Chapter 1

INTRODUCTION

In this chapter I present the origins of my interests in this thesis. The research topic is outlined with goals, research questions and the context of this study. A brief overview of the research approach, the research phases and thesis chapters is provided and the chapter concludes with a review of the significance of this thesis.

1.1 Origins of my research interests in this thesis

The origins of my interests in emancipatory health care practice began with my immigration to Australia. My German diploma was not recognised in Australia in 1987 when I arrived as a newly graduated physiotherapist. Before I sat the Australian Examination Council of Overseas Professionals examinations I observed physiotherapists treating patients in large teaching hospitals. Observing my Australian colleagues challenged my taken-for-granted professional identity. I quickly realised that physiotherapy was not practised the same way universally. In fact physiotherapy practice varied so much that I felt I could not work in an Australian context. I had not been trained in plaster and chest auscultation and suctioning techniques. Musculo-skeletal and neurological methods and techniques that I had learned in Germany were not encouraged and practised in Australia. My Australian colleagues challenged my knowledge base by asking for evidence to prove that these techniques were effective and had superior outcomes to theirs. I identified as a caring communicator and felt that I had sound hands-on tactile skills as well as skills in building professional rapport with people. Now I felt uncertain about my technical knowledge and skills. I started to wonder what underpinned the development of any physiotherapy practice. What were the values and interests that underpinned the way physiotherapists practise?

Experiencing this diversity of professional identities, clinical roles and approaches to physiotherapy practice first hand convinced me that physiotherapy practice is a social construct dependent on its context. This realisation made me curious to explore the influences that shaped all these diverse physiotherapy practice perceptions. It set me on the road of self-reflection and critical analysis of assumptions that formed the basis of practice approaches. I began not taking anything for granted.

There were several professional incidents that made me curious and triggered the questions that informed this thesis. One such incident occurred in a geriatric ward in a teaching hospital where I was clinical supervisor and senior physiotherapist. A fourth-year student came to me and stated that she did not know what to do with her patient. He was 86 years old, had had two strokes, one heart attack, a history of diabetes, mild symptoms of Parkinson disease, arthritis in both knees and mild symptoms of dementia. The student claimed that there was nothing she could do for this patient as a physiotherapist. I was amazed at the hopelessness, the deficits, negativity and ageist attitudes that this physiotherapist student had internalised. I did not hear from her one humane, social aspect concerning this patient. I wondered how this physiotherapy student defined physiotherapy. It made me consider more closely what physiotherapy could offer such a patient. If this 86 year old patient was viewed through medical, biophysical lenses then yes, there was very little one could do to restore his health. If, however, health was viewed through a psychosocial lens then this physiotherapy student would have told me about the patient’s family background and social connectedness and given an indication of his psychological attitude. And if this student had the interests of this patient in mind than she would have told me more about his fears, concerns and goals and would have considered goals related to enhancing quality of life and fostering the patient’s perceived ability to increase his mobility and activity, freedom and control. She would have mentioned any ageist attitudes of family and carers, or any taken-for-granted acceptance of this patient that there was no justified reason for rehabilitation.

This incident made me ask the question: How could an interest in patient emancipation impact on physiotherapy practice? Why was the practice interest of this student constructed inflexibly around correcting abnormal findings? How could the practice ideology of this student be shifted? What would a practice model look like that was informed by an interest in collaboration with patients towards achieving their individual movement potential? I noticed that working with people requires flexibility. Best practice could only be expressed in terms of guidelines because one approach could not be appropriate for all patients. One size does not fit all. At the beginning of my research I thought the variables that require flexibility were age, gender, level of education and social status. Further, professional patient relationships develop and change. Initially shy patients may gain more trust in their physiotherapists, feel more comfortable with the treatment routines and eventually emancipate themselves from their therapists.

Another incident that shaped my research interest was set in a university environment were I was an academic lecturer in health promotion and clinical education. As a lecturer of a postgraduate elective course entitled ‘Influencing Health Beliefs and Health Behaviours’ I exposed students to the flaws and challenges of the medical
Physiotherapy practice exists in a climate of constant change. These changes relate predominantly to three factors: changes in the physical, social, political information and technology contexts; changes in professional practice knowledge (Higgs, Fish and Rothwell 2004) and changes in professional and patient roles (Dewing and Pritchard 2004). If physiotherapy practice is to survive these constant changes it needs to be adaptable, aware and in command of its own directions. Changes in patient roles include the growing powerful patient rights movements in which more patient participation is demanded, increasing litigation claims against health care professionals (HCPs), and a growing diversity of patients. Some patients want to be told what to do and adhere to advice, others want to discuss their health issues to the extent of being fully involved in the clinical decision making process, yet others simply want to be listened to and taken seriously without many expectations of improvement in their chronic physical conditions. This last group of patients may be growing, as we are entering an era of longevity where people live with disabilities and chronic conditions. The rapid expansion in information technology gives people easy access to information. In Physiotherapists in their professional role need to keep abreast of the increasingly more diverse and complex roles that patients adopt. Practice models that entail aspiration towards predictability, control and certainty are a sound but not necessarily superior contribution to practice appropriate for all clinical contexts. Physiotherapists work in “acute” settings such as intensive care units where patients are unconscious, as well as in rehabilitation wards where patients remain hospitalised for many months, or in the community where people are assisted to maintain an active social and physical life.

These are times of constant change in medical technology, practice knowledge and increasing specialisation within health disciplines. There is also a shift in the perception of the concepts of health, illness, and health care services. With the arrival of the evidence-based movement and a tendency to demand scientific evidence for treatment approaches and outcomes, professional practice knowledge has been hijacked by technical scientific knowledge, which has been termed propositional knowledge (Higgs and Titchen, 2001). Natural science with its dualistic separation of objective and subjective knowledge presents a dilemma for holistic, patient-centred approaches to care. The dichotomy between objectivity and subjectivity brings with it a separation between theory and practice, between professional and lay perspectives to health and illness, and between therapist and patient. These differences are not particularly conducive to collaborative professional relationships. Propositional knowledge and up-to-date technical approaches are not sufficient to ensure patient satisfaction. And if patients are not satisfied one can assume that therapist satisfaction is at least threatened as well. Scientific evidence and best practice claims that are not carefully moderated for each clinical situation foster increasingly unequal power relations, with therapists as technical experts claiming authority to make decisions for patients based on best practice guidelines. This widening gap is exacerbated in the medico-legal world and results in practice dilemmas for physiotherapists: should they be technical experts giving objective advice based on professional technical knowledge or should they be patient advocates supporting patients to determine their own goals based on informed choice? If patients are placed at the centre of clinical practice then the question needs to be asked: What is appropriate care? Who should decide what appropriate means, the physiotherapist, the patient or both together?

Health care service clients belong to a better informed public today, with empowering knowledge of their consumer rights. Patients expect best technical treatment but also good communication and they want to be taken seriously. These developments present a dilemma for health care practitioners including physiotherapists. How can physiotherapists keep up with such changes without losing their professional identity?

In this research I set out to systematically develop a physiotherapy practice model that embraces constant change by appreciating practice contexts, and that transcends dichotomous questions by placing critique and change in its centre. None of the existing practice models, such as the competent clinician model, the reflective practice model and the scientist practitioner model (Higgs 2003) have a critical social perspective at their core. Critique with a vision of emancipatory practice offers the promise of a more mature, self-determining and pro-active physiotherapy community. This proposition lies at the heart of this research.
Emancipatory practice refers to the liberation of practice participants (therapist and patients) from the historical, cultural and social restrictions of the practice system and context. As a result the restrictions of the prevailing systems can be transcended and the participants can seek optimal individual outcomes. Emancipation here means freeing people, systems and practices from unnecessary constraints, and from unreflected, taken-for-granted values and professional roles.

In this thesis a critical social science (CSS) perspective is adopted with critique and emancipation as its two main features. A key aspect of CSS is to take a skeptical attitude towards the self as well as towards current situations and practices by becoming aware of unnecessary and inappropriate rules, conflict and challenges. Increased awareness of such invisible forces that constrain or impose practice approaches will enable people to understand what influences current practice. The evidence-based movement is driven by an interest in ensuring uniformity in practice approaches (i.e. ‘best’ practice), clarity and accountability in decision making and certainty in practice outcomes. If diversity of practice contexts and patients were limited, then evidence-based practice could readily be considered sound, sufficient and necessary. However, this movement medicalises health care, marginalises clinicians’ existing insights gained from professional experiences, and disregards qualitative ways of knowing (Stiwne and Abrandt Dahlgren 2004). What would practice look like if it were driven by the question ‘Who is benefiting from the various practice models and whose interests are being served with these approaches?’ These questions raise awareness of interests, assumptions and expectations that are tacit but have a strong influence on practice. It is my contention that instead of seeing change as an unavoidable external force and system norms as unquestionable, it is a necessary and reasonable expectation that all practitioners should be aware of and knowingly choose their practice interests, motivations and approaches. Reflective questions that would raise awareness of current practice would include the following: What are the potential tensions and conflicts in professional therapist-patient relationships and in clinical decision making? Why do patients at times not adhere to treatment plans? Why do some patients not share their fears and concerns with their therapists? What could happen if physiotherapists knew their patients more holistically and appreciated the wider contexts of their lives? What could happen if communications between therapists and patients were open and democratic (free of constraints)? What underpins current practice models and how would practice change if it was implemented or facilitated by critically self-aware physiotherapists?

1.2 Statement of the research topic

This thesis explores key features of CSS and related notions of emancipatory learning and their relevance to physiotherapy practice. The two key features of CSS involve firstly, challenging the status quo by questioning the historical, political and social agendas behind it, and secondly liberating the unreflected, taken-for-granted practices of the status quo from unnecessary constraints and situations that are based on power rather than critical thinking. Challenging and liberating the status quo during this research into physiotherapy practice includes scrutinising definitions of professionalism, claims to professional authority, perceived professional roles, decision-making practices and definitions of practice frameworks and contexts. The aim of this exploration is to identify relevant themes that could guide a review and transformation of current physiotherapy practice models towards a critical transformative perspective.

1.2.1 Goals

My ultimate goal is to influence physiotherapy practice. The principal goal of this research was to understand how adoption of a CSS perspective could influence physiotherapy practice and to envisage how physiotherapy might be practised when informed by CSS. I developed a CSS model for physiotherapy practice underpinned by theoretical and research knowledge derived from the literature and by contextual and experiential knowledge derived from the perceptions and critical reflections on their practice of the physiotherapists participating in my research project.

1.2.2 Context and boundaries of the project

The context of this study was Australian clinical physiotherapy practice. Participants were practising physiotherapists in two teaching hospitals in a metropolitan area. These physiotherapists were English speaking and had an adult patient workload prior to or at the time of the research phase. In the final research cycle one participant was included who was in private practice. The focus of this research was on clinical practice at the therapist-patient level. It was most practical and appropriate for the purpose of this thesis to limit the scope of investigation of physiotherapy practice to the introspection of physiotherapists at the clinician-patient level, in order to gain insight into self-understood practice models at an interpersonal rather than a system-based level. It is acknowledged that a comprehensive and sustainable CSS model would need to be embraced by physiotherapy management and further developed within the relevant organisational setting, ultimately within the wider health care system. It was beyond the scope of this research to investigate broader systemic issues beyond registering the participants’ reflections on and experiences with system supports and barriers.
Patients were excluded from this study. The focus of this study was not to explore perceptions and experiences of patients. Although patient rights movements do play a role in influencing professional health care practice, in this study I focused on physiotherapists only. I reasoned that a physiotherapy practice that was informed by a CSS perspective needed to focus on critical self-awareness and critique of self in relation to practice. The social and professional status of physiotherapists places them automatically in a hierarchical professional relationship with their patients. Before patients can be emancipated physiotherapists need to be become aware of the relevance and need for their own and their patients’ emancipation. The focus of this study was on physiotherapists and their emancipation from traditional practice models.

1.3 Overview of the research approach

The research approach taken was located in hermeneutics and specifically in critical hermeneutics. Hermeneutics is the art and science of text interpretation; it began as the interpretation of religious texts but has developed into an interpretive approach to any text (with text being interpreted broadly to encompass written texts, other media and bodily and spoken language). In other words, it is an interpretation of the meaning of both speech and action taken in a holistic manner as ways of making meaning. Hermeneutics as a branch of philosophy which recognises the importance of a question-and-answer dialogue to generate credible interpretations, meanings and new knowledge. By asking consecutive questions and seeking consensual meaning the dialogue becomes more deeply immersed in a deeper understanding of the phenomenon under investigation. Proponents of a critical hermeneutic approach are skeptical of the emerging interpretation arising from the question-and-answer dialogue because it could be influenced by one party dominating the dialogue and forcing negotiated meaning. In addition, it is a contention of critical hermeneutics that communication can be distorted and dominated by visible and invisible forces of which the communication partners are unaware. Domination (also understood as interests, ideology, pre-judgment and power issues) of either speech partner needs to be made transparent so that the meaning of dialogues can be openly understood within their context.

In this research, in order to ensure that text interpretations remained critical of interests and bias they were placed in relational dialogues, within various contexts, and compared among different groups of participants. These critical transformative dialogues predominantly followed a critical hermeneutics perspective but had elements of philosophical hermeneutics and action research incorporated. This strategy is compatible with a CSS perspective in that it is skeptical, self-critical, and searches for transformation. Table 1.1 presents an overview of the dialogue cycles. Each research cycle consisted of a question-and-dialogue hermeneutic cycle. The research design consisted of four research cycles that interdependently informed the development of a CSS model for physiotherapy practice. Each completed research cycle informed the next cycle of interpretations. These four cycles of critical interpretation contributed to the construction of the emerging CSS model for physiotherapy practice.

<table>
<thead>
<tr>
<th>Dialogue Cycles</th>
<th>Texts</th>
<th>Activity, approach, design</th>
<th>Product</th>
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<tr>
<td>First dialogue cycle</td>
<td>CSS and health related literature review</td>
<td>Exploration CSS essences and how they are applied in related professions</td>
<td>Text 1: Understanding core essences of CSS that are relevant for a conceptual CSS draft model for physiotherapy practice. First approximation</td>
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<tr>
<td>Second dialogue cycle</td>
<td>Based on text 1 CSS related physiotherapy literature review and transcripts from interviews</td>
<td>Ideology critique Describing and critiquing physiotherapy practice status quo in literature, and in-depth dialogue interviews with participants</td>
<td>Text 2: Portraying and critiquing status quo of current physiotherapy practice models: crystallising tensions and challenges in physiotherapy practice using critical social science lenses. Second approximation</td>
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<tr>
<td>Third dialogue cycle</td>
<td>Transcripts from participants’ interviews and notes from workshops</td>
<td>Trialling reflective, critical, transformative practice</td>
<td>Text 3: Establishing the potential for transformation towards a CSS practice approach through trialling it in practice. Third approximation</td>
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<tr>
<td>Fourth dialogue cycle</td>
<td>Transcripts from participants’ interviews</td>
<td>Critical dialogue</td>
<td>Text 4: CSS model envisioned, embodied and critiqued. Fourth approximation</td>
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1.4 Overview of chapters and development of CSS model

This chapter sets the scene for the research by providing background information of my research interests and an overview of this thesis. In the second chapter I discuss the research approach and strategies and explain how the CSS model was developed. Chapters 3-6 comprise the four texts analysed by applying critical transformative dialogues, leading towards the development of my CSS model for physiotherapy practice. The final chapter concludes with my CSS model, a critique of this model and implications for education and further research. An overview of the thesis chapters is depicted in Table 1.2.
Table 1.2 Overview of thesis chapters

<table>
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<tr>
<th>Chapter</th>
<th>Content</th>
<th>Cycle of Model Development</th>
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<td>Setting the Scene</td>
<td>Introduction</td>
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<td>2</td>
<td>Research approach, tools and strategies to develop a CSS model</td>
<td>Research Framework</td>
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<tr>
<td>3</td>
<td>Key CSS dimensions in CSS context</td>
<td>Text 1: Understanding core essences of CSS</td>
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<td>4</td>
<td>Key CSS dimensions interpreted into physiotherapy context from</td>
<td>Text 2: Critiquing the status quo of current</td>
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<td>physiotherapy literature and participants</td>
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<tr>
<td>5</td>
<td>CSS Draft Model 3: Exploring prototypical journeys of trialling CSS</td>
<td>Text 3: Trialling CSS as a practice model by</td>
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<td></td>
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<td>individual physiotherapists</td>
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<tr>
<td>6</td>
<td>CSS Draft Model 4: Evidencing embodiments of CSS values in physiotherapy</td>
<td>Text 4: Visioning and embodying CSS as a physiotherapy</td>
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<td></td>
<td>practice</td>
<td>practice model</td>
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<tr>
<td>7</td>
<td>Presenting my CSS model for physiotherapy practice</td>
<td>My CSS model</td>
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</tbody>
</table>

1.5 Significance of the project

Previous studies (Arnetz et al 2004, Hurley 2000, Jorgensen 2000, Parry 1997) have exposed the limitations of quantitative practice models and have argued for qualitative practice models and patient-centred approaches to practice. The thesis focuses on a practice model underpinned by critical self-reflection, questioning current practice interests and values, and liberating practice from unnecessary constraints. The study is significant because it makes CSS accessible as an alternative practice framework for physiotherapy practice and critiques both the model and process of introducing CSS into current (biomedical) practice settings. Drawn from relevant CSS literature this research provides a critical understanding of the value and potential limitations of CSS as a framework for physiotherapy practice. The relevance of CSS for physiotherapy practice has not previously been explored. The thesis contributes to the discussion of physiotherapy practice models and their maturation, and offers directions for the future.
Chapter 2

RESEARCH FRAMEWORK AND TEXT CONSTRUCTION

This chapter presents the framework and text construction of this research. In it I discuss how knowledge is understood in this study and I address the purpose, research questions, and research paradigms adopted and justify why this study predominantly utilised a critical hermeneutics approach. This approach supported and guided the construction and interpretation of research texts. Relevant ethical issues, participant recruitment and the research context are outlined.

2.1 Purpose and research questions

The goal of this research was to explore the notion of how physiotherapy might be practised as opposed to how it currently is practised. The research was developed in order to contribute to the body of knowledge concerning physiotherapy practice and to explore how critical social science (CSS) could serve as a framework for physiotherapy practice. The broad research questions were:

- What is the relevance and value of CSS for physiotherapy practice?
- What are the uses and limitations of CSS as a framework for physiotherapy practice?

It was recognised that a variety of professional practice approaches could be implemented within such a framework. Given the variety of approaches to practice which physiotherapists could reasonably adopt to suit their conception of the practice context, reality was interpreted as a construction of the human mind, with multiple realities being recognised. To come to know these realities it was determined that knowledge generation strategies should focus on interpretation of different conceptions and experiences of the application of CSS to practice using critical lenses. The term critical lens implies that, in addition to interpretation of texts, a notion of critique and scepticism towards understanding and interpreting the texts was part of the research strategy. The research purpose and questions stand in a close interrelationship: together they inform the chosen research orientation. Research questions disclose the intentions and interest in a research project. They also guide the desired research environment, for instance whether a study is best conducted in laboratory-controlled conditions, workplaces or in collective critical debates.

2.2 Locating this study in a research paradigm

According to Kuhn (1970), a research paradigm comprises the shared world view of a research community that guides research inquiries. A paradigm represents:

- the entire constellation of beliefs, values, techniques, and so on shared by the members of a given (scientific) community (Kuhn 1970, p. 175).

A paradigm is dynamic, developing over time and transforming as sciences become more and more sophisticated (Kuhn 1970). Paradigms are not discovered but evolve as a response or a natural development from existing paradigms, as for example postpositivism arose from positivism. Guba (1990, p. 17) described a paradigm as “a basic set of beliefs that guides action”. The researcher’s selected paradigm, types of research question, purpose and presentation of findings all need to come together within a cohesive research approach (Willis and Smith 2000). Oakley (1999) claimed that research questions help decide the appropriateness of the research method but that ultimately it is the research paradigm that dictates what research questions and methods to adopt. According to Oakley, paradigms have a distinct culture that defines the set of tools researchers can apply. Rather than viewing paradigms as rigid forms that dictate to researchers what methodological techniques to use, paradigms should be viewed as a way of operating and a way of viewing what knowledge and reality are. A research paradigm guides researchers in terms of what types of questions to ask and what tools to use to explore research questions. The questions and tools need to be congruent with the ontology and epistemology of the chosen paradigm. Appropriateness and congruence ensure that new knowledge is generated in relation to the research questions. The choice of research paradigm can be usefully justified by starting with the research question and determining what type of knowledge is going to be created. A systematic process of knowledge generation is assured when knowledge is understood for what it is.

By considering the type of knowledge to be generated, ontological and epistemological stances will become apparent. Ontology is concerned with the nature of reality; what can be known and what really exists. Ontology is defined as:

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1 The term text construction is used here instead of data collection. The former fits the hermeneutic framework whereas the latter fits the empirico-analytical framework better. In section 2.5 text construction is discussed in detail.
the branch of metaphysical enquiry concerned with the study of existence itself. It differentiates between ‘real existence’ and ‘appearance’ (Flew 1984, p. 255).

The task of ontology is an “investigation into that-which-is” (Gutman 1963, p. 196). Once it is decided that something can be known, the next step is to determine how this something can be known. This is the epistemological stance of the research project. Epistemology is concerned with the nature of knowing. Epistemology is defined as “the branch of philosophy concerned with the theory of knowledge” (Flew 1984, p. 109). What are the ways something can be known? The epistemological stance discloses the relationship between the knower and the known. Epistemology “seeks to understand what human knowledge is and how it comes to be” (Stroud 1989, p. 31). Epistemology examines what constitutes knowledge. Epistemology deals with how we can know what can be known, which influences the choice of research methodology. Methods are practical techniques used to conduct research. These three elements of what can be known (ontology), ways of knowing (epistemology), and techniques used to generate knowledge (methods), need to be congruent to the chosen research paradigm and research questions.

Knowledge is made up of scientific, personal, aesthetic and ethical ways of knowing (Fay 1987). If knowledge is generated with too great a dependence on one way of thinking and knowing, that knowledge is likely to present only one perspective of the researched phenomenon (Roberts and Taylor 1998). Researchers cannot claim to find the truth; they should state the context of the research and the field of knowledge or theoretical framework of the research.

It is postulated that science is ultimately based on social consensus, as it needs to be mediated through language (Morrow and Brown 1994). My posed research questions addressed the complexity of the phenomenon of physiotherapy practice. One of the key aspects of this research was to describe, interpret and then critique the status quo by illuminating ideology, power relations of professional relationships and the practice epistemology that underpins physiotherapy practice. Power relations, values and subjectivity were necessarily and intentionally included in this research.

In the empirico-analytical paradigm knowledge is described as being acontextual, ahistorical, generalisable and therefore transferable to other contexts (Habermas, 1968/1972). Typical research questions in the empirico-analytical paradigm are What happened? What did it achieve? The phenomenon to be studied is fragmented into isolated variables that are measurable and countable, with the aim of predicting future outcomes. Knowledge is said to be independent of time, place and people’s values and cultures. The research purpose is to discover knowledge by identifying cause-effect relationships and testing hypotheses. The goal is to predict and control future outcomes. The aim of this research paradigm is to provide access to the natural, objective world. It reports on factual accounts and outcomes. Its ontology assumes a stable single external reality. Its epistemology assumes that only empirical data counts as valid in producing reliable knowledge, to the exclusion of other ways of knowing.

My research did not attempt to predict, measure or generalise about the feasibility of a CSS framework for physiotherapy practice. For these reasons and due to the opposing position of CSS it was not desirable for this thesis to be located in the empirico-analytical paradigm.

The interpretive paradigm seeks understanding and illumination of phenomena by asking questions about What does it mean? The interpretive paradigm focuses on interpretations of phenomena, human interactions, their meanings and subjectivities that are brought to the interpretation (Holloway and Wheeler 1996). Creswell (1998, p. 19) described the assumptions of the interpretive paradigm regarding knowledge generation as:

Knowledge is within the meanings people make of it; knowledge is gained through people talking about their meanings; knowledge is laced with personal biases and values; knowledge is written in a personal, up-close way; and knowledge evolves emerges, and is inextricably tied to the context in which it is studied.

In the interpretive paradigm, knowledge is generated by studying phenomena in context and as they are perceived by the actors. Its ontology assumes that reality is socially constructed; the world is available to people only through their construction of it (McIntyre 1998). Its epistemology assumes that knowledge is generated by subject-to-subject inquiry within a given context. This paradigm is relevant to my research since it can be argued that practice, such as clinical practice, needs to be understood and explained in linguistic terms. Otherwise practice remains implicit and risks being perceived as incoherent. Reality is dynamic, changing and questionable. All knowledge is mediated by interpretations (Morrow and Brown 1994) and knowledge is also created through interpretation.

The critical paradigm generates knowledge within contexts, through dialogue, and with critique of meanings. It is based on the assumption that normative forces influence the way the world is perceived (Habermas 1968/1972, Morrow and Brown 1994). These forces could be hidden, distorted or unknown to us. Typical research question in
the critical paradigm are Whose interests are being served? Why is the status quo what it is? From an empirico-analytical perspective, the world is objectified, knowledge is objectified, and therefore humans, their actions and communications would similarly be objectified. Objectification means to turn human phenomena into categories or things that can be easily defined and labelled. Whilst there is a role in categorising phenomena in order to make complex issues accessible, objectifying phenomena to their most rudimentary commonalities depicts a reductionist perspective. Habermas (1963/1974) stated that the learning capacity of the social world distinguishes it from the natural world.

Researchers within the critical paradigm are genuinely skeptical towards knowledge being generated by only interpreting meaning. Such researchers seek also to reform the phenomenon under study by making the ideology of the status quo transparent (Altenbernd Johnson 2000, Silverman 1991). At the core of this paradigm is transformation and change (Habermas 1981/1984). This process of transformation is commonly conducted collectively, and co-researchers own the knowledge generated from this process (Winter 1996). The ontology of the critical paradigm is activism.Critical ontology is problematic as each ontological stance has ideology underpinning it, including the critical paradigm itself. Critical ontology assumes that reality is dynamic. The epistemological stance is manifested in reflexivity and ideology critique. The assumption in critical epistemology is that knowledge is generated through critique and critical self-reflection. The critical paradigm arose as a critique of the empirico-analytical paradigm, at a time when positivism and a technical approach to research were flourishing (Agger 1998).

Researchers within the critical paradigm seek to change the status quo (Habermas 1981/1987). While it would have been desirable to adopt the critical paradigm to reflect the goals of CSS this did not best suit the particular questions I was researching. My fundamental goal was to understand how CSS could be applied to physiotherapy practice. It was not within the scope of the research to seek to change particular physiotherapy programs or practices. The scope of this thesis is limited to suggesting change rather than bringing about change. Rather, the intentions were to gain glimpses of embodiment, visions and potentials of a CSS framework. Beyond my doctoral studies, however, I anticipate and wish that the publication of my findings will provoke awareness among physiotherapists of different approaches to their practice, informed by CSS, and that this will encourage them to rethink their practices. This research, therefore, did not adopt exclusively a critical paradigm approach. It is predominantly located in the interpretive paradigm, with inherent longer-term goals influenced by the critical paradigm philosophy of promoting understanding and change in practice. In one section of the research, the CSS trialling cycle, methodologies were adopted from the critical research paradigm. In this section I explored the uses and limitations of a CSS framework to physiotherapy practice by inviting participants to trial changes in their individual practice approaches. The epistemological stance here was that the way of knowing was generated through critical self-reflection and trialling a CSS practice approach within a confined cycle of the overall interpretive research design. This cycle was important because it provided participants with an opportunity to reflect on and more deeply understand the values, knowledge and actions that underpinned their practice. Their exploration contributed to the overall interpretation of practice approaches in physiotherapy.

Thus the research approach was based on a blending of the critical and interpretive paradigms to address both the predominantly interpretive goals of the project and the critical interpretation of the phenomenon under investigation (CSS). This blurring of paradigm boundaries also addressed two key concerns:

a) Habermas (1963/1974) argued that from a critical paradigm perspective, all other paradigms do not incorporate self-critique.

b) Proponents of the critical paradigm critique the interpretive paradigm by claiming that uncritical interpretations of people’s perceptions, beliefs and practices can be distorted because the influential forces that shape perceptions may not necessarily be transparent.

The critical paradigm could be seen as an extension to the interpretive paradigm in that it starts where interpretive inquiries end, reporting on critique of interpretations.

Consistent with this combined paradigm framework the chosen research approach was predominantly critical hermeneutics with elements of (interpretive) philosophical hermeneutics and (critical) action research. Critical hermeneutics is the research orientation that best fits the CSS theory and philosophy and hence it was adopted for this thesis. Indeed, CSS could be described as critical hermeneutics using Habermas’ view of hermeneutics. The ontological assumptions adopted in this thesis were that professional standards and policies and technical hands-on skills of physiotherapy practices can exist and can be observed, but that these standards and practices can only really be known, challenged and improved through interpretations in language and through critical self-reflection. The epistemological stance is that knowing occurs through dialogue, debate and self-reflection; and all of this requires language.
2.3 A critical hermeneutics research approach

Critical hermeneutics is a form of hermeneutics that works well with philosophical hermeneutics and action research. As highlighted below, the imprecise interfaces between philosophical hermeneutics, critical hermeneutics, and action research and between the critical and interpreting paradigms were used in this research to inform a critical transformative dialogue, and to explore my topic of CSS in physiotherapy.

2.3.1 The origins of hermeneutics

Hermeneutics has evolved historically from objective to philosophical to critical hermeneutic approaches. This development reflects a transaction from the universal truth claims of the empirico-analytical paradigm through the cultural knowledge development of the interpretive paradigm to a position skeptical of interpretation in critical hermeneutics.

Hermeneutics is largely located in the interpretive paradigm and refers to the theory and practice of interpretation.

Hermeneutics may be precisely defined as the art of bringing what is said or written to speech again (Gadamer 1996, p. 119).

The word *hermeneutics* originated from the Greek language and means to interpret (Altenbernd Johnson 2000). Hermes was the half-god who interpreted the gods’ messages to the people. Hermeneutics was commonly used as an approach to interpret biblical and other theological texts. It is also a field of philosophy that is grounded in a preference for interpretations located in text and language.

Hermeneutics has to do with a theoretical attitude towards the practice of interpretation, the interpretations of texts, but also in relation to the experiences interpreted in them and in our communicatively unfolded orientations in the world (Gadamer 1996, p. 112).

As a branch of philosophy, hermeneutics addresses the question of how humans understand written texts and the context within which a text is written. Hermeneutics makes a distinction between the orientation of the author and the reader. It is claimed that the intentions of an author cannot be fully conveyed via language but that the reader has to grasp the “spirit” of the author. Readers may interpret text differently to the intentions of the author. Hermeneutics refers to interpreting the essence of a text into one’s own context. It is considered important that interpretations embrace emotional, creative and holistic understanding. Schleiermacher (1977) was a theologian who studied text interpretation in the 18th century. He made explicit the paradox in understanding texts. He claimed that we cannot understand the whole of a text without understanding parts of it, and likewise we cannot understand parts of the text if we do not understand the whole. He related text interpretation to interpersonal communication: the listener needs to understand the context within which the speaker is making his/her arguments rather than listening to aspects of an argument out of context. The hermeneutics view is that texts are distant from the reader and readers need to be aware of this: readers should be able to read texts within their own contexts. Schleiermacher concluded that we cannot understand texts immediately. He was the creator of the question and answer dialogue cycles that became the key to hermeneutics, the hermeneutic circle. This circle is not repetitive: each answer to a question informs a new question, which in turn brings a new answer. The hermeneutic circle needs to be seen as a spiralling activity towards deeper understanding.

Dilthey (1976) extended Schleiermacher’s ideas of text interpretation to human behaviours and social constructs. He studied human phenomena from sociocultural as opposed to natural science perspectives, emphasising the importance of making analogies from the authors’ context into one’s own context. Readers have the capacity to make texts relevant to current situations. They can interpret texts in ways which may not be envisaged by the authors (Denzin and Lincoln 1994). This concept of analogies between interpersonal communication and interpreting texts for one’s own context is directly and acutely relevant to this thesis, where the aim is to transfer theory from the CSS context into the physiotherapy practice context. In this study this firstly involves understanding CSS in its historical context, then deciphering and interpreting it to explore its accessibility and relevance to physiotherapy practice.

2.3.2 Deeper interpretations

Gadamer insisted that we could only know what is grounded in our culture and tradition. He argued that we can understand other ways of interpreting only if this difference has some relationship to our own cultural understanding. New knowing is based on previous knowing and it unfolds in communication. Knowing is not an activity that happens in a blank brain space. Prior knowledge and prior values filter what will be adopted as new knowledge. Knowledge is based on pre-judgment and prior knowledge. Gadamer believed that it was important to disclose bias in the form of pre-judgments. The context of interpretation and of understanding texts needs to be grounded in pre-existing perceptions. Gadamer saw the purpose of interpreting as gaining deeper understanding.
In contrast to common usage, Gadamer argues that prejudice is not something that is negative or something that we should try to eliminate. In fact, he argues that we can only have access to the world through our prejudices [or pre-judgments] (Thompson 1990, p. 241).

Philosophical hermeneutics demonstrates that our interests and culture are part of our knowing and that there is no objective, interest-free knowledge as claimed under the empirico-analytical perspective. A hermeneutical perspective starts from the premise that there is pre-understanding. People understand new information by comparing it with their existing, old knowledge. Understanding occurs in context within people’s perspectives. It was important to commence the development of CSS as a framework for physiotherapy practice by acknowledging the historical developments of physiotherapy that led to its current understanding. Since interpretations are embedded in pre-understanding that is rooted within culture there is supposedly no correct interpretation. There are only deeper, further cyclical interpretations.

Gadamer claimed that deeper understanding between dialogue partners would help reach common ground that he termed fusion of horizons. This term indicates that Gadamer thought it possible to find common ground and share pre-understanding even though there are differences in interpretation. Gadamer claimed that the task of hermeneutics was to decipher ideology and power relations over and over again. He argued that having a tradition does not imply that people should emancipate themselves from their tradition. Gadamer linked reason to coming to an agreement. This supposition has implications for medicine in general and for this study of physiotherapy practice in particular. That is, knowledge that has been generated through professional experience and through negotiation with patients should not be separated from knowledge that has been generated through scientific inquiry.

Gadamer’s approach to health acknowledges the complexity of knowledge in health. In health, professional and lay people need to synthesise their perception of health, their knowledge and their pre-judgments in mutually agreed clinical decisions. Practitioners of philosophical hermeneutics appreciate the science as well as the art of medicine (Gadamer 1996), and in this case, physiotherapy practice. For me to gain insights into physiotherapists’ perceptions of their professional practice, I had to understand what influenced their perceptions. The philosophical hermeneutics approach was my choice for doing so. Reaching a fusion of horizons enabled me to appreciate how my participants’ perceptions of physiotherapy practice were influenced by their professional and personal values and experiences. However, philosophical hermeneutics and reaching a fusion of horizons between the researcher and the researched was not sufficient, as my purpose was to critique participants’ perceptions through critical lenses. Generating knowledge through interpretive dialogue would not fully address the question of what physiotherapy practice could look like if it were informed by CSS. I needed to blend philosophical with critical hermeneutics.

2.3.3 Critical interpretations

Critical hermeneutics refers to the theory and practice of critical interpretation. Alongside Habermas, other philosophers of critical hermeneutics who share an attitude of scepticism towards knowledge claims were Ricoeur (2000) and Caputo (2000). Practitioners of critical hermeneutics are not satisfied with philosophical hermeneutics’ position of viewing pre-judgment as the basis of interpretations. Such scholars refer to a hermeneutics of suspicion (Ricoeur 1981). They draw skeptical attention to tradition and prejudice. They start from the assumption that not all interpretations are equally convincing. They are skeptical that readers can grasp the “spirit” of authors’ texts, and they question the interpretations of texts that are based on misinterpretations of this “spirit”.

The cycle of an interpretation leading to deeper interpretation and then to consensus interpretation can only be the starting point. Critical hermeneutics scholars are skeptical of the process of reaching consensus because not all thoughts, traditions and prejudices have equal power and influence. Thought needs to be qualified, as thought is guided by interests and these interests could be subjective, objective or critical in nature. Simply respecting value systems may not be helpful when trying to determine realistic expectations and reach mutually acceptable clinical decisions. Respect may be a sound starting point, but critiquing values might be necessary in order to draw out the nature of oppression, power relations and dominant cultures. Mutual understanding and the fusion of horizons provide a promising start but may not result in uncoerced shared goals.

