
Becoming a practice profession

a genealogy of
physiotherapy's
moving/touching
practices

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Abstract

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.

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I sing the body electric
(Whitman, 1855)

Chapter 1

Physiotherapy: a dynamic practice profession

We are 'doers' and function in the here-and-now to solve problems presented to us with an imperfect understanding of how we reached our current position and no coherent view of our knowledge base of the essence of our nature as physiotherapists.

(Parry, 1995. p310)

Official definitions describe physiotherapy as a healthcare profession that works in partnership with patients to change their ability to move and function (Chartered Society of Physiotherapy [CSP], 2011a; Health & Care Professions Council [HCPC], 2013; World Confederation of Physical Therapy [WCPT], 2007). Physiotherapists are autonomous practitioners who are taught to use their bodies to establish and maintain therapeutic relationships with their patients, and to assess, diagnose and treat disorders of movement and function (CSP, 2011a; HCPC, 2013).

Physiotherapy's professional practice is therefore an embodied process that is produced and experienced through the bodily movements and interactions of the physiotherapist and their patient (Blackman, 2008; CSP, 2011a). Physiotherapy's focus on movement – whether as an outcome (CSP, 2011a; WCPT, 2007), a treatment approach (Wicksteed, 1948), or a conceptual structure (Beeston & Simons, 1996; Cott et al, 1995; Hislop, 1975; Williams, 1986) means that physiotherapy practice is dynamic and interactive. Over time, the techniques and practices defined by physiotherapy's Royal Charter have multiplied organically as individual physiotherapists interact with patients' moving bodies, and the changing environments and organisation of practice (Barclay, 1994; CSP, 2008a). The multiplication of physiotherapy practice over time is illustrated by the tabulated list of CSP's Professional Networks presented in Appendix 1.

What physiotherapy is and becomes as a practice profession depends on the bodies of physiotherapists and their patients, and the things they can do in a given time and place (Nicholls & Gibson, 2010). The evolution of physiotherapy is therefore sensitive to the discourses and structures governing professional practice and organisational change (e.g. Hugman, 1991; Larkin, 1983; Nicholls, 2008). Changes to healthcare design and delivery, and the developments in science and technology over the past decade or so have provided opportunities for the development and

expansion of physiotherapy practice (Kell & Owen, 2008). In healthcare settings, physiotherapists can be found doing work traditionally associated with medicine – whether as case managers co-ordinating the ongoing care of people with long-term conditions (e.g. Langridge & Moran, 1984), as advanced practitioners undertaking diagnostic triage in clinic settings (e.g. Hockin & Bannister, 1994; Levenson & Vaughan, 1999), or as first contact practitioners in primary care (e.g. Hattam & Smeatham, 1999; Holdsworth & Webster, 2004). As the role of biomedicine has expanded (Clarke et al, 2003; Turner, 1992), physiotherapy practice has continued to spread – into workplaces, hospices and care homes, and spaces associated with health and wellbeing. The movement of physiotherapy practice can be traced through the list of CSP’s Professional Networks presented in Appendix 1. Recent developments in technology are starting to change how physiotherapists and patients encounter one another. Within the National Health Service (NHS), some physiotherapy services provide a telephone triage system to determine whether someone needs to be physically seen or whether they can be given physiotherapy advice and a review at a later date (e.g. Bishop et al, 2013; Taylor et al, 2002).

While these developments are not of themselves necessarily problematic, they are generating questions within the profession about the purpose of physiotherapy practice; the value of physiotherapy’s interactive physical practices; and the requirement for both patient and physiotherapist to be present in the same place at the same time. As a physiotherapist (see Appendix 2) I see the discussions about the profession’s identities and practices unfolding on the pages of *Frontline* (the fortnightly magazine published by the CSP), on interactiveCSP (the CSP’s online community) discussion boards, and at CSP’s Annual Representatives Conference and its annual professional conference. In fact, looking back through the historic accounts of practice as this thesis will do, it is possible to see similar questions emerging at specific points in physiotherapy’s history. What is less clear, because physiotherapy does not have a comprehensive critical history of its embodied practices (Nicholls & Gibson, 2010), is the actions/inactions, discourses and structures that created those tensions – and how those tensions were resolved. It is in these areas that this thesis contributes.

Chapter structure and content

This first chapter presents an overview of the historic accounts of physiotherapy to draw attention to the richness of those accounts and to reflect on the current gap in the literature exploring the evolution of physiotherapy practice. Having introduced the research aim and objectives I offer a thumbnail sketch of the sociological themes of professionalism, gender and bodies that underpin this thesis. I will be returning to these themes in more depth in Chapters 2 and 3 as I begin the process of looking afresh at the literature describing physiotherapy as a practice profession. The chapter concludes with an overview of the structure and content of the thesis to show how the chapters work together to produce an historic account of contemporary physiotherapy practice.

Historic accounts of physiotherapy practice

The primary focus of the historic accounts of UK physiotherapy is on the evolution of physiotherapy's identity as a profession rather than on its practice (Nicholls & Gibson, 2010). I am using 'practice' to refer to the body work experienced and produced by physiotherapists, how their work is organised, and the discourses and disciplines that shape who can do what, how, when and where (Coffey, 2004). Critical analysis of physiotherapy produced by physiotherapists (e.g. Dixon, 2003; Nicholls, 2008; Nicholls & Cheek, 2006) and others (e.g. Hugman, 1991; Larkin, 1983) trace physiotherapy's journey from being a technically competent 'handmaiden' to the medical profession to becoming what has been argued to be a clinically autonomous profession whose practice is regulated by the State's governance machinery. Together these critical histories show how the professionalisation of physiotherapy has been shaped by discourses of professionalism and gender (e.g. Dixon, 2003; Hugman, 1991; Nicholls, 2008) and of physiotherapy's relationship with medicine and the State – as an employer since the 1940s, and as a regulator since the 1960s (Larkin, 1983).

There are two key texts that use archived materials that chart the development of physiotherapy as a practice profession by tracing the history of its educational and professional body - the CSP. Wicksteed (1948) focuses on changes to the organisation and practice of physiotherapy between 1894 and 1947, while Barclay

(1994) provides a detailed chronology of physiotherapy education and practice between 1894 and 1994. Both texts present changing practice as a series of events happening along a timeline in a seemingly unchanging social and cultural environment. This chronological descriptive approach creates space for nostalgia, and assumes that the development of a practice profession follows a linear pathway (Abbott, 1988). Despite these limitations, Barclay (1994) and Wicksteed (1948) offer an historic account that traces the professionalisation of physiotherapy alongside the evolution of its practices. This presentation uncovers a potential relationship between what physiotherapy is as a profession, what the bodies of physiotherapists are doing and how their practice is organised. Both texts show that physiotherapy practice changes over time; some approaches and modalities grow and flourish, others become adapted, while others fade from the practice repertoire.

The flows and fluxes in physiotherapy practice can be traced through the CSP's professional networks structure. Professional networks are established by practitioners to support the development of physiotherapy and physiotherapists in a particular field of practice (Barclay, 1994). Appendix 1 presents a tabulated timeline of the evolution of the professional network structure. This table offers a snapshot of what the bodies of physiotherapists are doing and how their practice is organised changes over time. The networks describe contemporary physiotherapy practice in terms of working with body systems and disease processes (e.g. cystic fibrosis, neurology, orthopaedics) or with specific types of bodies (e.g. ageing bodies, children's bodies, sporting bodies, women's bodies), or as practice that uses specific modalities (e.g. electrotherapy, injection therapy, water). Practice is also described in terms of its location (e.g. overseas, private practice) and function (e.g. management, research). The table and its footnotes suggest that the evolution of physiotherapy practice is organic and complex. Some bodies and practices develop and multiply (e.g. manual therapies), others become discursively reconstructed over time (e.g. practice with older people), while others seem to disappear from view (e.g. cranio-sacral therapy, rheumatic care, teachers of physiotherapy).

What is currently unclear in the historic literature is how and why physiotherapy practice – the things physiotherapists' bodies can do in a given place and time - has evolved to become what it is. The absence of physiotherapists' bodies in these historic accounts reflects the research methodologies used, and physiotherapy's epistemological perspective which downplays the fleshy reality of doing physiotherapy to produce a disembodied account of practice (Bithell, 2005; Nicholls & Gibson, 2010). From a Foucauldian perspective, history is dynamic – today's situation is just one possibility emerging from the events of yesterday. Rather than using history to find out how the present emerged from the events of the past, Foucault's methods are about using history to diagnose the present (Kendall & Wickham, 1999). This thesis is a personal response to the discussions emerging from within the profession that I am a part of. I hope by reviewing physiotherapy's past through the critical lens of sociology to generate fresh insights about the events, circumstances and bodies that have shaped what contemporary physiotherapy has become – as a practice and as a profession.

Research aim and objectives

The aim of this research is to generate a theoretically informed understanding of the tensions present in contemporary physiotherapy practice by exploring the events, discourses and actions shaping what physiotherapy could become over time.

Specific objectives:

- a. To generate an account of physiotherapy's epistemological and ontological understanding of the body and its bodily practices to trace the embodied processes of physiotherapy becoming a practice profession.
- b. To uncover a relationship between physiotherapy's identity as a practice profession and the practising bodies of physiotherapists.

The research aim and objectives are achieved by a qualitative study that draws on historic documents and physiotherapists' oral accounts of practice from the 1940s onwards to produce a genealogical account of the process of becoming a practice profession. My research explores the process of becoming a practice profession from inside physiotherapy – both in terms of my identity/practice as a researcher,

and of the data used to generate an historic account of being/doing physiotherapy. This work will also add to the growing body of knowledge about the evolution of healthcare professions in the UK, and demonstrate the added value and limitations of applying a genealogical approach to produce an historic account of becoming a practice profession.

I have deliberately limited the timeframe of my research. The 1940s saw considerable change in physiotherapy practice with developments in rehabilitation medicine, and a shift of training and subsequent employment to the new National Health Service (NHS) hospitals. The consequences of the events of 1948 can be heard today as physiotherapists voice their concern about employment of new graduates outside NHS practice (CSP, 2013a; CSP, 2014; Jones et al, 2010), or about Westminster's proposals to allow independent organisations to provide NHS services (CSP, 2011b). The timeframe provides opportunity to understand how the shift in regulation of physiotherapy from medicine to the state during the 1950s and 60s (Larkin, 1983), and the rise of neoliberalism from the 1980s onwards (Hood, 1991; Rivett, 1998) have shaped the identity and practices of physiotherapy. A timeline summarising key events from physiotherapy's past is presented in Appendix 3.

Sociological themes and perspectives

The historic accounts of physiotherapy draw attention to the discourses of professionalism and gender that permeate the professionalisation of physiotherapy (e.g. Barclay, 1994; Hugman, 1991; Nicholls, 2008; Wicksteed, 1948).

Professionalism and gender are both addressed by the sociological literature. The sociological literature has also something to say about the absent-present bodies (Leder, 1992; Shilling, 2005) of physiotherapists and their patients experiencing/producing physiotherapy over time (Nicholls & Gibson, 2010). My thesis draws on the sociological literature on professionalism, gender and the body to provide a critical lens for exploring the practice profession that I have been socialised into. This section presents a brief overview of each theme as a precursor to further exploration and explanation that will follow in Chapters 2 and 3.

Professionalism

Despite considerable theorising about 'profession' little progress has been made towards developing a universal definition (Abbott, 1988). This seeming lack of progress signals that profession is a dynamic entity that is situated in a specific time, place and socio-political context. The literature describing profession first appears during the early part of the 20th century. It draws on the 'traditional' masculinised professions of medicine, law and divinity and generates a list of traits or attributes that identify a profession from other occupational groups and the laity (Pattison & Pill, 2004). The trait theorists argued that a profession could be recognised by the presence of an esoteric body of abstract knowledge, scientific expertise, the presence of altruism and a means of regulating its members' practice (Abbott, 1988; Freidson, 1970). The limitations of the trait theory and its use as a political means of including/excluding certain groups from the privileges associated with professional status is well documented by the literature emerging from the 1970s onwards (e.g. Abbott, 1988; Davies, 1995; Freidson, 1970; Larson, 1977; Witz, 1992).

Having exhausted ideas about the function of profession, the literature shifts to explore the politics of profession (e.g. Abbott, 1988; Davies, 1995; Freidson, 1970; Hugman, 1991; Larkin, 1983; Larson, 1977; Witz, 1992). This body of work is informed by Weberian and Marxist thinking which is sensitive to organisational structure and power (Burrage & Torstendahl, 1990; Pattison & Pill, 2004). Rather than generating lists of traits that can be used to identify a profession, this body of work draws attention to the structures and systems that shape how 'profession' is done in practice. From this perspective, profession is recognised by its capacity for autonomy (Freidson, 1970) and the ability of its members to enact the diagnosis – inference – treatment sequence associated with problem-solving practice (Abbott, 1988). The most recent literature on professionalism explores how the political ideologies emerging from the 1980s onwards have produced a new form of professionalism where autonomy is replaced by accountability – to employers and the public (e.g. Bolton et al, 2011; Freidson, 2001; Light, 2001; Muzio & Kirkpatrick, 2011; Speed & Gabe, 2013). Chapter 2 will explore these bodies of literature further to show how a focus on doing rather than being a profession provides a perspective

that can be used to uncover the process of becoming a practice profession over time.

Gender

Historic accounts of physiotherapy show how its professional project has been shaped by discourses of gender that can be traced back to its inception in 1894 (Hugman, 1991; Nicholls, 2008; Wicksteed, 1948). Gender, like professionalism, is a contested and dynamic concept (Abbott & Wallace, 1997; Connell, 2009). In sociological terms, 'gender' is used to refer to the cultural and social expectations of men and women (Abbott & Wallace, 1997). The sociological literature describing gender presents it as two inter-related entities: as a social structure, and as a social practice (Connell, 2009). Gender as social structure describes the discourses and socialising processes that construct, normalise and reproduce 'male' and 'female' by defining and normalising certain behaviours and practices as masculine or feminine (Connell, 2009). Gender as a social practice describes the activities and behaviours that fulfil society's expectations of how men and women should act (Connell, 2009). Doing gender affirms gender as a social structure, which in turn makes the gendered performance possible and necessary (Lorber, 1994; West & Zimmerman, 1987; Witz, 1992).

When read through the lens of gender, accounts of physiotherapy's professionalisation tell a story of becoming more male – both in terms of the growing number of men joining the physiotherapy workforce, and physiotherapy's pursuit of masculine traits of autonomy and scientific rationality through its professional project (Davies, 1995; Hugman, 1991). The notion of gender as social structure and social practice presented by the sociological literature (e.g Butler, 1999; Davies, 1995; Halberstam, 1998; Lorber, 1994; West & Zimmerman, 1987; Witz, 1992) provides a theoretical reference point for understanding how physiotherapy is experienced differently by women and men (see Chapters 2 and 3).

Bodies

The final set of sociological literature relates to the body that sits at the heart of physiotherapy's identities and practices (Nicholls & Gibson, 2010). The sociological literature (e.g. Blackman, 2008; Coffey, 2004; Foucault, 1988; Leder, 1992; Lorber, 1994; Mol, 2002; Shilling, 2005; Turner, 1992; Twigg, 2006) challenges the dualistic mode of thinking about the body and bodily practices that is prevalent in physiotherapy (Bithell, 2005; Nicholls & Gibson, 2010). Body theory therefore offers a theoretical lens for looking afresh at the bodies, body work and bodily organisation and practices that make up physiotherapy's social world.

My thesis draws on the sociology of the body and embodiment to uncover the bodies of physiotherapists who are experiencing and producing the change in practice over time. Embodiment is about the interplay between the body and the world the body lives in (Blackman, 2008). Rather than reducing the body to its biological or social self, embodiment conceives the body as an integration of both (Shilling, 2005). The body therefore becomes a dynamic interface for exploring discursive practices, lived experiences and ways of knowing/being (Blackman, 2008; Coffey, 2004). From this perspective, the physiotherapist's body becomes a space where professionalism and gender become inscribed and performed in physiotherapy practice. The multiplication of physiotherapy practice expressed by the table in Appendix 1 can be understood if it is considered in terms of enactment. Enactment conceptualises the body in terms of what it can do rather than on what it is (Mol & Law, 2004). This shift in focus provides an opportunity for uncovering how physiotherapy evolves as the bodies of physiotherapists interact with practices, technologies, institutions and other objects in the practice setting (Blackman, 2008).

Thesis structure and content

The thesis is organised as follows. The second chapter draws on the literature on professionalism and gender to begin the process of thinking sociologically about the evolution of physiotherapy as a practice profession. The process of thinking sociologically provides a means of fighting familiarity by offering a critical lens for looking afresh at a world I have been socialised into. The chapter introduces

concepts of profession and gender that will run through the thesis, and presents an overview of the changing social and political context shaping the process of becoming a practice profession. By tracing accounts of physiotherapy's professionalisation in parallel with accounts of 'manning' the workforce, I show how physiotherapy has moved from an occupation restricted to women to become a profession practiced by women and a growing number of men.

The third chapter draws on sociology of the body and embodiment to focus on the bodies experiencing and producing physiotherapy practice. This chapter serves two purposes. It offers a critique of physiotherapy's epistemological and ontological understanding of the body and its bodily practices, and draws on the literature to uncover what is already known about how physiotherapy practice is done. The chapter will therefore familiarise the reader with the intimate embodied practices and processes associated with doing physiotherapy. At the same time it provides a way of looking at bodies and practices which is an alternative to the dualistic approach that as a physiotherapist I am used to. I introduce the Foucauldian structured body and the lived body associated with phenomenology before showing how they offer two complementary perspectives for researching the embodied processes of becoming a practice profession.

Chapter 4 presents a critical, reflective account of the process of researching my own profession. The chapter opens with an account of my researching self before explaining the principles underpinning the use of documentary and interview data to construct a history of the present. I then describe the process and praxis of collecting data from the CSP's qualifying curricula and depth interviews with physiotherapists who trained during 1940/60s before explaining how these data were subject to a discourse and phenomenological analysis. This analytic framing of data draws on the discussions about the structured and lived bodies and conceptual framework presented in Chapter 3. The final section of this chapter reflects on the process of linking and layering accounts of practice to generate an embodied montage of the process of becoming a practice profession over time. Different elements of that montage are presented in Chapters 5 – 7.

Chapter 5 draws on a genealogical analysis of physiotherapy's qualifying curricula to trace the events, circumstances and discourses that enabled physiotherapy to become a practice profession. The analysis is based on the argument that professional work is characterised by its autonomy and capacity to enact the diagnosis – inference – treatment sequence associated with problem-solving practice. This analytic focus generates an alternative account of the professionalisation of physiotherapy that complements existing historic accounts. The chapter shows that physiotherapy's capacity for autonomous problem-solving associated with profession emerged through the 1945 curriculum. I am arguing that that physiotherapy became a profession by reconstructing its massage, manipulations and movement knowledge/expertise to produce scientific practices that can handle moving bodies. The chapter traces the embryonic form of professional practice produced in 1945 on its journey to becoming formally recognised as autonomous consultative problem-solving practice during the 1970/80s.

Chapters 6 and 7 draw on the biographical interview data to present embodied accounts of physiotherapists' experiences of physiotherapy. Chapter 6 uses the concept of enactment to explore the process of becoming a physiotherapist through an analytic lens that is focused on movement. By following the moving bodies of physiotherapy students through physiotherapy training, the chapter uncovers the educational practices, disciplinary processes and the physical/affective body work associated with becoming a physiotherapist during the 1940/60s. Chapter 6 shows how movement is central to the disciplining and organisation of physiotherapists' bodies. I am arguing that the organisation of physiotherapy practice created opportunities for physiotherapists to enact autonomy in preparation for it becoming formally recognised in 1977. Chapter 7 uses the concept of embodiment to unpack the work experienced/produced by physiotherapy's hands from an analytic perspective that is sensitive to movement/touch. This chapter is divided into two sections. The first section presents an account of the discourse of the hand used by physiotherapists to construct their active moving/touching professional practices. The second section presents accounts of practice that show how physiotherapists' hands

experience/produce autonomous problem-solving practices that touch and move the bodies of physiotherapists and their patients.

Chapter 8 brings the analysis of physiotherapists' oral accounts and text-based footprints from Chapters 5 – 7 together with the sociological analysis of physiotherapy from Chapters 2 and 3 to review my research aim and objectives. This chapter is presented in four sections. The first section presents a summary of an account of physiotherapy as a profession and as a practice that shows how thinking sociologically generates fresh insights about the professionalisation of physiotherapy and its epistemology, ontology and practice. The second section presents a critique of my research methodology, methods and process that explains how my methodological choices affected the research process and outcomes. The third section concentrates on key conclusions from the study's findings to trace the embodied processes of physiotherapy becoming a practice profession. I will show how my methodological approach and theoretical framing of the bodies makes visible the process of becoming a practice profession that complements existing historic accounts of the macro-politics of physiotherapy's professional project and uncovers the relationship between physiotherapy's identity as a practice profession and the practising bodies of physiotherapists. The final section of the chapter offers recommendations for further work before reaching a final conclusion about my research.

Chapter 2

Thinking sociologically about physiotherapy as a practice profession

Autonomy stands at the very heart both of cultural concepts of masculinity and of professions. The image of the exercise of professional judgement and action is one of the one-to-one encounter with the client, in which knowledge and technique can be applied with a direct and visible result untrammelled by the constraints of bureaucratic rule.

(Davies, 1995. p60)

Official definitions (CSP, 2011a; HCPC, 2013; WCPT, 2007) describe physiotherapy as an autonomous healthcare profession that works with and in partnership with people to change their ability to move and function. Physiotherapists are therefore able to accept referrals for a physiotherapy consultation from the individual themselves, or from other people that work with that individual (CSP, 2011a). Physiotherapy practice has been regulated by the State since the 1960s (Barclay, 1994). State registration became mandatory for physiotherapists employed by the National Health Service (NHS) in 1967 (Barclay, 1994) and has been a legal requirement for all practising physiotherapists since 2004 (www.hcpc-uk.org). During this time, the number of physiotherapists registered to practice in the UK has risen from 9171 in 1967 to 48 601 in 2013 (see www.hcpc-uk.org/aboutregistration/theregister/oldstats/ and www.hcpc-uk.org/aboutregistration/theregister/stats/ respectively).

Physiotherapy is a physically active and interactive practice whose disciplinary roots can be traced back to the intimate practices of medical massage in 1894 (Nicholls, 2008; Wicksteed, 1948). There are two key texts that chart the development of physiotherapy as a profession by tracing the history of its educational and professional body - the Chartered Society of Physiotherapy (CSP), from its inception in 1894. Wicksteed (1948) focuses on changes to the organisation and practice of physiotherapy between 1894 and 1947, while Barclay (1994) provides a detailed chronology of physiotherapy education and practice between 1894 and 1994. Together they offer a rich descriptive account of the evolution of physiotherapy as a practice, and as a profession. Their descriptive chronological approach emphasises the distance of the past from the present and creates space for nostalgia (Jones & Green, 2006) – as befitting texts commissioned by the CSP to celebrate specific

jubilees in its history. A smaller body of critical histories of written by physiotherapists (Dixon, 2003; Nicholls, 2008) and others (Hugman, 1991; Larkin, 1983) uncovers the politics inherent in the process of becoming a profession. These critical histories show that discourses of professionalism (Dixon, 2003; Hugman, 1991; Larkin, 1983; Nicholls, 2008) and gender (Hugman, 1991; Nicholls, 2008), and the organisation of physiotherapy practice (Larkin, 1983) have shaped what the bodies of physiotherapists can do in a given time and place.

This chapter is not a literature review in the conventional sense, but is a chapter that draws on literature to begin the process of thinking sociologically (Coffey, 2004) about the evolution of physiotherapy as a practice profession. Thinking sociologically involves bringing sociological theories, themes and perspectives to explore, expand and rethink current understandings about the social world (Coffey, 2004). Thinking sociologically about physiotherapy creates space to explore continuities and change – of how physiotherapy’s past shapes its present and future practices. While physiotherapy and sociology both have something to say about what physiotherapy is, what physiotherapists do, and how their work is organised, both disciplines have distinctive ways of thinking (see Chapter 3 for a more detailed discussion). These epistemological differences generate different questions, interpretations and understandings of the realities of physiotherapy practice - which may sometimes appear in tension. While tensions can make the process uncomfortable for me as a physiotherapist, thinking sociologically offers a critical lens for challenging assumptions and prior knowledge, and for looking afresh at a world that I have been socialised into (Dewey, 1910).

Chapter structure and content

This chapter uses the sociological themes of professionalism and gender emerging from the histories of physiotherapy (Barclay, 1994; Hugman, 1991; Nicholls, 2008; Wicksteed, 1948) as a focus for thinking sociologically about the professionalisation of physiotherapy. The sociological literature provides a convincing account of the gendering of profession (e.g. Abbott, 1988; Burrage & Torstendahl, 1990; Davies, 1995; Freidson, 1970; Hugman, 1991; Jones & Green, 2006; Larson, 1977; Simpson, 2005; Witz, 1992). This chapter brings together that body of work with literature

from physiotherapy to build an account of how contemporary physiotherapy has evolved from being a women's occupation to become a profession practiced by women and a growing number of men. The chapter introduces theoretical concepts, ideas and arguments about profession, gender and physiotherapy that will be explored and developed through the thesis. The insights generated by this chapter will provide a conceptual framework for constructing a critical history of the evolution of physiotherapy as a practice profession.

The chapter is presented in two inter-related sections. The first section attends to profession. This section begins by focusing on the discontinuities in the physiotherapy literature from the 1970s onwards to uncover the tensions produced by physiotherapy's professionalisation. The section turns to the sociological literature to explore the changing construct of profession, before bringing both sets of work together to show how the tensions expressed by the physiotherapy literature relate to changing construct of professionalism over time. The second half of the chapter attends to gender and explores the impact too of increasing numbers of men practising physiotherapy. Given that professionalism and gender are dynamic concepts that are shaped by changing social, political and cultural contexts, the accounts in both sections are presented chronologically. This approach provides a framework for exploring how gender and professionalism have shaped the evolution of contemporary physiotherapy over time. The chapter concludes that professionalisation in physiotherapy has been shaped by a discourse of science, which has in turn produced (and sustained) a mode of professionalism that is attractive to a growing number of men.

Thinking sociologically about physiotherapy as a profession

Despite considerable sociological theorising about the concept of profession, there has been little progress towards developing a universal definition that stands the test of time (Abbott, 1988). Broadly speaking 'profession' describes a particular kind of occupation that carries specific rights, responsibilities and a social status because of its capacity to resolve problems arising in our everyday lives (Pattison & Pill, 2004). In practice it provides a structure for organising work and workers, and a process that is designed to protect the actions, interactions and interests of

professions and their clients (Abbott, 1988; Bolton et al, 2011). I would argue that the seeming lack of consensus about the nature of profession is a reflection of the dynamic and political nature of profession itself (Freidson, 2001). It is a body-in-process; always becoming through the relationships it has with technologies, practices, institutions and environments (Blackman, 2008; Bolton et al, 2011; Pattison & Pill, 2004). This section of the chapter draws attention to the discontinuities in the physiotherapy literature about 'profession', before turning to sociology of professions to explore the discourses and structures that are producing change. This account is not designed to provide a systematic review of the contemporary literature, but instead offers a narrative overview of physiotherapy's response to the changing discourses and structures shaping the ongoing process of becoming a profession.

Physiotherapy: in pursuit of 'profession'

The literature exploring the concept of 'profession' in physiotherapy appears from the 1970s onwards. When read as a chronology, these scholarly papers trace physiotherapy's progression towards becoming recognised as a profession – a process known as professionalisation (Richardson, 1999a). Papers published during the 1970s (e.g. Galley, 1977; Hislop, 1975; Piercy, 1979) justify a vision of physiotherapy as an autonomous profession, and outline the actions required to make that vision a reality. Having gained formal recognition of functional autonomy (the authority to make decisions and take action about physiotherapy practice) (Freidson, 1970) in 1977, the focus of the UK-based literature shifts from 'how does physiotherapy become a profession', to 'is physiotherapy a profession?' Papers from this period can be divided into two sets. One set of papers justifies physiotherapy's claim to professional status by showing how it fulfils the traits associated with professional practice (e.g. Dyer, 1982; Palastanga, 1990; Sim, 1985). The second set (e.g. Parry, 1991; Richardson, 1992; Sim, 1990) makes the case for developing an epistemology of physiotherapy to support its development of its professional practice – as an art and a science (e.g. Parry, 1994; Peat, 1981; Rothstein, 1992; Sim, 1985; Tyni-Lenne, 1989). Physiotherapy as an art/science is a recurring theme in the literature that I will return to again later in this chapter and in Chapter 3.

Papers published during the early 1990s (e.g. Bartlett, 1991; Parry, 1995; Rothstein, 1992) express physiotherapy's uncertainty about its identity as a profession. The authors present this uncertainty as being generated by changes in how physiotherapy services are organised, delivered and managed (CSP, 1991; Richardson, 1999a). By the end of the 1990s, the uncertainty about physiotherapy as a profession has been replaced by questions about how physiotherapy can meet the expectations of a new mode of professionalism. This new professionalism is described in terms of physiotherapists' responsibilities to deliver a high quality evidence-based service and to engage patients in decisions about their care (e.g. Dalley, 1999; Higgs & Hunt, 1999; Richardson, 1999b; Rothstein & Scalzitti, 1999). The literature does not critique or resist the changing construct of profession. Instead it focuses on the opportunities created by the change to promote the 'acceptance of physiotherapy as a profession and a science' (Richardson, 1999b. p15).

The reconstructed physiotherapy professional has scientific and interpersonal competence, capacity to handle and produce change in practice, and an orientation towards altruistic service (Dalley, 1999; Higgs & Hunt, 1999; Richardson, 1999b; Rothstein, 1992; Rothstein & Scalzitti, 1999). While the newly constructed mode of professionalism is distinct, its constitution carries some continuity with the traditional mode. The valuing of knowledge and orientation to public service present throughout the 1980s has been retained. The scientific discourse that appeared to restructure physiotherapy's knowledge and expertise during the 1980s has by the late 1990s become an integral element of physiotherapy's professional project. The technical autonomy that was pursued so keenly by physiotherapy during the 1970s (Barclay, 1994) has been replaced with a new form of tripartite accountability – to the patient, to the profession, and to the employer (CSP, 1996). Just over a decade after its appearance in the physiotherapy literature, this new mode of professionalism has become accepted, normalised and is being reproduced by the CSP's (2011c) code of members' professional values and behaviour.

The physiotherapy literature about profession tells a story about the relationship between physiotherapy and profession. It shows that physiotherapy is a dynamic,

socially constructed entity whose identity and practices are shaped by 'profession'. The physiotherapy literature does not question or challenge the concept of profession itself, but describes physiotherapy's pursuit and realignment of its practices to meet the contemporary expectations of profession at any given time. Profession is therefore an absent-presence within the physiotherapy literature (Leder, 1992). It is usually silent, but (re)appears as a tension or discontinuity in the literature when the relationship between physiotherapy and profession is under stress. The absence and presence of profession within the physiotherapy literature can therefore be seen as an indicator of movement – of physiotherapy, and of profession. In order to understand *how* contemporary physiotherapy has evolved as a practice profession, it is necessary to turn to sociology to get a picture of how profession has moved over time. The sociological account of the changing construct of profession will provide a theoretically informed framework for understanding the tensions and discontinuities presented by the physiotherapy literature.

The changing construct of profession: from autonomy to accountability

Professional traits

The process of conceptualising profession began during the early part of the 20th century by asking 'what is a profession?' The quest to understand the function of profession generated a taxonomy of essential qualities or 'traits' that differentiated a profession from other occupational groups (Abbott, 1988). The trait theorists concluded that a profession could be recognised by its monopoly over an esoteric body of specialised knowledge and scientific expertise, the presence of a service ethic (altruism), and a system of regulating the practice of its members (Pattison & Pill, 2004). Over time, the taxonomy expanded to include factors related to licensing credentials, institutionalised training, and control over pay for example (Pattison & Pill, 2004). The shifts within the taxonomy reflect the changing organisation of professional practice, and how the taxonomy was being used politically to include/exclude certain groups (Abbott, 1988). Having exhausted questions about what makes a profession, the trait taxonomy was applied to explore the process of professionalisation.

This body of work presents professionalisation as a series of actions taken by an occupational group of workers to (re)organise its practices and acquire the traits associated with profession (Abbott, 1988). The narrative presents professionalisation as a linear process that operates in a politically neutral environment. While the theory provides a conceptual framework for describing the process of becoming a profession, it overlooks the influence of specific events, actors and discourse in shaping how different occupational groups have sought to professionalise, and the profession they have become (Abbott, 1988). Within health care, the predominantly female provinces such as nursing, physiotherapy and social work became known as 'semi-professions' (Etzioni, 1969) on the basis that they had not yet become fully professionalised (Larkin, 1983; Witz, 1992). Their work was constructed as needing medical supervision and practice knowledge, in contrast to the autonomous theoretically informed work associated with professional practice (Freidson, 1970). This justification was based on underlying assumptions about the relative value of theoretical and practice knowledge (Larkin, 1983).

Professional power

By the 1970s, questions about profession had shifted focus from the qualities that made a profession to thinking about how professions maintain their position. These questions were particularly relevant for understanding the organisation of contemporary health care. Developments in medical technology from the 1940s onwards had created space for the emergence of new occupational groups (e.g. Occupational Therapy, Remedial Gymnastics), and the increasing specialisation of established occupational groups (e.g. Nursing, Physiotherapy) (Larkin, 1983; Wicksteed, 1948). By the 1970s, these 'semi-professions' were effectively part of an extended medical workforce, performing tasks that had been delegated to them by medicine (Freidson, 1970). The body of sociological work on professions in medicine emerging during the 1970s/80s challenged the trait theorists' construct of profession as being motivated by altruistic values of service by focusing on professions' pursuit of power. In day-to-day language, 'power' is used to describe an individual's capacity to act, but can also be used to describe an asymmetrical relationship (Lukes, 2005). For professions, these conceptions of power are enacted

as autonomy (the authority to make decisions and take action independently of others); and as dominance over the work of others (Freidson, 1970; Hugman, 1991).

The process begins as an occupational group seizes an opportunity or situation to create a social need for its services and establishes a discourse to gain control over a domain of practice. Once the domain is defined, the group (re)constructs knowledge and practices to produce 'expertise', which is legitimised and reproduced through professional regulation. The process of regulation serves to reinforce a profession's jurisdiction over that domain while enhancing its relative market position and capacity for autonomy (Abbott, 1988; Foucault, 1973; Freidson, 1970). This focus on power transforms the professionalisation narrative presented by the trait theorists from being a linear sequence of events to become what has become termed 'professional project'. A professional project is defined as the systematic attempt by a specific occupational group to establish a monopoly for its services, and raise its social status, income and prospects for social mobility (Larson, 1977). It is a dynamic political process that requires the occupational group to develop strategic alliances and engage with policy networks that are aligned with the centres of established power (Abbott, 1988; Burrage & Torstendahl, 1990; Larson, 1977). Professional projects are therefore historically located, specific to the occupational group, and subject to discourses shaping gender relations (Davies, 1995; Witz, 1992) – as the second half of this chapter will show.

This more critical body of work deconstructs the relationship between professional knowledge/expertise, professional autonomy and power that was implicit in trait theorists' work. A profession's survival depends on its capacity to (re)construct its knowledge/expertise in ways that maintain its ability to produce solutions for contemporary 'problems' and meet the expectations of the market (Abbott, 1988; Larson, 1977). While both sets of theories agree that knowledge/expertise is a key feature of profession, there is a significant difference in their interpretation of what knowledge does. The trait theorists present knowledge as being necessary to undertake the highly specialised tasks of professional practice and the responsibilities that entails. Abbott (1988) and Freidson (1970) present knowledge as being a dynamic entity that constructs a profession's identity, maintains (and

extends) its occupational jurisdiction, and ensures the currency of its problem-solving practices. Foucault (1973) presents knowledge and power as being inextricably linked in a symbiotic relationship that constructs the profession and justifies its existence through the process of governmentality. Governmentality can be defined as discourses and practices of knowledge/power that construct and legitimise what society perceives to be true, and shapes individual behaviour to conform (Lukes, 2005). The relationship between knowledge/power and subjectivities will be explored further in Chapter 3.

Professional-ism

Towards the end of the 1990s, sociological thinking about professions moved to explore how professional knowledge/expertise was organised and managed (Bolton et al, 2011; Muzio & Kirkpatrick, 2011; Speed & Gabe, 2013). This change of focus is evidence of how neoliberal ideologies and disciplinary practices were challenging traditional modes of professional practice (Freidson, 2001; Pill & Hannigan, 2010, Southon & Braithwaite, 1998). Neoliberal ideologies arose during the 1970s in response to the apparent failure of centralised economics and state-run bureaucracies in sustaining economic growth (Heywood, 2007). Their solution to the 'failure' of the system was to establish structures and systems based on market principles to promote business, private enterprise and individual choice (Heywood, 2007; Jones, 2005). This ideological shift enabled Government to devolve its responsibility for the Welfare State to bodies in the private sector and a growing number of quasi-State agencies (Pill & Hannigan, 2010). Although the State had less involvement in service organisation and delivery, it had a strong role in establishing systems of governance to hold services to account (for discussion later), and in nurturing discourses that promoted and prioritised individual interests and responsibilities over collective ones (Giddens, 1998; Heywood, 2007).

Undeterred by professions' resistance to neoliberal ideals, Government persisted with its plans and introduced a new mode of public management during the 1980s (Jones, 2005; Rivett, 1998). New Public Management (NPM) was designed to enable Government to enact neoliberal principles of devolving its responsibility for the Welfare State while strengthening its control over the work of public service

providers (Hood, 1991). NPM introduced a new raft of disciplinary techniques that were based on accounting to measure and monitor the cost and productivity of professional practice (Hood, 1995). NPM can be seen as a direct attack on the model of profession that had evolved with the Welfare State (Bolton et al, 2011). By challenging the professions’ capacity for autonomous problem-solving practice, NPM was effectively undermining the element of practice that was used to differentiate professions from other occupations (Abbott, 1988; Freidson, 1970).

NPM constructed professionals as ‘budget-maximising bureaucrats’ (Hood, 1995. p94) whose autonomy needed managing in the interests of effectiveness, efficiency and safety of public services (Bolton et al, 2011; Freidson, 2001). These ‘problems’ were managed by introducing new forms of performance management into healthcare. A new managerial and administrative elite became involved in clinical decision making (Light, 2001). Evidence-based standards and guidelines were introduced to standardise, measure and manage the performance and productivity of services locally (Bolton et al, 2011; Speed & Gabe, 2013). By the 2000s, a new mode of professionalism was beginning to emerge (Freidson, 2001; Light, 2001). Its key features are summarised in Table 1.

| Traditional professionalism | <i>New professionalism</i> |
|---|--|
| Based on autonomy | <i>Based on accountability</i> |
| | <i>Directed by discourses of evidence-based medicine and patient-centred practice</i> |
| Quality focused on process and determined individually | <i>Quality focused on outcomes measured by clinical research</i> |
| Focus on primary care, prevention and management | <i>Subspecialisation and hospital care as the centre of power and prestige</i> |
| Work to treat illness and injury | <i>Work to maximise well-being/function and manage chronic conditions</i> |
| Practice based on individualised specialist knowledge and expertise | <i>Practice based on standardised and measureable sets of knowledge and skills</i> |
| Professions delegate work they do not want to others | <i>Professions delegate/supervise work, and perform the work that others cannot do</i> |

Table 1: key features of new and traditional modes of professionalism (Freidson, 2001; Light, 2001; Speed & Gabe, 2013)

Table 1 shows the how the new professionalism was recognisably different from its powerful predecessor. The concept of profession had been reconstructed from

being about autonomy and dominance over the work of others to become ‘... an explicit statement of professional duties, responsibilities, values, and standards for doctors, developed and agreed on by the public and the profession’ (Irvine, 2001. p1807). This explanation of new professionalism in medicine shows how neoliberal ideals and discourses disciplined profession to transfer its autonomy for a model of collaborative accountability (Bolton et al, 2011; Light, 2001). The new mode of professionalism was enacted as a series of measurable (‘explicit’) expectations that have been produced outside the profession (‘for doctors’) before being refined and signed off by the profession and the market (‘public’) (Freidson, 2001; Speed & Gabe, 2013). The transition from the traditional to the new mode of professionalism was produced by introducing a new system of governmentality to reconstruct, organise and manage the work of professions (Bolton et al, 2011; Speed & Gabe, 2013).

The professional autonomy associated with traditional professionalism was produced and managed by the relationships between the professional body, Universities and the State (Burrage & Torstendahl, 1990; Freidson, 2001). I have mapped this relationship in Figure 1. The professional body defined the profession’s scope of practice and regulated its conduct; Universities provided professional education and supported the development of the profession through research; while the State managed the licensing process that maintained occupational closure (Burrage & Torstendahl, 1990; Pattison & Pill, 2004). While professions’ relationships with people using their services (as employers or as members of the public seeking professional advice) were important for maintaining professional credibility and an ongoing caseload of clients (Abbott, 1988; Freidson, 1970), control of practice sat with the profession/State (Pattison & Pill, 2004).

Figure 1 shows how neoliberal values of the market and NPM were used to disempower the relationships that had been responsible for producing professional autonomy (Muzio et al, 2011; Rivett, 1998). By devolving State authority to the market (consumers) and managers, Government was able to tip the balance of power in favour of consumers and employing organisations (Bolton et al, 2011; Freidson, 2001). Professions and Universities (as providers of professional

education) became accountable to consumer interests and managerial expectations in addition to the State registration bodies (Pill & Hannigan, 2010).

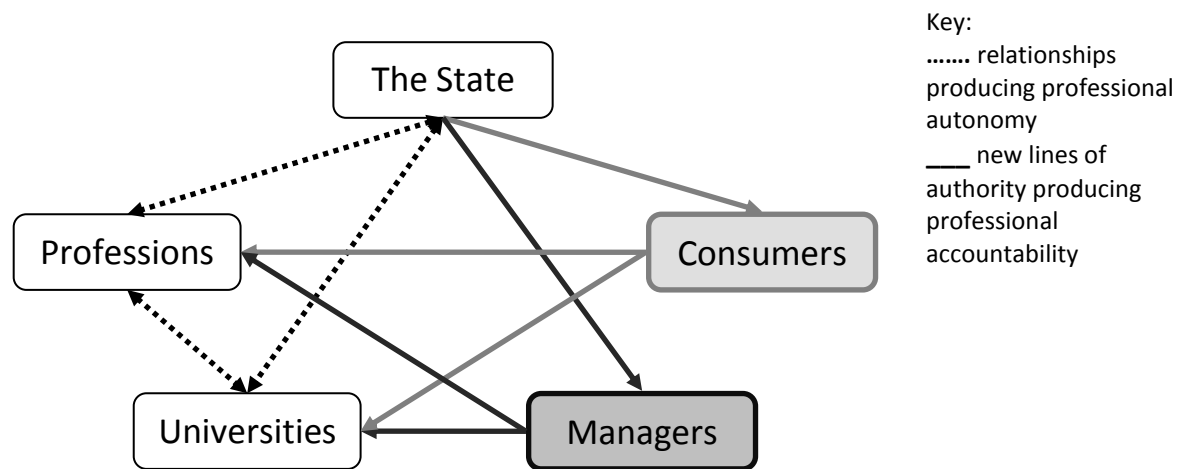


Figure 1: From autonomy to accountability - regulation of new professionalism (Abbott, 1988; Burrage & Torstendahl, 1990; Freidson, 2001; Muzio & Kirkpatrick, 2011)

The relationships responsible for producing new professionalism were legitimised and normalised by the discourses of evidence-based medicine (EBM) and patient-centred practice (Pill & Hannigan, 2010; Speed & Gabe, 2013). Both discourses started to appear independently of one another in the healthcare system towards the end of the 1980s (Rivett, 1998). EBM was defined as ‘the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients’ (Sackett et al, 1996. p71). Discursively, EBM constructs practice that is simultaneously serving the interests of managerialism for standardised cost-effective and efficient services, and professions’ value of specialised knowledge and scientific expertise (Freidson, 1970; Hood, 1995). Patient-centred practice is less easy to define (Mead & Bower, 2000). It is based on a set of principles that challenge the traditional patriarchal professional-client relationship by promoting values of compassion, dignity and respect, and shared decision making (Levenstein et al, 1986; Mead & Bower, 2000). The patient-centred practice discourse promotes the concept of informed choice associated with consumerism (Jones, 2005), and reproduces the popular public perception of profession being motivated by altruistic values of service (Bolton et al, 2011). New professionalism’s commitment to EBM is evident from the growing library of evidence-based publications published by professional bodies, and the accounts of EBM in action presented by

the professional literature. Reviews and reports addressing patient-centred practice in healthcare (e.g. IAPO, 2007; Picker Institute Europe, 2008) suggest that new professionalism has resisted this consumerist discourse. What is less clear from the literature is whether the resistance is generated by the profession, or whether the lines of professional accountability within organisations favour managerial demands over values of patient-centred practice.

The professions' engagement with evidence-based standards, guidelines and protocols created space for the introduction of competency-based accountability to discipline professional work (Pill & Hannigan, 2010; Speed & Gabe, 2013).

Competencies are defined as measurable sets of knowledge, skills and attitudes required to perform specific tasks or activities safely, efficiently and in ways that are socially acceptable within a specified environment (Caney, 1983). Competencies were introduced into healthcare during the 1980s as a means of evaluating the skill-mix required to deliver the safe and effective services (Hood, 1995). Application of the concept to analyse the work of professions has enabled organisations to reduce professional practice to a series of tasks and competencies (Freidson, 2001). The process enables managers to delegate professional work to a cadre of workers that have been trained and deemed competent to perform those specific tasks (Freidson, 2001; Light, 2001). While professions were used to delegating elements of their work to other occupational groups to enhance their market position, decisions about what to delegate and to whom had historically sat within the profession (Abbott, 1988). Competencies therefore serve a dual purpose. They ensure that practice delivered by non-qualified staff is effective, efficient and safe, while simultaneously disciplining professions' authority to make decisions about clinical work (technical autonomy), and the organisation of their practice (political autonomy) (Bolton et al, 2011; Speed & Gabe, 2013). Together the discourses and processes of EBM and patient-centred practice, and competency-based accountability discipline and reproduce new professionalism.

Key insights: physiotherapy and profession

The physiotherapy literature from the 1970s onwards describes physiotherapy's approach to professionalism, while the discontinuities uncover the tensions

produced through becoming a profession. Physiotherapy's pursuit of technical autonomy during the 1970s is evidence of the strong influence of a professionalising discourse associated with traditional professions of medicine, divinity and law (Hugman, 1991; Freidson, 1970). Physiotherapy's engagement with a trait-based model of professionalism has been ascribed to its relationship with medicine (Barclay, 1994) and its desire to avoid being sidelined from State-provided healthcare as the osteopaths had (Larson, 1983). The professionalising discourse valued abstract knowledge and scientific rationality over practice-based knowledge and experiential subjectivity associated with caring 'semi-professions' like physiotherapy (Hugman, 1991; Larkin, 1983). The professionalisation process would conceivably have required physiotherapy to reconstruct its existing knowledge/expertise and epistemologies to become more like the abstract knowledge and scientific epistemologies associated with profession (Abbott, 1988; Davies, 1995). The tensions generated by the reconstruction process were expressed by the papers published at the turn of the 1990s calling for a new epistemology to accommodate the art and science of physiotherapy practice (Squires, 2005).

The uncertainty about physiotherapy's identity as a profession expressed during the early 1990s (e.g. Bartlett, 1991; Parry, 1995; Rothstein, 1992) coincided with the rise of neoliberal discourses and disciplines responsible for deconstructing the traditional mode of professionalism (Freidson, 2001; Hood, 1995; Speed & Gabe, 2013). The shift seen in the literature towards the end of the 1990s suggests that physiotherapy and new professionalism were becoming aligned. The turbulence and uncertainty produced by reconstructing knowledge/expertise to meet the expectations of an evolving mode of professionalism in a rapidly changing (and fragmenting) practice environment (Freidson, 2001; Rivett, 1998) had settled. This period of relative stability provided an opportunity for physiotherapy to engage in processes that consolidated its reconstructed position and maintained its ongoing alignment with the new professionalism. For physiotherapy, the consolidation was achieved by a scientific discourse which by the late 1990s had become an integral element of physiotherapy's professional project.

The process of thinking sociologically leads me to conceive profession to be a combination of structure and embodied action. Despite the dynamic physicality of its practices, the concept of physiotherapy as an embodied action is under-theorised within physiotherapy (Nicholls & Gibson, 2010). Profession is a dynamic entity that shapes and is shaped by ideologies, discourses and structures that govern how people relate to one another in a given place and time (Davies, 1995; Freidson, 2001). It is also inherently political, adapting its knowledge/expertise to enhance its position in society while maintaining its capacity to produce autonomous problem-solving practice (Abbott, 1988; Freidson, 1970). Professions' problem-solving practices generate assessment and treatment independently of others. It is this 'scientific' process of using knowledge/expertise to produce a diagnosis and make inferences about treatment (Dewey, 1910) that differentiates professional practice from other forms of work (Abbott, 1988). A profession is therefore always in a state of becoming. It is not a static entity, but is constantly adjusting its knowledge/expertise and practices in response to its aspirations, and the discourses, structures and people in situations and settings it inhabits (this concept of enactment will be explored further in Chapter 3). For those professions where women have traditionally outnumbered men, this process of becoming is also subject to discourses of gender – as the next section will show.

Thinking sociologically about physiotherapy as gendered practice

Historic accounts of physiotherapy show how its professional project has been shaped by discourses of gender (Hugman, 1991; Nicholls, 2008; Nicholls & Cheek, 2006; Wicksteed, 1948). Social concerns about the physical intimacy of physiotherapy practice have, over time produced a highly disciplined workforce where the number of women has traditionally outnumbered men (Barclay, 1994; Harvey & Newman, 1993). This pattern is changing: men now represent almost 22% of the UK's practising physiotherapists (HCPC, 2012a). This section of the chapter draws on the physiotherapy literature to explore the reconstruction of physiotherapy from being something that only women could do, to become a practice that is performed by women and a growing number of men. Two inter-related narratives emerge from the literature about physiotherapy and gender. Historic accounts (e.g. Barclay, 1994; Nicholls, 2008; Wicksteed, 1948) tell the story

of the changing profile of who can practice physiotherapy in the UK. A second more diverse set of empirical work which appears from the 1980s onwards draws on physiotherapists' experiences and expectations of practice to uncover the effect of the changing gender profile on the working lives of men and women.

Before starting to unpack the physiotherapy literature, I will turn briefly to the sociology to produce a theoretically informed frame of reference to contain my analysis. Gender is a contested and dynamic concept (Abbott & Wallace, 1997; Connell, 2009). In general terms, 'gender' is used to refer to the cultural and social expectations of men and women (Abbott & Wallace, 1997). Sociologically, gender can be conceived of as a social structure, or as social practice (Connell, 2009). As a social structure, gender describes the discourses and socialising processes that construct, normalise and reproduce 'male' and 'female' by defining and normalising certain behaviours and practices as masculine or feminine (Connell, 2009). Being female becomes associated with feminine values of compassion and collaboration, which in turn is used to justify women's social roles as care-givers and team-players. The sex-based binary underpinning gender constructs male as being associated with masculine values of independence and competitiveness, which in turn justifies patriarchy: women's 'natural' vulnerability means that they require protection from men (Abbott & Wallace, 1997).

Gender as social practice, describes the activities and behaviours that fulfil society's expectations of how men and women should act (Connell, 2009). Doing gender appropriately simultaneously affirms and sustains society's expectations of 'male' or 'female', and legitimates and reproduces the practices and processes that maintain the gender order (West & Zimmerman, 1987). The gender order is a specific discourse that defines masculinity and femininity and justifies and reproduces the power relations between men and women over time (Connell, 2009). Maintenance of the sex-based binary underpinning the social construction of gender is potentially problematic for understanding the relationships between men, women and society (Abbott & Wallace, 1997). 'Female' and 'male' categories promote generalisations and stereotyping; boys are better at science than girls, or women's 'natural' caring abilities make them more suited to careers in nursing than

men for example (Lorber, 1994). If the stereotype is unfulfilled in practice (by a female scientist or a male nurse for example), it is the atypical individual rather than the structures and processes that produce the stereotype that is called to account (West & Zimmerman, 1987). For society, doing gender is about establishing structures and processes to produce and maintain gender differences which determine how women and men live and experience their everyday lives (Lorber, 1994). For individuals, doing gender is about learning to produce a performance that conforms to the social and cultural expectations of 'female' or 'male'. It is a process of becoming the same (Lorber, 1994).

