'm hosting an international conference in Auckland in February 2024 which, hopefully, will attract enough CPN members to allow us to hold another Salon.

But I didn't want to finish this message without saying a particular thank you to the people who have been at the heart of everything for me over the last eight years. To the small group of friends who got the CPN going in the first few months of 2014; to Jo Bloggs, whose unheralded labours kept us safe online; to the past and current Exec members; to all of you who gave your time freely to nurture the CPN; and to the thousands of people who have shared their dreams and ideas with me over the last eight years. I can't thank you enough for your fellowship. It's been an honour and a privilege to work with you.

And so to one last plea. If you've been a CPN member for some time and watched it from the fringes, think about getting involved now. The CPN is a living, breathing thing, and it needs the oxygen of your ideas, your inspirations, and your desires. Get involved.

As the great Margaret Fuller once said; "Today a reader, tomorrow a leader. If you have knowledge, let others light their candles in it. Very early I knew that the only objective in life was to grow".

Viva la revolución.

Why I've started ParaDoxa: And how you can get involved

17 January 2023

Hello folks,

Thank you to everyone who's already been in touch about this new venture. The response so far has been incredible. And we're only just getting started.

Before the site gets really moving, though, I thought I'd take a moment to tell you a little about me and explain why this, why now?

At the time of writing this, I've been an academic for just on 30 years this year. I'm also a physiotherapist, but I'm unusual in my own field because my work concentrates on history, philosophy, and sociology rather than biomedicine.

Eight years ago I set up the Critical Physiotherapy Network with a few friends. We initially thought it would be a small meeting of colleagues dotted all over the place, but it quickly developed into an international network of over 1,000 people from more than 50 countries. It was proudly free and independent, and it frankly restored my faith in physiotherapy.

But by 2022 I knew I needed a fresh start.

I've been a student of postmodernism — especially the writings of Michel Foucault — since starting my Ph.D. nearly 20 years ago. But over the last decade, I've been increasingly drawn to post-humanism and the turn away from human-centred research and practice, and towards 'material' philosophies like new materialism and object-oriented ontology.

More and more I've thought about ways these could be used to transform healthcare.

In 2017 I wrote a Foucauldian history of physiotherapy (The End of Physiotherapy), and last year (2022) published Physiotherapy Otherwise which analysed the physiotherapy profession sociologically. My plan was always to write a third book using philosophy to 'diagnose' my profession, and I began work on that last year.

The book will attempt to develop a post-human philosophy of healthcare (probably using physiotherapy as my case study — because that's what I know best). The work of Gilles Deleuze and Félix Guattari will provide the main thrust of the arguments, with an array of assorted co-conspirators alongside.

But to do this, I felt I needed to close one part of my academic life off, to open up another. So, a few months ago, I resolved to end my time with the CPN and the International Physiotherapy History Association and start down a new path. And that's what ParaDoxa is.

I'm convinced that:

- We're entering perhaps the most exciting and dynamic period in the century-long history of the healthcare professions, but this is undoubtedly a post-professional era. Future healthcare will look vastly different from the way it's configured today;

- We should not be placing our energy or trust in 'the state', or the 'free' market as the remedy for what ails us. We have to think beyond the Enlightenment and the legacy of industrial capitalism that has been so advantageous to the orthodox (Western) healthcare professions in the past;
- Similarly, we shouldn't look to revive the anthropocentric (human-centred) project, because there's too much other 'stuff' going on in health and healthcare (never mind what lies beyond it) to focus simply on the bits that we care about;
- There is something in the philosophies of Deleuze and Guattari, Irigaray, Spinoza, Nietsche, Bennett, Butler, Liebniz, Manning, Braidotti, Foucault, and others, that might give us a route map into an entirely new way to think about health and healthcare. (And if it doesn't give us a 'route map' exactly, it will at least give us some pointers to much better questions.)

So ParaDoxa is a passion project.

It's also a way to build a community among clinicians, researchers, students, teachers, and writers, who also want to think more about these things and share some of their ideas.