In the clinical context it is desirable that clinicians and patients understand each other’s values and priorities, but it is even more important that they are able to work together by sharing health goals that are acceptable and appropriate for both parties. The key question here is (Trede and Higgs 2003): “On what pre-conditions are these goals based on and how are decisions reached?” Proponents of critical hermeneutics are interested in a critique of the fusion of horizons process. Within a critical hermeneutics framework, interpretations of reality have to be carefully scrutinised and critiqued.

Critical hermeneutics scholars such as Ricoeur (1981) and Agger (1998) aim to demystify traditional or dominant traditions and practices by adopting a genuinely skeptical stance to interpretation. Habermas based his scepticism
on the assumption that social theorists can understand social actors better than social actors understand themselves. The position of critical hermeneutic scientists comes paradoxically close to that of the empirico-analytical position. To some extent both positions entail an outsider observer’s perspective. However, the purpose and interest of the outsider observer are markedly different. The empirico-analytical researcher intends to describe facts from a value-free, objective perspective. The critical hermeneutics researcher intends to critically interpret perceptions and meanings from historical, political and social perspectives.

Critical hermeneutics critiques the interpretation of interpretations. Critical hermeneutics scholars seek to critique meaning that actors (research participants) themselves may not be able to see. This objective differs from that of philosophical hermeneutics in that the latter implies a notion of interpretation that is trapped within the same line of interpretation. For example, interpretations could be informed by socially dominant meanings, in which case the interpretations of marginalised groups would potentially not be heard. Critical hermeneutics differs from philosophical hermeneutics’ methodology of interpretations that lacks closer scrutiny. Interpretations of interpretations could lead to distorted knowledge generation. The fusion of horizons of philosophical hermeneutics appears to be too easily influenced by dominant traditions and cultures. Habermas was convinced that a self-reflective methodology could overcome uncritical interpretation, and he criticised the incompleteness of reflection in philosophical hermeneutics wherein knowledge could be generated within a system of distortion. Making explicit the interests and intentions of interpretations is an important distinction between philosophical and critical hermeneutics. Philosophical hermeneutics is concerned with consensus, whereas critical hermeneutics is concerned with emancipation. In analysing the texts I was firstly searching for understanding. How did the text source (or interviewees) make sense of theoretical arguments (or their interpretations of their professional practice)? This question was located in philosophical hermeneutics. The critical analysis then consisted of drawing out the interests and assumptions within the context, to inform my understanding and interpretation. As the author of the text interpretation I adopted a critical stance to the text collation that was generated by the text source. In interpreting values and interests that underpinned the text a critical hermeneutics approach was taken. The transformative analysis then envisioned what understanding (or practice) would be like if these interests were made transparent and were transformed to emancipatory interests.

Habermas lobbied for a skeptical stance to reasoning and knowledge; he linked reason to emancipation. He argued that uncritical interpretation could lead to reiteration of the status quo. Habermas also moved away from the traditional Frankfurt School philosophy of critiquing for critique’s sake (Newman 1999). He established his CSS philosophy with a clear agenda towards autonomy and emancipation. There is an inherent optimistic streak in Habermas’ critical hermeneutics striving towards emancipation via critical rationality and rupture with tradition. Due to its skeptical and critical stance towards the study of existence, ontological claims within CSS are weak as they are only indirectly transparent through reflection and action. Habermas acknowledged this weakness of CSS ontology and embraced it by arguing that at least CSS’s ideology and interests of striving towards dignity, a good life and freedom from unnecessary constraints are made transparent. He saw ontology a problematic issue in his theorising of interpreting interests. He stated that generally ontology disguises the connection of its knowledge with the human interest in autonomy and responsibility. There is only one way in which it can acquire the power that it vainly claims for itself in virtue of its seeming freedom from presuppositions: by acknowledging its dependence on this interest and turning against its own illusion of pure theory the critique it directs at the objectivism of the sciences (Habermas 1968/1972, pp. 310-311).

Habermas concluded that the ontology of CSS is critique of interests, as interests distort observations, knowledge and theory. Thus critical ontology is dependent on its interest in freedom. Researchers with a focus on emancipation and on freeing practice from “frozen” approaches need to confront their pre-judgment and strive towards freedom, acknowledging subjectivity, power relations and interest in freedom. Critical ontology is vulnerable to criticism as it could be claimed that it develops just another interest-driven theory. However, a critical theory is driven by emancipatory interest which is explicitly “laid on the table”. Since a critical ontology discloses the connection between what can be known and what we want to know, it has a weak stance of what actually is, because a positivist or phenomenological ontology is viewed with skepticism. Whatever is claimed to be is subject to further critical interpretations. Critical ontology stands on an ever-changing and ever-evolving platform.

By continuously critiquing new philosophical directions, CSS ensures rethinking and transformation. The deeper the discussions on rationality and human interactions, the more complex and abstract the discussions become. Communicative and strategic actions are often interwoven in a complicated way, and the more formal the speech interaction the more likely this is (Habermas 1982). In strategic communication, language serves as a means of

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influencing. The more removed discussions are from the actual world the more they lose their appeal, accessibility and applicability.

2.3.4 Transformative actions
To understand the implications of CSS as a model for physiotherapy practice it was deemed important to include an action learning cycle in this study design. Action learning provides the opportunity for participants to go beyond reflecting and describing the status quo towards trialling new ideas, and then critically reflecting on them to draw conclusions on their trials. Action learning provides the link between practice and reflection, between self-evaluation and professional development (Winter 1996). The aim of the action learning cycle was to enrich the development of a CSS practice model and contribute to understanding the potential of transforming current practices. The critical paradigm approach has reflexivity as its core (Hall 1996). In my research this activity ensured that the emergent model was partly informed by what it advocated: trialling transformation. Further, the emergent model was grounded in local context and real life situations. Participants in this research cycle pursued their self-prescribed professional explorations and practice transformations. The action learning cycle was conducted because I hoped to glean a snapshot of the potential of trialling a CSS model rather than actually to transform practice on a larger scale. Although the participants explored the applicability and feasibility of CSS in their practice contexts, there was no attempt to recruit external support for putting in place sustainable support structures that might have assisted a more lasting change in practice beyond the individual practitioner’s conviction or initiative. To generate knowledge about CSS as a framework for physiotherapy practice it was deemed most congruent to test CSS in operation through action learning, so that the themes of CSS relevant to physiotherapy practice could be understood, trialled and critically interpreted.

2.4 Research setting, recruitment of participants and ethics
This study was conducted in a major teaching hospital in metropolitan Sydney. The physiotherapy manager gave permission to conduct this research in the physiotherapy department. Ethics approval was obtained from the University of Sydney and the ethics committee of the teaching hospital where participants were recruited. Anonymity and confidentiality were assured for this study. Informed consent was an important ethical practice in this research and participants were free to withdraw at any time. The information sheet informed the participants about the topic of this study as well as what was required of them if they agreed to participate. Each participant signed the consent form and nobody withdrew from the study.

I introduced my research topic to potential participants in a physiotherapy staff meeting and asked for volunteers to participate in this study. Information sheets and consent forms (see Appendix 1) as approved by the ethics committees were tabled, as well as a list for volunteers to enrol in the study. Physiotherapists had three choices: They could choose (1) not to participate in this study, (2) to participate in cycle 2 of the study which informed the second text, or (3) to participate in cycle 3 of the study which informed the third text (Figure 2.1). All physiotherapy staff at the meeting were invited to participate in the project. The only inclusion criteria were that participants carried an adult caseload.

Figure 2.1 Participants’ pathway options

<table>
<thead>
<tr>
<th>Introduction of research to physiotherapy staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>No participation</td>
</tr>
<tr>
<td>Participation in second cycle</td>
</tr>
<tr>
<td>Single in-depth, semi-structured interview</td>
</tr>
<tr>
<td>Outcome: creation of the second text</td>
</tr>
<tr>
<td>Participation in the third cycle</td>
</tr>
<tr>
<td>Two workshops</td>
</tr>
<tr>
<td>Series of 2-4 unstructured, in-depth interviews/dialogues</td>
</tr>
<tr>
<td>Outcome: creation of the third text</td>
</tr>
</tbody>
</table>

See Section 2.5 for details of the four texts comprising the data in this research.
Professional experience and seniority varied amongst participants, as did their field of practice within physiotherapy (see Table 2.1a,b,c). For the fourth text, physiotherapists who identified themselves as champions of patient-centred care and CSS tendencies were purposefully selected to critique the emerging CSS framework for physiotherapy practice from the second and third texts and discussed their practice in in-depth interviews.

Table 2.1a  Participants’ background - Text 2

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Year of graduation</th>
<th>Area of clinical experience</th>
<th>Current position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ada</td>
<td>Female</td>
<td>2001</td>
<td>Various</td>
<td>FYG</td>
</tr>
<tr>
<td>Belinda</td>
<td>Female</td>
<td>1961</td>
<td>Rehabilitation orthopaedics</td>
<td>Grade 2</td>
</tr>
<tr>
<td>Christine</td>
<td>Female</td>
<td>1989</td>
<td>Hand therapy</td>
<td>Grade 2</td>
</tr>
<tr>
<td>Dara</td>
<td>Female</td>
<td>1997</td>
<td>General, special care</td>
<td>Grade 1</td>
</tr>
<tr>
<td>Erika</td>
<td>Female</td>
<td>1992</td>
<td>Spinal injury</td>
<td>Grade 1</td>
</tr>
<tr>
<td>Felix</td>
<td>Male</td>
<td>1993</td>
<td>Outpatients</td>
<td>Grade 2</td>
</tr>
<tr>
<td>Greta</td>
<td>Female</td>
<td>1998</td>
<td>Aged care</td>
<td>Grade 2</td>
</tr>
<tr>
<td>Hilda</td>
<td>Female</td>
<td>2000</td>
<td>FYG</td>
<td>Grade 1</td>
</tr>
<tr>
<td>Ingrid</td>
<td>Female</td>
<td>1997</td>
<td>Spinal injuries</td>
<td>Grade 1</td>
</tr>
<tr>
<td>Jill</td>
<td>Female</td>
<td>1963</td>
<td>Community health</td>
<td>Grade 2</td>
</tr>
<tr>
<td>Karin</td>
<td>Female</td>
<td>1998</td>
<td>Rehabilitation</td>
<td>Grade 1</td>
</tr>
</tbody>
</table>

Table 2.1b  Participants’ background - Text 3

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Year of graduation</th>
<th>Area of clinical experience</th>
<th>Current position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zoe</td>
<td>Female</td>
<td>1997</td>
<td>Neurology</td>
<td>Grade 2</td>
</tr>
<tr>
<td>Donna</td>
<td>Female</td>
<td>1995</td>
<td>Orthopaedics</td>
<td>Grade 2</td>
</tr>
<tr>
<td>Carolyn</td>
<td>Female</td>
<td>1995</td>
<td>Respiratory medicine, other significant areas: intensive care, orthopaedics</td>
<td>Grade 3</td>
</tr>
<tr>
<td>Jocelyn</td>
<td>Female</td>
<td>1999</td>
<td>Hands, outpatients and various others</td>
<td>Grade 1</td>
</tr>
<tr>
<td>Allan</td>
<td>Male</td>
<td>1989</td>
<td>Outpatients</td>
<td>Grade 3</td>
</tr>
<tr>
<td>Petra</td>
<td>Female</td>
<td>&gt;20 years ago</td>
<td>Cardiopulmonary</td>
<td>Grade 3</td>
</tr>
<tr>
<td>Louise</td>
<td>Female</td>
<td>1998</td>
<td>Rehabilitation</td>
<td>Grade 2</td>
</tr>
<tr>
<td>Jacquie</td>
<td>Female</td>
<td>1980</td>
<td>Spinal injury, outpatients</td>
<td>Grade 3</td>
</tr>
<tr>
<td>Corinne</td>
<td>Female</td>
<td>1966</td>
<td>Cardiothoracic, neurology, orthopaedics musculoskeletal al.</td>
<td>Grade 2</td>
</tr>
</tbody>
</table>

FYG=First year graduate

Table 2.1c  Participants’ background - Text 4

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Year of graduation</th>
<th>Area of clinical experience</th>
<th>Current position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jill</td>
<td>Female</td>
<td>1963</td>
<td>Community health</td>
<td>Grade 2</td>
</tr>
<tr>
<td>Paul</td>
<td>Male</td>
<td>1985</td>
<td>Musculoskeletal physiotherapy</td>
<td>Self-employed</td>
</tr>
<tr>
<td>Raymond</td>
<td>Male</td>
<td>1972</td>
<td>Musculoskeletal physiotherapy and persistent pain</td>
<td>Grade 2</td>
</tr>
</tbody>
</table>

I anticipated that physiotherapists who agreed to participate in the study would have some interest in exploring their practice. If they were interested in understanding their practice at a deeper level and had limited time I expected that they would agree to participate in the second cycle of the study. Physiotherapists who were more in tune with notions of CSS approaches to practice might have been more inclined to participate in the third cycle also. The third cycle was more time-consuming and asked for a greater commitment. I explained the third cycle as a staff
development project using reflective practice and critical debates. Eleven physiotherapists volunteered for the second cycle and nine physiotherapists volunteered for the third cycle. Volunteers were asked to provide their contact details. I contacted the volunteers and negotiated dates and venues for conducting the in-depth interviews and workshops.

2.5 Constructing the texts: A process of critical transformative dialogues

Following the hermeneutic tradition, I needed to construct texts within a question-and-answer dialogue; these texts consisted of pertinent literature, transcripts from participants’ interviews and action plans, focus groups and field notes. Further, to adhere to the critical tradition of critical hermeneutics I then had to critique the emerging answers from each dialogue by starting another dialogue questioning the previous answers and draft model. Four texts or dialogues were developed. The first dialogue was the starting point for asking the questions that formed the second dialogue, and so forth. All four texts related to each other and together they formed a set of critical transformative dialogues.

Table 2.2 Critical transformative dialogues: Four texts

<table>
<thead>
<tr>
<th></th>
<th>1st text Understanding CSS Theory</th>
<th>2nd text Physiotherapy Status Quo</th>
<th>3rd text Trialling CSS</th>
<th>4th text Envisioning CSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Titles</td>
<td>Understanding core essences of CSS</td>
<td>Critiquing the status quo of current physiotherapy practice models</td>
<td>Trialling CSS as a practice model by individual physiotherapists</td>
<td>Envisioning CSS as a physiotherapy practice model</td>
</tr>
<tr>
<td>Purpose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questions</td>
<td>What is CSS? What are the relevant themes of CSS that could inform physiotherapy practice?</td>
<td>What do current physiotherapy practice models look like?</td>
<td>What would trialling a CSS model in practice be like? What are the strengths and limitations of these CSS applications?</td>
<td>What might CSS-informed physiotherapy practice look like? What are the pros and cons of such a CSS approach to physiotherapy practice?</td>
</tr>
<tr>
<td>Texts</td>
<td>CCS and health-related literature review</td>
<td>CSS-related physiotherapy literature review, transcripts from participants</td>
<td>Transcripts from participants</td>
<td>Transcripts from participants</td>
</tr>
<tr>
<td>Approach</td>
<td>Philosophical hermeneutics</td>
<td>Critical hermeneutics with elements of philosophical hermeneutics</td>
<td>Critical hermeneutics with elements of philosophical hermeneutics and action research</td>
<td>Critical hermeneutics</td>
</tr>
<tr>
<td>Text construction</td>
<td>Literature review</td>
<td>Literature review, single in-depth semi-structured interviews, workshop 1, field notes</td>
<td>Action plans, series of in-depth interviews, workshop 2, field notes</td>
<td>Deeply reflective and critical interviews</td>
</tr>
<tr>
<td>Researcher actions</td>
<td>“Dialogue” with authors through published literature</td>
<td>Reading, dialoguing with participants</td>
<td>Teaching, reflecting, trialling, dialoguing and critiquing with participants</td>
<td>Dialoguing and critiquing with participants</td>
</tr>
</tbody>
</table>
2.5.1 Critical transformative dialogues
Because this research explores the relevance and value of CSS as a framework for physiotherapy practice it was important to embrace the various facets of CSS in the research framework: describing the status quo, critiquing it, and exploring its transformation. I interpreted these facets as tasks that guided me to pose four smaller sequential research questions:

1. What are the relevant themes of CSS that could inform physiotherapy practice?
2. What do current physiotherapy practice models look like?
3. What would trialling a CSS model in practice be like?
   What are the strengths and limitations of trialling CSS applications in practice?
4. What might CSS-informed physiotherapy practice look like?
   What are the pros and cons of such a CSS approach to physiotherapy practice?

These sub-questions also describe the steps undertaken towards understanding the potential of CSS for physiotherapy practice. The questions were descriptive, critical and transformative in type. They were congruent with the CCS perspective because they reflected intention to describe and understand the status quo, then to critique and challenge the status quo and finally to influence the transformation of the status quo. Descriptive questions help describe the status quo. Critical questions help to challenge and critique the status quo and engage models of CSS in practice. Action and visioning questions facilitate transformative learning and change. All these questions represent the question-answer dialogues of the hermeneutic spiral. For my research I incorporated a critical component by critiquing answers and posing skeptical questions. As a result I have designed a critical transformative dialogue approach. This approach consists of four texts, four research cycles and four approximations (or evolutions) towards a CSS model for physiotherapy practice. An overview of these four texts is presented in Table 2.2.

The construction and interpretation of these four texts comprised the critical transformative dialogue research approach based on critical hermeneutics with blending in of elements from philosophical hermeneutics and action learning. Following the hermeneutic tradition, a question-answer dialogue facilitates deeper understanding that can shed light onto differences and commonalities between the two communication partners. These dialogues could be seen as comparing world views. Further, the question-answer dialogue is designed to generate new meanings. Depending on the intentions of the dialogues, meanings and interpretations may shift and transform. The critical intent of such dialogues concerns awareness and scepticism of interpretations, because interpretations are subject to influences of which the dialogue partners may themselves not be aware. To prevent this from happening the researcher in the critical hermeneutic tradition seeks to make these underlying influences transparent by openly posing skeptical questions that make the reader aware of bias in interpretation. Critical dialogues help interviewees to see influences that they initially could not see (Habermas 1981/1984). Critical transformative dialogues are thus dialogues that motivate interviewees to act on their new awareness of dominant influences. According to Habermas, transformation can arise through critical debates, actions to bring about change, and reflections on those actions. Blending the descriptive, critical and transformative elements of critical hermeneutics was designed as a spiralling and interconnecting process firmly knotting these elements together, finding common ground and synthesising interpretations with critique and potential for action (see Figure 2.2).

The first text, understanding CSS, guided the entire inquiry of this thesis: the development of a CSS model for physiotherapy practice. The first text set the foundation for the second text. The second text established the status quo and informed the starting point for the third text. The third text explored how the status quo could be transformed towards a CSS mode of practice. The fourth text expanded and critiqued the third text as well as revisiting all the previous texts.

Although these texts were constructed largely in chronological order, all four texts merged in correspondence with each other. Critical dialogue between the four texts culminated in the emergence of a CSS model for physiotherapy practice. The development of this model arose from blurring the interpretive and critical paradigms. As the core of this thesis, critical hermeneutics represented the interface between the interpretive and critical paradigms, although, at times, especially in Text 1, I used an orientation towards philosophical hermeneutics, and at other times I used an orientation towards action learning, especially in Text 3.
Qn. 1. What is CSS?

Qn. 2. What are PT practice models like?

Qn. 3. What does CSS practice feel like?

Qn. 4. What could CSS practice model be?

Key:
- Hermeneutic circle
- Critical dialogue of question and answer
- Fusion of horizons
Once all texts were gathered I analysed them using critical lenses. Critical lenses filter the text through a “sieve” that brings ideology, interest and assumption out into the open. At times I adopted a philosophical hermeneutic stance, seeking understanding of the status quo of current physiotherapy practices. At other times I adopted a critical hermeneutic stance, seeking to challenge this understanding. At other times again I adopted an action learning stance, critically debating and challenging co-researchers, and being challenged by them regarding understanding and critique of physiotherapy practice. These multiple stances were adopted to illuminate scepticisms from various angles as well as to provide sufficient triangulation for the phenomenon of a CSS model for physiotherapy practice.

2.5.2 Cycle 1 – Constructing the first text: Conceptual CSS model
The first text consists of a review of CSS literature. In Chapter 3 (CSS) I discuss Habermas’ theory of cognitive interests and communicative action and I critique his work using the great debates Habermas had with Gadamer (especially) and Foucault. These debates were critical to the evolution of CSS, as the debaters not only stated their positions but challenged and questioned each other’s position, making differences transparent. These debates were based on interest, intention and motivation that informed the respective theories. These debates, especially the Gadamer-Habermas debate, had critical transformative elements as they shifted the debaters’ position and set these thinkers on journeys to further explore key, non-consensual aspects. In a sense the Gadamer-Habermas and Foucault-Habermas debates are manifestations of critical hermeneutics. Apart from the theoretical CSS discussion in constructing the first text, I reviewed key literature that referred to CSS in related health professions. The dialogue between CSS and health-related CSS literature was explored. This dialogue crystallised the core of CSS for these professions and helped to conceptualise the relevant core of CSS for physiotherapy. The first text concludes with conceptual dimensions that could inform a CSS framework model for physiotherapy practice. It builds the theoretical foundation for the following three texts and the overall thesis. The first text is predominantly grounded in philosophical hermeneutics.

2.5.3 Cycle 2 – Constructing the second text: Critique of status quo
The conceptual dimensions of the first text guided the second spiral of gathering data for the second text. This process consisted of a literature review of relevant themes in physiotherapy practice, and interviews. Framing questions were extrapolated from the first text and the qualitative research literature (Lawler 1998, Minichiello et al 1996, Willis and Smith 2000):

   Can you describe the kind of physiotherapist you are, or the kind of physiotherapist that you could identify with?
   How do you know what your patients need?
   What are the biggest challenges for physiotherapists?

These questions included descriptive questions, designed to enable me to describe the status quo of physiotherapy practice models, and critical questions, designed to enable me to challenge the status quo. Existing physiotherapy practice models currently in operation were explored. Eleven physiotherapists were interviewed, using one-off dialogued interviews. The literature review explored current debates about physiotherapy practice models, in particular what the literature said about the use of CSS in physiotherapy. As there is a dearth of literature which explicitly discusses the relevance of CSS to physiotherapy practice, key words such as patient-centred care, practice paradigms, practice models and professional knowledge that had relevance to CSS guided the literature review. This review was placed in a dialogue with the interview data. In the third research cycle, themes of practice models that emerged from the literature and interviews were fed back to participants. Third cycle participants were asked to discuss, critique, debate and enrich these emerging themes. This approach created a dialogue between the literature and the experiences of the 2 sets of participants.

2.5.4 Cycle 3 – Constructing the third text: Trialling CSS
The third research cycle involved trialling and critiquing CSS as a physiotherapy practice approach. Participants in this cycle had contributed to the second text by critiquing the current status quo of physiotherapy practice approaches. Participants from cycle two did not participate in cycle three. Due to the self-selective nature for participation I assumed that physiotherapists who located themselves predominantly in a biomedical practice model would be less likely to agree to participate in this study. By providing a choice between describing their practice in one-off interviews and trialling CSS in their practice in a 9 month time frame, I hoped to attract a group of physiotherapists who felt comfortable with their current practice model and who wanted to describe it to me in interviews for the second research cycle. And I hoped to attract a group of physiotherapists for the third research cycle who were prepared to take a self-reflective, skeptical stance towards their current mode of practising, with a view to trialling CSS-informed changes to that mode. Only one participant of cycle two asked to be included in cycle three as well, because she was so intrigued by the interview for the second text that she wanted to be considered for the third cycle.
Cycle three had three parts to it: first, a pre-implementation workshop; second, an implementation cycle; and third, a critical appraisal workshop (see Figure 2.3). The first workshop invited participants to critique the second text, to learn about CSS and to draw up their self-determined action plans to explore CSS in their own practice. In this pre-implementation workshop, findings from the second cycle were presented. Because participants in the third cycle had no sense of ownership of the second text they could view it with a certain detachment, allowing them to critically reflect on its relevance to their own practice. Cycle three participants entered into a critical debate on the diversity of current practice approaches and the potential for a CSS practice model. During the workshop participants wrote their ideas on butcher’s paper, used sticky notes to contribute critical comments and ideas to the debate, and generally had no difficulty in raising delicate issues and engaging in a critical debate with each other. The pre-implementation workshop explored three key questions: (1) What are the pros and cons of current physiotherapy practice? (2) What is CSS? (3) How could participants (individually) explore CSS in their own practice?

Participants were educated on themes of CSS. A glossary of terms and three papers4 were distributed as background reading. Participants were asked to critically discuss these themes and their relevance and applicability to physiotherapy practice in general. Again, lively discussions ensued. Finally, all participants were asked to write their own action plans for trialling CSS in their practice situation. The action plans stated what aspects of CSS each participant wanted to explore individually on a deeper level over the next 9 months.

Figure 2.3 Design of cycle 3: The action learning cycle

Part 1. (Collective and) Individual

<table>
<thead>
<tr>
<th>Pre-implementation workshop</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-reading</td>
<td>reading and reflection</td>
</tr>
<tr>
<td>Present status quo from phase 2</td>
<td>didactic, active listening</td>
</tr>
<tr>
<td>Verify/identify further practice tensions</td>
<td>active, critical thinking</td>
</tr>
<tr>
<td>Critical debate</td>
<td>interactive, critical thinking</td>
</tr>
<tr>
<td>Education</td>
<td>interactive comments</td>
</tr>
<tr>
<td>Critical debate</td>
<td>interactive, critical thinking</td>
</tr>
</tbody>
</table>

Part 2. Individual

- Writing individual action plans
- Acting upon action plan
- Planning further reflections and/or actions
- Reflecting
  - Critical thinking
  - Transforming action plan
  - Moving forward with the plan

Part 3. Collective

- Critical appraisal workshop
  - Taking stock of individual action research phase
  - Critical debate
  - Challenging experiences
  - Challenging emancipatory learning framework
  - Education

---

At the end of workshop 1 participants were encouraged to write privately the goals and strategies they were interested to trial in a CSS framework. They kept a copy of these action plans and gave a confidential copy to me. These action plans were a manifestation of how they understood CSS. As each participant brought different professional practice and personal background to this study it was assumed that each would make different inferences about what a CSS approach could be for them, which, indeed, proved to be the case. I avoided a collective discussion on the action plans because I did not want individuals to all trial the same aspects of CSS or to restrict their personal journey of exploration. Guided by their action plans, participants explored the potential of transforming their current practices. Appendix 2 includes the pre-implementation workshop plan, glossary of terms and references, and sample action plans. A series of in-depth interviews traced their reflections and transformations. An appraisal workshop concluded this action learning cycle. Research questions posed in the action learning cycle were:

What would practice identity, professional roles, decision-making processes (etc.) be like in a CSS practice approach?

How keen are participants to transform aspects of their practice? Which aspects of practice are they prepared to change and can they change, and if not why not?

How relevant is CSS to the participants’ current practice perspective and situation?

During the 9 months I interviewed each participant in the action learning cycle two or three times. Interview times were negotiated with each participant. I used a copy of the action plans as the starting point of the first in-depth interview. In these interviews participants reflected on the workshop and on their action plans. They reported on their experiences and actions in trialling their plans. These interviews were unstructured, as I wanted participants to feel in control of their reflections and transformations. Some participants thought aloud in monologues during the interviews, whereas others used me as a facilitator for their reflections, as a resource person for further readings, or as a person to complain to about current systems and structures in their workplace. Occasionally I was asked what my opinions were. My goals here were to foster awareness and reflection, not to impose my ideas about “the right or best way” to practise. I happily let myself be drawn into critical debates and offered my perceptions, since the goal was to raise awareness and prompt exploration. Participants seemed to have no difficulty challenging and/or confirming me. I gained the impression that participants seized this opportunity to discuss their experiences and perceptions and give voice to what was otherwise marginalised. This discussion could relate to their own desired approaches which “the system” did not accommodate, or to the move to the emancipatory practices of CSS which were difficult to amalgamate into or replace the accepted norms of the medical model which held hegemonic sway in their hospital work environment. At the end of each interview a new interview date was negotiated at the convenience of the participant. Each interview lasted between 30-70 minutes. Over the 9 month period some events limited participant availability and involvement, such as illness, jury duty, heavy student supervising duties, imminent relocation of departments, promotions, change in rotations to other clinical areas, and one participant went on maternity leave 2 months into the trialling cycle. All these events were evidence of how physiotherapists have to cope with many influences in the real clinical practice world. It was quite remarkable that all participants remained in this study although they could not give it their full attention and commitment alongside other work and life responsibilities.

The aim of the critical appraisal workshop at the end of cycle three was to collectively take stock and appraise the relevance and value of CSS in physiotherapy practice. Participants shared their experiences and conclusions. Participants raised many questions that illuminated the challenges of putting CSS dimensions into practice within a complex health care system that was not actively supportive of them. In essence, participants were exploring new practice approaches in a context where the dominant practice norms supported the traditional medical model. This workshop concluded the action-learning cycle. Details and findings of the participants’ learning experiences and reflections are incorporated into Chapters 5.

All nine participants attended the pre-implementation workshop but only four attended the critical appraisal workshop. Three participants were absent due to maternity and annual leave, while two had a heavy patient caseload at the time. Due to the birth of her child and extended maternity leave one participant concluded her action learning prior to the second workshop. I conducted telephone interviews with the other participants who were absent at the concluding workshop, to invite their reflections and critique of the action learning cycle and the usefulness, relevance and difficulty in implementing CSS in their practice. The third text represents the various journeys that participants travelled while exploring, reflecting and trialling CSS themes; this text is represented in a series of vignettes in Chapter 4. The third text was predominantly grounded in action-learning research.

2.5.5 Cycle 4 – Constructing the fourth text: Imagining CSS

For the fourth cycle the key question was: How do physiotherapist champions of patient-centred, emancipatory care visualise a CSS framework for physiotherapy practice? The word “champion” was deliberately chosen to reflect people who chose to stand up for (to champion) practice approaches that represented the principles of CSS.
and to portray the capabilities, attitudes and actions that champions, or excellent models of a CSS mode of practice, would demonstrate. These people were invited by me to participate in this cycle. They were known to me or recommended by colleagues familiar with CSS theory and practice.

I wanted to gain critical understanding of these participants’ thinking, their values, practice approaches and professional identity. The aim of the fourth text was to gather evidence from physiotherapists who could visualise a CSS framework, whether they used it or not, or who already operated within such a framework. As part of this fourth cycle the new participant group was invited to critique the second and third texts. This fourth research cycle placed the emerging CSS model for physiotherapy practice from cycle 2 and 3 into another critical transformative dialogue. This fourth cycle consisted of deeply reflective and critical interviews.

There were four steps in this activity:

1. **Orientation.** As part of the invitation process I explained to the participants what my project was about and my goal of developing a CSS model for physiotherapy practice. I wanted to ascertain whether their practice was compatible, in their eyes and mine, with a CSS approach, and I wanted to assess whether it would be helpful to provide them with some pre-reading to familiarise them with terminology and concepts that were likely to be a significant part of the subsequent discussion.

2. **At the interview I presented the model of CSS for physiotherapy that had been developed from the research to that stage, see appendix 3 (as per chapter 6).**

3. **The participants were invited to:**
   - critique the model presented
   - share their stories of CSS practice.

   My role was to set the scene and moderate their critique and shared vision.

   An important part of adopting a CSS perspective is to envisage possibilities (Morrow and Brown 1994) and to know what steps to take towards realising these possibilities. Research questions posed to the fourth text were:

   • Firstly, in developing an alternative model to the status quo, what are the key features of status quo physiotherapy practice?
   • What could physiotherapy practice look like if it was underpinned by CSS?
   • What would underpin the practice ideology of this model?
   • What would practice consist of in this model?
   • Apart from direct changes to practice, what changes to the practice context would be needed to allow or enhance the transformation of practice to a CSS model?

   These questions explored the fine line between “utopian” and potential notions and implementations of CSS. The fourth text provided insights into the potential of CSS in physiotherapy practice. The fourth cycle was predominantly grounded in critical hermeneutics.

   These questions enabled me to explore the potential that existed for the status quo to be transformed towards a CSS approach. The task of this thesis was to search for the meaning and vision of a physiotherapy practice model informed by CSS via deep and critical interpretations of practice.

### 2.6 Development of a CSS model for physiotherapy practice

The interpretation of texts, both during and following the construction of the four texts, was based on critical hermeneutics principles. Critical hermeneutics explores the ideology, subjectivity and assumptions that underpin and shape practice models. Scholars in the critical hermeneutics tradition postulate that reality needs to be treated with scepticism. Phenomena should not be taken for granted, and researchers should be guided by an awareness of alternative, individualised choices rather than by linear directions and the ideal of one best choice. Researching such CSS dimensions as capacity for critical self-reflection, professional ideologies, power relations and practice epistemology could not be analysed in a simplistic determinist fashion. Rather, in the analysis I needed to recognise and honour the interdependence among these dimensions. The way physiotherapists use power relations can inform the professional knowledge they predominantly work with and the way they perceive their professional role. Likewise perceived professional roles can inform power relations.

I do not view practice ideology as a fixed code of rules, an object or a possession. Rather, ideology refers to what informs and is brought into physiotherapy practice and physiotherapy literature, such as assumptions, values, tendencies, intuitions, fears and hopes. Physiotherapy practice is influenced by ideological ideas.

The actual operation of ideology (and other themes of CSS in physiotherapy practice) is better illustrated by the cacophony of sounds and signs in a big city street than by the text serenely communicating with
Ideologies are shaped by practice and practice shapes ideology. Individuals can also be, and usually are, unaware of the ideology underlying their practice; it is seen as taken-for-granted presuppositions that do not need questioning, or simply are not questioned. Very often ideologies are seen as just commonsense. Within the biomedical model the quest for scientific objectivity potentially locates alternative practice models as subjective and ideological, and even more importantly, it hides its own subjectivity and ideology. Critical hermeneutics acknowledges the subjectivity, assumptions and ideology of the researcher and the researched. It places these assumptions in a critical dialogue, making assumptions explicit and transparent. The core of critical hermeneutics is to question and challenge interpretations, and to make distinctions between what is physiotherapy practice and what is the ideology of physiotherapy practice. Although I had assumptions and interests in developing CSS model knowledge, the skeptical critical attitude of the critical hermeneutics approach, as well as the research design of constructing four texts, ensured that my bias as a researcher was critically reflected so that new understandings of the application of CSS as a model for physiotherapy practice could be generated. My assumptions were shaped by my professional experiences as a clinical physiotherapist, clinical educator, health promotion academic and diversity health coordinator (I described the professional critical incidents that generated the initial research questions for this thesis in Chapter 1). Some of my assumptions were:

- Currently, physiotherapy is predominantly located within the medical model discourse which assigns power to physiotherapists and other health professionals. In order to shift these power relations the entire discourse of the medical model would need to change. It is important to note, however, that physiotherapists may not be critically aware of the power imbalance in therapist-patient relationships inherent in medical model practice and discourse (as reflected in Foucault’s (1963/1973) notion of power as producing reality and truth, and being sanctioned by social expectations that resides in the discourse within which health professionals must operate, rather than residing in individuals). Health professionals need to fulfil the expectations of their role, part of which, in the traditions of the medical model, is for patients to play a passive role. People can only exercise power if they are in a position of power within the context of a particular discourse. It is thus extremely difficult for people not to exercise power if they are in a context in which their role is associated with power. If they want to change the power relationship they have to change the context of practice in which they operate.

- Physiotherapists practise with unresolved tensions between scientific and clinical evidence, and therapist and patient expectations and values.

- Although physiotherapists would like to think that they practise patient-centred care, they may not realise that their well-meaning intentions to help patients in fact could tentatively disempower patients, or that these caring intentions could be interpreted by patients as paternalistic. Once physiotherapists are made aware of what underpins their intentions and how they might be interpreted by receivers of their practices they may be in a better position to become critical transformative reflectors of their practice.

- Physiotherapists may already practise many dimensions of CSS, but such practice has not been studied and documented. If this was so, it was my intention to give this rare and marginalised practice a voice.