When read through the lens of gender, accounts of physiotherapy's professionalisation tell a story of becoming more male. Physiotherapy has seen a growing number of men join the workforce throughout the 20th century (Barclay, 1994), and has pursued a mode of professionalism that values masculine traits of autonomy and scientific rationality (Davies, 1995; Hugman, 1991). In order to explore how both processes relate to the evolution of physiotherapy, I will refer to the increasing numbers of men as 'manning', and physiotherapy's adoption of traits associated with maleness as 'masculinisation'. This differentiation is especially important in understanding the evolution of a profession like physiotherapy that has traditionally been the sole domain of women. Making assumptions about masculine traits being exclusive to men leads to a silencing of the masculinised practices (e.g. leadership, academia) performed by women prior to manning the workforce, and within contemporary practice (Connell, 2009). Equally, the assumption that feminine traits are exclusive to women obscures the feminised roles and practices performed by male physiotherapists. This logic challenges the polarised sex-based binary by focusing on what is being performed rather than the sex of the actor (Lorber, 1994). It therefore accommodates the multiplicity of gender identities and practices produced by physiotherapists in their everyday practice (Connell, 2009).

Manning physiotherapy

At its inception in 1894, membership of the Society of Trained Masseuses (STM) was limited to women who had passed the society's examination (Barclay, 1994).

Men were excluded from membership on the grounds of a moral discourse which informed the Society's ruling about not giving general massage to members of the opposite sex (Wicksteed, 1948). This rule was clearly implemented as records speak of STM members being struck off for allowing female students to practice on male models and to receive instruction from men (Barclay, 1994). Viewed in context of the moral panic about the sensuality of massage which had led to the formation of the Society (Wicksteed, 1948), it could be argued that the Society's ruling about sex segregation served to protect the respectability of its members practice (Nicholls & Cheek, 2006). While the Society had been established by masseuses to protect massage practice, it was dependent on medical patronage – to support the expansion of practice and professional training, and to maintain a steady flow of work for its members (Nicholls & Cheek, 2006; Wicksteed, 1948). From a feminist perspective, this combination of sex segregation and dependence on medical patronage speaks of patriarchy (Nicholls & Cheek, 2006; Parry, 1995) – the subordination of women by men (Witz, 1992).

In 1905, the Society's approach to regulation was challenged by a request from the War Office to examine the massage practices of male orderlies from the Royal Army Medical Corps (RAMC) (Barclay, 1994). Reassured by the RAMC's observation that *'only men of thoroughly good character were allowed to train'* (Wicksteed, 1948. p61), the Society reviewed its expectation that all practical examinations would be conducted by a member (Barclay, 1994). Relaxation of this rule enabled the Society to invite the son of one of the Founders who was a trained masseur, to accompany the examiner on her visits to military hospitals to conduct the general massage element of the practical examination (Wicksteed, 1948). This seemingly pragmatic solution was a strategic move that supported the Society's professional project by demonstrating the social value of its work (Barclay, 1994; Freidson, 1970), while maintaining the moral discourse governing the respectability of its members' practice. As the Society's remit expanded to incorporate exercise and electrotherapy, the number of men completing the Society's entry examination grew, despite being excluded from membership on the basis of their sex (Barclay, 1994). The advent of the First World War forced the Society to review the moral discourse underpinning regulation of its members' practice. Pressure came from

the Armed Forces who claimed that the demand for massage was outstripping the supply of practitioners who were of the same sex as their patients; and from the War Office who sought to find meaningful work for those men who had been blinded on the Front (Wicksteed, 1948).

Men finally became eligible for full membership of the Society in 1920 (Barclay, 1994). Although the barrier had been removed, in practice, men’s access to membership continued to be restricted by the limited number of establishments available to train male students for the Society’s examination (Barclay, 1994). This pattern of limiting men’s access to physiotherapy training was slow to change as the information in table 2 shows.

| Year | CSSMG (1943) | CSP (1945) CSP (1955) | CSP (1965) | CSP (1974) | CSP (1984) | CSP/ CPSM (1996) |
|---|-------------------------|--|-----------------------|--------------------------|-----------------------|---------------------------------|
| Programmes accepting men/total number of programmes | 4/25 [16%] | No information presented | 16/38 [42%] | No information presented | 30/32 [93%] | 31/31 [100%] |

Table 2: proportion of schools accepting male students

Information from the CSP’s qualifying curricula shows how the number of physiotherapy programmes accepting male students expanded over time. The data in Table 2 show that the first wave of widening access to male students was generated by an increase in physiotherapy training provision overall. Twelve of the thirteen schools established between 1943 and 1965 to meet the growing demand for physiotherapists to work in the National Health Service and the Armed Forces (Barclay, 1994) accepted male students. The data presented in Table 2 should be read critically. Although the curricula show that the availability and geographical spread of training places open to men increased over time, they do not provide information about the actual number of places available to men. Accounts of practice from the 1950/60s suggest that although some schools advertised the availability of places for men, in practice they set an unspoken limit on the number of men they could accommodate (see Chapter 6). By obscuring the actual number of places open to male applicants, training schools could reduce the visibility of the

sex discrimination inherent in their admission processes, and maintain the feminised identity of physiotherapy.

Until this point in its history, physiotherapy seems to have resisted the entry of men into the workforce. Manning has been driven externally by an increasing demand for physiotherapy – whether as an occupation (e.g. blind ex-servicemen, Forces PT Instructors), or as part of an expanding NHS (Barclay, 1994; Wicksteed, 1948). The second, larger wave of widening men’s access to physiotherapy education occurring during the 1970/80s marked a shift in physiotherapy’s attitude towards manning the workforce. The timing of this shift coincided with the rise of the professionalising discourse in physiotherapy and enactment of the Sex Discrimination Act (1975). This legislation barred discrimination on the grounds of sex in education and employment, and would have therefore have challenged the admissions policies and practices that excluded men from physiotherapy education (Abbott & Wallace, 1997). The growth in the number of schools accommodating men during the 1980s was associated with the relocation of physiotherapy education from hospital-based training schools to Universities or Polytechnics (Thornton, 1994). By the time physiotherapy had become all-graduate entry in 1992, all physiotherapy programmes were open to men (Barclay, 1994). The changes are summarised in Table 3.

| Year | 1965 | 1977/8 | 1992/3 | 2007/8 |
|--------------------------------------|-------------------------|--|----------------------------------|--|
| Men entering physiotherapy education | Information unavailable | 6% (Ward, 1978) | 18.9% (Harvey & Newman, 1993) | 28% (Hammond, 2009) |
| Programmes accepting men | 42% | ‘more than half’ (Ward, 1978. p375) | 100% (Barclay, 1994) | 100% (www.csp.org.uk) |
| Exit qualification | Diploma | Diploma (37) BSc Physiotherapy (1) | BSc(Hons) Physiotherapy | BSc(Hons) Physio-therapy or pre-reg Masters |

Table 3: male physiotherapy students as a proportion of the annual national intake

The data in table 3 shows a growth in the number of men entering physiotherapy education in the UK as it moves from being a diploma to become a degree. Similar

patterns of manning an occupation as it becomes a profession were seen in physiotherapy in Australia (Westbrook & Nordholm, 1987) and Sweden (Johansson, 1999); and in other professions such as nursing and primary school teaching where women have traditionally outnumbered men (Simpson, 2005). Professionalisation for predominantly female occupations like these means adapting and reconstructing caring practices to become more scientific and technical in order to become recognised as professionalism (Davies, 1995; Elzinga, 1990). I will return to the relationship between manning, masculinising and professionalisation towards the end of this chapter.

Reproducing the gender order

The process of manning physiotherapy in the UK coincides with a shortfall in the NHS physiotherapy workforce that emerged during the 1970/80s (Barclay, 1994; Davies, 1990; Harvey & Newman, 1993). The shortage in staffing was presented as a problem with retaining newly qualified physiotherapists in the workforce beyond the first few years of their career (Davies, 1990; Harvey & Newman, 1993). This issue was in itself a consequence of the gendering of physiotherapy, and the physiotherapy workplace (Abbott & Wallace, 1997). Physiotherapy had traditionally been promoted as being suitable for academically-minded young women who sought a career in an activity-based profession (see Chapter 6). The majority of qualifiers were therefore females aged between 20 and 24, who were constructed as individuals who would typically spend a few years working in the NHS before leaving to raise a family (Davies, 1990). Their return to the workforce was limited by the organisational cultures and practices that did not readily accommodate the needs of working mothers (Harvey & Newman, 1993).

Rather than challenging the gendered assumptions and discriminatory practices pervading the workplace, physiotherapy took action to attract men into physiotherapy (Abbott & Wallace, 1997; Parry, 1995). Manning physiotherapy was presented as cost-effective solution that would stem the expensive flow of newly qualified physiotherapists from the NHS workforce (Barclay, 1994; Davies, 1990; Harvey & Newman, 1993). Men were presented as a good investment (Davies, 1990). They were less likely than young women to request extended periods of

leave to raise a family or care for older relatives; or to relocate with their spouse's work to another geographic region (Harvey & Newman, 1993). The proposal to 'man' physiotherapy, like the gendered assumptions it was based on, reproduced the gender order (Abbott & Wallace, 1997; Parry, 1995) and maintained the notion of a career in physiotherapy as a full-time lifelong commitment to the role.

The discursive reconstruction of physiotherapy as a career suitable for both women and men can be traced back to the late 1970s. Physiotherapy careers information from this time described physiotherapy as a career 'for both men and women which is mentally stimulating and physically active' (Williams, 1978. p375). By the late 1980s, CSP was presenting physiotherapy as a career that would be of interest to men and women because of the curing (masculinised) and caring (feminised) aspects of its practice (CSP, 1987; Davies, 1990). There was a strong emphasis in the careers information brochure (CSP, 1987) of the disciplined nature of the qualifying programme (mandatory attendance, heavy workload) and the personal attributes associated with professional practice. These attributes include behaviours associated with masculinities (e.g. emotional stability and initiative) and femininities (e.g. empathy and tolerance) (Abbott & Wallace, 1997). Discursively, physiotherapy became a profession that could accommodate men without disenfranchising its existing workforce of women. In practice, it became the art (feminised attributes) and science (masculinised attributes) described by the physiotherapy literature on profession published from the 1980s onwards.

Although men were relative newcomers to physiotherapy practice and are still outnumbered by women, surveys of physiotherapy's gender profile show that male physiotherapists are overly represented in senior posts within the profession in the UK (Davies, 1990; Harvey & Newman, 1993) and internationally (Maclean & Rozier, 2009; Westbrook & Nordholm, 1987). This pattern of vertical segregation where men rise to the top is seen in other professions such as nursing, social work and teaching where women have traditionally outnumbered men (Abbott & Wallace, 1997; Maclean & Rozier, 2009). Surveys of qualified and student physiotherapists about their experiences and expectations of a career in physiotherapy suggest that men actively seek the high levels of autonomy available to physiotherapists working

in management, occupational health and private practice (Davies, 1990; Johansson, 1999; Ohman et al, 2001; Rozier et al, 1998; Schofield & Fletcher, 2005). These roles are aligned with masculinised ideas of traditional professionalism: work is predominantly consultative, and provides opportunities to work with prestigious bodies (e.g. employers, medicine, fee-paying public, sporting bodies) and to supervise the work of others (e.g. as managers, or as owners of private practice) (Abbott, 1988; Freidson, 1970).

This same body of work shows evidence of horizontal segregation within the profession; some specialisms within physiotherapy seem to be less attractive to men (Abbott & Wallace, 1997). Musculoskeletal outpatients and sports medicine are popular specialisms for both men and women, but men are less likely to pursue a career in areas such as cardio-respiratory medicine, care of older people and paediatrics (Ohman et al, 2001; Rozier et al, 1998; Westbrook & Nordholm, 1987). The presence of vertical and horizontal segregation of practice within the literature suggests that physiotherapy is organised and practiced in ways that reproduce the gender order (Connell, 2009; Lorber, 1994). The male physiotherapist is presented as pursuing a career in specialisms associated with scientific rationality, leaving female physiotherapists to work in specialisms associated with care, collaboration and intuitive practice. Methodologically, these surveys are based on the male-female binary which reduces the bodies of men and women to two distinct and uniform categories that are unaffected by cultural, organisational and social change (Connell, 2009). This work presents the career choices and practices of male and female physiotherapists as something that is both natural and inevitable (Connell, 2009). It assumes that occupational roles and specialisms are uniform, and masks the influence of social, professional and organisational expectations and norms of what male and female workers can (and cannot) do in a given time and place (Lorber, 1994; Witz, 1992).

An emerging set of work (Hammond, 2009; MacLean & Rozier, 2009) is beginning to uncover the impact of gender on men's experience of becoming a physiotherapist – as a UK student (Hammond, 2009) or as a mid-career physiotherapist in the USA (MacLean & Rozier, 2009). Methodologically, while this research recognises the

presence of the male-female binary, it conceives physiotherapy's identities and practices as sitting on a male-female continuum. The research presents physiotherapy as a disciplined and disciplining process of (re)constructing personal identities and ways of being to take on qualities and behaviours associated with the expectations of a male physiotherapist in a given time and place (Butler, 1999; Connell, 2009; Lorber, 1994). The identity work involved can be physically and emotionally uncomfortable as the individual learns how to handle their own bodies and the bodies of others to meet the gendered expectations of different physiotherapeutic settings (MacLean & Rozier, 2009).

For early career male physiotherapists the process of becoming part of a caring profession is managed by physiotherapy's historic association with sport (Maclean & Rozier, 2009). I will be returning briefly to the role of activity and sport in generating physiotherapy practice in Chapter 6. Over time, the individual physiotherapist will gravitate to an area of practice where their personal gender identities can be comfortably accommodated by the gender order in that time and place (Butler, 1999; Maclean & Rozier, 2009). The male physiotherapists interviewed by Maclean & Rozier (2009) described the 'good physiotherapist' as one whose identities and practices could be assembled to produce physiotherapy practice that was simultaneously caring (feminine) and scientific (masculine). This is the physiotherapy as an art/science discourse that emerged during the 1980s that successfully reconstructed physiotherapy to become an attractive career for women and men.

Key insights: physiotherapy and gender

Historic accounts of physiotherapy describe the process of moving from being a women's occupation to becoming a profession that is practiced by women and a growing number of men. The process of thinking sociologically about physiotherapy and gender has uncovered a dynamic relationship between the gender profile of the physiotherapy workforce and its identity as a profession. There is evidence within the literature of physiotherapy's resistance to manning the workforce running from the 1900s through into the 1970s. Physiotherapy's initial resistance to manning the workforce was challenged through the first half of the 20th century by

growing demands for its services – as an occupation for men post-war, and as part of a rapidly expanding NHS. The underlying motive and logic of this resistance is obscured by the presence of a moral discourse which emphasises the intimacy of physiotherapy practice and justifies maintaining a feminised workforce (Barclay, 1994; Nicholls, 2008).

One possibility is that physiotherapy recognised an opportunity to enhance its market position by ensuring that workforce capacity did not exceed the demand. By limiting men's access to training, physiotherapy was assured that there would be a discrete flow of vacancies as women left the workforce on periods of maternity leave. The presence of vacancies made physiotherapy an attractive career; students were in effect guaranteed a job at the end of their training (Barclay, 1994).

Physiotherapy schools were producing cohorts of newly qualified staff every six months (Thornton, 1994), which meant that vacant positions could be filled within a reasonable timescale. By the 1970s, the maintenance of a heavily feminised workforce was constructed as being unsustainable - from a legal perspective, and also in terms of its capacity to meet the NHS demands for physiotherapy. This situation coincides with the rise of a scientific discourse associated with physiotherapy's professional project (see section 1) which challenges physiotherapy's resistance to manning by reconstructing an identity that is attractive to women and men. I will return to the relationship between professionalisation and manning in the concluding section of this chapter.

The literature draws attention to the work undertaken by physiotherapists to produce performances that meet the social and cultural expectations of a person of their sex in a given situation. By looking at the evolution of physiotherapy through the eyes of a male physiotherapist, it becomes possible to recognise how gender is done in everyday physiotherapy practice. What is less clear from the literature is the history that has produced the current situation. The literature does not explain how women and men have experienced and produced physiotherapy's move from being an exclusively female occupation to become a practice profession that attracts a growing number of men; why and how certain treatment environments, specialisms and roles become more (or less) popular and populated by men and

women; and how physiotherapists experienced and produced their gender identity in practice. These questions are especially relevant for a workforce where roles such as management and academia that are associated with men and masculinised practices would have originally been performed by women.

Conclusion

This chapter has demonstrated the value of bringing together the sociological themes of professionalism and gender to revisit the literature that describes physiotherapy's journey from being a women's occupation to become a profession practised by men and women.

The process of thinking sociologically has uncovered a relationship between the themes of professionalism and gender presented by the histories (Dixon, 2003; Hugman, 1991; Larkin, 1983; Nicholls, 2008) of physiotherapy. Section 1 of the chapter showed how physiotherapy, like other female-dominated occupations in health care, has historically pursued a traits-based model of professionalism (Elzinga, 1990; Hugman, 1991). This mode of professionalism is based on the traditionally male-dominated (and dominating) professions that value and enact autonomy, abstract knowledge and scientific expertise (Abbott, 1988; Freidson, 1970). These masculinised attributes (Connell, 2009) are enacted as autonomous problem-solving practices that diagnose and make inferences about treatment (Abbott, 1988). Physiotherapy's pursuit of a trait model of professionalism can therefore be seen as a process of masculinisation – of reconstructing women's knowledge/expertise and working practices to become more like work performed by professionalised men (Davies, 1995; Elzinga, 1990; Witz, 1992).

Based on my reading of the physiotherapy literature, I am arguing that the process of masculinisation and professionalisation was achieved by physiotherapy's engagement with a discourse of science. The effect of this discourse can be seen running through the literature that describes professionalisation in physiotherapy from the 1970s onwards. The process of becoming more scientific created tensions within the literature during the 1980s as physiotherapy sought a theoretical underpinning for its feminised practice-based knowledge/expertise (Davies, 1995;

Squires, 2005). The development of a scientific epistemology facilitated, and was facilitated by physiotherapy's move into Higher Education through the 1980s. The shift from hospital-based training schools into Higher Education supported physiotherapy's professionalisation and masculinisation process in three ways. Physiotherapy's move into University departments symbolised its status as a profession (Abbott, 1988), developed its capacity to research the scientific basis of physiotherapy practices (Barclay, 1994; Palastanga, 1990), and created opportunities to build an alternative (masculinised) career pathway.

At this point in its history, the physiotherapy literature draws attention to a staffing crisis in the NHS (Barclay, 1994; Davies, 1990). This crisis was generated during the 1970s by employers' failure to retain female staff beyond the first few years of their careers (Davies, 1990). Rather than challenge the gendered assumptions and discriminatory practices pervading the workplace, physiotherapy's female workforce became a problem. Employers presented men as a cost-effective solution to the expensive flow of newly qualified physiotherapists from the workforce. Physiotherapy's capacity to resist manning the workforce was limited. Discrimination on the grounds of sex had become illegal (Abbott & Wallace, 1997), and the rise of NPM meant that employers were becoming increasingly influential in decisions about professional education and practice (Muzio & Fitzpatrick, 2011). By the mid-1980s, physiotherapy was in a position to respond positively to employers' challenge to actively promote physiotherapy as a suitable career for men.

The scientific discourse had established a new identity for physiotherapy as being about the art/science of caring and curing, and was moving physiotherapy education towards the masculinised environment of Higher Education and all-degree status. The attractiveness of physiotherapy as a career for men and women was further enhanced by high levels of graduate employment and opportunities for career development in a supported environment (CSP, 1987). For men who chose to join the workforce, there was the added incentive of potentially accelerated career progression associated with the presence of vertical gender segregation in the workplace (Davies, 1990; Maclean & Rozier, 2009). Conceivably, it is this

combined process of professionalisation and masculinisation that has contributed to the rapid increase in the number of men registered to practice physiotherapy from 5% of the workforce in 1988 (Davies, 1990) to 22% in 2012 (HCPC, 2012a).

What a profession becomes at any point in time is determined by its relationship with the discourses and structures governing the practice of profession, and its position relative to other professions and occupations in the system (Abbott, 1988; Freidson, 1970). While this chapter has shown how physiotherapy's professional project has been shaped by discourses of gender and professionalism, and hints at the growing influence of employers from the late 1980s onwards, it does not explain how professionalisation was experienced and produced in practice. The bulk of the physiotherapy literature presented is focused on discourse and structural change at a macro level, and draws on scholarly work or methodologies that seek to generalise bodies and bodily practices. The nature of the literature obscures the actors, practices and relationships that have experienced and shaped what physiotherapy has become as a profession at any time. The next chapter begins to address this gap by exploring how the things that the bodies of physiotherapists and their patients can do, and how their work is organised, evolves as physiotherapy becomes a profession.

Chapter 3

Thinking through the body

The body is, in many ways, central to the profession's identity because it is the site upon which much of our therapeutic work takes place, and it provides the sociopolitical focus through which physiotherapists compete with other professions to assert our unique identity and our professional character.

(Nicholls & Gibson, 2010. p467)

Physiotherapists use their bodies to examine and assess bodily movement, diagnose movement disorder, and work with individuals to maximise their capacity for movement (HCPC, 2013). Physiotherapy is therefore an active and interactive practice that evolves organically as physiotherapists and patients respond to one another in the practice environment (Barclay, 1994; CSP, 2008a; Thornquist, 1994). Despite the obvious physicality associated with doing physiotherapy, there is very little evidence of the body and embodiment within the historic accounts of practice (Nicholls & Gibson, 2010). The histories available are either critical accounts of the macro-politics of physiotherapy's development as a profession (Dixon, 2003; Hugman, 1991; Larkin, 1983; Nicholls, 2008), or descriptive accounts (Barclay, 1994; Wicksteed, 1948) of physiotherapy responding to developments in medical practice, and the changing organisation of the post-war Welfare State. The bodies of physiotherapists and patients who are experiencing and producing change in practice over time remain an absent presence in these historic accounts (Shilling, 2005). Their bodies are implicitly there, but because their presence is taken for granted, their influence in producing a practice profession remains unaccounted for (Blackman, 2008).

This chapter draws on sociology of the body and embodiment to attend to the literature about experiencing/producing physiotherapy practice. I am using 'practice' to refer to the body work produced and experienced by physiotherapists and their patients, the organisation of their work, and the discourses and disciplines that shape who can do what, how, when and where (Coffey, 2004). To become a profession, an occupational group must construct its knowledge/experience, organise its work and discipline its workers to enact autonomous problem-solving practices (Abbott, 1988; Freidson, 1970; Larson, 1977). I am arguing that the

identity of an occupational/professional group (being) and what it does (practice) are therefore mutually dependent; movement in one repositions the other. This symbiotic relationship between identity and practice does not stop once an occupation has professionalised, but is an ongoing dynamic that shapes what a profession can become and the work its practitioners can do in a given place and time (see Chapter 2). The process of becoming a practice profession therefore requires attention to the dynamic relationships between structures governing what profession is, and the activities and actions of the bodies experiencing and producing professional practice.

Contemporary literature about doing physiotherapy constructs two forms of practice: physiotherapy as scientific technique, and as an affective/physical process. These distinct forms of practice are generated by two different epistemological perspectives on the body, which in turn inform how the practicing bodies of physiotherapists and patients can be researched (Blackman, 2008; Shilling, 2005). Physiotherapy as scientific technique dominates the practice literature, and is evidence of how the body-as-object discourse associated with medicine has shaped physiotherapy practice. Embodiment challenges the dualistic mode of thinking that values physiotherapy as a scientific technique above physiotherapy as an affective/physical process (Bithell, 2005; Nicholls & Gibson, 2010). Rather than reducing the body to a disembodied object, embodiment understands the body to be a dynamic interface for exploring discursive practices, lived experiences and ways of being and doing (Blackman, 2008). By challenging the dualistic mode of thinking about the body and how it might be framed and researched, embodiment offers an alternative perspective for thinking afresh about how physiotherapy is done (Coffey, 2004; Nicholls & Gibson, 2010).

Chapter structure and content

This chapter introduces the epistemological and ontological frameworks within which physiotherapy is located, and develops a theoretical position for making sense of the evolution of physiotherapy as a practice profession. It begins by introducing the two forms of practice present in the physiotherapy literature as a backdrop for exploring the concept of embodiment. The chapter then presents the

Foucauldian structured body and the lived body associated with phenomenology, before returning to the physiotherapy literature. I draw on Coffey's (2004) three dimensional framing of bodily practices to recover evidence of the structured and lived bodies in the literature that describes physiotherapy practice. The reframing of the physiotherapy literature is presented in three sections. Body discourse attends to construction of physiotherapy as a moving practice profession, and the processes involved in constructing a physiotherapist. Body work focuses on the literature describing the embodied process of problem-solving associated with professional practice. Organising physiotherapy practice steps away from the sensory environments of the physiotherapist's body and into the practice environment to explore how contemporary physiotherapy practice is organised. The chapter concludes by presenting a theoretical framework for researching the embodied processes of becoming a practice profession.

Physiotherapy practice

Contemporary literature presents doing physiotherapy as being either a scientific technique, or an affective/physical process. The first form of practice is commonly found in physiotherapy textbooks (e.g. Champion, 1997; Carr and Shepherd, 2010; Grieve, 1984). Read from cover to cover, physiotherapy textbooks present the theory, rationale and risks associated with a technique or modality, followed by instructions and practical tips for its effective practice. Having worked through the knowledge and skills required, the reader is offered case studies and empirical evidence to show how the practice can be applied and adapted in the real world. The emphasis on scientific theory and skilled work presented by these texts downplays the fleshy reality of doing physiotherapy to construct a scientifically-informed technical practice (Turner, 1992). The influence of this professionalising scientific discourse (see Chapter 2) can also be traced through the growing volume of randomised controlled trials and comparative studies undertaken to research the effectiveness of physiotherapeutic techniques and modalities in practice (e.g. Cross et al, 2010; Kemp et al, 2010; Salisbury et al, 2013).

The second form of physiotherapy practice presented by the literature moves beyond physiotherapy's scientific techniques to describe physiotherapists'

touching, moving and thinking body work. This alternative form of practice emerges from observational studies of physiotherapy practice in learning environments (e.g. Kell & Horlick-Jones, 2012; Rose, 1999) and in clinical settings (e.g. Cacchioni & Wolkowitz, 2011; Jones, 1995; Jorgensen, 2000; Parry, 2009; Roger et al, 2002; Thornquist, 1994). The move towards researching practice in situ could be seen as a response to voices from within the profession (e.g. Nicholls, 2008; Sim, 1985; Tyni-Lenné, 1989) calling on physiotherapists to adopt methodologies that capture the bodily interaction associated with doing physiotherapy. These observational studies describe the physical, cognitive and affective body work associated with learning to perform a specific physiotherapeutic technique (Rose, 1999); being socialised into physiotherapy (Kell & Horlick-Jones, 2012); and interacting with patients to produce change (Cacchioni & Wolkowitz, 2011; Jones, 1995; Jorgensen, 2000; Parry, 2009; Roger et al, 2002; Thornquist, 1994). From an embodied perspective, this small body of emerging research presents physiotherapy as a dynamic physical process that is produced as the bodies of physiotherapists and their patients relate to one another and the practice environment (Crossley, 2007).

The two forms of practice presented by the literature are generated by two different epistemological perspectives on the body, which in turn inform how the practicing bodies of physiotherapists and patients can be researched (Blackman, 2008; Shilling, 2005). The scientific practice presented by textbooks and controlled trials is produced by a dualistic mode of thinking about the body that is prevalent in physiotherapy (Bithell, 2005; Nicholls & Gibson, 2010). This Cartesian mode of thinking produces two bodies: an object, and a subject (Turner, 1992). The object body depicted in textbooks is a stable, rational entity that is contained by its biological structure (Blackman, 2008). Its structured rationality means that the object body can be known and understood from the outside-in, which makes it amenable to scientific study (Crossley, 2007). In contrast the subject body that appears in the observational studies is a dynamic being that has capacity for interaction and change, and becoming knowable through its actions and relations in the real world (Crossley, 2007). By focusing on the object body physiotherapy practice is reduced to a series of physical outputs that can be scientifically tested and measured in controlled clinical settings (Bithell, 2005).

While the object body of science enables physiotherapists to generate evidence of how a condition responds to a specific treatment protocol, it also fails to account for humans' capacity for interaction and change (Parry, 1997). In contrast, the dynamic, interactive forms of practice generated by the observational studies are produced by an alternative mode of thinking about the body and bodily practices. Rather than being objects whose actions are hidden behind a treatment protocol, the bodily practices of physiotherapists and patients become the focus of the research (Parry, 1997). Conceptually the bodies doing physiotherapy in the dynamic view of practice are embodied subjects who are in a continual process of becoming as they work together to experience and produce physiotherapy (Crossley, 2007). I am arguing that by privileging the object body physiotherapy risks undermining the movement that has become central to its identity and practice as a profession (e.g. Cott et al, 1995; Hislop, 1975; Williams, 1986). An alternative mode of thinking about the body is therefore useful to understand how physiotherapy has become a practice profession that is distinguished from others by its physicality and moving/touching practices. I am arguing that embodiment provides a conceptual framework that can attend to the relationship between structures that determine what profession is and the bodies experiencing/producing professional practice - without privileging one over the other (Coffey, 2004; Nicholls & Gibson, 2010).

Embodiment

This section of the chapter explores embodiment theory and in so doing shows how it can provide an alternative way of reviewing the development of a practice profession. Rather than reducing the body to its biological or social self, embodiment conceives the body as an integration of both (Connell, 2009). This integrative way of thinking aims to resolve the tensions generated by the dualisms discussed above by focusing attention on the dynamic interplay between the body and the world that the body lives in (Blackman, 2008). The body becomes a dynamic interface for exploring discursive practices, lived experiences and ways of knowing/being (Blackman, 2008; Coffey, 2004). This epistemological position is evident from body scholars' adoption of terminology that avoids reproducing body dualism. Corporeality talks of bodily-ness without reducing the body to its biology; materiality recognises the physical basis of being human without privileging its

biology; while somatic is used to describe a body that can feel (Blackman, 2008). In conceiving of bodies as 'objects of social practice and agents in social practice' (Connell, 2009. p67), embodiment draws on two sets of social theory. One attends to the discursive structuring of the body, the other to the lived experiences of the body (Turner, 1992) – which is where I turn next.

The structured body

Foucault's interest in how power and knowledge are used to make subjects generated alternative ways of thinking about bodies and bodily discipline (Twigg, 2006). Foucault challenged the idea that knowledge and power were oppositional, by arguing that they were inseparably intertwined and enacted through discourse (Lukes, 2005). Discourse can be defined as arguments and logic that are enacted through language, symbols and power relationships to generate knowledge and understanding about what is believed to be true at a given time and place (Blackman, 2008; Turner, 1992). From a Foucauldian perspective, the site of the discourse is the subjectivity of the individual – their sense of self and ways of being in the world (Weedon, 1987). Discourse then can be seen as a form of disciplinary power that produces and reproduces regulated, ordered and disciplined bodies (Foucault, 1977). The body therefore is not an unchanging being, but is a historically situated entity that becomes visible and is rendered sensitive to specific forms of disciplinary power through the interaction of discourses (Turner, 1992). Chapter 2 has shown how discourses of gender and professionalism have shaped physiotherapy's identity and practices, transforming it from being an occupation for women to become a profession that is attractive to women and a growing number of men.

Foucault's historic analysis draws attention to three key modes whereby human beings are made subjects (Twigg, 2006). The three key modes of subjectification are outlined below. The first is based on a process of division. This process involves establishing practices that separate, categorise, define and therefore produce specific social groupings – 'sick' or 'old' for example. Once categorised, the body can be managed, cared for and organised by an institution whose practices discipline the body and (re)produce subjectivities that are aligned with the

expectations of the social category (Turner, 1992). One such example is how 'patients' are produced and differentiated from the other bodies on the hospital ward by exchanging their day clothes for a hospital gown and a patient identity bracelet. The disciplinary power associated with dividing practices operates by organising the body's use of time and space (Twigg, 2006). Returning to the case of the hospital ward, this discipline is evident from the timetabling of meals, ward rounds and visiting times; and allocation of bed space according to sex or level of dependency for example (Goffman, 1968; Roth, 1963).

The second mode of subjectification involves classifying what and whom can be known, and establishing who has the authority to speak about those subjects (Foucault, 1973; Twigg, 2006). This is the process of governmentality introduced in Chapter 2 that is used by a professionalising occupation to gain control and establish their authority over an aspect of social life (Johnson, 1995). The process begins by generating discourse that creates a social need or problem. Once the need is established, the professionalising group uses knowledge/power to define the problem, and to establish specific tools and technologies to recognise, classify and regulate the problem (Turner, 1992). These techniques of bio-power discipline the body and reduce it to a scientifically measurable object that can be monitored, assessed and compared (Blackman, 2008). The disciplinary processing of the body-as-object produces a docile body (Foucault, 1977) while simultaneously expanding the profession's corpus of knowledge (Johnson, 1995). The profession's capacity to invoke knowledge/power legitimates the profession's social status, and enables it to extend its surveillance and control over previously lay areas of social life (Foucault, 1973). The process of governmentality is well documented by critical histories of medicine (e.g. Foucault, 1973; Hugman, 1991; Illich, 1976; Larkin, 1983; Witz, 1992). It is also present in contemporary healthcare practice as the discursive production of bodies that need exercise ('diabetic bodies', 'obese bodies', 'sedentary bodies' for example) and the associated interdisciplinary competition (between exercise therapists, nurses, personal trainers, physiotherapists, and sports therapists for example) for disciplinary control of those bodies (Johnson, 1995).

The third mode of subjectification involves the individual's application of disciplinary techniques to their own body (Twigg, 2006). These techniques are classified by Foucault (1988) according to the disciplinary logic and the bodies and practices they produce. Technologies of production discipline the body to produce, manipulate and transform things; technologies of sign systems discipline the body to recognise the significance of signs, meanings and symbolism; technologies of power regulate individual conduct; while technologies of the self describe the internalised processes of self-evaluation and self-disciplined body work required to produce an idealised state of being (Foucault, 1988). For professions, it is this ongoing process of deconstruction/reconstruction that ensures the individual practitioner is aligned with and habituated to the discursively produced expectations of practice at any given time (Freidson, 2001; Larkin, 1983; Nicholls, 2008). Drawing on the ideas of professionalism presented in Chapter 2, I am arguing that Foucault's modes of subjectification are significant for the construction of a practice profession such as physiotherapy. Chapters 5 and 6 will show how physiotherapy constructed its knowledge/expertise, organised its practices and disciplined the bodies of its members to experience/produce autonomous problem-solving processes associated with a practice profession (Abbott, 1988; Freidson, 1970).

Foucault's work presents the body as a malleable, unfinished entity that can be shaped, regulated and reproduced as part of the everyday processes and practices of social life (Blackman, 2008; Coffey, 2004). This body is a far cry from the scientific rational body object found in physiotherapy's textbooks. He argues that knowledge/power is enacted through the body (rather than against it), becoming ingrained and naturalised to produce subjectivities who themselves become the vehicles of knowledge/power (Lukes, 2005). Foucault's methodology draws attention to the relationships, institutions and technologies used by the bodies invoking knowledge/power. However Foucault's emphasis on knowledge/power is also criticised for obscuring the bodily experience and action of being discursively shaped, regulated and reproduced (Twigg, 2006). It has therefore been argued that Foucault's approach maintains the body dualism that prioritises the mind over the

physical body (Blackman, 2008). It is to the idea of the physical lived body and its capacity for experiencing and producing change that I turn next.

The lived body

In order to overcome some of the limitations of a Foucauldian analysis, researchers turned away from his focus on discourse towards a more embodied account of subjectivity and self. The concept of the lived body has its roots in phenomenology (Leder, 1992). From a phenomenological perspective, the lived body is a dynamic, sensory entity that perceives and constructs the world through its experiences of being in the world (Leder, 1992; Merleau-Ponty, 1962). The focus of a phenomenological approach is on a subjective but situated consciousness and experience. This is a direct contrast to Cartesian epistemology and its construction of the body as an object (Shilling, 2005). Merleau-Ponty's (1962) phenomenological account of human perception offers an embodied account of becoming aware of self and the world from the inside-out. He argued that awareness is simultaneously experienced/produced at three layers: body schema (pre-conscious level); motility; and sensory media.

Body schema is associated with senses of proprioception (awareness of the body's position in space) generated by muscles, joints and organs within the inner ear, and tactile sensations perceived by the body's physical boundary - the skin (Classen, 2005; Leder, 1992). In this schema, proprioception and touch produce an internal somatic map that enables the body to subconsciously orientate itself in relation to its environment and to position itself for action (Sheets-Johnstone, 2009). Merleau-Ponty (1962) presents motility as an extension of body schema that is experienced/produced as haptic sensations of proprioception, touch and kinaesthesia (awareness of the body as it moves through space). At this layer, the body has developed consciousness; it has an intention to move and a potential to use objects, and therefore has a capacity for agency (Leder, 1992).

The final layer of Merleau-Ponty's (1962) model is the sensory world of sights and sounds that exist beyond the physical boundary of the body. Phenomenologically, these visual and auditory perceptions provide and produce embodied

consciousness and knowledge about the environment and the body's place within it (Blackman, 2008; Crossley, 2007). Visual perception provides objective information about the body and its environment; its size, shapes and colours, the proximity and position of objects relative to one another for example (Merleau-Ponty, 1962). Auditory perception, on the other hand, provides information about movement within the body and within the environment; its speed, rhythm and direction of travel (Merleau-Ponty, 1962). These distinctions are evident in language: visual perception is spoken of in terms that are objective and reductionist e.g. focusing, mirroring, seeing straight, while the language of aural perception is affective e.g. tuning in, feeling upbeat, echoing (Blackman, 2008; Leder, 1992).

A body's knowledge of people and things is developed through interacting in structured situations in the real world (Crossley, 2007). Consciousness is in the first place, not a matter of 'I think that', but of 'I can' (Merleau-Ponty, 1962. p159). The body come to know 'a table' through embodied consciousness of its sensory qualities (a stable, horizontal surface that sits on legs), by experiencing what it can do (a work surface) and by learning its name ('a table') (Leder, 1992; Merleau-Ponty, 1962). As the body's horizons expand in the present moment and over time, it becomes conscious of the table-ness of other artefacts, and will begin to classify artefacts according to their location in space/time and its interpretation of what they do – a portable massage table, an up-down treatment 'plinth' for example. As they become associated with language and symbolism of a specific time, place and culture, the perceptions experienced/produced by the lived body become something concrete and objective (Crossley, 2007). The process of objectifying perceptions/experience through language/symbolism creates possibilities for articulating, transmitting and sharing embodied knowledge with other bodies (Leder, 1992; Turner, 1992). From a phenomenological perspective, learning is not a cognitive task of acquiring knowledge, but is a process of coming to know as the body moves, interacts and makes connections with its environment (Crossley, 2007; Sheets-Johnstone, 2009). Bodily knowing and doing are therefore inseparably intertwined (Leder, 1992; Thornquist, 1994) – as I will show later in this chapter.

The lived body presented by phenomenology is a sensuous dynamic agent that comes to know itself and the world through its interactions with the world (Crossley, 2007). This focus is on unpacking how practice and identity are 'done', on bodily activity and experience in the here and now. The lived body offers a means of understanding how bodies experience, embody (and resist) discursive construction, and how the bodily disciplines described by Foucault (1988) become habituated. The focus on bodily experience and interaction risks obscuring the social, cultural and historical context in which the action is happening (Blackman, 2008). By presenting action in what seems to be a politically neutral environment, phenomenology risks reproducing descriptive accounts of practice, and overlooking the potential influence of discourses and structures in shaping what a body can be and do. As a result, phenomenological approaches are also open to criticism for reproducing body dualism, albeit in a way that recognises the subjectivity of the body (Crossley, 2007; Turner, 1992).

Thinking about physiotherapy practice through the body

Conceptually, and as I have presented the argument so far, the structured and lived bodies appear to contradict one another. The structured body is a malleable entity that appears in response to discourse and discipline; the lived body appears through its action and interaction with its environment. While both bodies are conceptually distinct, the apparent contradiction is generated by the dualistic mode of thinking about the body (Shilling, 2005; Turner, 1992). I am arguing that rather than being two incompatible entities, the structured and lived bodies offer two complementary perspectives for understanding embodied identities and practices (Blackman, 2008). Epistemologically, the Foucauldian structured body is generated by focusing on embodiment from the outside-in, while the phenomenological lived body is generated by exploring embodiment from the inside-out (Turner, 1992; Merleau-Ponty, 1962). An outside-in perspective generates understanding about being, while an inside-out perspective produces understanding about doing (Crossley, 2007). I will apply both approaches to the next section.

Body discourse: constructing physiotherapy's bodies of practice

Physiotherapy's dualistic mode of thinking about the body has limited its capacity to theorise its bodily practices (Nicholls & Gibson, 2010). This next section of the chapter returns to the physiotherapy literature to recover evidence of the structured and lived bodies in the accounts of physiotherapy's bodily practices. Bodily practices can be considered in three different but inter-related ways: as body discourse; as body work; and as the organisation of bodies in practice (Coffey, 2004). This three-dimensional framework provides a structure for exploring how the discourses and discipline associated with the structured body shape and are shaped by the action and interaction associated with the lived body. I have used this analytic framework to generate an embodied account of how physiotherapy practice is constructed, and how the bodies of physiotherapists and patients produce/experience professional practice.

Constructing physiotherapy practice

Chapter 2 has shown that physiotherapy's engagement with the discourse of science from the 1970s onwards enabled it to remodel its knowledge/expertise and working practices to produce professional practice. Turning to the literature about physiotherapy practice from this time, there is a discrete body of scholarly work (Beeston & Simons, 1996; Cott et al, 1995; Hislop, 1975; Parry, 1994; Peat, 1981; Sim, 1985; Tyni-Lenné, 1989; Williams, 1986) that seeks to answer the question 'what is physiotherapy practice?' When viewed in context of professionalisation, this question seems inevitable for an emerging professional group. Physiotherapy's acquisition of technical autonomy in 1977 effectively removed the practice constraints and the occupational shelter previously provided by medicine (Barclay, 1994; Larkin, 1983). Having distanced itself from the protection of medicine, physiotherapy would conceivably have needed to construct a unique identity for its practices to maintain its position in the system of professions (Abbott, 1988).

The earliest of these papers (Hislop, 1975) is a starting point in physiotherapy's quest to establish a philosophical framework to support its development as a practice profession. Hislop (1975) conceptualises the body in terms of its capacity for movement – from micro (movement of bodily cells), and meso (movement of

bodily systems) to macro (movement of body in society) level; and physiotherapy as a practice that works to re-balance bodily movement at each level. The practice produced by the model becomes professionalised by connecting physiotherapy's capacity to affect movement with the science of human movement (known as kinesiology), and the ethics of compassionate care and altruistic service - traits that are associated with the traditional model of profession (see chapter 2).

Having established a professionalising foundation for physiotherapy's moving practices, the model connects them to pathokinesiology – the science of abnormal movement. Hislop (1975) argues that this body of knowledge/expertise is developed through doing physiotherapy, and is therefore what differentiates physiotherapy from other healthcare professions. The presence of pathokinesiology establishes a binary of normal – abnormal movement which prioritises the object body over the subject body (Turner, 1992). The dualistic mode of thinking presented by Hislop (1975) sits at odds with a model that otherwise appears to accommodate the dynamic interplay between biological and social bodies producing movement (Blackman, 2008; Turner, 1992).

Subsequent scholarly work builds on Hislop's (1975) model of physiotherapy as a moving practice to present physiotherapy practice as both an art and a science (e.g. Parry, 1994; Peat, 1981; Sim, 1985; Tyni-Lenné, 1989). The discursive tension presented by Hislop's (1975) model is dissipated by a logic that asserts the distinctive but equal contribution made by art and science to the process of doing physiotherapy (Sim, 1985). Physiotherapy's art is presented as being the skills required for human interaction, while its science is the knowledge required to analyse a body's capacity for movement (Tyni-Lenné, 1989). Without art, therapeutic relationships are compromised; without science, physiotherapy practice is reduced to a series of prescribed tasks (Peat, 1981). The resultant model is one that offers an embodied account of the profession:

I think of art as the soul of physical therapy, of the science and techniques as its body. Art contrasts with skill and craft in putting stress upon something more, in implying a personal unanalyzable creative force that transmits and raises the art or product beyond a skill or craft.

(Singleton, 1977, cited by Peat 1981. p171)

Having acknowledged the presence and co-dependence of physiotherapy art and science, Singleton silences physiotherapy's science to produce an alternative model of practice. Discursively, physiotherapy is no longer a series of skilled scientific techniques, but has become an embodied practice. Singleton's (1977, cited by Peat, 1981) model of embodied practice is difficult to objectify; its embodiment means that it is not possible 'to separate the [physio]therapy from the body of the [physio]therapist' (Bithell, 2005. p v). What physiotherapy is and how it is done in a given situation is therefore dependent on what the bodies of physiotherapists and their patients can do at that given place and time (Thornquist, 1994). Chapters 5 and 7 will show how this model of physiotherapy as art/science was reproduced by the curriculum and embodied by physiotherapists to produce professional practice.

Constructing physiotherapy subjects

The disciplinary techniques and tools for producing individual physiotherapy subjects are very visible within physiotherapy practice – as codes of conduct, standards of practice and educational curricula for example (Dixon, 2003; Nicholls, 2008). Professional texts like these discipline practice at two levels. By describing the behaviours, knowledge and skills required to practice (CSP, 2011a; HCPC, 2013), they define what physiotherapy is as a practice profession, and set a regulatory boundary on what the bodies of physiotherapists can and cannot do (Abbott, 1988; Freidson, 1970). These expectations in turn become embodied through processes of professional socialisation to generate the internalised self-disciplined body work required to maintain the physiotherapy subject (Foucault, 1988; Richardson, 1999a). Despite the visibility of physiotherapy's disciplinary tools, evidence of how, when or where those tools produce physiotherapy subjects is, in my view, elusive. While accounts of practice describe the physical and affective consequences of disciplining processes, the process itself remains hidden. This elusiveness suggests that either physiotherapy's disciplinary processes are no longer distinguishable from its practices (Lukes, 2005), or that the processes sit beyond the reach of physiotherapy's research methodologies.

The small body of literature that uncovers how physiotherapists' bodies are produced is focused on liminality; the ambiguous phase associated with rites of

passage (Blackman, 2008; van Gennep, 1960). A body's rite of passage involves moving from one stable state of being across a boundary, and into a transitional phase where its identities and practices are reconstructed, to produce a new stabilized state (van Gennep, 1960). The rite of passage into physiotherapy, like other occupations and professions whose practices are regulated, is disciplined by a formalised process of education and training (see Chapter 2). In order to become a physiotherapist, a student must successfully complete a qualifying programme that has been validated by the regulatory body, the Health & Care Professions' Council (HCPC, 2012b). Historically, physiotherapy qualifying programmes have run over a three year period of full-time study which integrates classroom-based learning with a mandatory period of 1000 hours of practice-based learning (CSP, 2012).

Concerns about the demographic profile of physiotherapy that emerged during the 1980s (see chapter 2) generated questions about whether physiotherapy's rite of passage favoured some bodies more than others. Retrospective analyses of students' progression through a physiotherapy programme (e.g. El Ansari, 2003; Hammond, 2009; Kell, 2006; Naylor et al, 2013) suggest there is a relationship between a student's age, ethnicity and sex and their academic performance. While the correlation between academic performance and ethnicity is statistically insignificant (El Ansari, 2003; Naylor et al, 2013), the relationship between gender and performance is significant, with female students consistently out-performing their male peers (El Ansari, 2003; Hammond, 2009; Kell, 2006; Naylor et al, 2013). This discrete body of work suggests that the move from traditional forms of summative assessment (e.g. essays and written examinations) to formats that emulate contemporary physiotherapy practice (e.g. reflective portfolios) has potential to disadvantage male physiotherapy students (El Ansari, 2003; Hammond, 2009; Kell, 2006). While these findings are limited to specific programmes and student cohorts, they suggest that the process of becoming a physiotherapist is shaped by a gendered discipline that appears to favour female students.

The literature describing physiotherapy students' experiences of becoming a physiotherapist (e.g. Davies et al, 2011; Kell & Horlick-Jones, 2012; Soundy et al, 2013; Whiteside, 2013) attends to situations where tensions appear in students'

rite of passage. Conceptually, these tensions emerge as the individual subject struggles to produce a performance that conforms to the social and professional expectations of 'physiotherapy' in a given place and time (Blackman, 2008; Goffman, 1968; Richardson, 1999a & b). These tensions seem to appear in practice placement settings. This element of the qualifying programme is where students experience and learn to produce physiotherapy practice in the real world, and become socialised into its ways of being and doing (Richardson, 1999a & b). It is a sometimes uncomfortable process of apprenticeship where students discipline their bodies to reproduce the practices generated by their practice educators (Kell & Horlick-Jones, 2012;). The structure and organisation of physiotherapy qualifying programmes means that the professional body therefore plays a significant part in shaping students' rites of passage, and in determining what the future physiotherapy body can become (Richardson, 1999a & b).

Body work: experiencing/producing professional practice

Physiotherapists use their bodies to produce the problem-solving sequence of assessment, diagnosis, treatment (Jones, 1995; May & Newman, 1980; Rose 1999) associated with professional practice (Abbott, 1988). The problem-solving process appears in the physiotherapy literature at the same time as physiotherapy was actively pursuing professional recognition (see Chapter 2). Articles published during the 1980s (e.g. Burnett et al, 1986; May & Newman, 1980; Olsen, 1983) offer critical descriptions of the pedagogic practices used to produce a problem-solving physiotherapist. More recently published work (e.g. Cacchioni & Wolkowitz, 2011; Edwards et al, 2004; Parry, 2009; Rose, 1999; Thornquist, 1994) provides rich accounts of how physiotherapists and patients work together to produce problem-solving practices. By attending to the relationality of physiotherapy, it shows how the physiotherapist's use of space, equipment and bodily techniques establishes and maintains a safe working environment for themselves and their patients (Cacchioni & Wolkowitz, 2011; Jorgensen, 2000; Parry, 2009; Rogers et al, 2002; Thornquist, 1997; Thornquist, 1994). Viewed together, this series of papers describes the affective, cognitive and physical body work of doing problem-solving, and presents a story-board of how physiotherapists' bodies experience/produce professionalisation over time.

Occupational body work reflects the physical/emotional demands of the occupation, its cultural identities, and how its work is organised (Cohen, 2011; Gimlin, 2007; Pocock, 2005). There are many definitions of body work, but the one I have chosen describes body work as ‘work that focuses directly on the bodies of others, who thereby become the object of the worker’s labour’ (Twigg et al, 2011. p2). The definition differentiates and separates the technologies of production associated with the structured body from the activities and processes experienced by the lived body. The differentiation of structured and lived bodies has potential to reproduce the dualistic mode of thinking about the body (Shilling, 2005; Turner, 1992). While this differentiation is potentially limiting, I am arguing that it creates a clear space for exploring the potential relationships between being a physiotherapist (structured body) and doing physiotherapy (lived body) (Blackman, 2008; Crossley, 2007). This clarity is necessary and important for understanding the process of becoming a practice profession.

This section of the chapter revisits the problem-solving practices that appeared in the physiotherapy literature during the 1980s, from the perspective of the phenomenological lived body. This analysis uncovers the disciplined physical/affective body work undertaken by the physiotherapist in coming to know and affect the patient’s moving body – as a subject and as an object (May & Newman, 1980). Problem-solving is experienced as an embodied process of comparing the sensations generated by handling the patient’s moving body with embodied knowledge generated from previous experience (Jones, 1995; May & Newman, 1980). Although physiotherapy’s problem-solving process is generated by the patient and physiotherapist (Rose, 1999; Thornquist, 1997), my analysis will focus on the physiotherapist’s body work. This unilateral perspective provides containment for unpacking and exploring the lived experience of producing the assessment, diagnosis and treatment sequence associated with professional practice (Abbott, 1988).

The process is shaped by the two forms of knowledge associated with professional practice; formal and practice knowledge (Freidson, 1970). Formal knowledge describes the theoretical and conceptual reference points that construct a

profession's identity and define its occupational jurisdiction (Abbott, 1988; Freidson, 1970). For contemporary physiotherapy this knowledge incorporates anatomy and physiology, behavioural science, kinesiology and medical ethics (HCPC, 2013). I am suggesting that physiotherapy has adopted these theoretical perspectives that explain why and how human bodies move to construct its moving practices (Higgs & Titchen, 2001; Hislop, 1975). By contrast, practice knowledge describes the knowledge and skills generated through experience of producing professional practice (Freidson, 1970). This form of knowledge is embedded in the real world and becomes embodied as the individual responds to the demands of a given situation. It is the 'knowing how' associated with physiotherapy's processes, procedures and rules of thumb, its techniques and modalities, and its professional ways of being (Higgs & Titchen, 2001).