An example of what I mean:

Most of my clinical work as a physiotherapist was centred around children and older adults with chronic lung disease. I had been given really good training in oxygen dissociation and lung anatomy, I knew lots of objective tests for VO2 max, and knew how to spot respiratory failure from an ABG. But I needed to become a qualitative researcher to understand why breathlessness really frightens people. Even then, though, the phenomenological research I was doing fell short, because it didn't tell me anything about the structural conditions of poverty, social isolation, and stigma that these people experienced. I needed sociology for that. Then Foucault came along and taught me to look into the conditions that made my work as a physiotherapist historically and socially possible. Learning that was life-changing but, even then, there seemed to be something missing.

I was looking for something that was capable of holding all of this together; something deep, philosophically strong; something that wasn't just naive 'holism' (no thank you, biopsychosocial model); something that could cope with the body, the soul, and the social.

And I wanted this for some really quite pragmatic reasons. I wanted a new kind of physical therapy — something that wasn't bound by the old dogma of biomedicine, interpretivism, or sociology.

I tried to write about this in an article back in 2019. Apologies for the long quote, but hopefully it explains what I was struggling with;

‘How can I reasonably practice as a respiratory physiotherapist and not have a view on the interplay between the ecology of air, the biology of breathing, the lived experience of gas exchange, the spirituality of breathlessness, or the symbiotic relationship between objects that are neither defined by what they are, nor by what they do? How can I not be interested in designer face-masks, and the creative conversion of oxygen, air and breath in works of art; or be concerned for cities like Delhi, where levels of carbon monoxide were 25 times the WHO recommended level at times last year? How can I privilege an anthropocentric view of breathing and ignore breathing as a form of anarchy, air as ‘landscape’, a negative space, and terra infirma? Air as terror and medium of social control? Combat breathing or muscular armor? My practice and thinking, surely, has to embrace the use of breathing in films and role player video games? And if oxygen is the ‘fuel’, how can I understand the role it will play in future robotics and space travel? I have to be interested in breathing as memory and history, in iron-lungs, ventilators and machine- assisted breathing. And I surely must want to understand why the diaphragm is the only skeletal muscle in the body that is both under voluntary control and essential to life? What of the interstitial (liminal) spaces between things – so important for the micro-anatomy of the lungs – but applied elsewhere too?’ (https://openrepository.aut.ac.nz/handle/10292/13056).

I’m sure the same expansiveness applies in whatever area of healthcare you live, work, or study in.

So, finding a philosophy that could be adequate to a more-than-human, post-qualitative, post-structural, post-professional kind of healthcare has been the focus of my work since then, and it’s the basis for everything that you will see in ParaDoxa.

Broadly, I’ve labeled all of this work post-critical. It’s not an ideal label, but it will do for now. If you’d like to know more about the ideas behind ParaDoxa, click on the ‘About’ tab on the website.

What you get if you subscribe

A regular diet of links, announcements, editorials, digests, podcasts, and assorted other bits-and-bobs, delivered to your email inbox every week.

While the community builds and the site grows all of this will be for free. All you have to do is write in your email address and subscribe.

I should also say I have a fantasy of doing this kind of work full-time and moving to a post-academy life where teaching and writing about post-human healthcare become my full-time work.

So, at some point in the future, I’ll create free and paid subscription arms to the site. But that won’t be for a while yet.

And finally, what can you do?

Firstly, click on the ‘Subscribe now’ button above and sign up;

Tell other people about ParaDoxa. Click the share button below and pass it on;

Chip in. Add comments to the blogposts, send me emails, chat on Zoom… whatever works for you. There are so many people out there doing amazing post-critical work right now, I’d love to hear from you and anyone you think would be interested.

Stay well, and stay in touch.

Touch… now that’s something I should look into…

Plump your mind-glutes

11 April 2023

I read this piece recently from Adam Mastroianni’s excellent Experimental History Substack.

The reference to the body metaphor appealed to my physiotherapist's brain, but it’s the idea that to be better at what we do we sometimes need to work on things that are a long way proximate to where we think the problem lies. The penultimate paragraph just blew me away.

A reader recently DM’d me this question on Twitter. I started typing a response, but then it got out of hand, and so I thought I’d just post it here.