These assumptions were used to frame my text construction and interpretation. To ensure that my ideology and assumptions were not distorting participants’ voices and the literature, I examined my own critical transformative journey. My initial interest in this thesis was to search for “What could CSS practice in physiotherapy look like?” I had no preconceived ideas about what such practice could look like concretely. I was curious to explore how practice could be transformed. I used my curiosity as a provocation and an engagement tool in my dialogues with participants. I exposed my research interests up-front. As I was a physiotherapist myself, I was familiar with physiotherapy culture; the participants felt I understood their context, and jargon was not an issue. My challenging questions and frankness helped participants to be clear and frank about their practice ideology. Further, this openness fostered rapport that went beyond niceness (in our interactions) to critical openness between us (and amongst participants in the workshops).

The theoretical and philosophical underpinnings of my research topic advise against solitary, fragmented interpretations of texts as much as possible. Hermeneutic analysis requires repeated interpretations in the form of question-and-answer dialogues (Gadamer 1976/1996) and a skeptical critical approach to the interpretation (Ricoeur 1981). Interpretations of texts commenced during text construction. I analysed literature and experiential data as I collected it. During interviews I wrote field notes in the form of descriptive as well as critical prompts whenever I felt that my assumptions were influencing the way I understood what interviewees were saying. As soon as the opportunity arose within an interview, I clarified my assumptions with interviewees.
Using this interviewing technique provided interviewees with opportunities to explain themselves at deeper levels and to expand and reflect on their understanding of their physiotherapy practice. It also gave them opportunities to challenge my assumptions. It ensured that I kept my assumptions transparent and it helped shed light on interviewees’ assumptions. This interviewing technique blended the construction of texts with initial critical interpretations of texts. All participants said at some stage in their interviews that they had not thought about this topic and these questions before. This was a fair indication that these physiotherapists had not reflected in depth about their practice approaches and ideologies in the past. Further, it indicated that the critical interviewing technique enabled interviewees and interviewer to become aware of hidden assumptions and taken-for-granted practices.

Bearing in mind that dialogue and critical debate were an essential aspect of text construction as well as text interpretation within my chosen research approach, I chose a three-stage approach to text interpretation informed by critical hermeneutics principles. I constructed describing-critiquing-transforming stages of interpretations.

2.6.1 Stage 1: Interpreting texts for what they said
Stage 1 was concerned with interpreting the text for what it said. I immersed myself in the text, reading the transcripts and listening to the tapes many times. I also went over my field notes and interpretations and notes I had made (“my interpretive log”) during text construction with the aim of familiarising myself with each text item and the context that surrounded it. I highlighted phrases and identified key quotes in the transcripts and literature texts. The purpose of this initial data analysis stage was to understand what the authors and interviewees were saying about the topic area (CSS in physiotherapy). I wanted to understand participants’ interpretation of their role as physiotherapist. From these descriptions I deduced practice frameworks that underpinned the practice approaches adopted in physiotherapy in general and by the participants in particular.

2.6.2 Stage 2: Critically interpreting the interpretations of previous texts
Next I critically interpreted the texts using my prior and emerging understandings and interpretations of physiotherapy practice and CSS. I used a repeated fusion of horizons approach. I moved from describing to valuing the data. In this stage I interpreted how participants had interpreted their practice (“interpreting the interpretations”). I distinguished between what physiotherapists said and what they actually meant by placing their arguments and understandings within a critical hermeneutics framework. I searched for inconsistencies, doubts, tensions and contradictions that they themselves may not have articulated. An example of the critical questions I posed to guide this second stage analysis is shown in Table 2.3.

<table>
<thead>
<tr>
<th>Interview transcripts</th>
<th>My second stage analysis questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allan: There was this lady where I took total control. This lady had a shoulder problem. She was actually looking for me to give her direction. She looked very comfortable when I started to tell her what to do. So I kept telling her what to do … I am clinically trained … I always decide what exercises to do. Then I let them work out how they are going to do that throughout the day. I would not think of giving them total control. I think it lies in their best interest to do what I say.</td>
<td>Allan is aware that he gives little control of treatments to these patients. He justifies this control with his professional expert knowledge and with his taken-for-granted assumption that patients trust him and automatically consent to his treatment plans. How does Allan know that his patient is actually comfortable? How aware is Allan of his patients’ wishes in relation to control of treatment and how conscious is he of the values that underpin his clinical training and clinical practice?</td>
</tr>
<tr>
<td>Zoe: Now when we [therapist and patient] are talking I think I need to feel comfortable and I need certain things. I need information from them [patients] to combine [with] what I think is best for them. So the patient needs to feel free to communicate. It is also about finding out how they think about their body, how they move. “How much do you walk around?” “Oh well I don’t know”. You know that gives me an idea about a patient’s relationship to her/his body.</td>
<td>Zoe wants to develop the best treatment plans for her patients. She does this by finding out more about her patients. But are decisions about treatment plans really made in collaboration? What does collaboration mean to Zoe? And who should decide what the best treatment plan is?</td>
</tr>
</tbody>
</table>
Thick descriptions from the transcripts were subjected to close analysis following Geertz (1973). Quotes were used to test and affirm the credibility of my interpretations and to ground the emerging model in the participants’ experiences and in the discourse of physiotherapy in the literature. Themes grounded in practice and discourse were then compared with the emerging CSS model developed from the first text to advance the emerging CSS model for physiotherapy practice. Following hermeneutics tradition, the literature and participants’ transcripts were placed in a dialogue, a hermeneutic circle. Themes from participants were related to and compared with themes from the literature. The hermeneutic circle informed the next draft model in the evolution of my CSS model.

2.6.3 Stage 3: Critically interpreting all texts using meta-hermeneutic circle approaches

In Stage 3 I analysed all draft models and synthesised a CSS practice model for physiotherapy practice. I revisited the four texts that helped develop emerging ideas, constructs and draft models towards a CSS practice model. The themes and flavours that each version developed were interpreted in a meta-hermeneutic circle approach to inform the final interpretation in this study, the CSS model for physiotherapy practice. Each draft model was an expansion and refinement of the previous version. Each version presented different aspects and perspectives to developing the CSS practice model. The arrows pointing to each newly arising draft model in Figure 2.2 illustrate the meta-hermeneutic circle approach. The draft models orchestrated the full sounds of all the texts including CSS literature, physiotherapy literature and three separate groups of physiotherapist participants. By producing four texts and using each text to critique the previous text and build the next text I successfully invited many “sounds” and voices to illuminate the emerging CSS model for physiotherapy practice.

2.7 Quality

In qualitative research a number of terms and related actions can be used to identify and address quality. In keeping with the theme of the research, CSS, I have selected to address the core issues of credibility and trustworthiness. These attest to the believability, relevance and rigour of the research and allow the reader to determine the transferability of these findings to his/her context.

Critique and reflexivity are fundamental activities of CSS. I engaged in these activities during the processes of text construction and interpretation. Reflexivity is defined as ‘engaging participants in self-conscious critique’ (Hall, 1996, p.29). What can be known is known through dialogue and critical debate. Reflexivity involves self-awareness that is made public. I acted reflexively throughout my research study. In the introductory chapter my motivation for exploring the research question were publicly disclosed. In this chapter I described the development of critical transformative dialogues as a method of CSS to ensure opportunities of critique. The findings Chapters 4, 5 and 6 as well as the conclusion Chapter 7 present the processes of self-reflection, dialogue with participants and dialogue with the text that portray the quality of my critical self-reflection. I was the tool for text interpretations. I was guided by critical lenses that I imposed on myself and the texts. The quotes, my analysis of them and my line of arguing expose my critical self-reflection. In addition, I have presented the critique of my participants and the audiences who provided feedback at my conference presentations and talks (e.g. ANZAME Conference 2005).

In Chapter 5 I reported on a series of interviews conducted with each Text Three participant over a nine-month period. During this time I was able to develop professional relationships with each participant and explore their practice issues in depth. To ensure I clearly understood what they had meant to say I used several techniques. I asked probing questions to provide opportunity for more detailed descriptions and deeper thinking. I explained to them how I had made sense of their input and asked them to verify my understanding. This gave participants the opportunity to correct, clarify or amend their statements and my interpretations of them. I challenged their thinking and sought clarification when it appeared they had made contradictory statements. I asked for justifications or examples of their practice positions/approaches. Asking them to embed their statements in stories ensured that the texts I produced were contextually grounded.

These questioning and critical-transformative dialogue techniques enabled me to transform my pre-judgmental stance to a higher critical dimension. The series of in-depth interviews as well as the workshops ensured sufficient opportunity to explore personal and professional values of the participants in relation to physiotherapy practice. It provided opportunity for rich and deep text construction. In section 5.6 I discussed my own journey of trialling CSS which is a journey of critique and emancipation from pre-judgments of CSS as well as physiotherapy practice.

Critical self-reflection can be distinguished from merely conforming with the values of the chosen framework (in my case CSS), and affirming prejudices. Self-reflection without critique can be self-righteous and narcissistic resulting in reinforcing the status quo (McNiff 1995). By placing my findings from each research cycle into a critical transformative dialogue with the next participant group I ensured that my thinking and knowledge generation was challenged. I exposed these challenges in critique of CSS in each of the 4 findings chapters.
2.8 Concluding remarks

The research framework adopted in this research was critical hermeneutics. This critical hermeneutics approach had elements of philosophical hermeneutics and action research. These elements consisted of describing and initially interpreting, challenging the initial interpretation by posing challenging, ideology-illuminating questions, and envisioning potential for transformation. A critical transformative dialogue strategy was applied to construct and interpret texts. Such dialogues are compatible with CSS theory in that both advocate a dialogue that is relational, critical, reflective and searching for emancipation. These themes are explored further in subsequent chapters as my model for CSS in physiotherapy emerges.
Chapter 3

CRITICAL SOCIAL SCIENCE: TEXT 1

Philosophers have always interpreted the world, the point is to change it. (Karl Marx, 1975, p.423)

This chapter outlines a critical social science (CSS) perspective as the theoretical underpinning for this thesis. It traces the development of CSS from Marx to Habermas and identifies Habermas’ work, particularly his theory of knowledge constitutive interests and communicative action, as the theoretical core underpinning this thesis. This section provides historical detail to describe my interpretation of CSS and how it informs my approach. The historical developments of physiotherapy have taken a similar course to the developments of the Enlightenment movement. Variations of CSS are briefly mentioned and reasons provided for their exclusion from this study. The influence of Habermas’ theories on emancipatory practice in health-related fields such as education, health promotion and nursing are reviewed. From these reviews of the theoretical and health-related literature on Habermas’ CSS, key concepts are extracted that could inform a CSS framework for physiotherapy practice.

3.1 Defining critical social science

This thesis explores an alternative model for physiotherapy practice based on CSS. CSS is a general term that encompasses many variations. Writers in the areas of multiculturalism, feminism and critical postmodernism have taken aspects of CSS into their approaches (Agger 1998). Although there is no agreed-upon general definition of CSS, its theoretical perspective has critique and emancipation as its core. It could be argued that science can be understood as comprising three basic paradigms, the empirico-analytical, the historical-hermeneutic, and the CSS paradigms. It is the last that is considered here. CSS is a term that embraces core features under a common umbrella: critique, critical self-reflection and emancipation. Among these features, critique encompasses critique of totalitarian systems, critique of hidden ideology and resistance against unwarranted domination and oppression. Critical self-reflection is an assessment of the way one has posed questions by becoming aware of one’s own frame of reference (Mezirow et al 1990). Critical self-reflection enables reflectors to justify their ideas and actions. Emancipation is the process of attaining freedom. Freedom will only occur when there is a stable, civil society with an egalitarian justice system and a critical attitude towards institutions and authorities. One attribute that is needed to foster emancipation and freedom is a critical attitude towards the normative bases of authority (Ray 1993, p. viii).

There are numerous accounts of the purpose, task and essence of CSS. Newman (1999) listed a search for reason, justice and critique as the constant themes of CSS. Short et al (1998) stated that CSS explains conflict and inequality issues as a crisis arising from historical-cultural developments, domination and control. Ewert (1991) described CSS the following way:

Empirical and interpretive social sciences describe the world as it is whereas critical social science goes beyond describing and towards trying to understand why the world is as it is and attempting to change it towards what it could be (p. 346).

Ewert (1991) highlighted the difference between CSS and the empirico-analytical and hermeneutic sciences, stressing that CSS entails transformation informed by emancipatory visioning. According to Fay (1987, pp. 4-5):

Critical social science is an attempt to understand in a rationally responsible manner the oppressive features of a society such that this understanding stimulates its audience to transform their society and thereby liberate themselves.

One dominant theme in the evolution of CSS has been the reinstatement and transformation of the notion of rationality as critical rationality, transcending objective, value-free notions of rationality. Fay (1987) contended that proponents of critical rationality seek to differentiate between manipulative and emancipatory reasoning. He stated:

The aspiration of CSS is to see through the plurality of conflicting meanings, goals, and activities of people’s lives to the deeper unity which it claims they possess (p. 69).

Kellner (1989, p. 32) said that CSS constituted itself as a critique of existing conditions which produce suffering and an instrument of social transformation which would serve the interests of increasing human freedom, happiness and well-being.

Critique is seen as a necessary first step to help people make informed decisions by becoming aware of agendas and intentions that might be disguised under a veil of well-meaning intentions but guided by distortions. A science that does not address domination and oppression remains self-ignorant (Fay 1987, p. 25).
Without such critical awareness of the status quo, reforms and alternatives to current situations would be in danger of steering towards repeating and reinforcing current situations. Critique is the necessary first step in the transformative process towards improving current situations.

From these descriptions an agenda of CSS emerges by which proponents question the motivation and influences that form the status quo, expose structures, thoughts and practices that cause unnecessary suffering and injustice, explore alternatives, and ultimately emancipate the status quo towards a situation that entails less suffering and more social justice and freedom. From these brief descriptions of CSS three core themes emerge: critique of the status quo, critical self-reflection, and emancipation of the status quo.

Critiquing the status quo links CSS to historical developments. The focus of critique in CSS evolved alongside the historical developments of modernism, a love of machines and technology, idealisation of empirical-analytical sciences and evidence-based movements, and communication technology. Thus CSS exists on the ever-changing platform of the present status. Before discussing notions of critique, critical self-reflection and emancipation, the historical developments of CSS from Marx to Habermas are outlined, together with the accompanying changes in the focus of critique.

### 3.2 Historical developments in CSS from Marx to Habermas

The historical developments in CSS before Marx can be traced to the German Enlightenment movement that developed from Kant, Hegel’s critique on Kant, and then Marx (Rasmussen 1996). According to Marxist theories the working class is the producer of goods, which places it, and it alone, in a position to understand the capitalist system of production. Workers are thus knowledgeable, have the capacity to be knowledgeable at least in some form, and have an implicit awareness of the way the process of production operates. Thus, given the right circumstances (of collective action), workers are able to offer an alternative (socialist) mode of production that does not involve oppression. Workers’ collective power through action was seen as the only effective way of overcoming capitalism. Marx saw revolutions as the way to overthrow capitalism and domination.

With the rise of fascism in the early 1900s, which was strongly supported by the working class, these assumptions needed rethinking. The Institute of Social Research was established in Frankfurt, Germany in the 1920s to develop Marxist ideas and to operationalise Western Marxism (Bottomore 1984). Horkheimer, Adorno and Marcuse were the main thinkers of this institute, which in the late 1930s became known as the Frankfurt School (Agger 1998). Members of the Frankfurt School wanted to understand how the (German) people, including the workers, were subjugated or attracted into fascism and how fascism worked to obscure the reality of its purpose. Horkheimer coined the term ‘critical theory’ in his seminal book *A Critical Theory* (1937/1972). The Frankfurt School is often used as a synonym for critical theory and should be seen as distinct from theories of criticism. Critical theory is understood as a critique of traditional theory. CSS denotes a break from Marxist theory, and for this thesis CSS is discussed from Habermas’ perspective on critical theory (Morrow 1994).

Newman (1999) described critical theory by starting with the statement that critical theory has been ‘through the hoops’ (p. 204). He outlined most succinctly the historical context within which critical theory evolved:

> One can understand a group of German thinkers in the nineteen thirties, faced with the apparent mass acquiescence to Nazism, doubting the idea of any one particular social class being the source of knowledge through struggle or the agents for social transformation. One can understand them in the forties, when science and technology were being used to create massive war machines, doubting the rationality of the enlightenment and seeing instrumental reason as a force for control and ‘masterly enslavement’ (Marcuse 1964, p. 25). One can understand those in the Frankfurt School in the nineteen fifties and sixties wanting to develop critiques that would dissociate truth from ideology, and to understand how and why knowledge was generated. After all, they had some unsettling case studies of ‘truths’ accepted by whole sectors of a society in their recent history, which now that the madness had subsided, were self-evidently nonsense. And one can understand how in the communications era of the seventies and eighties they would shift their attention away from cognition, with its implications of certainty, to language, with all its ambiguities and relativities; from the business of coming to know, to the process of reaching understanding (Newman 1999, p. 210).

From this historical outline the development of CSS can be categorised into five distinct phases (Rasmussen 1996). The first phase (1930s) is identified as the critique of traditional theory; the second phase (1940s) is the critique of instrumental reason and the decline of the Enlightenment; the third phase (1950s) is critique of aesthetic reconstruction; the fourth phase (1962) is critique of scientism; the fifth phase (1970) is critique of communications (see Table 3.1).
Table 3.1  Critical social science in historical perspective – Phases in development  
(Adapted from Rasmussen 1996 and Kellner 1989)

<table>
<thead>
<tr>
<th>Time</th>
<th>Thinkers</th>
<th>Focus of critique</th>
<th>Content</th>
<th>Key literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1930s Phase 1</td>
<td>Horkheimer</td>
<td>Traditional theory</td>
<td>Firmly grounded in Marxist theory; Opposition to repression and domination; Belief in the proletariat to start a revolution.</td>
<td>Critical theory (1937)*</td>
</tr>
<tr>
<td>1940s Phase 2</td>
<td>Horkheimer and Adorno</td>
<td>Instrumental reason</td>
<td>Rationality of the Enlightenment; Paradox and pessimism of critique of reason and rationality</td>
<td>Dialectic of Enlightenment (1944)*</td>
</tr>
<tr>
<td>1950s Phase 3</td>
<td>Adorno and Benjamin</td>
<td>Aesthetic reconstruction</td>
<td>Arts as critique; Art can represent that which cannot be represented in words; Art is not able to dominate in language.</td>
<td>The culture industry (1951)*</td>
</tr>
<tr>
<td>1960s Phase 4</td>
<td>Habermas</td>
<td>Scientism</td>
<td>Linking knowledge to interest; Focus on ideology critique.</td>
<td>Knowledge and human interest (1968)*</td>
</tr>
<tr>
<td>1970s and 1980s Phase 5</td>
<td>Habermas</td>
<td>Communications</td>
<td>Language and its ambiguity and relativities; The aim of communication being understanding with an emancipatory intent.</td>
<td>Theory of communicative action (1981)*</td>
</tr>
</tbody>
</table>

*Original year of publication in German. Translations in English were published at later dates. In this thesis references from the translated versions are used for linguistic reasons.

3.2.1 Critique of traditional theory, Phase One – 1930s

Horkheimer (1937/1972) outlined his relational theory, a critical theory, arguing that ideas influence theories and theories influence social environments. The social environment of the time followed the trend of bourgeois capitalism and fragmentation and division of labour, all under the name of social progress of reproduction. This social environment reproduced traditional theory or empirical sciences. Horkheimer described this relationship between the social environment, theories and ideas as reproducing itself with a lack of self-critique. According to Horkheimer, traditional theory is deductive, reductionist, and privileging of empirical science as a tool for achieving harmony. Differences between traditional and critical theory are displayed in Table 3.2.

Table 3.2  Distinctions of intentions and definitions of rationality  
(informed by Horkheimer 1937/1972)

<table>
<thead>
<tr>
<th></th>
<th>Traditional Theory</th>
<th>Critical Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intentions</td>
<td>To dominate</td>
<td>To emancipate</td>
</tr>
<tr>
<td>Rationality</td>
<td>Objective</td>
<td>Mediating objective and subjective</td>
</tr>
<tr>
<td>Influence on the status quo</td>
<td>To maintain the status quo</td>
<td>To emancipate from the status quo</td>
</tr>
</tbody>
</table>

Traditional theory was described as having conformist, quantitative values that reified the status quo (Horkheimer 1937/1972). The term ‘reification’ means the regard of something as having a god-like, superior authoritarian status. The notion of reification stems from Marxist theory and is used in critical theory literature, especially by Horkheimer, to describe a mechanism that reinforces current ideas and values lack of change in the status quo. Reification of the status quo occurs when there is a lack of self-critique in theory building. Thus capitalist systems and social structures appeared to be factual and unquestionable, or at least it appeared to be strange to question
social systems. But from the CSS perspective, theorists argued that what appeared to be driven by unchangeable laws were in fact reifications. Critical theorists’ idea of reification was that the capitalist system appeared more as a non-human construction than as a social system, and that it could be changed by means of social action by human beings. In his introduction to Horkheimer’s seminal book Critical Theory, Aronowitz stated succinctly what the task of critical theory was:

The task of critical theory … is to penetrate the world of things to show the underlying relations between persons. …Critical theory proceeds from the theorist’s awareness of his own partiality. Thus theory is neither neutral nor objective. Its partisanship consists in its goals: the reconstruction of society based on non-exploitative relations between persons (Aronowitz in Horkheimer 1937/1972, p. xiii-xiv).

Social structures and systems are historical and social phenomena constructed by people; thus these systems are not law-like but are questionable and changeable. Horkheimer described critical theory as oppositional and suspicious of any claims of truth and logic. He questioned the legitimacy of the physical sciences approach in connection with society:

Science, too, shows a double contradiction. First, science accepts as a principle that its every step has a critical basis, yet the most important step of all, the setting of tasks, lacks a theoretical grounding and seems to be taken arbitrarily. Second, science has to do with a knowledge of comprehensive relationships; yet, it has no realistic grasp of that comprehensive relationship upon which its own existence and the direction of its work depend, namely society (Horkheimer 1937/1972, p. 8).

According to Horkheimer, all scientific claims needed to be analysed for their hidden intentions and influence on society. The emphasis of critical theory was on ‘social justice, dignity for all and a right to a reasonable life’ (Newman 1999, p. 205). Scientific intentions, however, reinforce current values and domination rather than facilitating emancipation. Horkheimer claimed that economics and the idea of rationalisation crippled humanity. A critical perspective would view compassion as an emotional impulse mediated by insight whereas a traditional theory would view compassion as pure emotionalism.

3.2.2 Critique of instrumental reason, Phase Two – 1940s

The Enlightenment movement had arisen as emancipation from the myths that had been used to dominate people’s lives. With World War II raging, hopes that such emancipation would materialise were buried. Reason had been hijacked for the purposes of fascist regimes; it was used as a source of power to dominate people. In the second phase of CSS, the emphasis was still on social justice, dignity and a reasonable life, but the hopes that the working class were the legitimate means of transforming the status quo did not materialise. The focus of critique within the Enlightenment movement shifted to scientists and the empirical sciences. Horkheimer and Adorno, both of Jewish descent in exile from Nazi Germany in California, and both educated in philosophy, began concentrating on epistemology, critiquing positivism and pointing out its limitations. Critical theory turned towards philosophy and a radical critique of science (Kellner 1989). Their philosophical position moved away from Marxist ideas and political struggle towards analysing the relationships between humans and nature.

Horkheimer and Adorno, in their seminal work *Dialectic of Enlightenment* (1944/1972), analysed the paradox of the Enlightenment (or rationality). Rationality was seen as a two-edged sword: rationality can reveal the intentions behind domination and unnecessary regulations but at the same time rationality can be used to hide domination. Horkheimer and Adorno saw a paradox in rationality in that it could be used as an argument for emancipation and reform or as an argument for power and domination over others.

The Enlightenment was seen as self-defeating. Natural science and its interpretation of rationality could be seen as emancipating society from mythology. However, a rationality defined as objective and context-and value-free only replaced myths by domination without emancipation. According to Horkheimer and Adorno (1944/1972), positivism used instrumental reason (or objective rationality) as its ideology. Rationality that left underlying values and ambitions unreflected was not the rationality that the Enlightenment movement originally advocated. Objective, value-free rationality was in no position to eliminate ideology. One ideology was simply replaced by another without achieving emancipation.

Reason as it expressed itself in the development of scientific knowledge and inquiry in Western society became ‘instrumental reason’, whose concern was self-preservation through control and repression (Newman 1999, p. 206).

If the complexity of reason was reduced to the empirico-deductive perspective of knowledge then knowledge definition was reduced to ideology. The notion of instrumental knowledge presented a threat to creativity, subjectivity and critical reflective thinking. But the question remained: how could there be a rationality that embraced creativity and subjectivity as well as rational critical thinking? Habermas later addressed these questions.
Becoming aware and questioning actions and regulations is seen as an enabling exercise for identifying creative ways of dissolving contradictions and eliminating unnecessary regulations that lead to domination. Critical theory established a tradition of examining existing phenomena from a dialectical perspective. Dialectic means a search for contradiction and conflict, and illumination of how underlying assumptions, values and ideologies influence perceptions. A dialectic argument builds on oppositions or contradictions between a thesis and an antithesis to transform them into a synthesis. Dialectical analysis seeks to overcome the limitations of opposing arguments by finding new understandings of current situations. It can transform a crisis into a new perspective by synthesising its opposing arguments. The dialectic of the Enlightenment had its role in critique but it could not find a foundation for its perspective without its own ideology. Dialectic maintains that any perspective, even a theory or viewpoint of truth, contains its opposite within it. In this second phase, critical theorists were understandably pessimistic and inward looking.

Adorno and Horkheimer found themselves in a kind of intellectual cul-de-sac. (Newman 1999, p. 206).

Horkheimer had focused on critiquing society as a whole without suggesting alternatives and discussing the position of critical theory. If it did not strengthen critical theory, at least the critique of positivism and instrumental reason gave rise to postmodern times resulting in pluralistic, discursive, and open-ended Marxism (Morrow 1994, p. 33).

Reason can function critically, but on the other hand, it cannot ground itself in any one perspective (Rasmussen 1996, p. 27).

This insight into the paradox of rationality gave rise to postmodernity. If rationality can be used to dominate as well as to emancipate, then rationality is all relative. Critique for critique’s sake is groundless, and to state your ground means to disclose your values and your ideology (Derrida 1982). What criteria should be used to define pure ideology from impure ideology, emancipatory rationality from oppressive rationality?

3.2.3 Critique of aesthetic reconstruction, Phase Three – 1950s
In Phase 3 in the 1950s, when post-war capitalist economies were blossoming, critical theory turned from critique of instrumental reason to critique of mass media. Adorno led the arguments to link art to the dialectic of enlightenment. Art, being non-verbal, cannot be judged and critiqued by objective, value-free reason.

Art has the capacity to represent, but in its very representation it can transcend that which it is representing (Rasmussen 1996, p. 29).

Art was not able to dominate as reason could. Art is non-verbal communication. Art could suggest freedom and justice but it could not claim it. However, Adorno (2001) was critical of mass culture, including television and film. He argued that the culture industry standardised all art. Reducing art to pop culture exploited the arts as a manipulative force to influence non-cognitive reasoning and perceptions. Consequently even in art, creativity and individuality are stifled and critical thinking shattered.

3.2.4 Critique of scientism, Phase Four – 1960s
In the 1960s, the fourth phase of critical theory and the second generation of critical theorists emerged. Habermas, a student of philosophy, history, psychology, German literature and economics, is the best known second-generation critical theorist emerging from the post-Frankfurt-School era. His work borrows from all these disciplines and it is one of the features of his writing to move from one discipline to the other, making his work at times inaccessible to his readers (Reese-Schäfer 2001). In the late 1950s he was Adorno’s assistant, and in 1964, after Horkheimer’s death, he became his successor as professor of philosophy and sociology at Frankfurt University. Habermas took a fresh look at critical theory, distancing himself from the groundless position of pure critique by focusing on the validity of science and the interests hidden in theories that developed knowledge. In the 1960s Habermas focused critique on positivism, arguing that technology and science constituted the new ideology, replacing religion and myths. He began his argument by analysing the Greek tradition of theory, which postulated that theory was linked to the conduct of life. He concluded that theory must have a connection to action. He developed a theory of cognitive interests which he discussed in his three books Towards a Rational Society (1971/1972), Knowledge and Human Interest (1968/1972) and Theory and Practice (1974).

3.2.5 Critique of communications, Phase 5 – 1970s and 1980s
The development of social sciences moved from a strong ontological stance to knowledge generation with Heidegger, to a more epistemological stance to knowledge generation with Gadamer. Habermas provoked considerable debate with his theory of cognitive interests. His ideas were contested and criticised. In this fifth phase Habermas’ critical theory moved away from the 1960s radical critique of society and social systems to a critique of individual emancipation and communication. Postmodern and critical paradigms moved closer together. Habermas engaged in philosophical debates with postmodern thinkers, showing an astonishing capacity to critically self-
reflect and as a result change his position. He refined and also rejected some of his earlier philosophies and developed new directions informed especially by the Gadamer-Habermas debate (see Section 3.4).

There are objections that I accept and that force me to reflect on their consequences (Habermas 1982, p. 219).

Gadamer’s objections regarding critical self-reflection forced Habermas to spell out more clearly a theory of communicative action based on interests, power relations and knowledge. In this fifth phase Habermas moved towards a critique of language and communications.

The historical developments in critical theory from Marx to Habermas describe a journey of critique. The focus of this critique moved from positivism through science, art, and knowledge constitutive interests to a critique of communications. The focus similarly shifted from social class and systems to individual reflection and communicative intentions. CSS lost its radical edge of rejecting positivism outright, but at the same time it lost its marginalised position. CSS today is part of the establishment (Dubiel 2001). The only two constants in these developments of CSS were critique and a search for emancipation.

3.3 Theory of cognitive interests: Knowledge and human interests

In his influential book *Knowledge and Human Interest* (1968/1972), Habermas drew explicit connections between interest and knowledge. He claimed that ideas shape our interests and actions. The starting point of any knowledge is interest, because without interest there would be no knowing. Interests shape the types of questions that are asked and the strategies that are applied to search for responses. Habermas was critical of the notion of objective, value-free knowledge because such knowledge could be generated only under certain conditions. These conditions needed to be controlled, resulting in exclusion of some variables. These conditions dictate how to conduct scientific inquiries to generate knowledge, and they differentiate objective knowledge from subjective values. Although science must remain objective and rational it ignores the fact that even objectivity and rationality are based first on interests.

Because science must secure the objectivity of its statements against the pressure and seduction of particular interests, it deludes itself about the fundamental interests to which it owes not only its impetus but the conditions of possible objectivity themselves (Habermas 1968/1972, p. 311) [original italics].

Interest can be understood as the motivation for wanting to find out something. Interests are shaped by specific viewpoints and values. Habermas differentiated three interests: technical, practical and emancipatory interests:

The approach of the empirical-analytic sciences incorporates a technical cognitive interest, that of the historical-hermeneutic sciences incorporates a practical one; and the approach of critically oriented sciences incorporates the emancipatory cognitive interest that … was at the root of traditional theories (Habermas 1968/1972, p. 308).

Habermas referred back to the original mission of the Enlightenment movement of freeing society from domination. He avoided the negative enlightenment of the Frankfurt School by avoiding simple condemnation of empirical-analytical approaches to knowledge generation. He sought to elevate the critical perspective to knowledge generation to an equal level with the empirico-analytical perspective. He described the different interests of the three sciences, natural, social and critical, and how these different interests generated different types of knowledge (see Table 3.3). Different interests influence the questions that are asked and the concept of what the focus of an inquiry should be.
Table 3.3  Habermas, interests and the natural, social and critical sciences
(informed by Habermas 1968/1972)

<table>
<thead>
<tr>
<th>Science</th>
<th>Methodological tools for validity</th>
<th>Interest</th>
<th>Knowledge</th>
<th>Defining reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empirico-analytical (natural science)</td>
<td>Controlled observation</td>
<td>Technical cognitive: prediction objective evidence</td>
<td>Facts Truths</td>
<td>Technical control</td>
</tr>
<tr>
<td>Historical-hermeneutic (social science)</td>
<td>Understanding meaning, Interpretations of texts</td>
<td>Practical cognitive: mediation finding consensus</td>
<td>Inter-subjectively negotiated meaning</td>
<td>Mutual understanding in the conduct of life</td>
</tr>
<tr>
<td>Critical (critical science)</td>
<td>Self-reflection</td>
<td>Emancipatory-cognitive: transformation emancipation</td>
<td>Critical of natural and social influences and negotiated understanding</td>
<td>Toward emancipation from seemingly natural constraint</td>
</tr>
</tbody>
</table>

3.3.1 Technical cognitive interest
Technical cognitive interest demonstrates an orientation to control the environment and predict future processes and their outcomes, and is underpinned by attention to certainty and predictability. Certainty and predictability can be claimed when certain actions are conducted as controlled, objectified processes resulting in certain outcomes. Controlled processes are understood as observations under preset, laboratory-like conditions. Technical interest is guided by experiments conducted by scientists to control their environments. A technical interest that generates predictive knowledge confidently prescribes rational purposive actions. These actions are a consequence of following technical rules (expert advice) based on empirical knowledge. Factual, objective theory is pursued in order to guard against regression to pre-rational, subjective beliefs and myths. By differentiating facts and technical, value-free knowledge from personal cultural knowledge, superiority is claimed for objective theory and this is used to justify marginalisation of subjective beliefs. Habermas claimed that the empirico-analytical approach is based on objective illusions because its scientific ontology fails to consider the foundation upon which facts are built.

3.3.2 Practical cognitive interest
Practical cognitive interest starts with a concern for understanding. In hermeneutic theories, facts are described and understood by searching for meaning. Hermeneutic rules, with the interpretations of texts, make knowledge accessible. Knowledge is not considered independent of the knower. Knowledge generation is dependent on the researcher’s prior knowledge. The focus is no longer on discovering causality but rather on understanding the meaning of the observed world. People have a practical interest in understanding each other through communication. The interest is in understanding, and finding consensus pursuing practical interest involves people’s prior understandings in generating new knowledge. Whereas empirico-analytical sciences exclude prior knowledge of the researcher in the generation of research knowledge, historical-hermeneutic sciences embrace such knowledge and use it within the research process itself, not just as background to the research. Practical cognitive interest is enclosed within prior knowledge and existing traditions as these traditions are applied to generate meanings and find consensus.

3.3.3 Emancipatory cognitive interest
Emancipatory interest starts with a concern for emancipation. The critical sciences have an interest in disclosing values and in exposing contradictions and structures that appear to be law-like and taken-for-granted when in fact they were influenced by human interests in the first place. It is through the perspective of critique that knowledge develops awareness of its interests. In critical theories, facts can be observed and described and meanings can be mediated via interpretations, but it is critique with emancipatory interests that challenges factual explanations and meanings that have been generated on the basis of technical or practical cognitive interests.

Practical and technical interests can be comprehended only as moments in the emancipatory interest in reason (Schroyer 1973, p. 151).

Habermas considered it important to embrace values as well as facts in order to define rationality with an emancipatory notion:

To dissociate values from facts means counterposing an abstract Ought to pure Being (Habermas 1968/1972, p. 303).
Habermas emphasized the point that relying on interpretations of observations does not acknowledge the power of critical interpretation. When interpretations purposefully exclude variables, interpretations of observations are vulnerable to bias. Bias towards certainty and prediction can undermine potentials, visions and unrealized capacities. To establish merely what is prevents natural sciences from grasping conditions of possibilities (Thompson and Held 1982). Technical knowledge lacks meaning and contextual relation to the social world. A critical social scientist is interested in going beyond producing nomological and consensual knowledge, towards exposing:

when theoretical statements grasp invariant regularities of social action as such and when they express ideologically frozen relations of dependence that can in principle be transformed (Habermas 1968/1972, p. 310).

Habermas claimed that natural science involves gaining technical control. He did not challenge this aim as such, because technical control and prediction are the philosophical underpinning of natural science. CSS critiques technical and practical interest. However, Habermas saw a dilemma in the fact that CSS also needs to determine its own ontological stance and philosophical base. In its search for emancipation and pure reason, CSS would need to eliminate ontology and free itself from philosophy, as it would need to free itself from its own illusions: its search for pure rationality, reason and interest. However, as knowledge and human interest were the foundation of Habermas’ thesis, he conceded that there could be no such thing as pure rationality.