Physiotherapy's problem-solving process is initiated by a request for a physiotherapy assessment – from the person themselves, or from someone acting on their behalf (e.g. General Practitioner, medical consultant or other healthcare worker). The physiotherapy referral generates basic information about the individual - their presenting problem, sex and age, and physical location. This information is used by the physiotherapist to determine when and where the physiotherapy assessment will take place – on a hospital ward, in a clinic, or at home for example. Conceptually, the referral is the first stage of a process of becoming a physiotherapist and a physiotherapy patient (Blackman, 2008). Having generated a sense of the patient's body from the referral information, the physiotherapist resumes the process of collecting information as they physically meet the patient. From a phenomenological perspective, the physiotherapist's initial perception of the patient generates information about the patient's object body – its shape and size, posture and position in space (Merleau-Ponty, 1962). As their bodies move physically closer into a shared auditory/visual field, perceptions change. The process of verbal introduction affirms the identities of the physiotherapist and patient, while creating a space to hear the patient's body – its tone, volume and pitch, breath control and co-ordination of speech (Blackman, 2008; Merleau-Ponty, 1962). As physical contact is made – whether as a formal handshake or a hand on the elbow to guide the patient out of their chair - the

patient's body is transformed (Rose et al, 2002). It is no longer the object produced by the referral information and perceived from a distance, but has become a dynamic entity that can be seen, heard and touched (Leder, 1992).

Having established a connection with the patient's body, the physiotherapist begins the systematic process of taking a history, screening and examining the patient's moving body (Edwards, 2004; Jones, 1995; Rose, 1999). The physiotherapy assessment is experienced/produced in three phases: the 'subjective' (history), the 'objective' (examination), and diagnosis (May & Newman, 1980). The 'subjective' is a structured conversation led by the physiotherapist (Olsen, 1983; Parry, 2009). It confirms the data from the referral and invites the patient to provide a brief account of their present condition, past medical history and social history (May & Newman, 1980). The content of the conversation develops the physiotherapist's awareness of the patient's subject body, while its structure establishes the boundaries for the patient-physiotherapist interaction and prepares them both for the next phase of the assessment (Jones, 1995; Parry, 2009). The transition from subjective to objective is marked by a change in bodily position. The physiotherapist rises from their seated position, and having offered a brief explanation of what the objective will entail, invites the patient to expose the body part and position themselves for examination (Kell & Horlick-Jones, 2012; Thornquist, 1997).

The objective examination is a systematic process of handling the patient's body to generate information about how their body moves (May & Newman, 1980). It is a demanding choreographed performance that requires physical, cognitive and affective body work to position, palpate, move and manipulate the patient's body to reach a diagnosis (May & Newman, 1980). The objective examination is experienced/produced by physiotherapists' hands, with the occasional use of a few simple pieces of equipment such as a tape measure, tendon hammer or stethoscope for example (Rose, 1999). Phenomenologically, the physiotherapist perceives the patient's moving body as auditory and visual, proprioceptive (body position in space), kinaesthetic (body movement through space) and vestibular (balance and posture through space) sensations (Ayres, 1979; Rose, 1999). These

embodied perceptions generate knowledge of what the patient's movement is like; its co-ordination, flow, resistance, symmetry for example (Sheets-Johnstone, 2009).

The sensing body work associated with the objective assessment transforms the patient's moving body. It ceases to be the dynamic entity present at the start of the problem-solving process, and becomes a permanent record of words, numbers, body charts and graphs that define specific components of its movement (Rose, 1999; Turner, 1992). The containment creates space for the physiotherapist to draw on their formal knowledge and embodied knowledge of past encounters to recognise the significance of and relationships between the snippets of sensory data experienced/produced as they handle the patient's moving body (Jones, 1995). The synthesis of existing knowledge with sensory cues experienced/produced by the physiotherapist's handling generates a series of hypotheses – objective ideas of what is causing the movement imbalance (Jones, 1995). These hypotheses are tested, refined and reduced as the physiotherapist and patient continue to interact and assemble a logical explanation of what is causing the patient's movement imbalance (May & Newman, 1980).

Once the physiotherapist has reached a diagnosis, the physical body work of performing specific tests and measures becomes the affective body work of communicating a diagnosis and constructing a physiotherapy plan (May & Newman, 1980). The shift in body work moves the patient and physiotherapist from the dynamic haptic/visual sensory environment of the physical examination into a shared auditory/visual space beyond the immediate physical boundary of their bodies (Merleau-Ponty, 1962). Phenomenologically, this shared auditory/visual environment provides an objective space (visual perception) that accommodates movement (auditory perception). Its moving containment supports the affective processes of reaching a shared understanding of the diagnosis, setting treatment goals, and negotiating a physiotherapy treatment plan. The treatment planning process involves working with the patient to make informed choices about which combination of modalities will be most likely to affect the diagnosed problem and its underlying causes (Olsen, 1983). Conceptually, this stage of the problem-solving process draws on past/present embodied realities to envisage and co-construct a moving body of the future (Jones, 1995; Thornquist, 1994).

Physiotherapy's scope of practice incorporates manual therapy, exercise and movement, electrophysical modalities and kindred physical approaches (CSP, 2008A). Drawing on Merlau-Ponty's (1962) work on perception and Sheets-Johnstone's (2009) work on moving bodies, I am suggesting that each modality is experienced as a specific blend of sensations which can be directed to generate movement of the micro, meso or macro body. Physiotherapists and patients therefore have access to a wide variety of treatment techniques that can be used to transform the patient's moving bodies. Manual therapy is experienced as haptic sensations generated by the physiotherapist's moving touch; exercise and movement as the kinaesthetic/proprioceptive/vestibular sensations generated as the body moves through space; and electrophysical modalities as tactile sensations generated by heat, cold and electrical current. Physiotherapy treatment is a skilled technical practice that is directed at producing specific outcomes (May & Newman, 1980). These outcomes are generated via an interactive process that unfolds as the physiotherapist and patient experience/produce the bodily movements generated by the treatment modality (Cacchioni & Wolkowitz, 2011; Thornquist, 1997).

Physiotherapy's moving modalities originated as physical treatments prescribed by doctors (Barclay, 1994). By the 1970s, however, some of the techniques associated with manual therapy and exercise and movement were being used to produce assessment (Barclay, 1994; Grieve, 1984). While historic accounts (Barclay, 1994; Grieve, 1984) mark the move, they do not explain how the transition was experienced/produced in practice. The transition of techniques to produce assessment/treatment is significant in terms of physiotherapy's evolution as a practice profession (Abbott, 1988) as I will show in Chapters 5 and 6. From the outside, the process of doing treatment can therefore appear very similar to the choreographed work of producing the objective assessment. Both processes require physical, cognitive and affective body work to position, palpate, move and manipulate the patient's moving body (Grieve, 1984; May & Newman, 1980). Although both processes may appear very similar, conceptually the body work and the bodies they produce are distinct. The objective assessment deconstructs the patient's moving body to produce a diagnosis. Treatment works with specific components of the patient's moving body and reassembles them to produce a body

that can move and function. Chapters 5 and 6 will explore how these processes of deconstruction and reconstruction are produced/experienced in practice.

The final stage of physiotherapy's problem-solving process is evaluation of the outcome produced by treatment, and of the problem-solving process as a whole (May & Newman, 1980; Olsen, 1983). Evaluation is an embodied process that demands self-awareness and objectivity, and an ability to draw on existing formal and practice knowledge to make a reasoned judgement about the outcome of their practice (May & Newman, 1980). The process can be seen as a form of governmentality that regulates individuals' performance by encouraging them to establish a set of intended outcomes against which their performance is measured retrospectively (Lukes, 2005). As a process of critical reflection, evaluation has potential to generate new knowledge about the individual components of the practice generated by a specific patient and physiotherapist (Dewey, 1910; Higgs & Titchen, 2001). This is the process of situated learning associated with the development of practice expertise (Squires, 2005). I am suggesting that the regulatory/situated learning function of evaluation generates bodies that can produce change while being capable of being changed (Crossley, 2007) - as I will show in Chapters 6 and 7.

This inside-out analysis of the body work of physiotherapy starts to uncover a relationship between physiotherapy's identity as a practice profession and the practising bodies of physiotherapists and patients. The appearance of the problem-solving process during the 1980s is consistent with physiotherapy's pursuit of professionalisation from the 1970s onwards (see Chapter 2). Physiotherapy becomes a practice that integrates theory and embodied knowledge generated from previous patient encounters with living data to make inferences about the patient's movement disorder and the likely outcome of treatment. This is the body work of physiotherapy's scientific practice (Dewey, 1910) that differentiates professions from other occupational groups (Abbott, 1988; Freidson, 1970). Conceptually, physiotherapy's problem-solving bodies are not fixed organisms composed of bodily systems, organs and processes, but are bodies-in-process (Blackman & Venn, 2010). The body-in-process is a dynamic entity that is constantly

changing in response to the relationship it has with practices, technologies, institutions and other objects (Mol, 2002). This body's actions unfold as it experiments and moves in response to its aspirations, and the situations and settings it inhabits (Blackman & Venn, 2010; Sheets-Johnstone, 2009). It therefore has capacity to move and cause physiotherapy practice to multiply over time and across practice settings (Mol, 2002), as the next section will show.

Organising physiotherapy practice

Barclay (1994) traces physiotherapy's journey from its beginnings in medical massage to become an organised body that works in a variety of roles, across a range of settings with diverse client groups. Her account shows that some practices grow and flourish and become organised, while others become restructured or obscured as the bodies and practice environments that physiotherapists work with move and diversify. Contemporary physiotherapy is described in terms of handling body systems and disease processes (e.g. cystic fibrosis, neurology, orthopaedics), or specific types of bodies (e.g. animals, older people, women), or as practice that uses specific modalities (e.g. acupuncture, electrotherapy, water). Physiotherapy practice is also described in terms of the location of practice (e.g. overseas, private practice) or its occupational role (e.g. management, research) (Barclay, 1994; CSP, 2010). The evolution and changing organisation of physiotherapy practice can be traced through the CSP's professional network structure. Professional networks are formed by physiotherapists to support the post-qualifying development of physiotherapy and physiotherapists in a particular field of practice (Barclay, 1994). I have produced a table to show the changing structure of the professional networks in Appendix 1.

The table in Appendix 1 shows how physiotherapy has evolved from being a body concerned with practices of manual therapy, exercise and movement, electrotherapy and kindred approaches to become an organised body of multiple identities and practices (Parry, 1997). Physiotherapy practice multiplies as it becomes embodied by specific body forms (e.g. ageing, animal, sporting), bodily systems or parts (e.g. musculoskeletal, neurology, respiratory, hands); and as it moves into specific practice environments (e.g. community, industry, international

private practice). As practice moves and multiplies, new roles emerge to support and protect the development of professional practice by providing organisational and strategic support (e.g. Superintendent) and research and development capacity (e.g. physiotherapy teacher, researcher) (Freidson, 1970). When read in context of socio-political developments occurring in healthcare, the table in Appendix 1 traces how the identities and practices of physiotherapy relate to the changing discourses, technologies and organisation of practice and a proliferation of expertise.

The first identities/practices appear around the 1920s; a time when the Society was taking steps to organise and standardise the education and practice of its members to justify its Chartered status (Barclay, 1994; Wicksteed, 1948). It is unsurprising therefore that the earliest identities to emerge were either using specialised technologies to support their practice (blind physiotherapists) (French, 1995), or involved in reproducing standardised practices (teachers) (Wicksteed, 1948). The next change is seen during the 1940s; an era marked by Government investment in medical rehabilitation services, and the introduction of a State-funded healthcare system (Rivett, 1998). Investment in medical rehabilitation during the 1930/40s meant that it was an expanding area of practice – for physiotherapy and other occupational groups such as Occupational Therapy and Remedial Gymnastics (Wicksteed, 1948). The emergence of orthopaedic and industry-based identities/practice in 1944 and 1947 respectively are evidence of physiotherapists' response to the tensions created by the expanding but increasingly competitive field of rehabilitation (Abbott, 1988; Barclay, 1994). I will be exploring physiotherapy's relationship with rehabilitation and the post-war Welfare State in Chapter 5.

The other identity/practice to emerge during the 1940s was the Superintendent Physiotherapist. They had responsibility for the smooth running of the physiotherapy service, and for working with medical colleagues and hospital management to plan service provision (Barclay, 1994). This is a challenging role for members of a practice profession (see Chapter 7), but its presence constructs a workforce that could be organised to meet the demands of an expanding welfare state (Barclay, 1994). The multiplication of identities/practices appears limited

during the 1950/60s despite evidence of physiotherapy moving to support medical practice in burns and plastics, rheumatology, and spinal injuries for example (Barclay, 1994). I am suggesting that this mismatch is produced by the organisation of the physiotherapy workload at this time. Chapter 6 will show that the workload was divided according to patients' location within the hospital ('general wards', 'maternity', 'outpatients' and 'community'), which in turn limited the stratification required for new identities/practice to emerge (Abbott, 1988).

Once physiotherapy had gained freedom from direct medical supervision in 1977, its identities/practices multiplied rapidly (see Appendix 1). The identities/practices that appeared during the 1980/90s are diverse: some represent physiotherapy's technical practices (e.g. Bobath, electrotherapy, hydrotherapy); others are aligned with specific services and organisational structures (e.g. cardiac rehabilitation, community, psychiatry); while others reflect an interest in alternatives to the biomedical model (e.g. acupuncture, pain). I am suggesting that this pattern of expansion is evidence of the uncertainty and opportunities generated by the rise of neoliberal ideals and introduction of New Public Management (NPM) during the 1980s (see Chapter 2). Physiotherapy services began to compete for contracts – amongst themselves, and with other groups such as osteopaths and chiropractors. In competitive situations like this, professions seek to protect their knowledge/expertise and compete by promoting the practices that differentiate them from other groups (Abbott, 1988).

Service redesign was changing how the workforce was organised (Rivett, 1998). Therapy staff were increasingly likely to be allocated to an interdisciplinary or interagency team employed to provide services for a specific patient groups (e.g. people with rheumatological conditions, people with learning disabilities, people rehabilitating following an amputation) (Barclay, 1994). The drive for cost-efficiency created opportunities for physiotherapists to undertake work previously done by doctors (e.g. injection therapy, extended scope practice), while consumer interest in whole person approaches during the 1980s created opportunities to integrate complementary therapy approaches into practice (CSP, 1985). Appendix 1 shows that practice continued to multiply during the 2000s, but at a much slower rate.

This suggests that physiotherapy had reached a state where further multiplication was not possible or viable, or that consolidation of its existing position was more desirable. The table shows how the organisation of physiotherapy's embodied practices created capacity for it to move and multiply over time and across practice settings. I will be exploring the relationship between the organisation of physiotherapy practice and physiotherapists' capacity to experience/produce autonomous practice in Chapter 6.

Becoming a practice profession from the outside-in/inside-out

The chapter has drawn on sociology of the body and embodiment to show how the structured and lived body offer two complementary perspectives for understanding how physiotherapists 'do' the process of becoming a practice profession over time. From an embodied perspective, I am arguing that physiotherapy practice is a space where the structured and lived bodies meet, mesh and affect what physiotherapy is, what the bodies of physiotherapists can do, and what they can become (Coffey, 2004; Connell, 2009; Mol & Law, 2004). I have mapped my understanding of these dynamic interactions in Figure 2.

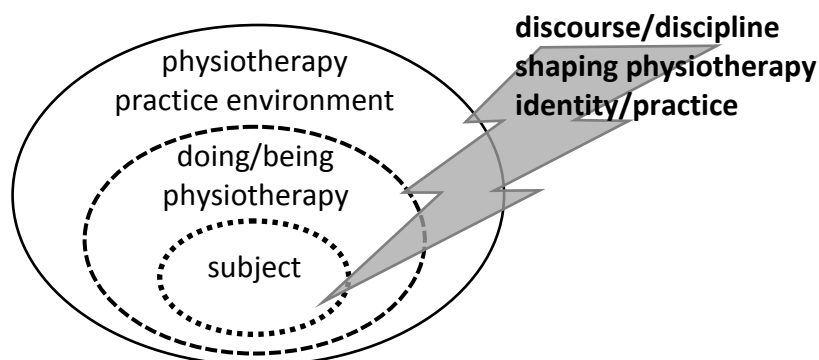


Figure 2: becoming a practice profession from the outside-in, and the inside-out

Figure 2 presents a conceptual framework for understanding how the lived and structured bodies of physiotherapy interact to affect the process of becoming a practice profession. The relationships between the physiotherapist as a subject, the embodied processes of doing/being physiotherapy and physiotherapy's practice environment generated by the lived body are represented visually by a set of 3 concentric circles. At the heart of the lived body presented in Figure 2 is the individual subject. This subject becomes a physiotherapist as they interact with the

patients, artefacts and technologies present in physiotherapy practice settings to experience/produce physiotherapy practice. Conceptually, the subject and the physiotherapy identity and practice they do are fluid (represented by the hashed lines in Figure 2), but are contained by the physiotherapy practice environment. The structured body is represented in Figure 2 by a lightning flash. The structured body perceives embodiment from the outside-in and therefore offers a methodological approach for uncovering how discourse and discipline produce the identities and practices that are experienced/produced by the lived body.

The model offers a series of focal points for exploring how the discourses of gender and science introduced in Chapter 2 shape and are shaped by the things physiotherapists' bodies can do in a given place and time. I will be returning to these themes later in the thesis.

Conclusion

Physiotherapy's dualistic approach to the body means that the literature is either focused on what physiotherapy is (being) or on its practices (doing). As a result, very little is currently known about the embodied processes of professionalisation in physiotherapy. While being and doing are conceptually distinct, I am arguing that their relationship is significant for understanding the process of becoming a practice profession. 'Being' focuses on knowing the body as an object – something that can be contained and understood from the outside-in- while 'doing' focuses on knowing the body from the inside-out as a dynamic embodied subject that is in a continual process of becoming (Crossley, 2007; Mol & Law, 2004). This chapter has explored physiotherapy's bodily practices to show how the discourses and disciplines associated with the structured body interact with the sensing lived body to produce professional practice.

This chapter has drawn on sociology of the body and embodiment to challenge the dualistic mode of practice presented by the physiotherapy literature. I have used Coffey's (2004) three dimensional framing of bodily practices to recover evidence of the structured and lived bodies doing physiotherapy practice. This reframing of the physiotherapy literature offers an account of the discourses and disciplinary

processes that produce physiotherapy practice, physiotherapy's body work and the organisation of its practices. I have shown how the structured and the lived bodies offer two complementary perspectives for understanding how physiotherapists produce/experience the process of becoming a practice profession over time. The next chapter moves on to look at the process of researching the meeting and meshing of the lived and structured bodies being/doing physiotherapy. I will show how the conceptual framework informed my choices about collecting data, and provided space for analysing the relationship between physiotherapy's identity as a practice profession, and the processes of doing physiotherapy.

Chapter 4

Thinking through the research process: perspectives, principles and praxis

It [praxis] is not simply action based on reflection. It is action which embodies certain qualities. These include a commitment to human well being and the search for truth, and respect for others. It is the action of people who are free, who are able to act for themselves. Moreover, praxis is always risky. It requires that a person 'makes a wise and prudent practical judgement about how to act in this situation'

(Carr & Kemmis, 1986. p190)

The primary focus of the historic accounts of physiotherapy published to date is on the evolution of physiotherapy's identity as a profession (Nicholls & Gibson, 2010). Analysis of this body of work shows how the narrative presented is shaped by the researchers' ways of knowing/doing history. Barclay (1994) and Wicksteed (1948) offer a descriptive account of the professionalisation of physiotherapy practice, and of the changes in what physiotherapists do and how their work is organised over time. Their chronological approach creates space for nostalgia and assumes that the development of a practice profession follows a linear pathway (Abbott, 1988; Jones & Green, 2006). By contrast, the critical histories of physiotherapy uncover the political process of constructing a professional identity through the acquisition of professional traits. These disembodied accounts show how the professionalisation of physiotherapy has been shaped by discourses of gender (e.g. Dixon, 2005; Hugman, 1991; Nicholls, 2008), and of physiotherapy's relationship with the medicine and the State (Larkin, 1983). My research builds on this existing body of work by adopting a genealogical approach to history that uncovers the embodied processes of physiotherapy becoming a practice profession.

While this project is not explicitly (auto)biographical, its focus is the identities and practices of a profession that I have been a part of for almost 30 years. I was therefore experiencing/producing the research as an insider who is familiar with the organisation, processes and practices that make up the social world of physiotherapy. From a feminist perspective, my insider status was not necessarily a threat to the research process, but was a position that could be accommodated and valued by adopting a consciously reflexive approach to account for my presence/influence on the research process and praxis (Stanley, 1990). Earlier

chapters have started to address my familiarity with physiotherapy by thinking sociologically (Coffey, 2004) about the social world of physiotherapy practice. I have drawn on the literature from physiotherapy and sociology to paint a picture of contemporary physiotherapy in terms of its gender and professionalism (Chapter 2), and its epistemology/ontology and praxis (Chapter 3). This chapter continues the process of discovering physiotherapy by explaining my epistemological/ontological perspective and my methodological approach, and by offering a reflexive account of the research process.

From a Foucauldian perspective, history is socially constructed – today's situation is just one possibility emerging from the events of yesterday (Weedon, 1987). In the case of physiotherapy, the events of yesterday are recorded in the text-based materials stored in its archives and recounted through the oral accounts of practice presented by physiotherapists. Whilst documents and oral accounts are familiar sources for researching physiotherapy's history (e.g. Barclay, 1994; Dixon, 2003; Hugman, 1991; Larkin, 1983; Nicholls, 2008), they are epistemologically distinct (Crabtree & Miller, 1999). Documents offer a permanent record of a present at a particular point in the past, while oral accounts provide a perspective of a particular point in the past from the distance of an unfolding present (Crabtree & Miller, 1999; Prior, 2003). Used together, the temporality of these data creates opportunities for exploring a situation from multiple perspectives (triangulation) and for uncovering how a phenomenon emerges as opposed to recording the fact that it does (Ballinger & Cheek, 2006; Crabtree & Miller, 1999). The research demands a reflexive approach that explains how the multiple methods and perspectives adopted are perceived and understood, linked and layered to produce a 'montage' (Denzin & Lincoln, 2011.p5) – a moving account of the process of becoming a practice profession over time.

Content & structure

As a physiotherapist researching the history of my own profession, I cannot ignore the potential impact my insider identity and practices may have had on the research. My research proposal was reviewed and approved by the School of Social Sciences Research Ethics Committee (SREC) at its meeting in June 2008 [SREC/375].

The chapter opens with a brief introduction to the concept of reflexivity, before introducing myself and explaining how my personal/professional identities and experiences of physiotherapy practice have affected the research process. The chapter turns briefly to describe the genealogical approach to history that underpins this research before presenting an account of my research praxis. From a feminist perspective, ethics, method and analysis are inseparable elements of research praxis (Stanley, 1990) and are therefore described and discussed together. The middle section of the chapter explains my choice of sources/methods, and shares a reflexive account of using documents and depth interviews to generate accounts of physiotherapy practice. Although both methods were used in parallel, I present them independently of one another, for clarity. This section also explains why the interactive website I had proposed to support the analytic aspect of my research through engagement of a wider community of physiotherapists was not pursued. The final section of the chapter explains the process of linking and layering the different perspectives generated by the documents and interviews to construct an embodied montage of physiotherapy becoming a practice profession.

Reflexivity: becoming aware of my researching self

Researchers have traditionally sought to exclude the self from the research process as a means of reproducing scientific objectivity. Chapter 3 has already shown the limitations of prioritising objectivity for coming to know and understand how physiotherapy practice works in the real world. I am arguing that the exclusion of self from research is untenable because research is an embodied process of interacting with the bodies, practices and processes that make up the social world (Carr & Kemmis, 1986; Stanley, 1990). As the researching self cannot be separated from the research, it becomes necessary to develop a conscious awareness of how embodied knowledge/expertise and values have shaped the research process (Finlay, 2002; Stanley & Wise, 1993). This awareness of the researching self can be developed and accounted for by integrating a form of critical self-reflection known as reflexivity into the research process (Stanley, 1990).

Reflexivity can be defined as:

a confessional account of methodology or as examining one's own personal, possibly unconscious reactions. It can also mean exploring the dynamics of the researcher-researched relationship and how the research is co-constituted.

(Finlay, 2002. p536)

Finlay's (2002) definition presents reflexivity as a dynamic process that critiques the research process from two perspectives. When it is focused inward, reflexivity generates a conscious awareness of the researching self as it experiences/produces research. When it is focused outward, it produces knowledge and understanding of the social interactions, relationships and contexts affecting the research process (Stanley & Wise, 1993). Reflexivity supports the ethical conduct of research by attending to the bodies and bodily practices associated with experiencing/producing research (Finlay, 2002). The process provides a means of uncovering the dynamic relationship between embodied knowing and doing that is inherent in the research process, but does so in a way that avoids prioritising one over the other (Mol, 2006; Stanley, 1990).

On becoming a physiotherapist/researcher

I first became aware of physiotherapy at the end of the 1970s through a visit to the local department with my mother who was receiving treatment for a knee injury (see Appendix 2). Until then, my only experience of healthcare practitioners was of the doctors, nurses and radiographers who looked after me when I broke my wrist, and my GP who prescribed pills and potions to remedy the usual childhood illnesses. I remember being struck by the physical interactivity of physiotherapy practice and its emphasis on working with people to help them maximise their capacity for movement and function. Over 30 years later, I am still fascinated by physiotherapy's capacity to move/touch the lives of physiotherapists and their patients (see Chapter 3). I became a physiotherapy student in 1985 and qualified in 1988. This era in physiotherapy's history is marked by the pursuit of all-graduate entry and formal recognition of physiotherapy's status as a profession; and by the rise of neoliberal ideals and managerial discourses and practices that were

challenging the mode of professionalism that physiotherapy was seeking to construct (see Chapter 2).

My physiotherapy career has taken me on a journey across a variety of organisations and roles. Through my practice as a community paediatric physiotherapist and CSP Steward, CSP Professional Adviser and physiotherapy lecturer I have developed a growing awareness of the political nature of professional practice. Politics are present in the day-to-day practices of individual physiotherapists as they decide who gets what (treatment, grade on clinical placement, salary progression and so forth) why, how or when for example. Politics are also present in the workings of the collective body of physiotherapy in the gendering of its practices (see Chapter 2), or as it seeks to influence policy nationally and locally in ways that maintain and enhance its position in the market for example (Hugman, 1991; Larkin, 1983; Nicholls, 2008). The research process has helped me recognise that my attentiveness to the presence of personal/professional power relationships in practice is consistent with feminist ways of being/doing (Stanley, 1990). It is my interest in the politics of physiotherapy – as a dynamic practice and profession that have shaped the development of this research.

As well as providing familiarity with the social world that I am researching, my physiotherapy background means that I am accustomed to handling documents and conducting interviews. Documentary and interview data are an integral part of the problem-solving process that sits at the heart of contemporary physiotherapy practice (see Chapter 3). While the process of using documents and interviews to generate data may be familiar to me, my disciplinary background creates an epistemological/ontological tension in context of this research. As a physiotherapist, I have been socialised to conceive data as fact – something that was ‘true’ (whether objectively or subjectively) at the time the information was recorded (Parry, 1997). This epistemological position is consistent with the hypothetico-deductive mode of reasoning that sits at the heart of physiotherapy’s problem-solving approach (Higgs & Jones, 2000; Parry, 1997). Physiotherapy’s linear mode of hypothetico-deductive reasoning is epistemologically and

ontologically distinct from the dynamic mode of dialogic reasoning associated with interpreting and connecting accounts of practice to generate an historic account of becoming a practice profession (Kendall & Wickham, 1999; Stanley & Wise, 1993). The research process has therefore been a process of unlearning what had become a familiar way of thinking/doing, which has created space to explore alternative principles, perspectives and praxis as they apply to physiotherapy.

This short reflective account together with the content of Appendix 2 shows how physiotherapy becomes inscribed through training and subsequent physiotherapy practice (Foucault, 1988). The account explains how my interest in profession, practice and power shaped the focus of my research and signals how my 'physiotherapy-ness' affected the research and became affected by it (Blackman & Cromby, 2007). Having accounted for the influences of my personal identity/practice on the research, the next section of the chapter describes the research process.

A genealogical approach to constructing history

Foucault's genealogical approach is both an historical perspective and an investigative approach that constructs a critique of the present (Weedon, 1987). Genealogy rejects the notion of a single reality and pursuit of a universal truth (Kendall & Wickham, 1999). It adopts an epistemological position that recognises the existence of multiple perspectives and plural understandings that make up individuals' social realities (Ballinger & Cheek, 2006). It follows therefore that Foucault's genealogical approach challenges the idea of history as a process of discovering a linear chronology of facts, and conceives history as a process of uncovering a series of multiple possibilities (Carabine, 2001). Rather than taking a retrospective view of the past from the ever-growing distance of the present, genealogy traces the descent of a contemporary phenomenon as it appears in the past and moves into the present (Weedon, 1987).

As an investigative approach, genealogy attends to breaks in the chronological sequence of events and focuses on the discourses shaping and being shaped by the

bodies and bodily practices present in the situation (Carabine, 2001; Kendall & Wickham, 1999). Discourses

...are historically constituted bodies of knowledge and practice that *shape* people, giving positions of power to some but not to others. But they can only exist in social interaction in specific situations. So discourse is both action and convention. It is never just one or the other.

(Halberstam, 1998. p121. Emphasis in original)

Halberstam's (1998) definition focuses attention on the relationship between discourse and the performing body. Here discourse is presented as a creative force, something that can only exist in a specific time and place. While the definition acknowledges that Foucault's subjects are produced by discourse, they are not passive entities but are performing bodies with capacity for interaction and change (Kendall & Wickham, 1999). Following this line of thought, it can be argued that discourse and performance are not only inter-dependent but that discourse becomes integral to the identity/practice being performed (e.g. Butler, 1999; Connell, 2009; Mol, 2002). This notion of performativity (Butler, 1999) was presented in relation to gendered practices in Chapter 2. Drawing on critiques of Foucault's work on bodies and bodily practices (e.g. Butler 1999; Lorber, 1994; Mol, 2002), I am suggesting that Foucault's subject is a dynamic, reflexive entity that comes into being through the interaction of discourse and social processes, which themselves are specific to a given time and place.

From this perspective, Foucault's genealogy is a suitable approach for uncovering the dynamic interaction between the discourses and bodies experiencing/producing the process of becoming a profession over time. This approach to history provided a methodological framework for constructing an account of physiotherapy becoming a practice profession that accommodates the conceptual model of practice introduced in Chapter 3, and builds on the existing corpus of historical work while addressing some of its limitations. Genealogy's acceptance of plurality and its attention to the socio-political context from which situations emerge (Carabine, 2001; Weedon, 1987) reduced the risk of (re)producing a nostalgic descriptive account of physiotherapy practice (e.g. Barclay, 1994; Wicksteed, 1948). Its focus on the meeting and meshing of bodies

and discourses in practice reduced the likelihood of (re)producing a disembodied account (e.g. Dixon, 2003; Hugman, 1991; Larkin, 1983; Nicholls, 2010) that overlooks the bodily presence of physiotherapists experiencing/producing change (Carabine, 2001; Kendall & Wickham, 1999).

The genealogical process begins with a contemporary problem which creates a focus for undertaking an historical analysis of 'how' the present has emerged from the past as opposed to 'why' (Weedon, 1987). The contemporary 'problem' at the heart of this research is how the changing discourses and structures governing professional practice affect what physiotherapists can do in a given time and place (see Chapter 1 and 2). My aim was to trace the embodied processes of physiotherapy becoming a practice profession in order to uncover a relationship between physiotherapy's identity as a practice profession and the practising bodies of physiotherapists. Foucault's genealogical approach is text-based (Ballinger & Cheek, 2006). Having established a focus for the genealogy, the next step was therefore to identify sources of data and appropriate methods to generate text-based accounts of physiotherapy's past (Carabine, 2001).

Turning to the research methods literature (e.g. Atkinson, 1998; Crabtree & Miller, 1999; Finlay & Ballinger, 2006; Roberts, 2002), there were a number of potential approaches for generating historic accounts of practice including interviews, group work, official documents and records, and autobiographical texts (diaries, journals and personal correspondence). I chose to use two separate but inter-related sources of data to uncover the 'actions and conventions' (Halberstam, 1998. p121) shaping the process of physiotherapy becoming a practice profession. The first source of data was the CSP's qualifying curricula – documents that prescribe the design, delivery and content of physiotherapy training at a given point in time. The second source of data was generated by interviewing the products of the CSP's qualifying curricula – UK-trained physiotherapists who had a lifetime's experience of being/doing physiotherapy. The relationship between the documentary and interview data meant that my handling and analysis of data generated by one source/method informed my engagement with the other.

Rather than working as a linear sequence, the research became an interactive cyclical process of collecting, interpreting and connecting data from multiple perspectives which gradually uncovered the process of becoming a practice profession. This dynamic, dialogic process is represented in Figure 3.

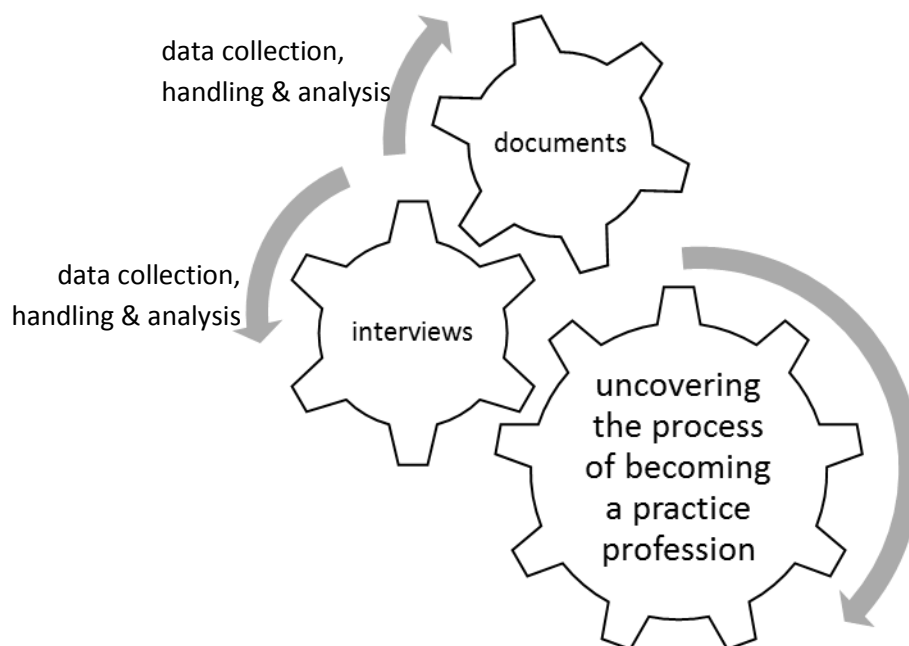


Figure 3: using documents and interviews to construct a genealogical account

The next section of the chapter describes the process and praxis of collecting documentary footprints and oral accounts of physiotherapy practice, and of processing those data to produce texts for analysis. Although each method is presented separately for clarity, I will draw attention to specific examples where data generated by my engagement with the documents shaped the interview process – and vice versa.

Research process and praxis

Collecting and processing documentary footprints of physiotherapy practice

To become a profession, an occupational group must construct its knowledge/expertise, organise its work and discipline its workers to produce autonomous problem-solving practice (Abbott, 1988; Freidson, 1970). In physiotherapy, this process can be traced through a range of text-based artefacts

published by its educational, professional and trade union body - the CSP. These publications include:

- CSP Rules of Professional Conduct - 7 editions published between 1971 and 2011
Publications that present the legal and ethical principles underpinning physiotherapy and the rules that govern the practice of chartered physiotherapists at a given point in time.
- CSP Standards of Practice - 4 editions published between 1990 and 2013
Texts establish measurable and achievable standards of practice and therefore offer a sense of what physiotherapy practice is like at a given point in time.
- CSP qualifying physiotherapy curricula - 9 versions published between 1945 and 2012.
Content defines physiotherapy, describes its knowledge/expertise and presents the pedagogic process of producing a physiotherapist ready to join the workforce at a given point in time.
- the Society's journal, *Physiotherapy* - published monthly between 1914 and 2003, and quarterly since 2004
Publication that presents research and scholarly articles (and items of news, CSP Council and Standing committee minutes, and advertisements for physiotherapy courses/events and jobs until late 1980s). Content describes developments in physiotherapy education, practice and research and physiotherapy's response to changing structures and organisation of physiotherapy practice at a specific point in time (see Chapters 2 and 3).

While all these publications were potentially relevant for uncovering the process of becoming a practice profession, I chose to use the CSP's qualifying curricula as a source of data for my research. The CSP's qualifying curricula are part of the CSP's quality assurance processes for accrediting training programmes that lead to a qualification to practice physiotherapy and eligibility to apply to join the state register (Thornton, 1994). Each curriculum articulates the CSP's expectations of

physiotherapy education in terms of learning outcomes, course structure and content, and how students' learning and competence to practice physiotherapy is assessed at a specific point in time (Tidswell, 1991). The CSP's qualifying curriculum is reviewed regularly to ensure that it is reflecting contemporary practice in physiotherapy and in education, and that it is producing physiotherapists who are fit for current and future practice (CSP, 2002; Thornton, 1994).

The CSP's qualifying curricula are official publications that shape and are shaped by the ongoing development of physiotherapy – as a practice and as a profession (Tidswell, 1991). As such, the curricula have a 'documentary status' (Prior, 2003. p2) and can therefore be conceived as sources that can be mined for research data. I accessed copies of the documents published between 1945 and 2002 from the CSP's Library and Information Services. A copy of the 2012 curriculum which became available towards the end of my documentary research period was downloaded from CSP's website (<http://www.csp.org.uk/documents/learning-development-principles>). This document was not included in my analysis because of the timing of its publication and the fact that I had been closely involved with its production (see Appendix 2).

Preparing the curricula for analysis

Although the CSP's qualifying curricula are presented as textual data, additional work was required to prepare them for analysis. As documentary data, the curricula

...are not neutral, transparent reflections of organisational or occupational life. They actively construct the very organisations they purport to describe. Analysis therefore needs to focus on how organisational realities are (re)produced through textual conventions.

(Atkinson & Coffey, 2011. p77).

As such, analysis of their content and the physiotherapy identities and practices presented by each curriculum document must be situated in its temporal and socio-political context (Prior, 2003). This process involves returning to the time, place and situations from which the document was prepared, produced and published. By attending to the social worlds from which the document emerged, the method addresses the epistemological/ontological tension produced as a document becomes the object of historic research (Prior, 2003). The method avoids the risks

of (re)producing descriptive nostalgia, and is consistent with Foucault's genealogical approach (Weedon, 1987).

Having established a chronological timeframe for my research, the first task was to familiarise myself with the socio-political contexts from which the curricula and the physiotherapists I interviewed emerged. This familiarity was developed by reading historic accounts and critical analyses of physiotherapy and the British Welfare State (e.g. Barclay, 1994; Bolton et al, 2011; Davies, 1995; Jones, 2005; Larkin, 1981; Nicholls, 2008; Rivett, 1998; Wicksteed, 1948). The outcome of this reading is presented by the chronological table in Appendix 3. The table maps significant events occurring within physiotherapy and external to it alongside a timeline of political ideologies. Although the focus of my thesis is 1945 to present date, the tabulated content stretches back to 1894 to provide a context for knowing the situation from which 1940s physiotherapy emerged. The visual presentation uncovers the dynamic rate of change occurring in practice, and a sense of whether change in practice was being led from within physiotherapy or external to it. In retrospect the process of developing this table was invaluable in developing a working memory (and a summarised reference point) of the changes occurring in physiotherapy. Although I had envisaged that this table would support the process of data analysis, it also became a useful aide memoire for sharing with interview participants at appropriate points in our conversation.

Although the CSP's qualifying curricula are presented as textual data, additional work was required to prepare them for analysis. This preparatory process transposed a collection of individual documents that were presented in a variety of formats (e.g. A5 booklet, spiral-bound brochure, digital pdf) into a single dataset describing the form, function, content and context of each document (Prior, 2003). The transposition began by reading and re-reading and annotating the curricula to become more familiar with their overall look, feel and content. From my initial reading of the 1945 – 2002 curricula, I could see that although they shared a common purpose (producing a qualified physiotherapist) and broadly similar structure (definition of physiotherapy followed by a syllabus) the content of each document changed over time. When read in isolation, each curriculum defines the

identity and practice of physiotherapy, and describes the educational process of becoming a physiotherapist at the time the curriculum was produced and published. When read as a chronological series, shifts in physiotherapy's knowledge/expertise and the organisation of its practice become visible.

My initial engagement with the curricula generated a dataset containing the following information:

1. Format: this section of the dataset aimed to summarise information about the physical presentation and production of the curriculum. These data included author (year of publication); document title; the personnel involved in preparing the document (where recorded); format/pagination; qualification associated with the curriculum (see Appendix 4).
2. Context: this section of the dataset aimed to describe the contextual factors shaping the preparation of the curriculum, its relationship with other documents and policies, and a general sense of the curriculum itself.
3. Summary of content:

Given the volume of information presented by each curriculum this section of the documentary dataset was divided into three inter-related subsections:

- a. 'definition of physiotherapy' contained a verbatim translation of the definition of physiotherapy as presented by the curriculum.
- b. 'eligibility-access' contained information about the admission criteria (academic requirements and personal attributes) and the number and location of training schools.
- c. 'knowledge/expertise' contained information about how the physiotherapy course was structured and organised, and the behaviours, knowledge and skills taught.

Conceptually, this structure provided a framework for exploring movement in physiotherapy's identity and practice from three perspectives: a. the identity of physiotherapy practice; b. the sociocultural identity of physiotherapy's collective body; and c. changing theory and skills associated with doing physiotherapy.

I chose to build, present and store the dataset for each curriculum as an MS Excel workbook. The software provided a quick and easy way of tabulating and annotating the data, and linking it to other texts as necessary – as shown in Figure 4.

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | |
|---|---|--|---|---|--|---|---|--|---|---|---|---|---|---|---|--|
| 1 | content (1945-1984)/goals of pre-registration education (1991)/outcomes (post 1996) | | | | | | | | | | | | | | | |
| 2 | 2002 | 1996 | 1991 | 1984 | 1974 | 1965 | 1955 | 1945 | | | | | | | | |
| 3 | 1. practice within core areas of physiotherapy | 1. enable individuals & groups to optimise their health & social wellbeing | 2. able to identify patients likely to benefit from physiotherapy while understanding the limits & scope of practice | The objectives of pre-reg education are to produce a physiotherapist able to: | on completion of the course, the physiotherapist will: | no learning outcomes listed - just curriculum content + regs for training. | Focus of content here seems to be about regulation for training & exams + cost of process | content of curriculum seems to be about providing knowledge of structure-function | | | | | | | | |
| 4 | 2. manage oneself & work with others to optimise results | 2. manage oneself & work with others to optimise results | 3. able to diagnose the problems of patients taking into account the physical, psycho-social, cultural & environmental factors, & use the results to plan appropriate intervention | [1] DEMONSTRATE a knowledge of, & an ability to apply an investigative approach to, academic & clinical subjects | 1. have a knowledge of the basic facts & theories mentioned in the syllabus & be able to understand & explain them | Can see why 1974 is such a turning point (Scholey's Founders' lecture 1984) | evidence of shift in anatomy/physiology section - no change in content, but notes about 'in outline only' suggesting that 1945 curriculum may have been too heavy on certain things | content++ about techniques. Clear use of 'input-based' approach to education - notes about number of hours of lectures/practicals required | | | | | | | | |
| 5 | 3. enable people to optimise their health & social wellbeing | 3. promote equality to all individuals in physiotherapy practice | 3. check legal framework of practice | [2] ANALYSE & ASSESS the physical, psycho-social & environmental state of the patient from a physiotherapeutic point of view | shift from ax as being about comparison with norm/individual (1974) to looking for wider implications... Check ICF | physical/psycho-motor skills assessed... Becomes 'implementation of programme' by 1984 | pathology & bacteriology | new section (compared with 1943 syllabus) about rehabilitation. Throughout the training - general principles of rehab should be borne in mind | | | | | | | | |
| 6 | 4. deliver physiotherapy in response to individual need | 4. deliver physiotherapy in response to individuals' need | 4. able to monitor the application of rx to ensure continuing use of appropriate modalities, the progression of rx, the revision of goals & the most appropriate time for the termination of rx | [3] SYNTHESISE knowledge & assessment of the patient to identify treatment objectives | 3. be able to examine & assess a patient by recognising deviations from the normal, & keep adequate records | Noteable absence - no ethics/professional etiquette in curriculum... Seems strange given timing (post PSM Act (1960)) | hydrotherapy integrated into qualifying programme (previously a separate qualification) | Rehab defined as: "Measures, ancillary to medical & surgical treatment, designed to assist the restoration of maximum function in sick & injured persons." | | | | | | | | |
| 7 | 5. promote equality to all in physiotherapy practice | 5. research & evaluate physiotherapy practice | 5. able to utilise appropriate methods of recording & communicating details of clinical diagnosis, rx application, progress & outcomes in accordance with medico-legal & pt rx requirements | [4] PLAN a therapeutic programme for each patient to achieve treatment objectives while recognising the involvement & priorities of other members of the health care team | 4. be able to select, plan & progress a treatment programme, & assess its effectiveness | | | Physio methods of rehab can be classified as follows: | | | | | | | | |

Figure 4: sample of knowledge/expertise subsection of curricula dataset

While the transposition of document to data may seem to reduce the richness and individuality of each text, in practice it supported my research praxis. The tabulation of data removed the official document that I had been disciplined to read as factual information and instructions about the content and organisation of physiotherapy teaching practice from the research field. The transposition of text helped me make the epistemological/ontological shift needed to see the curriculum as a document designed to construct particular ways of being/doing physiotherapy. The tabular (re)presentation of the curricula dataset also uncovered patterns, (dis)continuities and shifts in presentation, content and function of the curricula (Atkinson & Coffey, 2011). An example of these shifts can be seen in detail by returning to the table in Appendix 4 that presents the 'format' section of the documentary dataset.

By focusing on the middle column of the table in Appendix 4, shifts in the personnel preparing the curriculum appear, moving from medicine in 1945 to a combination of physiotherapists, managers and students in 1991. When read alongside the timeline of events presented in Appendix 3, the data in this column trace shifts in the role of medicine, management and service users in shaping physiotherapy practice. These shifts coincide with the account of physiotherapy's professionalisation and the changing construct of profession presented in Chapter 2. I used this process of layering and linking the changing curricula to key events occurring within and external to physiotherapy to inform which of the eight documents to include in the genealogical analysis.

Foucault's genealogical method attends to breaks in a trajectory and shifts in how practice is produced, which in turn provides a focal point for further exploration and analysis (Carabine, 2001). I chose the curricula published in 1945 and 1984. Both curricula are sited on the cusp of significant change to the organisation and delivery of the UK's healthcare system; from the emergence of a nationalised health service during the 1940s to its marketisation from the 1980s onwards (Rivett, 1998). The 1945 curriculum and its accompanying 40-page pamphlet (CSP, nd) detailing the massage, manipulation and movement techniques to be taught, represented a break from the past. It was the Society's first national physiotherapy curriculum, introduced to replace its examinations in massage and medical gymnastics (conjoint), electrotherapy and hydrotherapy (Wicksteed, 1948). The new curriculum was designed to standardise physiotherapy training across the UK and to produce a nationalised workforce of physiotherapists ready to meet the demands of the new NHS (Thornton, 1994).

The 1984 curriculum also sits at a point of transition and change occurring within physiotherapy and externally to it. The 1970s was marked by a growing scepticism about the authority of medicine and the capacity of the biomedical model to address the needs of contemporary society (e.g. Engel, 1977; Foucault, 1973; Illich, 1976). This period coincided with the rise of neoliberal ideologies and managerialism which would challenge the traditional mode of professionalism pursued by physiotherapy (see Chapter 2). The 1984 curriculum was the first

published following physiotherapy's acquisition of clinical autonomy in 1977, and was preparing the way for physiotherapy's pursuit of all-graduate entry (acquired in 1992) (Barclay, 1994). Physiotherapy's status as a profession/occupation in transit was marked by introducing the GradDipPhys to replace the MCSP (which had been in situ since 1945) as the curriculum's exit qualification (see Appendix 4).

Having selected the 1945 and 1984 curricula I created copies of both texts for annotation and discourse analysis. I will return to explain how both curricula were analysed later in the chapter. The next section of the chapter turns to my use of interviews as a method of generating oral accounts of physiotherapy practice.

Collecting and processing oral accounts of physiotherapy practice

The research interview is a space where experiences and knowledge are shared and meaning co-constructed through the interaction of interviewer and interviewee (Miller & Crabtree, 1999). Broadly speaking, the interview is a conversation that has a purpose and a structure (Kvale & Brinkman, 2009). Research interviews can take on many forms – from a highly structured list of standardised questions to the 'tell me about...' reflexive conversational interviews associated with ethnographic or phenomenological research (Finlay & Ballinger, 2006). The research interview provides an opportunity to work collaboratively with an individual to recollect, explore and understand the past in order to construct a history of the present (Fadyl & Nicholls, 2013). It is a flexible and portable research method that has capacity to capture embodied memories generated by individuals' experiences of being/doing over time (Finlay & Ballinger, 2006; Kvale & Brinkman, 2009; Miller & Crabtree, 1999). These qualities were closely aligned with my research aims, approach and methodology which confirmed my gut feeling that interviews were an appropriate method for this research. The process of undertaking research with human participants raises a number of ethical considerations, and a requirement to submit a research proposal to the School of Social Sciences Ethics Review Committee (SREC). My proposal was reviewed and approved in June 2008 [SREC/375]. The application process created a space to think critically about how the regulatory standards governing my practice as a physiotherapist (HPC, 2007; 2008) would address the ethical issues associated with interview research.

Ethical considerations

As a research method, interviews raise specific questions about the ethics of selecting and accessing participants; the nature of the researcher-participant relationship; and the processes used to collect, handle, store and represent data that relates to individuals' personal and professional identities and practices (Kvale & Brinkman, 2009). These ethical issues of equality of opportunity, balance of power and consent, confidentiality and data management, and duty of care were familiar from my physiotherapy practice. They are addressed by the British Sociological Association's (2002) statement of ethical practice, and by the standards (HPC, 2007; 2008) in place to regulate physiotherapy practice in the UK, including the practice of physiotherapists such as myself engaged in research. While the BSA's (2002) statement does not have the same legal status as the standards regulating my physiotherapy practice, it enabled me to think critically about how my professional responsibilities as a physiotherapist applied to the process of experiencing/producing social science research.

The data generated by the research interview depend on the quality of the interviewer-interviewee relationship which is itself shaped by the interview purpose, structure and the social context in which the interaction is occurring (Kvale & Brinkman, 2009). Following this logic, the process of knowing, and of coming to know is situational – located in a specific time and place (Miller & Crabtree, 1999). From a feminist perspective, the situated nature of knowing and coming to know associated with the research interview means that ethics becomes an integral element of research method, analysis and praxis (Stanley, 1990). Rather than separating ethics from method and praxis, they are presented and discussed together. The next section of the chapter explains how I selected and recruited participants before moving on to reflect on the design and praxis of the interviews, and the preparation of interview data for text-based analysis.

Sampling, access and recruitment

My concern at the outset of this project was to ensure that my research was drawing on information-rich sources from across the breadth of the profession (Miller & Crabtree, 1999) – both in terms of its clinical specialisms and its

occupational roles (see Appendix 1). The majority of the physiotherapy workforce has traditionally been employed in clinical practice with a small but growing minority working as physiotherapy managers, educators or researchers (Barclay, 1994). My initial thought therefore was to adopt a sampling strategy that reproduced the occupational profile of the physiotherapy workforce – as a means of understanding how becoming and doing physiotherapy was like from a variety of perspectives. As I developed a deeper understanding of the dynamic and situated nature of professional identities and practices (e.g. Butler, 1999; Halberstam, 1998; Lorber, 1994), I came to see the limitations of using what is in effect a socially constructed occupational framework to inform my sampling strategy (Foucault, 1988). Rather than risk data overload and the imposition of contemporary structures on identities and practices that were performed in the past, I adopted an inclusive sampling strategy that focused on the length of an individual's physiotherapy career, not on their occupational role. I was therefore able to trace the development of physiotherapy practice (both as an individual and as a collective professional body) through the experiences of physiotherapists whose careers spanned a period from the late 1940s to the present day.

As a CSP member I have access to the Society's professional networks and communication tools. My recruitment strategy was informed by discussions with members of the CSP's Retirement Association (CSPRA) in November 2008. The CSPRA is a professional/social network for chartered physiotherapists who have retired from paid physiotherapy employment. Despite being of retirement age, many CSPRA members remain actively engaged in the social world of physiotherapy practice through their voluntary work and ongoing involvement in CSP activities and events. The group, who were supportive of my research, advised me that *Frontline* (the CSP's fortnightly magazine) was well-read by older members of the profession, and that a growing number of their network had access to email. Following this advice, I posted a notice in *Frontline* (03.06.09) inviting physiotherapists who trained during 1940/60s to contact me (by post, e-mail or telephone) for further information about the project. My call in *Frontline* generated 28 responses. These individuals were sent an information letter (see Appendix 5) outlining the project and inviting them to contact me if they needed further information or wanted to

participate in the research. Fourteen of the 28 physiotherapists who had expressed an initial interest agreed to participate in the research. This number fell to twelve once the interview dates were planned because of individuals' availability (a long vacation and relocation overseas).