> I’m a relatively new writer and I’m really interested in working to get better at this craft. Obviously the biggest part of the improvement equation is reps, and I’m solid there; I write frequently. But I’m curious as to whether there is anything you’ve done to help you develop your style and voice.

-Alex Michael, who writes A Questionable Life

Hi Alex,

Yes! These things helped a lot:

I went to an orthopedist

I downloaded a lot of music illegally in the early 2000s

I was in a community theater production of Godspell

I got a D on a paper

A woman spat into my mouth in front of a crowd of 90 people

Here's what I mean.

1. PLUMP YOUR MIND-GLUTES

I have flat feet and bow legs—from the waist down, I kind of look like a Loony Tune. This is the wrong design for a human body, as my feet often remind me, by hurting.

I recently went to an orthopedist and asked her if there was anything I could do to make sure I can still walk when I'm 60. She told me the problem is actually in my hips. They aren't strong enough to compensate for my goofy legs, so my ankles roll in a weird way with every step, which in turn puts pressure on my non-existent arches, causing them to cry out in pain. To save your feet, she said, buff your glutes.

There's something profound in that: sometimes the thing that hurts isn't the thing that needs to be fixed. And if causes and effects can become estranged even in the short distance of a human leg, imagine how hopelessly separated they can get in the infinite space of a human mind.

But if you don't appreciate that, you'll treat the brain like it's a big dumb lump of muscle, as if you can make certain parts bigger just by squeezing them over and over. This is only true for the stupidest, simplest tasks, and is not at all true for complicated, mysterious tasks. To improve at anything interesting—science, law, friendship, whatever—repetition won't be enough, and it might not even help.

(One of my friends is a clown, and once, when I was watching her practice her routine, I asked her how she got good at it. She said something like, "I got good at juggling by juggling a lot. I got good at being a clown by, as a kid, coming home one day and discovering my dad's dead body.")

All that is to say: if you want to get better at writing, maybe the best place to do it isn't at the keyboard. You've gotta go find your mind-glutes. I'm not sure where yours are, but maybe it'll help if I show you mine.

Remembering Norman Denzin

12 Sep 2023

Back in 2007, I presented a paper at the frankly enormous Qualitative Inquiry Conference at the University of Illinois's Urbana-Champaign campus, a couple of hours train ride south of Chicago. It was a memorable trip for a number of reasons.

My first memory was of seeing the American football stadium which held 110,000 people and hosted only a handful of games every year. When the home team played, the town emptied which, I suppose, would've made it an ideal time to be a bank robber.

The second was the appearance of the singer José González performing an evening set sitting on his amplifier in the student cafeteria on the first night of the conference. (You might remember González from the 'bouncing balls' advert from around the same time). It still seems incongruous that such a well-known singer was there and performing such a low-key set.

The third was the experience of seeing my doctoral supervisor — Prof Julianne Cheek — repeatedly stopped for customs checks at every airport on our way back to Oslo after the conference had finished. Julianne was later told by a security guard that the reason she kept getting stopped was because she had a 'flag' on her boarding pass, probably because of an underlying security concern. (We were still experiencing a lot of post 9/11 travel paranoia back then). Julianne surmised that the only reason why she might have this flag was because she had once written with the nurse sociologist Sam Porter who had, in turn, served as Gerry Adams' private Secretary (Adams was then President of Sinn Féin, the political wing of the provisional IRA).

But this was all in the future as I sat in the auditorium for the conference opening. Just as the conference was due to begin, a man – looking uncannily like the janitor – walked up to the microphone to make an announcement. I thought he was going to tell us that somebody had left their lights on in the car park, or had dropped a credit card in the foyer. But as he spoke, it became apparent that this was the very honourable Norman Denzin.

I'd never seen a picture of him, but even if I had I would've been surprised that this rumpled, frowsy, monkish-looking man could have been the doyen of new thinking in qualitative research, whose name I'd seen in countless publications. And yet here he was, with his unruly shock of white hair, cargo shorts, and ill fitting pull-over, addressing an auditorium of at least 2000 people.

Many of you will have heard of his recent death and will have your own memories of his work: his incredible output and his bravery and innovation. And perhaps some of you may have even met him. I never had that good fortune. 10 rows back in the auditorium was as close as I got.