3.3.4 Scientism and the ideology of science
In delineating the interests that underpin knowledge Habermas built the basis for a systematic critique of empirico-analytical sciences. It is important to state first that Habermas did not reject outright the knowledge generated for natural sciences. He argued that empirico-analytical approaches to knowledge generation were most appropriate when studying the natural world. The issue that Habermas took up was that the natural science approach pervades, infiltrates and tries to predict and control the social world. This infiltration of natural science interests into social world interests was coined scientism, a term describing:

the reduction of all knowledge to that furnished by the empirical sciences, where these are conceived as an unproblematic reflection of reality (Outhwaite 1994, p. 20).

Habermas problematized the conditions for objectivity. He described scientism as follows:

‘Scientism’ means science’s belief in itself: that is the conviction that we can no longer understand science as one form of possible knowledge, but rather must identify knowledge with science (Habermas 1968/1972, p. 4).

Only knowledge derived from empirico-analytical approaches is accepted as scientific knowledge. From a scientific perspective, all other approaches to generate knowledge are seen as myths or emotions. But technological understanding is a fragmented, isolated and alienated understanding removed from social reality. Habermas claimed that a philosophy that is linked to traditional theory cannot relate to practice and action. The three key objections that Habermas (1963/1974) outlined against traditional theory, positivism or empirico-analytical perspectives are that it (1) did not disclose interests, (2) was context stripping, and (3) widened the gap between theory and practice. These points were expanded as follows:

(1) Empirico-analytical methods do not disclose their interests. These interests lie simply in explaining causal relationships and predicting and controlling future outcomes. Empirico-analytical methods deprive self-reflection, emancipation and historical context. Empirico-analytical methods have an ‘inadequately clarified status of the interests that direct knowledge’ (Habermas 1963/1974, p. 14). ‘Such methodology cannot make it plausible how theories could have any truth at all…’ (p. 15).

(2) The quest of universality is context stripping. Universality of theory claims cannot be simply transferred and related to real contexts and particularities. The intention of traditional theories to make universal truth claims automatically excludes consideration of other interests and a regard for diversity. In order to maintain universal truth claims any other assertions that contradict them are automatically discarded as inadequate or inferior.

(3) ‘The gap between the relationship of theory and practice stresses the split between objectivity and subjectivity, between facts and values, and between experts and lay people. Scientific knowledge cannot simply be complemented by intuitive knowledge’ (Habermas 1963/1974, p. 266). As long as there is the theory-practice gap there will be a hierarchy of knowledge with universal scientific knowledge at the top and intuitive, culturally diverse knowledge at the bottom. Traditional theory excludes subjectivity and context, and therefore disregards social reality and potential.
Social philosophy, having taken a monologic form, is no longer capable of essentially relating to praxis, but merely to goal-directed purposive action guided by social-technical recommendations’ (Habermas 1963/1974, p. 3).

Habermas accepted that technical interest was here to stay but he rejected its infiltration into the social life world. He argued that such intentions are unreflected and conceal the assumptions behind the natural sciences, especially when objectivity is taken for granted, accepted as the truth and not examined for its intentions. Interests can be hidden behind objectivity. Habermas accepted that natural science and its interest in prediction were intimately linked, but he challenged the pervasiveness of rationality of technology in natural sciences that imposed itself onto the social world. Rather than rejecting natural science as such Habermas critiqued scientism as the ideology of the natural sciences (Outhwaite 1994).

The CSS perspective on knowledge presupposes that interests and values influence all knowledge and interpretation, and that these interests and values form ideologies. Ideology can be defined as:

a collection of beliefs and values held by an individual or group for other than purely epistemic reasons (Honderich 1995, p. 392).

An ideology, being socially constructed (Therborn 1999), can be challenged for its interests and underlying values. Ideology is based on the interest people have in something. In the CSS perspective, the task is to question all aspects of life that are taken for granted; this includes a critique of people’s ideologies. A core theme of CSS is the critique of positivism, scientism, and the attempt to objectify knowledge or place it on a hierarchical scale.

Although positivism began life as a critique of ideology (of religion, dogma, speculative metaphysics, etc.), it became a central element of technocratic consciousness and a key aspect of modern ideology (Held 1980, p. 11).

By excluding all ways of knowing that could not be measured empirically with the senses, empirico-analytical methods became an ideology. Habermas contended that empirico-analytical approaches to knowledge generation have their merits in the natural world but they are certainly not sufficient for human emancipation. Further, the conditions of generating knowledge need to be examined and made transparent. Facts are understood in sensory experiences, and are reported in observations. Validity is established intersubjectively in order to be objective. The need for describing facts and for sensing them makes the claim for objectivity and truth ambiguous. Excluding aspects of knowledge reduces it to ideology. Habermas’ ideology critique is concerned with disclosing ideologies that do not stand up to open, uncoerced critical dialogue on their values and beliefs. Ideology critique lays open the power relations that distort communicative structures and reify the status quo. The ideology of CSS is emancipation.

The real problem, Habermas argues, is not technical reason as such but its universalization, the forfeiture of a more comprehensive concept of reason in favor of the exclusive validity of scientific and technological thought, the reduction of praxis to techne, and the extension of purposive-rational action to all spheres of life (McCarthy 1978, p. 22).

The term scientific should not exclude the connection of theory with practice and experience. In Theory and Practice (1963/1974) Habermas argued that the role of critique is to find the connection between theory and practice and thus reduce the widening gap between them. Excluding practical questions from theory-building means losing the connection between theory and practice. An insistence on viewing the world objectively houses a deep-seated interest in controlling uncertainty and determining what is real and rational as opposed to what is irrational and irrelevant. The conditions that accommodate knowledge need to be clarified. A critical social theory needs to be grounded not only in observations (technical interest) or dialogue (practical interest) but in a critical self-reflective dialogue with an interest in emancipation. A theory that is built exclusively on objectivity and observation will create a gap between it and practice. That gap will assist theory to focus on one dimension of human behaviour only, the objectively observable behaviour. One-dimensional approaches to theory-building lay the basis for domination and manipulation as they exclude critique and reflections, even if that is not specifically intended.

Habermas outlined a critical theory with two important characteristics. First, a theory is seen within its historical context, making insights possible and disclosing its self-interest. Second, a theory is action-oriented and has a connection to practice. The key to this critical theory is critique. Critique rejects the monologic, one-dimensional characteristics of philosophy and science. Critique informs philosophy and science and is in constant search for a connection between theory and practice. Ontology is the study of what exists. Habermas claimed that what exists can be known without language but it can be interpreted only in language. Epistemology is the study of what can be known about what exists. Habermas linked ontology closely to epistemology. His critical theory is based on an
ontological-empirical connection between theory and practice. CSS epistemology addresses knowledge and human interest, and is a methodology of critique (Habermas 1963/1974).

Habermas directed critical theory from Marxist philosophy to a philosophy based on critical self-reflection and a critique of validity. This move was innovative but also controversial (Rasmussen 1996). Validity critique distinguishes between claims that can be justified and claims that cannot be justified. Critiquing validity claims and focusing on methodology reduced critical theory to a historical phenomenon (Dubiel 2001). At the same time Habermas made critical theory more accessible and relevant to other fields than philosophy and sociology. The issues of responsibility and autonomy, which are crucial aspects of professionalism and ethical behaviour in health care practice, can be directly informed by Habermasian knowledge and human interest theory. Knowledge and human interest are not free from ideology, and any search for pure theory and pure reason appears utopian. The following discussion of the Gadamer-Habermas debate exposes the ontological and epistemological stance of CSS and makes fine distinctions between interpretive and critical interpretive perspectives.

3.4 The Gadamer-Habermas debate

Between Phases 4 and 5 of the development of critical theory a productive encounter was played out between CSS and philosophical hermeneutics (Nicholson 1991). Although both can be traced back to the 1920s they did not have a rigorous dialogue until the 1960s. Habermas instigated the debate by responding to Gadamer’s major arguments in his book *Truth and Method* (1960/1992) with a long essay titled *On the Logic of the Social Sciences* (Habermas 1967/1988). The following scholars refer to the ongoing dialogue labelled the Gadamer-Habermas debate: Altenbernd Johnson, McCarthy, Nicholson and Ricoeur.

This Gadamer-Habermas debate was not conducted face-to-face as verbal dialogue; rather it was a responsive interaction in form of books written over several years. Therefore it was a highly theoretical debate. Arguments and counter-arguments were exchanged spanning a wide range of philosophical aspects, but for the relevance of this thesis only the epistemological issues are detailed below. The points of contention were how reality could be accessed, and the role of critical reflection, language and authority in generating knowledge (Nicholson 1991), and the relevance of are scientific inquiry for advancing social and political situations (Misgeld 1991). It was Gadamer’s intention to reinstate tradition (1960/1992) as the starting point of any meaningful exchanges, whereas Habermas (1968/1972) argued for a strong critique and rupture with tradition. Against the background of Nazi Germany, this debate could be seen as highly political and emancipatory for German philosophy. According to Nicholson (1991, p. 151), this is one of the deepest, most interesting and most important philosophical debates in recent times.

The Gadamer-Habermas debate is relevant for this thesis as it addresses questions of (1) whether scientific knowledge is relevant to individual clinical cases and (2) whether scientific knowledge advances practice. It is germane that one of the core issues of this thesis is to explore the relevance of critical self-reflection to physiotherapy practice. What could the implications of critical self-reflection be for practice epistemology and professional roles? On a micro-level of physiotherapy practice, critical self-reflection has implications for clinical decision-making and for analysing the intentions of communications between physiotherapists and patients. Although the Gadamer-Habermas debate has broad implications for many spheres of life, the one level that is directly relevant to physiotherapy practice evolves from the debate on the role of the tradition and cultural background of speech partners. This role forms the inherited frames of reference from which speech partners start their interpersonal negotiations to gain access to reality and find common understanding. Frames of reference and communications raise epistemological questions. Whereas Habermas debated from a rebellious, democratic standpoint with emancipatory interest, Gadamer debated from a mainstream tradition level with practical interest (Nicholson 1991). Their different intentions in generating new understanding (knowledge) have implications for the types of questions that are posed to interpret texts.

Gadamer and Habermas had in common the goal and desire to critique empirical-analytical approaches to knowledge generation. Both challenged the primacy of objectivity and stressed that critical self-reflection was a vital component of knowledge generation, one that empirical-analytical science excluded. Both agreed that communication and interpretation were necessary to generate new knowledge and meaning. It is in the detail concerning communication and interpretation that Gadamer and Habermas differ (see Table 3.4).
Table 3.4  Differences between the philosophical positions of Gadamer and Habermas

<table>
<thead>
<tr>
<th>Categories</th>
<th>Gadamer</th>
<th>Habermas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hermeneutic tradition</td>
<td>Philosophical hermeneutics</td>
<td>Critical hermeneutics</td>
</tr>
<tr>
<td>Interest</td>
<td>Cultural-historical</td>
<td>Emancipatory</td>
</tr>
<tr>
<td>Dialogue as Interpretation</td>
<td></td>
<td>Critical self-reflection and critique</td>
</tr>
<tr>
<td>Rationality</td>
<td>Linked to agreement</td>
<td>Linked to emancipation</td>
</tr>
<tr>
<td>Knowledge generation</td>
<td>Deeper interpretations</td>
<td>Transformative action</td>
</tr>
<tr>
<td>Tradition</td>
<td>Transformed by carefully considering what is possible in given situations</td>
<td>Ruptured if necessary for achieving emancipation</td>
</tr>
<tr>
<td>Pluralism</td>
<td>Pleasant illusion of pluralist tolerance</td>
<td>Pluralism is desirable but under universal agreements which need constant rethinking</td>
</tr>
<tr>
<td>Communication</td>
<td>Dialogue</td>
<td>Debate</td>
</tr>
</tbody>
</table>

Gadamer (1960/1992) claimed that there would be no understanding if it were not based on existing understanding. He emphasized the importance of prior understanding enmeshed in culture. According to Gadamer, we are shaped by our culture and we cannot fully understand and judge issues outside of our own culture. He claimed that there is no correct interpretation, but there are only deeper understandings and interpretations. Understanding is about finding common ground between old and new understandings, between alternative frameworks and values. To Gadamer, dialogue had the intention of finding common ground and reaching consensus. This process is termed ‘fusion of horizons’. It occurs when two speech partners respect each other’s understanding and reach agreement on common understanding. This common understanding does not represent the prior understanding of each partner but a shift by each towards a new, common understanding.

The aim of interpretation is to reach common understanding, consensus and mediation (Gadamer 1960/1992). Gadamer hoped that this transformation would be a smooth transition. The method of achieving it is by revisiting the dialogue (or transcripts, texts). Gadamer advocated interpreting interpretations of interpretations. He believed that people need to communicate with each other repeatedly in order to reach consensus. He aimed to rehabilitate prejudgment and prior understanding. Pre-judgment should not have an exclusively negative value (Scheibler 2000). Gadamer argued that understanding is built on prior understanding, and that a positivist perspective would deny prior knowledge, whereas a critical perspective would denigrate prior knowledge as distorted and in need of transformation. He positioned himself in philosophical hermeneutics, rejecting Habermas’ critical modernist approach to Enlightenment because in such an approach all authority and tradition were analysed with the aim of dissolving them. Gadamer felt it was problematic to view authority and tradition in an exclusively negative light.

Habermas rejected Gadamer’s idea of using interpretation to achieve consensus (1967/1988). He reasoned that if interpretation had only the practical interest of reaching consensus, then interpretations would only enable people to politely agree with each other. Habermas disagreed with Gadamer’s notion of interpretation as a tool to help people cope in this world. Instead, he advocated that interpretations be scrutinised for their underlying intentions, using an emancipatory interest approach. In CSS the emphasis is on freeing people from unnecessary constraints. According to Habermas, Gadamer’s fusion of horizons was vulnerable to dominant traditions and cultures, and such fusion without acknowledgment of interests might lead to distorted understandings (1968/1972). From a critical perspective, interpretations could be informed by socially dominant meanings, and the interpretations of marginalized groups would potentially not be heard. Habermas rejected philosophical hermeneutics because it implied a notion of interpretation that is trapped within culture. He viewed all knowledge with scepticism, as from his stance all interpretations could be tainted with ideology.

Ideologies are subtle attempts to portray the present as both rational and necessary, especially given the apparent alternatives, past and present (Agger 1998, p. 8).

When an ideology is uncritically embraced the implicit values may be concealed and those values may favour certain interpretations over others. Not all interpretations are equally valid and not all traditions and cultures have equal authority. Habermas insisted on critique of interpretations, in particular critique of ideology, because ideology is closely informed by cultures and norms. Therefore, Habermas warned, cultures and ideologies need to be challenged.

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Further, Habermas (1971) believed that critical social scientists can understand social actors better than social actors understand themselves. Some people might be so convinced about their practice that they cannot see beyond their own horizons. Gadamer’s fusion of horizons might remain incomplete if the actors cannot reflect on the influences on their frames of reference and understandings, such as norms and cultures. Knowledge and its connection to human interest pointed to the importance of critical reflection, of understanding human interests and ideology in particular. The aim of critique is to remove unreflected statements, distortion and domination from the process of generating understanding.

According to Habermas (1971), rational rather than consensual reasoning should dominate a dialogical process. Consensus and mediation imply giving in to others, probably giving in to the more authoritarian rather than the more powerful argument. The critical perspective does not hide political intent but rather makes it a prerequisite, whereas the interpretive perspective, although not hiding domination, is apolitical by adopting a more subtle (hidden) approach to interpreting interpretations. For Gadamer, reason was linked to agreement; for Habermas, reason was linked to emancipation. While Habermas chose a more confronting and explicitly critical approach to understanding Gadamer chose a fusion of horizons approach, where interpretations of interpretations slowly dig deeper to find common understanding. Habermas was not afraid of breaking with traditions and norms as long as such a rupture was guided by emancipatory principles for the human good. Emancipatory principles included unconstrained and uninhibited public debates, a capacity to be critical of self and others, and active affirmation and realisation of these principles (Misgeld 1991).

Gadamer (1971) continued the debate by claiming that Habermas was utopian and not realistic. He thought that emancipatory principles could not be achieved: history provided many examples, such as mass media communications and the prevalence of scientific methods, to inform policy development (Misgeld 1991). However, Gadamer did not dismiss emancipatory principles but sought to strive towards them by building them into existing traditions. He stated that we live in culture, we are culture, and that there always will be power relations. Power relations are a reality and cannot be dissolved.

Gadamer (1971) was opposed to the notion of acquiring a critical, outsider stance to human communications, claiming that human relationships are primarily social relationships and not therapeutic ones. Besides, he argued, critical self-reflection also requires interpretation. People will not think about why someone said something but rather what they said. Gadamer positioned himself as wanting to understand people by engaging with them. He sought to critique understanding by engaging in further dialogue, in deeper understanding. His methodology was more concerned with helping people to reach deeper understanding and to cope better with situations. Gadamer wanted to reinstate culture as a phenomenon that was here to be interpreted. The search for deeper knowing cannot be interrupted by an outside, critical stance.

Habermas (1982) conceded that CSS may not be able to transcend its own dialogue. It cannot critique itself as an outsider. Critical self-reflective scientists remain within their cultural values and ideology, underpinned by a commitment to emancipation. Such a commitment cannot guarantee success but it can guide interpretations and actions.

To be sure, the concept of communicative rationality does contain a utopian perspective; in the structures of undamaged intersubjectivity can be found a necessary condition for individuals reaching an understanding among themselves without coercion, as well as for the identity of an individual coming to an understanding with himself or herself without force (Habermas 1982, pp. 228-229).

Habermas stressed that a theory of communicative action would be a formal theory. As soon as such a theory was applied to the real world, pluralism and relativism would make it appear utopian. However, Habermas remained firm on his insistence that we can be aware of our values and ideology. Habermas wanted to make ideology and critical reflection explicit in dialogical processes.

Both Gadamer and Habermas advocated that interpretation and communication be raised to more reflective levels. Habermas advocated critical self-reflection and a perspective that is critically removed from culture and pre-understanding, whereas Gadamer argued for a hermeneutically trained consciousness. Gadamer emerged from this debate confirmed in his goal of fusion of horizons, and claimed it to be realistic and practical. He found the debate useful as he saw a need to further develop hermeneutics as a practical philosophy (Altenbernd Johnson 2000). He exhorted Habermas to rethink his ideology critique, on the basis that nobody can escape their own ideology and culture. Habermas was drawn to develop a theory of communication.

Habermas stood firm in pointing to authority and dominance in communication, which permeates interpretation. He explained that authority by definition is dogmatic (Scheibler 2000). Habermas (1971) pointed to the problem of
subjectivity in hermeneutical reflection. He saw it as a weakness that Gadamer did not indicate how speech partners could overcome their subjectivity. Habermas felt that Gadamer’s fusion of horizons was a pleasant illusion of pluralist tolerance (Misgeld 1991). In contrast, Habermas’ agenda was transformation, change and action towards emancipation, undistorted reason and democratic relations. He agreed with Gadamer that pluralism was desirable, but only after universal agreement on emancipatory principles. And those principles required constant rethinking. Habermas’ position clearly showed that he was searching for a justified foundation for his critical approach to understanding. His was an inherently optimistic perspective, that people can think for themselves and identify power interests. He was driven by a vision of critique of current situations, underpinned by critical scepticism.

The Gadamer-Habermas debate crystallised the complexity of understanding and human communications. These philosophers had similar methods but different intents. Gadamer conceded that his resurrection of tradition and culture could easily be misunderstood as a return to uncritical acceptance of domination. This was clearly not his intent, and this debate clarified his interpretation of culture and tradition. Meanwhile the debate shifted Habermas’ position from a focus on scientism and ideology critique to a focus on communication. Habermas conceded that he had to fine-tune his theory of communicative actions. As a result he wrote the two-volume book “theory of communicative actions” (1981/1984, 1981/1987) and immersed himself in theory development of language and communication. He also acknowledged the importance of grounding his theories in practice.

3.5 Theory of communicative actions

Having established that all philosophies, theories and methodologies are based on interests and ideologies, Habermas conceded that CSS was also based on its own ideology. He shifted his focus from critiquing scientism and ideology towards critiquing intersubjective communications and interpretations. He turned to human interaction, seeking to understand how values and assumptions can distort interactions. He posed new questions on reason: What is good reasoning? How can reason be criticised and how can some reasoning be stronger than other reasoning? He explored these questions to find solutions to validity claims. He developed a theory of communicative actions based on rational, uncoerced interactions, free of domination and technical bias, placed in ideal speech situation (1981/1987).

3.5.1. Ideal speech situation

In an ideal speech situation speech partners aim to communicate and not to manipulate in order to reach consensus through rational discussion. Three aspects of argumentative speech underpin rational discussion (Habermas 1981/1987, p. 25). First, argumentation is a process free of coercion. Only the better argument should force consensus, not internal or external influences. Argumentation is seen as reflection. Second, participants must have a hypothetical stance without any pressures. Third, arguments need to be transparent and have intrinsic properties that help decide whether to accept or reject validity claims. These arguments are intersubjectively recognised so that they can be transformed into knowledge and actions. Thus, the process of argumentation needs to be grounded in a critical stance towards self-reflection and self-understanding.

Participants in argumentation have to presuppose in general that the structure of their communication, by virtue of features that can be described in purely formal terms, excludes all forces – whether it arises from within the process of reaching understanding itself or influences it from the outside – except the force of the better argument (and thus that is also excludes, on their part, all motives except that of a cooperative search for the truth). From this perspective argumentation can be conceived as a reflective continuation, with different means, of action oriented to reaching understanding (Habermas 1981/1987, p. 25).

Habermas insisted that being critically aware ensures that interests come out of hiding and are made conscious. The presupposition of the ideology of CSS is a commitment to rationality. The conditions for ideal communication can then rest on an interest of finding consensus, free from domination and hidden motives. Reaching consensus through rational discussion has ethical implications. A critical theory of communication is opposed to rhetorical, deriding statements, opposed to one-way communications where predominantly only one communication partner speaks, and opposed to the use of ideology for the purpose of deception (Agger 1998). To put it bluntly, an ideal speech situation is a micro-democracy. Democratic communication is undistorted and rational. It is free of bullying, discriminating, marginalising or reducing communication partners to ignorant or even irrational people. Habermas theorised that an ideal speech situation was protected against repression and inequality. He claimed that it was possible in speech acts to differentiate between strategic and communicative actions.

Habermas described strategic actions as based on instrumental reason with the aim of manipulating and dominating the conversation. In contrast, communicative actions are based on emancipatory reasons with the aim of deriving the best argument. Habermas claimed that communicative actions are foundational and based in rationality. Basing communicative actions on reflection, mutual respect and interest in emancipation ensures that the best arguments can be agreed upon. The focus on emancipation and critical reasoning links communicative actions with
legitimation, because the theory of communicative actions differentiates between rational and false consensus (Roderick 1986). Habermas was convinced that language originally arose as a form of communication rather than a form of domination. He claimed that interactions based in ideal speech situations humanise communications.

3.5.2 Critical rationality
Rationality, knowledge and evidence are differently defined and understood in objective, social and critical worlds. Rationality begins with the objective world concept of propositional knowledge. But it should not end there, because a purely objective rationality is a closed rationality. Objective rationality for objectivity’s sake is meaningless and not applicable in real social life. Further, there is considerable scope for rational disagreement, and rationality defined as logical reasoning has been challenged (Honderich 1995). A CSS philosophy takes a sceptical stance with regard to all social/human situations that are presented as law-like, frozen or unchangeable.

Everything that is set down in the law is in a necessary tension with a definite action and cannot contain within itself practical reality in its full concrete form (Hoy 1988, p. 4).

Although Habermas did not reject empirico-analytical science he did protest against its claim to be superior to social science and CSS. He enhanced the debate on scientific reasoning (Outhwaite 1994). A CSS perspective on rationality rejects all forms of rationality that subordinate human consciousness and actions to the imperatives of universal laws (Giroux 1983, p. 8).

Rationality that embraces a readiness to learn and openness to criticism is a rationality underpinned by critical subjectivity. Rationality needs to have a reflective relation to nature and to self in order to enhance subjective self-understanding free from dogma. To deny the inclusion of reflection and subjectivity in the definition of rationality distorts rationality and reduces it to alienated objective reasoning. Hoy (1988, p. 69) described the CSS perspective on rationality as a struggle against one-sided capitalist rationality that denies the possibility of constructing a society of undistorted communications and free equal participation.

Hoy’s (1988) discussion of rationality concluded that rational people:
- interpret their desires and feelings within cultural standards
- have a reflective attitude towards those standards
- learn from mistakes
- free themselves from illusions.

With this attitude of reflection and critical thinking a rational person steers clear of domination and distorted communications. A rational person then has the capacity to critique. From the above summary of a rational person it can be deduced that a rational profession is one that exhibits the same attributes. Rationality described as critical subjectivity embraces the self and the social and natural worlds. It blurs personal and professional knowledge. However, objective rationality as manifested in technical knowledge is acontextual, fragmented, and not relational or concerned with others. In comparison, a CSS perspective focuses on knowledge informed by critical thinking and acting; it deals with knowledge of man as an acting being concerned with what is not always the same as it is but can also be different; the purpose of this knowledge is to govern action (Hoy 1988, p. 4).

Another aspect of CSS knowledge is a concern for other people and not self-concern. It is understanding or knowing through negotiation with others in mutual interest. This knowledge entails thinking with others, and going through processes together. A CSS framework positions rationality and knowledge as a process and a negotiation.

Habermas noted that Horkheimer and Adorno focused on relations between object and subject but failed to see that a theory of rationality based on subject-to-subject relations was possible. He contended that there is no such thing as pure reason, because all knowledge is embedded in discourse (Newman 1999). There is no reason without language. Habermas emphasised the importance of communication and of critiquing communication. He argued that practices that are not based on negotiation and dialogue are practices that are based on structure and regulation.

As the rationalisation of the lifeworld progresses, so does the risk of disagreement among the parties to interaction. The less the need for mutual understanding is covered in advance by traditions that pre-decide which validity claims are recognised, the greater the burden placed on the actors to achieve common understandings of situations, and the greater the danger of deficits and failures. (McCarthy in Habermas 1981/1997, p. xxxi).
Reduced communication can lead to misunderstanding and to disagreement. Finding common ground and exposing values and interests set the scene for rational communications and decisions. Habermas sought to integrate science and philosophy. He sought rational communication that strove towards meaning and freedom. He insisted that scientific validity claims could be overthrown and proven wrong via reflection. Rethinking distorted knowledge claims was based in thinking and education. Habermas concluded that people could overcome conflict and domination by making their assumptions and values explicit, exchanging their ways of reasoning and reaching consensus on the basis of emancipation. The theory of communicative actions focused on speakers and how they reason and seek consensus. Habermas concluded that people need to interact with others by knowing themselves, which means being aware of one's background knowledge or the preunderstandings on which one’s reasoning is based.

Every process of reaching understanding takes place against the background of a culturally ingrained preunderstanding (Habermas 1981/1997, p. 101).

Arguments need to be understood within the objective, social or subjective world. Once preunderstanding is made transparent, argumentation proceeds in ideal speech situations (Habermas 1981/1997, p. 100). Apart from redirecting the focus of critique, Habermas also generated an optimistic excitement, focusing on the potential of CSS. However, what this CSS might look like in practice was yet to be ascertained (Dubiel 2001). Rescher (1993) critiqued Habermas’ ideal speech situation and its assumption that communications need to lead to consensus. Not all communications can lead to consensus if the arguments are totally unacceptable for the speech partners. In such a situation it would be more emancipatory to refuse to find common ground than to give in and reach consensus.

Agreeing neither in opinion nor in ends (goals, objectives, values), people can nevertheless be led to go along with the disapproval or diversity of others through a realistic realization that, in the circumstances, the cost of working to redirect their thinking into the paths of agreement is simply too high (Rescher 1993, p. 179).

The real world is not necessarily the ideal world. In the real world there is diversity and pluralism in interpretations. The quest for consensus can be difficult. However, to end communications in disagreement could lead to unproductive actions. Emancipation in this case could mean finding some common ground in order to continue to pursue one’s goals.

Before I consider how health-related professions have been influenced by the theory of cognitive interests and communicative actions, I now briefly introduce variations of CSS and provide justification for their exclusion from the main framework of this thesis.

3.6 Variations of CSS
There are variations within CSS that were excluded from this study. It is beyond the scope of this thesis to discuss all the variations of CSS. The variations of CSS discussed briefly here are certain approaches to feminist theory and postmodernism. These variations help to crystallise the focus of Habermasian critical theory.

3.6.1 Feminist theory
According to Agger (1998), some approaches to feminist theory form a variation of CSS which centres on oppression from a gender perspective. Its focus is on gender, class and culture. In feminist theory, class is not the only source of oppression; gender is as well. Emancipation is viewed as an everyday struggle that occurs at home as well as at work (Belenky et al 1986). Boundaries between private and public life are blurred. Feminist theory opposes the labour division between the genders, with males earning money and females nurturing at home. Feminist theory politicises personal life. Capitalism and its division of work and family are perceived as barriers to feminist emancipation, as is the acculturation of genders into their roles. Feminist theories share with CSS a mission for emancipation.

The structural ideas of feminist theory are the same as those of CSS. Both oppose oppression and one-dimensional thinking (Agger 1998). The difference is that feminist theory focuses on gender issues whereas CSS explores beyond such issues. Feminist theory certainly has contributed to the advances of CSS but because of its focus on gender it is not included this thesis where gender is not the prime concern.

3.6.2 Postmodernism
Habermas saw himself as a modernist, strongly opposing postmodernism. But some approaches to postmodernism can be seen as a variation of CSS (Agger 1998, Pease and Fook 1999). Postmodernism arose as a response to modernism. The postulate of modernism is that progress is characterised by rationality, science, technology, objectivity, and an empirico-analytical interpretation of Enlightenment. Postmodernism critiques this understanding of progress by modernism as narrow. The essence of postmodernism is pluralism (Agger 1998). Postmodernists reject large narratives, universal theories and globalisation of thinking. They pay attention to small stories and case
studies in context. They postulate that people have different opinions and beliefs that are influenced by rational as well as irrational forces and are subject to change.

The world is not black and white but is composed of differences. Postmodernists are not necessarily opposed to science and theory, but they reject positivist science because it seeks to formulate universal theories, and they reject positivist theories because they exclude difference. It is the study of the otherness, the differences and the detail that unites postmodernism with CSS (Agger 1998). Postmodernism has contributed to CSS by providing more insights and interpretive techniques for making sense of interpersonal communications. However, postmodernism is apparently less radical and political than CSS. In its emphasis on pluralism, postmodernism deals with fragmented issues rather than the bigger picture of influences. Postmodernist researchers uncritically accept what people say and what they feel. The quality of description falls short of drawing out manipulative forces, of searching for transformation and change. The main focus of postmodernism is describing and understanding what is. The focus of its conclusions is commonly that truth is relative; and therefore all is relative. (It is noted that some postmodernist thinkers, such as Richard Rorty (1982), claim that some viewpoints/theories are in fact better than others according to certain criteria, which then is no longer a relativist perspective.)

Because CSS distances itself from an emphasis on ontology, postmodern approaches with strong ontological perspectives are excluded from this study. Bourdieu’s (1990) postmodern approach bordered on linear determinism. He described phenomena with an underlying intention of determining future outcomes. This approach is rejected in this thesis as its tendencies come close to the positivist perspectives of controlling and predicting. However, other postmodern perspectives that approach a critical perspective such as philosophical hermeneutics are included. The Foucault-Habermas debate briefly mentioned next as it informed the development of Habermas’ perspective on power relations.

**Foucault-Habermas debate**

Foucault and Habermas had exchanges about power relations (which were suddenly terminated by Foucault’s death). In the 1970s and 1980s until his death in 1984 Foucault studied social structures and how they build a sphere of power and control (1963/1973). He and Habermas shared a rejection of supposedly superior rational ways of knowing and understanding the world that resulted in excluding, dominating and assimilating other ways of knowing. Both sought to radicalise rationality, defining it as embracing acting and being as well as knowing. Thought was conceived as a product of interests embedded in social context. Both described the present from an objective outsider perspective in order to illuminate the contradictions and intentions behind assumed, taken-for-granted, unproblematic shared meanings. Both saw a need for critical analysis of empirico-analytical science and of its definition of rationality.

They [empirico-analytical sciences] see the rationality that came to prevail in modern society as an instrumental potential for extending our mastery over the physical and social worlds, a rationality of technique and calculation, of, regulation and administration, in search of ever more effective forms of domination (McCarthy 1994, p. 246).

The aim of critical analysis of such rationality was to transform self-understanding. Foucault agreed with Habermas that the ability to adopt a critical distance from taken-for-granted, assumed-as-rational structures and practices depended on historical context. They differed as to where to go from critique. Table 3.5 summarises the Foucault-Habermas debate and highlights their differences concerning reflexivity, meaning, science establishment, rationality, and critique of rational practice.

**Table 3.5  Foucault-Habermas debate: Commonalities and differences**

<table>
<thead>
<tr>
<th>Foucault</th>
<th>Topic</th>
<th>Habermas</th>
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<tbody>
<tr>
<td>Immerse in context only</td>
<td>Reflexivity</td>
<td>Combine context with critique</td>
</tr>
<tr>
<td>Distance people to externalise their perspectives</td>
<td>Meaning (people’s perspectives)</td>
<td>Engage people to transform their perspectives</td>
</tr>
<tr>
<td>Develop anti-science</td>
<td>Critical of traditional science</td>
<td>Develop CSS</td>
</tr>
<tr>
<td>Always embedded in power imbalances</td>
<td>Rationality</td>
<td>Can be embedded in power balances</td>
</tr>
<tr>
<td>Social life is constitutive of effects of power</td>
<td>Critique of rational practice</td>
<td>Social life is constitutive of search for freedom, justice and human good</td>
</tr>
</tbody>
</table>
Positivist philosophy is still the dominant perspective in the 21st century (Newman 2006). Economies and political

3.7 The current status of critical social science

Positivist philosophy is still the dominant perspective in the 21st century (Newman 2006). Economies and political

systems are built on expectations of control, profit and maintaining current power relations. Conducting research

into causal relationships, isolating variables, and generating nomological research data are still perceived as the

preferred approaches to knowledge generation by key players in research and knowledge use hierarchies. The aim

of empirico-analytical approaches to the sciences is to explain the world as it is and to predict outcomes. For

example, rational choice theory, making life choices based on weighing up advantages and disadvantages, fits under

the umbrella of empirico-analytical approaches to social sciences. Determinism, control, prediction and causal

relationships are key aspects of the empirico-analytical approaches to scientific study that prevail today, reflecting

the dominant perspective of the physical science. The current pervasive fascination with and adherence to evidence-
based practice is a key manifestation of this hegemony. These approaches to knowledge generation are strategies in

a small world, which often cannot see the need for different sciences and different ways of knowing.

Critical social scientists oppose these intentions of prediction, determinism and control. They aim rather to

understand the social world, why it is what it is. By gaining insights and understanding the complex relations that

form the status quo, they hope to see possibilities for change (Agger 1998). With its lack of capacity to predict,

control and pre-determine outcomes but with its capacity to question and transform the status quo, CSS is often

perceived by mainstream cultures as a threat to disturb the status quo and current power balances. Not being part of

the mainstream has manoeuvred CSS towards a marginalised position of simply critiquing the mainstream norms.

Classical critical theory of the first generation critical theorists is historical evidence of this marginalisation.

Proponents of CSS still perceive a

necessity of ongoing critique, one in which the claims of any theory must be confronted with the

distinction between the world it examines and portrays, and the world as it actually exists (Giroux 1983, p.

8).
CSS arose as an impetus of resistance against oppression and mystification in the middle ages. As a science of resistance, CSS responded and fed off the mainstream sciences that were readily accepted and were the norm. Critiquing and searching for reform automatically placed CSS in a marginalised position. It is still dismissed by many as reactive anti-science, destructive and negative (Morrow 1994). CSS will continue to move dominant paradigms out of their comfort zones, in an attempt to destabilise rigid, oppressive thought, practices and social systems. However, it must be recognised that Habermas’ CSS gained new recognition by refocusing on language and communication theories. Habermas successfully engaged with dominant thinkers to increasing the status of CSS among the sciences. Its value in critiquing, making contradictions explicit and acknowledging complexity constructively has been widely accepted.