A summary profile of the twelve participants is presented as a table in Appendix 6. I have sought to protect participants' identity as far as possible by the use of pseudonyms and reflexive disclosure of information (Coffey & Atkinson, 1996) about place/time of training, clinical specialism and occupational role. Although I had dismissed a purposive sampling strategy, Appendix 6 shows that participants' experiences of physiotherapy covered a variety of clinical specialisms, practice settings (hospital, community and private practice) and occupational roles (clinical, academic [education/research] and managerial). The gender profile of participants is more heavily weighted towards men than the gender profile of physiotherapy would have been during the 1940/60s when participants qualified. The three male participants were typical of their generation having started physiotherapy training as mature students, either via the Armed Forces [Derek and Frederick] or via one of the handful of training schools that accommodated men [Michael] (see Chapter 2). The remaining nine participants were women, who like other female physiotherapists of their generation had entered physiotherapy training on leaving school (Barclay, 1994). Six of these nine women had trained in one of the ten Physiotherapy Schools in London, and the remaining three had trained in the northern cities of Liverpool [Fran], Manchester [Pam] and Sheffield [Jane].

Four participants were subject to the CSP's first national curriculum which was published in 1945 and was designed to produce a physiotherapy workforce for the new NHS (Thornton, 1994). The other eight trained under the CSP's 1955 curriculum which was very similar in content and design to the 1945 curriculum and was in force until 1965. Eight of the twelve participants had retired from regular physiotherapy practice at the time of the interviews. Two of the younger participants [Fran and Michael] were still engaged in successful private practices, and a further two [Derek and Hilda] had recently stopped their unpaid physiotherapy practice in the voluntary sector. Collectively, participants'

experiences of physiotherapy spanned a period of over sixty years - from 1947 to date. When placed alongside the history of physiotherapy practice, this timeframe is significant. Participants' careers would have been evolving through the development of the NHS following its introduction in 1948, the professionalisation of physiotherapy during the 1970/80s and the more recent changes occurring to the organisation and structure of physiotherapy practice (Chapters 1 and 2).

Interview design

The primary purpose of the research interviews was to collect physiotherapists' experiences of being/doing physiotherapy over time and to create space for reflecting on how they related to the history of physiotherapy. Physiotherapists' embodied and temporal accounts of experiencing/producing physiotherapy practice were key to understanding how discourses, bodies and bodily practices meet and mesh in practice settings to determine what physiotherapy can become. Having established a purpose, the next step was to design an interview process that had enough flexibility to accommodate individuals' experiences; alongside a focus on being/doing physiotherapy, while being culturally and socially appropriate so as to maximise the quality of the interaction (Kvale & Brinkman, 2009). Returning to the methods literature (Atkinson, 1998; Crabtree & Miller, 1999; Finlay & Ballinger, 2006; Kvale & Brinkman, 2009; Roberts, 2002) there were two interview approaches that could potentially meet the needs of my research.

The life history interview and the depth interview have a similar structure and process: both use open verbal questions to generate, analyse and evaluate accounts of an individual's life experiences (Atkinson, 1998; Miller & Crabtree, 1999). The differences appear in the interview focus and interaction, and in the texts they generate. The life history interview offers an open space to collect a description of a person's life journey which generates a stand-alone biographical narrative record (text or voice recording) presented in the participant's own words (Atkinson, 1998; Roberts, 2002). The depth interview is focused on a specific topic or phenomenon, which provides some containment for recounting and reflecting on past experiences, and generates a text that makes the interviewing process and co-construction of history transparent (Miller & Crabtree, 1999). Although the idea

of the life history was appealing, some elements of the approach created discomfort - as this note from my research diary (07.2007) shows:

Do I need to know about someone's whole life span in order to understand how their physiotherapy practice evolved? Do I have capacity (skills and time) to collect, analyse and represent individuals' life stories in the ways suggested by Roberts (2002) and Atkinson (1998)? Does the removal of the structure/prompts that facilitated the generation of data (Roberts, 2002; Atkinson, 1998) mask the process of co-constructing history occurring within the interview? That seems inconsistent with a genealogical approach that focuses on how history is made...

These misgivings led me to choose depth interviews as a method that provided space for the guided journey associated with life history work (Miller & Crabtree, 1999; Roberts, 2002) and for working with participants to explore their personal journey in relation to physiotherapy. The focus offered by depth interviewing reduced the risk of data overload, while the text generated by the interviews reduced the potential methodological tension by ensuring that the process of co-constructing accounts remained transparent, and that the lived experience of physiotherapy was not lost in translation (Butler, 1999; Fadyl & Nicholls, 2013; Finlay, 2006; Kvale & Brinkman, 2009).

Interview praxis

As a research method, the depth interview has a recognisable structure and focus that generate accounts of practice, personal opinions and perspectives, and provides opportunities to explore the lived experience of being/doing (Kvale & Brinkman, 2009). As a result, no one interview is identical to the next – it is a process that unfolds as the interviewer and participant respond reflexively to the interview situation (Miller & Crabtree, 1999). The 'success' of the interview in generating data depends on the interaction of interviewer and participant and their capacity to work together to explore a topic or phenomenon of mutual interest (Kvale & Brinkman, 2009). I knew from my physiotherapy practice about the affective and cognitive body work required to engage in reflexive conversations with relative strangers. I was also keen to create space for reflection throughout the research process and so adopted a staged approach to interviewing (Hagelund 2004; Miller & Crabtree, 1999).

The first stage of interviewing was focused on establishing a relationship with the participant and working with them to generate an account of being/doing physiotherapy practice over time. This descriptive, story-telling stage was followed six to twelve weeks later by a reflective/analytic interview focused on verifying and unpacking data generated from the first stage and relating it to the developments in physiotherapy as a practice profession. This staged approach to interviewing minimised the risk of interview overload for both parties and created space to reflect on the data generated as the research was in progress. The interview schedules for both stages (see Appendix 7) were designed to provide a personalisable structure and focus that characterises the method (Miller & Crabtree, 1999).

Twelve sets of depth interviews were conducted between April 2009 and August 2010. The interviews were conducted in a location of the participants' choice. These ranged from public (e.g. coffee shop, hotel lounge) and semi-public (e.g. golf club, physiotherapy clinic) spaces to the privacy of participants' homes. These locations were conducive for developing the collaborative interpersonal relationship associated with the method (Miller & Crabtree, 1999). Interviews became a research conversation conducted over a cup of coffee, and in some cases depending on the timing of the interview and participants' availability were followed by a light meal together. Each interview was recorded with the participant's consent on an Olympus DM-1 digital recorder. These recordings were transcribed verbatim and shared with the participant for verification (Crabtree & Miller, 1999). The digital audio recording was supplemented by a written record of non-verbal cues, points of specific interest, new ideas generated by conversation, 'door-handle' information and reflections of the interview (Kvale & Brinkman, 2009) which were typed up after the interview. All data (audio and text) generated were stored securely on a password-protected computer in accordance with the Data Protection Act 1998.

As the interview schedule in Appendix 7 shows, the first stage interviews were effectively a grand tour (Miller & Crabtree, 2009) of the participant's physiotherapy career. These interviews lasted for between 70 minutes and 2 hours. The length

and number of each interview and the number required to capture a participant's account depended on nature of their career, their communication style and interaction with the interview process. My role during these interviews was as a facilitator and active listener, offering guidance, reassurance and prompts required to enable the participant to (re)construct their past in the present (Hagelund, 2004; Kvale & Brinkman, 2009):

- H: It was 1947. I was seventeen [G: right] and it was really a bit under the age for training. Because the training was three years... and I would qualify when I was twenty, and you needed to be twenty-one to qualify [G: really?] So erm, I went into physiotherapy training with Miss Farquharson who, had an establishment in [laughs] oh my goodness - in London. It's not there any more. It was a private establishment [G: right] and not attached to a hospital. And erm, some of my fellow students were gentlemen who'd come out of the army, who were sponsored by the Government to do a training [G: of course]. And interestingly enough, I mean, and some of them were a lot older, but I've never ever seen another name that I knew from my training in any journal or - I mean sometimes the girls particularly get married and you don't recognise them [G: mmm], but there were a lot of men there and I've never seen them er; in, produce anything or, or organise anything. I think some of the men particularly were interested in sport [G: right], but of course the sports physiotherapy wasn't developed like it is now [G: no]. So I went through my training and erm, I don't know if you want to...?
- G: I was about to say, what was that training like? Because you've got the syllabus here!
- H: It was in a big house [G: right]. It was one of these big erm, I don't know, how old it would have been, but it had 3 storeys I think and a basement. And the lectures were in what would have been the large front room I suppose, but it was a very big room. It would have been about as big as this area [a space of about 20 feet square]....
- G: Goodness! So how many of you were there – roughly?
- H: Erm, I think she had three, three years [G: right]. And in our year, I suppose there were about fifteen [Hilda continues her account of physiotherapy training]

This data extract from the first interview with Hilda follows on from my introductory preamble which was designed to establish ground rules and create a mutually safe space that supported the conduct of the interview (Kvale & Brinkman, 2009). Having established her consent to participate in the research, I invite Hilda to tell me about her experience of becoming a physiotherapist. Hilda's opening lines in this extract establish the temporal, personal and social/cultural situation from which her story will unfold (Roberts, 2002). Having set the context for her story of

becoming a physiotherapist, Hilda pauses to seek reassurance from me that her account is significant to both of us (Coffey & Atkinson, 1996). Hilda's response illustrates the process of switching roles from being a listener to becoming a narrator (Roberts, 2002), while my inflections and prompts illustrate the process of 'assigning competence' (Miller & Crabtree, 1999. p105) as we switch roles, and of facilitating the flow of data. The extract also illustrates the potential of the depth interview for generating rich, vivid and detailed accounts (Kvale & Brinkman, 2009) of what being/doing physiotherapy was like in a given time and place.

Although I was familiar with using interviews to generate data about people's lived experiences from my physiotherapy practice, the richness, immediacy and significance of participants' accounts created tensions for my interview method:

An enjoyable but nerve-wracking process. The interview schedule worked well. Glad I'd prepared a script for the introduction – helped to have a structure to get the interview going. I'm worried that I talk too much. Susie's stories were very real – I just kept wanting to jump in and ask for more information about what she was saying there and then. Need to find a way of managing the balance between listening & probing for clarity/detail without imposing my questions on the story-telling space.

This note made following my first research interview in April 2009 describes the affective body work of that first research interview, and the discomfort of performing a familiar task (interviewing) in an unfamiliar role (researcher). While my desire to jump in could have been interpreted as the genuine interest and enthusiasm for what I was hearing, it also risked compromising the interview relationship by undermining the story-teller's assigned competence (Miller & Crabtree, 1999). I learnt from that interview with Susie to use my interview notepad more effectively to document questions that occurred to me as stories were unfolding rather than verbalising them in the moment. This adjustment enhanced the flow of subsequent interviews and provided a list of questions and topics for follow-up at a more appropriate point in the interview process.

The second stage interview created space to verify and make sense of the accounts generated during the first stage (Finlay, 2006), and to explore how individuals'

experiences of being/doing physiotherapy related to the evolution of physiotherapy's identities and practices over time (see Appendix 7). These interviews lasted for between 55 minutes and two hours and were recorded, transcribed and processed in the same way as previous interviews. The second stage interviews were collaborative and discursive, and focused on the process of linking and legitimating data and meaning emerging from preliminary analysis (Crabtree & Miller, 1999). The interview space became like a cutting room (Denzin & Lincoln, 2011): a place where transcripts and living memories were brought together with data from physiotherapy's historic accounts and the qualifying curricula (see Appendix 1, 3 and 4) to begin building an embodied account of the process of becoming a practice profession. This process generated new ideas and stories as well as legitimating existing ones, as can be heard in this extract from the opening lines of the second stage interview with Derek:

- D: Well it [the transcript] talks about gender issues. I've been conscious ever since I started to be a physio, because of social attitudes, and because men are men, there's always been the risk or suspicion that if anything was thought to be inappropriate, where have I gone now? Yes, people will invariably think, he probably did because he's a fella. And, that's fair enough because chances are that's right.
- G: But is it?
- D: Well I don't know you see, there were one or two scandals where men have behaved inappropriately, and I don't remember any where a female physiotherapist took advantage of a male patient... [shares an account from his managerial practice of delegating work to reduce risk of male staff being wrongly accused of inappropriate behaviour].
- G: That's interesting because that's one of the things I was going to ask you to talk to me about. Because that's what really struck me from the transcript was gender. [prompts to affirm Derek's observations and open a dialogue about gender in practice]
- D: It's just occurred to me that now that we're open with our sexuality, it might be that females are slightly more at risk from same sex lesbian patients...?
- G: Have you come across that?
- D: No, no, just this very minute I'm trying to think around the subject, and well, what if?... Now that we've mentioned it, there was one occasion. Did I tell you when I was in... [shares an account of being inappropriately touched by a male patient in a clinic setting in the Middle East].

This extract illustrates the nature and depth of discussion that typified the second stage interviews. Derek's opening line presents his analysis of the transcript I sent, which unbeknown to him affirms my interpretation of the same data. Our common

understanding of the significance of sex and gender in his practice gives us both permission to begin uncovering the topic, which in turn generates fresh memories of doing gender (Lorber, 1994; West & Zimmerman, 1987) from Derek's managerial and clinical past.

At the outset of this research, I planned to develop and maintain an interactive website/blog as a way of sharing the accounts and exploring themes, and verifying my analysis with a wider community of physiotherapists (see Appendix 5). I quickly came to see from experience of the first two sets of interviews that my proposal to develop a website was becoming redundant. The data generated by the interviews together with participants' capacity to work with me to develop linkages across the datasets proved so rich that developing a project website/blog would have compromised the research process rather than complementing it. I can see in retrospect that my desire for verification of my analysis from peers outside the research was generated by physiotherapy's positivist epistemology/ontology (Parry, 1997) which at that point in the project I had not yet distanced myself from. Following discussion with my supervisors, I did not pursue my original plan to develop a project website/blog to support the research process.

Analysing documentary footprints and oral accounts of physiotherapy practice

The documentary data from the curricula presented a static snapshot of being/doing physiotherapy in 1945 and in 1984 (Prior, 2003). Both curricula offered a definition of physiotherapy, a detailed description of its knowledge/expertise and where physiotherapy it was practiced and with whom, and an overview of the process of producing a physiotherapist – from entry into training to final examination. In addition, the CSP's 1945 curriculum carried a separate instruction manual (CSP, nd) specifying the massage, manipulation and movement techniques to be embodied by students through their physiotherapy training.

The interview data offered rich vivid accounts of physiotherapy practice from the 1940s onwards expressed in participants' own words. This dataset offered a sense of what becoming a physiotherapist and of experiencing/producing physiotherapy practice felt like, and what that meant to physiotherapists and the people they

worked and lived with. The data described the bodily experiences of being/doing physiotherapy (embodiment), their relationships with other bodies (relationality) and how their practice was structured and organised (Blackman, 2008; Mol, 2002). Despite being subject to almost identical qualifying curricula (Tidswell, 1991) and professional governance structures (see Appendix 3) the interview data describe practice that was recognisably physiotherapy while being distinct to the individual. I heard stories about practice in hospitals, clinics, people's homes and their workplaces from across the UK and overseas. I also heard what it was like to move from being/doing clinical practice to become a manager, a physiotherapy teacher, or researcher, or combinations of those practices (see Appendix 6).

Conceptually the data collected from the curricula and interviews were distinct. The documentary data generated a static account or snapshot of being/doing physiotherapy at the time the curriculum was produced and published (Prior, 2003) while the interview data presented embodied memories of being/doing physiotherapy that are reproduced in the present (Crabtree & Miller, 1999; Sheets-Johnstone, 2009). Rather than being problematic, the perspectives generated by the temporality of the data were harnessed positively and critically to explore a situation or emergence of a phenomenon from multiple perspectives (Crabtree & Miller, 1999). When handled reflexively, this plurality provided a means of unwrapping the multiple layers that make up the embodied complexities of physiotherapy practice (Kell & Horlick-Jones, 2012; Rose, 1999) as it evolved over time. As well as this movement across time, the curricular and interview data also provided insights of the process of becoming a practice profession at three different levels. The curricula are focused on the process of producing a national physiotherapy workforce (macro-politics), while physiotherapists' accounts of practice offered a window on the politics of being/doing physiotherapy at an organisational (meso-) and an individual (micro-) level. Together the curricula and interview data created opportunities to build an historic account that is multi-dimensional and dynamic – a montage of the process of becoming a practice profession (Denzin & Lincoln, 2011).

Analytic perspectives: discourse and phenomenology

The 1945 and 1984 curricula were subject to a Foucauldian discourse analysis, while the verbatim transcripts were subject to Foucauldian discourse analysis and a phenomenological analysis (Ballinger & Cheek, 2006; Larkin et al, 2006).

Foucauldian discourse analysis offered an outside-in perspective for exploring how discourses operate to produce certain identities and practices in particular situations (Ballinger & Cheek, 2006). The phenomenological analysis focused on what reality feels like and what that means (Finlay, 2006). It therefore offered a way of recognising, articulating and understanding things that are taken-for-granted or previously hidden in the practice setting (Larkin et al, 2006). Both analytic perspectives recognise the importance of language as a means of simultaneously describing and producing reality (Larkin et al, 2006). Moving from one approach to the other involved moving from an epistemological/ontological position where the subject is the originator of discourse and language (phenomenology) to a position where discourse and language is conceived as something that produces the subject (Larkin et al, 2006). By using discourse and phenomenological analysis together I was able to explore how physiotherapy's structured and lived bodies interact to experience/produce the process of becoming a practice profession over time (see Chapter 3).

Analytic process

The analytic process began by reading and re-reading a text to familiarise myself with it (Crabtree & Miller, 1999), before interrogating it for evidence of discourses (curricula and interview transcripts) and lived experiences (interview data) of being/doing physiotherapy. This process and a sample of the prompts I used to explore the data from both perspectives are presented in Figure 5.

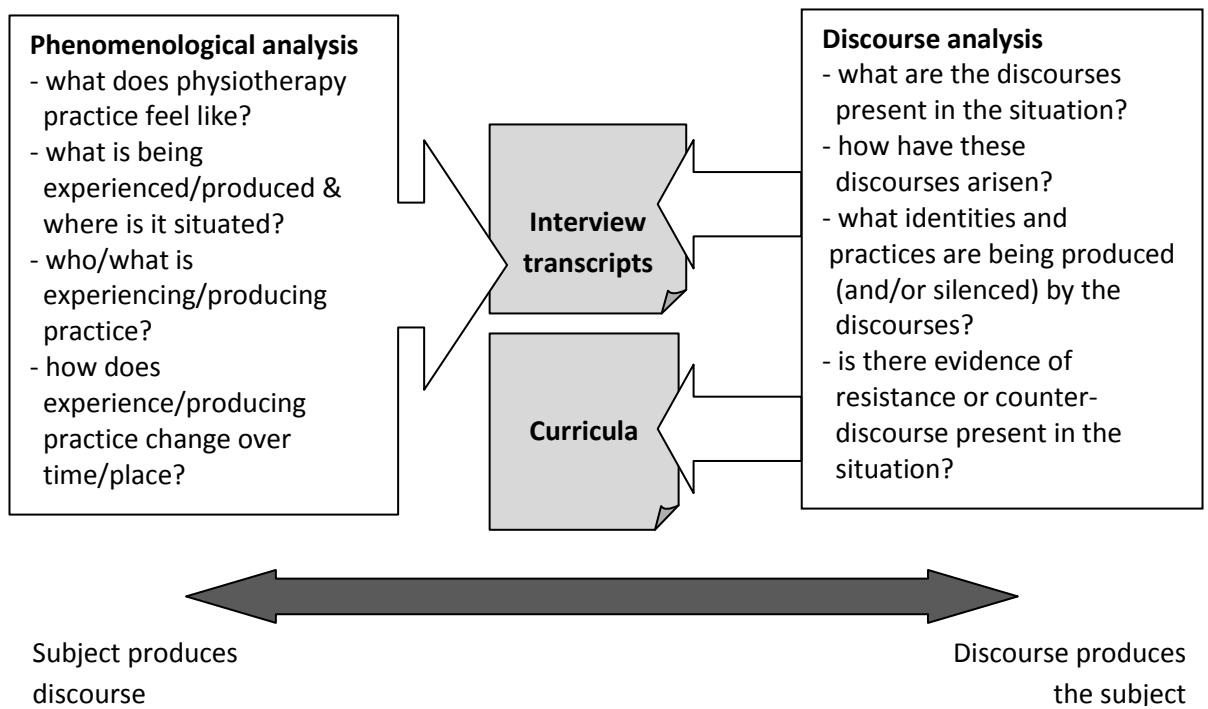


Figure 5: analysing data from two perspectives (Ballinger & Cheek, 2006; Finlay, 2006; Larkin et al, 2006).

The analytic process of reading, re-reading, analysing and annotating texts began with a Foucauldian discourse analysis of the curricula. In Foucauldian terms, the content and design of qualifying curricula are discursive – working to produce and maintain physiotherapy subjects who are fit for future practice (Foucault, 1988). Using the prompts presented in Figure 5, I attended to what the body could know and do, and how the knowing/doing body was disciplined to know and do certain things over forms of identities and practices (Ballinger and Cheek, 2006; Carabine, 2001).

This first stage of analysis produced an account of the identities, knowledge/expertise, bodies and practices produced by the 1945 and 1984 curricula. These accounts were brought together to look for (dis)continuities and shifts in what was being produced and for evidence in the accounts of becoming a practice profession. This second phase of analysis was informed by Abbott (1988) and Freidson’s (1970) observations that profession is recognised by its members’ capacity for autonomy and capacity to enact the diagnosis – inference – treatment sequence associated with problem-solving practice. This second stage of analysis uncovered the process of moving from being a handmaiden to medicine in 1945 to

becoming a practice with capacity to diagnose and treat independently of medicine in 1984. The final stage of the analytic process involved revisiting the circumstances, events and socio-political contexts of the 1940s and 1980s (see Chapters 2 and 3, and Appendix 3) to produce a genealogical account of becoming a practice profession. This account is presented in Chapter 5.

Having analysed the curricula, I turned to explore the data presented by the interview transcripts using the prompts described in Figure 5. The Foucauldian discourse analysis of the interview data focused on how the discourses running through physiotherapists' accounts of practice produced and shaped the bodies and bodily practices of physiotherapists and their patients (Ballinger & Cheek, 2006). The phenomenological analysis involved working systematically through the interview data looking for the appearance of a feeling moving body in the text, then using the prompts in Figure 5 to describe what it was experiencing and becoming through its interactions with the practice environment (Finlay, 2006; Merleau-Ponty, 1962). As a physiotherapist I was able to relate directly to some of the artefacts, techniques and circumstances presented by the data – the warm humidity of the hydrotherapy pool, the smell of a sluice room, the anxiety generated by 'bad news'. My familiarity with the practice created a tension. What was I analysing - the experience presented by the data or my embodied reaction to it? This tension was addressed by becoming aware of the personal memories generated by the data, and having recognised their presence, putting them to one side to refocus on the body appearing in the text – a process known as bracketing (Finlay, 2006).

This first cycle of discourse and phenomenological analysis generated a series of situated accounts of how being/doing physiotherapy was experienced/produced by the CSP's qualifying curricula and by the bodies of practising physiotherapists (Carabine, 2001; Finlay, 2006). The process of exploring an account from two perspectives is illustrated by this analytic memo from an account generated during the first interview with Jane.

...you would go to all the patients that needed going, sort of going 'round and 'round. And I can remember, when I was working with one patient, I was being shadowed by a woman who wanted to come back to physio after having about five years off for her kids. This old boy there – got an awful chest. And I was doing shaking and vibrations on him. And she said “I don’t think I’ll ever do that” she said “You’ll kill him” I said “But he’ll die if I don’t! So you’ve got no alternative.” And she said “I’m not coming back.” I said “but you don’t have to do this. Go onto maternity. Or go and do something else” you know. But she never did come back.

Situation:

Here Jane is describing her experience of working on the wards at her local hospital during the early 1970s. She is being shadowed on this particular day by a physiotherapist who is seeking to return to physiotherapy practice having taken time out to raise a family.

Phenomenological analysis (underlined text):

Jane’s body experiences physiotherapy as being/doing a physically dynamic practice – both in terms of the location of the practice (‘round and round’) and the work done (‘shaking and vibrations’). Jane’s experience of moving around the hospital site suggests that she works with wide variety of patients. She is potentially free to move because she does not need any specialised equipment? On this particular ward, Jane is experiencing/producing the dirty manual labour of helping an older patient expectorate the phlegm associated with an ‘awful chest’ (Twigg, 2006). Having attended to the patient, Jane turns to the physiotherapist shadowing her practice which shifts the focus of the action from the embodied dirty work of clearing a chest to a conversation with her peer.

Discourse analysis (highlighted text)

Two discursive acts: Jane - the patient; Jane - the shadowing physiotherapist. As Jane approaches the body-as-machine discourse associated with medicine (Turner, 1992) produces ‘an awful chest’ - the object of Jane’s physiotherapy. Having established patient-physiotherapist identities, Jane’s dialogue with her peer shifts attention to the nature of physiotherapy practice. The discourse of risk (‘you’ll kill him’) established by the shadowing physiotherapist is pitted against duty of care (he’ll die if I don’t) – which is the position that Jane adopts (‘so you’ve got no alternative’). Jane manages the tension by attending to the alternative forms of practice (you don’t have to do this) which in turn constructs physiotherapy as being a practice that has specialisations (‘maternity’, ‘something else’). The risk-averse physiotherapy identity/practice is silenced – the shadowing physiotherapist does not return to practice.

What practice is being experienced/produced?

In this ward situation, physiotherapy is experienced/produced as a physical, embodied (no equipment) practice that is both clean (conversational) and dirty (clearing phlegm). It has capacity to move across the hospital site. The absence of equipment and potential breadth of Jane’s embodied practice seems to challenge

the notion of specialisation - acquisition and organisation of advanced theoretical knowledge and technical skills in a specified area (Freidson, 1970). The tension between Jane's experience (generalised physiotherapy practice) and her construction of physiotherapy as a specialised practice could suggest that physiotherapy's specialisation is a work-in-progress at this point in time? (confirmed by the table of professional networks in Appendix 1). Jane's reference to patient's 'that needed' suggests that she is not the person making the decision, but her freedom to move suggests that she decides when patients are treated, and what that treatment is (Jane confirms this later in another account).

As this analytic memo shows, my analysis of the interview transcripts generated a collection of snapshots of a physiotherapist experiencing/producing physiotherapy practice in a particular time and place. These snapshots of practice were interrogated further for evidence of how the practice experienced/produced by individual physiotherapists related to the professional identities/practices produced by the curricula at a specific point in time. This stage of analysis uncovered the dynamic process of becoming a physiotherapist during the 1940/60s which is presented in Chapter 6. The final stage of the analytic process involved working with the collection of snapshots to look for linkages, (dis)continuities and contradictions between them – not as a way of seeking to make generalisations about practice, but as a way of building a multi-dimensional embodied account of being/doing professional practice in physiotherapy over time. This montage of physiotherapy practice is presented in Chapter 7.

Conclusion

This chapter has presented a reflexive account of the process of researching my own profession. I have described the genealogical approach to producing a history of the present and made the case for using documents and interviews as complementary methods for generating an embodied account of the process of becoming a practice profession. The chapter traces the research process and my praxis – from collecting text-based footprints and physiotherapists' oral accounts of being/doing physiotherapy over time to the conduct of discourse and phenomenological analysis of documentary and interview data. I have illustrated the process with snippets of data from the interview, my research diary and analytic memos to uncover the research process and how I was affected by it.

The combination of methods and analytic perspectives generated multiple accounts of experiencing/producing physiotherapy practice at a specific place and time, and over time. These accounts were linked and layered to generate an embodied montage that traces how physiotherapy has become a practice profession over time. The layering process begins in Chapter 5 which presents a genealogical analysis of the discourses, events and circumstances shaping the process of becoming a practice profession.

Chapter 5

Constructing a practice profession

Diagnosis, treatment, inference and academic work provide the cultural machinery of jurisdiction. They construct tasks into known 'professional problems' that are potential objects of action and further research. But to perform skilled acts and justify them cognitively is not yet to hold jurisdiction. In claiming jurisdiction, a profession asks society to recognize its cognitive structure through exclusive rights; jurisdiction has not only a culture, but also a social structure.

(Abbott, 1988. p59)

Physiotherapy has historically pursued a traits-based model of professionalism (Elzinga, 1990; Hugman, 1991). In less than fifty years, physiotherapy moved from being a technically competent handmaiden to medicine to become what has been argued to be a technically autonomous profession whose practice is regulated by the State (Barclay, 1994). This journey was shaped by physiotherapy's relationship with medicine and the State – as an employer since the 1940s, and as a regulator since the 1960s (Larkin, 1983). This chapter draws on the CSP's qualifying curricula 1945 – 2010 to understand how physiotherapy has reconstructed its knowledge/expertise and reorganised its practices to become a practice profession. The chapter is informed by sociology of profession (see Chapter 2) and the body (see Chapter 3), and is situated within an established work within healthcare that uses a Foucauldian approach to understand contemporary professional/organisational practices and identities.

The analysis is based on the argument that professional work is characterised by its autonomy (Freidson, 1970) and capacity to enact the diagnosis – inference – treatment sequence associated with problem-solving practice (Abbott, 1988). This analytic process unwraps the practices constructed by the physiotherapy curricula from the outside in (see Chapter 3). Conceptually, physiotherapy's capacity for autonomous and problem-solving practices are most likely to emerge from the innermost layers of the curriculum, expanding and becoming visible as an occupation becomes recognised as a profession (Abbott, 1988; Davies, 1995). The analysis begins by situating a curriculum in its temporal and socio-political context. It then moves on to analyse the curriculum's construction of physiotherapy practice by beginning with the curriculum's definition of contemporary practice. The insights

developed from the outer layers of the curriculum provide a context for exploring how physiotherapy's knowledge/expertise are structured and organised to produce the identities and practices presented by the curriculum's definition. This analytic process provides a means of uncovering the dynamic process of becoming a practice profession.

The chapter draws on a genealogical analysis of the CSP's qualifying curricula to trace the events, circumstances and discourses that have produced contemporary physiotherapy practice (Carabine, 2001). As documentary data, the CSP's qualifying curricula are a statement of physiotherapy's knowledge/expertise, and the pedagogic processes that produce a physiotherapist at a given point in time (Foucault, 1988). The curricula are reviewed regularly to ensure they are producing a physiotherapy workforce that is able to provide solutions for contemporary problems (Barclay, 1994; Freidson, 1970). The 1945 and 1984 curricula were selected for analysis because they represent breaks in the process of becoming a practice profession (Carabine, 2001). Both curricula are sited on the cusp of significant change to the organisation and delivery of the UK's healthcare system; from the emergence of a nationalised health service during the 1940s to its marketisation from the 1980s onwards (Rivett, 1998). The chapter will show how these changing circumstances and discourses created opportunities for physiotherapy to re-construct its knowledge/expertise to produce solutions for contemporary problems, and to become a practice profession.

Chapter structure and content

The chapter presents a chronological account of the process of becoming a practice profession. Rather than creating space for nostalgia (Jones & Green, 2006), the chronological presentation provides a social, political and temporal frame of reference that contains and contextualises the analysis of the 1945 and 1984 curricula. The chapter uncovers the discourses, situations and circumstances that enabled physiotherapy's professional practice to become recognised from the late 1970s onwards (Barclay, 1994). Its analytic perspective produces an alternative account of physiotherapy's professionalisation which complements existing narratives. The chapter shows that the technically competent handmaiden to

medicine produced by the 1945 curriculum and presented by the historic accounts of physiotherapy (e.g. Dixon, 2003; Larkin, 1983; Nicholls, 2008) had capacity to produce autonomous problem-solving practice. I am arguing that the autonomous problem-solving practices associated with profession appear and expand as physiotherapy integrates movement/touch techniques to move moving bodies. The chapter traces how the embryonic forms of professional practice produced in 1945 evolved so that by 1984 physiotherapy was recognised as an autonomous consulting profession whose practice was regulated by the State. This story begins in the 1940s with an account of the process of producing a new identity for 'physiotherapy'.

Pre 1945: building capacity for rehabilitation

Rehabilitation was the 'buzz word' of the 1940s (Barclay, 1994; Wicksteed, 1948). Although it was not a new concept, it had become increasingly popular during the 1930s as a means of helping people regain their independence following illness or injury (Barclay, 1994). Rehabilitation was distinct from other forms of medical treatment because it was an ongoing process that required 'active work on the part of the patient' (Wicksteed, 1948. p150) and concurrent input from a series of occupational groups. The journey from incapacity to functional independence was co-ordinated by medicine and delivered in specialised rehabilitation units by a growing number of 'allied professions' (Wicksteed, 1948. p142) including chiropody, occupational therapy, osteopathy, physiotherapy and social work (Barclay, 1994). During the 1930s, members of the Chartered Society of Massage and Medical Gymnastics (CSMMG) had responded to the increasing demand for rehabilitation by integrating some of the work-hardening approaches (graded exercises, functional activities and work simulation) associated with the Forces' Physical Training Instructors into their practice (Wicksteed, 1948).

By the 1940s, many CSMMG members were working alongside other allied professions to support development of medical rehabilitation in burns and plastics, neurology, orthopaedics, rheumatology and spinal injuries (Barclay, 1994; Wicksteed, 1948). Some of these occupational groups were a potential threat to physiotherapy's market position because their practice challenged physiotherapy's

monopoly over manual therapy, exercise and movement, electrotherapy and kindred physical approaches. Chiropodists were using manipulation, radiant heat and other forms of electrotherapy, while Occupational Therapists and Remedial Gymnasts worked through the medium of exercise, movement and functional activity (Barclay, 1994). Recognising the changes that were occurring in practice, CSMMG re-opened discussions about finding a title to replace 'Massage and Medical Gymnastics' in 1941 (Wicksteed, 1948). The discussion created divisions amongst the Society's membership. Members proposing the change constructed massage as a dated treatment approach and a hindrance to the rise of functional rehabilitation, while those resisting change argued that the loss of massage from the Society's title was a denial of its heritage (Wicksteed, 1948).

Although massage and medical gymnastics had been taught and examined together by the Society since 1922 (Wicksteed, 1948), I am arguing that the tension emerging in 1941 was produced by the discourses associated with the disciplinary roots of both treatment modalities. Massage had its roots in the discipline of nursing, while movement came from the disciplining gymnastic methods associated with Swedish Remedial Exercises (Nicholls, 2008). Discursively, massage produced care and nurturing (Twigg, 2006), while movement produced an aesthetic and physical discipline based on biomechanical science (Nicholls, 2008). The discursive tension between caring touch and scientific movement was obscured during the 1920/30s by the competition for control of electrotherapy practice (Larkin, 1983; Wicksteed, 1948). By the 1940s, the tension was brought into sharp focus by the growing social and political demand for scientific biomedical practices that could help people recover from illness and injury (Rivett, 1998).

The emerging biomedical scientific discourse favoured the Society's scientific movement practices over its caring touch. Rather than losing the combination of treatment modalities that made its practice unique (Wicksteed, 1948), the Society used the opportunity created by the social and political situation to address the discursive tension. Following considerable debate, members voted to accept 'Physiotherapy' to replace 'Massage and Medical Gymnastics' in 1942, just weeks after publication of the Beveridge Report (Barclay, 1994) whose recommendations

would become the blueprint for the post-war Welfare State (Rivett, 1998). The report defined rehabilitation as ‘a continuous process by which disabled persons should be transferred from the state of being incapable under full medical care to the state of being producers and earners’ (Beveridge, 1942. p162). The Society’s new title was therefore politically significant. Adoption of ‘physiotherapy’ removed the ‘implied restriction in the field of activities’ (Wicksteed, 1948. p150) and created space for the Society to reconstruct its practices by obscuring the division between massage and medical gymnastics. ‘Masseurs’/‘masseuses’ became a gender-neutral workforce of ‘physiotherapists’ who were trained to deliver physiotherapy/rehabilitation treatments – as the next section will show.

The 1945 curriculum

Producing a nationally standardised workforce

The Society’s responsibility for the education and regulation of electrotherapy, exercise and movement, massage and kindred approaches was established by the Royal Charter (Barclay, 1994). The CSMMG examinations in ‘massage and medical gymnastics (conjoint)’, ‘electrotherapy’, and ‘hydrotherapy’ were introduced during the 1920s in response to campaigns by medicine about the growing number of ‘quacks’ (unqualified practitioners) who were offering a variety of physical techniques to treat the ailments of a fee-paying public (Larkin, 1983; Wicksteed, 1948). The CSMMG’s portfolio of examinations was of mutual benefit to medicine, and to the CSMMG and its members. Medicine was able reinforce its professional status by delegating specific physical treatments to a body of competent workers (Freidson, 1970). CSMMG could begin the process of professionalisation by establishing their claim to a specialised body of knowledge and skill linked to formalised systems of healthcare. The Society’s examination system differentiated its members’ practice from the ‘quacks’ who were competing for clients, while its relationship with medicine ensured members’ access to a steady flow of work (Abbott, 1988).

Although the Society had specific rules and regulations governing the scope and conduct of its national examinations, it did not stipulate how candidates should be prepared for the examinations. As a result there was considerable variation in what

physiotherapy students were taught (Wicksteed, 1948). The review of training established in 1943 (Tidswell, 1991) sought to bring the education of physiotherapists ‘in line with that of their colleagues in other branches of the Medical Services’ (CSP, 1945. p1). The timing of the review suggests that the Society recognised an opportunity to enhance its market position by providing a solution for a potential workforce planning issue. Its new national curriculum was designed to produce a nationally standardised workforce of physiotherapists who were ready to meet the demands of a post-war Welfare State for physiotherapy/rehabilitation services (Thornton, 1994).

The curriculum published in 1945 defined and standardised the structure, content and examination process of physiotherapy training across the UK (Wicksteed, 1948). Curricular content was structured across three levels which were delivered over ‘a period of three academic years of full-time study’ (CSP, 1945. p1). Progression from one level to the next was determined by examinations which were set and administered by the CSP (CSP, 1945. p2-3). A summary of curricular content is presented in Table 4. Additional information to help physiotherapy teachers interpret the ‘massage, manipulation and movement’ techniques was published as a supplementary 40-page pamphlet (CSP, nd).

| | Curriculum content (CSP, 1945. p4-11) |
|--------------------|--|
| Formal Knowledge | Anatomy and physiology Electro-mechanics Kinesiology Pathology of medical and surgical conditions Psychology Professional etiquette |
| Practice knowledge | Care of patient Massage, manipulation and movement Electrotherapy |

Table 4: Summary of CSP (1945) qualifying curriculum

The curriculum was designed to produce a workforce with knowledge of the medical and surgical body that could deliver the physical treatments prescribed by medicine safely and efficiently.

Producing physiotherapy/rehabilitation

The 1945 curriculum reorganised the techniques contained by the Royal Charter to become:

Physiotherapeutic methods of rehabilitation which...[were] classified as follows:

(a) Individual Remedial Treatment -
Massage, manipulations and movements
Remedial exercises, including apparatus
Electrotherapy
Hydrotherapy

(b) Group Remedial Exercises –
Free, assisted or resisted by means of remedial apparatus
Remedial games and equipment.

(CSP, 1945. p3)

This extract shows how the practices of massage, medical gymnastics and electrotherapy that belonged to physiotherapy ('physiotherapeutic methods') were organised to become 'methods of rehabilitation'. Discursively, physiotherapy became a scientific process ('method') that could produce a series of corrective and curative ('remedial') treatments.

The curriculum's classification caused the exercise and movement techniques associated with medical gymnastics to multiply to produce physiotherapy/rehabilitation treatments for individuals or groups. When applied to an individual, the reconstructed medical gymnastic techniques reproduced the movements and remedial exercises that would have been familiar to CSMMG members since the 1920s (Barclay, 1994). When applied to a group of people, the reconstructed medical gymnastic techniques reproduced the functional rehabilitation practices adopted by CSMMG members during the 1930s (Barclay, 1994; Wicksteed, 1948). Discursively, physiotherapy positioned itself to support the rapid expansion of medical rehabilitation services without compromising its capacity to provide individualised one-to-one treatments. Maintenance of one-to-one treatments was important for developing capacity for professional practice (Freidson, 1970), and for differentiating physiotherapeutic exercise and movement

from the mass group exercise and movement produced by Remedial Gymnastics (Barclay, 1994).

Having positioned its practices to treat individuals and groups, the 1945 curriculum established the boundaries of physiotherapy by listing the range of bodies that were amenable to treatment. Physiotherapy/rehabilitation could affect diseased 'circulatory', 'genito-urinary', musculoskeletal ('muscles and fasciae', 'bones and joints'), 'nervous' and 'respiratory' bodily systems; injured 'bones, joints, muscles and tendons'; 'localised' infection; and bodies in poor public health (CSP, 1945. p10-11). Physiotherapy practice was not limited to a specific body part or system like chiropody (feet) or osteopathy (bones and joints), nor confined to a single modality like for example, radiography (radiation/electrotherapy), or occupational therapy and remedial gymnastics (exercise/movement) (Barclay, 1994; Larkin, 1983). Physiotherapy's capacity to produce multi-modal treatments for the range of bodies requiring rehabilitation differentiated its practices from its rivals and protected its position in the system (Abbott, 1988; Freidson, 1970). Although physiotherapy was subordinate to medicine like the other 'allied professions' (Wicksteed, 1948. p142), I am arguing that it occupied a unique position in the 1940s healthcare system because its scope of practice mirrored the breadth of medical practice.

The work of the physiotherapist was directed by medicine:

Rehabilitation, as far as physiotherapy is concerned may be defined as follows:

"measures, ancillary to medical and surgical treatment, designed to assist the restoration of maximum function in sick and injured persons."

(CSP, 1945. p3)

Having secured physiotherapy's position within rehabilitation ('as far as physiotherapy is concerned'), the curriculum established physiotherapy's subordinate ('ancillary') position relative to medicine. The subordination settlement between physiotherapy and medicine produced two forms of practice: the restoration of function in sick bodies directed by physicians, and restoration of function in injured bodies directed by surgeons. Function was constructed as

something that is related to the body ('function in') rather than something the body does. The body therefore became an object whose dysfunction could be restored by physiotherapy/rehabilitation that had been prescribed by medicine.

The reconstruction of the body was generated by the content of the CSP's medically orientated curriculum. The curriculum reduced this human body to a series of separate functioning systems ('bones and joints', the 'muscular system', the 'nervous system', and 'skin' for example), and physiological processes ('temperature regulation', 'metabolism' and 'menstruation' for example) (CSP, 1945. p4 – 5). These anatomical and physiological bodies were processed by a classification system of 'pathology of medical and surgical conditions' (CSP, 1945. p10 – 11) to become a medical body that operated on a normal/abnormal binary (Turner, 1992). The construction of the body as a containable object whose problems can be resolved by medical intervention is evidence of the body-as-machine discourse associated with medical practice (Leder, 1992). The curriculum trained physiotherapists to process the medical body through 'inspection and palpation' (CSP, 1945. p4). These are the techniques of gaze and touch used by doctors to process a medical body (Foucault, 1973). I am arguing that together the body-as-machine discourse and discipline of gaze and touch (re)produced medical practice (Turner, 1992), and extended the authority of medicine over the bodies of physiotherapists and their patients (Twigg, 2006).

Although physiotherapists had capacity to produce medical practice, the subordination settlement created a division of labour which prevented physiotherapists from becoming doctors (Larkin, 1983). Doctors' gaze and touch produced medical diagnoses and prescriptions for treatment (Abbott, 1988; Foucault, 1973) while physiotherapists' gaze and touch recognised 'conditions suitable for treatment', 'contraindications' and the 'untoward effects' of physiotherapy's techniques (CSP, 1945. p7-9). Physiotherapeutic gaze and touch did not produce a diagnosis, but processed the medical body to ensure that physiotherapy/rehabilitation prescribed by medicine was suitable and safe. I am arguing that physiotherapy's acceptance of medical discipline benefited physiotherapy and medicine. Physiotherapy's capacity to produce safe and suitable

physiotherapy/rehabilitation ensured physiotherapists received a steady flow of work, which in turn justified and reinforced physiotherapy's position in the competitive system of rehabilitation (Larkin, 1983; Wicksteed, 1948). Medicine had ready access to an ancillary workforce of professional physiotherapists who were disciplined to ensure the safe delivery of physiotherapy/rehabilitation to individuals and groups (CSP, 1945 p3) within the constraints of the biomedical model (Barclay, 1994; Larkin, 1983). Some of the practices were more in line with traditional understandings of biomedical treatments, while in other areas physiotherapy had to actively construct its practices to give the appearance of scientific objectivity demanded by biomedical science – as the next section shows.

Reconstructing physical treatments: moving towards professional practice

The 1945 curriculum organised physiotherapy's techniques into two groups: 'electro-mechanics and electrotherapy', and 'massage, manipulations and movement' (CSP, 1945. p6-9). These techniques were transformed by a curriculum that was constructed to provide:

not so much a technical training as education in the principles underlying the administration of physical treatment, providing a foundation on which to build rather than a series of physical skills.

(Wicksteed, 1948. p146)

Wicksteed's (1948) account of the curriculum review process describes how the 'physical skills' associated with physiotherapy's techniques become 'physical treatment'. The curriculum achieved this transformation by establishing a body of theoretical/abstract knowledge ('principles') that became associated with ('underlying') the administration of 'electro-mechanics and electrotherapy', and 'massage, manipulation and movement' treatments. The curriculum associated 'electrotherapy' with the physics of electricity and radiation which explain how particles ('molecule', 'atom', 'ion') move ('conduction', 'convection') (CSP, 1945. p6-8). 'Massage, manipulation and movement' became associated with 'kinesiology' - the branch of physics that explains how the physical properties of the body generate 'body movement' (CSP, nd. p3). By associating its practices with knowledge of physics, physiotherapy became a scientific discipline whose techniques move the body. Electrotherapy became a treatment for the

physiological body whose functioning depends on its ionic balance and the movement of molecules through its systems (CSP, 1945. p4-5). By contrast, massage, manipulation and movement treatments produced movement of the muscles, joints and structures of the anatomical body (CSP, 1945. p4-5). These physiotherapeutic treatments produced two forms of practice that processed the rehabilitating body and began the process of becoming a practice profession.

1. Electrotherapy: treating the physiological body, producing technical practice

By 1945 electrotherapy was being prescribed to treat a growing range of conditions associated with the physiological body (Barclay, 1994). Electrical currents were used to stimulate muscles weakened by nerve damage; light to promote healing and resolution of various skin conditions; and diathermy to treat septic and inflammatory conditions (Kovács, 1945; Osbourne & Holmquest, 1944). The electrotherapy treatments produced by the 1945 curriculum were based on the theoretical principles and processes of applying 'direct and low frequency currents', 'high frequency' and 'radiations' (CSP, 1945. p6-8). These principles and processes disciplined the physiotherapist to use 'apparatus' that created and transmitted radiation ('radiant heat and infra-red generators', 'quartz applicators') (CSP, 1945. p8) and generated and conducted currents ('voltaic cell', 'induction coil', 'electrodes') (CSP, 1945. p6-7). The electrotherapy treatments generated by the 1945 curriculum were physical ('intensity', 'resistance', 'density') and dynamic ('interrupted' 'oscillating', 'surged' currents) (CSP, 1945. p6-8). They were applied to a body that was an absent presence (Shilling, 2005), which in turn asserted the disciplined technicality of electrotherapy practice and accommodated electrotherapy's capacity to produce movement. Discursively, electrotherapy became a scientific, technical treatment that moved the physiological body.

Physiotherapy's electrotherapeutic treatments can also be seen as resisting the scientific discourses. Electrotherapy treatments were generated by apparatus which required 'care' and 'simple repairs' to maintain (CSP, 1945. p6 – 8) and were delivered by an operator trained to take precautions against accidents', and to 'avoid[ance of] untoward effects' (CSP, 1945. p7). This discursive construction of electrotherapy as risky but careful practice can be traced back to the late 1920s

when medicine introduced systems of examination and registration to control the use of medical electricity and light (Barclay, 1994; Larkin, 1983). Over a decade later, the 1945 curriculum managed the potential risks associated with electrotherapy treatments by specifying the terms and conditions of practice:

Note: It is not intended that members of the Chartered Society of Physiotherapy should take the responsibility of the application of electrotherapy in conditions where its application is attended by special risks.

(CSP, 1945. p8. Emphasis in original)

Having introduced a discipline of care and caution, the curriculum established a boundary on physiotherapy's application of electrotherapy. Physiotherapists were trained to relinquish their responsibility for the delivery of electrotherapy treatments in the presence of 'special risks'. By implication, the responsibility for electrotherapy treatments in risky conditions sat outside physiotherapy, and with the body prescribing the treatments – medicine. Discursively, the physiotherapist delivering electrotherapy became a technician who could take responsibility for highly skilled and specialised work in routine situations. Because the 'special risks' were undefined, the boundary containing physiotherapy's scope of electrotherapy practice could expand to fill the vacuum created as medicine relinquished techniques as they become routinised.

2. Massage, manipulation and movement: anatomical bodies and autonomous practice

Historic accounts of massage from the 1940s suggest that it was a modality in transition. While whole body massage was becoming less popular, specific massage techniques were being adapted and related to the post-operative management of amputation, plastic surgery and other situations where bodily movement was compromised (Barclay, 1994; Wicksteed, 1948). Dismissing massage could therefore have potentially compromised physiotherapists' ability to relate to the emerging biomedical body, and physiotherapy's alignment with the developments occurring in medicine. Rather than dismissing massage, the 1945 curriculum removed the division between massage and medical gymnastics and associated both modalities with 'the general laws of kinesiology' (CSP, nd. p9). Massage

became ‘massage (manipulation of soft tissue)’ (CSP, 1945. p9) – a hands-on practice (‘manipulation’) that moved (‘manipulation’) the malleable structures beneath the body’s surface (‘soft tissues’). This discursive reconstruction enabled massage to become part of a series of ‘massage, manipulation and movement’ (CSP, 1945. p9) techniques that processed the anatomical body:

1. Massage (manipulation of soft tissues)
2. Methods of obtaining relaxation
3. Movements (with and without apparatus)
4. Mobilisation of joints
5. Class work

(CSP, 1945. p9)

The anatomical body processed by ‘massage’ was an immobile recipient ‘of’ movement that was bound by its physical structure (‘soft tissues’). By contrast, the anatomical body processed by ‘relaxation’, ‘movements’ and ‘class work’ was a dynamic entity that moved in response to the situations and settings it inhabited (Blackman, 2008). This dynamic anatomical body was a body-in-process that could perform a variety of movements ‘with or without apparatus’, and could be disciplined to relax, and change its posture (CSP, 1945. p9).

The curriculum’s reconstruction of massage and medical gymnastics produced a structured process used to move the anatomical body from incapacity to functional independence – as the next sections show.

2.1. Massage: manipulating the debilitated body, producing autonomous practice

The massage treatment produced by the 1945 curriculum was a treatment ‘for both medical and surgical cases when there is much debility and the patient is unable to perform any exercise’ (CSP, nd. p4). The bodies referred for massage were dis-abled (‘much debility’ ‘unable to perform’) by illness (‘medical cases’) or surgery (‘surgical cases’). The patient’s debility was reproduced by the detailed instructions about massage treatment provided by the curriculum (CSP, nd. p4-9). The focus of these instructions was on the physiotherapist’s bodywork - the bodily positions,

movements and activities (Twigg et al, 2011) required to perform massage. These instructions directed the physiotherapist to prepare the patient's body for massage by careful positioning:

The patient must be thoroughly relaxed in the lying position on a bed or couch of suitable height and comfortably supported with pillows; there should be a sufficient supply of blankets at hand to ensure warmth for the body and limbs during treatment.

(CSP, nd.p4)

Through the physiotherapist's positioning the patient's body becomes a still ('thoroughly relaxed') and disembodied ('body and limbs') object. Once the patient's body has been positioned, the physiotherapist covered those body parts that were not being moved or touched (CSP, nd. p4 – 9). The use of blankets maintained the clinical focus of the practice by physically focusing the therapist's touch and gaze, and provided a warm shield that protected the therapist from the potential involuntary physical responses to handling (such as flatulence, flushing, or sexual arousal). I am suggesting that this combination of positioning and draping was produced by the bodywork of care which was drawn with massage into physiotherapy from the discipline of nursing (Twigg, 2006; Barclay, 1994). The physiotherapist's bodywork produced comfort (see Chapter 6) and prepared the body to receive a series of very physical movement/touch techniques such as 'effleurage', 'stroking', 'pounding' and 'shaking' (CSP, nd. p4 – 9).