My ex-doctoral supervisor Julianne along with Mitchell Allen, César Cisneros-Puebla and Joy Pierce have just published a lovely tribute to Norman and I really encourage you to read. It's a poignant reminder, as they put it, that;

‘when one of the giant evergreens falls in the forests of the Pacific Northwest, its desiccated trunk becomes a nurse log, an elevated platform rich in humus and protection against pathogens that hosts dozens of new sprouts rising to restore and expand the canopy. Norman’s departure from our lives is this kind of transformation, one that nourishes the seedlings of ideas of future generations of mighty qualitative scholars, some of whom may be spoken about with the same reverence with which we describe Norman today’.

Would that we could all do as much to nourish the soil as much as Norman did, and will continue to do for years to come.

34 pieces of practical wisdom

21 November 2023

From the very first days of ParaDoxa I’ve kept a running page of quotes, ideas and sayings that I love. Over the year my Quote Horde has grown quite large. As we close in on the end of 2023 I thought I’d pull out some of my favourite pieces of practical wisdom discovered during the past year. Navigate the Quote Horde under the Resources tab if you’d like to see the full list.

“The trouble with setting goals is that you’re constantly working toward what you used to want” - Sarah Mancuso

"Ideas won't keep; something must be done about them" - Alfred North Whitehead

“I write entirely to find out what I'm thinking” - Joan Didion

“Another world is not only possible, she is on her way. On a quiet day, I can hear her breathing" - Arundhati Roy

“What he needed was to find fifty more people like him, who had stopped being themselves without realizing it” - Jennifer Egan

"The power to do things for people is also the power to do things to people" - Isabel Paterson

"The difficulty lies not so much in developing new ideas as in escaping from old ones" - John Maynard Keynes

“A frequently circulated, probably apocryphal, story tells of Judith Butler being challenged by a graduate student at a session of the Modern Languages Association annual conference circa

1990. Poststructuralist social analysis of the sort Butler offered was notoriously complex and very influential. The student objected to Butler's use of inaccessible theoretical vocabulary on the grounds that it excluded many readers in a manner not consistent with feminist ethics. Butler's allegedly impatient response was "Don't give theory to the patriarchy"

"When we try to pick out anything by itself, we find it hitched to everything else in the universe" - John Muir

"Some of the major disasters of mankind have been produced by the narrowness of men with a good methodology" - Alfred North Whitehead

"You won't be able to recognize the things you really care about until you have released your grip on all the things that you've been taught to care about" - William Deresiewicz

"As a rule, strong feelings about issues do not emerge from deep understanding" - Steven Sloman

"There's nothing I like less than bad arguments for a view I hold dear" - Daniel C. Dennett

"Thinking is a mode of practice in its own right, and practice thinks" - Erin Manning

"If I read a book that cost me $20 and I get one good idea, I've gotten one of the greatest bargains of all time" - Tom Peters

"It's good we have symphonies and music where there's a development, but a waterfall doesn't need an Act 1, 2, 3, then an outcome, and nor do the leaves on a tree in a storm" - Nils Frahm

'There is no method except yourself' - Harold Bloom

"Before you embark on a journey of revenge, dig two graves" - Confucius

"Commonsense, though all very well for everyday purposes, is easily confused, even by such simple questions as ... when you feel a pain in the leg, where is the pain? If you say it is in your head, would it be in your head if your leg had not been amputated? If you say yes, then what reason have you for ever thinking you have a leg?" - Bertrand Russell

"Omnia explorate meliora retinete" (explore everything; keep the best) - John Evelyn (1620-1706)

"Things are not difficult to make; what is difficult is putting ourselves in the state of mind to make them" - Constantin Brancusi

"I do not think it matters whether one agrees or not, as long as one is forced to think" - Vanessa Bell

"Remember that if the devil | wants to kick somebody, he won't do it | with his horse's hoof | but with his human foot" From the poem Pig Roast by Tadeusz RóŹewicz (tr. from Polish by Joanna Trzeciak)

“We can only see a short distance ahead, but we can see plenty there that needs to be done” - Alan Turing