Habermas publicly stated that his agenda was to receive acceptance within academia and universities, and he succeeded (Agger 1998). He wanted to introduce critical theory as part of the agenda in mainstream academia. But with his focus on communicative theory he somewhat diluted the political agenda. With his sharp critique of the role of tradition he lost connection to history and seemingly reduced power relations to interpersonal levels of communication.

In academia CSS is still marginalised as the science of praxis and activism. Governments and funding bodies are geared to support research based on positivist or post-positivist methodology rather than action research. When academics claim professional objectivity they are purposefully not acknowledging the link between intellectuality and politics. When power relations are challenged, professional objectivity, professional knowledge and professional boundaries are threatened. Further, positivist academics use professional objectivity as an ideology to disguise the current values and intention that maintain the present social order (Agger 1998). CSS is seen as a threat to professional bodies and to professionalism as such. However, notions of critique and critical self-reflection have gained recognition and inclusion in shaping training and professional practice.

3.8 Critical social science operationalised in service professions

Reflective learning, problem-based learning, patient-centred care, consumer participation, self-help groups, and the advent of consumer advocates in health care organisations are all indications of a shift away from the traditional medical model where power is internalised by expert professionals. Inclusion of a critical perspective in educational theory has enabled the health professions to follow suit by developing contextualised CSS perspectives of practice. Critiquing the status quo, applying critical self-reflection and focusing on emancipation have influenced curriculum development and professional practice. In this section education, health promotion and nursing are discussed to provide a snapshot of CSS in operation. Education has relevance to physiotherapy practice in terms of professionalisation, professional education and development. Education and health promotion have relevance to physiotherapy practice as they inform patient education practices and the role of physiotherapists as educators. Nursing has relevance through its common interest with physiotherapy practice in clinical caring.

3.8.1 Education: Emancipatory practice

When we view professional clinician-patient relationships through educational lenses, clinicians become educators and patients become learners. Clinical practice then could be equated with emancipatory practice. I have discussed the potential of emancipatory practice as a model for physiotherapy practice elsewhere (Trede et al 2003).

Habermas’ theory of cognitive interests separating values from facts has implications for teaching and learning. The different interests of knowledge impact on traditions and notions of teaching and learning and of professional practice, as listed in Table 3.6. Technical interest in education favours the didactic teaching of facts. Technical interest in assessment is manifested in multiple-choice tests, didactic lectures with one person lecturing and many students passively listening, competency-based education with fragmented elements and clearly defined outcomes. Carr and Kemmis (1986, p. 60) explained technical interest in education and research from a historical perspective:

The choice of the word positivism was to convey opposition to any metaphysical or theological claims that some kind of non-sensorily apprehended experience could form the basis of valid knowledge. It was this desire to liberate thought from dogmatic certainties, coupled with an optimistic belief in the power of ‘positive’ knowledge to solve practical problems, that gave positivism its original appeal.
Deeming empirical facts as evidence that legitimately override opinion and value judgements would exclude reflection, meaning and communication from explaining reality. Carr and Kemmis (1986, p. 61) challenged this position, asking:

Why must educational research be based on the methodology of the natural sciences?

In searching for laws, natural science perspectives favour the status quo and maintaining practices as they are now. But theories of prediction and control of educational outcomes are virtually non-existent. Carr and Kemmis (1986) claimed that freedom has not emerged from positivism; this realisation focused their writing on integrating theory with practice. They stated:

Valid knowledge can only be established by reference to that which is manifested in experience (p. 60).

Educational theory that is based on critical theory is called critical pedagogy. The educational discourse of critical pedagogy includes critical literacy, critical thinking, action science and transformation theory, all leading to emancipatory learning and emancipatory practice (Mezirow 1998). The operationalisation of critical pedagogy is manifest in curricula that focus on critical self-reflection and action (Lovat and Smith 1991). Curricula with a CSS influence not only embrace experiential, collaborative and problem-based approaches to learning but also embrace recognition of prior learning, critical self-reflection, learner self-determination and emancipation.

Leading adult educators in critical pedagogy include Steven Brookfield (1987), Patricia Cranton (1996), Paulo Freire (1973), Budd Hall (1981), Jack Mezirow and Associates (1990), Mike Newman (1999), Lyn Tett (2001), and Jane Thompson (2000). Freire (1973) believed that education within an authoritarian framework underpinned by an interest to control students would lead to passivity, silence and obedience of students. Education within a democratic framework underpinned by self-direction and discussion, on the other hand, would lead to active, critically self-reflective students. The purpose of reflection is not merely to gain further understanding of historical or political contexts, but to ally knowledge with a political purpose towards transforming society (Rasmussen 1996). Knowledge is not used to silence and domesticate action. Freire’s focus, for instance, was on liberating oppressed groups. The purpose of reflection does not end at increased knowledge. Reflection upon knowledge should trigger action. In a CSS framework knowledge and action are closely linked. Emancipatory knowledge questions, activates, changes and transforms current situations.

Freire (1973) described three learning phases: listening, dialogue and action. Listening entails hearing marginalised voices and spending time understanding the status quo from other people’s perspective. Dialogue entails clarifying and raising awareness and understanding of the status quo from a political, historical and cultural perspective. Action includes collaborating collectively to transform the status quo to a more emancipatory state.

Brookfield (1990) developed three arguments for critical thinking based in CSS. First, critical thinking is part of being an adult and appreciating the ambiguity, complexity and contradictions involved in social, adult life. Second, critical thinking is essential for survival within constantly changing contexts of work and other aspects of life. Trying to make sense of and justify work practices requires critical thinking rather than following instructions and guidelines based on unchallenged assumptions. Third, critical thinking is part of being a democratic citizen. Critical thinking enables people to avoid being manipulated by mass media messages and political agendas.
Cranton (1996, p. 76) asserted that critical self-reflection is central to learning and that such learning develops both personal and professional growth.

This is not to say that instrumental and communicative learning about teaching are not a part of becoming an educator, but rather that development requires moving beyond the acquisition of new knowledge and understanding, into questioning our existing assumptions, values, and perspectives.

Cranton viewed being an educator as more than being a knowledge expert. An educator is a critical thinker who teaches scepticism and develops communication skills based on critical self-awareness and transformative learning.

Mezirow (1990) focused on critical self-reflection and transformative learning in individual learners. His critical theory of adult learning and education has the closest relevance to physiotherapy practice as both are concerned with working with individuals. He defined critical self-reflection as an assessment of the way one has posed problems and of one’s own meaning perspectives (Mezirow 1990, p. xvi).

This notion of critical self-reflection implies that people view problems from within their own values and frameworks. A critical perspective towards self-reflection involves allowing people to gain insights into their pre-judgments, values and other influences, and to question them. Mezirow differentiated between thoughtful action without reflection and thoughtful action with reflection. The former occur in almost all actions including routine practices. People may reflect by asking themselves How do I best act in this situation? They proceed by answering this question from within their existing, unchallenged perspectives and act accordingly.

However, thoughtful action with reflection occurs when people reflect by asking themselves What are the assumptions on which I base my assessment and consequent actions? Inviting people to question their own meaning perspectives enables them to challenge their assumptions and biases and helps them expand their horizons. Critical self-reflection located in emancipatory learning fosters people’s capacity to become aware of distorted meanings, to challenge unnecessary restraints, confront emotional barriers, explore alternative perspectives and adjust old ways of understanding (Mezirow et al 1990). Thus transformative learning is defined as the process of learning through critical self-reflection, which results in the reformulation of a meaning perspective to allow a more inclusive, discriminating, and integrating understanding of one’s experience.

Learning includes acting on these insights (Mezirow et al 1990, p. xvi).

Emancipatory learning starts with the acknowledgment that learning includes subjectivity, by defining knowledge as a social construct embedded in power relations, and by acting on critical subjectivity and emancipatory knowledge. Critical self-reflection and transformative learning are demanding aspects of learning that are best accomplished after childhood. Critical self-reflection are adult dimensions of learning and thinking, underpinned by the premise that critical dialogue is defined by reasoned assessment and rationality from a CSS perspective (Mezirow 1998). Reasoned assessment involves informal logic as well as critical reflection. Reason can be dependent on non-rational forces such as instinct, imagination and experience (Halstead 1994).

In his review of Habermas’ influence on the education literature, Ewert (1991) concluded that proponents of emancipatory learning in education have successfully applied Habermas’ CSS including critique, critical self-reflection and transformation. Emancipatory learning and meaning transformation are realistic and practical solutions to the theoretical concepts of CSS.

3.8.2 Health promotion

Health promotion in the 21st century focuses on improving the health of marginalised groups. One particular group of health promotion academics adopted a CSS perspective, focusing their work on reforming structures and emancipating practices. Joan Eakin, Ann Robertson, Blake Poland, David Coburn and Richard Edwards formed a CSS study group in Canada. Together they published a paper (Eakin et al 1996) proposing a CSS perspective to health promotion research. They posed reflexive questions to traditional research and practice in health promotion. They argued that the assumptions underlying traditional approaches did not address social inequality, inequity in access to health services and disjuncture between research knowledge and real-life experiences within health promotion practice. From their CSS perspective they sought to operationalise CSS by challenging the assumptions, ideology, power and contradictions in current practices.

Further, Eakin et al (1996) argued that collective and individual levels of intervention should not be separated. Rather than separating individual from collective knowledge (clinical practice from population health) they proposed dialectic relationships between them. Instead of defining poor health from the perspective of epidemiological evidence and focusing interventions on producing better epidemiological health outcomes, they recommended viewing health issues from a socio-political perspective focusing on community participation.
towards better quality of life. This CSS study group saw it as a necessity to integrate the political context and power relations into health promotion approaches.

Labonte focused on empowerment practices in health promotion by advocating community participation (Labonte 1997, Labonte and Robertson 1996). He differentiated between power-over, power-to and power-with. Power-over means domination and control over others. It relates to telling people what to do, on the basis that there is one best way of knowing and doing. Power-to relates to handing over power to others and respecting their understanding. Power-with relates to working together with mutual respect and searching for consensus. Foucault (1980) argued against the traditional notion of power as a personal possession of people or groups that enabled them to control others. For Foucault, power was embedded in discourse, meaning within social relations. In the area of medicine, for example, power was not seen as a personal possession of medical practitioners or health workers but was embedded in the discourse of modern medicine. Within the framework of this discourse patients and health care workers (experts) were cast in terms of positions of power. Regardless of how much he or she wished to relinquish power to patients, an individual medical practitioner could not do so unless a radical transformation were to occur within medical discourse. Foucault had no desire to examine how this might occur. But he argued that a transformation in discourse would result in a new set of power relations. One of the important aspects of Foucault’s approach was that he demonstrated how power operated and how it served to position people in its trajectory.

Labonte also focused on the relationship between theory and practice. He developed a knowledge generation method using experiential practice knowledge in the form of narratives. Labonte et al (1999) developed a story-telling method where health care practitioners retell one of their professional incidents to colleagues. The group then enters a structured discussion where group members share their understanding of the implications of the story. The aim of the discussion is to gain insights, reach consensus and formulate changes to practice, based on a critical debating process. This approach is based on critical self-reflection of practice experience. It entails valuing the shared knowledge of a group, knowing by doing, and critically reflecting on doing. Labonte and colleagues concluded that the story-telling method fosters transformative learning to improve current situations.

Freire (1972, 1973) had a decisive influence on moving health promotion towards a CSS orientation. Not only Labonte et al (1996) and Eakin et al (1996) but also many others based their theoretical work on his ideas. Wang (2000) related Freire’s notion of education literacy to critical health literacy. Wang used the World Health Organization’s (1998) definition of health literacy and differentiated between basic, functional and critical health education approaches within health literacy. Table 3.7 shows the influence of different types of interest on health care practice.

<table>
<thead>
<tr>
<th>Author</th>
<th>Topic (Health Care Practice)</th>
<th>Technical interest</th>
<th>Practical interest</th>
<th>Emancipatory interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wang (2000)</td>
<td>Health literacy</td>
<td>Compliance of pre-determined, simple behaviour</td>
<td>Compliance of pre-determined behaviour in an ideal environment</td>
<td>Self-determined action for participants with perceived benefits in changing their health behaviours</td>
</tr>
<tr>
<td>Carr and Kemmis (1986)</td>
<td>Education research</td>
<td>Causal explanation</td>
<td>Understanding</td>
<td>Reflection</td>
</tr>
<tr>
<td>Skelton (1998)</td>
<td>Patient Education</td>
<td>Patient needs to be self-responsible</td>
<td>Patient needs to be listened to</td>
<td>Patient needs to be liberated from hidden agendas</td>
</tr>
<tr>
<td>Caplan (1993)</td>
<td>Health Education</td>
<td>Behaviour and attitude modification</td>
<td>Improve understanding, challenging key labellers, correcting stereotypes</td>
<td>Reveal and challenge the ‘political’ in health; change social control systems instead of so-called deviants</td>
</tr>
</tbody>
</table>

Health care practices that are informed by an interest to predict and control health outcomes will favour causal explanations, evidence-based practice and compliance. Health care practices that are informed by an interest in practical and social solutions will favour community participation and social cultural evidence. Health care
practices that are informed by an interest in emancipation and transformation will favour facilitation of debate and of communication aiming for community self-determination. Wang (2000) supported a CSS approach, recommending that the role of health educator should be seen as that of a facilitator of learning and a partner of consumers. Caplan (1993) asserted that discussion needed to focus on epistemology and preferred methodologies to investigate health and well-being. Wallerstein and colleagues (Wallerstein and Bernstein 1988, Wallerstein and Sanchez-Merki 1994) and Minkler (1999) were among many who further developed, adapted and applied Freire’s (1973) popular education model in advancing health promotion interventions. The three themes that all popular educators have in common are:

1. critique of epidemiological focus of evidence and behaviourist approaches to health promotion intervention programs
2. critical self-reflection activities with health care practitioners and health consumers
3. actions based on collaborative strategies to achieve self-determined health goals.

Emancipatory practice is based on the premise that health educators need to be critically self-aware of their values and purposes before they can be facilitators of emancipatory learning for their patients and other health consumers. Critical health promotion theorists and practitioners resist the notion that because health care practitioners are health experts in their field they have a licence to tell consumers what is best for their health.

Critique of behaviourism
The field of health promotion arose from the need to educate populations and individuals about health issues in order to improve public health. The slogan underpinning health education was *prevention is better than cure*. Prevention and education was based on the traditional approach to learning, where people were given medical information in the form of technical knowledge. This approach tends to ignore people’s choices about their health goals and the fact that the ideal of perfect health is a construction of medicine and more generally a social or socio/economic construct. It was assumed that people would adopt this medical expert knowledge, change their attitudes towards lifestyle behaviours involving aspects such as drug use, exercise and food, and adopt healthier behaviours.

On the basis of these assumptions various theoretical behaviour change frameworks were developed, such as the health belief model (Becker 1974), the theory of reasoned action (Fishbein and Ajzen 1975), the transtheoretical model (Prochaska and Di Clemente 1982) and Bandura’s social learning theory (Bandura 1977). Behaviourist educational approaches to health education were based on assumptions that people were ignorant about their health, made poor personal choices, and just needed to be told what was good for them to change their health-related behaviour (Ajzen and Fishbein 1980). The blame for poor health was placed on individuals. These assumptions have been challenged (Cornell 1996, Seedhouse 1997) and these models were largely replaced after the 1990s. Ideals regarding health change over time and with cultural influences. Although behaviourist models now acknowledge social, cultural, and class factors as well as other external factors, the interest of behaviour change theories remains with the prediction and control of behavioural outcomes.

Critique of didactic patient education
Patient education has been defined as

*a planned learning experience using a combination of methods such as teaching, counselling, and behaviour modification techniques which influence patients’ knowledge and health behaviour ... (and) involves an interactive process which assists patients to participate actively in their health care* (Bartlett 1985, p. 667).

Bartlett differentiated between informal, unplanned patient education and systematic protocols. The patient education literature has predominantly focused on the latter. Patient education and individual behaviour change approaches like behaviourist change models have traditionally been located within biomedical and biophysical contexts. The literature on patient education in clinical disciplines has tended to reduce the educational encounter to issues related to communication, information giving and interpersonal skills. The aim of such theorising was to gear patient education towards the provision of medical knowledge derived from empirico-analytical research approaches, in order to seek improved compliance (Kerssens et al 1999, Skelton 1997, 1998).

The effectiveness of these approaches is questionable, especially with disadvantaged groups, and in terms of long-term effects and sustainability. For disadvantaged and marginalised groups health may not rank highly as a priority. Most didactic patient education approaches focus on immediate rather than long-term change. It is assumed that patients share the same values concerning health beliefs and health behaviours (Trede 2000). But patient education is not simply a matter of skill acquisition; it is also concerned with ideologies and values (Caraher 1995). An evaluation of back care schools confirmed that more was needed than medical knowledge dissemination when attempting to influence change:
what the teachers considered as important to transmit was not necessarily what the patients either regarded as meaningful to themselves or kept in mind. These results stress the necessity of taking into account the patients’ representations (Cedraschi et al 1996, p. 244).

Rather than concluding that back care schools in general are ineffective, Cedraschi et al questioned the purpose and approach of these back care schools.

### 3.8.3 Nursing


### Participatory action research

Lindsey et al (1999) suggested linking nurse practitioners and nursing researchers more closely in order to reduce the theory-practice gap. Clinical and research positions in nursing have traditionally been separate. Lindsey et al advocated combining these two roles within one position. Encouraging clinical nurses to become co-researchers within a participatory action research framework is a strategy that may reduce the research-practice gap. The advantageous implications of participatory action research were listed as being more responsive, critically aware of each other, effective and satisfactory for both parties. Such research approaches are methodologies of the CSS paradigm. McCormack et al (2004) stressed the importance of participation, collaboration and critical reflection in developing nursing practice. They based their research on practice-based evidence. Such evidence is inclusive of the perspectives of nurses, patients and carers.

Lutz et al (1997) discussed the relevance of the Gadamer-Habermas debate to the nursing praxis debate. They considered the relevance of the interpretive, critical and critical hermeneutics paradigms for nursing praxis and concluded that knowledge arising from all these paradigms could lead to emancipation and critical self-reflection. For example, they asserted that the impact of interpretive accounts without critical intention could nevertheless lead to critical self-reflection and emancipation. They suggested applying any of these paradigms, as they seemed very similar and appeared to differ only in their use of language. Implications noted for clinical inquiry in nursing were that hermeneutic, critical and critical hermeneutic approaches all had the potential to develop critical awareness in nursing inquiries. Although I agree that philosophical hermeneutics has the potential to raise critical awareness this is certainly not its prime intention. If a research intention is to raise critical self-awareness, to transform and emancipate, then critical hermeneutics and participatory action research are the optimal choices. I agree with Wainwright (1997) who criticised this superficial blurring of paradigms, stating that only critical hermeneutics and the critical paradigm could critique interpretations and usefully discuss clinical practice from such an espoused theory stance. Purpose and knowledge generation need to be congruent to produce credible research. The inherent focus of the interpretive paradigm is not change, but that is the focus of the critical paradigm. While the contextual approaches within the interpretive paradigm deepen understanding, it is the critical paradigm that enables decision-making and action. I discussed these philosophical issues in Chapter 2.

### Emancipation and power

Fulton (1997) conducted focus groups with British nurses, exploring their views on empowerment. Four major categories emerged from her study: (a) empowerment concerning decision-making, choice and authority; (b) personal power concerning assertiveness, knowledge and experience, and negative connotations; (c) relationships with the multidisciplinary team concerning medical power, autonomy in relation to medical staff, and autonomy within multidisciplinary team; and (d) feeling right about oneself concerning confidence, low self-esteem and being manipulative. Fulton concluded that nurses were ‘an oppressed group’ (p. 534) that they felt uncomfortable and disempowered by ‘not getting their voices heard’ (p. 534) and that the nursing literature did not provide messages on how to liberate the profession.

Padgett (1998) claimed that nursing emancipation could only eventuate when roles, goals, meanings and priorities in nursing are addressed within a framework of power and economics. The nursing literature has also focused on how structures, conditions of practice and the nursing literature shape nursing practice. Clare (1993) stressed the point that transforming curricula without transforming the conditions of practice would not achieve emancipation for nurses. Cohen (1992) argued that nurses had to become political at all levels, from nursing education, nursing practice, nursing management to decision-making positions at health policy levels. Changing curricula to include
socio-political contexts of nursing might positively contribute to sensitising junior nurses to the nursing socialisation process and give them a sense of nursing power. However, Habermas would disagree with Cohen by pointing to the underpinning interests of the medical model. He would point out that the interests of the still dominant medical model are to maintain the power imbalance between doctors and nurses. Politicising the medical model would not change power relations but transforming it to a CSS model could.

An important aspect of attempts to change the power imbalance, or to seek to empower others, is to understand the context, discourse and personal conceptualisation of power within which the ‘empowerer’ operates. To succeed in sharing power this individual needs to understand these issues and want to act to empower. A second issue is the extent to which the individual can act to empower within a system and discourse which inherently define certain people (e.g. health professionals and seniors) as having power and disempower other people (e.g. patients and subordinates). Foucault’s argument that power is not a personal possession would place more emphasis on this second issue. A discussion of changes to medical discourse is beyond the scope of this thesis. Rather, this research focuses on operationalising ideal communication situations at a micro level of individual power relations between physiotherapists and patients.

**Nursing practice, expertise and discourse**

Operationalisation of CSS has been reported in research into nursing practice. Bjornsdottir (1998) studied the discourse of language, ideology and nursing practice. She identified two discourses, the medical model discourse comprising public, technical and formal language and the caring discourse comprising private, biographical and reflective language. Bjornsdottir argued that much of nursing practice takes place behind closed curtains, and that the nurses in her study were sensitively aware of the private nature of their work. She saw a need to synthesise the private and public discourses.

Hardy et al (2002) confirmed the existence of a complex, reflective, and at times unconventional discourse in their exploration of nursing expertise. In the dominant medical discourse expertise is traditionally understood as technical expertise, but practice expertise in nursing exposes complex practice knowledge, including technical and intuitive knowledge, and a holistic approach to care. Hardy et al concluded that the clinical expertise discourse, based on complexity, reflection and critical thinking, can be isolating and challenging. Titchen (1998) applied aspects of a CSS perspective in exploring the notion of critical companionship in clinical practice. She explored strategies that enhanced the relationships between nurse and patient and between facilitator and clinical nurse. She concluded that consciousness raising, self-reflection, critique and critical dialogue were themes that facilitated clinical learning.

In the nursing literature detailed above it has been argued that CSS is relevant to nursing. Themes directly related to CSS include the theory-practice gap, emancipation and power, discourse analysis and *care* in particular, and the intuitive, tacit aspects of practice knowledge.

**3.9 Defining key dimensions as a basis for operationalising CSS in physiotherapy practice**

The two core themes guiding the development of CSS as shown in this review are critique and emancipation. Critique is conducted with a self-critical and self-reflective stance and emancipation is achieved with transformation, change and action. In this thesis critique means critically reflecting on physiotherapy practice approaches. Critique would need to address how power relations, professional identity and ideology influence rationality, knowledge and evidence in practice. Questions asked would explore why things are done the way they are done. Critique entails thinking for oneself and not relying on others, being critical, and questioning behaviours, practices and what is generally accepted as the norm and as common knowledge.

Critical qualities enable people to examine advantages as well as disadvantages and to see the same situation from different perspectives. To be critical does not imply pointing to deficits and mistakes, or searching for perfection. To be critical implies being aware of values, interests and power relations of self and others. Emancipatory learning attributes include collaboration, mutual respect, acknowledging emotion, careful timing, identifying readiness to learn, appropriateness in teaching delivery including using jargon-free, plain language, openness to difference and ability to listen. Important qualities to operationalise CSS in the physiotherapy context are a critical stance to self, patients and context, and the flexibility to act appropriately in each situation.

To develop a physiotherapy practice model based on CSS may start with, but requires more than, applying critical self-reflection to practice situations. All knowledge that clinical physiotherapists bring to their practice would need to be challenged for tacit intentions and hidden agenda. By hidden agenda I mean that physiotherapists may unknowingly accept practice knowledge and practice professional dominance that is not conducive to physiotherapy goals; or physiotherapists may undermine others for their own ends. Bringing the professional agenda out of hiding is part of the consciousness-raising and critical self-reflection of CSS. Accepted but unreflected practice knowledge
could then be transformed to critical practice knowledge. Personal as well as professional self-understandings and identity would need to be clarified and exposed to debate. Professional relationships and roles would need to be rethought in the light of power relations. Practice contexts, including individual patients’ diverse backgrounds, would need to be considered. If it is agreed that physiotherapy practice is influenced by the wider health care context and system, by clinical education, undergraduate training and professionalisation, then all these aspects would need to be embraced in developing a practice model based on CSS.

The dimensions of a CSS model for physiotherapy practice are based on themes of critique and emancipation. As operationalised in education, health promotion and nursing, these dimensions could be:

- Capacity for critical self-reflection
- Redefining professional identities and roles
- Democratising professional power relations
- Rethinking rationality and professional practice epistemology
- Rethinking the practice context.

A model for physiotherapy practice from a CSS perspective would have to begin with physiotherapists and their capacity to critically self-reflect on their values, interests, professional training, culture and professional self-understanding. First, physiotherapists need to emancipate themselves before emancipating others (Chavasse 1992). An ability to assess one’s own perspective and to make transformative changes accordingly will place physiotherapists in a situation where they can potentially facilitate the same in their patients.

It is assumed in a CSS perspective that a practice model is a distortion of an ideal conceptual model. A critical perspective challenges social structures, work hierarchies, and mainstream cultures that silence communication partners. From that perspective physiotherapy practice as it is predominantly practised today can be questioned. In empirical-analytical science the ideal is to control and predict practice outcomes. In historical-hermeneutical science the ideal is to understand and find consensus. In CSS the ideal is to describe and understand why practice models exist the way they do, and to strive to imagine how they could exist differently. A practice model from a CSS perspective would be a continuous process of describing and understanding current models and imagining different models informed by critique, critical self-reflection, transformative learning and visioning.

3.10 Concluding remarks

In this chapter I have set the scene for the overall approach of my thesis. I have discussed CSS from a historical perspective. An overview of the aspects of CSS that are adopted for this thesis is provided. CSS today no longer focuses exclusively on a critique of positivism and its technical knowledge and objective rationality. Rather it focuses on what differentiates CSS from postmodern and interpretive perspectives. By continuously critiquing new philosophical directions CSS ensures that rethinking and transformation of new directions occurs and that CSS concurrently transforms itself. This is evidenced in the development of CSS, in the key CSS philosophical debates and in the emerging theorising and operationalising of CSS that has occurred in education and health professions.

The deeper the discussions of rationality and undistorted, ideal communications are, the more complex and abstract the discussions become. Communicative and strategic actions are often interwoven in a complicated way. The more formal intersubjective communications are, the more likely it is that communicative and strategic actions are mixed (Habermas 1982). The more abstract, theoretical and removed discussions are from the lived world the more they lose their appeal, accessibility and applicability professional practice. CSS is a philosophy theorising about democracy, society and politics. It has no direct link to professional practice, health and clinical practice. However, CSS can be used and has been used as a philosophical and value base for health-related professions. As Dubiel (2001) concluded, the task of CSS is to operationalise CSS rather than to continue with the theoretical and philosophical debates. This thesis addresses this task by studying the status quo, a trial and embodiment of CSS in physiotherapy practice.
Chapter 4

PHYSIOTHERAPY STATUS QUO: Text 2

Even if we could agree on what ideally rational people would do under ideally rational circumstances, this would provide precious little guidance as to how to proceed in the real world. Knowing how to play a perfect hand in a card game will not help us to decide how to play the imperfect hands that fate actually deals us.

(Rescher 1993, p. 178)

This chapter portrays and critiques the status quo of physiotherapy in terms of practice approaches. It discusses values and professional ideology as major factors influencing health care practice models. Three different practice models are identified. This chapter comprises the second text of this thesis. It includes professional health practice literature (physiotherapy literature in particular) and transcripts from interviews conducted in this research. The physiotherapy literature that addresses issues of paradigms, professional values, practice frameworks and professional practice knowledge is examined. In the final section the literature and the interviews are critiqued using a critical social science lens.

4.1 Professional practice, its philosophical underpinnings and professional interests

Professional practice does not develop in isolation. It is influenced internally by professional ideology and identity and externally by social, economical, political and cultural forces that change with time.

4.1.1 What makes practice professional?

A profession is a community of people who identify with common practice knowledge, practice interventions and practice goals. Professional practice defines itself through a structured body of knowledge, expertise, regulating bodies, autonomy (Richardson 1992) and accountability (Eraut 1994). Professional clinical practice occurs in a variety of practice settings. These settings are influenced by health care systems, professional practice roles and professionals themselves. Health care professionals are accountable to themselves, their profession, the system within which they work and society at large. Professionals accept responsibility for their own actions, ensure that their services are accessible to the diverse needs (e.g. disability) of their patients, respect patients’ interests and moderate competing expectations. Professionals mediate assumptions held by the public and strive to achieve acceptable professional as well as patient outcomes. As professionals, physiotherapists have to decide which conditions they can treat and which ones need to be referred to other professionals because they are outside of the professional expertise of physiotherapy.

Eraut (1994) explored professionalism in relation to accountability, professional status, competence and professional knowledge. He concluded that professionals need to be committed to serving the interests of their clients, to self-monitoring to review the effectiveness of practice, to developing their expertise, and to contributing to their professional organisation and the advancement of their profession. Professionals are accountable to service receivers, their professional bodies and to themselves. A key question is: What criteria determine the nature of accountable professional practice? Should physiotherapy practice be informed predominantly by empirico-analytical frameworks of the natural sciences or also by hermeneutic frameworks of the social sciences? Discussion needs to reflect on definitions of practice knowledge, what counts as evidence, and what role patients’ experiences can play in health care. Whatever the definitions of accountability and standards for professional practice are, practice is underpinned firstly by values and ideology.

4.1.2 Ideology and other influences on professional practice

Professional health care practice is a complex concept, and is influenced by education, research, practice setting, practice knowledge and personal world-views. Professional practice in higher education emphasises research and lecturing skills (Eraut 1994), whereas professional practice in clinical settings emphasises the appropriate application of research knowledge, communication skills and working effectively in the workplace (Cross 1999). University trained health care professionals may feel disappointed or poorly prepared for their clinical practice if their education has emphasised technical, empirico-analytically based research knowledge and if the assessment techniques they have been taught have focused more on technical knowledge than on practical knowledge and skills such as communication skills and ethical moral values of practice. Shin (2000, p. 264) studied the experiences of nursing students in practice and reported:

Students were disappointed when they entered clinical work after training at uni. They had to realise that “their home and school life until now was very different from the outside world”.

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These students had internalised the values, norms and skills of university nurses but not of clinical practice nurses. The values of academics and practitioners of the same profession may all work towards advancing their profession but may entail opposing visions of what constitutes professional practice and how it should be advanced. Table 4.1 illustrates technical and practical interests, and it implies how both inform different criteria for accountability, practice approaches and practice knowledge.

**Table 4.1 Technical and practical interests that shape practice knowledge**

<table>
<thead>
<tr>
<th>Technical Interest</th>
<th>Practical Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Best available external evidence</td>
<td>Individual clinical expertise</td>
</tr>
<tr>
<td>External evidence</td>
<td>Internal judgment</td>
</tr>
<tr>
<td>Practice is defined as objective, pure, accountable</td>
<td>Practice is defined as subjective, emotional, risky</td>
</tr>
<tr>
<td>Clinician values</td>
<td>Patient values</td>
</tr>
<tr>
<td>Generalised majority</td>
<td>Individualised minority</td>
</tr>
<tr>
<td>Normative approach</td>
<td>Diversity approach</td>
</tr>
<tr>
<td>Generalisations (statistics)</td>
<td>Particularisations (individual)</td>
</tr>
<tr>
<td>Cause-and-effect linear logic</td>
<td>Interrelational meanings</td>
</tr>
</tbody>
</table>

It is these interests that shape theories or models of practice which in turn inform professional practice. It is the interpretation based on professional interests that makes generic attributes of professionalism meaningful. The way clinical treatments are documented provides insights into what interventions are valued and therefore documented and what types of interventions are not documented and thus marginalised. Reporting and documenting are often seen as breaking down clinical practice into isolated problems with single solutions (Bjornsdottir 1998). In a study of language, ideology and nursing, Bjornsdottir found that although nurses were reporting on measurable, observable interventions, subjective, emotional and social interventions were not documented in the medical records. The differences in public and private discourse of documenting clinical practice as gleaned from the nurses in Bjornsdottir’s study are listed in Table 4.2. In reviewing the distinctions made in Tables 4.1 and 4.2 it is useful to reflect on the value of abstract differences between these interests and practices. While the clarity and interpretation of the two abstractions helps us to see the argument (i.e. the potential consequences of adopting one fashion or the other), in reality practitioners may adopt shades and blends of both positions in the grey and human walks of practice and in their own practice evolution.

**Table 4.2 Public and private discourses of documenting clinical practice  (adapted from Bjornsdottir 1998)**

<table>
<thead>
<tr>
<th>Public discourse</th>
<th>Private (silent) discourse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectivity and alienation</td>
<td>Understanding patients’ perspectives</td>
</tr>
<tr>
<td>Official practice</td>
<td>Actual practice</td>
</tr>
<tr>
<td>Reporting of tasks completed</td>
<td>Not reporting tasks completed</td>
</tr>
<tr>
<td>Application of science and technology</td>
<td>Application of human sensitivity</td>
</tr>
<tr>
<td>Working with relatives and patients is not relevant</td>
<td>Working with the complex social/family situation</td>
</tr>
<tr>
<td>Science is accepted as superior way of knowing</td>
<td>Hermeneutics is accepted as a credible way of knowing</td>
</tr>
<tr>
<td>Health is the absence of disease</td>
<td>Health is a sense of wellbeing</td>
</tr>
<tr>
<td>Clinical practice is instrumental, performing individual tasks</td>
<td>Attending to the lived realities</td>
</tr>
<tr>
<td>Mistakes and negligence are scrutinised</td>
<td>Nurse-patient relationship is not discussed</td>
</tr>
<tr>
<td>Getting the work done</td>
<td>Valuing human relations</td>
</tr>
</tbody>
</table>

Bjornsdottir (1998) contended that private discourse would gain more acceptance and recognition if the medical plan was negotiated in collaboration with nurses and allied health staff. The conclusions from Bjornsdottir’s paper raise the question of what interests shape professional discourse and interdisciplinary relations. Professional relations that are predominantly informed by instrumental and technical interests appear to marginalise the private
discourse of clinical practice that is informed by practical and emancipatory interests. The problem with such marginalisation, it can be argued, is that authentic and holistic caring for patients is neglected. The public discourse of professional accountability measures quantifiable aspects of care, excluding human quality and at times patient care priorities. Marginalisation can lead to patient alienation, misdiagnosing, and gaps in providing quality care (Titchen and McGinley 2004) and complaints. A critical appreciation of the complexity of clinical practice includes learning from practice, cross-checking ideas, verifying assumptions, and articulating new knowledge derived from practice (Higgs, Fish and Rothwell 2004). It can be argued that embracing both public and private discourses and including other than technical interests that informs practice knowledge, reduces alienation and marginalisation and works towards ensuring quality and satisfaction for both health care professionals and patients.

The health literature tends to separate discussion of research, academic matters and basic science from practice, clinical settings and the art of practice. The former are based on empirico-analytical ways of knowing and practising whereas the latter are based on hermeneutic ways of knowing and practising. There is a relative dearth of literature based on a third perspective, the critical social science perspective.

In their seminal paper on the philosophy of medicine, Szasz and Hollender (1956) mentioned this third perspective as a critical-emancipatory approach to medicine. However, they argued that medicine is ill-placed to adopt an emancipatory approach, because of its typical one-to-one clinician-patient relationships. They saw therapeutic practice as foreign to emancipatory practice. The values of emancipation (freeing from unnecessary system constraints) appear to contradict the values commonly embedded in therapy (coping within systems). Traditionally, therapies are seen as helping patients cope with their conditions. An underlying assumption seems to be that the problems, dysfunctions and deficits lie with patients and they need fixing. Physiotherapists and other health care professionals are seen as the experts and patients as ignorant lay people. Emancipatory frameworks question such majority norms, and seek to liberate patients from “deficit thinking” towards “potential thinking and building” capacity, to live quality lives. Ideology and values influence research, education and ultimately professional practice. This is illustrated in Figure 4.1.