The physicality of massage required the physiotherapist to adopt 'walk or stride standing' as a means of reducing strain during execution of the work (CSP, nd.p4). The spatial organisation of practice (patient recumbent, therapist standing) maintained the physiotherapist's authority over the patient's passive inert supine body (Twigg, 2006) while providing the material strength and mobility for performing the task. From the standing position, the physiotherapist's body was directed to perform a specific series of movements, as this excerpt from treatment for the 'lower leg' illustrates:

Give effleurage from the foot to the glands in the popliteal space; kneading with two hands, the inner one on the calf and posterior tibial and the outer one on the anterior tibial and peroneal muscles, work to the insertion of the muscles and back again and give thumb kneading to the latter groups. Change stance to stride standing and give picking up to the calf muscles. Change position of the leg to ½ crook...

(CSP, nd. p5)

Here, the directions for giving a massage are expressed in terms of specialised knowledge of anatomy ('glands', 'muscles'), remedial gymnastics ('½ crook', 'stride standing') and massage ('effleurage', 'clapping'). Discursively, the patient's body became a series of anatomical structures ('popliteal space', 'peroneal muscles') that were processed by the physiotherapist's handling. The choreography was specific, and required the physiotherapist to have control over the movement of their own body in relation to the patient's anatomical body. I am arguing that this combination of specialised knowledge, discursive structuring of the body and disciplined bodywork establishes massage as technical practice (Turner, 1992).

The movement generated by processing the anatomical body was accommodated by training the physiotherapist to adjust the speed of their handling:

The rate [of massage] depends upon the condition for which treatment is being given and varies accordingly. In practising technique, however, the operator chooses a moderate rate which can be speeded up or slowed down as required.

(CSP, nd. p4)

The adjustment in speed was produced by the physiotherapist's knowledge of the condition being treated and its anticipated response to massage, and their ability to regulate bodily movement/touch as the treatment proceeds. This combination of specialised biomedical knowledge, and the self-disciplined ability to adapt a skilled practice in-action produces autonomous expert practice (Schön, 1983). The potential risks associated with the intimacy of practice were managed by the body-as-machine discourse (Leder, 1992); the patient's body became a condition while the physiotherapist became an operator. This discursive structuring of the body and self-disciplined bodywork is a form of governance that manages the intimacy of massage and makes it sanitised and safe for the patient and physiotherapist (Twigg, 2006; Shilling, 2005).

2.2. Movement: handling the moving body, producing problem-solving practice

The movement techniques produced by 1945 curriculum were organised so that the physiotherapist 'confronted with any disability would be able to give a complete training to her patient' (CSP, nd. p38). This 'complete training' was achieved by:

3. Movements (with and without apparatus)
 - (a) Passive movements
 - (b) Assisted and resisted movements
 - (c) Principles and use of apparatus for fixation, suspension, assistance, resistance and traction
 - (d) Free exercises
 - (e) Posture training
 - (f) The value of simple occupations in the home or hospital...
- (CSP, 1945. p9)

This extract describes a series of techniques which produce a graded sequence of bodywork that moves the body from a state of inactivity ('passive movements') to become ready for work ('value of simple occupations').

The sequence of graded bodywork commenced with a process that 'break[s] up a movement into its component parts in order that each part of the movement may be worked at until performed both freely and easily' (CSP, nd. p38). The deconstruction of bodily movement was produced by training physiotherapists to perform an 'analysis of muscle action and joint movement' (CSP, 1945. p9). The analysis is disciplined by the biomechanical discourse associated with medical gymnastics (Nicholls, 2008) as this extract shows:

- 5. Knee-joint: flexion and extension**
- | | | |
|--|---|----------------------------------|
| Ly. with hip and thigh supported ½ ly. High sitt. S ly. | } | <i>K. flexors and extensors.</i> |
|--|---|----------------------------------|
- (CSP, nd. p17)

The medical gymnastic shorthand presented here describes the work of bending and straightening a knee joint. The movement is described in terms of its starting position ('lying', 'sitting' and their derivatives); the axis ('knee joint') and plane of movement ('flexion and extension'); and the muscle work producing the movement

(‘knee flexors and extensors’). The biomechanical discourse associated with medical gymnastics reduces the complex movement combinations of a moving body to a series of standardised positions, movement and work (Nicholls, 2008). This three-dimensional framework contains and objectifies the patient’s moving body, and provides a structure that was used to analyse and reconstruct the body’s movement.

Drawing on Mol’s (2002) concept of multiple bodies, the physiotherapist’s movement analysis produces two anatomical bodies. The first of these is the skeletal body which is composed of a series of bony levers and articulated joints which provide anchorage for the muscular body and fulcra that direct its actions (CSP, 1945. p4). The skeletal body was treated using ‘relaxation’, ‘mobilisation’ and ‘movement (with or without apparatus)’. These treatments increased the body’s structured flexibility by ‘gradually stretching the tightened soft tissues which limits the movement’ (CSP, nd. p37). The second muscular body is recognised by the dynamic properties of its ‘muscles, tendons, aponeuroses and fasciae’ and its capacity to generate forces that stabilise and move the skeletal body (CSP, 1945. p4). The muscular body was treated by ‘movements (with or without apparatus)’ which increased the body’s dynamic strength by gradually increasing the volume and complexity of its workload (CSP, nd. p12-40). Conceptually, the skeletal body was associated with structured flexibility, the muscular body with dynamic strength (Gardiner, 1953). Both bodies were processed (‘worked at until’) by physiotherapy treatment to produce movement that is free (skeletal body) and easy (muscular body).

The process of reconstructing the patient’s moving body began by disciplining the muscular body to produce ‘static contractions’ to control the position of the skeletal body (CSP, nd. p36). The patient’s bodywork reduced their dependence on the ‘passive movements’ performed by the physiotherapist to maintain joint and muscle mobility (Gardiner, 1953). Once the muscular body could generate contractions then:

swinging movements must be taught either with gravity eliminated (slings) or gravity assisting a pendulum like movement. In the latter the student will have to work out the position the patient must take up in order to get as much assistance as possible from gravity...

(CSP, nd. p38-39)

This extract shows that as it starts to move, the body part was transformed by the biomechanical discourse associated with medical gymnastics to become a weight ('gravity') that swings rhythmically from a fixed point ('pendulum like movement') (Nicholls, 2008). The discursive reconstruction of the body allowed the physiotherapist to enact the 'laws of mechanics' (CSP, nd. p3) to problem-solve ('work out') how to position the patient to maximise the effect of gravity. The containment and structure associated with this autonomous problem-solving process produced skilled technical practice (Freidson, 1970) that could continually adjust the movement produced by a moving body.

'[T]raining should then progress to the natural movement and use of the part' (CSP, nd. p39). This natural movement is produced by a series of 'free exercises' (CSP, nd. p24-35) that discipline the muscular and skeletal bodies to work towards a specified set of treatment goals ('objective'):

Objective

Kicking ball or bean bag.

Throwing bean bag off ankle into hands.

Throwing ball held between ankles.

(CSP, nd. p25- 26)

These goals moved the body beyond the biomechanical movements generated by the earlier stages of treatment to become activity-oriented ('kicking', 'throwing'). Movement activities were disciplined by small pieces of equipment ('ball or beanbag') and generated by a body that could co-ordinate and sequence the movement of its separate components ('ankles into hands'). Once the body could generate movement activities, it was ready to produce 'natural movements and use of the part' (CSP, nd. p39). Natural movements were not confined to a specific joint or body part as this sequence of leg movements illustrates:

Slow walking with short steps - normal walking - walking up and down stairs facing up the stairs - downstairs normally - preparing for running - running - jumping. Bicycling and work on the sliding rowing seat would be introduced to obtain greater muscle strength and mobility of joints.

(CSP, nd. p39)

This extract presents a sequence of graded movements associated with everyday activities ('walking' 'stairs'). Discursively, this sequence of movements normalises the body ('slow walking' becomes 'normal walking') and moves it on its rehabilitative journey towards maximum function (CSP, 1945.p3). The naturally moving body is therefore able to move through space and time. It can adjust its pace ('walking', 'running') and rhythm ('short steps', 'jumping'). The muscular and skeletal bodies described earlier in the initial treatment phase have become a necessary absent presence (Leder, 1992). They work silently together to perform everyday movements, but reappear to be disciplined by the bicycle and rowing machine associated with functional rehabilitation (Gardiner, 1953). The final stage of physiotherapy's movement treatment disciplined the body's limbs and trunk to work together to perform occupational activity

e.g. putting coal on a fire, using a floor polisher, scything, cross-cut sawing etc. If these occupations are not available the student must be familiar with the use of hand apparatus to substitute such as balls, medicine balls, punching ball etc.

(CSP, nd. p39)

Occupational activity is produced by a body that can handle moving equipment as it moves through space and time. This process then returns the physiotherapeutic body to its daily labour. The presence of gymnastic apparatus ('medicine ball', 'punching ball') retains the clinical focus of processing a body that can no longer be contained by a single body part and (re)produces activity that is both physiotherapeutic and occupational. The presence of apparatus establishes a boundary that differentiates physiotherapy treatment from the craft-based activities of Occupational Therapy (Barclay, 1994), and from the patient's occupational bodywork.

The processing of the physiotherapeutic/occupational body was distinct from earlier phases of physiotherapy/rehabilitation. It required specialised biomechanical knowledge to analyse the multiple combinations of movement associated with an occupation, and creativity to substitute apparatus to generate a treatment that reproduces an occupation's choreography outside the occupational environment (CSP, nd. p39). This final phase of rehabilitation was produced by the process of diagnosis – inference – treatment associated with the problem-solving

practice of a consulting profession (Abbott, 1988). Professional inference is present when the connection between diagnosis and treatment is obscure (Abbott, 1988). I am arguing that the free and easy movement of the physiotherapeutic/occupational body extended beyond the highly structured algorithms used to produce the technical treatments associated with previous stages. As patients' bodies begin to move independently, the process of inference becomes less clear, and the autonomous problem-solving processes associated with professional practice (Abbott, 1988; Freidson, 1970) begin to appear.

Key insights: 1945 curriculum

The 1940s was marked by the rise of medical rehabilitation and emergence of the post-war Welfare State (Rivett, 1998). CSMMG responded to the opportunities by removing the historic division between massage and medical gymnastics to construct a new identity aligned to rehabilitation. The curriculum was designed to support the expansion of the State-run healthcare system by producing a nationally standardised physiotherapy workforce ready to work in the new NHS (Thornton, 1994). Historic accounts present the 1940s physiotherapist as a self-disciplined, competent technician who could apply a programme of massage, exercise and movement and electrotherapy treatments prescribed by a doctor (Barclay, 1994; Larkin, 1983; Wicksteed, 1948). Analysis of the 1945 curriculum has shown how the integration of massage and movement constructed a physiotherapy/rehabilitation identity and produced an embryonic form of professional practice.

The massage handmaiden produced by the curriculum was a skilled expert who enacted autonomy as they adjusted their handling to comfort the debilitated body and prepare it for movement. The movement handmaiden enacted the diagnosis – inference – treatment sequence to deconstruct and reconstruct the movements of the moving body on its journey towards functional independence. I am arguing that autonomy and problem-solving appeared because the physiotherapist was working to reconstruct a dynamic body. The risk of handling patients' bodies was managed by a biomedical discourse which disciplines the physiotherapeutic interaction and began the process of professionalising physiotherapy's knowledge/expertise (Freidson, 1970; Turner, 1992). I am arguing that physiotherapy's relationship with

medicine contained and obscured physiotherapists' capacity for professional practice (Freidson, 1970). The next section shows how the embryonic forms of professional practice emerged as autonomous problem-solving practice during the 1980s following removal of physiotherapy's subordination settlement with medicine.

1950s – 1970s: professional development

The CSP's national curriculum and examination scheme was launched an academic year ahead of the National Health Service (NHS) in 1947 (Barclay, 1994). Having aligned physiotherapy practice to meet the demands of medicine and expectations of the post-war Welfare State, the CSP took action to gain formal recognition of its professional practice through State registration (Barclay, 1994; Thornton, 1994). Following considerable negotiation with medicine, the Council for Professions Supplementary to Medicine (CPSM) opened a state register for physiotherapy in October 1960 (Barclay, 1994). Although the title 'physiotherapist' was not legally protected, the newly formed CPSM Board was able to define qualifications, set standards of training and adjudicate on ethical issues pertaining to physiotherapy practice (Larkin, 1983). Physiotherapy continued to evolve organically during the 1950/60s as physiotherapists used their capacity for movement to engage with developments in medicine and the changing organisation of healthcare services. Changes in practice were accommodated by adding new content to the curriculum in 1964, which led to a major review of the curriculum during the early 1970s (Tidswell, 1991).

The revised curriculum was published in 1974. It consolidated physiotherapy's capacity for producing professional practice by producing a physiotherapist who could 'assess and treat patients, and evaluate progress' (CSP, 1974. p1). The addition of 'introduction to research' and 'organisation and management' to the 1974 curriculum reflects physiotherapy's recognition of how research, regulation and organisation of healthcare had also become key to how practice was done (Rivett, 1998). The space to accommodate new content and to achieve integration of knowledge and skills was gained by reducing the time spent on clinical placement from the 1500 hours introduced in 1955, to 1000 hours (Tidswell, 1991). The

reduction in the proportion of time spent in practice relative to the classroom is evidence of a shift from a technical to a professional education (Freidson, 2001). This curriculum introduced a list of suggested placement locations which included community, education, industry, management and sports (CSP, 1974). The relocation of physiotherapy's expertise into settings outside the hospital wall diluted its physical presence in the hospital, while increasing physiotherapists' capacity for autonomous problem-solving and the visibility of their professional practice (Abbott, 1988).

Physiotherapy's capacity for technical autonomy was formalised by publication of a health circular by the Department for Health & Social Security (DHSS) in 1977. The role of the DHSS in the authorship of the professional practice publication is evidence of the interventionist approach adopted by the State to control the organisation and working relationships involved in the delivery of healthcare (Abbott, 1988). HC(77)33 updates the terms of the subordination settlement between medicine and physiotherapy:

In asking for treatment by a therapist a doctor is clearly asking for the help of another trained professional... It follows from this that the therapist has a duty and a consequential right to decline to perform any therapy which his (sic) professional training and expertise suggests is actively harmful to the patient. Equally, the doctor who is responsible for the patient has the right to instruct the therapist not to carry out certain forms of treatment which he (sic) believes to be harmful to the patient.

(HC(77)33 para 2b)

HC(33)77 maintained the hierarchical position of medicine relative to physiotherapy, but reconstructed their working relationship. The doctor retained overall responsibility for the patient; the physiotherapist became the expert to whom the doctor referred for help. Although the patient had to be referred by the doctor, the agency for the physiotherapist lay in their ability to refuse on the basis of their professional judgement ('training and expertise'). This new co-constructed relationship between physiotherapy and medicine was expressed in terms of ethicality (Freidson, 1970) – of how their expertise and relative autonomy is put to good use. The relationship was established and maintained by the principle of non-maleficence; doctors and physiotherapists carried a mutual responsibility to ensure

that the physiotherapeutic process does not harm the patient (Beauchamp & Childress, 1979).

After physiotherapy's technical autonomy was formalised in 1977, the CSP re-opened a debate to review its position on physiotherapy degrees in 1979 (Tidswell, 1991). Although a pre-registration degree route to qualification had been possible since 1969, in practice the development of UK Physiotherapy degree programmes rather than hospital-based training was very slow (Barclay, 1994; Piercy, 1979). The review coincides with discussions occurring at Government level about the education and training of the professions supplementary to medicine (Barclay, 1994; Piercy, 1979). A short discussion paper (Piercy, 1979) published in *Physiotherapy* (the CSP's journal) outlined the arguments for and against degree status and invited comments from CSP membership. Piercy's (1979) paper argued for all-graduate entry as a means of enhancing the effectiveness and efficiency of patient care by producing a workforce with cognitive skills to critically evaluate and research clinical practice. However there was resistance to this change from within the CSP. Members' concerns are summarised in an editorial in *Physiotherapy*:

... what will undergraduates learn in addition to the common syllabus which will make them special? And if they devote so much time to academic studies, how will they gain the practical experience necessary to make them useful staff members? These misgivings are all the more deeply felt because physiotherapy is essentially a practical profession.

(Whitehouse, 1979. p337)

The resistance to all-graduate entry was expressed in terms of time: creating time for academic studies would reduce the time available for practical experience. The resistance established a hierarchy: the practice knowledge generated through experience of doing physiotherapy being valued above the formal knowledge produced by academic study (Freidson, 1970). While embodied practice knowledge differentiates physiotherapy from its rivals (Freidson, 2001), the silencing of formal knowledge threatened physiotherapy's ability to legitimise its autonomy (Freidson, 1970) and to define its professional jurisdiction (Abbott, 1988). Six months after the debate had opened, the CSP published a position statement on all-graduate entry. This statement (CSP, 1979) justified the Society's pursuit of all-graduate entry as means of improving patient care, service delivery and cost efficiency. Its assertive

tone challenged the resistance to change from within its membership (Thornton, 1994), while its emphasis on effectiveness and efficiency reflected the CSP's response to the emerging discourses of scientific rationality associated with New Public Management (NPM) (see Chapter 2).

The 1984 curriculum

Producing a professional workforce

It was amidst this changing and increasingly regulated practice environment that CSP undertook a review of its qualifying curriculum and examination system. The 1984 curriculum replaced the prescribed structured syllabi associated with earlier curricula, with a modular framework of learning aims, objectives and indicative content

from which each school can develop its own curriculum and methods of assessment to achieve the... overall objectives for physiotherapy pre-registration education.

(CSP, 1984. p3)

The shift from prescribing input to measurable outputs is evidence of the CSP decentralising physiotherapy education to facilitate the transition towards all graduate entry. The redesigned curriculum enabled CSP and CPSM to retain nationwide control over entry into physiotherapy, while providing educational institutions the flexibility they needed to establish Physiotherapy degrees (Barclay, 1994).

Physiotherapy's bodies of knowledge were re-organised by a modular framework that was made up of three sections:

Foundation Studies... provides the academic basis for the practice of physiotherapy.

Physiotherapy Studies... considers the particular knowledge and skills essential to the practice of physiotherapy.

Clinical education... provides the integration between theory and practice and the transformation of academic study into skilled, effective and evaluative therapy.

(CSP, 1984. p3)

The restructuring of physiotherapy's formal and practice knowledge reduced the tensions that had emerged during the debate about all-graduate entry. The

modular framework silenced the time (years of study) structuring earlier curricula. Discursively the tension between formal and practice knowledge could not be sustained because the 'time' that they were competing for was no longer present. While the curriculum retained the division between formal and practice knowledge, it silenced their differential value by establishing a symbiotic relationship that produced physiotherapy practice. Discursively, formal knowledge became the 'foundation' for practice, while practice knowledge became the 'essence' of practice. Without formal knowledge physiotherapy practice has no foundation; without practice knowledge physiotherapy becomes an academic exercise. When formal and practice knowledge were brought together in a clinical setting (CSP, 1984. p19), they became transformed to produce 'skilled, effective and evaluative therapy'. Although the integrated formal/practice knowledge produced therapy in a clinical environment, it did not become clinical practice but retained its status as 'education'. Discursively, the curriculum produced a semi-permeable boundary that prevented students from becoming totally subsumed into the qualified workforce. Pedagogically, the education/practice boundary protected the learning process (Thornton, 1994); politically, it maintained pressure on workforce planners to address the shortage of physiotherapy (see Chapter 2). Professionally, it created opportunities for the emergence of a 'clinical educator' role (a physiotherapist who took on responsibility for co-ordinating and supporting students' placement learning) and the development of a recognised professional structure within the workplace (Freidson, 1970).

The curriculum's modular structure created space for refreshing and reorganising physiotherapy's bodies of formal and practice knowledge. Bodies of occupational knowledge are said to change by one of two strategies: replacement and addition (Abbott, 1988). Knowledge replacement of the 1984 curriculum was one that updated existing content to accommodate developments in research, technology or practice which maintained the currency of physiotherapy practice and refreshed existing knowledge relationships (e.g. 'anatomy and physiology', 'patient care'). Knowledge addition also maintains the currency of practice, but this strategy can also strengthen existing knowledge relationships (e.g. expansion of 'kinesiology' and 'psychology) or establish new ones (e.g. 'human growth and development'

‘clinical sciences’) (Abbott, 1988). Knowledge replacement maintains existing practices, while knowledge addition causes practice to change and expand. The 1984 curriculum adopted both strategies – as shown in Table 5.

| Curriculum | CSP (1945) | CSP (1984) |
|--------------------|--|---|
| Formal Knowledge | Anatomy and physiology | Anatomy and physiology |
| | Electro-mechanics | The principles of thermal, electrical and ultrasonic procedures |
| | Kinesiology | Biomechanics and fluid dynamics Movement studies |
| | Pathology of medical and surgical conditions | General pathology |
| | Professional etiquette | Professional ethics, the rules of professional conduct and the role of the professional body |
| | Psychology | Human growth and development |
| | | Concepts of health and disease Organisation and administration of health care* Research and evaluation* |
| Practice knowledge | Care of patient | General patient care |
| | Massage, manipulation and movement | Manipulative skills Movement skills |
| | Electrotherapy | Thermal, electrical and ultrasonic procedures |
| | | Technology Aids and appliances* Habilitation* |
| | | Clinical interviewing, assessment and recording Clinical sciences Communication and teaching* |

* denotes content introduced by the CSP's 1974 curriculum

Table 5: summary of CSP qualifying curricula 1945 and 1984

Table 5 shows how physiotherapy's body of knowledge expanded between 1945 and 1984 to accommodate the changing organisation and structure of healthcare. Conceptually, the expansion of formal knowledge maintains occupational jurisdiction and capacity to move as practice evolves; while the expansion of practice knowledge extends an occupation's scope of practice to meet the changing demands of practice (Freidson, 1970). I am arguing that the 1984 curriculum

transformed the technical expertise and professional practices associated with physiotherapy/rehabilitation to produce the autonomous professional practices prescribed by HC(77)33. As the next sections show, this process of reconstruction preserved physiotherapy's established position as an expert in human movement, while realigning its practices with the demands for effectiveness, efficiency and individual choice (Freidson, 2001; Rivett, 1998).

Defining boundaries of practice

The introduction to the 1984 curriculum presented physiotherapy as being a 'dynamic and evolving' practice and therefore difficult to define beyond:

A systematic method of assessing musculo-skeletal, cardio-vascular, respiratory and neurological disorders of function including pain and those of psychosomatic origin and dealing with or preventing those problems by natural methods based essentially on movement, manual therapy and physical agencies.

(CSP, 1984. p2)

By 1984, physiotherapy had become a logical process ('method') that used low-risk ('natural') physical techniques to manage disordered bodies. Discursively, it was a consulting profession that could assess, diagnose and treat actual or potential bodily dysfunction independently of medicine (Abbott, 1988; Freidson, 1970). Physiotherapy's professional jurisdiction extended to disorders of the 'musculo-skeletal, cardio-vascular, respiratory and nervous systems' involved in producing movement (CSP, 1984. p5-6). The practices of the 1984 curriculum were the techniques of 'movement, manual therapy and physical agencies' established by the Royal Charter in 1920 (Wicksteed, 1948). This practice boundary reappeared in 1984 because it was no longer obscured by physiotherapy's subordination settlement with medicine. Its presence protected the credibility of physiotherapy practice by ensuring that the problems referred fell within its remit. The maintenance of the boundary by subsequent curricula suggests that it also served a protective function which differentiated physiotherapy from its competitors while enabling its practices to evolve (see Chapter 3).

The curriculum's definition of physiotherapy produced two distinct bodies that appear as signs of actual or potential dysfunction before being managed and

silenced by physiotherapy practice. The first was an anatomical/physiological body whose roots can be traced back to the 1945 curriculum. Students came to know this object body through 'anatomy and physiology' (CSP, 1984. p5), although by 1984 its content had been reshaped by a scientific discourse: 'bones and joints' (CSP, 1945. p4) for example became 'osteology' and 'arthrology' (CSP, 1984. p5). This body's dysfunction was limited to a list of conditions associated with the bodily systems that produce movement including 'cardio-vascular conditions', 'diseases of bone joint and soft tissue', and 'neurology' (CSP, 1984. p14). The second body was a dynamic entity whose disorders of function were produced by a combination of behavioural ('psycho') and physical ('somatic') factors (CSP, 1984. p2). This psycho/somatic body can be distinguished by its capacity to move and be moved (Blackman, 2008).

Physiotherapy students came to know the psycho/somatic body through the curriculum's expanded psychology content ('human growth and development') and new 'concepts of health and disease' module (CSP, 1984. p7-8). The body produced by these modules was a dynamic entity that was on a journey 'from conception to death in old age' (CSP, 1984. p7). It was a body that had a 'self-image, self-esteem and body image' (CSP, 1984. p7), and could become affected by 'loss and grief', 'deprivation' 'institutionalism', 'stress, tension and anxiety' (CSP, 1984. p8). Unlike the moving anatomical body produced by physiotherapy's movement practices in 1945, the psycho/somatic body has a past, present and a future; and capacity to become a feeling subject through its interactions with the environment (Turner, 1992). I am arguing that the psycho/somatic body was generated by a biopsychosocial (BPS) discourse which emerged during the late 1970s as an alternative to the body-as-machine discourse associated with traditional biomedicine (Turner, 1992).

The BPS model is based on a premise that an individual's response to disease (and its management) is produced by the interaction of the biological, psychological and social factors present in the situation at any given time (Engel, 1977). The BPS model challenged the reductionism of biomedicine by constructing a subject body with capacity for movement, interaction and change (Turner, 1992). The risks of

handling a body that could affect and be affected were managed by introducing techniques to recognise and regulate bodily change (Crossley, 2007; Turner, 1992). Physiotherapists were trained to measure changes in 'human growth and development' against 'the normal milestones of development stages and the multi-factorial influences which aid or hinder individuals in achieving these goals' (CSP, 1984. p7). The presence of 'health and disease' could be measured in terms of nominal 'levels' (e.g. mild, moderate or severe) or by comparing the body with 'national and local patterns of disease and disability' (CSP, 1984. p8).

The normative markers disciplined the subject body and reduced it to a scientifically measurable object that could be monitored, assessed and compared over time (Turner, 1992). In effect, the curriculum appeared to be adopting the rhetoric of the BPS model while reproducing the practices associated with the biomedical model (Jones et al, 2002) – a tension which is associated with the shift towards biomedicalization (Clarke et al, 2003; Turner, 1992). Discursively, physiotherapy becomes a scientific practice (Dewey, 1910) with capacity for surveillance and control over patients' bodies (Foucault, 1973) in 'hospitals' and 'community settings' including 'industrial premises, limb fitting and appliance centres and sheltered housing' (CSP, 1984. p19).

Producing a problem-solving process

The 'systematic method' presented by the curriculum's definition of practice, deconstructed the disordered body to produce a defined 'problem' that could be recognised, handled and resolved by physiotherapy (CSP, 1984. p2). This problem-solving process was produced by a physiotherapist trained to:

- ANALYSE and ASSESS the physical, psycho-social and environmental state of the patient from a physiotherapeutic point of view;
- SYNTHESISE knowledge and assessment of the patient to identify treatment objectives;
- PLAN a therapeutic programme for each patient to achieve treatment objectives while recognising the involvement and priorities of other members of the health care team;
- IMPLEMENT that programme with the maximum degree of safety, effectiveness and efficiency;

EVALUATE the effectiveness of both assessment and therapeutic programme; and vary the programme as necessary to meet revised objectives according to the patient's progress and potential for recovery. (CSP, 1984. p2. Emphasis in original)

The curriculum's objectives reproduced the problem-solving approach (PSA) used to structure the design and delivery of qualifying physiotherapy programmes in the United States (Burnett et al, 1986; Olsen, 1983; Newman & May, 1980). The 1984 curriculum was drafted at a time when neoliberal ideologies were emerging to challenge the traditional mode of professionalism (see Chapter 2). In healthcare, new forms of managerial discipline were challenging professions capacity for autonomy, while new structures and systems were paving the way for the UK's healthcare system to become more like the marketised mixed economy of the United States (Clarke et al, 2003; Freidson, 1970; Jones, 2005). The PSA was a tried-and-tested pedagogic process (May & Newman, 1980; Olsen, 1983) that was producing a graduate physiotherapy workforce with capacity to deliver autonomous problem-solving practice for a mixed economy of healthcare (Freidson, 1970). By importing the PSA from the USA, the curriculum was able to produce a workforce that could respond to demands of the market, without compromising physiotherapy's recently acquired technical autonomy and pursuit of all-graduate entry.

Physiotherapy's problem-solving process ran as a sequence of analysis and assessment; synthesis; planning; implementation; and evaluation (CSP, 1984. p2). I am arguing that this disembodied perspective produced a physiotherapy workforce that was able to meet the expectations of New Public Management (NPM) while successfully pursuing professionalisation. The curriculum's objectives attended to the physiotherapist's cognitive body work which obscured the interactive physical/affective body work of problem-solving described in Chapter 3. Discursively, physiotherapy became an objective scientific process of integrating information collected in practice with existing knowledge to produce diagnoses, treatment objectives and plans, and an evaluation of practice (Dewey, 1910). The final stage in the sequence – evaluation of practice, is a discipline associated with professional practice (Freidson, 2001). Its appearance in the 1984 curriculum

asserted physiotherapy's capacity to diagnose and handle disordered bodies independently of medicine (CSP, 1984[S]). The curriculum's construction of physiotherapy practice as a cognitive process provided opportunities to emphasise the higher level thinking skills ('ANALYSE', 'SYNTHESISE', 'EVALUATE') (Bloom, 1956) associated with degree programmes (Tidswell, 1991). The objectives aligned physiotherapy with NPM expectations of scientific rationality (Hood, 1995), while asserting its capacity for technical autonomy (Freidson, 2001) and justifying its claim for all-graduate entry.

Physiotherapy's consultative process began with an examination ('ASSESS') of the patient's physical, psycho-social and environmental status (CSP, 1984. p2). The extension of the examination beyond its earlier biomechanical limit created space to accommodate and deconstruct ('ANALYSE') patients' anatomical/psychological and psycho/somatic bodies. Physiotherapists were trained to take 'a relevant history from the patient, medical records and significant others' (CSP, 1984. p12) and to 'examine the patient methodically applying specific techniques as appropriate' (CSP, 1984. p12). Although the physiotherapy assessment replicated the two-stage process used by medicine, physiotherapists did not reproduce a medical examination (Freidson, 1970). Physiotherapy's physical examination was limited to the structure and function of the musculo-skeletal, cardio-vascular, nervous and respiratory systems (CSP, 1984. p12) contained by physiotherapy's jurisdictional boundary. Knowledge of the patient as a subject and as an object were integrated ('SYNTHESISE') by the disciplining framework of normative markers established by the curriculum's 'Foundation Studies' modules (CSP, 1984. p5-8) to produce a potential solution. This is the process of professional inference which connects assessment and diagnosis to treatment (Abbott, 1988).

Physiotherapeutic inference reconstructs the multiple bodies produced by the physiotherapist's assessment to envision ('identify') what the patient's body could become ('objectives'). Having envisioned the body produced by treatment, the 'PLAN' established the physiotherapeutic process ('programme') that would discipline ('programme') the patient's body and produce the vision. The planning process generated a prediction of 'the patient's expected response or achievement

level' (CSP, 1984. p18) and a justified decision about 'an appropriate physiotherapy procedure for each problem' (CSP, 1984. p18). The plan became enacted ('IMPLEMENT') to produce a programme of physiotherapy. The final stage disciplined the physiotherapist to 'EVALUATE' their work ('assessment and therapeutic programme'). The objectives and plan that disciplined the bodywork of the physiotherapist and their patient reappeared to evaluate their work. If the body envisioned by the planning process had not been produced, the objectives and treatment were adjusted to reflect 'the patient's progress and potential for recovery' (CSP, 1984. p2). The unmet objectives were produced by a change in the patient's status rather than by flaws in the physiotherapist's assessment or plan. The focus on the patient asserted the ethicality of physiotherapy's professional practice while obscuring the process of trial and error associated with consulting professional practice (Freidson, 1970).

The risks associated with NPM's construction of professional practice (Freidson, 2001; Hood, 1991) were managed by reducing the problem-solving process to a series of tasks. Each task generated a series of specific measurable outputs ('objectives', 'prediction', 'physiotherapy procedures') which the physiotherapist was trained to document in the patient's physiotherapy record (CSP, 1984. p14). The problem-oriented medical record (POMR) produced by the problem-solving process (Heath, 1978; Richardson, 1979) transformed the outputs experienced in practice and produced in the privacy of the consulting space to become a permanent, standardised and public record of physiotherapy practice. The physiotherapy record became a form of surveillance that made physiotherapy practice known to researchers, regulators and administrators of physiotherapy services (Scholey, 1985).

Producing safe and efficient professional practice

The 1984 curriculum's definition of practice reconstructed the 'electrotherapy', 'massage, manipulation and movements' treatments produced by earlier curricula to become '...natural methods based essentially on movement, manual therapy and physical agencies' (CSP, 1984. p2). The shift from treatment to a systematic ('methods') process was possible following publication of HC(33)77 (DHSS, 1977) -

the health circular which gave physiotherapists authority to assess, diagnose and treat patients independently of medicine. By silencing 'treatment' the definition distanced physiotherapy from the traditional biomedical model (Turner, 1992) and justified physiotherapists' work with bodies (e.g. sporting bodies, older bodies, painful bodies) that did not have a medical label (see Appendix 1). Becoming a process created space to provide 'education of patients and families' and 'advice on methods of adjustment to disability' (CSP, 1984. p17) – the consultative disciplining practices associated produced by professions (Abbott, 1988). The shift from treatment to process also provided cover to realign physiotherapy's techniques to meet the realities of contemporary practice.

Reducing the risk of electrotherapy

The curriculum's definition of practice silenced electrotherapy, which suggests that it was a potentially contentious area of practice. Earlier curricula had constructed electrotherapy as a highly skilled but risky technical practice that required medical supervision. By 1984, the maintenance of 'risky' supervised practice was problematic for physiotherapy's professional project, and its capacity to meet the expectations of NPM for safe practice (Freidson, 2001). At the same time, electrotherapy was presented as an evolving area of practice whose effects were supported by scientific research. Articles published in *Physiotherapy* present evidence to support the application of heat/cold, electrical currents and sound waves to treat acute injuries and painful conditions and reports of experimental work on the use of currents to produce information about the integrity of muscles and nerves (e.g. Dyson & Suckling, 1978; Haynes, 1984; Wall, 1985). The loss of electrotherapy had potential to weaken physiotherapy's position in the system by reducing its scope of practice and compromising its ability to engage with new technologies that produced scientifically-informed diagnosis and treatment (Clarke et al, 2003; Abbott, 1988).

Although electrotherapy was missing from the curriculum's definition of practice, its techniques appeared alongside physiotherapy's 'Manipulative Skills' and 'Movement Skills' as 'Thermal, electrical and ultrasonic procedures' (CSP, 1984. p16). This discursive shift reduced the risks associated with 'electrotherapy' by

reproducing the techniques emerging from research, which in turn generated a practice that is both scientific and rational. These new forms of electrotherapy became 'procedures' – scientific techniques that had potential to produce diagnosis and treatment. The curriculum managed the risk associated with emergent forms of practice by producing a physiotherapy workforce that could:

1. Discuss the physical and physiological effects [of thermal, electrical and ultrasonic procedure]
2. Discuss the precautions, dangers and contra-indications [of thermal, electrical and ultrasonic procedures]
3. Demonstrate competence in the application of:
 - (a) Local and general thermal techniques
 - (b) Superficial and deep high frequency techniques
 - (c) Pulsed and continuous ultrasound
 - (d) Low and medium frequency currents
 - (e) Local and general ultra violet radiation techniques
4. Discuss the principles of electro-diagnosis
5. Discuss the use of biofeedback

(CSP, 1984. p16)

This extract illustrates the process of introducing new techniques into a workforce that has acquired technical autonomy. Physiotherapy's acquisition of technical autonomy in 1977 moved the responsibility for managing risks associated with electrotherapy from the supervising body of medicine to the individual physiotherapist (Freidson, 1970). The curriculum managed this shift by producing a workforce that had possession of the knowledge, skills and attitudes ('competence') to apply thermal, electrical and ultrasonic procedures (Caney, 1983). Competence was embodied ('possession of') and therefore had capacity for movement. It was a form of governance produced by the NPM discourse that standardised practice across an organisation by disciplining the behaviours of individual workers (Caney, 1983; Hood, 1995). I am arguing that the curriculum's reconstruction of electrotherapy was simultaneously addressing the demands of NPM for safe practice while maintaining physiotherapy's ability to move without compromising its position in the system of professions (Abbott, 1988).

Metamorphosis of massage, manipulation and movement

The acquisition of technical autonomy in 1977 removed the historic division of labour that had separated medical assessment and diagnosis from physiotherapy

treatment (Freidson, 1970). The removal of medicine created a vacuum which drew the manual therapy techniques that had emerged in practice during the 1960s into the diagnostic space (Grieve, 1984). By 1984, the techniques of 'massage, manipulation and movement' from earlier curricula had become skills – an ability to perform a specific task (Oxford, 1998). This discursive shift enabled 'Manipulative Skills' (CSP, 1984. p15) and 'Movement Skills' (CSP, 1984. p15 – 16) to produce two forms of practice: assessment and treatment.

The multiplication of physiotherapy's manipulative and movement skills was disciplined by the task-based focus of the problem-solving approach (May & Newman, 1980). When physiotherapy's manipulative and movement skills became 'assessment procedures', they generated knowledge about the body's capacity for movement - as this extract shows:

3. Measure and chart joint range both actively and passively to identify causes of limitation...
8. Detect abnormality in co-ordination of movement including balance and equilibrium...
9. Evaluate the functional ability of the patient.

(CSP, 1984. p12)

When manipulative and movement skills were enacted as treatment, they affected the patient's moving body - as this extract shows:

B. Manipulative skills...

2. Maintenance/improvement of alignment of the joints...
6. Maintenance/restoration of normal muscle tone...
9. Maintenance/improvement of circulation and tissue nutrition...

C. Movement skills...

2. Maintain and restore range of movement and joint stability...
6. Re-educate posture, sensation, balance and co-ordination...
8. Re-educate function relative to normal activities...

(CSP, 1984. p15-16)

Physiotherapy's problem-solving process is transformed by the disciplined multiplication of physiotherapy's manipulative and movement skills. It ceased to be a series of individual tasks and became a disciplined sequence of manipulation/movement that generated diagnosis and treatment. Physiotherapists' use of manipulation/movement made diagnosis and treatment difficult to differentiate, which maintained the obscurity of physiotherapy's professional

inference process. Physiotherapy's inference process is not directly visible within the curriculum, but its presence can be traced through the flow of information and knowledge produced by manipulative/movement skills. Returning to the data presented above, 'measure[ment] and chart[ing] of joint range' (CSP, 1984. p12) generated objective information about the range of movement of the skeletal body. This information was taken into physiotherapy's knowledge system to 'identify causes of limitation' and generate instructions that 'maintain and restore range of movement and joint stability' (CSP, 1984. p12 & 15). I am arguing that the integration of manipulation/movement and its enactment through the PSA generated a scientific professional practice that moved the patient's moving body (see Chapter 6).

Key insights: 1984 curriculum

In healthcare, the 1970/80s is marked by the rise of neoliberal ideals and new modes of management that were challenging the traditional form of profession (see Chapter 2). Traditional biomedicine was also challenged by a discourse that recognised the role of psychological and social factors in shaping an individual's response to disease (Engel, 1977). It was in the midst of this rapidly changing and increasingly regulated practice environment that physiotherapy gained recognition as a practice profession (Barclay, 1994). The 1980s physiotherapist was a hands-on practitioner who could assess, diagnose and treat movement dysfunction of a growing number of bodies independently of medicine (Barclay, 1994; Hugman, 1991; Nicholls, 2008). Physiotherapy was presented as being an expanding practice – in terms of its scope, its practice environments and work roles (see Appendix 1).

Analysis of the 1984 curriculum has shown how the embryonic forms of professional practice produced by massage, manipulations and movement in 1945 appeared to produce autonomous problem-solving practice. Physiotherapy's professional practice became fully visible following publication of HC(33)77 (DHSS, 1977) which removed the subordination settlement that was containing and obscuring its presence. Physiotherapy's problem-solving practice was reproduced and aligned to meet the demands of NPM for safe, efficient practice by importing a pedagogic practice used to produce physiotherapists in the United States. The PSA

provided a structure that contained the anatomical/physiological and psycho/somatic bodies while accommodating their capacity for movement and change. The PSA reduced the professional process of diagnosis – inference – treatment to a series of tasks that could be scientifically measured and recorded. The potential fragmentation of physiotherapy's problem-solving practice was managed by reconstructing physiotherapy's massage, manipulations and movement techniques to generate assessment and treatment. This autonomous problem-solving practice became enacted as a scientific process of diagnosis/treatment produced by movement/touch (see Chapter 6).

Conclusion: constructing a practice profession

This chapter has drawn on the CSP's qualifying curricula and existing historic accounts to trace the events, circumstances and discourses that enabled physiotherapy to become a practice profession. I am arguing that physiotherapy has become a profession by reconstructing its massage, manipulations and movement techniques to produce practices that can handle moving bodies. The association of professional development with intimate physical body work sits at odds with the notion of professionalisation as a process of distancing practice from messy realities of clients' living bodies (Davies, 1995; Twigg, 2006). I am suggesting that the practice – profession tension is managed by the discourse of science that runs through physiotherapy's history. In 1945 it was shaping the development of physiotherapy's knowledge and managing the risks associated with physical intimacy. By 1984 the discourse was producing autonomous problem-solving practices that processed moving bodies safely and efficiently.

By focusing on the process of producing autonomous problem-solving practice rather than the process of acquiring professional traits, the chapter presents an alternative account of the professionalisation of physiotherapy that complements existing narratives. The chapter uncovers the political processes of reconstructing physiotherapy's knowledge/expertise over time to provide solutions for contemporary problems and enhancing its position within the system of professions. The outside-in perspective and documentary data analysed produce a disembodied account of becoming a practice profession. While this level of analysis

is appropriate for understanding the process of constructing a profession, it silences the bodies of individual physiotherapists who are producing/experiencing the process of becoming a practice profession. It is to these bodies that I turn next.

Chapter 6

Becoming a physiotherapist

... it is useful to think of a profession as an occupation which has assumed a dominant position in a division of labor,[sic] so that it gains control over the determination of the substance of its own work. Unlike most occupations it is autonomous or self-directing. The occupation sustains this special status by its persuasive profession of the extraordinary trustworthiness of its members. The trustworthiness it professes naturally includes ethicality and also knowledgeable skill.

(Freidson, 1970. p xvii)

Contemporary physiotherapy is a practice profession (Bithell, 2005) that works with and in partnership with patients to change their ability to move and function (CSP, 2011a; WCPT, 2007). Chapter 5 has shown how the autonomous problem-solving processes associated with profession (Abbott, 1988; Freidson, 1970) emerged through the reconstruction of physiotherapy's massage, manipulation and movement techniques. A profession's autonomy – its freedom to act - is dynamic and relational (Freidson, 1970). Following this logic, I am suggesting that physiotherapy's autonomy can be traced by attending to the movement of physiotherapists' bodies and the things that determine what they can do in a given time and place (Foucault, 1988; Freidson, 1970). This chapter uses data generated from the depth interviews to uncover how physiotherapists' bodies become disciplined and organised to produce autonomous physiotherapy practice. The chapter brings together Freidson's (1970) work on the production and organisation of professional practice with more recently published work that draws on the concept of enactment to think critically about embodied practices and identities.

Enactment conceptualises the body in terms of what it can do, rather than on what it is (Blackman, 2008), which requires a shift to privilege action over knowing (Mol & Law, 2004). Conceptually, the body presented in this chapter is not a fixed organism composed of bodily systems, organs and processes, but is a dynamic entity that is constantly changing in response to the relationships it has with practices, technologies, institutions and other objects (Blackman, 2008). The actions of the enacted body unfold as it experiments and moves in response to its aspirations, and the situations and settings it inhabits (Fox, 2002); it is in a continual process of becoming (Mol & Law, 2004). Autonomy is experienced and expressed in

the present ('I do') or future ('I can do'). I am arguing that the dynamic, relational qualities of the enacted body and its present/future orientation provide a conceptual framework for understanding how physiotherapy's capacity for autonomy becomes embodied, disciplined and organised.

The chapter draws on data from the depth interviews conducted with 12 physiotherapists who were subject to CSP's 1945 curriculum or its almost identical successor published in 1955 (see Chapter 4). The 'becoming a physiotherapist' narrative appeared across the dataset; a consequence of inviting interviewees to share their experiences of a career in physiotherapy. This chapter attends to the sense of movement that was running through the 'becoming a physiotherapist' narrative. From a phenomenological perspective, accounts of practice provide a series of snapshots of an individual's embodied memories and perceptions of the possibilities of practice in a given time and place (Sheets-Johnstone, 2009). Viewed together as a storyline, these snapshots of practice present an embodied and animated account of an interviewee's experience of and response to the social organisation, practices and disciplines present in a given place at a given time. The chapter's analytic framework draws on Sheets-Johnstone's (2009) phenomenological analysis of dance, and Mol's (2002) analysis of multiple practice to create a set of reference points from which to explore the movement experienced/produced by the bodies of physiotherapy students as they moved into physiotherapy. The framework allows practice and its organisation to be explored from the perspective of moving bodies; moving environments; and moving time. The chapter will trace the movement of bodies through physiotherapy training to uncover how physiotherapists become disciplined and organised to experience/produce autonomous practice.

Chapter structure and content

The chapter presents a moving account of the process of becoming a physiotherapist during the 1940/60s. By following the moving bodies of physiotherapy students through physiotherapy training, the chapter uncovers the educational practices, disciplinary processes and the physical/affective body work associated with becoming a physiotherapist. The curriculum was structured and

organised to provide students with a graduated exposure to the moving and touching practices associated with doing physiotherapy. Physiotherapists learnt to adapt their bodies and bodily practices to fit in with the practice environment whilst retaining the distinctiveness of physiotherapy practice as they moved across the hospital site. By disciplining their bodies to assemble a diverse range of medicalised physiotherapy practices, physiotherapists were able to work across ward/disease boundaries. I am arguing that physiotherapy's capacity to move across organisational boundaries moved its practices beyond the immediate supervisory gaze of medicine and enabled physiotherapists' bodies to experience/produce autonomous practices. The process of producing a moving workforce began by selecting bodies who would be fit to produce the self-disciplined, skilled movements associated with enacting autonomous physiotherapy practice.

Selecting independently-minded, physically fit bodies

Interviewees' accounts of their decisions to pursue a career in physiotherapy spoke of being attracted to a job that was

... a practical profession. You're there to help the patient. That's why we train I think.

[Susie, retired physiotherapist]

Interviewees were motivated by the blend of activity ('practical'), altruistic service ('help the patient') and specialised knowledge/skills ('train') associated with being a physiotherapist. Derek and Frederick joined the Armed Forces as ward orderlies and pursued physiotherapy training through that route, while Michael moved into physiotherapy from a job in heavy industry. The female interviewees moved into physiotherapy training as a progression from a grammar or independent school - as anticipated by the CSP's redesigned national curriculum:

The Chartered Society has attempted to view the preparation of the student in the profession of Physiotherapy as a graduated process of education continuing from Secondary School to the point at which membership of the Society is attained.

(CSP, 1945. p2).

This data extract presents physiotherapy training as a structured rite of passage ('preparation of the student') that moves the student from the familiarity of

secondary education into the professional body of physiotherapy (van Gennepe, 1960). Discursively, the curriculum disadvantaged mature students who would be starting the structured transition into physiotherapy from a space outside secondary education. While not the focus of this chapter, this extract uncovers one of the factors that would have contributed to the workforce planning problems that emerged during the 1970/80s (see Chapter 2). As the curriculum was designed to be attract school-leavers, the remainder of this first section attends to female interviewees' experiences of moving into physiotherapy training.

Interviewees spoke of schools encouraging them to pursue careers in medicine, nursing or teaching; physiotherapy was not mentioned. The invisibility of physiotherapy as a career option for this cohort of academically able young women was reflected the intimate privacy of its practices (Twigg, 2006), and its social and academic status relative to medicine and teaching (Delamont, 1989). Interviewees' accounts of finding out about physiotherapy construct an independently-minded young person who could navigate the career development process 'very much on our own' [Annie, retired physiotherapy clinician/manager]. Interviewees' awareness of physiotherapy usually came from talking to friends and family, or through independent research as Fran's story of 'wagging school' illustrates:

... me and my friend took time off school to go to the Education department in Manchester. So they immediately phoned the Headmaster and said "These two are wagging school!" But we wanted careers advice about what to do if we weren't doctors... they said to me "Do you like gym?" So I said "Yes" so they said "Oh, physiotherapy then." So then I looked into physiotherapy, and I liked the thought of it.

[Fran, private practitioner/retired physiotherapy lecturer]

Fran's academic ability meant that she was being pushed 'half-heartedly' into medicine by her teachers. The advice Fran was able to access by breaking school rules and taking initiative, describes physiotherapy as an occupation for individuals who enjoyed physical activity, in Fran's case interest in 'gym'.

The construct of physiotherapy as a physically active occupation is reproduced by the expectation for prospective candidates to demonstrate 'proof of physical fitness' (CSP, 1945. p2) to gain entry to training. Discursively, physical fitness

requires disciplined body work (Lorber, 1993; Mangam & Park, 1987). Its presence at the entry-gate into physiotherapy training establishes a student body that is ready to embody the skilled choreography of physiotherapy practice; and has capacity for physical self-discipline required to produce therapeutic relationships (Mangam & Park, 1987; Sheets-Johnstone, 2009). Training schools obtained proof of students' physical fitness through a 'fitness test and things' [Jane, retired physiotherapist (industry)] and by probing interview questions:

I was slight. And he [the School Principal conducting the interview] said "Ooh you're not very big... It's a very physically demanding job!" But I was always very wiry and very tough. And I said to him "I can row a boat. I ride ponies. I can run, I can climb, I can swim. What more do you need?"

[Bridget, retired physiotherapist]

Bridget's account of her interview for a training place in the 1960s describes it as a space where candidates' physical appearance and their capacity for assertiveness and self-discipline were under scrutiny. The School Principal draws on the construct of physiotherapy as an active occupation ('physically demanding') and his perception of Bridget's body ('not very big') to challenge her physical capacity for physiotherapy. Bridget's response asserts her physical capacity ('I can...') and politely returns the challenge ('What more do you need?'). The interview becomes a dialogic process that enables the candidate and the School to explore the individual's potential to become an autonomous, self-disciplined, physically active physiotherapist.

Disciplining credible bodies/practices

The CSP's qualifying curriculum is designed to produce a physiotherapist who can meet the expectations of contemporary practice. The 1945 and 1955 curricula were both designed to produce a body of self-disciplined, skilled experts to deliver programmes of physiotherapy/rehabilitation prescribed by medicine (see Chapter 5). Physiotherapists' 'skill and precision' was produced by ensuring that '...theoretical and practical work are begun and progress together throughout the course' (CSP, 1955. p3) as Frederick explains:

And so we were doing anatomy and physiology, electrotherapy theory, massage theory and practical. And everything else associated with that. Ooh, exercise! We did an awful lot of 'rehabilitation'. The wheel had just been reinvented – again! But we did, all of that over the whole of the three years. So you had to take an exercise class, and had to work an exercise programme out. And you had to demonstrate your massage techniques, your handling techniques, and your interrogation techniques

[Frederick, retired physiotherapy lecturer/physiotherapist]

Frederick's account of physiotherapy training in the Armed Forces describes how theoretical knowledge and technical aspects of practice were aligned and reproduced via physiotherapy's bodily techniques. Frederick's observation about the 'reinvention' of exercise is evidence of how the curriculum sought to simultaneously retain its multi-modal techniques while reconstructing its practice to align with the Government's emerging rehabilitation agenda and its emphasis on the 'active body' (see Chapter 5). The curriculum's emphasis on exercise, which would have been underpinned by the study of 'movement, remedial gymnastics and sport' (CSP, 1955.p3), produced a cadre of physiotherapists whose bodies were also physically disciplined and capable of undertaking the active, moving practices of rehabilitation. It also ensured that physiotherapists had the necessary knowledge and skills to design and deliver an exercise programme – for an individual, or for a group (CSP, 1955.p3). This discursive repositioning of physiotherapy to become a practice that was suitable for individuals and groups (see Chapter 5) would have enabled physiotherapy services to meet the growing organisational demand for medical rehabilitation at a time when physiotherapists were in short supply (Barclay, 1994).

The timeframes established by the curriculum meant that students could not 'work on patients for at least 6 months' (CSP, 1944. p3). This provided time for students to learn the choreographed movement of physiotherapy's techniques by 'doing loads of practice on ourselves' [Susie, retired physiotherapist] in the controlled environment of the practical class:

...what seemed to consume us at that time, was hours of massage. We did an awful lot of massage and all the different techniques. And that seemed to me what, at that time, differentiated physiotherapy from other therapies, was the amount of massage we did.