“Raymond Roussel said that after his first book he expected that the next morning there would be a kind of aura around his person and that everyone in the street would be able to see that he had written a book. This is the obscure desire harboured by everyone who writes. It is true that the first text one writes is neither written for others, nor because one is what one is: one writes to become other than what one is. One tries to modify one’s way of being through the act of writing” - Michel Foucault

‘Death twitches my ear; “Live,” he says... “I'm coming”’ - Virgil

“When you're sure of what you're looking at, look harder" - Richard Powers

“Don't wait for inspiration. It comes while working” - Henri Matisse

These Strangers, in a foreign World | Protection asked of me - | Befriend them, lest yourself in | Heaven | Be found a | Refugee - Emily Dickinson

‘Writing is painful as a life. I feel that even after decades. Doesn’t get easier, which surprised me. The yearning and failing parts don’t get easier. And then there are the miraculous times when fluency is effortless. Or even the times of just being absorbed deeply. Can’t think of anything better. I regret being unable to occupy that state constantly but to be there at all seems a marvel beyond all others’ - Louise Gluck

"Avoid the temptation to work so hard that there is no time left for serious thinking" - Francis Crick

“Keep the company of those who seek the truth- run from those who have found it” - Václav Havel

“The goal is always to find projects that offer a sense of freedom. Sometimes, you only get that in little bits… but I like that in each project I do, I can search for my idea of quality or find the context for a new definition of quality…; searching for your own idea of quality, a pursuit that requires freedom, for which you must advocate” - Patricia Urquiola

‘Be as generous as you can, but selfish enough to get your work done’ - Austin Kleon

A year in review

12 December 2023

I haven't written many personal pieces this year (more on that below), but I'm feeling in a reflective mood so, if you'll indulge me, I'll try to sum up what a wondrous year 2023 has been.

A challenge: Organising ISIH 2024

Offering to host the 8th international In Sickness & In Health conference in Aotearoa New Zealand in two months time felt like — still feels like — an incredible honour. Outside the Critical Physiotherapy Network (CPN), the ISIH community is my extended family. I've been to five of the last seven conferences, and the friends I've made over that time have been so important to me in my working career. Learning how to plan a conference has also been a steep but rewarding hike. (AI tools promise to make many laborious tasks easier, but they were nowhere to be seen when I spent a March hand scraping the first authors' email addresses from three years worth of a bunch of health sociology journals to build our contact list.) I really hope next year's conference will be one of the best yet and the spread and depth of peoples' abstracts fills me with optimism.

Something to be proud of: ParaDoxa

It's by no means perfect, but I've become quite proud of this little corner of the Internet. Stepping away from a decade of blogging for the CPN felt momentous, but I'm glad I did it. I needed to try something new, and the CPN needed new impetus. I kept the Weekly Digests going and added some podcasting. The 12 5-4-1 interviews I've done this year have been a blast. Researching people's interests and chatting to them about their work through the lens of their peers has been inspirational. I also loved writing the two series on post-humanism and post-professionalism. I'll try to do more of those blog series next year.

Something to look forward to: A new book

After I finished *Physiotherapy Otherwise* at the end of 2021 I began a year-long sabbatical. It was while I was on sabbatical that I decided to start ParaDoxa. I also decided on the subject of a new book I wanted to write, and began where I always begin with the heavy reading. I love long-form writing for its slow, deliberate pace and the space it gives you to develop ideas in three dimensions. But for me, that joy only comes with some hard slog, working through concepts and ideas that can sometimes mangle your melon. A book is always a leap into the unknown for me, and I draw heavily from other theorists and philosophers who often feel like a lighthouse in a dense sea fog. But I've always felt it's been worth it, and I always get to the

point where I can see a book taking shape. I'm at that point now and the next year promises to be filled with exciting epiphanies.

Something to work on next year: More personal blogging

Over the last few weeks I've been collating the 1,000 or so blog posts I wrote over a decade for the CPN and the IPHA. Reading some of them again made me realise that I'd stopped using blogposts as an exercise in drafting. If you approach them as a temporary, unfinished and ephemeral text, blogposts can be a great way to develop ideas. That's not to say that your reading of them doesn't matter, only that the main reason I've written blogposts in the past has been to work out ideas in my own head that I can then incorporate into my academic writing and teaching. I want to do more of that next year, and inflect the work with a post-critical, post-human healthcare perspective. Finding ways to express the more-than-human is really hard, and I have no answers yet. Testing those ideas in blogs might help and, perhaps, that helps others too.