**Figure 4.1  Ideology and professional practice**
4.1.3 Status, power and knowledge
The dominant values of professional practice are influenced by current social, political and economic values. Professional practice is influenced by many factors. It is a dynamic phenomenon that is never quite settled but rather keeps evolving with social, economic and cultural trends and with shifts and changes within health care systems and health insurance policy in particular. In the current climate of the Australian health care system, professions are more interested in advancing their technical knowledge than their creative, context-appropriate knowledge. Practice knowledge that is rational, objective and external to the knower fits the values of economic rationalism, empirico-analytical approaches to research, evidence-based practice and outcome-driven performance indicators.

Generic attributes of professionalism in the medical professions have been summarised as altruism, accountability, excellence, duty, honour and integrity, and respect for others (American Board of Internal Medicine, 1995). It is easy to agree with these generic attributes of professionalism, but it is their interpretation that shapes actual practice. Professionalism and what professional practice should look like are influenced by the ideology of a profession (Eraut 1994). Ideology comprises the basic values, interests and vision upon which practice is built. Practice knowledge that is critical and conscious of diversity fits the values of critical and skeptical rationalism, multidisciplinary holistic care, hermeneutic and process-driven reflective practice.

4.1.4 Social forces and power
A deeper discussion of professional practice embraces its complexity, uncertainty, instability, uniqueness, value conflicts, power interests and expectations from within the profession and from society. Those values that have strongest influence on professional practice are also the current dominant values in society. There is an interrelationship between contemporary social and professional values (Crowe 2000; Traynor 2000). The more congruent social and professional values are, the higher the social status of that profession (Newman 1994). If a society values technology, prediction and control of events then a profession that is perceived as predominantly technical practice, with a successful prediction rate and minimal uncertainty of outcomes, is highly regarded and enjoys high social status and privileges. These privileges include professional authority, autonomy and power. Among the health professions, medicine enjoys the highest status and greatest power. This is reflected in health care system hierarchies. However, systems are shifting and there is a growing trend in society and health care to endorse multidisciplinary approaches to practice. Duckett (2004, p. 101) discussed these changes occurring in the health care system in relation to power shifts:

Changes may begin to address some of the power imbalances in the health sector and provide a sounder basis for more equitable teamwork in health care. This will be to the long-term benefit of patients and other consumers.

Duckett alluded to power imbalances between the medical and allied health professions and how they shape models of practice. Professional power implies that professionals do what they want despite resistance from others. People with power limit what others can do, say, perceive and think (Inglis 1997). It could be argued that professional practice is steered more by social forces and power than by critical reasoning.

4.1.5 Power gradient and practice knowledge
The term professional is immediately placed in opposition to non-professional. When professional practice concerns professionals working with lay people then there are, immediately and at least to some extent inevitably, power differentials. Professionals possess professional knowledge which is to be assumed superior to lay knowledge. Knowledge is power (Paechter et al 2001). The more developed the technical practice knowledge of a profession, the higher the status of a profession and the more power is invested in that particular profession.

The hierarchy of professional and social status is closely linked to the rigour of professional knowledge. Currently, rigour and highest status are accorded to theoretical, technical knowledge. As Schön (1987, p. 9) asserted:

The relative status of the various professions is largely correlated with the extent to which they are able to present themselves as rigorous practitioners of a science-based professional knowledge.

The more professional practice knowledge is based in the basic technical sciences the higher its reputation and professional status. Schön alluded to the temptations of professions to pursue higher professional and social status by advancing technical, propositional professional knowledge. The evidence-based practice movement arose from the desire to assure the public of uniform, rigorous, scientific practice. Evidence-based practice builds on the assumption that bio-physical conditions are just that: evidence of purely physical conditions that are not related to other conditions outside of bio-physical that influence health. It excludes the more human conditions that
contribute, such as fear, anxiety, family situations, expectations and beliefs, which complicate the physical picture. There is no doubt that professional practice and professional practice knowledge need to be based on evidence. The public, health insurance companies and governments demand health care services that are based on accountability, efficiency and low-risk interventions. The aim is to provide best outcomes for patients and other customers. The question is, who should be allowed to decide what the best processes and outcomes are and what should count as evidence in the professional practice context?

The evidence-based medicine (EBM) movement arose in the UK in the late 1980s as a reaction to discontent with the National Health Service in general and clinical practice in particular, that were not seen to be sufficiently based on scientific evidence (Smith 1988). EBM can be regarded as a mission to bring certainty to clinical practice and to eradicate ambiguity and diversity. The aim behind this movement could be seen as reclaiming the declining professional authority over lay beliefs. EBM is an extension of the Enlightenment Movement searching for the absolute truth. Early EBM chose objectivity, purity and scientific rationality as defined by the empirico-analytical paradigm as its gold standard. It set up a ladder of hierarchies of knowledge that set knowledge derived from randomised control trials above all other ways of generating knowledge. The empirico-analytical paradigm was placed above all other paradigms.

From a naïve historical perspective one could claim that EBM set out on a mission to improve medical knowledge and thus to improve health outcomes, by fine-tuning research and giving it more acknowledgement than clinical practitioners did at the time. This philosophical position set up a totalitarian approach to clinical practice. The search for prediction and unambiguous treatment outcomes is a simplification of clinical reality. Generalisations need to reject otherness, minorities and diversity. Some aspects of evidence need to be excluded. Complexity is not compatible with EBM. Diverse perspectives were marginalised and silenced in order to produce uniform evidence. The critique of instrumental reason, scientism and EBM was discussed in chapter 3.

The totalitarian universe of technological rationality is the latest transmutation of the idea of reason (Marcuse 1970, p. 105).

Reason and credibility were hijacked by an ontology based in empiricism. By excluding other ways of knowing, EBM built harsh dualities between knowledge and beliefs, art and science, values and facts. I listed these in Table 2.6 from a general learning, practice and knowledge perspective. Distinctions were made between beliefs and sound information. What were the intentions in making such distinctions? Professional practice is facing uncertainty, complexity, increased diversity and patient participation, which can lead to increased value conflicts. How well are physiotherapists equipped to address these emerging challenges in their practice? What is the evidence of best practice regarding communication skills, valuing diversity and working with uncertainty? Strong criticism of the evidence-based practice movement has arisen. Empirico-analytical research approaches that inform evidence-based practice are ill prepared for the complexity and humanity of real-life practice settings (Bithell 2000; Chan and Chan 2000; Cox 1999; Traynor 2000).

By the mid-1990s the EBM movement adjusted its position and concessions were made. The role of clinical judgment was acknowledged. Instead of a dualism a hierarchy of knowledge and evidence is now presented (Traynor 2000). EBM acknowledges the importance of carefully applying evidence-based practice to individual clinical situations. “Evidence-based medicine is not ‘cookbook’ medicine” (Sackett et al. 1996, p. 72). However, Sackett et al. have insisted that RCTs are still less misleading and more informative than clinical judgment. The message remains that evidence-based practice is the only credible mode of practice. Although proponents of the movement admit that it is imperfect they still claim that propositional knowledge is necessary and superior to other practice knowledge (Herbert et al. 2001). According to Traynor, the developments of evidence-based practice today still do not release its grip and desire to follow law-like practice, and it maintains its hierarchy of knowledge.

4.1.6 Change and the need for a vision and maturing profession

In these times of rapid and constant change, especially in the health care context, it seems normal that professional practice is in dispute. When choices or acknowledgements of philosophical frameworks and professional interests are unresolved and there is a lack of common agreement, then professional practice attributes are also not settled. With the rising power of consumer groups and their increasing command of medical information via the internet, there is a public outcry for more accountability in medicine. The professional power and social privilege that the medical profession has enjoyed over the last 60 years are now seriously questioned (Lupton 1997). There is a shift in lay perceptions of professions and professionalism. Professionalism can encourage division because of its professional as opposed to lay status.

Professionalism has the potential to impose one uniform perspective of professional practice by reinforcing the status quo with an absence of challenge (Meek 1998). There is a struggle between technical, economic, socio-
cultural and emancipatory interests in professional practice. Social, local and global change is a constant factor nowadays, and in that context it is important for a maturing profession to have a vision, otherwise the profession will merely react to external forces and lose its professional core and identity. Visions are informed by professional interests and values, and these in turn influence practice models and theories. Higgs et al. (1999) stated that narrowly defined professions may be concerned with technical practice knowledge and evidence-based practice only. Such definitions appears to value the protection of professional authority and reinforcement of professional boundaries rather than fostering professional development.

It would be simplistic and limiting for a profession to define its practice purely on the basis of technical knowledge and skills. As professions develop and mature they become more involved with questions of expertise development and knowledge growth. Higgs et al. (1999) claimed that a mature profession is one that enters into dialogue, is self-reflective, and pro-actively transforms with global changes. Professional practice models can be categorised in a number of ways. One such categorisation is based on the philosophical underpinnings of practice. Table 4.3 illustrates the illness, wellness and capacity models and their inherent interests.

<table>
<thead>
<tr>
<th>Practice model</th>
<th>Illness model</th>
<th>Wellness model</th>
<th>Capacity model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kind of interest</td>
<td>technical</td>
<td>practical</td>
<td>emancipatory</td>
</tr>
<tr>
<td>Approach</td>
<td>clinician-centred</td>
<td>patient-centred</td>
<td>patient-empowered</td>
</tr>
<tr>
<td>Philosophical paradigm</td>
<td>empirico-analytical</td>
<td>interpretive</td>
<td>critical</td>
</tr>
<tr>
<td>Health definition</td>
<td>reductionist</td>
<td>holistic</td>
<td>holistic</td>
</tr>
<tr>
<td>Focus of health</td>
<td>technical</td>
<td>practical</td>
<td>political</td>
</tr>
<tr>
<td>Clinician power</td>
<td>clinician has power</td>
<td>clinician may share some power</td>
<td>equal power sharing</td>
</tr>
<tr>
<td>Patient power</td>
<td>disempowered</td>
<td>empowered</td>
<td>empowered in a way that can be sustained</td>
</tr>
<tr>
<td>Practice knowledge</td>
<td>propositional-technical</td>
<td>propositional-technical and experiential</td>
<td>propositional-technical, experiential and political</td>
</tr>
<tr>
<td>Stance towards status quo</td>
<td>taking things for granted, Accepting, reinforcing</td>
<td>being aware of taken-for-granted things</td>
<td>challenging status quo and changing frameworks</td>
</tr>
<tr>
<td>Role of patient</td>
<td>passive, obedient, not asked to think for self</td>
<td>interactive, participative but obedient, encouraged to think a bit for self</td>
<td>interactive, participative, contributing, self determining, learn to think for self</td>
</tr>
<tr>
<td>Role of clinician</td>
<td>teacher</td>
<td>listener</td>
<td>facilitator</td>
</tr>
<tr>
<td>Context of decision-making</td>
<td>out of context</td>
<td>in psycho-cultural context (definitely not political)</td>
<td>historical-political context</td>
</tr>
<tr>
<td>Clinician as helper</td>
<td>helping to survive</td>
<td>helping to cope</td>
<td>helping to liberate</td>
</tr>
<tr>
<td>Clinicians helping patients</td>
<td>to comply</td>
<td>to cope</td>
<td>to liberate</td>
</tr>
<tr>
<td>Clinician self-awareness</td>
<td>unreflective</td>
<td>reflective with the aim to empower</td>
<td>reflective with the aim to transform</td>
</tr>
</tbody>
</table>

A professional practice model defines what knowledge is accepted as professional knowledge and what knowledge is considered to be not relevant or “inferior”. The latter knowledge could be even ignored because it counts only as a myth or belief. This (often) taken-for-granted and silent agreement about what counts as professional practice knowledge or what constitutes practice epistemology shapes professional identity and contributes to the way professionals practise. Professional identity is shaped by attitudes, assumptions, expectations and self-awareness regarding one’s professional role. To ensure professional development, social relevance and maturity of a profession, other aspects of professional practice knowledge than predominantly technical knowledge need to be included, such as the ethical, social, cultural and political aspects of practice knowledge.

Professional practice consists of more than applying learned knowledge in practice (Higgs 1999). Professional practice engages people and responds to particular situations. Professionals live and develop their practice in interaction with their patients. Patient-centred health care places the patient at the centre of health care, as a participant in decision making rather than a recipient of health care services determined by professionals. In modern approaches to disability, for instance, disabled people themselves are perceived as making an important, even
essential contribution to client/professional interactions. This can be seen in the work of Carl Rogers (1969), who is an influential adult educator in the US. He considered that clients should not only learn to think for themselves and question what the professional is doing but should also contribute, for the therapy to be effective. Thus according to Rogers, in therapy patients’ contribution is not just encouraged to make them feel important, but the therapy will not work without their contribution. This is more than just allowing clients to participate is an aspect of the therapy.

Both personal and professional practice values inform professional identity. Higgs and Titchen (2001) described four aspects of professional practice: knowing, doing, being and becoming. These entwine the person in the practice, and the past, present and future of the practitioner’s knowledge and practice. Professional knowledge and skills are complemented with self-knowledge, reflection and growth. Higgs and Titchen envisaged professional practice as

a rare blend of people-centred and interactive processes, accountability and professional standards, practice wisdom, professional artistry, openness to knowledge growth and practice development and engagement in a professional journeys towards expertise (p. 5).

The definition by Higgs and Titchen (2001) espouses a reflective learning and creative framework for professional practice. It uses terms such as artistry, wisdom and journey, all of which imply that professional practice is more than a science or a combination of technical knowledge and skills. Higgs and Titchen describe professional practice frameworks as people-centred, context-relevant, authentic and wise. People-centredness involves placing patients and interpersonal communications at the centre of practice. Practice context implies that professional practice takes into account cultural issues, uncertainty and ambiguity. Authentic practice is achieved when practitioners reach a fitting match between professional, self and patient expectations, and a comprehensive understanding of ethics and practice values. Wise practitioners are not just problem solvers but also have capacity for vision, creativity and possibilities. This professional practice description develops a vision for health care practice that encompasses the complexity and diversity of practice. It provides a framework for a practice model that shapes communications and professional relationships with the aim of building capacity. The way professions are defined provides not only understanding of their body of knowledge and skills but also insights into their future directions, their aspirations and ideology.

4.2 Practice models in the physiotherapy literature

The physiotherapy literature discussed here explores the historical milestones and definitions of physiotherapy, and the dimensions of professional practice knowledge in physiotherapy.

4.2.1 Definitions of physiotherapy practice

Physiotherapy as a profession emerged from massage therapies in the early 20th century. Physiotherapy originated from clinical patient care practice and was first applied in neurological and orthopaedic settings. Physiotherapy today is strongly influenced by orthopaedic medicine and neurology (Helders et al. 1999).

The World Confederation of Physical Therapy (WCPT) was formed in 1950s. Its latest definition states that physiotherapy is concerned with identifying and maximizing movement potential, within the spheres of promotion, prevention, treatment and rehabilitation. Physical therapy involves the interaction between physical therapists, patients or clients, families and caregivers, in a process of assessing movement potential and in establishing agreed upon goals and objectives using knowledge and skills unique to physical therapists (WCPT 2004, p. 28).

This definition broadly describes physiotherapy’s purpose and goal. Most physiotherapists would agree with these statements. Global definitions need to be sufficiently broad to embrace all facets of practice. They provide a baseline identity for the profession. Physiotherapy is practised differently in different countries. In some countries physiotherapy education does not exist, in others it is offered as a diploma and in yet other countries it is well advanced in university courses.

Apart from these global differences, there are three broad fields of work and development in physiotherapy: clinical practice, professional education and research. Educational and research practices in physiotherapy are more recent fields than clinical patient care. It is predominantly the research and education fields that have given physiotherapy its professional and social status. However, it has been observed that these three physiotherapy roles are not moving in the same direction (Helders et al. 1999). Although there is agreement about professional physiotherapy practice goals, which are to ensure quality of practice, to develop knowledge and practice, and to teach and prepare the next generation of physiotherapists, the directions to achieve these goals are influenced by different and at times opposing forces interests (see Figure 4.2).
Physiotherapy practice that focuses on technical, scientific knowledge promotes and advances propositional knowledge. Technical interests direct patients into a passive receiver role and physiotherapists into a technical expert role. The practice context in its narrowest technical view is confined to closed strategies such as protocols and pre-determined sequences of questions to elicit relevant data for diagnosing and treatment. In contrast, physiotherapy practice that focuses on social, cultural and historical influences to knowledge prioritises and advances professional craft knowledge. Hermeneutic interests imply that patient roles are participative and active and that physiotherapists are negotiators with effective listening skills. Physiotherapy practice that focuses on emancipatory knowledge prioritises and advances critical awareness of the relations between power and knowledge. Emancipatory interest defines patients as activist learners and physiotherapists as facilitators of emancipatory learning. All three dimensions of practice interest have currency and together reflect the complexity of physiotherapy practice.

4.2.2 Australian milestones

Australian physiotherapy is respected as among the world leaders of the profession. In Australia, physiotherapy education transferred to the tertiary education system in 1966 and primary contact practitioner status commenced in 1976 (Higgs et al. 1999). The *Australian Journal of Physiotherapy* is indexed in Medline and CINAHL and publishes research papers that are predominantly based in the empirico-analytical research paradigm. PEDro, an international database for evidence-based practice in physiotherapy is housed at the School of Physiotherapy in the University of Sydney. The high status of Australian physiotherapy can be linked to these historical milestones and to the fact that the physiotherapy profession organises and controls its professional knowledge through universities. These developments follow the footsteps of the medical profession. They have been achieved by directing physiotherapy towards an empirico-analytical approach to research and the medical practice model. However, Higgs et al. (2001a) and Noronen and Wikstrom-Grotell (1999) have argued that physiotherapy should not be based exclusively on empirico-analytical research approaches and the medical model, as this restricts the scope of physiotherapy.

Decisions in society leaning on the medical or biomedical model can prevent the development of knowledge within physiotherapy and thus prevent the opening of new opportunities to physiotherapists (Noronen and Wikstrom-Grotell 1999, p. 183).

Noronen and Wikstrom-Grotell (1999) stressed the importance of not losing sight of the social and interpersonal aspect of physiotherapy practice. They explained:

the importance of interaction between the physiotherapist and the patient, understanding the patient as a whole, and cooperating with him or her, must be emphasized as an important part of physiotherapy (p. 184).
4.2.3 What is physiotherapy?

Although physiotherapy is becoming a well-established profession, the discussion about what physiotherapy is and what should underpin its professional knowledge base continues unresolved (Bithell 2000; Domholdt 1995; Parry 1997; Richardson 1999). Domholdt asserted that the physiotherapy profession is far from agreeing on a new research perspective for physiotherapy practice apart from the empirico-analytical paradigm based on quantitative methods. Parry confirmed this by bluntly asking:

What is physiotherapy? Its intellectual status is not yet settled. Is it a health science, a pseudoscience or a multiparadigm science or not a science? (Parry 1997, p. 424).

She further stated

In times of crisis, established disciplines turn to philosophy … There is, however, no dominant subject philosophy in physiotherapy. Meanings and intentions have not yet been clarified to that extent (p. 424).

We are left with the question: Does physiotherapy practice have to choose between scientific research that develops best practice models based on empirico-analytical interests, and hermeneutic research that develops patient-centred practice models based on practical interests? There is no consensus in the literature as to which theoretical perspective physiotherapy should subscribe to. Ekdahl and Nilstun (1998) reviewed the scientific ideals of physiotherapy researchers, focusing on Swedish doctoral dissertations with regard to research paradigms. They stated, “there is still no general agreement within the profession as to what is the essence of physiotherapy” (Ekdahl and Nilstun 1998, p. 160), but argued for the relevance and value of interpretive perspectives.

Hurley (2000) described the physiotherapy profession as wanting to please line managers, uncritically following trends that are unevaluated, and being frightened of innovations. He claimed that all clinicians would want to base their treatments on evidence derived from research but, he asked, what type of research is needed to provide the relevant evidence? For clinicians, research needs to be relevant and important to all stakeholders including patients. Further, research needs to be clinically realistic and appropriate for patients. Hurley advocated for practice-based research that generates practice-based evidence. He encouraged physiotherapists to take calculated risks and to be confident to say what they know and what they do not know. Taking calculated risks means choosing and knowing about the available research evidence but qualifying the applicability of this research to the individual patient.

The driving forces that inform professional practice models are summarised in Table 4.4 which compares the most important forces that shape a therapist-centred model (technical) and a patient-centred model (practical).

Table 4.4 Driving forces for therapist- and patient-centred models

<table>
<thead>
<tr>
<th>Therapist-centred Practice Model</th>
<th>Patient-centred Practice Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic rationalism</td>
<td>Grassroots democracy</td>
</tr>
<tr>
<td>Eliminating uncertainty</td>
<td>Embracing uncertainty</td>
</tr>
<tr>
<td>Uniformity in treatments</td>
<td>Diversity in treatments</td>
</tr>
<tr>
<td>Evidence-based movement</td>
<td>Practice-based movement</td>
</tr>
<tr>
<td>Empowering clinicians</td>
<td>Empowering patients</td>
</tr>
<tr>
<td>Efficiency (cost benefit)</td>
<td>Effectiveness (patient benefit)</td>
</tr>
<tr>
<td>Determining best treatment option</td>
<td>Identifying choice</td>
</tr>
<tr>
<td>Professional authority</td>
<td>Shared authority</td>
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<tr>
<td>Increasing patients’ coping skill</td>
<td>Increasing patients’ coping skill and increasing patients’ autonomy skills</td>
</tr>
<tr>
<td>There is one single reality</td>
<td>There are multiple realities</td>
</tr>
<tr>
<td>Single practice approach</td>
<td>Multidisciplinary practice approach</td>
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</table>

These driving forces divide the physiotherapy literature into arguing for one practice model or the other. Placing these driving interests into a dichotomous force field as displayed in Table 4.4 may be informative but is not useful for advancing the profession. Physiotherapy clinical practice occurs in the context of practice settings, the disease condition, and therapist-patient professional relationships. The influence of each of the listed forces depends on the
given clinical situation. Placing these interests in a hierarchical order, which automatically values some interests more than others, is not constructive or beneficial for either therapists or patients. Proponents of the evidence-based movement in physiotherapy appear to be reinforcing the view that patient-centred approaches are inferior to therapist-centred ones. Although Herbert et al. (2001) asserted that “the best decisions are made with the patient, not found in journals and books” (p. 203), they still concluded:

Evidence-based practice is, in our view, the best of a number of imperfect models of clinical practice in the sense that it is likely to produce the best outcomes for patients with available resources. Evidence-based practice is imperfect, but necessary (p. 210).

Despite acknowledging that clinical practice models are all imperfect, Herbert et al. (2001) advocated EBP after a search for best practice models. The reasons provided revolved around unbiased estimates of outcomes, professional imperatives, and validity. All these reasons entail an interest in prediction and controlled outcomes. These interests reflect scientist values. The evidence-based movement speaks the language of detachment, objectivity and technical professionalism. Clinical judgment, collaborative decision making and inclusion of patients are only marginally mentioned. There is no doubt that EBP plays a role in physiotherapy practice. It is alarming, however, that although the current EBP literature admits flaws and acknowledges the role of professional judgment and collaborative decision making and goal setting, EBP proponents advocate EBP as the superior model. Inclusion of these patient-centred values as an afterthought exemplifies scientism. This tendency to mention other models but to marginalise them without making professional interests transparent is dangerous, as it confirms physiotherapists’ professional power over patients. Such practice has totalitarian tendencies, in that it advocates decisions and treatments based on one-dimensional knowledge. As Traynor stated, evidence-based practices are “disturbing because of their totalizing ambitions” (2000, p. 155).

Professional practice remains unreflective as long as it does not acknowledge the interests that underpin the epistemology and ontology of different practice models. In clinical practice, physiotherapists need to identify the problem, ask strategic questions to appreciate the patient’s perspective, analyse the problem, and then take thoughtful action to address the patient’s/client’s health care needs. Practice knowledge needs to embrace multiple perspectives in order to ensure appropriate and accountable practice. Physiotherapists have begun to recognise that EBP, with its quantitative values and its aim to generalise, fails to address some important health care questions (Parry 1997). These questions concern, among other things, practice context, patient perspectives, history and ethics. Parry claimed that the physiotherapy profession is ready to explore ways of knowing “beyond the traditional group design” (p. 429). She stated that the physiotherapy profession needs to find a balance between social relevance and scientific validity in practice, and concluded that it is futile to place qualitative and quantitative approaches in dichotomous positions. Physiotherapy should not need to choose between them. She advocated that the profession should see the merit in both approaches rather than perceive one as superior to the other.

There is room for all of us, the positivists and the interpretivists, to collaborate in the search for more complete answers to research questions raised in practice (Parry 1999, p. 432).

What should be the underlying principles to clinical physiotherapy practice? According to the WCPT (2005), physiotherapy

champions the principles that every individual is entitled to highest possible standard of culturally-appropriate health care provided in an atmosphere of trust and respect for human dignity and underpinned by sound clinical reasoning and scientific evidence.

These principles embody a commitment to social relevance and wise practice customised to individual clinical situations at the same time as they commit to standards and scientific evidence. Such principles are informed by practice knowledge that embraces technical, practical and personal practice knowledge.

### 4.2.4 Professional practice knowledge

Practice knowledge can be categorised as comprising (Higgs et al. 2001b, p. 5):

- propositional, theoretical or scientific knowledge
- professional craft knowledge or knowing how to do something
- personal knowledge or knowledge arising from life experiences as a person and in relationship with others.

Each form of knowledge is an important part of professional practice knowledge. Propositional knowledge is derived from empirico-analytical research and theorisation. It is public knowledge because it has been made public and can be tested publicly. Propositional knowledge is based largely on linear cause-and-effect thinking. Propositional knowledge makes generalisations. It is found in textbooks and can be taught didactically. Propositional knowledge is factual and procedural knowledge that is commonly detached from the complexities of
the human world; it is grounded in the rules of the natural world. Non-propositional knowledge is derived from experience. It includes practice-based and personal knowledge.

Personal knowledge is developed from personal life experiences. These experiences enable professionals to appreciate personal needs such as the need for dignity, independence and hope (Richardson 2001). Personal knowledge is accessed through self-reflection; it enables professionals to be engaged with patients rather than detached. Professional craft knowledge is non-propositional knowledge that is acquired through professional practice experiences. It helps practitioners integrate physical needs with patient context factors. Successful integration of propositional and professional craft knowledge leads to expertise (Jensen et al. 1992). Experts use general knowledge and particularise it for diverse patient needs. All these knowledge domains are accessed in practice to make up professional practice knowledge. Although professional practice knowledge comprises all three knowledge domains, it is the propositional knowledge that is perceived as providing highest professional standards. As Higgs et al (2001a, p. 6) stated:

The credibility of the health professions in the eye of the public and body politic may be dependent on their propositional knowledge.

It is this public and political (economic) interest in technical, rational reasoning that favours propositional knowledge and an evidence-based practice approach over a patient-centred approach. Not only public values but also professional culture fosters technical reasoning and professional knowledge based on propositional knowledge (Richardson 2001). However, public interest is shifting, and the voice for patient-centred care is gaining strength, particularly with reference to culturally appropriate treatment, access and equity of services. Consumer focus is shifting from curing to caring, and from technical to practical reasoning. Experts draw from professional craft knowledge more than from propositional knowledge (Boshuizen and Schmidt 2000). The nature of clinical practice lends itself to blurring these three different forms of knowledge (propositional, personal and professional craft knowledge) to build a personalised professional practice knowledge blend.

Discussion in the physiotherapy literature has not prescribed or agreed upon what practice perspective physiotherapy should subscribe to. Such discussion has focused on two main practice models, the therapist-centred and the patient-centred. A third model based on critical social science as a practice perspective has not been considered comprehensively in the physiotherapy literature. This is the topic of the current research project.

4.3 Interpretation of physiotherapy practice models and their interests

In phase 2 of my research I interviewed 11 physiotherapists to inform my interpretation of health care models. Pseudonyms were assigned to preserve anonymity. These interviews provided descriptions of practice and an understanding of the status quo of physiotherapy practice models. Interviews lasted from 15 to 70 minutes depending on the participants’ availability. Framing questions that guided the interviews were the following:

- What kind of physiotherapist are you?
- What kind of physiotherapist do you identify with?
- How do you know what your patients need?
- What are your main practice challenges?

Some participants used the interviews as an opportunity to pause and reflect on their practice whereas others answered the interview questions promptly, and evidently considering practice as a straightforward matter. However, all participants said at some stage that the questions were hard to answer as they had never thought about these aspects of their practice before. This is a general indication that these physiotherapists had not reflected in depth about their practice.

These are things I haven’t given a great deal of thought. You do things automatically without thinking why you do them. (Belinda)
I don’t really ... I haven’t really thought about that, actually, it’s a hard question. You’re making me really think about what I’m doing, aren’t you? It’s great. (Felix)

The interviews responses revealed that physiotherapy practice is complex. For example, participants could not be simply slotted into following one of the three practice models as illustrated in Table 4.2. Participating physiotherapists did not think in terms of practice models and they did not articulate their practice in terms of philosophy and values that underpin their practice. Each physiotherapist had developed his or her practice approach from interpretations of diverse personal and professional experiences. Practice was so much more than knowing (propositional knowledge) and doing (procedural knowledge). For these interviewees, practising was being with patients in relation to themselves as professionals. Focus was on self and less on patients. The interviews did not
strongly reveal aspects of becoming. Part of the reason for this was that the interviews were single interviews that did not trace physiotherapists’ journeys. There was no discussion of future directions or aspirations of professional practice. However, invariably participants discussed how their practice had changed since graduation.

It was evident from the interviews that the abstract practice models of the literature (including the medical model, the patient-centred model, the illness model, the wellness model) were not applied in their pure state in clinical environments. Participants mixed elements from the various practice models of health. None of the participants operated in one practice model alone. The individual practice model of each participant occurred on a continuum and could be thought of ranging from a predominantly traditional to an emancipatory approach, with limited emphasis on the latter. Within this broad continuum are layers of continua, on which practice could be mapped at varying points. This means that a physiotherapist whose practice was located in a traditional illness model might exhibit traits of wellness model practice. Apart from the variations between and within individual practice models, practice models can change over time.

In summary, interviewees in this study could be located within various practice models. However, the reality of clinical practice appeared to blur these models. There were layers within each model. Figure 4.3 illustrates the continuum and the extreme ends of the various practice models.

**Figure 4.3 Practice approaches**

| Unconscious | Known |
| Tacit | Knowing |
| Minimal capacity development | Explicit capacity development |
| Detached from self | Being self |
| Safe replication | Calculated risk |
| Single perspective | Multiple perspectives |
| Telling | Listening and responding |

These affiliations were identified by analysing the practice values that informed the participants’ practice, and how aware and critical they were of their practice. The degree of self awareness and critique (as portrayed below) became transparent through their descriptions and interpretations of their understanding of professional role, clinician power, professional practice knowledge, professional relations (including physiotherapists as educators).
and how they saw themselves as patient advocates. One theme that pervaded was professional power. For this reason there is no heading dedicated to professional power but it is mentioned in all the headings.

4.3.1 Understanding of their professional role
The way physiotherapists described how they practised provided insights into their understanding of their professional role. Their role understanding was closely linked to their clinical reasoning, their practice context, their professional relationships with others, professional power, their practice knowledge and how they defined physiotherapy health problems (see Figure 4.5).

Figure 4.5 Aspects of practice that shape understanding of being a physiotherapist

![Diagram showing aspects of practice that shape understanding of being a physiotherapist]

All the physiotherapists worked with clinical reasoning, in practice contexts, had professional relations, drew from their practice knowledge and had a working definition of what constitutes a physiotherapy health problem. Each of these aspects of practice can be shaped, understood and applied differently. The justifications for their way of practising illuminated their frames of reference. At first superficial glance practice appeared to be uniform. All interviewees described their professional task as broadly following the path of taking a history, planning and evaluating treatments, and improving the patient’s wellbeing. Belinda succinctly summarised the sequential operations of her physiotherapy practice:

> You look at their [patients’] past history, you look at their deficiencies and just plan to correct those deficiencies, if it’s possible. I find that a bit straightforward. You see what you see and see what is needed and just react to that. (Belinda)

When asked what kind of physiotherapist they were, interviewees described themselves (broadly) as caring, helping, realistic and practical. However, when they were asked to describe and explain their understanding of being caring, helping, realistic and practical in more detail, some diverse values and purposes of practice emerged. These values or self-understandings influenced how their professional identity was viewed, how their professional power was used, what type of professional relations they used and how they worked within their practice context. When asked how she knew what care her patients needed, Hilda replied:

> I look at how much oxygen they’re on, listen to their chest, and you know, all those sorts of things. [after further probing questions] I do my own assessment by asking patients. I think they normally quite like it when you are asking them. (Hilda)
Hilda mentioned the propositional and professional craft knowledge she used to identify and analyse a problem. When she described how she would integrate these two forms of knowledge to decide on therapeutic action it became apparent that she favoured being guided by propositional knowledge. When Hilda was asked to describe how she negotiated with patients who did not want to comply with her treatment, she replied:

> You have to just keep talking to them and just keep explaining and by telling them what bad things are going to happen, which isn't a very nice thing to do, but, if they're still not complying then you just, I mean, you can't treat them. (Hilda)

Patients’ needs were equated with a need to bring abnormal medical symptoms back as close to normal as possible. Although she would ask patients how they felt and what they thought they needed, Hilda would use technical, clinical findings to determine which treatment approach was appropriate. There appeared to be little incorporation of patient perspectives into her needs assessment and treatment plans. Hilda worked in an acute respiratory setting. In acute life-threatening situations her practice identity was reduced to the scientific technical expert with a therapist-centred duty-of-care approach.

Adele, a first-year graduate physiotherapist, displayed a more holistic view to needs assessment:

> As a physiotherapist although you are treating a condition you are also treating the patient. In physiotherapy there are very few areas where you are solely treating the condition. (Adele)

Adele could not provide practice examples. She had only 6 months of practice experience but she had the assumption that practice included the patient to some extent. There was a sense that she had not yet become the practitioner she described. Others were more passionate about their positions.

All interviewees claimed that it was important to listen to patients and they stated that they were somewhat patient-centred. However, in practice when experiencing interest clashes they reinforced their therapist-centred approach on the basis of technical interests. Felix, who had 9 years of clinical experience, displayed ownership and strong conviction of his professional identity. He stated that patients needed to participate but when he talked about his practice it became evident that he did not foster patient participation. During the interview he started to examine his convictions and became aware of what they were and what influenced them.

You try to get the patient involved as much as possible, definitely. Explain to them the possible strategies that are involved. And, of course, then you ask them are they okay with, are they willing to go through with all that, you know, be it some form of manual treatment, some form of exercise. You tell them how long you expect them to be coming for, so you ask them are they willing to put up with that, are they going to participate in the treatment exercises and so on. So, in that way, do you think that means they're participating? Do you think that's actually getting them actively involved? It's not really, is it? Not really, now that I'm thinking more about it. It's almost like you're telling them what to do, really, aren't you? But you're informing them about what you're doing, though … I thought I was trying to get them involved by informing them as much as possible. That's all. That's the way I can do it. I don't actually tell them, okay, what do you think we should do about this, and get them to sort of come up with it. (Felix)

Felix first portrayed himself as a patient-including physiotherapist, but he noticed that he was not really engaging patients in the decision-making process. His professional relations emphasised his professional status and claiming professional power over patients. Physiotherapists necessarily need patients to at least cooperate, especially for exercise therapy. There is a difference between patient participation as a result of egalitarian negotiations with hermeneutic reasoning compared with patient participation arising from imposition based on the therapist’s technical reasoning. The difference lies in the interest and motivation that guides communication between the therapist and patient. Communication can be influenced by how the therapist’s interests dominate or liberate patients (as well as the influence of patient interests on their own behaviour). Felix’s interest was to dominate. Figure 4.6 illustrates the different therapist interests that frame and influence the type of patient participation that occurs in communication. When one observes treatment it may appear that physiotherapists and patients are working together in a democratic communicative manner. However, the interests behind such cooperation remain
invisible. Patients may cooperate because they are conditioned into complying unconditionally with professional advice. The influence of professional power, hidden interests and negotiation skills potentially remains invisible.