[Hilda, retired physiotherapy manager/physiotherapist (voluntary sector)]

From a phenomenological perspective, the movement component of learning a physiotherapy technique required attention to proprioceptive (body position in space), kinaesthetic (body movement through space) and vestibular (balance and posture through space) sensations produced as the body moved through space and time (Ayres, 1979; Rose, 1999). Together these embodied perceptions simultaneously provided and constructed knowledge about students' bodies and their environment (Ayres, 1979; Blackman, 2008). With repetition and attention to what the movement did and how it felt from within the body, movements were learnt (Rose, 1999), and became inscribed as kinaesthetic memories (Sheets-Johnstone, 2009). Kinaesthetic memory provides information about movement, weight, resistance and position of the body, which the body draws on (together with feedback from auditory, touch and visual receptors) to reproduce a movement, to fine-tune a movement in action, or to adapt a movement in response to a specific situation or environmental demand (Ayres, 1979). Thus it can be argued that the enactment of kinaesthetic (bodily) memories allows the body to move in a way that is both unique to the individual body yet recognisable to an audience, while simultaneously improvising the movement to meet the demands of the situation (Sheets-Johnstone, 2009).

In the context of professional practice, kinaesthetic memories were enacted under professional autonomy to allow the physiotherapist to fine-tune or adapt a standard set of movements to accommodate the physical needs of the bodies they worked with and the demands of the environment (Glover, 2002; Rose, 1999). The practical class was a space where students embodied two roles: an object of a peer's practice while working as a model, and a moving/touching agent when working as a 'therapist'. It was a space where the professional bodies of physiotherapy became enrolled into the practices of movement and activities that were practiced and repeated such that expertise and confidence was built up ahead of its enactment in a clinical environment (Benner, 1984). I am arguing that the social and educational activities and organisation of the practical class differentiates physiotherapy from other healing professions, and produces an authentic professional practice that is acceptable and credible to a lay person (Freidson, 1970).

The practical class required students to cross a boundary from a world where physical touch was reserved for private/intimate spaces into an environment where the semi-naked bodies of strangers came to know one another through movement/touch. Phenomenologically, becoming un/dressed increases the intensity and volume of sensations experienced/produced at the body's surface which increases the body's awareness of itself and its environment (Ayres, 1979; Merleau-Ponty, 1962). The combination of heightened self-awareness and growing awareness of the un/dressed bodies of relative strangers present in the open space of the practical room had potential to produce a strong emotional reaction:

And, remember this is the '60s, and we were not as used to exposing our bodies as you are today. There were people who actually were horrified.

[Bridget, retired physiotherapist]

The horror expressed by some of Bridget's peers reflects the emotional discomfort and abjection experienced/produced as the boundaries of a body were breached (Twigg, 2006). For the small number of schools where men and women trained together, students' moving un/dressed bodies were contained and disciplined by the spatial organisation of the practical class:

There were only four men in our set. So, for practical classes we were screened off, in case we saw the girls in their bras. This was the '60s you know! So we were all screened off, because they had to take their tops off you see.

[Michael, private practitioner/retired physiotherapy lecturer]

Michael was a mature student at the same physiotherapy school as Bridget during the 1960s. The school was one of the few outside the armed forces that accepted men during the 1950/60s (see Chapter 2). Michael's account attends to the presence of a screen which divided the un/dressed bodies of men and women within the practical class. Phenomenologically, the screen was a physical boundary that limited the visual and haptic perception of the bodies on either side (Merleau-Ponty, 1962). The screen offered a degree of privacy to the un/dressed bodies in the practical class on reducing their visibility, and by physically containing their capacity for movement (Blackman, 2008). Symbolically, the screen reproduced the curriculum's body-as-object discourse that classified bodies according to their biological differences (Twigg, 2006). The un/dressed bodies in the practical room became standardised same-sex 'models' that facilitated one another's learning. While the screen was designed to manage the risks associated with touching

sensual subjects (Twigg, 2006), by limiting students' capacity to experience bodies of the opposite sex, students embodied gender-specific knowledge and habituated gender-specific actions (Burkitt, 1999). The spatial organisation of the practical class maintained the same sex ruling introduced by Society almost sixty years earlier (Wicksteed, 1948) and reproduced the gendering of physiotherapy practice (see Chapter 2).

Disciplining physiotherapy's bodies through the work of another

At the end of six months, students in the 1940/50s moved from the controlled learning environment of the classroom to spend between 4 – 6 weeks on a hospital ward (CSP, 1945; CSP, 1955) to 'learn about nursing essentially' [Pam, retired physiotherapy manager]. The nursing practice content of the CSP's 1945 and 1955 curricula was designed to introduce students to basic nursing procedures such as lifting and bed-making, applying splints, bandages and sterile dressings, and monitoring of vital signs. Interviewees spoke of their experience of nursing in terms of movement; of how it felt to move from working with healthy bodies in the practical classroom to handling bodies that were hospitalised as the result of medical disease. Nursing practice was

very helpful, 'cause it gave you an opportunity to see how the ward worked. And it was quite a shock, because I was put on a men's surgical ward... and I was not used to sort of bathing men and that sort of thing.

[Thea, retired physiotherapist]

Nursing practice was an emotional experience for Thea. Her response to being on a male surgical ward was comparable to the 'horror' expressed by some of Bridget's peers on becoming un/dressed for practical sessions. Thea's experience of body work to date was with active female bodies like her own in the controlled unisex environment of the physiotherapy practical class. Her 'shock' expressed the discomfort produced by performing unfamiliar intimate body work with the abject male bodies present on the surgical ward (Blackman, 2008; Twigg, 2006). Thea's account expresses the physical and emotional work required to move from the norms and practices of the familiar unisex classroom to an unfamiliar hospital ward of other bodies.

Bridget's account of nursing practice expresses the vulnerability she felt at moving onto a medical ward. Like Thea, Bridget presents her evaluation of the overall experience before explaining how ward work felt. Nursing offered:

... a really good grounding for people who have never been exposed to sick people... You are the lowest of the low - you have to do the mundane jobs, which means that you do appreciate the help that other people give you. But you also see it from the patient's point... because you're just a supernumerary on the ward, we had the time just, to find out how they felt. And I think that was really important... [to] have that time where you can actually communicate with people.

[Bridget, retired physiotherapist]

In medical settings, professional healthcare work associated with physical touch (and not involving technical scientific aspects of say for example surgery) has an arguably lower status (Twigg, 2006). As a supernumerary nursing probationer, Bridget describes being given mundane physical work to do on and with patients' bodies. The active, repetitive nature of this work meant that it quickly became automated (Ayres, 1979; Sheets-Johnstone, 2009) which in turn enabled Bridget to attend to the affective body work of interacting with bodies on the ward ('appreciate the help', 'find out how they felt'). Bridget's vulnerability ('never been exposed') and status as a supernumerary nursing probationer allowed her to move into the patient's world. The emphasis within the selection process and qualifying curriculum on physical fitness (CSP, 1945; CSP, 1955) meant that it was unlikely that students had bodily memories of having a 'sick' body. The absence of such kinaesthetic memories left Bridget relying on visual perception ('see') and affect ('how they felt') to construct the patient's reality (Sheets-Johnstone, 2009). By taking time to interact with patients through seeing and feeling, Bridget was starting to develop embodied knowledge of the signs (the objective bodily appearance of a disease) and symptoms (the subjective bodily experience of a disease) that would be presenting as patient problems in her future physiotherapy practice.

Freidson (1970) notes that the social organisation of the profession is central. Fran's account illustrates how nursing practice created space for observing how a ward is organised, and for learning the embodied choreographies of ward-based practice.

... with coming through nursing practice first, you very much got the impression of who Sister was, and who Matron was, and what the rules were, on the ward, about sitting on beds, or which direction the pillows were in... And it was sort of ingrained into you then, so as a physio, you did fit in with the nurses on the ward, 'cause you knew what the routines were... Just knowing the cleaning mechanism and that... if a patient had messed the bed, I would not be bothered [not be uncomfortable], as a physio, to clear that, and then get on with the treatment.

[Fran, private practitioner/retired physiotherapy lecturer]

Fran describes the ward as an environment where the position and movement of objects – beds, pillows and the bodies of staff and patients - were governed by disciplinary structures and processes such as knowing one's place, which direction pillows lie, and the process for changing dirty sheets. Fran's account expresses how the discipline became 'ingrained' into her bodily practices, which enabled her, as a physiotherapist to 'fit in' with the nursing practices on the ward. The experience of nursing practice enabled Fran to develop embodied knowledge to become comfortable performing routines associated with the bodily care of patients on the ward (Twigg, 2006). Rather than asking 'a nurse to clear that [mess]' [Fran, private practitioner/retired physiotherapy lecturer], there was a pause in the physiotherapy treatment while Fran worked across the division of labour associated with dirty work (Twigg, 2006) to strip the dirty sheets and attend to the patient's bodily needs. Having established a clean space, like the environment of the practical classroom that she would have been familiar with as a student, the flow of Fran's physiotherapy continued. By momentarily crossing a boundary to become a nursing auxiliary, Fran was able to maintain the environment and her interaction with the patient undisturbed by other personnel, which in turn maintained a spatial and professional boundary for physiotherapy practice on the ward.

Interviewees' accounts of ward-based physiotherapy during the 1960s and 70s describe how at certain times of day, the ward environment became temporarily transformed into a space that was exclusive to physiotherapy:

We did a lot of class-work on the wards... And you had to go in and take a class which meant nipping round to check they were all doing their ankle exercises or whatever... They'd have to be ready for physiotherapy at nine o' clock or whatever. And you took the class for half an hour. And they rarely disturbed the class. Obviously, there'd be some doctors or certain other things going on, but generally you got that half hour to yourself.

[Fran, private practitioner/retired physiotherapy lecturer]

Fran's account describes how the social organisation of the ward established boundaries that constructed the professional space of physiotherapy (Freidson, 1970). Her experience expresses how the discursive repositioning of physiotherapy as being suitable for individuals and groups (CSP, 1955) was enacted on a hospital ward. Ward-based exercise classes were run on surgical wards because of 'a realisation of circulatory problems and that people needed exercise - people were still in bed at least a week before they even put their feet to ground' [Thea, retired physiotherapist]. Fran's account describes how patients were made ready for her arrival, and once the class had started the 30-minute flow of physiotherapy practice was rarely disturbed. The spatial and professional boundary present in Fran's account of working with an individual patient extended during the exercise class to delineate the space occupied by Fran and the patients taking part in the class. The only personnel to move across this extended spatial and professional boundary were 'some doctors' whose presence in the physiotherapy practice space seemed inevitable ('obviously') and remained unchallenged – a reflection of medicine's status relative to other practices on the ward (Davies, 1995; Twigg, 2006). The absence of nurses from the class-taking environment suggests that, unlike the doctors, they were unable to cross the boundary of physiotherapy practice and were possibly using the opportunity produced by Fran's presence to undertake tasks away from the ward environment.

In this situation, physiotherapy was constructed by the absence of nursing. The transformation of the ward environment generated by the physiotherapy class was subject to the discipline of clock time (Adam, 2004; Davies, 1995). Although Fran's

class-working practice was directed towards patients, her account speaks of clock time (Adam, 2004). Fran moved quickly and productively 'nipping round' to check that the exercises were being performed as instructed during the thirty minutes of undisturbed practice. The presence of clock-time distinguished Fran's class-taking practice from her work with an individual patient: while there was a sense of movement ('getting on with') in her practice with an individual, it was not expressed in standardised terms of hours and minutes that quantified the length of the class. Clock time appeared during class-taking because of how the practice transformed the ward environment to become a space that was exclusive to the physiotherapist and a group of patients. By accepting the discipline of clock-time, physiotherapy became synchronised and integrated with the flow of activity on the ward (Adam, 2004) in a way that maintained the distinctiveness of its practice in the ward environment.

Unlike nursing staff, ward-based physiotherapists were not usually assigned to a single ward, but would 'go 'round the wards, teaching exercises following operations, and that sort of thing' [Hilda, retired physiotherapy manager/physiotherapist (voluntary sector)]. Physiotherapy's freedom to move across the hospital site differentiated its practices from other professions whose movements were contained by the ward/disease boundaries associated with social organisation of a hospital (Mol, 2002). The process of moving around the hospital meant that a physiotherapist would have bodily awareness of a hospital ward at the time of their visit, but not of what had been happening since their last visit. This gap in knowledge of the situations and events occurring on the ward was bridged by establishing a working relationship with nursing staff, as Fran explains:

I managed to sort of get on with them [nursing staff], and get to know more of what was going on on the ward and therefore got to know more about the patients.

[Fran, private practitioner/retired physiotherapy lecturer]

By reaching across the physiotherapy/nursing boundary, Fran facilitated the flow of information about the changing processes and situations from nursing staff who had been physically present on the ward in her absence (Davies, 1995). This flow of information about the ward produced the knowledge about patients' signs and

symptoms that the CSP's 1955 curriculum taught physiotherapists to interpret before applying a programme of physiotherapy practice prescribed by the doctor (Tidswell, 1991).

Bridget's experience of practice with patients with arthritis describes how the ward environment and its nursing routines created opportunities to maintain the flow of physiotherapy practice during the physiotherapist's absence:

Because they [referring to a set of parallel bars] were something on the ward, all the time, that the patient could be helped, if an auxiliary or a nurse had spare time. The nursing staff would have it, timetabled in if you like, into their [the patient's] routine. "Look, if you have a spare moment, could you help Mr Bloggs? He needs to practice." And that did work. They were a bit like assistants really. And a lot of walking in parallel bars - but it all took place on the wards.

[Bridget, retired physiotherapist]

Bridget describes how some wards included as a permanent piece of equipment a set of parallel bars – as is still the case on rehabilitation wards in contemporary hospital settings. Parallel bars are a standard piece of physiotherapy equipment. The bars are usually about 15 – 20 feet long and run about two feet apart; they are effectively a pair of handrails that provide a safe physical and emotional space for working on patients' balance and walking. Their association with balance and mobility and physiotherapy constructed a rehabilitative identity for the ward, while their material presence symbolised the rehabilitative body work experience/produced on the ward. The physical design of the bars produced a boundary that contained the patient's walking body and the body of the physiotherapist if the patient needed their assistance. Bridget's account describes how the parallel bars enabled physiotherapy practice to be maintained in the physiotherapist's absence by the ward-based staff ('auxiliary or nurse').

On crossing the boundary into the physiotherapy space between the parallel bars with a patient, the nurse started to produce physiotherapy practice. This account is distinct from Fran's previous descriptions of ward-based physiotherapy where nurses were excluded from the physiotherapy treatment space. The presence of the parallel bars meant that the specific body work Fran undertook to maintain a spatial and professional boundary for practice on the ward had become

superfluous. Because she did not need a bodily presence to maintain the boundary for physiotherapy practice, Bridget could ask nursing staff to undertake the walking practice associated with the parallel bars as an integral part of the patient's routine on the ward. Although nurses could enter the physiotherapy treatment space, they did not become physiotherapists because the physiotherapy activities they performed were delegated by Fran ('a bit like assistants') for doing 'if they have a spare moment'. This process of delegating an activity reasserted a hierarchical relationship between physiotherapy and nursing, and maintained the productive flow of physiotherapy practice ('and that did work') in the absence of the physiotherapist.

Collectively, these accounts begin to show how the CSP's qualifying curriculum (CSP, 1945; CSP, 1955) produced physiotherapists who through their understanding of the physical and social organisation of a hospital ward 'made it easier for [nurses] running the wards' [Thea, retired physiotherapist]. Students' initial unfamiliarity with the nursing environment is described in terms of how the work, bodies and context contrast with the physically active, young and healthy bodies of the practical classroom environment. The contrast created a sense of vulnerability that enabled physiotherapy students to enter the patients' world where they started to become aware of the body's potential for multiple realities (Mol, 2002). It is here that they began to learn the symptomology of the medical and surgical conditions they would meet in their future physiotherapy practice. Students crossed the gap between the physiotherapy practical classroom and nursing environment of the ward by engaging in the disciplining movement introduced in the practical classroom to reassemble their bodies to 'fit in' with the norms and practices associated with nursing. Having learnt to negotiate the physiotherapy/nursing boundary, the data suggest that there was constant movement across it as physiotherapists responded to the bodily needs of their patients and contributed to the overall productivity of the ward, in ways that maintained the distinctiveness of physiotherapy practice.

Multiplying practices

The use of movement as a means of discipline, learning and practice described in the accounts of nursing practice was sustained and amplified as students were introduced to physiotherapy practice. Despite introducing an expectation that students would have completed 1500 hours of practice supervised by clinical or teaching staff on qualification, the CSP's 1955 curriculum offered no further guidance about the content, structure or outcomes of students' clinical experience. Teaching staff were therefore free to develop packages of supervised practice that accommodated the availability of placements locally, and the interests and expertise of staff supervising the students. By creating space to accommodate local variations in the organisation of physiotherapy practice, the curriculum acknowledged the autonomy and capabilities of academic staff to design appropriate learning opportunities, and of managers and clinical staff to organise and deliver a physiotherapy service.

Interviewees' experiences of CSP's 1945 and 1955 qualifying curricula suggest that although there were geographic variances in the sorts of practices students were able to access, training schools adopted broadly similar approaches to ensure students 'got a very varied training' [Annie, retired physiotherapy clinician/manager]. After six months of training and a period of nursing practice, students were introduced to supervised physiotherapy practice alongside ongoing theoretical work:

You then had mornings of theory, and afternoons working on the wards or in the departments.

[Pam, retired physiotherapy manager]

Despite the curriculum's attempt to integrate theory and practice, physically and discursively, they remained in tension. Theory and practice became dis-integrated by becoming associated with a specific temporal rhythm (morning or afternoon) and physical location. 'Lectures and theoretical work' [Bridget] happened in 'the classroom' [Thea] or 'lecture theatre' [Steph], while clinical practice happened in 'the gym' [Thea], 'the department' [Bridget/Pam/Steph], or 'on the wards' [Pam]. I am suggesting that the divide was produced by a professionalising discourse which sought to draw attention to the presence of 'theory' necessary for professional

practice within the qualifying curriculum (Freidson, 1970). Drawing from the work of Mol (2002), the timetable produced two bodies – the theoretical body that was done in the classroom, which became the practising body as it moved into a clinical environment. The transition from the classroom to the clinical environment was typically undertaken on foot or by public transport, and required an extended lunch-break:

We worked our way through the syllabus as it was, but only on the half days. We went to our placement on the other half, which sometimes got a bit complicated with distance and stuff... We must have had an hour and a half lunch hour - enough to get ourselves back from wherever we were.

[Susie, retired physiotherapist]

Susie's account of the split timetable describes the transition from doing the practising body on placement to become the theoretical body in the classroom. The transition is described from the perspective of the classroom which means the practising body was being done out of view on placement, as the theoretical body moved systematically 'through the syllabus' in a single location. The spatial/temporal gap between the practice site and the classroom offered an opportunity to rehearse autonomous problem-solving ('got a bit complicated') associated with their future work as physiotherapists. While not a focus here, clothing such as a 'blazer' [Thea] or 'cloak' [Steph/Susie] were used by some Schools to delineate and discipline students' transition between sites (Delamont, 1989). Physiotherapy's outdoor garments provided physical protection and a specific identity in return for being identifiable and therefore subject to rules governing the practices associated with that identity (Foucault, 1988).

The transition from the hospital to the classroom was organised over the middle of the day; a time 'when everybody took their break' [Steph]. The timing of transition minimised any disruption to the flow of practice caused by students' departure from the workplace. It also provided opportunities for students to adjust their body clock and embody the timetabled practices of a physiotherapy department. Susie talks about her lunch-time in terms of spatial relocation ('get ourselves back') and clock time ('hour and a half'). Clock time introduced an element of standardisation and offered students a structure to pace their journey and co-ordinate their movement with public transport timetables (Adam, 2004). Just as with Fran's class-

taking experience, clock time enabled the practising bodies from across a number of different placement sites to become synchronised with the classroom timetable (Adam, 2004), and provides a measured space for students to prepare their bodies for an afternoon of classroom-based practice.

The movement produced by the split timetable became amplified as students clocked up the 1500 hours of supervised physiotherapy practice mandated by the CSP's (1955) qualifying curriculum:

...we did rotations as a Junior in all departments, rotations as an Inter in all departments, and rotations as a, Finalist student in all departments... Six week rotations in the department... our clinical experience was 1500 hours in those days

[Steph, retired physiotherapy manager]

Steph's account describes how supervised practice was timetabled to ensure that students' gained experience of the fields of practice covered by the syllabus in a way that was aligned with the expectations of the examination structure (CSP 1945; CSP, 1955). The focus of Steph's account is the spiralling flow of movement produced by pausing to practice for six weeks in one placement site before moving onto the next – a cycle which was repeated at three different levels. While Steph and Susie describe their experience of supervised practice in terms of movement, the planes, axes and timeframes of movement are distinct: one is linear, the other rotatory. Susie describes a linear flow running daily along the axis between placement and classroom sites, while Steph describes a flow that rotated through placement sites around a moving axis over a three year period. Rather than being incompatible, they describe how the timetable is organised to meet the qualifying curriculum's expectation of the integration of theory and supervised practice (CSP, 1945; CSP, 1955) on a daily basis (Susie) over a three year period (Steph). This integration is evident from the silence of the classroom-based practice that would have been timetabled to fit alongside supervised practice (Tidswell, 1991) in Steph's account. Here, the flow of classroom practice has become an implied presence, moving steadily onwards towards the final examination, providing a dynamic axis around which students' placement-based practice can rotate.

The integration of classroom and placement practice generated by the physiotherapy timetable was enhanced by the relocation of Physiotherapy Training Schools into NHS Hospitals during the 1940s (Barclay, 1994). The relocation of physiotherapy education can be seen as part of a wider plan to bring medical education closer to the patient's bedside (Rivett, 1998). The integration of theory and practice symbolised by the physical relocation of training schools was reinforced discursively by the curricular requirement for students to be 'treating patients under the supervision of Teachers of Physiotherapy and other Chartered Physiotherapists' (CSP, 1955.p6). These curricular requirements meant that some teaching staff became subject to the same linear and rotational movements as students they worked with.

You see, the practical as well - we moved round. So I was initially over at Drakewood Hospital for my practical half day, and then teaching in the School for the other half day. And then I might be on, we had limb-fitting, you know, the different wards.

[Fran, private practitioner/retired physiotherapy lecturer]

Fran's description of teaching practice during the 1970s describes how her day was split between practice and classroom settings, and how she, like the students she taught, moved around different placement settings. The spatial and temporal boundary between the practice and classroom setting is present in the account, but Fran's transition is silent which suggests that she had become socialised through her previous experiences to negotiate the boundary. Fran's ability to work across the boundary meant that she was able to work with students to create connections between classroom and placement settings:

... we had smaller sets teaching. We used to have October and May intakes, so it was lovely... And then, one year, we had a couple who had dropped out and things, so by the time we got to the wards, there were nine of them. So if I had a particularly good patient that I'd seen, it was quite feasible to take nine people onto the ward to see that patient. If it was an unusual case, I'd take four in, and then the five in or whatever, and it could be done.

[Fran, private practitioner/retired physiotherapy lecturer]

Fran's account describes the process of taking a handful of students onto the ward to visit a specific patient from her clinical caseload; a practice that only becomes possible with a small group of students. This account of practice is distinct from Fran's earlier descriptions of working with an individual patient or a group of

patients on the ward in terms of the bodies presented – the students, the patient and Fran herself. The focus of this account is the patient’s bedside; the silence of other ward-based activity suggests the presence of the professional boundary that delineated the bedside environment as a physiotherapy practice space. This account builds on Mol’s (2002) observations of bodies and practices multiplying as they move across a hospital site by showing how multiplication can happen in a single practice space. As Fran entered the ward with her students, the body in the hospital bed ceased to be a patient and became an object of students’ learning (‘an unusual case’). On reaching the bedside, Fran’s practice multiplied to become an integrated flow of seeing the patient (clinical practice), and doing work with students (teaching practice). Her practice multiplied because of its relationship with the bodies in the bedside space, and became integrated because the body in the bed became the central focal point for Fran and her students.

This account illustrates how Fran’s ward-based practice enacted the expectations of the CSP’s qualifying curriculum to integrate theory and practice (Tidswell, 1991) by working to extend the boundaries of the classroom to reach the patient’s bedside. Although Fran’s account makes this integration seem effortless, her description of moving to practice in an unfamiliar area of ward-based practice highlights the emotional work required:

And I think, depending on your experience, in some wards you could be a lot more helpful. I think I took the approach, that if you went on and said you needed to learn things, and didn’t pretend you knew it all, that helped with the clinicians. They had more respect for you then - that maybe you didn’t know everything, but you did know the theory behind a lot of things.

[Fran, private practitioner/retired physiotherapy lecturer]

Here Fran is reflecting on the movement around different placement settings and her approach to developing working relationships on the ward with her clinical colleagues. There are two contrasting bodies in this account: Fran’s body that is rich in theory and is carrying some embodied knowledge about practice from previous experiences (Sheets-Johnstone, 2009), and the clinician’s body that, by implication knows everything about physiotherapy practice in a particular field. Having established a clinical body that is distinct from her own, Fran worked to negotiate the boundary by establishing a relationship based on learning; exchanging

embodied knowledge of doing 'things' for 'the theory behind a lot of things' with her clinical colleagues. By using her teaching body, Fran produced a flow of knowledge across the theory/practice gap which enabled her clinical body to become 'a lot more helpful' in the ward environment.

Collectively, these accounts of supervised physiotherapy practice show how the temporal rhythms and physical movement present in the design and organisation of the curriculum worked to produce an active disciplined body (Blackman, 2008). The movement of physiotherapy students and teaching staff between placement and classroom sites produced two bodies: a theoretical body associated with classroom practice, and a clinical body that appeared in the placement setting. The accounts describe the initial discomfort felt as students moved from doing a clinical body to become a theoretical body, and of how time and dress were used to discipline their movement. Over time, theory and practice became integrated by structuring students' supervised practice to run as a spiral around a constantly moving flow of classroom based practice. Teaching staff, like their students, were also subject to a split timetable. Their presence in the placement setting caused bodies and practices to multiply: physiotherapy patients became learning objects as Fran works with her students on the ward. Fran's ability to become a teacher/clinician facilitated the flow of knowledge between the classroom and clinical setting and enacted the curriculum's mandate to integrate theory and practice.

Moving towards professional autonomy

The spiral of movement associated with supervised practice passed through three levels which were associated with the CSP's examination structure and structured around a specific timeline. Students needed to have completed at least eighteen months training before entering the Preliminary examination, thirty months before entering the Intermediate, and thirty-six months before entering the Final examination (CSP, 1945; CSP, 1955). The movement through each level was associated with increasing levels of autonomy and exposure to the multiple bodies of physiotherapy practice. This process produced a hierarchical structure that disciplined the student body. In some cases, the hierarchy was reinforced visually by uniform markers such as coloured belts or tabs on epaulettes [Thea/Steph] or by

the spatial organisation of a treatment area [Bridget]. This section describes the transitional movements that mark students' rite of passage to becoming qualified physiotherapists.

Students' initial exposure to physiotherapy departments was characterised by undertaking basic tasks under supervision as Thea explains:

... and then half a day we would be going into the gym or you know, but very much, under supervision. We would be doing very, very simple things.

[Thea, retired physiotherapist]

Thea's account of an early placement describes the linear flow of movement from the classroom into the department. Once she had arrived into the gym, the flow of movement became spatially confined because she was working 'very much under supervision'. The containment meant that the gym environment could become more like the practical classroom environment where Thea's practice would have been supervised by a physiotherapy teacher. This reduced the differences in relative flows of practice between classroom and placement sites, which eased Thea's transition into the placement environment.

As placements progressed, the initial spatial containment described by Thea was reduced:

Then the physiotherapy to begin with was a lot of, we phoned for ambulances, we took the patients down to the ambulances. We were just helpers in the department. We folded bandages. We folded pads for electrotherapy and things.

[Fran, private practitioner/retired physiotherapy lecturer]

Fran, like Thea was undertaking basic activities, but she was no longer confined to the physiotherapy department because she was following the flows of activity required for processing physiotherapy patients. The movement present in this account provided opportunities for Fran to develop embodied knowledge of the spatial layout and infrastructures of the hospital (Sheets-Johnstone, 2009) – knowledge that she would draw on later as her practice moved into the ward environment. Fran's description of the activities she performed as a 'helper' uncovers some of the individual components and processes that became assembled through doing physiotherapy. She describes handling patients' bodies, information

(‘phoned for ambulances’) and physical equipment (‘bandages’) – components that would have been familiar from her previous experience of doing nursing practice (CSP, 1955). This account describes how Fran was learning to assemble these already familiar components within a physiotherapy department so that they became physiotherapy practice.

Students’ experience of physiotherapy practice started to move beyond undertaking basic physiotherapy tasks under supervision once they had sat the preliminary examination:

You weren’t allowed to do very much initially... until you’d taken your Prelims at eighteen months. And then after that, you would have your own caseload.

[Pam, retired physiotherapy manager]

The preliminary examination consisted of a series of written papers on anatomy, physiology and the principles of electrotherapy, and a short oral examination on anatomy and physiology (CSP, 1945; CSP, 1955). Although the examined content was focused on the theoretical content of the curriculum, the conduct of the oral examination provided opportunities for examiners (doctors and teachers of physiotherapy) to observe and give feedback on candidates’ physical appearance and behaviour in the public space of the examination hall. The ‘prelim’ therefore became a means of assessing students’ readiness for professional practice. As such it was a milestone in the rite of passage to becoming a physiotherapist (van Genneep, 1960), marking the transition from ‘helpers in the department’ [Fran] to carrying a physiotherapy caseload.

Students’ initial caseload was restricted to the more familiar medical and surgical conditions listed in the qualifying curriculum. Many of the patients on students’ caseloads had long-standing conditions which meant that they were already familiar with physiotherapy practice:

And then we were allowed to have patients. And the patients had been coming to hospital for years, for the students to practice on them really... OA [osteoarthritis] knees that were just on continuous treatment. MS [Multiple Sclerosis] patients... But it did give us that ability to talk to people, and practical hands-on. And they would pass on “The girl last time did this

with me, so..." which would influence what we thought we should be doing. You know – professional patients.

[Fran, private practitioner/retired physiotherapy lecturer]

Fran's reflection of being 'allowed to have patients', describes how a student caseload was assembled to provide opportunities for students to learn through their interaction with patients who had long-standing experience of physiotherapy. The account reproduces the practical classroom where students acted as models and gave feedback on each others' practice, but moves it into the less familiar environment of the physiotherapy department. Physiotherapy practice was being done because Fran was working with a body who had a 'medical and surgical condition' rather than with the healthy bodies of her peers. The patients she describes in this account had embodied knowledge of physiotherapy practice because they 'had been coming to the hospital for years' for treatment. The relationship of Fran's relative inexperience and the patient's embodied knowledge combined with the absence of a physiotherapy supervisor in the treatment space caused the patient's body to multiply. They became a 'professional patient' – simultaneously teaching Fran how to do physiotherapy practice, supervising that practice, and becoming the object of practice.

Physiotherapy practice in the 1950/60s was organised according to the location of patients within the hospital. In general hospital settings, physiotherapists were allocated to work 'on the wards, in outpatients or on maternity' [Jane – retired physiotherapist (industry)]. Students' placements were structured to emulate the organisation of physiotherapy practice which provided opportunities for students to learn how to move across the hospital site:

We weren't all going to have specialities – because they were General Hospitals. We did rotations as far as they could. In those days General Hospitals had a chest ward, a medical ward, an orthopaedic ward, care of the elderly, children's ward. So you did get an opportunity to experience - but it was General Hospital. So because we didn't have specialities, we had specialist placements... And you had two - in your final year.

[Bridget, retired physiotherapist]

Bridget's account illustrates how medical discourses have shaped physiotherapy practice both in terms of curricular design (see Chapter 5) and organisation of practice (Hugman, 1991; Larkin, 1983). She describes the process of rotating

through a variety of medical specialisms, which became increasingly specialised over time. The wards contained medicalised bodies; patients had become ‘a chest’, or a bone (‘orthopaedic’), or were the objects of medical intervention based on their age (‘care of the elderly’ and ‘children’). By working on medicalised bodies in practice settings that were aligned with the organisation and structure of medicine (see Chapter 5), physiotherapy became a medicalised practice. Despite becoming a medicalised practice that was aligned with and subordinate to medicine (see Chapter 5), I am arguing that the organisation of physiotherapy practice differentiated it from medicine. Although a doctor was free to move across the hospital site, their practice was bound by a medical or surgical specialism which served to reinforce their status (Freidson, 1970). Physiotherapists on the other hand were organised to move across the ward/disease boundaries constructed by medicine (Mol, 2002; Turner, 1992):

You would go to all the patients that needed [physiotherapy], sort of going ‘round and ‘round

[Jane, retired physiotherapist (industry)]

Jane’s account shows how the rotational movements she embodied as a student became enacted on a daily basis to produce programmes of physiotherapy that were responsive to the changing needs of bodies on the ward. These complex patterns of movement moved physiotherapy practice beyond the immediate supervisory reach of medicine (Turner, 1992) and provided opportunities for physiotherapists to enact autonomy:

Oh no. No, no. ‘If you were on the wards, you could do what you liked... at the General, you really used your own erm, judgement. And you were expec-, you know, if you’d been around, and you were a Senior.

[Jane, retired physiotherapist (industry)]

Having confirmed the relative freedom [‘could do what you liked’] associated with ward-based practice, Jane attended to the embodied decision-making (‘used your own erm judgement’) involved. Discursively, ‘judgement’ appeared with movement and time (‘been around’) – a reflection of the movement, repetition and time required to embody knowledge/expertise required to enact autonomous decision making (Rose, 1999; Sheets-Johnstone, 2009). Rather than being a threat to medicine, I am arguing that physiotherapy’s autonomy enhanced the efficiency and effectiveness of ward-based medical practice. The division of labour established by

physiotherapy's subordination settlement with medicine contained physiotherapy's autonomy to delivering treatments that were sensitive to the changing needs of the rehabilitating bodies on the ward (Abbott, 1988; Freidson, 1970; Larkin, 1983).

The curriculum was organised to develop students' capacity for autonomous practice. Progression through the curriculum was marked by increasing the amount of time spent in clinical settings being exposed to an increasingly diverse range of medicalised bodies:

And then in the last year, we had probably two days or two afternoons in the School – the rest of the time working on the wards, or doing things in different hospitals, in different specialities. Supervised by whoever was there at the time.

[Jane, retired physiotherapist (industry)]

Jane's account of her final year describes a change in the rhythm of practice. The steady beat between placement and the classroom described by prelim students had become less regular. There was still a linear flow of movement between classroom and placement sites, but finalist students paused in the placement site before returning to the classroom. This pause in placement was filled with movement across boundaries within the placement site – 'working on the wards' 'doing things in different specialities'. The absence of another person in this account suggests that Jane was working with minimal supervision, which was preparing her to become a productive member of the physiotherapy department 'who can do the job on day one' [Michael, private practitioner/retired physiotherapy lecturer].

The growing integration with the physiotherapy department over time was reflected in the structuring of the students' timetable:

No - a physio's working day. Yes because when I qualified in '64 I worked nine to five with an hour's break - for lunch. But I also did Saturday mornings and evening clinics.

[Bridget, retired physiotherapist]

Here Bridget is responding to a question about the influence of timetabling on the process of making the transition from Finalist student to becoming a qualified physiotherapist. Her response shows how the timetable was used to discipline

students' bodies to prepare them for working practice. The socialisation process meant that on completing the Final examination the transition of becoming a physiotherapist was complete:

And the amazing thing was, you finished on the Friday... Nobody, there was no presentation. You just came to the end of that Friday, and that was your last day. So there was, there was absolutely nothing... You finished your training, and you said goodbye, but there was nothing to celebrate it - which is most odd.

[Steph, retired physiotherapy manager]

Steph's description of her last day of being a student reflects her surprise at the absence of ritual to mark the transition into qualified practice. Rituals are present when there is a boundary to cross (van Gennepe, 1960). The absence of ritual at the end of the training programme suggested that there was no boundary to cross; the curriculum design and students' movement meant that they had become incorporated into the body of physiotherapy. The transition was complete. The theoretical body and practising body had become integrated to become an autonomous, self-disciplined, physically active physiotherapy body ready to start work on Monday.

Conclusion

This chapter has followed the process of becoming a physiotherapist to show how movement is central to the disciplining and organisation of physiotherapists' bodies. My analysis has uncovered the disciplined and disciplining body work required to move from an interest in becoming a practical professional to enacting embodied professional practice. The curriculum was organised to provide a graded exposure to the moving/touching body work of doing physiotherapy in ways that simulated and replicated the organisation and realities of its practices. The process of becoming began by handling un/dressed bodies of peers in the clean, stable environment of the practical class before moving to handle patients' bodies as a supernumerary nursing probationer on a hospital ward. Here, students embodied the movements that became enacted as a semi-permeable boundary that contained physiotherapy practice while accommodating the movements needed to contribute to the efficient running of a ward.

Having learnt the physical/affective work of handling bodies and boundaries, students moved into physiotherapy practice. Their movement amplified as they moved between classroom and clinical settings (linear movement), and around the multiple specialities that made up physiotherapy practice (rotational movement). The linear movement produced embodied theory/practice, while the rotational movements generated kinaesthetic memories required to adjust and improvise movement as patients and environments changed. Together these movements prepared students to enact the autonomous decision-making practices required for physiotherapy practice. I am arguing that physiotherapists' autonomy was generated by organising its practices to run across the ward/disease boundaries constructed by medicine. Physiotherapy's cross-cutting practices moved physiotherapists beyond the immediate supervisory reach of medicine, which created the space for autonomy. The close alignment of and movement between education and practice produced physiotherapists who were work-ready and able to enact authentic, autonomous physiotherapy practice immediately on qualification. It is to these practices that I turn next.

Chapter 7

Physiotherapy's moving/touching practices

We touch when we take the time to relate and to use all of our skills. When orthopedic [sic] therapy becomes relegated to the isolated uses of manual therapy techniques, with emphasis on snaps, crackles, and pops, we are not touching. But when we teach our patients and use our skills as movement specialists by relating to our patients, we are touching.

Rothstein (1992. p249)

The hand is a sensory-motor organ (Ayres, 1979). Its rich nerve supply and anatomical structure allow humans to use their hands to manipulate tools, to form social relationships, and to make sense of the world through touch (Classen, 2005; Turner, 1992). Hands are embodied; they are simultaneously physical and affective and provide a means of interacting productively with society (Peloquin, 1989; Turner, 1992). Physiotherapy's hands can be seen on the lozenge badge worn by chartered physiotherapists where they symbolise physiotherapy's moving and touching practices (Anon, 1994). Physiotherapy's hands can be heard running through its practice lexicon in phrases such as manual therapy (a series of movement/touch techniques including massage, mobilisation and manipulation) and manual handling (the process of moving/touching bodies). Physiotherapists' living hands come to know the patient's body from three different perspectives. The physiotherapist's sense of touch knows the body's surface temperature and texture; proprioception (awareness of the body's position in space) knows the body as a three-dimensional entity that has a shape, contours and depth; while kinaesthesia knows the body through its movements (Ayres, 1979; Sheets-Johnstone, 2009). This chapter draws on the interview data to explore how physiotherapists' hands experience/produce professional practice. The chapter is informed by sociology of profession (see Chapter 2) and body work (see Chapter 3), and is sited within an expanding collection of healthcare literature that uses the concept of embodiment to make sense of professional practices and identities.

Embodiment challenges the idea of the biological and social existing as separate entities and focuses attention on the dynamic interplay between the body and the world the body lives in (Blackman, 2008; Twigg, 2006). Embodiment provides a conceptual framework that acknowledges the bodies and body work of

physiotherapists and patients that produced/experienced the professionalisation of physiotherapy presented in Chapter 5. This chapter presents an embodied account of physiotherapy's professional practice as seen through the analytic lens of the phenomenological lived body. A phenomenological perspective is especially relevant for analysing physiotherapists' accounts of practice because of its capacity to attend to the sensuous bodies and body work associated with doing physiotherapy (Crossley, 2007). As such it uncovers how physiotherapists construct professional identities and practices through their experience of and interaction with artefacts, practices and technologies in their work environments (Blackman, 2008; Sheets-Johnstone, 2009).

The chapter draws on discourse analysis and phenomenological analysis of depth interviews conducted with 12 physiotherapists who trained during the 1940/60s (see Chapter 4). As such, they would have shaped and been shaped by the changing discourses, situations and practices that produced the CSP's 1984 curriculum (see Chapter 5). One theme that ran through the interviews was the 'hand' and haptics. This chapter uncovers how the discourse of the hand constructed a practice profession, and reproduces physiotherapists' experience of physiotherapy as an intimate physical practice that touches and moves the bodies of physiotherapists and their patients. This chapter will explore the different ways in which physiotherapy's hands touch and move the bodies of physiotherapists and their patients and produce professional practice. The chapter will show that physiotherapists experience/produce the autonomous problem-solving processes associated with a practice profession through their handling of patients' moving bodies (Abbott, 1988; Freidson, 1970).

Chapter structure and content

This chapter is presented in two sections. The first half unpacks the discourse of the hand which was threaded through interviewees' accounts of experiencing/producing physiotherapy practice. This section of the chapter shows how interviewees present their hands as an embodied medium for experiencing/producing the relationships and moving/touching practices associated with an active and practical profession (see Chapter 6). Having positioned their

'hands' as the means of producing physiotherapy practice, 'hands-on' becomes the tactile/proprioceptive sensations associated with physiotherapeutic touch, while 'handling' becomes the tactile/proprioceptive/kinaesthetic (collectively known as haptic) sensations associated with physiotherapy's moving/touching practices (Ayres, 1979). I am arguing that the discourse of hands reproduces the curricula's integration of movement/touch that created capacity for professional practice (see Chapter 5). The second half of this chapter presents an analysis of the practices produced/experienced by physiotherapists' hands from the task-oriented activities experienced/produced by hands-on and ends with the autonomous problem-solving processes experienced/produced by physiotherapeutic handling. This section shows how the integration of movement/touch produced by the CSP's qualifying curricula (see Chapter 5) becomes embodied to produce a dynamic professional practice that touches and moves the lives of physiotherapists and their patients. The process of constructing professional practice begins with physiotherapists' hands.

Discourse of the hand

Hands: producing embodied autonomous practices

Interviewees presented their hands as a means of producing and experiencing the active practicality of physiotherapy practice:

...our hands, I think were our greatest tool. Greater than any machine we were ever given...

[Annie, retired physiotherapy clinician/manager]

Annie describes physiotherapy's hands as a valuable tool that are an integral part of physiotherapy's body ('our') whilst being an extension of it ('tool'). Discursively, Annie constructs a hierarchy that values the embodied practices produced by physiotherapists' hands above the technical practices produced by equipment or machinery. Annie spent most of her career working with children and adults with profound physical disabilities where practice was characterised by therapeutic handling and positioning (Rennie, 2007). Hands were valuable in this setting because, unlike the programmed movements of mechanical equipment, they were

embodied and could therefore respond and adapt to the changing rhythms and movement patterns of patients' moving bodies (Shilling, 2005).

The responsiveness and adaptability of physiotherapists' hands generated practices that could move across organisational boundaries (see Chapter 6):

We didn't have any electrotherapy, which was gradually phasing out. You know, you didn't have the bits and pieces that you had in the Department. You had your hands.

[Steph, retired physiotherapy manager]

Here, Steph is describing her transition from the hospital-based practice to work in the community during the 1980s. This movement was produced/experienced by hands that could practice independently of equipment ('electrotherapy') or apparatus ('bits and pieces'). Her account reproduces the construct of physiotherapy as 'natural methods based essentially on movement, manual therapies and physical agencies' (CSP, 1984. p2) that appeared during the 1970/80s (see Chapters 3 and 5). By constructing hands that were responsive to patients' bodies and could work independently of equipment, Steph's physiotherapeutic hands became the practice (Mol, 2002). I am arguing that the embodied autonomy inherent in Steph's community-based hands/physiotherapy constructed a professional identity for physiotherapy practice (Freidson, 1970; Shilling, 2005).

Physiotherapists' embodied hands create tensions for physiotherapy's professional project. Their capacity to work independently of equipment produces a performance that can be 'pooh-poohed... [and] known as low tech' [Derek, retired physiotherapy manager/physiotherapist (voluntary sector)]. 'Low tech' hands are potentially problematic for a professionalising occupation because they are poorly defined and appear to produce practices associated with low status manual work (Abbott, 1988; Freidson, 1970). There is evidence of physiotherapy managing this tension by introducing technologies such as tape measures, goniometers (a long-armed protractor used to measure joint angles) and computer programmes into the qualifying curricula during the 1970/80s (CSP, 1974; CSP, 1984). The presence of technical equipment provided definition of the practice by differentiating physiotherapy's hands from the hands of the laity, and the plethora of other 'manual' workers (e.g. nurses, osteopaths, occupational therapists) practising in the

healthcare system (Abbott, 1988). Equipment also made the performance given by physiotherapy's embodied hands appear technical (Goffman, 1959 [1971]), and replaced the subjectivity of sensory perception with standardised objectivity of a tool (Turner, 1992). I am suggesting that the adoption of equipment by physiotherapy during the 1970/80s would have supported the professionalisation of its embodied practice, while aligning physiotherapists' identities and practices with the discourse of scientific rationality associated with NPM (Freidson, 1970; Hood, 1995).

Physiotherapy's occupational status is also potentially compromised in environments where physiotherapy's embodied hands are found managing the negativities of the body. The tension created by these situations is described by Pam's account of working with a distressed student on placement:

Now she [a student on placement] was eighteen months into her training, and didn't like touching older people. I think they'd concentrated on the academic side. The basic nitty gritty hands-on – you're gonna get your hands dirty. And patients are going to do a wee all over you if they're elderly and incontinent.

[Pam, retired physiotherapy manager]

In this account, the student's hands had moved onto a hospital ward to work with frail bodies ('elderly'). Pam makes sense of the student's discomfort in terms of an imbalance between the theoretical ('academic') and physical ('hands-on') elements of physiotherapy's professional practice. Having established that physiotherapy has an 'academic side', Pam turns her attention towards the hands that are the basis ('nitty gritty') of physiotherapy practice. Her focus on the physicality of practice ('touching', 'dirty') and use of textural language ('nitty gritty') constructs a feminised pair of hands that interact with their environment through touch (Davies, 1995). Physiotherapists' hands are susceptible to becoming soiled ('gonna get dirty') in the hospital ward environment because they are working with bodies whose boundaries are unpredictable ('incontinent') (Twigg, 2006). In the ward environment described by Pam, physiotherapists' hands experienced/produced multiple practices. They had been disciplined to enact the autonomous

moving/touching practices associated with physiotherapy, and the dirty work associated with intimate physical care (see Chapter 6).

Physiotherapy's capacity for dirty work creates a tension for its professional identity. Although physiotherapists' hands were able to maintain a boundary that protected physiotherapy from other ward-based work (see Chapter 6), their association with low status care work activities and abject bodies potentially obscured their capacity for autonomous professional practice (Freidson, 1970; Twigg, 2006). This threat was managed by a professionalisation discourse that differentiated physiotherapy's hands from other hands present in the ward environment:

Nurses have contact, but in a different way to physio. They're, what they're doing is tasks. They're bathing, they're putting them on commodes perhaps... which is giving the patient, much more comfort from their hands. We're giving comfort with our hands, but it's a different – it's just a totally different approach.

[Steph, retired physiotherapy manager]

Steph's reflection on her experience of ward-based physiotherapy presents the hand as a means of expressing and providing care ('giving comfort') through physical touch ('contact') (Peloquin, 1989; Roger et al, 2002). Although nurses and physiotherapists used their hands to care, Steph's account attends to the differences in how their hands experience and produce that care. Nurses' hands produced care by performing intimate but time-limited physical tasks ('bathing', 'putting them on commodes') while physiotherapists' hands produced care as they practiced physiotherapy. Task-oriented hands transferred care 'from' the carer to the patient, in contrast to the process-oriented hands that produced and shared ('with') caring practices that were experienced as physical and affective (Burkitt, 1999; Peloquin, 1989). Discursively, Steph distances physiotherapy's hands from the dirty work associated with nursing and focuses on their physical/affective practices that generate physiotherapy/care (Twigg, 2006).

These hands are unique to physiotherapy as Derek explains:

And she [Joyce Williams – Chair of CSP Council 1982-5] once said to, either to me or to a group of us “We’re the only people who are licensed to touch!” You know, we have the hands on our logo...

[Derek, retired physiotherapy manager/physiotherapist (voluntary sector)]

Derek’s account of a conversation with Joyce Williams positions hands as symbolic of physiotherapists’ regulated touch, which itself is unique to physiotherapy. The logo that Derek refers to is the CSP’s lozenge-shaped enamel badge (Figure 6) whose design remains unchanged since its introduction in 1943 (Anon, 1994).



Figure 6: CSP lozenge (downloaded from <http://www.csp.org.uk/images/csp-lozenge-0>)

The badge denotes that the wearer is a chartered physiotherapist whose practice is bound by the CSP’s professional code and standards of practice. CSP members are encouraged to wear the badge on their work clothing as a ‘hallmark of professional quality’ (www.csp.org.uk/using-csp-brand).

The badge is made up of two parts: a central panel containing heraldic patterns and symbols which is bound by a border containing the Society’s title and its motto ‘digna sequi’ which speaks of the wearer’s obligation to pursue worthy aims (Anon, 1994). The symbolism in the central panel maintains the separateness of technical electrotherapeutic practice from the autonomous movement/touch practice produced by the 1945 curriculum (see Chapter 5). The three lions represent physiotherapy’s Royal Charter itself; while its practices are represented by a pair of

the hands (practices of exercise and movement, manual therapy and kindred approaches) and the rays of light and electric current radiating from a sphere (electrophysical modalities) (Anon, 1994). The spatial organisation of physiotherapy's practices in the central panel of the badge is open to interpretation. The central panel can be seen to construct a hierarchy that positions its technical electrotherapy practices above its practices of movement/touch. Alternatively, the positioning of the hands between the lions presents physiotherapy's movement/touch practices as being core to its chartered status. Whichever interpretation is chosen, physiotherapy's hands are visually contained by the Society's title and motto.

The visual imagery and spatial organisation of the badge constructs and legitimates its wearer as someone who uses their hands to practice. The wearer's hands have a royal connection (the lions) and are contained by an ethical ('digna sequi') and professional ('Chartered Society of Physiotherapy') framework. I am arguing that the symbolism speaks of the CSP's desire to construct the practices produced by its members' electric and physical hands as honourable, and presents the Society as the guardian and regulator of those practices (Freidson, 1970). At the same time, the badge constructs the work produced by physiotherapists' hands as something that requires regulating, and positions the CSP with its royal charter as the body to achieve that (Barclay, 1994). The Society's regulatory role is reinforced by engraving the individual's membership number on the reverse of their badge. The badge therefore becomes a symbol of the individual's license to practice, which in turn constructs a professional identity for the wearer and their work (Freidson, 1970).

Hands on: producing touching practices

Having positioned 'hands' as the means of producing physiotherapy, interviewees used 'hands-on' to describe the experience of making physical contact with another body:

...we did quite a bit at the RNIB, which did translate quite well across, because they'd do a lot of tactile. Maybe looking more at the examination of patients and things, and hands-on stuff - more so than the visual aids.

[Fran, private practitioner/retired physiotherapy lecturer]

As a student teacher, Fran spent time on placement at the Royal National Institute for the Blind (RNIB) Physiotherapy School. All students at the RNIB School had a visual impairment (French, 1995) and were therefore dependent on their auditory and haptic senses to learn and practice physiotherapy. Their presence of blind physiotherapists in the workforce demonstrates physiotherapy's ability to accommodate the absence of vision and its dependence on the sensations experienced/produced through its hands (French, 1995; Way, 1950):

He was the first blind person I'd worked with... and he was just absolutely amazing. He taught me more about touch and feel than any of the others [placement educators]

[Pam, retired physiotherapy manager]

Pam's reflection of being on placement as a student sets the blind physiotherapist in a league of his own ('absolutely amazing') because of the qualities of his practices – as a physiotherapist and educator. Pam's placement educator would have developed his ability to 'touch and feel' in the RNIB classroom described by Fran. The RNIB classroom was a touch-oriented ('tactile') learning environment where students perceived and came to know physiotherapy through their hands ('examination of patients and things'). The absence of vision reduced the modes and volume of sensory information available, which allowed the body to focus on tactile/proprioceptive ('touch and feel') sensations experienced/produced by hands-on (Merleau-Ponty, 1962). The body produced by hands-on appeared as a relatively stable object that could be described in terms of shape, size and structure, and its texture and temperature (Classen, 2005). As later sections in this chapter will show, the body generated through touch became embodied to inform the diagnosis-inference-treatment process associated with physiotherapy's professional practice (Higgs & Jones, 2000; Rose, 1999).