My five things from 2023

Taking inspiration from the 5-4-1 interview format, here are five recommendations for you for the holiday season. I've come back to these weekly, sometimes daily, over the last year and I think you'll like them:

- Jason Kottke's fine hypertext products. Kottke has been sending quirky links from around the web for 25 years now, and he rarely fails to make me smile. A lot of the left-field links I add to the Weekly Digest come from here.
- Daniel Lapoujade's *Aberrant Movements*. This, more than any book this year, mangled my melon. Originally published in 2017, *Aberrant Movements* analyses Deleuze and Guattari's entire body of work as 'the schizophrenic processes of the unconscious and the nomadic line of flight traversing history—in short, the forces that permeate life and thought'. Heady stuff and almost as opaque as D&G's own writings, but I'd say it's a must-read for anyone trying to think with Deleuze and Guattari.
- JJSauma's Selector Radio Show on Mixcloud. I listen to a lot of dub techno and ambient music during the day — a blissful blend of pure rhythm and sound — and, to me, Jiménez-Sauma's mixes are the best. He's no academic slouch, either, with a masters degree in sound and music computing, he knows how to make great music on so many levels.
- You can't have failed to notice that there's an arms race going on to develop (read, 'sell') AI bots and tools to you at the moment. But the Internet is an irrepressible beast and there are still quite a lot of developers working on tools without the profit motive in mind. My favourite AI tool this year has been Research Rabbit. Developed by

the Open Collective, it is a completely free tool that helps you link research together. Fantastically useful and well worth supporting.

- And the sort-of-non-work-related book I've recommended most often this year has been Nick Hayes' *The Book of Trespass*. Beautifully written, searingly critical and anarchistic, but also joyous, rebellious and heart-warming, it's a fine read and a great piece of critical social history.

So finally, thank you to all of you who have read, commented, emailed, enjoyed or been stimulated by ParaDoxa this year. Here's to 2024. Let's hope for more of the same, but different.

ISIH 2024 in the rearview mirror

20 February 2024

I don't think I realised how much the In Sickness & In Health conference had consumed my time and attention over the last few months until Monday morning when, with it all over, I turned back to my 'old' job.

It felt as if my normal work belonged to a BC before-conference world, with me like one of Susan Sontag's citizens of that 'other place'.

A big part of that sense of alienation from my prior work life came from the deep emotional investment that had gone into the conference.

We'd set out quite deliberately to make an event that wasn't like the typical business conference. You know the sort: you fly in from some distant land, deliver a 10-minute talk, field one or two adversarial questions, then spend the rest of the conference looking for someone to talk to.

And, from my perspective, this was the biggest 'win' of the conference. I got a genuine sense that people felt connected, involved and invested.

This was in no small part to our focus on a more indigenous Māori approach to meetings; one that emphasises the importance of taking time to connect. The pōhiri we held at the start brought people carefully into the space, the extended break times, the lovely weather, the lovely food, and the 40-minutes for each talk seemed to give people space to extend their arms around their audience.

And our four keynotes didn't disappoint, either. Annemarie Jutel's vivacious interrogation of diagnosis, Erin Stapleton's on-point analysis of toxic masculinity when we are all first female, Pouroto Ngaropo's warm embrace of our shared histories, and Ian Buchanan's palpation of

lines and assemblage in the work of Deleuze and others, acted like the point of the conference spear.

I spent as much time as I could in workshops, and some of the quality of work that I saw blew me away. ISIH has always been a place where you'd find some of the brightest minds in critical healthcare, but this year was exceptional. There were works here that I'll be pondering for months to come. Hopefully some of that will come out on ParaDoxa over 2024.

Speaking of which, next week I'll be returning to business-as-usual for this site and starting what I hope will be a provocative series looking at whether critical posthumanism has a neoliberal problem.

But that's for next week. Today, I'm just trying to remember how Canvas works again!