Figure 4.6  Interest in participation

Felix started to become aware of this difference during the interview. The difference might not be readily visible, since in both approaches patients can be active participants. It may become apparent in the longer time frame: when patients do not return, when patients have not adhered to self-exercising, e.g. home exercise programs. Felix stated that he preferred it when patients engaged in active exercise treatments. He was mainly concerned with his rationale for active exercise than with patient resistance to active exercises:

It could be the way we're taught [at university], but it makes more sense and the research in this sort of treatment approach … I mean, there's actually research findings there. I much prefer to use exercise and those kind of things as a treatment, but sometimes I may use the more passive treatments to make them feel better and encourage them to do their exercise and hopefully they feel better about doing their exercise. So you try and manipulate that
way a little bit, but... the exercise treatment is self-management. The more active treatment is the main part of treatment. (Felix)

Felix argued his preference for active exercise treatment with scientific evidence from the research literature. He wanted to make patients more independent by prescribing active exercises despite the fact that he knew that most patients preferred passive physiotherapy interventions. He excluded patients’ reasoning. He was convinced of his practice approach to the extent that he did not mind it when patients did not return for more treatment:

Yeah, some can be very unhappy. I've had patients walk out on me because I don't put my hands on them. I feel bad [about that]. Maybe I didn't explain it well enough. But, then, sometimes I sit down and think about it. I think I did my best, it's their bad luck if they didn't really want to try out that option. (Felix)

Felix had strong convictions and ideals and was remaining true to them. He was knowingly pursuing his preferred strategy of active exercise treatment. Although Felix used other treatment options to please his patients he labelled doing so “manipulation”. Pleasing patients was a nuisance because he did not believe in other treatment options and saw them only as a way of persuading patients to then comply with his treatment plans. In his view his treatment plans were the right ones. Herein lies a fundamental contradiction: he described exercises as promoting independence but in reality his expectation of them being performed was actually prescriptive and a form of dependence on his power and control. Felix displayed pure instrumental, technical values that underpinned his understanding of his professional role and power. Felix critiqued patients’ beliefs but he did not critique his own beliefs. When he was asked how he built trust with his patients he said he would tell and explain patients exactly what was going on in order to gain their confidence.

Even if they [patients] don't get better, they really appreciate knowing exactly what's going on. So even though they don't completely get rid of their pain, they'll appreciate knowing exactly what's going on. Sometimes, you know, not bragging or anything like that, but sometimes people say [that] they've been to so many doctors or specialists or whatever and this is the first time someone's ever actually explained to them what's going on. And they feel so much better about it, what to do and of course they're going to cooperate with their treatment when they know exactly what's going on. (Felix)

Patients who shared Felix’s interests became empowered to comply and do the active exercises independently. Such patient empowerment is built on therapist-centred interests and goals. Patients who do not share these interests do not feel empowered. In the previous quote Felix said that patients had walked out on him and in the latter quote he stated that patients were grateful simply to hear explanations. Felix was driven by technical interest. He expected his patients to adopt his interests and work with him or leave. Felix’s values were non-negotiable. Being flexible and “giving-in” to patients was perceived as unprofessional or at least manipulative.

Belinda, a physiotherapist with more than 20 years experience, had similar convictions. At first glance she appeared to be patient-centred. She understood physiotherapy as a service where patients were clients. She considered that clients come first and the physiotherapist is there to help them:

I think you have to remember that the person is a client, you are there for their benefit. They're not there for ours. And while you have certain aims, you have to take into consideration what they're aiming to do and what they're going back to in their personal life. And you just work as hard as you can or make them work as hard as they can, to get where you want, or where they want to go. So, it's a mutual thing, I think, and quite often physiotherapists will want exactly the same as their clients want. (Belinda)

When patients share the same aims then physiotherapists appear to work mutually with patients. Mutuality did not work for Belinda when there were clashes in aims and interests between therapist and patient. Belinda stated that she would not work mutually on a power-sharing basis with patients who had different ideas about treatment.

I can say that many patients want to take some control, like they're quite happy to be advised, but they don't want to feel as though they're being ordered to do something. They want to do their own thing, but they're quite happy to be advised how to do it. I usually say do this, do that. And if they are not happy about that then we'll find out why. ... I think I'm
not very (pause) pushy, really. I will accept other people's opinions. I am in control of the steering wheel. But they can put in their suggestions, as far as I'm concerned. I don't like them doing their own thing. And they don't usually. If it [patient's input to treatment plan] is logical and if it is proper for their problem, yes, I would allow a bit of scope [for patients to make decisions] but not a lot, I must say. (Belinda)

Belinda practised within a therapist-value framework that claimed decision making authority predominantly for the professional. Belinda did not challenge her interpretations of practice. She decided what counted as logical and proper. Belinda had a service to offer and patients could take it or leave it. A customer service approach to clinical practice does not easily fit the notion of caring, and working and learning together. Customers are people who know what they want, they know where to find it, they know who can provide it and they have the money to buy it. A customer framework reduces health to a commodity. People who are sick are not customers. Leaving practice approaches unreflected reinforces the status quo of practice. Non-reflection and unwillingness to allow for flexibility and diversity can unintentionally reinforce professional dominance. This quality of uncritical and taken-for-granted assumptions also became apparent when Belinda was asked how she made professional judgments:

I don't know. I think it comes with experience to a certain extent. Often you don't even realise you're making them. (Belinda)

Awareness of professional power use does not ensure that power is not misused, but it might be the first step to reduce its misuse. The following quote is an example of how challenging practice assumptions and reflecting on experiences can emancipate a physiotherapist's frame of reference from unnecessary, unreflected and often unintentional professional domination to bring about clinician liberation and consequently patient liberation:

The penny dropped for me only after 10 years of clinical experience. I had [a patient with] an above-knee amputation and he had a prosthesis. He walked perfectly in the gym. I had him walk without a limp. I was really pleased with all this. Then I met him downtown in the shopping centre: he had his knee locked, he was walking on the inner quarter of his foot, foot stuck out at right angle and he was perfectly happy. I stood and looked at him and thought "I can make you walk perfectly without a limp but you don't want to do that". And you know when he came to treatment he would do it but obviously he wasn't feeling safe and he didn't want to do it that way and that is that. I think I wanted him to do what I wanted. I was trying to be a perfectionist. And it has also to do with all the other physiotherapists. They are checking on you that you are doing it all properly. (Jill)

Seeing her patient mobilising in a “non-ideal” way but with confidence and seeing him integrated into a social community life made Jill start to question her goal-setting practices and her professional interests. Why should she make patients walk without a limp if all they wanted was to walk safely? Jill became aware of clashes between professional and patient goals. She was aware of peer expectations and she felt pressured to comply with the professional physiotherapy culture that she described as follows:

Finish people quickly and have them better and not bounce back for more treatment. Otherwise they may think what physio is that, she isn't doing it properly. There is a lot of pressure. I am part of that but I try not to be too much part of it, but I acknowledge it. (Jill)

Jill was aware that her practice identity was shaped by multi-dimensional influences. She acknowledged that her clinical area, working in the community, had strongly influenced her practice identity. Jill accepted the mainstream physiotherapy culture but at times distinguished herself from it. She portrayed the dominant physiotherapy culture with critique and awareness rather than with acceptance.

Dara was aware that patients and clinicians did not necessarily share the same goals. She would adapt her goals or involve the clinical team in deciding on how to work with patient clashes.

If I've got hugely different goals to the patient, I have to change my goals. I can't make a patient do something. You can reason with them, give them all the information, and if it’s that different, you obviously need to get the team involved, explain the huge difference, whether there's going to be other interventions, like rehabilitation or if other options are going to be suitable. (Dara)
It is laudable to include the team, as one could assume a team would provide multiple perspectives on value clashes. Conflict may be better reconciled by including the multidisciplinary team than by interpersonal professional relationships. However, one needs to be aware that multidisciplinary teams may not offer a diverse perspective or effectively moderate conflict between a health care professional and patient. The team may reinforce the professional’s perspective and place patients in even less powerful situations. One cannot make assumptions about the way multidisciplinary teams operate; one needs to be skeptical and ask: How are team decisions reached? Are they democratic and in the patients’ best interests from a patient perspective or in a patients’ best interests from a medical rational perspective? Teams may be used to drive technical rather than emancipatory values. Dara was aware of physiotherapy norms and the value of being a specialist physiotherapist rather than a generalist physiotherapist who rotates from ward to ward. Dara had more than 5 years of clinical experience. However, she saw her strength in her life experiences and her general people skills and chose to remain unspecialised.

I think I have got a lot of general skills, but more with people than technical skills. But I think I’m a good physiotherapist because I’ve got a lot of different types of skills. I think you could be as specialised and as knowledgeable as someone with a PhD, but if you don’t have good people skills as a physiotherapist you can’t liaise with the nurse and the doctor and then it doesn’t necessarily make you a good physiotherapist. (Dara)

Dara saw one of her professional attributes as being a good communicator. She saw more value in applied knowledge and skills than in specialised, fragmented knowledge that did not address people skills. Less specialised propositional, technical knowledge led her to claim less professional power.

4.3.2 Professional practice knowledge
Physiotherapists who identified strongly with a therapist-centred approach to identifying and analysing problems had developed a professional practice knowledge base that favoured propositional knowledge. These physiotherapists tended to marginalise their personal knowledge and focus on developing their clinical procedural knowledge. Practice knowledge was based on procedural skills, and craft knowledge and skills were less valued. Belinda described her development of professional practice knowledge as depending on procedural clinical learning:

Obviously the more you can learn from post-graduate studies and what have you, that is all very fine, but I think you have to build up a personalised [practice model] and quite often you don’t realise you are using it. I learnt something two months ago at a conference and wanted to see if it worked [in practice for me]. You have to have the experience of the knowledge.

(Belinda)

But when she was asked what made up her professional practice knowledge she said:

It might even be technical 70%, intuitive 30%. I do think intuitive knowledge is very helpful.

(Belinda)

Belinda valued technical propositional knowledge (70%) more than clinical knowledge (30%). She did not explain intuitive knowledge further and why she thought it was helpful. Parts of her professional practice knowledge remained inaccessible to her.

Erika stressed the importance of transforming propositional knowledge and placing it in clinical perspective. She valued her clinical knowledge more than her technical knowledge.

When you come out of university you know nothing (laughs). So much of it (practice knowledge) comes with experience. It (clinical experience) puts your knowledge in context, in perspective. You have no perspective of what your knowledge means when you come out of university. You’ve got it there, in fact, I probably had more of it, to a certain extent, then, but you don’t know what it means in the context of seeing a patient over a period of time.

(Erika)

Treatment progression, individualising treatments, understanding and making sense of technical knowledge in clinical settings was how participants described the difference between the professional practice knowledge of beginning and experienced physiotherapists.
When I first graduated from university, my first rotation was in outpatients. And I thought that I could do all my techniques adequately and I was confident, I’d passed my student unit and I look back now and I think how on earth did anybody ever got better (laughs). I didn’t have much understanding of progressing treatments and individualising treatments and I think that’s sort of grown. Also, I think, just over time I had an understanding of, I think, what works best for particular presentations, maybe or how to modify the way I do that treatment depending on the patient’s response to the initial treatment. That’s all become more refined, rather than recipe like. It’s become individualised. And I’m still doing that. I mean, I’m still evolving and learning to change those things now. (Christine)

Christine described her professional journey and how it was still growing and developing. She was aware of diverse needs and presentations and felt she had the capacity to act on them and transform her practice.

Jill was the only one who discussed the issues of EBP for clinicians. She explained the difficulties she had with applying EBP:

The more you read RCTs, the more you see what hasn’t been done. And you look and you say “oh no that is not applicable. Why haven’t they asked other questions? Why have they done this intervention?” There was a trial with hip protectors. Someone came and encouraged people to wear them. The study found that hip protectors gave people more security. They didn’t say that the fact that someone came around and encouraged them had any effect. Maybe I am just too critical but many of the controlled trials are flawed. But it is really good as a complement and it provides you with a much bigger picture. (Jill)

Jill critically appraised EBP. She found that RCTs addressed different types of questions from the ones she was posing in her practice. She was skeptical about the generalized knowledge produced. Jill reinterpreted evidence-based knowledge for her individual clinical cases. Erika also displayed a strong interest in a practical approach to practice knowledge. She felt that clinical experiences put knowledge into context.

Felix acknowledged that EBP did not comprise all of professional practice knowledge and he conceded that clinicians operated with professional craft and personal knowledge.

There’s a lot of emphasis on evidence-based practice and clinical effectiveness, even though something [treatment intervention] is not evidence based. A lot of treatments are sort of what the general feeling is about a particular condition and treatment, you tend to go with that. I know this [practice knowledge] just through clinical experience. Unfortunately, not everything can be proven by randomised control trials, you know. So sometimes there are particular forms of treatment that you know work best for a patient but they may not be proven to be clinically effective in a randomised controlled trial. (Felix)

Even Felix, who aspired to the predictable, technical approaches to practice, conceded that practice knowledge did include professional craft knowledge. Nevertheless, Felix valued developing his technical propositional knowledge more than any other aspects of practice knowledge.

A new dimension to professional practice knowledge that was only touched on with these participants was developing knowledge of patients’ body awareness to expand the traditional pain scale approach to working with patients’ body awareness. Acknowledging, appreciating and working with patients’ body awareness could guide physiotherapists in how to work with patients in partnership. Incorporating body awareness needs a clinician-patient environment that makes patients feel safe getting in touch with their body so that they can provide true feedback about how the prescribed exercises are working for them.

It is of interest to note that only Jill described using patients’ body knowledge, body awareness and their actual biofeedback to exercises. She would prepare patients for what a treatment would feel like before she performed it. This is good practice to help patients anticipate body sensations, especially when they involve painful procedures such as suctioning or muscle stretching. However, telling patients what it will feel like might silence their feedback if they felt something else, perhaps in part out of a desire to please their therapist.
Ingrid discussed body awareness, but from an angle that it tells patients themselves what they should be doing without using the patient’s biofeedback to determine the need for exercising:

I don’t know if I let them explore it [body awareness], but I know that when I go to patients and I start doing the exercises, the first thing they’ll say to me is, “is it [the muscle] tight?”. So, they’re asking me have I been doing the right thing. Or I’ll say to them, “did you do your exercises?” and they’ll say “no” and I say “I assumed that because your hands are really tight”, or something like that, so that they understand why they need to do it [stretching exercises]. (Ingrid)

Ingrid reported that patients would ask her if their muscles were tight. This suggested that patients were not in touch with their body because they did not judge tightness of their muscles themselves. Alienating patients from their body fosters dependence on physiotherapists. Bringing patients in touch with their body sensations may foster deeper physical understanding of the rationale behind exercising, in that knowing would result from doing and feeling.

4.3.3 Professional relations

The way physiotherapists define themselves as professionals impacts on their professional relations. Physiotherapists who view themselves as technical experts may be more authoritarian than emancipation-oriented physiotherapists. However, there are many layers within any approach, including that of the technical expert physiotherapist. Empathy, the role of advocacy and teaching, as well as patients’ age and ethnicity, played an important part in the way the physiotherapist participants conducted professional relations. Belinda would listen to her patients and appreciate their age, family background and other social factors, but when it came to doing the treatment she expected the same compliance from all her patients. Novice physiotherapists may engage in very different types of professional relations due to their lack of clinical experience compared with their more senior colleagues. Novices may be more likely to share power with patients, feeling less authoritarian because of their undeveloped professional craft knowledge. There are various influences that shape professional relations.

Professional relations include physiotherapist-patient, physiotherapist-colleague, physiotherapist-clinical staff. Dara placed considerable emphasis on her life experiences, saying she drew from them in her professional relations with others. She related to others the way she wanted to be treated by them. She had the capacity to appreciate what it might be like being a patient and adjusted her practice accordingly:

I’d know what I’d feel like if I was lying in bed and someone just came in and made me get up and I wouldn’t do it. I just sort of look how I’d want to be treated. (Dara)

When I suggested she could give an in-service on her practice philosophy to her colleagues she was quick to decline, pointing out that she respected other physiotherapists’ approaches and that she identified as a mainstream physiotherapist. Although she categorised herself as someone who would share power and be flexible she stated that she could be assertive:

I can be very assertive with doctors and teams if I want something for a patient and I will fight for them. (Dara)

Dara chose to use her professional power when she deemed it appropriate. She would not treat all patients the same way and she would not allow patients to abuse her power-sharing attitude:

I’m very much an advocate, but there might be tough patients, you know, different ethnic groups, who will treat you slightly more “do this, do that”. I’m quite happy to say “your arms aren’t broken, you get the phone, you get your [blanket]”. (Dara)

Dara’s professional relations were not uniform; they depended on her understanding of what was appropriate behaviour. She assessed clinical situations from her professional perspective and made use of her professional power and advocacy as she saw fit. Although Dara tried to think from a patient perspective, she might not have anticipated what it would be like to get the phone or blanket herself.

In terms of patient trust, Belinda was aware that patient groups differed in trust characteristics, such as older patients and ethnic patients. The former were more trusting, the latter less so.
I think this [older] generation of people see anybody in medicine or allied health as knowing everything. I think probably the people in their 20s and 30s are far more critical and are far more likely to question what you do. (Belinda)

The way physiotherapists educated patients and the way they saw their role as patient educators also shed light on their professional relations. Christine took her professional role to educate her patients in hand therapy seriously. She wanted her patients to understand her treatment rationale. She would try different strategies to teach her patients:

I use anatomical models and pictures and also make analogies, I’ll ask the patient to repeat back to me what their understanding of it is. Particularly with some sort of post-operative guidelines that are quite complex and there’s a lot required of the patients. And I’ll give them written exercises with pictures and some other guidelines as well, to try and - well, from my point of view, to try and improve their compliance, but also from their point of view, to increase their understanding of the reason that they’re doing this physiotherapy program. (Christine)

Christine used different teaching strategies to help patients learn. Analogies, models and pictures are creative, learner-centred approaches. Her aim was to help patients understand the physiotherapist’s rationale for treatment. She was not attempting to work with the patients’ understanding. Christine thought along the lines of compliance and getting patients to understand physiotherapy thinking. She did not describe using patient cues to help them learn. Although well-intended, her professional relationships with patients were therapist-centred.

Ingrid, who worked in an acute medical ward, was the same type of patient educator.

I suppose I try and teach them what is good for them. So, I suppose, in a way, I’m a teacher, and I try to get them to see what’s important for them and how things have changed. And, they ask me questions as if to say, “why is this important?” (Ingrid)

Her patient education strategy resembled that of a didactic yet benevolent teacher. Ingrid knew what was good for patients and what they needed to know, from a therapist perspective. She made assumptions about what was important for patients based on her own rather than patients’ values.

Someone [a patient] said to me “I look forward to doing physiotherapy each day because it takes my mind off [my injury], and it’s one of the only things in here that you look forward to doing, because it takes your mind off other things”. So, I could be a diversional therapist, I suppose (laughs). (Ingrid)

The tone of Ingrid’s voice and her laugh gave the impression that being seen as a diversional therapist by this patient was disempowering for her professional practice identity. She valued her professional role as technical educator more than her role as a professional patient companion. Ingrid provided a second example of a patient’s gratitude for her social skills:

When this patient left [the ward], he said to me, “well, thanks for treating me, you know” and I said, “I didn’t really do that much”. He wasn’t a patient that was in here for me, he was in here for medical reasons, other than what I could do for him. And I said “I just came along and chatted to you basically everyday” and he said “yeah, thanks for that”. (Ingrid)

These different ways of relating to patients, either as a detached expert teacher or an engaging professional friend, and not wanting to be perceived as a diversional therapist but fulfilling a social need for patients, constituted a contradictory and challenging situation for Ingrid. Therapy takes many forms, including direct intervention, scientific procedures, description of options, listening to patients. In this quote Ingrid did not recognise that they are all parts of therapy. Ingrid was not aware of the advantages of her ability to relate well with patients when educating them.

In contrast to Ingrid, Jill used her ability to relate to patients as a tool to help patients learn:

Actually I did something the other day what I had never done before. He [the patient] had a faulty pacemaker and he was sitting at home waiting to die. He would not let his wife go out
to the washing line unless there was a neighbour staying with him. He was worried about his slow pulse. I felt it and couldn't find anything wrong with it. So I asked him would you feel mine? And mine was much faster than his. That was the first time I said to someone would you feel my pulse and I feel yours. It's made a breakthrough with him. He is now walking 1km. He wouldn't walk to the shops. But he did it the other day with a lot of satisfaction to himself. To feel my pulse was the thing that convinced him. I know it is not professional and I do want to be seen as a professional. (Jill)

Jill understood that her patient had a mental block about his cardiac situation. She intuitively knew that rational reasoning would not help this patient learn. She took a calculated risk by allowing him to feel her pulse. This patient learned emotionally through feeling. Although Jill had developed, applied and was consciously and successfully using her professional craft knowledge she still felt that it was not professional. Jill was struggling with what should be and what actually was constitutive of her professional practice knowledge. She was using her creativity to help patients make sense of their problems. Others used their creativity to help patients comply and understand how physiotherapists saw the problem.

In summary, participants initially stated that they valued technical knowledge that enabled them to effectively treat symptoms. During the interviews, however, they asserted that they were treating people and not symptoms. Some stated that they knew nothing upon graduating from university, and that clinical experience had taught them the knowledge they now applied. Some participants were creative in their patient education practice whereas other followed classic behaviourist approaches to patient education. Within each approach to patient education distinctions were identified: for instance there was a difference in creative patient education. Ingrid was creative by using models, diagrams and analogies to help her patients learn. Her creativity aimed to help patients understand the therapist’s perspective. Jill was creative by identifying what her cardiac patient needed to learn (feeling someone else’s pulse). Her creativity was applied to liberate patients from fears and other individual assumptions.

Although all participants were aware of social and personal factors that influenced practice they fell short of using such knowledge as an asset to build capacity in their patients. Social and personal factors were interpreted as a barrier to pure treatment and smooth professional relations. Participants’ use of professional power was predominantly justified with technical, instrumental reasoning. Professional authority appeared in most cases as a taken-for-granted fact. There were few signs of skepticism of their practice. These physiotherapists had not really emancipated themselves from technical interest driven practice. It appeared that most of them saw no need to transform their practice.

### 4.4 Critique of practice models

This chapter concludes with a critique of current physiotherapy models, drawing together information from the literature and the nature of clinical physiotherapy practice. Current in the field literature is predominantly influenced by the evidence-based movement and natural science. My goal was to bring that together with an exploratory study with a number of physiotherapists. Since the focus of this research was on exploring critical social science, this early phase was intended to provide a background to this exploration by broadly mapping the status quo of physiotherapy practice. A detailed investigation of the current status quo was beyond the scope of this research.

There is a dearth of physiotherapy literature that makes professional ideology and reflexivity explicit. Various ideologies are put forward but there is little reflexive discussion about how ideologies compare and how they could inform a more mature physiotherapy profession. It is important to be aware of the strong influence of theories and “facts” upon the physiotherapy profession’s values and interests. Physiotherapy goals and directions are driven by specific interests which influence theory, education, professional practice and knowledge development. Often these interests are not made explicit and remain hidden (Skelton 1998).

Physiotherapists in the first group were able to describe their practice. They provided examples of how they put their clinical reasoning into practice. The extent to which these interviewees challenged their own practice and questioned themselves was minimal. Some participants were more convinced and set in their ways of practising than others. There was little evidence that participants incorporated themselves in their practice. Rather, they saw themselves as professionally detached from the clinical situation. Their focus was on the patients and the physical symptoms, and was largely exclusive of self. Only Dara talked about her past professional life and how it influenced the way she practised. Although participants talked about older patients or ethnic patients they did not talk about how they saw older people or ethnic people.

Three practice models emerged from the portrayal of the status quo of physiotherapy practice. Practice Model 1 presents pure instrumental reasoning, Practice Model 2 practical-instrumental reasoning and Practice Model 3
critical-social reasoning, as illustrated in Table 4.5. Practice challenges to clinical reasoning as perceived by participants of the first group are displayed on a continuum of practice models in Table 4.5. Participants in the first group could not be simply allocated to one of the three models. Table 4.5 uses participants’ quotes to exemplify each model only. Most participants moved between Models 1 and 2, as discussed below.

Table 4.5 Practice challenges of clinical reasoning as perceived by participants on a continuum of practice models

<table>
<thead>
<tr>
<th>Practice Model 1: Pure instrumental reasoning</th>
<th>Practice Model 2: Practical-instrumental reasoning</th>
<th>Practice Model 3: Social-critical reasoning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Try to get competent in all the areas and know everything (Hilda)</td>
<td>Develop good clinician-patient relationships so that best possible quality of care can be delivered (Felix)</td>
<td>Work with the public and their expectations of physiotherapy (Jill)</td>
</tr>
<tr>
<td>Get it right without having x-ray vision (Erika)</td>
<td>Work on a ward as the sole physiotherapist (Ingrid)</td>
<td></td>
</tr>
<tr>
<td>Get people to do what you want or what you think is good for them (Greta)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Practice Model 1 was exemplified by three interviewees, Hilda, Erika and Greta, who were searching for a best practice model. They strongly identified with an exclusively instrumental reasoning approach to physiotherapy practice. Instrumental reasoning challenges are framed within technological rationality that aims for a totalitarian uniform practice model which assumes that one can master all knowledge and that professionals know best what patients need. Patients are expected to be passive recipients. There was uncritical acceptance and very little challenge of current situations and no interest in change.

Physiotherapists stated that they needed to apply propositional knowledge in practice and they would only adopt new knowledge if they could understand it in their practice. Their way of understanding and reasoning was influenced by professional values. Most values were located in quantifiable, technical interests. Ingrid did not value patients thanking her for her social interactions. Had patients thanked her for her technical physiotherapy interventions Ingrid would have appreciated that more. Evaluation of professional practice was predominantly based on therapist values. Patient values were mentioned but were not as highly regarded.

The way physiotherapists reasoned about their practice could not be described as self-owned practice. Belinda, for instance, was not aware of the contradictions in her comments regarding practice knowledge. She stated that she included patients’ background in her treatment but at the same time she always remained in control of the treatments. Even if Belinda became conscious of the diverse layers of practice knowledge she would revert to scientific knowledge. She stated that her practice knowledge was predominantly scientific knowledge rather than professional craft knowledge.

Practice Model 2, a more practical layer of instrumental reasoning, was exemplified by Felix and Ingrid. They saw a necessity to involve patients but their instrumental reasoning prevailed over practical reasoning. Physiotherapists reported about patients’ conditions but very rarely discussed why they were like this. This limited recognition of patients as complex human beings within physiotherapy decision making and intervention reflects a tendency to favour therapist-centred practice models. There was little evidence to suggest the therapists had significant capacity to respect patients’ perspectives let alone empower patients. Practice Model 2 raised the issue of patients’ perspectives but kept it firmly within a biomedical framework.

In this study the health care system seemed to reinforce a traditional practice model based on technical interests. Physiotherapists claimed that they had not sufficient time to work with diversity in patients. Patients needed to comply because there was not time to negotiate. Treatments had to be reduced to the basics. Developing professional relationships with patients was increasingly difficult due to their reduced length of stay in hospitals. Greta accepted the fact that there were not sufficient numbers of walking frames in the geriatric ward. She did not have capacity to question and address this issue with management. By her accepting rather than challenging the status quo the walking frame situation did not improve. Patients remained immobile.

Practice Model 3 was exemplified by only one participant, Jill, who focused on patient issues. Jill appeared to have developed a practice model based on critique and transformation. She described clinical situations where she took risks because she was embracing uncertainty. This approach had transformed her practice, but she still held on to traditional professional values although she critically assessed them. She was critical of and concerned about public
perceptions of physiotherapy. She stated that these public expectations forced physiotherapists to work within those perceptions and expectations. She felt she had little power to influence those expectations.

All 11 participants of this research phase had not heard of the term “critical social science” and did not use its jargon terms such as oppression, critique, critical self-reflection, transformation and emancipation. These physiotherapists could be called the uninformed group. Although Practice Model 3 had the closest resemblance to a CSS framework, Jill, who embodied that model, was uninformed about CSS.

In the current global health care climate, practice reasoning is commonly more dominated by instrumental than by critical reasoning. Schroyer (1973) reminded us that this is not surprising when the global trend is towards instrumental, technical reasoning. In the opening chapter of his book entitled The need for critical theory Schroyer claimed

> We are wedded to an instrumental concept of reason whose one-sidedness blocks our capacity to recognize the sociocultural significance of our acts and lowers our ability to act intelligently in novel situations (p. 21).

The status quo of physiotherapy as explored in this chapter confirms Schroyer’s assertion from over 30 years ago. The trend in health care is with the empirico-analytical paradigm that endorses evidence-based practice as the gold standard for health care practice including physiotherapy practice.
Chapter 5

TRIALLING CSS PRACTICE MODELS: TEXT 3

It [the trialling phase] has been really good for me because it’s sort of started me on the road to thinking. The interesting thing is it [CSS] actually goes beyond practice. It’s a part of your life skills too. (Corinne)

In this chapter I discuss the interpretation of the third text, trialling CSS. This chapter traces the journeys of the trialling group members from the pre-implementation workshop, where they critiqued findings from Phase 2 and determined their action plans, to the appraisal workshop where they reflected on their journeys.

The methodology of construction of the third text was described in section 2.5.4. It comprised the action learning phase of this research. In sequential order, the third text construction consisted of a pre-implementation workshop, the development of action plans, a series of in-depth interviews, and an appraisal workshop. Field notes complemented the text construction. Participants in this cycle were invited to explore alternative ways of thinking and approaching physiotherapy practice. Nine physiotherapists participated in the third text construction and their demographic backgrounds were detailed in Table 2.1a,b,c as participants of text three activities.

This chapter analyses the focus and outcomes of the participants’ action plans. Participants’ experiences of trialling CSS are critically interpreted. The interpretations are guided by the five CSS dimensions recognised in section 2.9. Diverse journeys of trialling a CSS approach to practice are identified and summarised by portraying them as three prototypical narratives. A critical appraisal of CSS by the trialling group completes the trialling phase. The chapter concludes with reflections on my journey of trialling CSS.

5.1 Critical reflection on current status of physiotherapy practice

The first objective of the pre-implementation workshop was for the participants to reflect on the status quo (i.e. their understandings of physiotherapy practice in general and their own practice in particular) and current influences on practice.

In this third research phase (see Section 2.5.4 Phase 3 – Constructing the third text: Trialling CSS), focus shifted from descriptions of practice to critique of practice and exploration of CSS as a practice model within the real life of practising physiotherapists. At the workshop that commenced this phase I presented findings from Phase 2 for two reasons:

1. to extend and critique the portrayal of status quo of physiotherapy practice that I had developed. The process of presenting my interpretations of the current status quo of physiotherapy practice to this second group of participants enabled them to critique and respond to this portrayal rather than, as with the first group, describing their practice and raising their awareness only.
2. to form a launching pad to help them become aware of practice and personal interests and to explore alternative ways of thinking for their practice.

The initial interpretations were presented as three themes: professional identity, professional power and clinician-patient relationships. The second group, which consisted of new participants, were asked to discuss my critique of current practices of the 11 Phase 1 interviewees. Their critique of my portrayal of the status quo of physiotherapy focused on putting the themes into context. They added more patient-centred dimensions and were critical of the more therapist-oriented instrumental reasoning displayed by the first participants. Table 5.1 illustrates the initial elements under each of the three themes. The first theme was professional identity and the key question addressed was “What does it mean to be a physiotherapist?”; the second theme was professional power and the key question was “How do physiotherapists gain trust of their patients?; the third theme was clinician-patient relationships and the key question was “How well do physiotherapists know their patients?” The elements that were added by the new participants are displayed in the group 2 responses in Table 5.1.

5 Capacity for critical self-reflection, redefining professional practice identity, democratising professional relations, rethinking rationality and values, and rethinking practice context
6 please refer to Appendix 2 for the complete teaching plan for this workshop
Table 5.1  Portraying the status quo of physiotherapy practice by participants in the trialling phase

<table>
<thead>
<tr>
<th>Themes</th>
<th>Group 1 Responses</th>
<th>Group 2 Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional identity</strong></td>
<td>To be realistic</td>
<td>To focus on function, e.g. help patients walk</td>
</tr>
<tr>
<td></td>
<td>To be practical</td>
<td>To provide broad based education – working with all the patients’ needs</td>
</tr>
<tr>
<td></td>
<td>To improve patients’ quality of life</td>
<td>To be a patient advocate: help to bring the bits together (report to the team)</td>
</tr>
<tr>
<td></td>
<td>To be really friendly</td>
<td>To understand individual patient’s perspective</td>
</tr>
<tr>
<td></td>
<td>To promote independence</td>
<td>To inspire</td>
</tr>
<tr>
<td></td>
<td>To build good muscle strength</td>
<td>To know the patient in depth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To provide optimal care for patients physically and mentally: this is the goal for treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To determine what patients have and have not got</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To be productive and experience work fulfilment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To help patients set goals: empowerment helps patients take control of their lives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To promote wellbeing: including being in control (of health)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To build patient capacity to make decisions and take actions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To be there all the way (from acute to discharge and beyond)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To be accessible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To think ahead, e.g. beyond ICU</td>
</tr>
<tr>
<td><strong>Professional power</strong></td>
<td>Focusing on:</td>
<td>Using:</td>
</tr>
<tr>
<td></td>
<td>• Technical (propositional) knowledge</td>
<td>• Knowledge from experiences of colleagues</td>
</tr>
<tr>
<td></td>
<td>• Naming the health problem</td>
<td>• Sorting out the doctors – break the medical model!</td>
</tr>
<tr>
<td></td>
<td>• Determining treatment plan</td>
<td>• Knowing your place in the hierarchy</td>
</tr>
<tr>
<td></td>
<td>• Being a patient advocate in case and family conferences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Labelling patients as non-compliant</td>
<td></td>
</tr>
<tr>
<td><strong>Clinician-patient</strong></td>
<td>Basing relationships on:</td>
<td>Based on:</td>
</tr>
<tr>
<td><strong>relationships</strong></td>
<td>• Clinical history</td>
<td>• Family dynamics and relationships</td>
</tr>
<tr>
<td></td>
<td>• Patient’s technical/procedural data, e.g. oxygen level</td>
<td>• Social situation, cultural issues, social relationships, and background</td>
</tr>
<tr>
<td></td>
<td>• Patients’ fears and priorities</td>
<td>• Desire to get well</td>
</tr>
<tr>
<td></td>
<td>• Trust, respect for physiotherapist</td>
<td>• Common goals</td>
</tr>
<tr>
<td></td>
<td>• Avoiding misunderstanding</td>
<td>• Whether patients see themselves as victims or helpless</td>
</tr>
<tr>
<td></td>
<td>• Reinforcement</td>
<td>• Existence of depression/ psychological problems</td>
</tr>
<tr>
<td></td>
<td>• The satisfactions physiotherapists gain from their professional relationships with patients?</td>
<td>• Appreciation that non-compliance gives patients control</td>
</tr>
<tr>
<td></td>
<td>• Patients’ health improvement (even as minor as a toe wriggling after spinal injury)</td>
<td>• Patient expectations, patients’ health beliefs, emotions, addictive and compulsive personality</td>
</tr>
<tr>
<td></td>
<td>• Enjoyment at being involved in health promotion</td>
<td>• Our biases: who we focus on, who we work hard with</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Seeing a smile</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Achieving goals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ‘Liking to be liked’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enjoying being part of the process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trying to have a positive impact</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enjoying being a change agent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Seeing patients regaining control and taking responsibility for their whole health and wellbeing</td>
</tr>
</tbody>
</table>
The additions made by the second group evidenced a strong voice for being in practice. There was more emphasis on patient focus. Professional identity included being a patient advocate and understanding the patient’s perspective. For the first group professional power revolved around the physiotherapist-patient relationship, but the second group expanded it to knowing what power physiotherapists have within the multidisciplinary team. The second group portrayed clinician-patient relationships with an emphasis on the patient perspective, including the culture, health beliefs and internal motivation of patients. The second group critiqued the first group’s narrow portrayal of physiotherapy practice which emphasised the physiotherapist’s perspective but neglected the patient’s perspective. The second group also focused on physiotherapists in terms of the intra-relationship between personal and professional identity.