As well as being used to experience and know the body through touch, 'hands-on' also described the experience of using touch to direct movement and to produce practice that was recognisably physiotherapy:

... And setting somebody up in slings in a frame. And, the examiner coming up and saying 'Well do you not leave them to get on with it by themselves?' And well no you wouldn't. Because you always had hands-on. You always provided manual resistance, you directed them in what you wanted them to do.

[Steph, retired physiotherapy manager]

Here Steph is reflecting on her experience of the CSP's 'Inters' – a practical examination designed to assess students' ability to perform massage, manipulation and movement, and electrotherapy techniques (CSP, 1955). Steph was asked to demonstrate sling suspension – an assisted exercise technique that worked a body that did not have strength to move against gravity (see Chapter 5). The movement was produced by placing the weak body part in a sling suspended from a frame, and instructing the patient to move the suspended body part (Gardiner, 1953). The presence of the physical technology of slings, ropes and a suspension frame to assist the patient's movement created potential for the patient to exercise independently ('get on with it by themselves') and for the physiotherapist to be released from the treatment space. Steph challenged the pressure to leave the patient by asserting the value of 'hands-on' for resisting and directing the patient's movement.

By maintaining hands-on, Steph transformed sling suspension from being a disembodied biomechanical technique to become an embodied process of movement generated by as the physiotherapist and patient work together (Blackman, 2008). Steph's hands were experienced as physical pressure via the sensory receptors present in the patient's skin, and as resistance via the proprioceptive sensors present in the patient's muscles and joints (Sheets-Johnstone, 2009). The sensations of pressure/proprioception produced by Steph's hands activated the muscular body and provided direction for the skeletal body as it moved through space (see Chapter 5) – without the need for verbal instruction. By activating and directing a moving body through touch, hands-on created space for the physiotherapist and patient to talk/listen to one another while maintaining the direction and flow of physiotherapy treatment (Roger et al, 2002).

While hands-on was used by interviewees to talk about the presence of manual contact in practice, hands-on was also associated with an element of nostalgia; of referring back to a time when practice was different (Jones & Green, 2006):

People are doing their degrees in three, four years, and not so much hands-on. As I said [we did] six months in school, then two afternoons in the department a week seeing patients, and then two days, three days or something, and then slightly less when you're doing your Interims and then your Final... In the end you only went into school for about two afternoons a week.

[Jane, retired physiotherapist (industry)]

Jane's description of physiotherapy training during the 1950s attends to the organised moving process of becoming an autonomous practitioner (see Chapter 6). Hands-on is presented as time spent working in clinical settings embodying the knowledge/expertise required to become a physiotherapist ('Interims' 'Final'). The nostalgia present in her account implies that the contemporary curriculum is less favourable because there is less time for 'hands-on'. Jane is expressing the tension produced by the mind/body binary that was present in physiotherapy throughout its quest for all-graduate entry during the 1970/80s (see Chapter 5). The nostalgia for hands-on speaks how the practices produced by the curriculum become embodied and subject to the discourse, systems and practices of the organisations employing physiotherapists (Cohen, 2011; Jones & Green, 2006). Until the mid-1990s, career progression within the National Health Service (NHS) required physiotherapists (like their peers in medicine and nursing) to relinquish hands-on clinical practice and move into a managerial or academic role (Twigg, 2006; Barclay, 1994). Interviewees' accounts of practice from the 1970s onwards suggest that the devaluation of physiotherapy's hands-on practice inherent in the NHS career structure was not universal. Hands-on practice could be maintained and rewarded financially by leaving the NHS to work in the UK's independent or voluntary sectors [Jane] or by becoming self-employed [Fran] or by working overseas [Michael]. Sociological analyses of the organisation of body work (e.g. Cohen, 2011; Davies, 1995; Gimlin, 2007; Twigg et al, 2011) show that modern bureaucracies like the NHS promote efficiency, standardisation, and disembodied practices. I am arguing that the discourses of efficiency and standardisation associated with bureaucracy challenge the individualised subjectivity of physiotherapy's embodied hands-on practices (Davies, 1995). This poor alignment would explain why physiotherapy's

hands-on practices are susceptible to devaluation within the NHS, and why physiotherapists become affected by their move into managerial roles:

... physiotherapy Superintendents – they were usually working physiotherapists. They were more and more administrative and supervisory, which didn't suit a lot of the Superintendents. It was put on them. They wanted still to keep their hands on... Because they go into physiotherapy as a caring profession. You want to be with people. That's what motivates me – and why I didn't like all this [managerial] stuff.

[Hilda, retired physiotherapy manager/physiotherapist (voluntary sector)]

Hilda's reflection on her experience of becoming a Superintendent physiotherapist (a post that carried managerial responsibility) expresses the discomfort produced by moving away from hands-on practice. The Superintendent's role added a growing workload ('more and more') of 'administrative and supervisory' tasks to the physiotherapist's hands-on practices. Hilda's account constructs two types of Superintendent: those who felt comfortable ('suited') in a managerial role; and a larger group who felt burdened ('put on') by a role that detracted from their capacity for hands-on practice. By referring to the group of managerial physiotherapists as 'they', Hilda aligns herself with the second group who were motivated by feminised hands-on practices rather than the disembodied practices ('stuff') associated with bureaucracy (Davies, 1995; Gimlin, 2007). Hilda's desire for producing embodied practices that touched people's lives was fulfilled outside her paid employment by volunteering in her local hospice.

Derek's account of becoming a District Physiotherapist (a role that involves managing physiotherapy services across a number of NHS hospital/practice sites) expresses a similar tension created by the loss of hands-on in his daily work:

When I first came to Iddleston as a District Physiotherapist, with practically no hands on - that wasn't what I really wanted to do. It's nice having the, the power, the glory and the money, but it really wasn't what I wanted to do.

[Derek, retired physiotherapy manager/physiotherapist (voluntary sector)]

Derek's description of his NHS managerial role as having the power and the glory implies that hands-on is a low status, poorly paid job. In order to progress within the NHS and fulfil his expectations of providing financial security for his family,

Derek had to abandon the hands-on work that was central to his practice. Derek responded to the discomfort produced by his situation by using his managerial skills to gain support from a non-governmental organisation to establish an adolescent sports clinic in his local town. This achievement created a practice environment where he could maintain and develop his hands-on practice alongside his managerial role - at the expense of spending time with his family. He resolves the tension caused by sacrificing hands-on by re-constructing the District Physiotherapy role as an alternative form of embodied physiotherapy practice:

I remember her saying that she regretted no longer having hands-on. But she said “The way I justify it to myself is...if I’m working on patients, I can have an influence on maybe four or five people per day. As a District Physiotherapist I can have an influence over the whole county.”

[Derek, retired physiotherapy manager/physiotherapist (voluntary sector)]

Derek’s reflection on a conversation with a peer presents an embodied account of physiotherapy management. The loss of hands-on associated with the managerial role was compensated for by being able to change the lives of those touched by the physiotherapy service, while maintaining the discourse of hands-on which was emerging as central to the identity and work of physiotherapists (even at a senior level). Derek’s peer constructed managerial practice as a form of labour that produced change, but was not dependent on manual contact. The outcomes of her practice were presented in objective terms (number of patients, geographical spread) consistent with the discourses of rational thought and scientific knowledge associated with NPM (Hood, 1991) which were shaping NHS policy and practice from the late 1970s onwards (Rivett, 1998). Derek’s account of NHS management suggests that physiotherapists sought to avoid devaluation of physiotherapy’s hands-on by producing an alternative form of practice that could touch moving bodies while producing outcomes aligned with the demands of NPM.

Handling: producing moving practices

Having positioned their hands to produce physiotherapy, and hands-on to produce touching practices, interviewees used handling to talk about using their hands to produce movement:

...by learning how to massage you did learn how to handle limbs. And a massage as an actual treatment, I think, had its advantages, but it certainly gave you confidence in handling limbs and things, which I think, is quite hard.

[Thea, retired physiotherapist]

These data show how the curricular reconstruction of 'massage, manipulation and movement' was enacted to produce hands that could move/touch and rehabilitate the anatomical/physiological body (see Chapter 5). Thea's recollection of a 1950s physiotherapy massage class produces two distinct forms of physiotherapy: 'massage as treatment', and 'handling of limbs'. Phenomenologically, Thea's massaging/handling hands experienced/produced tactile, proprioceptive and kinaesthetic sensations (Ayres, 1979). I am arguing that the work produced by the combination of tactile/proprioceptive/kinaesthetic (collectively known as haptic) sensations generated by Thea's hands was determined by the state of the patient's body. When applied to a static body, Thea's hands produced the choreographed processes of positioning, touching and moving a body associated with massage as a treatment (see Chapter 5). When applied to 'limbs' – bodily parts that are recognised by their capacity for movement (Gardiner, 1955) - Thea's hands moved the body. Discursively, handling was experienced as a demanding ('quite hard'), dynamic process of physically moving/touching a moving body through space and time.

As well as being able to physically move moving bodies, physiotherapists use handling to experience/produce moving relationships:

If you've got somebody in pain, you know, it's the way, the way you handle them can make a huge difference as to how, you sort of, build a rapport, you know...

[Thea, retired physiotherapist]

Thea's account of working with painful bodies expresses how handling becomes a means of experiencing/producing a therapeutic relationship ('rapport'). The painful body handled by Thea is not amenable to biomedical containment, but has capacity for movement, interaction and change (Turner, 1992). In this situation handling extends beyond physical movement/touch of 'limbs and things' to become an

embodied process of affective/physical body work used to deal with ('handle') a painful body ('them'). By interweaving affect and material practice Thea accommodates the patient's capacity to move and to be moved, and creates a space for establishing a therapeutic relationship (Blackman & Venn, 2010). Thea's accounts present handling as a dynamic practice that is constantly moving in response to the moving bodies of the physiotherapist and their patients. When it is working with an anatomical/physiological body, handling becomes a process of physical movement/touch that produces rehabilitation. When it is working with a painful body, handling becomes an affective/physical process that produces therapeutic relationships and creates capacity for change.

Key insights: hands, hands-on, handling

The first half of this chapter has traced the discourse of hands running through interviewees' accounts of physiotherapy practice. The presence of hands within the interview data is evidence of how the practices produced by the qualifying curricula became inscribed in practice and reproduce the hands on the Society's lozenge badge (Foucault, 1988). From the inside-out, physiotherapists' hands are a sensory-motor interface, and as such experience/produce the relationships and moving/touching techniques associated with physiotherapy practice (Classen, 2005; Turner, 1992). Interviewees used 'hands-on' to describe the tactile/proprioceptive experience of making physical contact with another body, while 'handling' describes the haptic experience of moving/touching another body (Sheets-Johnstone, 2009). I am arguing that the discourse of the hands produced dynamic embodied physiotherapy practices that created opportunities for the emergence of professional practice – as the next section will show.

Physiotherapy's living hands

Having considered how physiotherapists constructed their practice, the chapter moves on to explore the practices experienced/produced by physiotherapy's living hands. This section draws on physiotherapists' accounts of doing physiotherapy to show how their hands generated physiotherapeutic relationships and knowledge which were integral to physiotherapy's problem-solving practice (see Chapter 3). In the real world, the process of producing knowledge – problem-solving – moving

relationships is experienced as a single physiotherapeutic process. The divisions within this section of the chapter are therefore somewhat arbitrary, but provide a structure for exploring physiotherapy's problem-solving processes from 3 different perspectives.

Experiencing/producing knowledge

The knowledge required to move and touch patients' bodies was also developed through the anatomy and physiology content of the CSP's (1945; 1955) qualifying curricula:

I mean we used to practice anatomy surface markings with your eyes shut...
And I mean I could tell you anywhere now by just touching, with my eyes shut. What and name... all the muscles - every muscle attachment.

[Frederick, retired physiotherapy lecturer/physiotherapist]

Frederick's account describes the experience of learning about the contours ('surface markings') of the body through his hands – in much the same way as his peers at the RNIB School. By occluding his vision, Frederick came to know the body in terms of shape and size, temperature and textures of its surfaces (Merleau-Ponty, 1962). The blindfold disciplined Frederick's body to associate the subjective information experienced/produced at the surface of the bodies of his peers with the objective anatomical body ('muscles – every muscle attachment') produced by the qualifying curriculum (Crossley, 1997). The flat images and textual descriptions of the standardised anatomical body presented by the medical textbooks (CSP, 1945; 1955) became an embodied three-dimensional map of the medical body. This embodied knowledge of the medical body became inscribed as a blueprint that shaped how physiotherapists came to know patients' bodies in the clinical setting:

But the number of times, when I had students I'd say "Feel it, touch it!" you know. And it's so important – that if you don't know what normal feels like, how can you say "This is abnormal?"

[Derek, retired physiotherapy manager/physiotherapist (voluntary sector)]

Here, Derek is reflecting on his experience of working with physiotherapy students on placement. There were three bodies in the learning environment: the student, Derek, and the absent-present patient who was the object ('it') of physiotherapy's gaze and hands-on practice (Kell & Horlick-Jones, 2012; Turner, 1992). Derek's

encouragement to 'feel' invited the student to attend to the bodily sensations experienced/produced through physical contact ('touch') with the patient's body (Blackman, 2008). Feel is a noun, verb and adjective used to refer to elements that are sensual, somatic and experienced/produced through the body (Blackman & Crombie, 2007). Discursively, Derek's instruction reproduced the moving/touching practice associated with physiotherapeutic handling of the object body described earlier. Derek's account described how 'touch' and 'feel' generated knowledge of the patient's body which could be compared against the blueprint of the medical body embodied in the classroom (May & Newman, 1980). In the clinical setting, the embodied blueprint of the body acquired a normative function which produced knowledge of the patient's deviant body ('this is abnormal') (Jones, 1995; Turner, 1992).

Feelings are embodied phenomena that require language and discourse to become meaningful and communicated (Blackman & Crombie, 2007). Having used their hands to experience/produce a deviant body, physiotherapists develop language to articulate the qualities of the abnormality they perceive:

... somebody comes in and says, 'I've torn my hamstring!' And I say, 'OK, lie on your front, and let me feel.' And I feel for the bit of scar tissue, or spasm in the hamstring muscle... It feels something like a cigarette or a cigar, buried in the muscle, if you've got a strip of fibres that are in spasm or a, scar tissue.

[Derek, retired physiotherapy manager/physiotherapist (voluntary sector)]

This account describes Derek's experience of being approached by an athlete for a physiotherapeutic opinion of a newly acquired sports injury. Derek's embodied knowledge of anatomy and physiology enables him to recognise the abnormality in the athlete's body through his hands. Derek responds to athlete's embodied knowledge ('I've torn my hamstring') by instructing the athlete to position their body ('lie on your front') to expose the injured part. Derek likens the sensory perceptions of spasm, swelling and heat associated with a muscle tear to an everyday object ('a cigarette or cigar') that he and the athlete would recognise (Merleau-Ponty, 1962). Having defined the abnormal body described by the athlete, Derek uses the label to feel for the muscle tear (Buttimer, 1976). Once the athlete lies down, their body becomes a hamstring muscle, and then a strip of fibres within

the muscle belly under Derek's hands. The focusing of Derek's hands deconstructs the athlete's body which in turn exposes the abnormal body 'buried in the muscle' (Leder, 1992). Derek's hands leave the body in a deconstructed state because they have completed the task generated by the athlete's request for a diagnosis. It is likely that the athlete would have knowledge from previous experience of how to treat a muscle tear, which would explain why inference and treatment processes associated with physiotherapy's problem-solving practice (Jones, 1995) are silent in Derek's account.

Experiencing/producing autonomous problem-solving practices

Frederick and Derek's accounts describe how their hands experienced/produced objective knowledge about what a body is (being) (Crossley, 2007). Frederick's hands came to know the precise location, orientation and actions of the body's musculature, while Derek's embodied knowledge of the medical body produced an objective physiotherapeutic opinion. Steph's account of handling expresses how embodied knowledge about what the patient's body is generates instructions about what the physiotherapist's body should do (Abbott, 1988):

It's being handled almost isn't it? You know, the way you approach somebody and the way you feel a joint. You don't just palpate, or look for swelling, you actually feel that swelling, and see what you can do to get rid of that swelling. To get movement in that joint.

[Steph, retired physiotherapy manager]

On approaching the patient, Steph sees that they have a swollen joint. This visual perception enables Steph to focus her handling; she feels the joint to develop a haptic perception of the qualities of the swollen joint - its temperature, texture, and the qualities of its movement. Her handling is affective: it works to simultaneously produce a relationship with the patient's body, knowledge of the patient's joint, and ideas of how to promote movement in the joint. Steph uses touch to make informed judgements about the quality of the swelling, while simultaneously perceiving whether or not her touch reduces that swelling. Steph, like Derek is attending to an isolated part of the patient's body, but because she works with affect ('the way you feel a joint') Steph's handling reconstructs the patient's body ('to see what you can do... to get movement in that joint'). The process of bodily

reconstruction completes the assessment – inference – treatment sequence associated with professional practice (Abbott, 1988).

Physiotherapy's handling techniques started to move across the division of labour that separated assessment from treatment during the 1960s (Barclay, 1994). This move was initiated by a renewed interest amongst physiotherapists from the UK and Australia in some of the manual techniques used by osteopaths to mobilise the musculoskeletal body (Barclay, 1994). Physiotherapy students at St Thomas' School during the 1960s were introduced to some of these techniques as an integral part of their training:

We had a course of lectures with him [Dr Cyriax] as juniors, and then as finalist students. And then we would work with him in the department. So that covered the whole gambit of examining joints, frictions you know making diagnosis from your examination. And then you would do manipulations. So there was a lot of autonomy within that.

[Steph, retired physiotherapy manager]

Their teacher, Dr Cyriax was 'an Orthopaedic Physician... who learnt manipulation...through his father's association with bone-setters' [Michael, private practitioner/retired physiotherapy lecturer]. Cyriax's course was in effect an apprenticeship, where learning depends on the knowledge/expertise of the master and students' ability to emulate their master's practices (Higgs & Titchen, 2001). It was structured to replicate the movement between theory ('course of lectures') and practice ('work with him in the department') produced by the physiotherapy curriculum itself (see Chapter 6). Discursively, Cyriax's course produced a professional practitioner who had embodied knowledge/expertise to examine, diagnose and treat the orthopaedic body independently of medicine. While not the focus of this chapter, the development of manipulation (a specific osteopathic technique that mobilises a joint beyond the limits of movement available) was contentious (Barclay, 1994; Grieve, 1984). As a result, the post-qualifying training required to build capacity for assessment – inference – treatment via manual therapy techniques within the existing physiotherapy workforce was often delivered 'quietly – on the sly' [Michael, private practitioner/retired physiotherapy lecturer].

Over time, manual therapy techniques were reconstructed to differentiate between mobilisation (techniques that moved a joint the end of its available range) and the 'more violent and a bit more aggressive' [Susie, retired physiotherapist] technique of manipulation (Grieve, 1984). I am suggesting that this division enabled physiotherapy to distance itself from the osteopathic manipulation techniques that were creating tensions amongst physiotherapists without compromising its capacity to adopt the handling skills required to produce assessment and diagnosis. These gentler 'manipulative procedures' were formally introduced into physiotherapy's handling repertoire by the CSP's 1974 curriculum 'for the assessment and appreciation of joint movement; [and] for their specific effect' (CSP, 1974. p16). Embodiment of these skills through the curriculum produced a physiotherapy workforce that was ready to handle the responsibilities of technical autonomy following removal of the subordination settlement with medicine in 1977.

Experiencing/producing moving relationships

While some elements of physiotherapy may appear task oriented (Roger et al, 2002), Hilda's account of swaddling patients in hydrotherapy shows how a series of physical tasks become an affective/physical process that produces care without compromising productivity:

Because they used to come out of the hydro, they had like a tunic which you tied around the neck I think... and round the waist so that their modesty was seen to. When they came out of the water, they'd have rope-soled slippers and you'd walk to the shower. And they'd go in the shower and then they'd come out, and then you'd put a towel round them and you'd remove this garment that dropped to the floor. And then they would walk in their slippers to a resting room which was warm and nice. And so then they would sit on the couch - with this towel round them. And on the couch was a blanket and so you'd wrap... you tried to get their arms away from their body with a sheet between... and then you'd wrap the blanket round them. And they had a towel... you put that round their feet, and made them comfortable. And then they rested there for twenty minutes to cool down... it's a lovely experience, because you're blissfully there, and you're nice and warm and you're just drying off. So you didn't have to dry anything, you just dried in this position.

[Hilda, retired physiotherapy manager/physiotherapist (voluntary sector)]

Hydrotherapy uses the physical qualities of warm water to produce a change in movement and function (Campion, 1997). It requires therapist and patient to

become equally un/dressed and responsive to one another's movements in the rich sensory environment of the pool. Once in the water, the level of un/dress is less challenging for both patient and therapist, but the transition back to dry land creates problems in terms of exposure and personal safety (Campion, 1997). The hydrotherapy environment produces enacted bodies that are constantly changing in response to one another and the environment (Blackman, 2008).

Hilda presents a step-by-step account of the activities and tasks that maintained her patient's emotional and physical safety during the transition from the pool to dry land. Although the tasks of assisting patients to bathe and dress while maintaining their safety would have been familiar to Hilda's nursing colleagues (Twigg, 2006), the environment (hydrotherapy), props (couch, tunic and rope soled slippers) and specialised techniques she used to move the body made the performance physiotherapy (Goffman, 1959 [1971]). Hilda would have learnt these techniques on the six-month hydrotherapy course she completed in 1950 (hydrotherapy was a separate post-qualifying course until 1955 when it was integrated with the qualifying curriculum). The sense of movement (pool-shower-rest room) present in Hilda's account shows how space is organised to manage different levels of bodily exposure and physical intimacy, and the risk of fainting caused by a rapid drop in temperature. From a phenomenological perspective, space is not a static container of physical objects and events, but is a dynamic continuum where individuals and objects interact to create meaning (Buttimer, 1976). The handling process described by Hilda was only meaningful in the space of the hydrotherapy environment, where it operated to transform patients' bodies and express care.

Hilda's attention, like ours, was orientated towards the patient's body as it moved from the hydrotherapy pool to the rest room. Despite being equally un/dressed and wet on leaving the pool, Hilda's own bodily sensations were relegated to the background which enabled her to attend to the patient's body (Merleau-Ponty, 1962). It is only when she was sure that the patient was warm and comfortable that Hilda attended to her own body – when it appeared wrapped in the towel, sheet and blanket. Hilda is able to describe the physical and emotional experience of being swaddled because the CSP's hydrotherapy training would have required

students to practice skills on one another. The process of swaddling provides a practical solution for managing the physical and emotional risks of handling un/dressed bodies (Twigg, 2006). Hilda guided the patient from the humidity of the pool/shower area into the dry warmth of the rest room and invited them to lie down. In this position, their wet un/dressed and active body was dismembered ('get their arms away from their body') by a sheet and blanket to become a warm, dry object. The blanket worked symbolically to close the patient-physiotherapist partnership established in the pool by constructing a visual boundary around the patient's body and blocking skin-on-skin contact between patient and therapist.

The process of handling the transition from pool to rest room produced physical/emotional comfort and expressed a feminised form of care (Hughes, 2005, James, 1992). Once the patient's body was swaddled, it was left to rest for twenty minutes to dry off and cool down. Rest room bodies were uniform, predictable objects that could be measured in units of time (Cohen, 2011), and were therefore no longer in need of supervision by a physiotherapist. From an organisational perspective, the hydrotherapy rest room enhanced productivity by controlling time and space. The swaddled body freed up the physiotherapist to re-enter the pool with another patient knowing that their last patient was cared for. The rest room was the space where the handling processes that had produced comfort and expressed feminised care became subject to the masculinised discourses that produced standardised organisational practices (Pocock, 2005).

Physiotherapists have been employed by the public sector to work in people's homes since the 1960s (Barclay, 1994). The shift to community-based work requires the physiotherapist to develop a therapeutic relationship with their patient and a working relationship with the individual's family/carer (CSP, 1965). Annie's account of meeting a child and his family for the first time demonstrates how physiotherapists experience/produce these three-way therapeutic relationships through their hands:

But I always knew, when I got there the parent was going to be very concerned, probably in a very high emotional state, because they've just been told that they've got a child who is going to have life-long problems... And sometimes it would be just as simple as lying a child on his tummy over a cushion or across my knee... talk to him while you're doing it and the child would stop crying and would relax. Something simple like that. And not anything else, just sit and talk to the family, just whilst you're talking to the family, patting the child and just gently stroking it, rocking it, doing whatever we do best, a bit of vibration... bit of movement, bit of passive movement, whatever. Depending on what's wrong with the child. All the time the parents are involved and you're talking to the parents, and then they feel confident and you can get on and do it.

[Annie, retired physiotherapy clinician/manager]

Having arrived in the home, Annie's first task was to establish a relationship with the child and his family. By moving her handling practices beyond the boundaries of the hospital wall, Annie distanced herself from the organisational practices and environments that regulated employees' use of time and space (Cohen, 2011). The clock time and spatial organisation of tasks experienced by Hilda and her patient in hydrotherapy are silent in Annie's account. Her awareness of time is expressed as the process of working with the child and his parents to produce physiotherapy rather than in terms of hours and minutes. Annie's handling was subject to the socio-cultural rules governing the family's practices and was bound by the spatial organisation of the home she is visiting. The absence of spatial movement in the account suggests that Annie and the family were working together in a single room. This intimate domestic environment enabled her to express the feminised qualities of movement/touch that value connection and attachment (Davies, 1995; Hughes, 2005).

Her practice was portable and 'simple' and operated independently of props and equipment beyond the bodies and soft furnishings available in the domestic environment. Annie silenced her own bodily needs in order to provide a stable physical and emotional platform for her practice, and to perceive and respond to the physical, emotional and social change produced by her handling. She started by attending to the child's stiffness and crying, which was expressing the emotional tension present in the situation. She moved the child's body and placed him on a stable platform (a cushion or her lap) that could accommodate change in his muscle

tone, and started talking to him. This produced relaxation in the child's body, and a quietening of the auditory environment. These sensory changes were likely to reduce the emotional tension present, and draw the family's attention to Annie's moving/touching performance (Merleau-Ponty, 1962). Annie used the auditory space, emotional stability and attention produced by repositioning the child to start establishing relationships with the child and his family.

Establishing a relationship with the child's family required Annie to re-direct her visual, auditory and oral attention from the child's body towards the family. Rather than excluding him from her interaction with the family, Annie switched her mode of relating to the child from talk to 'patting', 'stroking' and 'rocking', forms of movement/touch used by adults to establish a relationship with a young child (Morris, 1971). As she continued her conversation with the family, Annie adapted her handling and introduced physiotherapeutic handling techniques - vibrations (manual application of rapid vibratory movement to the body's surface which can be used to change muscle tone) and passive movements (a process of moving joints, muscles and soft tissue through their full range of movement). This marked a transition in Annie's handling. Until this point, Annie was using physical movement/touch and talk to perform the emotional work required to manage the feelings present in the room (Gimlin, 2007). The introduction of physiotherapeutic handling techniques signified that she had established a working relationship with the child and was now focused on the problem-solving process required to generate a treatment plan.

Annie chose a technique from her repertoire based on her understanding of the child's problem and knowledge of the handling techniques available to address his needs (May & Newman, 1980). She used her bodily senses to perceive change in the child's body as she handled him, and responded reflexively by adjusting her handling in response to his reaction. By responding to one another's touch, Annie and the child ceased to be two separate bodies, but became two halves of one that existed in the context of physiotherapy (Merleau-Ponty, 1962). Her bodily ways of knowing and ability to respond to and co-construct physiotherapy with the child's moving body ('whatever we do best') produced a feminised form of problem-

solving practice (Davies, 1995). Although Annie's hands did not produce a diagnosis, they were producing an understanding of the child's moving body and its response to handling techniques ('a bit of vibration... bit of movement, bit of passive movement, whatever'). The haptic integration of child/physiotherapist required Annie to continue her emotional work with his parents to ensure that they did not feel excluded from physiotherapy. The verbal/visual contact created space for the parents to become actively involved in Annie's performance. This involvement built their confidence in Annie's handling and enabled the physiotherapy performance to proceed and develop. By attending to one another, the child and his parents experienced how touch, movement and talk worked to change the child's posture and movement, while Annie learnt about the child and his family. Annie's hands were therefore enacting the same assessment – inference – treatment process associated with autonomous professional practice (Abbott, 1988) described by Steph earlier in the chapter.

I am arguing that physiotherapists' handling generates an embodied problem-solving process that integrates patients' bodies and affects their capacity to interact productively with society:

... so I knew about pain pathways and those sort of neuro facts anyway, so trying to connect that with the mobilising [a treatment directed at the body's musculoskeletal system] as well – I enjoyed. And I do enjoy working out where it comes from. When I worked at Storeham, I had a patient who came to me – a retired gentleman and he did a lot of restoring of furniture. That was his hobby... But he had a problem because one of his hands got pins and needles in and he couldn't move it very well. So, that's why he'd come [to physiotherapy outpatients]. And he expected me to treat his hands, but I treated his neck, and we cleared it up in two treatments. And he was so pleased because I had literally saved his hobby as far as he was concerned.

[Susie, retired physiotherapist]

Susie's account describes how the integration of two bodies of knowledge (musculoskeletal and neurology) enabled her to recognise that the source of the patient's problem (nerves in his neck) was not where his symptoms were felt (pins and needles and poor movement in his hands). By using her hands to mobilise the patient's neck, she affected the sensory-motor functioning of his hands, which enabled him to return to his hobby. By handling with affect to

deconstruct/reconstruct her patient's moving body, Susie was also moved by the process to become the person who has restored the patient's occupation (Blackman, 2008).

Although Susie, Steph, and Annie's hands were generating problem-solving practice, their working environments caused the practice to multiply. The multiplication of physiotherapy's handling illustrates how the movements in space that make up a performance are closely related to the space itself (Goffman, 1959 [1971]; Merleau-Ponty, 1962). Steph and Susie's accounts are located in a physiotherapy department or hospital ward; a familiar, but spatially confined environment where the treatment couch or bed takes centre-stage. Because the environment is familiar, Steph and Susie could focus their attention to the patient and moving their body; which produces a more clinically focused account of affective handling. Annie's performance space was an unfamiliar domestic setting where her main priority was to establish a working relationship with the child and its family so that they could all feel at home in one another's company. Annie's focus on handling her relationships with the child, family and the domestic environment obscures the problem-solving practice generated by Annie's hands.

Steph, Susie and Annie's accounts of handling to problem-solve transform the staged problem-solving approach described by the physiotherapy literature (see Chapter 3). Rather than being a series of physical tasks and cognitive processing (e.g. Jones, 1995; May & Newman, 1980), problem-solving becomes an integrated (and integrating) process of affective/physical handling that affects patients' moving bodies. The accounts reproduce the practice described by the scholarly papers describing physiotherapy practice as art/science (see Chapter 3). Drawing on the accounts of practice presented in this chapter, I am arguing that the integration of art/science is achieved through physiotherapists' embodied hands. Physiotherapists' embodied hands become the practice, which in turn reproduces Williams' (1986) vision of physiotherapy as being synonymous with handling.

Conclusion

This chapter has followed physiotherapists' hands into the workplace to show how they produce embodied professional practices that move and touch their patients' lives. Physiotherapists' hands can be used with or without affect. Without affect, physiotherapists' hands physically move/touch patients' bodies, while affective hands move/touch patients' physically and emotionally, and produce change (Blackman, 2008). Physiotherapy's hands are sensitive to the changing organisation and discourses governing the working practices of female-dominated practices like physiotherapy (Cohen, 2011; Freidson, 2001; Pocock, 2005). Interviewees' accounts suggest that embodied subjectivity of physiotherapy's hands was threatened by the discourses of rational thought and scientific knowledge that emerged to discipline professional practice during the 1970s (Hood, 1995). Although the devaluation of physiotherapy's hands was not universal, physiotherapists sought to protect the value of their work by constructing alternative forms of hands-on practice, or by maintaining the movement/touch rhetoric. This strategy enabled individual physiotherapists to retain a physiotherapeutic identity while allowing physiotherapy to extend its practices and maintain its position in the healthcare system.

Physiotherapists' accounts of experiencing/producing physiotherapy describe how their hands are integral to the autonomous problem-solving processes associated with professional practice. Physiotherapists' hands are disciplined to experience/produce embodied knowledge of the moving body and conditions and situations that cause movement dysfunction. This embodied knowledge generated from previous experiences enables the physiotherapist to come to know the patient's body in the present and generate a diagnosis and a treatment plan, which in turn shape what the patient's body can become (Jones, 1995). The accounts of physiotherapy's living hands establish a practice binary: task-oriented hands, and process-oriented hands. Handling as task describes how movement/touch is used to perform a specific activity with a patient; while handling as process describes embodied moving/touching body work that is integral to the interaction with a patient as a subject/object. Physiotherapy being/doing is therefore assembled

through and in practice as the bodies of the physiotherapist and patient move in response to one another's movement/touch in the practice environment.

Chapter 8

On becoming a practice profession

We all *have* and *are* a body. But there is a way out of this dichotomous twosome. As part of our daily practices, *we also do (our) bodies*. In practice we enact them. If the body we *have* is the one known by pathologists after our death, while the body we *are* is one we know ourselves by being self aware, then what about the body we *do*? What can be found out and said about it? Is it possible to inquire into the body we *do*? And what are the consequences if action is privileged over knowledge?

(Mol & Law, 2004. p45 emphasis in original)

My PhD research set out to generate a theoretically informed understanding of the tensions present in contemporary physiotherapy practice by exploring the events, discourses and actions shaping what physiotherapy could become over time. The starting point for my research was a sense of uncertainty emerging from within physiotherapy during the 2000s about the things physiotherapists' bodies could do in a given place and time. As I explained at the outset of this thesis, changes to the design and delivery of healthcare practice had provided opportunities for the rapid expansion of the physiotherapy workforce and the development of physiotherapy practice during the 1990s (Kell & Owen, 2008). By the 2000s physiotherapists could be found working in an increasingly diverse range of settings beyond the traditional clinic, hospital or home setting (e.g. Barclay, 1994; CSP, 2002). Some physiotherapists had extended their role and were undertaking the diagnostic and consultative work traditionally associated with medicine (e.g. Levenson & Vaughan, 1999; Hattam & Smeatham, 2004). For others, developments in information and communication technology were changing the affective, cognitive and physical body work associated with doing physiotherapy (e.g. CSP, 2002; Taylor et al, 2002).

While these developments of themselves were not necessarily problematic, there was evidence from within the profession of questions being asked about the nature and purpose of physiotherapy, its body work and organisation of its autonomous problem-solving practices (e.g. CSP, 2008b). Previously generated critical histories of physiotherapy (e.g. Nicholls, 2008; Nicholls & Cheek, 2006; Dixon, 2003; Hugman, 1991; Larkin, 1983) focused on the process of acquiring a professional identity (being), which limited what they were able to say in response to the questions emerging about doing physiotherapy as a practice profession (Mol & Law, 2004).

My thesis was interested in extending the ideas about identity and history discussed in previously generated accounts to then consider what sociologists have referred to as the question of embodiment. I found that the concept of embodiment offers a way of researching physiotherapy that place the bodies of physiotherapists experiencing/producing the process of becoming a practice profession centre stage. Rather than reducing the body to a disembodied object, the physiotherapist's practising body becomes a dynamic interface for exploring discursive practices, lived experiences and ways of doing and being (Blackman, 2008).

My research aim was achieved by a qualitative study that drew on historic documents and physiotherapists' oral accounts of practice to:

- a. generate an account of physiotherapy's epistemological and ontological understanding of the body and its bodily practices to trace the embodied processes of physiotherapy becoming a practice profession.
- b. uncover a relationship between physiotherapy's identity as a practice profession and the practising bodies of physiotherapists.

My research is underpinned by three inter-related themes of professionalism, gender (Barclay, 1994; Hugman, 1991; Nicholls, 2008; Wicksteed, 1948) and the absent-present body (Nicholls & Gibson, 2010) emerging from the historic accounts of physiotherapy. In this thesis I explored the evolution of physiotherapy as a practice and as a profession presented by interviews with a single generation of physiotherapists (subject to the CSP's 1945 curriculum or its almost identical successor published in 1955) and by the CSP's 1945 and 1984 qualifying curricula. By recovering the bodies that have historically been reduced to a silent object by physiotherapy's positivist epistemology (Bithell, 2005; Nicholls & Gibson, 2010), I have produced an embodied account of becoming a practice profession which offers a fresh perspective on physiotherapy as a practice and as a profession. This concluding chapter revisits my research objectives to present a critical reflection of the research design and process, and a genealogical account of the process of becoming a practice profession.

Structure and content of this chapter

The chapter is presented in four sections. The first section presents a summary of an account of physiotherapy as a profession (Chapter 2) and as a practice (Chapter 3). I will show how the process of reviewing literature produced within physiotherapy from a sociological perspective generated fresh insights about the professionalisation of physiotherapy and its epistemology, ontology and practice (research objective a). The second section offers a critical reflection on my research methodology, methods and process (Chapter 4). I will describe the tensions created by my methodological choices and explain how they impacted on the research process and outcomes. The third section concentrates on key conclusions from the study's findings (Chapters 5 – 7) to present one possible explanation of how the actions, discourses and situations of the past have enabled the tensions present in contemporary practice to emerge (research objective a). I will show how my methodological approach and theoretical framing of the bodies producing/experiencing physiotherapy over time makes visible the process of becoming a practice profession that complements existing historic accounts of the macro-politics of physiotherapy's professional project and uncovers the relationship between physiotherapy's identity as a practice profession and the practising bodies of physiotherapists (research objective b). The fourth section offers recommendations for further work before reaching a final conclusion about my research.

Framing physiotherapy – as a profession and as a practice

Professionalisation of physiotherapy

In the second chapter, which takes the place of a conventional literature review, I used the sociological themes of professionalism and gender emerging from the histories of physiotherapy (Barclay, 1994; Hugman, 1991; Nicholls, 2008; Wicksteed, 1948) to produce two narrative accounts about the professionalisation of physiotherapy. The first narrative drew on sociology of profession and accounts of physiotherapy's professional project presented by the physiotherapy literature to show how the concept of 'profession' changes over time. The professional body presented by this narrative is a dynamic entity that shapes and is shaped by ideologies, discourses and structures that govern how people relate to one another

in a given place and time. The second narrative drew on historic accounts and documents to follow physiotherapy as it moved from being an occupation restricted to women to become a profession practised by women and a growing number of men. My analysis uncovered a relationship between physiotherapy's pursuit of a traits-based mode of professionalism during the 1970/80s (Barclay, 1994; Hugman, 1991) and the rapid increase in the number of men registered to practice physiotherapy from 5% of the workforce in 1988 (Davies, 1990) to 22% in 2012 (HCPC, 2012a).

Together, the narratives in Chapter 2 offer a fresh perspective on physiotherapy's professional project. While existing accounts refer to a relationship between the themes of professionalism and gender, their methodologies obscure the parallel processes of professionalisation and manning/masculinisation of physiotherapy that appears through my analysis of the literature presented in Chapter 2. By attending to the gendered discourses and practices as they emerge from physiotherapy's past, I have uncovered a dynamic relationship between the themes of professionalism and gender that appears to shape and be shaped by physiotherapy's professional project. Drawing on sociological analyses of medicine (e.g. Abbott, 1988; Freidson, 1970; Turner, 1992) I argued that physiotherapy's pursuit of a traits-based model of professionalism (Hugman, 1991) was based on the traditionally male-dominated professions that value and enact autonomy, abstract knowledge and scientific expertise. When read through the lens of gender, physiotherapy's pursuit of these masculinised attributes tells a story of reconstructing women's knowledge/expertise and working practices to become more like work performed by professionalised men (Davies, 1995; Witz, 1992).

Turning to the professionalisation process that appeared in the physiotherapy literature from the 1970s onwards, my analysis showed evidence of physiotherapy's engagement with a discourse of science. Chapter 2 explained how the discourse appeared to create tensions as physiotherapy sought a theoretical underpinning to professionalise the feminised practice-based knowledge/expertise embodied by its female-dominated workforce. The tension associated with professionalising a feminised practice was managed by constructing a new identity for physiotherapy

as being about the art/science of caring and curing. I have shown that this discursive shift, together with the physical move of physiotherapy education towards the masculinised environment of Higher Education and all-degree status, made physiotherapy a more attractive career option for men. I argued that the combined process of professionalisation and masculinisation of physiotherapy accounts for the exponential growth in the number of male physiotherapists joining the workforce from the 1980s onwards. Similar claims about the relationship between professionalisation and masculinisation of practice have been made in relation to other traditionally feminised workforces such as nursing, social work and teaching (e.g. Burrage & Torstendahl, 1990; Davies, 1995; Etzioni, 1969; Witz, 1992), although they have not been extensively assessed in relation to physiotherapy before.

Physiotherapy's epistemology, ontology and practice

The focus of the third chapter was the bodies of physiotherapists experiencing/producing contemporary physiotherapy practice. I used sociology of the body and embodiment (e.g. Blackman, 2008; Crossley, 2007; Shilling, 2005; Turner, 1991; Twigg, 2006) as a perspective for reviewing literature that emerged as physiotherapy was becoming professionalised during the 1970s, to describe what physiotherapy practice is and how it is done. Chapter 3 addresses the first element of my first research objective. It presents a critique of physiotherapy's epistemological and ontological understanding of the body and offered an embodied account of physiotherapy's bodily practices that contrasts with the more familiar dualistic accounts of practice generated by physiotherapy's positivist epistemology (Bithell, 2005; Nicholls & Gibson, 2010). My critique of physiotherapy practice presented by the literature draws on two sets of embodiment theory; one attends to the Foucauldian structured body, the other to the lived body associated with phenomenology. Although the structured and lived bodies appear to contradict one another, I argued that this seeming incompatibility is generated by a dualist mode of thinking about the body (Shilling, 2005; Turner, 1992) and showed how they offer two complementary perspectives for looking afresh at physiotherapy practice – from the inside-out (lived body) and the outside-in (structured body). I used Coffey's (2004) three dimensional framing of bodily

practices to recover evidence of the meeting and meshing of the structured and lived bodies presented by the physiotherapy literature.

My reframing of the physiotherapy literature produced three fresh accounts of physiotherapy practice. My account of physiotherapy's body discourse attends to a series of scholarly papers that set out to describe and define the essence of physiotherapy practice (e.g. Beeston & Simons, 1996; Cott et al, 1995; Hislop, 1975; Parry, 1994; Peat, 1981; Sim, 1985; Tyni-Lenné, 1989; Williams, 1986). I argued that the earliest of these papers published in 1975 established a philosophical framework based on kinesiology (the science of movement) to support physiotherapy's development as a practice profession. Subsequent scholarly work builds on the discursive construction of physiotherapy as a moving practice that is underpinned by scientific knowledge of movement, to present physiotherapy as an embodied art (skills for human interaction)/science (knowledge of movement) that moves human bodies. I am suggesting that this shift which increases the visibility of physiotherapy's science is evidence of how the professionalising/masculinising and manning of physiotherapy described in Chapter 2 is experienced/produced through physiotherapists' scholarly work. I am arguing that the construction of physiotherapy as a moving practice that is simultaneously an art and a science is significant for its development as a practice profession. The discourse runs through the qualifying curricula (Chapter 5), shapes the disciplinary processes associated with becoming a physiotherapist (Chapter 6) and physiotherapists' accounts of doing physiotherapy (Chapter 7).

The second analytic account in Chapter 3 attended to the body work of physiotherapy. The account drew on the literature describing the process of problem-solving that first emerged during the 1980s (e.g. Burnett et al, 1986; Cacchioni & Wolkowitz, 2011; Edwards et al, 2004; Jones, 1995; May & Newman, 1980; Olsen, 1983; Parry, 2009; Rose, 1999; Thornquist, 1994). The earliest articles in this series which coincide with UK physiotherapy's pursuit of professionalisation during the 1980s, describe the pedagogic practices that produce a problem-solving physiotherapist in the United States (May & Newman, 1980; Olsen, 1983). I later show through my analysis of the CSP's curricula in Chapter 5 how these pedagogic

practices crossed the Atlantic into the 1984 curriculum to produce a professionalised UK physiotherapy workforce that was competent to assess, diagnose and treat disorders of bodily movement and function independently of medicine. By revisiting the problem-solving practices presented by the literature from the perspective of the phenomenological lived body I uncovered the disciplined physical/affective body work undertaken by the physiotherapist in coming to know and affect the patient's moving body – as a subject and as an object. My analysis showed how physiotherapy's lived body produces a scientific problem-solving practice that integrates theory and embodied knowledge with living data to make inferences about a patient's movement disorder and the likely outcome of treatment.

Drawing on the sociological concept of enactment, (e.g. Blackman & Venn, 2010; Mol, 2002; Sheets-Johnstone, 2009) I argued that physiotherapy's problem-solving bodies are bodies-in-process; dynamic entities that change in response to the relationship it has with practices, technologies and institutions and other objects. From this perspective, physiotherapy has capacity to move (and be moved) in ways that cause physiotherapy practice to multiply over time and across practice settings – as the third of my analytic accounts of practice showed. This account steps away from the sensory environments of the physiotherapist's body and into the practice environment to trace the flows and flux in the organisation of physiotherapy practice over time as described by Barclay (1994) and Wicksteed (1948). By focusing on what physiotherapy's body was able to do over time, my analysis traced physiotherapy's journey from its beginnings in medical massage to become an organised body that works in a variety of roles across a range of settings with diverse client groups. This analysis signalled a relationship between physiotherapy's identity as a practice profession and the practising bodies of physiotherapists. I can give an example of how this relationship is conveyed in the literature with an example of the story of physiotherapy's relationship with ultra-violet light.

Ultraviolet: illuminating the relationship between practice and identity

Ultraviolet light was introduced into physiotherapy's practice repertoire in 1928 as part of a campaign by medicine to regulate its use (Barclay, 1994). 'Artificial

sunlight' and other forms of medical electricity had become a popular treatment used by a growing number of 'quacks' (unqualified electrotherapists) to treat the non-specific disorders of a wealthy clientele (Wicksteed, 1948). Medicine responded to the perceived threat to their market position by putting pressure on the CSMMG (the precursor to the CSP) to introduce a syllabus and examination in electrotherapy and light (Larkin, 1983; Wicksteed, 1948). The examination was of mutual benefit to medicine and CSMMG members. Medicine was able to reinforce its status by delegating the application of ultraviolet light to a body of competent workers (Freidson, 1970). CSMMG members were able to begin the process of constructing professional practice by establishing their claim to a specialised body of knowledge and skill which differentiate their practice from the 'quacks' who were competing for clients (Abbott, 1988; Freidson, 1970). Supported by the patronage of medicine, CSMMG members were able to extend their practice to treat the constitutional 'diseases of darkness' such as skeletal tuberculosis and rickets (Barclay, 1994. p91). By applying its practice to meet a social need physiotherapy was able to maintain its market position and establish an occupational monopoly (Abbott, 1988).

By the 1940s, public health measures to improve air quality and limit overcrowding reduced the number of bodies needing artificial sunlight to maintain their constitution. Having established an occupational monopoly and produced evidence of its competence in ultraviolet, physiotherapy is able to respond to change by transferring its practice to support developments in dermatology (Abbott, 1988). Here, physiotherapists applied ultraviolet to activate the medicated ointments used to treat 'skin conditions' such as psoriasis, acne and alopecia (CSP, 1945. p10-11). During the 1950s, developments in medical physics produced lamps that could direct the antiseptic and healing properties of ultraviolet light to a specific area of the body (CSP, 1955). This new mobile technology was adopted by ward-based physiotherapists who used it for the 'cleaning and healing of wounds, pressure sores and ulcers' (CSP, 1965. p11) caused by lengthy periods of bed-rest post-surgery. The movement in the physical location of ultraviolet treatment suggests that physiotherapy was gaining freedom from the direct medical supervision of its practice (Freidson, 1970).

Developments in surgical and nursing practices, and changes to the organisation of healthcare during the 1980s meant that physiotherapists' use of ultraviolet was in decline by the 1990s. It is last mentioned as a modality in the CSP's 1991 curriculum – a reflection of its relocation into dermatology departments for use by a new generation of trained healthcare assistants, while the mobile lamps were superseded by introducing ward-based technologies and practices focused on skin care and patient mobility. Viewed from the perspective of professional practice, the transfer of ultraviolet light to healthcare assistants is significant. Ultraviolet light is a treatment. Its application requires skilled practice, but because the bodies requiring treatment come with a diagnosis, the autonomous decision making processes associated with professional practice (Abbott, 1988) are redundant. I am arguing that the maintenance of ultraviolet light within physiotherapy's practice repertoire would have reduced the credibility of its recently acquired professional status (Barclay, 1994).

This short account of physiotherapy's relationship with ultraviolet light illustrates the dynamic process of being/doing physiotherapy practice over time. By focusing attention on the practising bodies of physiotherapists through a narrow lens of a single technique, a dynamic relationship between physiotherapy's identity as a profession and the things physiotherapists can do in a given place and time starts to appear.

My reframing of the physiotherapy literature in Chapter 3 produced fresh accounts of the body work and organisation of contemporary physiotherapy practice, and of the discourses and disciplines that shape what physiotherapy's bodies can do in a given time and place.

Despite placing the body of physiotherapy centre-stage, the accounts of being/doing physiotherapy generated by my analysis of the literature seem remote and disembodied. While I was able to uncover the moving discourses, identities, organisation and body work of physiotherapy's professionalising practices, the nature of the literature (a combination of historic accounts, research papers and scholarly articles) limited the possibility of accounting for how physiotherapy's

embodied practices are experienced/produced by physiotherapists. The data generated through my research interviews attend to this gap as I will explain in the next sections of this chapter.

Research methodology, methods and process

As I explained in Chapter 4, I used CSP qualifying curricula and physiotherapists' oral accounts of practice to produce a genealogical account of the process of becoming a practice profession. This section of the chapter offers a critical reflection of my research that focuses on the tensions generated by my adoption of a feminist philosophical framework and genealogical approach. The section will therefore enable the reader to make an informed decision about the quality of my research and the credence of its findings and recommendations for further work.

Feminism

While feminist research takes on many different forms, it is characterised by an interest in women and women's work, sensitivity to power dynamics, and a valuing of subjectivity and relationality (Butler, 1999; Stanley & Wise, 1993). Gender does not feature strongly in my findings (see next section), but feminism has provided a philosophical framework for questioning the gendered assumptions underpinning physiotherapy, and for sensitising me to the personal/professional politics of power that determine how women and a growing number of men experience/produce physiotherapy over time. While my research was not explicitly autobiographical, it has involved exploring the organisation, processes and practices that make up the social world of physiotherapy that I am a part of. From a feminist perspective, the researching self cannot be separated from the research (Stanley, 1990). As I argued and explained more fully in Chapter 4, feminist methodologies more generally encourage a reflexive account of the research process. In this thesis I have understood reflexivity to be a form of critical self-reflection that produces an embodied account of the praxis and processes involved in producing/experiencing research.

The accounts of my researching self presented in Chapter 4 and Appendix 2 explain how I have affected and been affected by the research process. As well as making

the research process more transparent, these accounts describe the body work of moving from the positivist epistemology/ontology I had been socialised into as a physiotherapist (Chapter 3) towards a subjective relativism valued and practiced by feminist scholars (e.g. Butler, 1999; Halberstam, 1998; Parry, 1997; Stanley & Wise, 1993). This process was challenging as this extract from my research diary explains:

I hate my PhD - the research process is painful & scary. It feels like being in no-man's land – I'm no longer a 'proper' physiotherapist, but I'm not a social scientist either.

(research diary 10.2010)

In retrospect I can see that the process of unlearning what had subconsciously become a familiar way of knowing/doing was personally challenging because of how an individual's epistemology/ontology is closely aligned with their personal/professional identity (Brew, 2000). The account of my research praxis and process potentially contributes to the handful of edited volumes (e.g. Byrne-Armstrong et al, 2001; Finlay & Ballinger, 2006) reflecting on the process of doing qualitative research as a healthcare practitioner. Such texts are potentially valuable as historic markers for tracing shifts in professions' epistemology/ontology, but more importantly are useful for supporting individual professionals experiencing/producing that shift as they engage in qualitative research.

Foucauldian genealogical approach

I adopted a Foucauldian genealogical approach to trace the descent of contemporary physiotherapy as it emerged from the past into the present. Foucault's genealogical approach is both an historical perspective and an investigative approach that constructs a critique of the present (Weedon, 1987). As an historic approach, genealogy adopts a critical stance - conceiving history as a process of uncovering a series of multiple possibilities rather than a process of discovering a linear chronology of facts (Carabine, 2001). As a methodology it provided a means of framing the meeting and meshing of the structured and lived bodies I introduced in Chapter 3 as they experience/produce the process of becoming a practice profession (this argument is explained in Chapter 4). In order to practice a form of genealogical approach described by Carabine (2001),

Halberstam (1998) and others, I found it necessary to set aside the familiar stories of physiotherapy's quest to acquire the traits associated with a professional identity. This setting aside of traits enabled me to focus on how professional practice is experienced/produced by physiotherapists' bodies and the things they can do in a given place and time which meant I was able to show how profession becomes a dynamic entity that shapes and is shaped by its interaction with changing social, political and cultural contexts over time (Freidson, 2001; Pattison & Pill, 2004). This differs from the linear chronologies of physiotherapy practice presented by Barclay (1994) and Wicksteed (1948), and the disembodied historic accounts of physiotherapy's pursuit of professional traits presented by Hugman (1991) and Larkin (1983), but is compatible with other sociological work on the professions such as that by Abbott (1988) and Freidson (1970).

Framing time

Foucault's genealogical method attends to breaks in a trajectory and shifts in how practice is produced, which in turn provides a focal point for further exploration and analysis (Carabine, 2001). My initial reading of the historic texts for the literature review focused my attention to the actions, discourses and events shaping physiotherapy as it moved from being a body whose training and practice was supervised by medicine (1940s) to becoming a body of graduates whose autonomous practice was regulated by the State (1990s). My reading of events through a sociological lens (Chapter 2) showed physiotherapy's professionalisation to be a political process of reconstructing its knowledge/expertise in response to changing structures and systems in healthcare (Appendix 3). By following the flow of actions I became aware of a break in the trajectory appearing during the 1940s as the Society responded to the introduction of the Welfare State by establishing a new 'physiotherapy' identity (1943) and a new national qualifying curriculum (1945). The second break appeared during the late 1970s as the arguments used to acquire autonomy for physiotherapy in Australia (Galley, 1977) were adopted by physiotherapy in the UK to gain freedom from medical supervision (DHSS, 1977). My analysis uncovered the level of activity occurring at this point in physiotherapy's chronology with successive reconstruction of its knowledge/expertise (1984; 1991; 1996) as it moved into Higher Education and responded to neoliberal ideas and

New Public Management emerging to shape the organisation and practices of healthcare workers (Appendix 3).

This timeframe opened opportunities to gather data from multiple sources. As the 1940s are within living memory, I was able to draw on the oral accounts and reflections of practising physiotherapists alongside text-based sources documenting physiotherapy's past. My preliminary analysis of historic texts uncovered differences in the physiotherapy body produced by the curriculum over time and highlighted the potential tensions created by collecting stories from successive cohorts of physiotherapists. In this thesis I explored the evolution of physiotherapy as a practice and as a profession presented by the CSP's 1945 and 1984 qualifying curricula and by interviews with a single generation of physiotherapists (subject to the CSP's 1945 curriculum or its almost identical successor published in 1955). Conceptually, this approach provided a stable set of reference points for following the collective body of physiotherapy as it became a practice profession through the dynamic interactions of a cohort of its members with the changing structures and organisation of professional practice (Abbott, 1988; Freidson, 1970).

The data generated through my research provide multiple rich descriptions of how physiotherapy's bodies were disciplined and organised (Chapters 5 and 6), and how they experienced/produced physiotherapy (Chapters 6 and 7) from the 1950s, through the recognition of technical autonomy in the 1970s, the rise of neoliberal ideals and new public management during the 1980s, and into the 1990s. The accounts of practice gradually fade towards the 2000s as all but two interviewees (both still work in private practice) moved towards retirement from their lifelong careers in physiotherapy. The containment provided by my decision to work with physiotherapists who qualified during 1940/60s has enabled me to uncover how physiotherapy's pursuit of a traditional mode of professionalism was done in practice, and to signal a shift towards a new mode of professionalism that emerged from the 1980s onwards (Chapter 2). My research timeframe pre-dates the practices analysed by a growing body of sociological work (e.g. Bolton et al, 2011; Davies, 1995; Freidson, 2001; Jones & Green, 2006; Pill & Hannigan, 2010) that

explores how from the 1990s onwards. This is a potentially productive area for further research – as I will discuss later.

Although Foucault's genealogical approach was aligned with my research aim, objectives and philosophy, my relativist epistemology means that my account of becoming a practice profession should be read with a healthy dose of scepticism. It is just one possible version of physiotherapy's story, generated through my interactions with physiotherapists and their accounts of physiotherapy practice in a given place and time. And it is to this story of becoming a practice profession I now turn.

Key conclusions: on becoming a practice profession

Chapter 5 presents a discourse analysis of physiotherapy's qualifying curricula from 1945 and 1984 that generated a smooth genealogical account of the professionalisation of physiotherapy. The conceptual framework for my analysis was based on Abbott (1988) and Freidson's (1970) argument that professional work is characterised by its autonomy and capacity to enact diagnosis – inference – treatment sequence associated with problem-solving practice. By prioritising the process of producing autonomous problem-solving practice over the acquisition of professional traits, my analysis traces the process of becoming a practice profession back to the 1945 curriculum. I am arguing that physiotherapy became a profession by reconstructing its massage, manipulations and movement techniques to produce practices that could handle moving bodies. The association of professional development with intimate body work cease a tension, which I am suggesting was managed by the discourse of science that runs throughout physiotherapy's history (Chapters 2 and 5).

In 1945 the discourse of science was shaping the development of physiotherapy's knowledge and managing the risks associated with physical intimacy. By 1984, the scientific discourse is producing autonomous problem-solving practices that can process the biomedical and emerging biopsychosocial bodies safely and efficiently, and a physiotherapy workforce that can meet the expectations of an emerging mode of professionalism. The same discourse is also appearing to masculinise

practice and change the gender profile of the workforce as physiotherapy pursues all-graduate entry (Chapter 2). My analysis has uncovered the political processes of reconstructing physiotherapy's knowledge/expertise over time to provide solutions for contemporary problems and enhancing its position within the system of professions. As such it adds to the existing critical histories of physiotherapy and other feminised professions by offering a genealogical account of constructing a practice profession. By focusing on the structured body presented by documentary data, my analysis of the curricula reproduces the silencing of the bodies generated by the macro-level analyses of physiotherapy's critical histories. It is to these bodies I turn next.

Chapter 6 draws on the concept of enactment emerging from my analysis of physiotherapy practice (Chapter 3) as a lens for analysing interviewees' accounts of becoming a physiotherapist during the 1940/60s. I developed an analytic framework based on Sheets-Johnstone's (2009) phenomenological analysis of dance and Mol's (2002) analysis of diabetes to follow the moving bodies of physiotherapists as they embodied physiotherapy's knowledge/expertise and the physical/affective body work required to manage professional boundaries and produce autonomous problem-solving practice. This analytic framework which prioritises the physiotherapist's lived body has enabled me to look beyond the pedagogic process of becoming a physiotherapist to show how movement was used to discipline and organise physiotherapists' bodies and body work – from the entry gate into training and on into qualified practice. The analysis presented in this chapter contributes to the growing body of qualitative work that explore how physiotherapy education is experienced/produced in practice.

Drawing on Foucault's (1988) ideas of the discursive construction of the body, I am arguing that the accounts presented in Chapter 6 show how the movement discourse that constructs physiotherapy's professional identity (Chapters 3 and 5) operates to discipline and organise physiotherapists' bodies and practices. The discourse/discipline of movement ensures the constructive alignment of physiotherapy's identity as a moving profession, and the capacity of its workforce to enact moving professional practice. The discipline of movement is significant for

the development of physiotherapy as a profession. Drawing on Mol (2002), Abbott (1988) and Freidson (1970) I am arguing that by producing bodies that were disciplined to move, and organising practises that cut across the ward/disease boundaries constructed by medicine, physiotherapy was able to move beyond the immediate supervisory reach of medicine. This in turn created space for physiotherapists to enact autonomy associated with professional practice – as the accounts in Chapter 6 have shown.

In Chapter 7 I used the concept of embodiment emerging from my analysis of physiotherapy practice (Chapter 3) as a framework for following physiotherapists' hands into the workplace. The chapter attends to the structured and living bodies present in interviewees' accounts of experiencing/producing physiotherapy practice. One of the themes emerging from my preliminary analysis of the interview data was the 'hand' and haptics. My analysis unpacks the significance of physiotherapy's hands – in terms of their symbolic construction of physiotherapy's professional identity and their discursive construction of physiotherapy's moving/touching practices; and their capacity to experience/produce embodied professional practices that move and touch patients' lives. My methodological framing of the structured and lived bodies enabled me to uncover how the discourse of the hand constructs a practice profession, and reproduces physiotherapists' experiences of physiotherapy as an intimate physical practice that is both affective and professional. The accounts of practice presented in Chapter 7 show how physiotherapists' living hands are sensitive to the changing organisation and discourses governing the body work of traditionally female-dominated professions like physiotherapy. I am arguing that this finding is significant in the context of neoliberal ideals and new public management practices that seek to maximise productivity and manage risk (Chapter 2).

Read together, the chapters in my thesis explore the events, discourses and action shaping (and being shaped by) physiotherapy practice. In contrast to existing historic accounts that trace the evolution of physiotherapy's professional identity (being), my research has prioritised the bodies doing physiotherapy practice over time and has produced an embodied account of becoming a practice profession

which offers a fresh perspective on physiotherapy as a practice and as a profession. From a 'doing' perspective, I argue that professionalism ceases to be an acquisition that is bestowed by a statute or policy document and becomes a dynamic process of experiencing/producing autonomous problem-solving in practice. My analysis shows how a profession's capacity for autonomous and problem-solving practices emerge in practice, expanding and becoming visible as an occupation gains recognition as a profession. For physiotherapy, this is evident from the emergence an embryonic form of professional practice in the 1945 curriculum (Chapter 5) which was enacted and developed through the integration of physiotherapy movement/touch (Chapter 7) and by the discipline of movement which enabled physiotherapists to practice beyond the immediate reach of medical supervision (Chapter 6) – ahead of the formal recognition of physiotherapy's technical autonomy in 1977.

My research contributes to the existing (disembodied) critical histories of physiotherapy as a profession (e.g. Dixon, 2003; Hugman, 1991; Larkin, 1983; Nicholls, 2008) and supports Nicholls & Gibson's (2010) claim about the potential value of embodiment as a lens for developing a deeper understanding about the social worlds of physiotherapy. My research complements the discrete but growing body of work exploring how physiotherapy is experienced and organised in practice (e.g. Cacchioni & Wolkowitz, 2011; Kell & Horlick-Jones, 2012; Parry, 2009; Roger et al, 2002; Thornquist, 1997), but rather than being focused on contemporary practice traces how being/doing physiotherapy moves and multiplies over time. It also adds to the sociological literature about the organisation of healthcare occupations and practices (e.g. Abbott, 1988; Etzioni, 1969; Freidson, 1970; Hugman, 1991; Larkin, 1983; Mol, 2002; Witz, 1992) by offering an account of a body that is a moving part of a division of labour organised around the dominant profession of medicine.

Recommendations for further research

My research has been conducted from inside physiotherapy both in terms of my identity/practice as a researcher, and in terms of the data generated. I have sought to challenge my familiarity with a social world that I am part of by drawing on

sociological themes and perspectives of professions, gender and the body to look afresh at physiotherapy as a practice profession. This chapter demonstrates that I have achieved the research objectives established at the outset of the project. I have generated an account of physiotherapy's epistemological and ontological understanding of the body and its bodily practices (Chapter 3) to trace the embodied processes of physiotherapy becoming a practice profession (Chapters 2 – 7). In doing so, I have uncovered a relationship between what physiotherapy is and the things physiotherapists' bodies can do in a given place and time.

By prioritising doing over being, the bodies of physiotherapists who are experiencing/producing professional practice appear (Mol & Law, 2004) to uncover the embodied processes of physiotherapy becoming a practice profession. My thesis has shown that the process of becoming a profession requires an occupational group to construct its knowledge/experience, organise its work and discipline its workers to enact autonomous problem-solving practices (Abbott, 1988; Freidson, 1970; Larson, 1977). I am arguing that the identity of an occupational/professional group and what it does are therefore mutually dependent; movement in one repositions the other. This symbiotic relationship between identity (being) and practice (doing) does not stop once an occupation has professionalised, but is an ongoing dynamic that shapes what a profession can become and the work its practitioners can do in a given place and time.

Chapter 2 showed clearly how the professionalisation of physiotherapy practice is shaped by a gendering discourse that produces a masculinisation of physiotherapy and a manning of its workforce. While the gendering of physiotherapy practice is present in my empirical chapters (expressed by the tensions between movement and touch during the 1940s or the theory-practice debate of the 1970s), my analytic framing of Chapters 6 and 7 obscures the influence of sex and gender on what physiotherapy can become. The interview data contains rich accounts of gender (e.g. handling sexed bodies, using gender to maximise the impact of physiotherapy) which could be fruitfully uncovered using a narrative analysis. This research would contribute to the discrete set of papers exploring gendering of physiotherapy and

to the larger body of work on the masculinisation of traditionally female-dominated professions.

As I explained earlier, my methodological decision to concentrate on the experiences of interviewees who qualified during 1940/60s means that the accounts of practice generated fade towards the 2000s as interviewees approached retirement. My analysis of the 1984 curriculum and interviewees' accounts of contemporaneous practice has signalled a shift in physiotherapy's professionalism that I have been unable to address in this project. I believe that the genealogical approach that I have adopted can very fruitfully be applied to explore how physiotherapists experienced/produced the new mode of professionalism that had appeared and was becoming consolidated as the data generated by my project fades. The timeframe would accommodate the events, discourses and situations associated with the changing identities, organisation, and body work of physiotherapy mentioned at the outset of this chapter. This research would add to the growing body of work exploring how neoliberal ideals and the new mode of professionalism shape (and are shaped by) professional bodies, identities and practices. The contribution would be distinct because the methodology would generate an embodied perspective from a professionalised body that is closely aligned with medicine (Chapter 5), which in the context of new professionalism presented in Chapter 2 mean physiotherapy can become either a cost-effective handmaiden or a potential threat to medicine's monopoly of practice.

Conclusion

'Many historic accounts end on the flat note of closure or winding down' (Barclay, 1994. p318). I am arguing that this thesis ends in mid-sentence as it leaves physiotherapy at a time of change as the profession seeks opportunities to raise its profile, extend its practices and promote its new professionalism. There is evidence of this activity through the professional body's promotion of self-referral pathways within the NHS (CSP, 2009), its recent acquisition of independent prescribing rights (CSP, 2013b) and promotion of physiotherapy as a cost-effective solution for meeting the needs of an ageing population and for addressing the public health risks of physical inactivity (<http://www.csp.org.uk/your-health/physiotherapy->

[works](#)). Work is now underway to refresh the Society's vision of physiotherapy produced by 'Charting the Future' (CSP, 2008b) to ensure that physiotherapy is positioned to meet society's 'problems' and that it can produce evidence to show its employers and the public that 'Physiotherapy Works'. Although it draws on physiotherapy's past, the argument that sits at the heart of my thesis is relevant for a professional body seeking to (re)construct its professional identity and practices to produce a new future.

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Appendix 1

the CSP's Professional Networks: tracing the evolution of physiotherapy practice over time

| Title of network at inception (footnotes detail subsequent change) | 1920/30s | 1940/50s | 1960/70s | 1980/90s | 2000/2010s | present |
|--|----------|----------|----------|----------|------------|---------|
| Association of Blind Certified Masseurs [1] | 1919 | | | | 2002 | |
| Association of Teachers of the CSP [2] | 1922 | | | | 2002 | |
| Association of Superintendent Physiotherapists [3] | | 1944 | | | | |
| Association of Orthopaedic Chartered Physiotherapists | | 1945 | | | | |
| Association of Chartered Physiotherapists in Industry [4] | | 1947 | | | | |
| Obstetric Physiotherapists' Association [5] | | 1948 | | | | |
| Organisation of Chartered Physiotherapists in Private Practice [6] | | 1952 | | | | |
| Association of Manipulative Physiotherapy [7] | | | 1967 | | | |
| Riding for the Disabled [8] | | | 1970 | | | |
| Association of Chartered Physiotherapists in Sports Medicine [9] | | | 1972 | | | |
| Association of Paediatric Chartered Physiotherapists | | | 1973 | | | |
| Association of Chartered Physiotherapists in Research [10] | | | 1977 | | | |
| Chartered Physiotherapists in Geriatric Medicine [11] | | | 1978 | | | |
| <p>[1] Renamed Association of Blind Chartered Physiotherapists in 1953 (French, 1995)</p> <p>[2] Renamed CSP Association of Teachers in 1980s; & Chartered Physiotherapists in Education in 1992</p> <p>[3] Renamed Association of District & Superintendent Chartered Physiotherapists in 1976; the Association of Chartered Physiotherapists in Management in 1992; before becoming Leaders & Managers of Physiotherapy Services in late 2000s</p> <p>[4] Renamed Association of Chartered Physiotherapists in Occupational Health & Ergonomics during 1980s</p> <p>[5] Renamed Association of Chartered Physiotherapists in Obstetrics & Gynaecology in 1978, before becoming Association of Chartered Physiotherapists in Women's Health in 1990s</p> <p>[6] Renamed PhysioFirst during late 1990s</p> <p>[7] Renamed the Manipulative Association of Chartered Physiotherapists in 1968 before adopting its current title Musculoskeletal Association of Chartered Physiotherapists in 2007</p> <p>[8] Association of Chartered Physiotherapists in Riding for the Disabled formed as a subgroup of RDA in 1980s. before adopting its current title Association of Chartered Physiotherapists in Therapeutic Riding.</p> <p>[9] Renamed Association of Chartered Physiotherapists in Sports & Exercise Medicine in 2000s</p> <p>[10] Renamed Physiotherapy Research Society in 1990s</p> <p>[11] Renamed Association of Chartered Physiotherapists with a special interest in Older People in 1985, before adopting its current title 'AGILE' during late 1990s</p> | | | | | | |

APPENDICES

| Title of network at inception (footnotes detail subsequent change) | 1920/30s | 1940/50s | 1960/70s | 1980/90s | 2000/2010s | present |
|---|----------|----------|----------|--------------|------------|---------|
| Association for Chartered Physiotherapists in Respiratory Care | | | | 1980 | | |
| Association of Community Physiotherapy [12] | | | | 1980 | 2003 | |
| Association of Chartered Physiotherapists in Neurology | | | | 1981 | | |
| Association of Chartered Physiotherapists in Psychiatry [13] | | | | 1982 | | |
| Rheumatic Care Association of Chartered Physiotherapists | | | | 1982 | 2003 | |
| Association of Chartered Physiotherapists in Mental Handicap [14] | | | | 1983 | | |
| Association of Chartered Physiotherapists in Animal Therapy | | | | 1984 | | |
| Acupuncture Association of Chartered Physiotherapists | | | | 1985 | | |
| Association of Chartered Physiotherapists in Exercise, Recreational & Preventive Therapy | | | | 1985 1990 | | |
| Hydrotherapy Association of Chartered Physiotherapists [15] | | | | 1987 | | |
| British Association of Bobath Trained Therapists | | | | 1988 | | |
| British Association of Hand Therapists | | | | 1989 | | |
| Association of Chartered Physiotherapists in Independent Hospitals [16] | | | | 1989 | | |
| Association of Chartered Physiotherapists in Oncology and Palliative Care | | | | 1989 | | |
| Chartered Physiotherapists Promoting Continence [17] | | | | 1990 | | 2014 |
| Association of Chartered Physiotherapists interested in Massage | | | | 1990s | | |
| Association of Chartered Physiotherapists in Reflex Therapy | | | | 1992 | | |
| <p>[12] Renamed Association of Chartered Physiotherapists in the Community in late 1980s</p> <p>[13] Renamed Chartered Physiotherapists in Mental Healthcare in 2001</p> <p>[14] Renamed Association of Chartered Physiotherapists For People With Learning Difficulties in 1991</p> <p>[15] Renamed Aquatic Therapy Association of Chartered Physiotherapists in 2008</p> <p>[16] Renamed Association of Chartered Physiotherapists in Independent Hospitals & Charities in 1998; before adopting its current title Association of Chartered Physiotherapy in Independent Healthcare in 2011</p> <p>[17] Network in the process of disbanding to become part of the Association of Chartered Physiotherapists in Women's Health (March 2014)</p> | | | | | | |

| Title of network at inception (footnotes detail subsequent change) | 1920/30s | 1940/50s | 1960/70s | 1980/90s | 2000/2010s | present |
|--|----------|----------|----------|----------|------------|---------|
| McKenzie Institute Mechanical Diagnosis & Therapy Practitioners | | | | 1992 | | |
| Electrotherapy Interest Group [18] | | | | 1992 | | |
| British Association of Chartered Physiotherapists in Amputee Rehabilitation | | | | 1993 | | |
| Association of Chartered Physiotherapists in Orthopaedic Medicine [19] | | | | 1993 | | |
| Physiotherapy Pain Association | | | | 1994 | | |
| Association of Chartered Physiotherapists in Cardiac Rehabilitation | | | | 1995 | | |
| Extended Scope Practitioners | | | | 1995 | | |
| Medico Legal Association of Chartered Physiotherapists | | | | 1997 | | |
| Association of Chartered Physiotherapists in Bioenergy Therapies [20] | | | | 1998 | | |
| Association of Chartered Physiotherapists in Cranio-sacral therapy | | | | 1998 | 2005 | |
| Association of Chartered Physiotherapists Interested in Vestibular Rehabilitation | | | | | 2004 | |
| Association of Chartered Physiotherapists in Cystic Fibrosis | | | | | 2001 | |
| Haemophilia Chartered Physiotherapists Association | | | | | 2001 | 2012 |
| ISG4CP (International study group for Chartered Physiotherapists) [21] | | | | | 2001 | |
| CSP Retirement Association | | | | | 2003 | |
| <p>[18] Renamed Association of Chartered Physiotherapists in Electrotherapy in mid 1990s before adopting its current title Electrophysical agents & diagnostic ultrasound professional network in 2012/3</p> <p>[19] Renamed Association of Chartered Physiotherapists in Orthopaedic Medicine & Injection therapy in 2000s</p> <p>[20] Renamed Association of Chartered Physiotherapists in Energy Medicine in 2001</p> <p>[21] Renamed 'ADAPT' in 2008</p> | | | | | | |

Table 1: Professional networks recognised by the Chartered Society of Physiotherapy (based on Barclay (1994), CSP Annual Reports and Professional Network websites)

Appendix 2

accounting for myself

My personal journey into physiotherapy started towards the end of the 1970s when my mum was referred for treatment by our GP. I remember visiting the local physiotherapy department with her and noticing how the physiotherapist used her hands – to examine, diagnose and work with patients to resolve their problems. Growing up as a single child in a lower middle-class family, there were unspoken expectations that I should pursue a career in a respectable occupation with guaranteed employment. School encouraged its sixth-formers to apply for University which left me torn between pursuing a Sociology degree or a physiotherapy diploma. I have vivid memories of heated debates with my dad about the benefits/risks of becoming an unemployed Sociology graduate versus the security of a career in physiotherapy, which was at that time a shortage profession (see Chapter 2). Fuelled by my desire to help others help themselves and the prospect of a job that offered freedom to move, I secured a place on the physiotherapy programme at Cardiff to start in September 1985.

My memories of physiotherapy training are of having to work hard to conform to the bodily discipline associated with becoming a physiotherapist (Foucault, 1988). Registers were taken every morning, there was a packed timetable, frequent classroom tests, and specific dress codes. The process of learning to handle bodies began in a familiar classroom environment before moving into the dynamic un/dressed space of the practical class (see Chapter 6). Most of my peers were sporty individuals who were proud of their athletic bodies and comfortable being un/dressed, watched and handled. I had no interest in sport and spent practical sessions feeling fascinated by what I was learning but over-exposed in my un-athletic skin. As we moved into clinical settings, we became socialised to reproduce a professional image – a neat haircut worn off the collar, a pressed uniform worn with navy shoes and socks. I struggled with this interpretation of professionalism; its focus on appearance seemed superficial compared with the values of respect and mutuality I had come to associate with professional practice (Pattison & Pill, 2004).

I qualified in 1988 and followed the advised route into a ‘hospital-based rotational post, working under the supervision of senior physiotherapists’ (CSP, 1984. p2). I joined a large physiotherapy department in central London that provided the semi-structured learning opportunities required to consolidate my practice (Richardson, 1999). As well as working through the usual rotations in outpatients and different medical/surgical wards, I spent time in the Hospital for Tropical Diseases, an HIV/AIDS unit, and on a ward that was researching Parkinson’s disease. Patients taught me what living with bodily dys/function was like, while my movement around the hospital site helped me see how disease and disability were socially constructed and organised by medicine (Turner, 1992). Over time, the hierarchical structure and disciplines associated with the organisation of a hospital (Freidson, 1970) became uncomfortable. So I swapped my physiotherapy uniform for ‘mufti’ and joined a community-based children’s physiotherapy service in 1991.

The early 1990s was an era marked by the marketisation of healthcare and a shift in the locus of control from the acute hospitals towards primary care (Barclay, 1994). Although there was potential for community services to benefit from the new arrangements, in practice the shrinking healthcare budget failed to follow the patient (Rivett, 1998). The expectation for community physiotherapy to do more with less increased the pressure on

staff and created the need for another shop steward within our department. On becoming that CSP steward I saw first-hand how national policy and local politics determined how services were organised and delivered (Abbott, 1988), and the impact that had on the lives of physiotherapy staff and service users. As I pursued my interest in paediatric physiotherapy through successive departments I became increasingly aware of the gendering of physiotherapy practice (see Chapter 2).

Paediatric physiotherapy is a feminised specialism, both in terms of the sex of the workforce (Maclean & Rozier, 2009; Davies, 1990) and the embodied, collaborative nature of the work (Connell, 2009). The diverse case-mix associated with paediatric physiotherapy together with possibilities for flexible working accommodates multiple ways of being/doing female (Butler, 1999). I worked with women who were single-mindedly pursuing a professional career, and women who were successfully juggling the responsibilities of caring for family members alongside their professional career development. Physiotherapy with children rarely happens in isolation; it tends to be an interprofessional endeavour (Leathard, 1994). I was very comfortable working collaboratively with colleagues from other disciplines (e.g. medicine, nursing, other therapies, psychology, social work, teaching) and agencies outside health (e.g. local authorities, voluntary bodies). My comfort with a semi-permeable practice boundary generated questions about the nature of professional identities and practices, which led to me joining a part-time MSc in Interprofessional Health and Welfare Studies in 1995.

Nearing the end of the MSc in 1998, I spotted an ad for a Professional Adviser's post at the CSP. This post offered an opportunity to apply the critical awareness of the politics of professional identity and practice generated by the MSc, while contributing to the development of my profession at a time of change. My arrival at CSP coincided with a flurry of healthcare policy consultations emerging from the New Labour government. The principled, pragmatic and collaborative approach to policy development adopted by the new government contrasted with what had gone before (Giddens, 1998). The new ways of working offered structured opportunities for all bodies with a vested interest in healthcare (professions, the public, employers and education) to influence policy development by providing evidence of 'what works' to meet a specific policy aim (Giddens, 1998). While Government's new approach strengthened the CSP's influence in shaping policy, in retrospect I can see that it was part of the wider process of shifting the balance of professional power to construct a new mode of professionalism (see Chapter 2).

Government's drive towards greater productivity meant that work that was previously the sole domain of medicine was becoming increasingly delegated – to 'advanced practitioners' from nursing and members of the allied health professions. While these emerging 'extended scope practice' roles created opportunities to develop new career pathways, they also generated debate amongst the profession about the scope of physiotherapy practice itself. While the CSP's Charter was seen by some as a framework that enabled practice to respond positively to change, others perceived its openness as a threat and sought to define the list of modalities that were within scope. As the CSP's Professional Adviser with a remit to support members seeking to take on advanced practice roles (whether they were working within scope or extending beyond it), I found the development of ESP roles personally challenging. On the one hand, they were an opportunity for career development and raising the profile of physiotherapy, but also

risked reducing the physiotherapy process to a series of measurable task-based competencies – albeit that they were working at an advanced level.

Five years later with costs of life in London continuing to rise, I relocated to Cardiff. I applied for a policy officer post for a charitable organisation, but realised on the morning of that job interview how deeply ingrained my professional identity is, so withdrew from the selection process. A few weeks later in 2004 I took up a post as a lecturer in the department where I'd trained. The building had changed very little during the 20 year gap. There were ghosts everywhere during those first few weeks reminding me of my resistance to the disciplined process of becoming a physiotherapist. The physiotherapy programme itself had changed significantly both in terms of content and the end product. During the 1980s, Cardiff like many other physiotherapy training schools in the UK produced around 28 new graduate diplomates a year (CSP, 1987). By 2004 Cardiff was releasing about 90 new BSc(Hons)Physiotherapy graduates into the workforce each year. While the programme was designed to produce physiotherapists who were fit to practice in the NHS (CSP, 2002), flaws in the UK's workforce planning processes meant that some graduates would be forced to seek employment outside the state sector.

In my role as an educator, I carried responsibility for the personal and professional development module. This module ran through the 3 year programme and provided a space to work with students to help them recognise their changing personal/professional identity and practice, and support the development of critical thinking and political awareness. These qualities were things I'd come to see as important for a workforce that was needing to be adaptable in order to respond to a changing environment in ways that would allow physiotherapy to continue to expand – as it always had. Many students seemed to resent spending time in this space; content was deemed to be 'airy-fairy' compared with the 'scientific' knowledge/expertise developed through other modules (anatomy and physiology; clinical sciences; research etc) on the programme. And yet, by the end of the programme, many of the same students reported wishing that they had paid attention to the module earlier in their studies. My experiences of working with students helped me to think afresh about the process of becoming a physiotherapist. Of how being/doing physiotherapy is shaped by our experiences of practice and the structures governing that practice at a personal, organisational and national level, which in turn shapes what the physiotherapist themselves can become (see Chapters 2 and 3).

By 2009, the changes happening around service design and delivery, and expanding opportunities for physiotherapy meant that the CSP's Rules of Professional Conduct, Standards of Practice and qualifying curriculum were in need of review. I took a part-time secondment from my post as a physiotherapy lecturer to join the CSP's 'Charting the Future' project team as the person responsible for developing the CSP's physiotherapy framework. The framework (published in 2011) describes the values, behaviours, knowledge & skills used by the physiotherapy workforce in the UK at 6 different levels. On a practical level it has a number of uses including physiotherapy programme design/delivery; individual career planning; and service redesign/job evaluation. Conceptually, the framework offers a structure that creates agency for physiotherapy to move – as individuals, and as a collective body. In my current role as CSP Adviser for CPD, I can see how Government's policies and structural redesign are creating tensions for the identities and practices of physiotherapy. This research is a personal response to those tensions and a wish to plan for the future by engaging critically with physiotherapy's past.

Appendix 3

historical timeline of events 1894 – 2010

| political ideology | Event – external | Year | Event – internal |
|---|---|------|--|
| Social liberalism | BMA activity promoting need to regulate medical massage | 1894 | 9 nurses and midwives form a Council of trained masseuses |
| | | 1895 | Society of Trained Masseuses (STM) formed |
| | | 1905 | First men able to take the Society's exams, but not admitted to membership |
| | | 1910 | Exams in Swedish remedial exercises (SRE) established for candidates with a massage certificate + six months training in SRE |
| | National Insurance Act (1911) – makes provisions for access to health services for people in employment | 1911 | |
| | World War 1 1914 – 1918 | 1914 | |
| | | 1915 | Almeric Paget Military Massage Corps formed to work where requested by War Office |
| | | | Examination in medical electricity (techniques previously used by physicians) introduced |
| | | 1920 | Royal Charter granted. Men admitted to membership |
| | | 1927 | Conjoint exam in massage and SRE established as a minimum qualification |
| | | 1929 | Examination in light and electrotherapy introduced (separate curriculum from conjoint exam curriculum) |
| | | 1936 | |
| | Board of Registration of Medical Auxiliaries (BRMA) established at BMA House – to register (and regulate) practitioners working in occupations ancillary to medicine – including physiotherapists, radiographers and dispensing opticians | 1936 | |
| | World War 2 1939 – 1945 | 1939 | Massage Corps formed |
| Publication of Beveridge Report – sets out vision for creation of the welfare state | 1942 | | |

| political ideology | Event – external | Year | Event – internal |
|--------------------|---|---|--|
| Social democracy | | 1943 | Society's name changed to the Chartered Society of Physiotherapy (CSP) |
| | | | Entry examinations revised |
| | | | 4 of the 25 training schools recognised by CSP offer places for male students |
| | Butler Report & Education Act (1944) – changes to the provision of education for children and young people | 1944 | CSP withdraws from BRMA – frustrated by its limitations |
| | Goodenough Report (1944) – changes to the design and delivery of medical education | | |
| | | 1945 | Incorporation of Physiotherapists amalgamated with the CSP |
| | | | revised physiotherapy curriculum introduced. |
| | NHS Act 1946 leading to the formation of the National Health Service (NHS) on 7 July 1948 | 1948 | |
| | Cope Report (1951) – proposal to establish a state register for occupations auxiliary to medicine – managed by medicine. Groups affected worked together to oppose proposals | 1951 | |
| | NHS (Medical Auxiliary) regulations - specified the training and qualifications required for NHS employment and proposed a revised form of regulation – managed by the State. | 1954 | |
| | | 1955 | revised physiotherapy curriculum introduced |
| | Professions Supplementary to Medicine Act (1960) – establishes Council for Professions Supplementary to Medicine (CPSM) to regulate physiotherapy & other allied health professions | 1960 | |
| | CPSM register opened. Registration was voluntary initially, becoming mandatory for NHS practitioners in 1964 | 1962 | |
| | | 1965 | revised physiotherapy curriculum introduced. 16/38 training schools recognised by CSP accept men |
| | | 1968 | Faculty of Physiotherapists amalgamated with the CSP |
| | 1970 | The Physiotherapists Association Ltd amalgamated with the CSP | |
| | 1972 | First physiotherapist elected as Chair of CSP Council | |

| political ideology | Event – external | Year | Event – internal |
|---|--|--|---|
| social democracy | | 1974 | Revised physiotherapy curriculum introduced. Number of clinical hours reduced from 1500 to 1000 hours. |
| | Sex Discrimination Act (1975) | 1975 | |
| | | 1976 | First degree course in physiotherapy starts at Ulster Polytechnic |
| | | | CSP certified as an independent trade union. |
| | DoH memorandum HC(77)33 gives physiotherapy professional autonomy | 1977 | |
| | Rise of biopsychosocial approach (Engel, 1977) as challenge to medical model | | |
| | | 1978 | Privy Council approves a Bye-law change to enable physiotherapists to treat patients without prior medical referral |
| | | 1979 | 7/36 qualifying programmes recognised by CSP have moved from physiotherapy schools into Polytechnics |
| | Physiotherapy & Remedial Gymnastics Officer employed at DoH | 1980 | |
| | Publication of WHO International Classification of Impairments, Disability & Handicaps (ICIDH) | | |
| | United Nations International Year of Disabled Persons | 1981 | |
| | First report of the Pay Review Body for Professions Allied to Medicine | 1984 | revised curriculum of physiotherapy introduced. 30/32 training schools recognised by CSP accept men |
| | | | CSP members vote 'no' to proposal to affiliate with the TUC |
| | | 1985 | Society of Remedial Gymnastics & Recreational Therapy amalgamates with CSP |
| | 1986 | Student members admitted to CSP for first time | |
| | 1988 | | |
| Publication of the Griffiths Report (1988) – recommends introducing managerialism into the NHS | 1988 | | |
| Publication of Caring for People (1989) & Working for patients (1989) – government's response to the Griffiths report. Reports support idea of managerialism & enhanced role for independent & not-for-profit sectors as a means of controlling cost and enhancing productivity of healthcare services. | 1989 | | |
| neoliberalism | | | |

| political ideology | Event – external | Year | Event – internal |
|--------------------|---|------|---|
| neoliberalism | NHS and Community Care Act (1990) – purchaser:provider split established by creating NHS Trusts and making GPs fundholders responsible for purchasing health services for their local population | 1990 | CSP publishes Standards of Practice |
| | | 1991 | revised physiotherapy curriculum introduced |
| | Further and Higher Education Act (1992) – enabling Polytechnics to become Universities | 1992 | Profession becomes all graduate entry CSP affiliates to TUC following a referendum |
| | | 1993 | Last national CSP examinations CSP members vote to open a helpers' list |
| | | 1994 | Acupuncture and injection therapy accepted by CSP Council as falling within the scope of physiotherapy practice (kindred physical approaches) |
| | | 1996 | revised physiotherapy curriculum introduced 31 University departments offering BSc(Hons)Physiotherapy. All offer places to male students |
| | Publication of First Class Service: quality in the NHS – introduction of 'clinical governance' as a means of ensuring quality, reducing post-code lottery and managing spiralling legal costs of complaints of NHS services | 1998 | Emergence of 'new' role within the NHS – 'Extended Scope Practitioner. This role together with rise of 'clinical specialist' roles create pressure to develop clinical career structure |
| | Health Act (1999) - establishes Primary Care Trusts to commission & provide health services for population. Responsibility of Trust CEO to ensure the quality of service provision | 1999 | |
| | DoH (2000) NHS Plan – projects a 49% increase of therapists within the NHS in 10 years | 2000 | |
| | Publication of WHO ICF – body structure & function; activity; participation. Acknowledges impact of environment & personal factors on health outcomes | 2001 | |
| | Guidance published to introduce the Allied Health Professions Consultant – a new clinical role within the NHS | | |
| | Health Professions Order (2001) – process of modernising regulation of Allied Health Professions | | |
| | | | |

| political ideology | Event – external | Year | Event – internal |
|--------------------|--|------|---|
| Neoliberalism | Health Professions Council (HPC) introduced to replace CPSM. | 2002 | revised physiotherapy curriculum introduced New edition of CSP's Rules of Professional Conduct & Standards of Practice |
| | HPC register closed – title 'physiotherapist' becomes legally protected | 2004 | |
| | Introduction of 'Agenda for Change' – a new pay/grading structure & system for NHS employees | | |
| | | 2005 | CSP makes the case for physiotherapists working in England to be given supplementary prescribing rights (independent prescribing is achieved in England in 2013) |
| | | 2006 | CSP relinquishes regulation of physiotherapists working with humans. Maintains regulatory function for physiotherapists working with animals and CSP associate (support workers) and student members. |
| | | 2007 | Graduate employment 'crisis' – supply of new physiotherapists exceeding NHS posts available/funded. |
| | | 2008 | 'Charting the Future' – a CSP project designed to create a 5-year vision for physiotherapy, revise its Rules of Professional Conduct, standards of practice & qualifying curricula, & develop a career/competencies framework |
| | First cycle of HPC re-registration/CPD audit for physiotherapy | 2010 | CSP successfully lobbies GPs/NHS commissioners for physiotherapists to be recognised as first contact practitioners within the NHS – rise of self-referral to musculoskeletal outpatients services |

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Appendix 4

bibliographic timeline: CSP's qualifying curricula 1945 - 2012

| Author(Year) | Title | Prepared by | Format and pagination | Qualification |
|-----------------|---|--|---|---|
| CSP(1945) | Curriculum of the Chartered Society of Physiotherapy | CSP with input from '...Professors of medicine, surgery, anatomy, physiology & kindred subjects' (p1) | A5 booklet 12 pages Accompanied by a 48-page A5 booklet listing the practical skills to be taught | MCSP |
| CSP (1955) | Regulations and syllabus for the examinations in Physiotherapy | CSP with input from '... Professors of medicine, surgery, anatomy, physiology, and kindred subjects' (p3) | A5 booklet 20 pages | MCSP |
| CSP (1965) | Syllabus and regulations for training for membership of the Chartered Society of Physiotherapy | No reference made to development process | A5 booklet 15 pages | MCSP |
| CSP (1974) | Curriculum of study (1974 - amended 1978) | No reference made to development process | A5 booklet 21 pages | MCSP |
| CSP (1984) | Curriculum of study 1984 | No reference made to development process | A5 booklet 19 pages | GradDipPhys |
| CSP (1991) | Curriculum of study of the Chartered Society of Physiotherapy | curriculum review group including physiotherapy teachers, managers, newly qualified physiotherapists and a health services manager | A5 loose-leaf format 52 pages | GradDipPhys or Physiotherapy degree |
| CSP/CPSM (1996) | The curriculum framework | curriculum review group – physiotherapy teachers, clinicians, managers and a student | A4 spiral bound colour print/card 35 pages | BSc(Hons) Physiotherapy |
| CSP(2002) | Curriculum framework for qualifying programmes in physiotherapy | Written by CSP officer with governance via CSP committee structures + CPSM | A4 Available as hard copy or download 85 pages | BSc(Hons) Physiotherapy |
| CSP(2012) | Learning and Development principles for CSP accreditation of qualifying programmes in physiotherapy | Written by CSP project worker with governance via project board/CSP committee structures | A4 Available as pdf download 18 pages | BSc(Hons) Physiotherapy or pre-registration MSc |

Appendix 5

ethical processes – information letter and consent form

date

Dear [insert name]

The identity of physiotherapy – language, values and practice

Thank you for responding to my notice in *Frontline*/posting on interactiveCSP/call via a named CSP network [delete as appropriate] asking for retired physiotherapists to contact me for further information about this study.

Before you decide whether or not you would like to take part in this study, it is important for you to understand why the research is being done, and what it will involve. Please take some time to read the information about this study carefully, and talk to others about the study if you wish. It is up to you to choose whether to take part in this study.

Background information

I am a physiotherapy lecturer at Cardiff University. I am also a PhD student in the School of Social Sciences Cardiff University, and my thesis is researching the history of physiotherapy as a profession.

By using documents and oral histories, I hope to explore how the physiotherapy has evolved as a profession in the UK. I will also analyse the factors that have influenced the evolution of physiotherapy. I hope that this exploration will help us understand the current position and organisation of physiotherapy as a profession, which may help inform the choices physiotherapy has for its future.

Part of this study will involve collecting documents and accounts that trace the history of physiotherapy. Much of this information will be collected from existing archives and includes reports, meeting notes from the Chartered Society of Physiotherapy (CSP), newspaper articles, pamphlets and posters, and personal letters for example.

In addition, I hope to interview physiotherapists who have been part of the profession since the 1950s/1960s. The interviews will seek to explore with participants their experiences of being a physiotherapist, and their perceptions of how the profession has evolved. These personal histories will help me understand what it was like to live through the stories and events that are documented in the archive materials.

Because this is a study about the evolution of physiotherapy and its future, it is important that I get feedback on my study from the profession. I will develop and maintain an interactive website to share some of the stories and ideas emerging from the analysis of documents and interviews with physiotherapists. This website will be publicised through existing physiotherapy networks. Access to the

interactive sections of the site will be limited to physiotherapists, but there will also be some basic information about the study which anyone will be able to read.

What will happen if I agree to take part?

If you choose to take part in this study, I would like to talk with you about your experiences of physiotherapy as a profession and career, and your ideas about how physiotherapy has changed since you joined the profession. I would also like to ask your opinion on my understanding of specific events that are documented in the archive materials. Because sharing your experiences and opinions in this way may take some time, I would like to talk to you on three separate occasions.

The first interview would allow us to talk about the project, and allow you to tell me your story; the second would be to check that I have interpreted your story correctly and for us to discuss any other issues that are important to you. The third interview would be for us to talk about the interviews generally, and how you would like me to present what you have told me.

Having three interviews will help me be sure that I have done justice to your story and opinions. Each interview would take no more than two hours of your time. Because it is important that your story and opinions are recorded accurately, I would like to tape-record each interview – with your permission of course.

If you would be interested in taking part, but are put off by the thought of three separate interviews, please contact me to discuss other ways that we could work together.

When and where will the interviews happen?

The interviews will take place between October 2008 and December 2009. I am happy to meet at a time and place that is convenient to you.

Will the things I say be kept private?

When I transcribe each interview, I will change the names of you and everyone you mention. The original recording and transcripts will be kept in a secure place in Cardiff University and only my two supervisors and I will have access to them. If I would like to post information about you or your experiences on the study's website, I will ask your permission before doing so. If you agree, you will decide whether you want to be named, or remain anonymous.

You can ask for a copy of the transcripts at any time during the study if you want to check that it is accurate. During the third interview, I will ask you how you would like your story to be presented in my study. Again, you can decide whether you want to be named, or whether you would prefer to remain anonymous. As a Chartered Physiotherapist, my research practice is bound by the Standards of the Health Professions' Council and the CSP's Rules of Professional Conduct.

What if I change my mind about taking part?

You can change your mind at any time about taking part. It doesn't matter if it's before, during or after the interviews, all you have to do is let me know.

What are the possible benefits of taking part?

I believe that your stories and experiences can help the profession make sense of its past, present and future. The information gained from the study will increase

the knowledge that we have about the evolution of physiotherapy as a profession in the UK. On completion of my PhD thesis, I will provide you with a report of the research findings.

What are the possible risks of taking part?

It is possible that the interviews could raise uncomfortable memories or feelings for either of us. If you feel uncomfortable at any time during the interview, we will stop the interview, and you would not need to explain why.

What will happen to the findings of the research study?

The research findings will be included in my PhD thesis. The findings might also be published in academic and professional journals, and used in presentations at professional conferences/seminars. You will not be identified in any reports, publications or presentations unless you give me permission to do so.

Who has given me permission to carry out the study?

This study has been approved by the School of Social Sciences Research Ethics Committee at Cardiff University, and is jointly supervised by Professor Amanda Coffey and Dr Sara McBride Stewart.

Thank you for taking time to read this information. If you would like to take part, please contact me to organise a time and place to meet. If you need more information about the study before choosing whether or not to take part, please do not hesitate to contact me.

I look forward to hearing from you

Yours sincerely

Gwyn Owen MSc MCSP

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The identity of physiotherapy – language, values and practice

This consent form is designed to check that you understand the purposes of this study, that you are aware of your rights as a participant and to confirm that you are willing to take part.

| Please initial below as appropriate | | |
|--|--------------|-----------|
| | YES | NO |
| 1. I have read and understood the information provided to me for the above study. I have had the opportunity to consider the information and ask questions about it. | | |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. | | |
| 3. I understand that I may decline to answer any question(s) during the interviews and may stop the interview at any point without giving a reason. | | |
| 4. I understand that the interviews will be recorded and that they will be transcribed after the interviews. | | |
| 5. I understand that I can ask for copies of my interview transcripts to check them for accuracy. | | |
| 6. I understand that no-one will have access to the interview recording and transcript beyond the researcher and her two supervisors. | | |
| 7. I understand that the data from my interviews will be anonymised and stored securely. | | |
| 8. I understand that the researcher will ask me how I would like the information from my interviews presented, and will ask my permission before presenting any of my data on the study's website or any other publication/presentation. | | |
| 9. I understand that the findings from this research will be included in the researcher's PhD thesis and may also be published in academic and professional journals, and used in presentations at professional conferences or seminars. | | |
| 10. I agree to take part in the study | | |
| Signature: | Date: | |
| Participant's Name in block letters: | | |

2 copies: 1 for participant and 1 for research file.

Address slip – to receive a copy of the transcript or summary of research findings

If you would like to receive a copy of your interview transcript please provide your contact details here:

Name.....
Contact address:
.....
.....
.....

The researcher will provide a summary of the findings from this study. If you would like to receive a summary, please make sure you include your contact details on the provided address slip (if not already provided above).

Name.....
Contact address:
.....
.....
.....

Appendix 6

summary profile of research participants

This table is designed to offer enough information to get a sense of the participants' physiotherapy profile without compromising their anonymity.

| Pseudonym | Training (region/curriculum) | Focus of clinical practice (specialisation) | Occupational roles (employment settings) |
|------------------|---------------------------------|--|--|
| Brenda | London 1955 | Learning disabilities | Clinical (NHS) Managerial (NHS) |
| Bridget | London 1955 | Community paediatrics | Clinical (NHS) |
| Derek | Forces 1945 | Musculoskeletal outpatients & rehabilitation | Clinical (Forces & NHS) Managerial (NHS) |
| Fran | Liverpool 1955 | Neurology | Clinical (NHS & private practice) Academic |
| Frederick | Forces 1955 | Musculoskeletal Rehabilitation | Clinical (Forces and NHS) Clinical leadership (Forces) Academic |
| Hilda | London 1945 | Rehabilitation | Clinical (NHS & 3 rd sector) Managerial (NHS) |
| Jane | Sheffield 1945 | Rehabilitation | Clinical (NHS & self-employed in industry) |
| Michael | London 1955 | Rehabilitation & musculoskeletal outpatients | Clinical (NHS, overseas & private practice) Managerial (NHS) Academic |
| Pam | Manchester 1955 | Rheumatology | Clinical (NHS) Managerial (NHS) |
| Steph | London 1955 | Rehabilitation & reablement | Clinical (NHS) Managerial (NHS) |
| Susie | London 1955 | Trauma & Orthopaedics | Clinical (NHS) |
| Thea | London 1945 | Musculoskeletal outpatients & community-based rehabilitation | Clinical (NHS & overseas) |

Appendix 7

interview schedule*Interview #1: producing an account of being/doing physiotherapy practice*

Purpose:

- To create space for the interviewee to share their account of a career in physiotherapy - from the initial selection process; their experience of physiotherapy training/professional socialisation; their work experiences; & their experience of transition towards retirement.
- To negotiate plans for the next interviews

Introduction:

Ice-breaking conversation & thank you for agreeing to meet

Reminder of purpose of project (interviewee will have already received the information sheet & consent form) – space to ask whether they have any questions.

Describe what interview process could be like – set of very broad questions – to help you tell me about your physiotherapy career. I would like to audio tape the conversation – which I expect to last no more than a couple of hours. I'm keen to tape our conversation to help me really listen to what you're saying, without having to worry about taking detailed notes. You might see me jot a few notes while you're talking – they'll be reminders for me of things that you talk about that I might want to talk about later. Once the conversation is recorded – I will type it up - & send you a copy – so that you can check that I've represented our conversation accurately, & for you to change if you want to. Is that OK? [pause] Are there any other questions? [pause] If you don't have any other questions – can I ask you to complete the consent form please? [space] Thank you.

1. So, you mentioned on the phone/email [dependent on how I've contacted them previously] that you qualified as a physiotherapist in (time/place). Can you tell me what got you interested in becoming a physiotherapist?

Prompts: finding out about physiotherapy as a career; process of choosing training school; entry process

2. So, you trained at, what was that like?

Prompts: number of students; structure of training; what staff were like; any rituals/initiation ceremonies; assessments; experience of placement learning; rules & regulations (spoken or unspoken); training school's expectation of students on qualification

3. What happened once you'd finished your training?

4. Once you'd completed your rotations [it would have been rare for physiotherapists qualifying in 1950s/1960s to specialise immediately/work outside the NHS on qualification] what happened next? Prompts: where did you go next.... Did you specialise? How did you decide what to specialise in....? [might have some information about the interviewee's speciality from previous contact with them]

5. Remaining interview space to focus on guiding interviewee to share accounts of practice as they moved through the remainder of their career. Encourage interviewee to share examples of what being/doing physiotherapy was like in a given time & place. Looking here to generate embodied accounts of movement, (dis)continuity & change: of individual, organisation & physiotherapy practice/profession. Examples:

- process of career progression: within &/or across an organisation/specialism – UK/overseas
- career breaks (e.g. for raising children/caring for older relatives) & subsequent return to practice
- changes in career direction (e.g. from clinical to management/education/research roles)
- moving from paid physiotherapy employment towards retirement/other

Listen out for interviewee's coda

Closure: Thank you. Check if that's all – for now [pause]. Reminder of next steps – is that OK? Thanks/goodbyes.

Interview #2: unpacking the data

Purpose:

- To reflect on interview #1 with the interviewee
- To verify the interviewees' account of their physiotherapy career & to fill any gaps emerging from reading the transcript from interview #1
- To facilitate the interviewee's analysis of the key factors that shaped the development of their physiotherapy career
- To ask the interviewee about how physiotherapy has changed over time - & what factors have shaped that change
- To negotiate closure/discuss what will happen to the data

Introduction:

Ice-breaking conversation and thank-you for agreeing to meet again

Reminder of purpose of interview #2

Negotiating consent to proceed

Main body:

1. Reflection on interview #1 – process and content

Prompts:

Check whether participant wants to amend the transcript from interview #1 – errors, omissions or clarification

Create space for clarifying any gaps in my understanding of the interviewees' account

2. Exploring & attending emergent issues arising from interview #1

Ask interviewee whether any issues emerged for them following the interview/reading the transcript - attend to those issues

3. Making connections

Reflect on themes and issues emerging from other strands of the research (interviews with other participants and analysis of documents)

Encourage interviewee to share their thoughts on those themes/issues

Explore whether/how those themes/issues resonate with their own experience of practice

4. Evolution of physiotherapy – as a practice & as a profession

If this area has not been addressed, encourage interviewee to share their thoughts on how physiotherapy has changed over time – by reflecting on their lived experience.

Prompt: has physiotherapy practice changed? In what way? And how do you think that happened? What's the consequence of the change?

Closure:

Check whether there are things the interviewee was hoping to cover that have been missed.

Thank for time. Explain what will happen to the data/next steps in the research. Check re ongoing access should there be any questions emerging as research progresses.

Thank-you's/goodbyes.