A new key dimension added by the second group of participants was a focus on physiotherapists themselves as people. Participants critiqued the didactic attitude to teaching that informed patient education practice. They stressed the importance of attitude towards work, such as enjoying being part of the process of accompanying patients’ recovery and trying to have a positive impact with patients. They also added that physiotherapy needed to be interpreted in its clinical setting and context. They said that each department has a unique culture and that this culture affects the way physiotherapy is practised. They said certain departments would foster certain physiotherapy identities and approaches. The second group presented a broader vision of physiotherapy practice. This might be partly due to the opportunity to reflect, discuss and become collectively aware of how they saw physiotherapy practice. The first group had had single interviews, whereas the second group started their project by building on existing findings.

Involving the trialling group in critiquing the second text prepared them for the following three objectives of the pre-implementation workshop:

1. to think about patient-centred practice
2. to explore the notion of emancipatory practice
3. to understand what critical pedagogy is in terms of:
   • clinicians as facilitators of emancipatory learning
   • open clinician-patient relationships

5.2 Action plans and context of trialling group

At the conclusion of the pre-implementation workshop (where they were introduced to CSS and provided with resource materials for further exploration of this ‘new’ practice framework) participants were invited to write down their self-determined action plan for trialling CSS in their practice. The plan included aims and strategies. These plans were evidence of how participants could identify ways of operationalising CSS in their practice. The action plans allowed diverse insights into participants’ intentions for trialling CSS, including:

- what they had understood about CSS
- what CSS themes participants wanted to explore and trial in their practice
- what interested them about CSS as gleaned from their choice of planned actions
- what intentions they had to trial aspects of CSS.

From the workshop, participants had come to understand that CSS had to do with reflection and becoming aware of the diversity and complexity of their patients. Seven participants wanted to focus on their patients. Five planned to pay attention to self and four aimed to explore their professional relationships with patients. Only two included exploring their practice in relation to mainstream practice. Table 5.2 lists the foci that participants mentioned in their action plans.

---

Table 5.2  Participants and their intended foci within a CSS framework for practice

<table>
<thead>
<tr>
<th>Patient</th>
<th>Self</th>
<th>Therapist-patient relationship</th>
<th>Self compared to perceived practice norm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dorothy</td>
<td>Alan</td>
<td>Zoe</td>
<td>Jocelyn</td>
</tr>
<tr>
<td>Jocelyn</td>
<td>Carolyn</td>
<td>Jocelyn</td>
<td>Zoe</td>
</tr>
<tr>
<td>Zoe</td>
<td>Corinne</td>
<td>Zoe</td>
<td>Jacquie</td>
</tr>
<tr>
<td>Corinne</td>
<td>Zoe</td>
<td>Jocelyn</td>
<td>Louise</td>
</tr>
<tr>
<td>Petra</td>
<td>Carolyn</td>
<td>Zoe</td>
<td>Jocelyn</td>
</tr>
<tr>
<td>Carolyn</td>
<td>Louise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Louise</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Most participants intended to explore their patients’ perspectives more. During the pre-implementation workshop participants noticed that they had not listened well to their patients and they perceived a need to focus better on patients. Five participants wanted to reflect on their own practice and their clinical reasoning. Four planned to explore their professional relationships with patients. Jocelyn and Jacquie were the only ones who intended to focus on the bigger picture outside of the patient, physiotherapist and professional relationship context. Jacque was interested to reflect on the practice norm in her department whereas Jocelyn wanted to compare her practice to that of her peers. Jacque intended to become more aware of when to use which type of model. She did not plan to trial CSS but rather to consciously become aware when it was warranted and when not. Jocelyn was the only participant who intended to explore all of the four foci that were mentioned in the action plans. Petra, Alan and Dorothy had a single focus. One could assume that a single focus action plan does not lend itself well to a CSS approach to practice. However, one could also assume that an initial single focus could evolve into a multifaceted action plan to practice development further down the track.

Table 5.3 lists the strategies participants wrote down in their action plans that identified their focus for this CSS trial. All participants identified suitable action plans with aims and strategies that appeared manageable to them. The CSS themes of critical self-reflection, awareness of power relations and the complexity of professional therapist-patient relationships were the main focus. The strategies that participants wanted to use to trial a CSS approach promised to be appropriate in relation to the identified CSS dimensions. Table 5.4 clusters all the identified strategies and matches them with participants.

Table 5.3  Strategies that participants had planned

<table>
<thead>
<tr>
<th>Patient focused</th>
<th>Self focused</th>
<th>Professional relationship focused</th>
<th>Systems focused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explore what patients want</td>
<td>Gain insights into decision making</td>
<td>Be an advocate for patients</td>
<td>Increase awareness of others’ professional patterns that I want to emulate or avoid</td>
</tr>
<tr>
<td>Give patients more information</td>
<td>Explore how patient-centred I really am</td>
<td>Collaborate with patient and family in goal setting</td>
<td>Look at our [physiotherapy department] report writing documents and look at the questions we ask and see which way they are slanted [therapist- or patient-centred] and see if I can add some questions that will allow both ends of the model to be used</td>
</tr>
<tr>
<td>Increase patient education</td>
<td>Increase understanding of my role as physiotherapist</td>
<td>Learn from my patients in any areas that empower me to improve my skills as a therapist</td>
<td></td>
</tr>
<tr>
<td>Give patients a more active role</td>
<td>Explore the difference between a therapist and a friend</td>
<td>Explore compliance issues</td>
<td></td>
</tr>
<tr>
<td>Empower patients so they can take responsibility</td>
<td>Explore my practice and how to change it</td>
<td>Educate with the aim of giving more power to patients in professional relationships and to foster collaboration</td>
<td></td>
</tr>
<tr>
<td>Let patients feel more involved</td>
<td>Explore my own practice patterns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explore how to tell patients in acute settings what they have to do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make better use of patient feedback</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listen better to patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieve patients’ goals and relate short-term to long-term goals</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5.4 Strategies matched to participants

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question patients to check their concerns</td>
<td>Louise</td>
</tr>
<tr>
<td>Ask strategic, mindful questions to explore patient goals</td>
<td>Corinne, Jacquie, Dorothy</td>
</tr>
<tr>
<td>Dialogue, collaborate, respond to patients’ questions, aim to set realistic goals</td>
<td>Corinne, Louise, Jocelyn, Carolyn</td>
</tr>
<tr>
<td>Listen to patients</td>
<td>Jocelyn, Corinne, Carolyn</td>
</tr>
<tr>
<td>Self-reflect, write a diary, take time out from practice to examine practice</td>
<td>Carolyn, Jocelyn, Zoe, Petra</td>
</tr>
<tr>
<td>Collect patient feedback</td>
<td>Carolyn</td>
</tr>
<tr>
<td>Empathise, consider patient perspective</td>
<td>Zoe, Petra</td>
</tr>
<tr>
<td>Explain better, more patient education</td>
<td>Petra, Dorothy</td>
</tr>
<tr>
<td>Examine what is documented about the patient’s perspective</td>
<td>Jacquie</td>
</tr>
<tr>
<td>Note what criteria are used for decision making, keep a log book</td>
<td>Alan</td>
</tr>
</tbody>
</table>

These strategies addressed concerns relating to the therapist, the patient and their professional relationship. Strategies focused on therapist interest, on patient interest, or on collaboration and dialogue. The focus was on reflection and exploring own practices. The chosen strategies did not appear to have skeptical, challenging and critical notions. For example, ‘empathise, consider patient perspective’ is a good strategy but what is the purpose behind this strategy? To empathise with patients could lead to feeling sorry for them and patronising them. To empathise could also mean to use patient perspectives as a starting point for learning, growing and helping patients to transform those perspectives. However, the strategies were planned, intended actions, they were not the actions themselves.

The complexity of intention and hidden agenda of implementing these strategies in practice could not be determined solely by analysing the action plans. As an example, ‘listen more to patients’ could be interpreted as a CSS strategy taking more notice of and collaborating more with patients. But listening could also be used to build rapport with patients, without incorporating what was listened to into physiotherapy management. Listening could be a sound starting point towards emancipation but listening without declaring the intention behind listening could not guarantee a CSS approach. Participants were asked to reflect on their goals and strategies by ongoing reading of the resource materials, in their trial endeavours and during within-trial interviews.

5.2.1 The context of the trialling group

Four weeks after the pre-implementation workshop I started to contact each participant. We talked briefly over the phone about how they were going with their action plans. Some had spent little time on their action plans whereas others already reported some insights. The trialling phase lasted nine months, which is a considerably long time. It was anticipated that participants would be busy amidst all their work responsibilities and they needed extended time to work on this project. Further, trialling included a reflection-planning-action cycle that could not be meaningfully completed in a much shorter time frame. Many unforeseen events occurred that distracted participants from trialling CSS:

- Carolyn was on jury duty for two months.
- Dorothy went on maternity leave two months into the trialling phase.
- One month into the trialling phase Louise was promoted and commenced work as a senior physiotherapist in a different area to where she was when she attended the pre-implementation workshop. She also went on extended holidays and missed the critical appraisal workshop.
- Alan felt that his clinical supervision workload had increased. Consequently he had considerably less time to reflect on his own practice and trialling CSS. He apologised for his absence at the critical appraisal workshop.
- Jacquie had management issues she had to attend to due to major physical and organisational changes in her department.

All these events reflect typical work reality for physiotherapists in hospital settings. Participants spent less time on this project than they had anticipated. Although I intended to conduct up to four in-depth interviews with each participant, I conducted only two in-depth interviews with Louise, Jacquie, Zoe and Dorothy, and three with Petra, Alan, Carolyn, Corinne and Jocelyn. Participants did not manage to attend more interviews because they had not made sufficient time to reflect and trialling CSS. At the completion of each interview I asked participants whether they wanted to refine their action plan, pose new questions arising from their experiences with the trial, and trial other strategies. Often, participants asked me for guidance rather than them determining their own journey. After most final interviews there was a sense of having exhausted trialling CSS at this time. No further questions were raised and participants had formed their opinions of CSS.
5.3 Trialling CSS dimensions
The interpretation of the trialling phase was informed by the five dimensions of the theoretical CSS model that was developed in Chapter 3 as being relevant to physiotherapy practice. These five dimensions are:

- capacity for critical self-reflection
- democratising professional power relationships
- rethinking rationality and values that inform clinical reasoning
- redefining professional identity and roles
- rethinking the practice context.

Each of these dimensions is considered here, illustrated with quotes, reflections and examples from participants’ experiences in trialling CSS.

5.3.1 Critical self-reflection
Reflection means thinking back and scrutinising beliefs and or actions. Mezirow and associates (1990, p. xvi) defined reflection as “examination of the justification for one’s beliefs, primarily to guide action and to reassess problem solving”. Reflection is more than recalling experiences. Reflection is learning from experiences. The extent of learning depends on the depth of reflection. The nuances of reflection are outlined in Table 5.5.

<table>
<thead>
<tr>
<th>Term</th>
<th>Activity</th>
<th>Degree of Transformation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transformative learning (cycle 3)</td>
<td>Emancipatory learning emancipating from current frameworks</td>
<td>Transformation in knowledge, skills and attitudes</td>
</tr>
<tr>
<td>Critical self-reflection (cycle 2)</td>
<td>Questioning the understanding from multiple frameworks</td>
<td>Some shift in attitude to appreciate the complexity and multiple realities but no change, tokenism, minor shifts</td>
</tr>
<tr>
<td>Critical reflection (cycle 2)</td>
<td>Understanding from multiple frameworks</td>
<td>As above</td>
</tr>
<tr>
<td>Reflection (cycle 1)</td>
<td>Understanding within the given framework</td>
<td>No shift in knowledge, skills and attitude</td>
</tr>
<tr>
<td>Experience (cycle 1)</td>
<td>Recalling an experience</td>
<td>No shift</td>
</tr>
</tbody>
</table>

People reflect to understand and make sense of the reasoning that guides their beliefs and actions. Reflection that leads to a critical examination of an experience adds another dimension. Critical reflection questions the reasoning and interests that underpin beliefs and actions. To critically reflect means to challenge beliefs and to appreciate what underpins these beliefs and values. A further dimension to critical reflection is focusing reflections on self. Critical self-reflection means questioning the personal and professional values that underpin one’s professional practice and clinical reasoning in particular. It assesses the way one practises by focusing on the roots of thinking because it questions one’s frame of reference. As a result of critical self-reflection people may rethink their frame of reference and transform their practice. Such transformative learning means an adjustment or change in beliefs and actions. If these beliefs and actions result in freeing self from unnecessary constraints then this transformation is emancipatory and the reflective activity is emancipatory learning. One of the core themes of CSS is emancipatory learning. Reflections that occur within a taken-for-granted frame of reference do not critique these parameters. The critical dimension of reflection would challenge this frame of reference and identify a need for transformations and emancipation from the status quo.

Scholars of critical social science advocate critical self-reflection as a tool for professional development. According to Cranton (1994, p. 76), “development requires moving beyond the acquisition of new knowledge and understanding, into questioning our existing assumptions, values, and perspectives”. Participants in the trialling group varied in their willingness to critically self-reflect on their practice. Participants who chose to focus on self appeared more willing to critique self than those who focused critical thought on patients, colleagues or the health care system. However, some participants conducted self-reflection without a critical stance, which consequently did not lead to transformation. For example, one physiotherapist reflected and concluded that physiotherapists need to tell patients to comply. The issues of compliance, its power relations, its claim for best practice remained unquestioned and taken-for-granted. This participant’s capacity for critical self-reflection was limited to a preliminary cycle of reflection. Participants who had capacity to critique self, others and wider contexts were best placed to achieve emancipatory learning. Self-critical participants who had labelled patients as difficult, lazy or irresponsible started to question these labels. They reassessed how patient-centred they really were in practice. These participants had an ability to scrutinise their previously taken-for-granted reasoning and way of practising. They started to enter the second cycle of reflection.
Dorothy did not display a capacity to critically self-reflect. She recounted her practice without providing examples from her practice. Dorothy made statements without further elaborating or justifying them. The way she thought and spoke of her practice did not provide opportunities to engage in a critical dialogue. In the two interviews I conducted with Dorothy, our dialogue had an unreflective character because she stated her strategies and practices to me as though to justify herself. She explained rather than questioned herself. Below is an example of how Dorothy made statements asserting certainty which exemplified instrumental reasoning:

"You obviously need to pick your patients if you are trying these strategies on. The main thing is giving them options. So telling them what needs to be done in the day and sort of working around them if they want to mobilise first or do exercises first. So putting it back onto them making the decisions." (Dorothy)

Why is it obvious to pick your patients and why are options so important? The aims and strategies of her action plan focused on patients. They did not focus on her reasoning. Dorothy’s assumptions and professional position were the starting point of her reflections on her actions. She neither challenged her clinical goal-setting nor her degree of collaboration with patients in decision making. Dorothy decided what patients needed to accomplish each day. Patients were given choice only within her practice framework. Dorothy took for granted that she was:

- making the decisions on treatment goals
- deciding what type of patient could be given some choice and control over the treatment sequence
- determining when patients were ‘stubborn’, ‘too passive’ or ‘difficult’
- deciding when patients needed ‘pushing’ rather than accommodating.

Dorothy set her practice framework without having challenged it, including her goals and aims for each treatment session. Only within this framework did she allow patients to make choices. Dorothy felt this approach worked for her and her patients. She claimed patients felt more empowered because they knew what to work towards:

"They are more positive, I guess because they know exactly what is required of them, you know what you are aiming to get out of the session. It is better communication. They seem cooperative with it." (Dorothy)

Dorothy described better communication as making her intentions and aims clear to patients. Communication was reduced to helping patients understand her better. It excluded a two-way communication process where she would have to understand her patients better and negotiate an agreed plan of action. Her self-determined strategies for trialling CSS were ‘to explain better and conduct more patient education’. She applied these strategies in a didactic fashion, and considered that this helped her patients cope better with her treatment regimen. Patients knew her aims and were better placed to cooperate within her practice framework. This approach to communication is not emancipatory because there was no scope for questioning and negotiating Dorothy’s aims. Patients had a pre-selected and limited choice of options given to them by Dorothy.

In her first interview, Dorothy changed her aims to ‘ask strategic, mindful questions and to explore patient goals’. When we met for our second interview she reported that she was puzzled how little patients knew and understood what physiotherapy was all about. Dorothy reasoned that patients who didn’t know what physiotherapists did could not tell physiotherapists what they wanted, so these patients could not have control over their treatments. Dorothy took her practice framework for granted. She did not see a need to incorporate patients’ perceptions into a collaborative treatment plan. Patients had to understand what physiotherapy was but she did not need to know what patients’ understanding of physiotherapy was. She did not challenge the purpose of explaining and her perception of what constitutes good communication.

"Giving the patients options is definitely making them feel more in control and you get a better response out of them. They feel not just like sitting there having things done to them. They are having a bit more of a say what is happening to them. So it is good for both." (Dorothy)

Dorothy experienced working in collaboration with patients as a positive experience. However, she chose whom to collaborate with, and collaboration was narrowly defined by her. Dorothy noticed that patients who shared her values and expectations made her more relaxed and she was able to give them choice. These patients did not challenge her practice. With difficult patients she felt she had to be more forceful.
You get a few people that you need to push or you are not going to get anywhere with them. Patients with stubborn personality won’t do anything no matter what reason you give them. (Dorothy)

Dorothy concluded that thinking about what patients wanted made her more aware of her practice. It made her aware of choosing when to use a collaborative approach but it failed to make her aware what criteria, what values informed her judgment. Dorothy stated that this project had made her more aware but it had not changed her practice. She emerged confirmed in her practice. With her limited self-reflection and critique it is not surprising that she felt reconfirmed in her practice. Her reflections sought confirmation of the status quo, not transformation or emancipation. There was no quality of skepticism or self-challenge. Dorothy may have refined her existing skills and actions but she did not seek to transform them.

Alan

Alan engaged in a similar type of reflection to Dorothy. Although he focused on self and not on patients, his focus was not questioning self but becoming conscious of how he made decisions. Alan became more aware of his frame of reference but he did not challenge this frame of reference. He did not exceed the preliminary cycle of reflection. Alan noticed that he gave choice to patients who shared the same understandings. These patients appeared to be physiotherapists themselves or well educated patients who were able to assert themselves and articulate their needs. Patients who appeared unreliable, non-compliant and somewhat difficult were not given options. For Alan an ideal patient understood his treatment plans, worked with him on his terms and displayed common sense:

I guess the ideal patient is someone who wants to get better. That’s the important thing, they need to have common sense because that is all it is. I guess an ideal person is prepared to listen to education and to the advice I give. [If patients say the advice doesn’t apply to me] that is going to be hard. They are harder people to get good results. Because you know when they are saying that [it means] that they are not really taking in what you are suggesting. They are likely to go and do something contrary to what you advise them to do. I always document those discussions carefully in my notes because most times I know something bad is going to happen and in this current climate where people are likely to complain about you, litigate against you, it is a liability. So you have to document carefully. (Alan)

Alan did not think about what common sense meant to him, he simply equated his sense-making with common sense, which excluded any other way of making sense. A critical perspective would demonstrate skepticism about what common sense means because the status quo is challenged. Rather than exploring with patients where the difference in thinking lay and why advice was not seen as relevant, Alan would document his actions to cover himself legally. This approach displayed little critical reflection but rather self-protection.

I think it lies in their best interest to do what I say (Alan).

Alan believed that his advice needed to be followed. He did not see it as his role to listen to patients and tailor his advice to make it relevant to individual patients and negotiate decisions with them.

Alan and Dorothy were not prepared to move out of their practice comfort zones. They did not question their frames of reference. They started from the premise that their advice and goals needed to be followed. Some minor detail of sequence could be left to patients to decide but the limitations of choice were clearly and narrowly defined.

Petra

Petra had been working in acute care settings for more than 20 years and she felt her practice had changed over the years rather than through this trialling phase. She remembered one particular critical incident where she had had to treat over 50 patients in four hours on a weekend. She felt she could not treat each patient adequately. Rushing through her patient list made her distressed and her treatment ineffective. She started to take her time when treating patients.

I really think my attitude started to change ages ago. It always takes me heaps longer to treat patients now than it used to. I think this is partly because I listen to what they have to say, and try to take it at their pace, and I sometimes get a bit frustrated because I don’t get a lot of other work done that I need to and I feel I only see a few patients (Petra).
Petra’s practice transformation was almost forced on her externally by the long patient list rather than as a result of challenging her practice values. She stated that she was very comfortable in an acute setting where she felt less negotiation and collaboration were possible or even necessary, due to the acuteness of disease conditions.

I am a mover. I am the person to see the patient walk through this door, whatever their situation, my aim is to get them walking regardless of what they are, who they are (Petra).

Petra worked within a biomedical model where the acuteness of a condition and the physical symptoms dictated treatment plans. She reasoned that because of the acute setting there was no place for critical self-reflection. The issue of acute setting and CSS is discussed further in 5.3.5 rethinking the practice context.

Corinne
Corinne displayed a capacity for critical self-reflection. Corinne had over 30 years of clinical experience and outpatients was her area of expertise. She questioned her practice and surprised herself:

After the pre-implementation workshop I have been taking more notice about what I am doing with people and I was very surprised to find that I do tend to use quite a lot of physiotherapy [practitioner] power. I was actually very surprised to notice that. I had an incident the other day: I was doing something with a quite young lady and I was palpating her knee and she pushed my hand away and said ‘you are hurting me’. I considered this palpation was appropriate for her age, health and all that. Well it was funny, it was more ‘think of my feelings’ reaction rather than ‘Oh dear [sorry]’ but I thought ‘how dare you’. I am not used to being treated like that (laughter). I didn't consider my palpation being too severe and I was thinking ‘oh, I don't like this’. The way she said it did not sit well with me. (Corinne)

There are several layers of critical self-reflection in this quote. Corinne first of all became aware of her professional authority and she realised that she was using it more than she had thought. She described a situation where she was challenged by a patient. Instead of defending herself she acknowledged her patient’s complaint. She admitted that she did not like the fact that this patient had complained to her but more importantly she did not appreciate her patient’s tone of voice. She interpreted the tone of voice as disrespectful to her. Corinne questioned her assumptions and actions as well as those of her patients. She displayed a critical perspective to her thinking. She reflected on her attitudes towards her patients and was able to identify what irritated her about them:

I sense irritation when they [patients] are really focused on themselves. Every little twinge is noted. We have elderly people coming in and they have huge problems and they are happy when they have a little bit of relief of pain. With other people where I think they are actually pretty good and they come in and have another little bit of an ache or pain. I get irritated with that. I hope it doesn't show but I would like to move them on (Corinne).

Corinne is critically aware of her irritation with some patients and she understood why. She could see her irritation in the context of her own practice, seeing older people who were more in pain than others. At the same time she appreciated her patients’ background and she tailored treatments to incorporate them:

A lot of Greek and Italian people have been really hard-working. I notice a lot of young physiotherapists have a serious exercise approach and I think to some people this is appropriate but to some it is not. (Corinne)

Corinne made a distinction between the ‘ideal’ treatment from a professional physiotherapist perspective and the ‘appropriate’ treatment from an individualised perspective. Corinne questioned traditional practice approaches and she saw contradictions in them:

I have enormous difficulty with evidence-based practice. I have difficulty taking it on board. I give you an example: most trials on electrical equipment, such as ultrasound, will say that there is no evidence that these machines work or are critical. The interesting thing is that all our physiotherapists use these machines when they have something wrong with themselves. That tells me that these things help, that they reduce inflammation. So I intend to use them. In regards to evidence-based practice I have a problem that people are not machines and it is difficult to fit people into that scientific area that they want to use for evidence-based
practice. I don't understand why clinical experience cannot be a valid way of determining if something is useful or not. (Corinne)

Corinne questioned evidence-based practice on the basis of her observations and critical thinking. She identified contradictions because research suggested machines had no effect, whereas physiotherapists were confidently using these machines. Corinne also challenged the assumptions of evidence-based research because it isolated variables and did not reflect the practice context. Corinne felt that evidence-based practice looked upon patients as machines, excluding emotional and other human qualities in its research designs. She provided another example of the importance of context:

I had a lady with low back pain. It was always the same but it was never very obvious. My objective assessment never reproduced that low back pain. I asked the patient, 'let me understand when do you get the pain'. 'When I am sitting on the floor'. 'What are you doing sitting on the floor?' 'I am feeding my daughter who is very handicapped'. 'Oh, tell me a bit more'. 'So I am sitting on the floor and she is getting bigger, she is 12. She sits between my legs and I feed her'. Now I think I am getting a bit of an idea of what is going on here. 'Do you lean against a wall or do you sit in the middle of the room? 'I usually sit in the middle of the room.' What about sitting up against the wall with a pillow behind your back? 'I will do that next time'. Then she got better. You know this is about asking the right questions. I hadn't twigged before. I didn't have the information. I didn't know about the child. (Corinne)

Corinne felt that questioning skills were vital in making correct assessments. She had learned to make time to conduct thorough assessments and listen to patients more carefully. She also felt it important to critically think why patients could not do certain movements or exercises. She did not want to base her treatment on her assumptions, rather she checked her assumptions with her patients.

Can they [patients] not do this exercise because their muscles are too weak, because the actual position they're starting from is uncomfortable for them or hurting them or because they don't believe they can do it? You know, I'm sort of looking at all those aspects to see well, why can't they do it? (Corinne)

Corinne had capacity to challenge herself and her peers, as well as traditional approaches to practice and current trends in research. She had capacity for critical self-reflection that led to transformation of some aspects of her practice as described and listed in Table 5.5.

**Louise**

Louise had a capacity for critical self-reflection in that she identified weaknesses in her practice. She said she needed to improve her communication skills.

I tried to make things as easy as possible to follow, [using] written documentation that the person has to follow, constant reiteration with doctors and others, repeat it every day. I think sometimes my communication needs to be a bit more refined. It is something I regret. (Louise)

Louise was starting to reflect on her teaching and communication skills. Repetition and taking advantage of a doctor's authority appeared ineffective. She felt she lacked confidence and clarity in speaking which made her communication skills less effective.

Some participants were able to identify weakness, contradictions and distortions in their own practice. However, most displayed an incompleteness of reflection because their reflection did not include critically reflecting on their practice assumptions and frame of reference. Participants such as Dorothy and Alan displayed intentions of understanding themselves better rather than challenging themselves. In contrast, Louise and Corinne could identify their own professional weaknesses and were curious to challenge and emancipate themselves from them.

Findings from this critical analysis confirm Habermas’ (1968/1972) contention that only critical self-reflective approaches can overcome uncritical interpretations and self-understanding, and in this context, professional identity. Philosophical hermeneutics is concerned with consensus whereas critical hermeneutics is concerned with emancipation. A philosophical hermeneutic approach to interpretation may deepen understanding, and Dorothy and Alan achieved that but it did not change the status quo of their professional identity during the trialling phase.

5.3.2 Democratising professional relationships
One of the CSS dimensions for physiotherapy practice identified in chapter 3 was democratising professional relationships. Professional relationships concern communication and how speech partners relate, listen, negotiate and come to agreement with each other. A CSS framework strives towards egalitarian relationships so that critical reasoning can guide communication and decision making rather than purely professional or social power. Physiotherapists have permission to assume professional power over their patients due to their professional status and knowledge. Thus professional relationships in the physiotherapy context start with uneven power relationships where physiotherapists have more power than their patients. Democratising relationships would imply that patient knowledge had to be taken more seriously. During their CSS trialling participants wanting to democratise their relationships with patients would have to be willing to challenge their use of professional power. These challenges included critically listening to patients and incorporating a critical element into communicating with patients. In this approach the physiotherapist and patient would negotiate on a level that includes objective and subjective thinking such that clinical reasoning occurs on a critical level.

A prerequisite for democratising professional relationships is becoming aware of our own assumptions and the expectations that shape relationships. Once aware of our assumptions it is then important to become aware of the patients’ assumptions and expectations. Louise worked with para- and quadriplegic patients in in- and out-patient settings. She was able to express her assumptions, become aware of them and check them with patients in treatment sessions. She described working with a patient who did not accept that she had become a paraplegic and could not walk.

Recently a person came to us having been somewhere else first and saying that she wanted to walk and she thought she could. A physiotherapist in that other hospital had told her that she could walk again. She tried to stand up in the parallel bars and fell straight down to the ground. She came to us and we tried to explain that her legs weren’t strong enough to bear her weight but there are options for paraplegics to walk with appropriate splints.

F: What were you thinking when you heard that the other physiotherapist thought the patient could be walking?

I didn’t believe it. The patient told the whole team, doctors and physiotherapists ‘I think I can walk again’. This patient wanted to blame the health care professionals that she still couldn’t walk. That patient wanted to show that she could do it. The desire wanting to walk was so great. I thought that it was going to be really difficult to get her to be quite rational because she had been so... I mean to actually pull yourself out of a wheelchair and fall to the ground it is quite extreme. We asked her can you move your leg and she couldn’t and she realised that she couldn’t bear weight through those legs. But I thought she is so extreme thinking it is going to change her life. But when she was actually educated about the weakness in her leg, the lack of neurological function in her legs. I used an analogy and explained that there are other options, so not to say blanketly ‘no you cannot try this’. Giving her other options was important. (Louise)

Louise

Louise made assumptions based on her first impressions of this patient. She thought this patient did not trust staff and wanted to shock them. She also thought this patient was irrational and that it would be difficult to help her realise the permanency of her situation. However, Louise considered the patient’s background and listened to her fears so that she could better understand her behaviour. Louise realised that the patient did not have sufficient information about her condition and also needed emotional support. Louise was careful not to judge this patient by her behaviour alone. She critically reflected on this behaviour by questioning the underlying meaning and reason. She explored the patient’s agenda and her wider context. Louise started to help her realise what she was capable of doing.

She wasn’t a regular paraplegic and she wasn’t rehabilitated through a spinal ward. I think that really highlights the importance of education because she had no idea what was going on. She saw tangible things but she didn’t understand. (Louise)

To Louise, education meant exploring choices with her patient. Louise said that her approach with this patient was to collaborate and facilitate patient learning.

I was just fine-tuning, she was very much directing it. (Louise)
Louise would not leave responsibility entirely with patients when it came to exercising and following a treatment plan. She viewed her treatments as working together with patients rather than telling them what to do.

I don't like the word non-compliance, I talk about patients not taking something on board (Louise).

This comment implies that there is more to professional relationships than patients complying or not complying with professional advice. Working together is a mutual affair. If there were a compliance issue it would always be placed at the patients’ feet. Traditionally, physiotherapists rarely question their part in patient non-compliance. Louise established professional relationships that were based on listening, educating and negotiating. Making sure that patients understood her and she understood them created an enabling environment for democratising professional relationships. She would even allow patients to fail because she believed that some patients needed to experience setbacks in order to understand why certain treatments were applied. She felt objective rationality was not necessarily helpful for all her patients to emotionally and critically understand why certain treatment regimens were necessary.

I had a couple [of patients] who started off like that [resisting treatment]. They come to trust you, seeing them every day, listening to their stories, they get to know their peer support, they realise that they can't function. But often that won't happen until they are discharged. One guy had to go out, experience failing a few times, get pressure areas, come back in, go home again, and now he is very nice to people. Just everything was such a big obstacle, everyone involved in his rehab was his enemy, and couldn't be trusted. He had to do it all himself and go through it that way. And so for him it worked. (Louise)

Louise allowed patients to challenge her and test themselves because she felt that they needed time and space to start thinking and feeling for themselves.

I tend to be a negotiating person. ... This patient said to me 'I can use my legs to get to the toilet, I can stand'. I said 'can you try moving your leg? Do you have feeling in your leg?' 'No but I can use my legs to do this'. 'If you can't move your legs can you see that you can't put weight through them?' It was just like being shell-shocked. I thought 'you are kidding me', and I don't know how but he hadn't processed. That was a recent challenge. That patient cried and cried. And now we are really good. I can be quite firm with that person but it took that initial breaking in I suppose. (Louise)

Louise was not afraid to enter into dialogues with patients. She would question them, make them aware of their reasoning and help them come to their own conclusions. She did not feel disempowered or unprofessional in her approach to facilitating learning. Instead she claimed that making unreflected use of professional status by telling patients what they needed was ineffective and ultimately frustrating.

You really need that skill [negotiation] because conflict and didactics doesn't get you anywhere. It sets up two polar opposites, which is a great way to fuel conflict (laughter). But if you try to acknowledge someone else's point of view whether you agree or not, at least I mean to give them a little bit might make them give you a little bit and get that concept going. Like there is this threatening kind of a guy. I have spent hours and hours with this person on few occasions. He came up to me the day he left and said he really appreciated all that interaction. And it was like 'oh, ok'. Whereas to stand back and say 'no you are on the wrong track. That's wrong; let's do it may way', that is not realistic. (Louise)

Louise believed that patients would find their own way of living with their disabilities. She was aware that there was not one best way of dealing with disability; each patient needed to make their own journey in their own time. As a result of trialling negotiating with patients, Louise found that patients communicated more honestly with her. She had a patient who initially would not tell her if he was in pain or not.

This is a person who initially wouldn't have said anything about his pain. He was on a tilt table and didn't report that he had pain; but he had a fractured ankle. I got him to say how much pain he had. That person is doing that now with a lot of encouragement. (Louise)
Pain is a subjective perception. Physiotherapists can anticipate how much certain movements might hurt but they cannot be sure for each individual. Physiotherapists who appear focused on measurable outcomes may not create a safe environment for patients to report honestly on their individual pain perception or other subjective feelings and interpretations of treatments. In 5.2.1 Critical self-reflection, pain was discussed from a therapist’s critical self-reflective perspective. Corinne found it difficult to accept that patients complained of pain when she thought her procedures should not hurt. Physiotherapists have professional power that can remain unchallenged by patients and that can silence patients. When patients challenge physiotherapy power they can be labelled ‘difficult’. Democratising professional relationships emancipate patients and therapists from previously taken-for-granted assumptions. Feeling comfortable working with uncertainty and diversity of interpretations without feeling obliged to accommodate the other can empower relationships and transform them to critical reasoning-driven rather than power-driven relationships. Physiotherapists who make it clear through their interactions with patients that they welcome patient participation develop open relationships where expectations and interests are made explicit. When Corinne was asked to make some statements about her professional power she reflected:

I am not sure. Yes, in some terms I would say that I like it [professional power]. Sometimes it enables me to deal with a patient that is difficult for some reason. And the difficulty may be that they are not getting better. So then I can in a sense put the blame onto them. (Corinne)

Corinne was conscious of her professional power and she sometimes used it to blame patients rather than to admit that she was unsure how to help. In the subsequent interview Corinne appeared clearer about her stance with respect to professional power. The following quote describes how although she was aware and critical, Corinne sided with her interests using her professional power:

I decided I’ve actually become a lot more authoritarian, that I am a lot more authoritarian than I thought I was; and in some cases I’ve made a conscious decision to be like that and not to act in a co-operative way with them [patients]. There may be several reasons. From my point of view if a patient does not want to take on any responsibility for themselves … I would probably treat them in a more authoritarian way. If they were demanding, I would tend to be more authoritarian with them. I tend to react to that [demanding patients]. I don’t like them telling me what to do. I don’t mind them telling me if I’ve asked them. So I’ve noted that about myself. But if they come and tell me what they want, like the lady who says ‘I want ultrasound here’, I tend to react against that.

FT - Even though if you would have done ultrasound anyway?

It doesn’t necessarily mean I wouldn’t do it [ultrasound]. I’m talking about how I feel about it, my personal reaction. I would probably do that if that’s what I thought was necessary, yeah, that’s ok. It’s possibly even more the way they ask it, even the fact that they do ask it. So there’s a whole lot of stuff there that I’ve seen in myself that I hadn’t noticed before just by being [more] aware of these things. (Corinne)

Corinne alluded to the fine nuances of professional power relationships. If patients assumed more egalitarian relationships by asking or suggesting treatment modalities she would react negatively. Corinne used her professional power to decide which patients she granted permission to negotiate and collaborate with her. The following quote highlights how Corinne took professional power for granted. She claimed professional authority to choose to listen, negotiate and collaborate with patients who were in a less powerful position to initiate more egalitarian relationships. Corinne was critically aware of her power play. She struggled with her prejudice against some patients.

I think I give patients a chance to say something. You’re always going to get people who slip through the net, who don’t ask questions. There’s one woman in particular who I think has got that really lax posture. I’m having awful difficulty getting much relief for her from what she is doing, from her problem. But I get the feeling she doesn’t really care, she doesn’t really try. Perhaps that’s not really true. Perhaps I’m not really listening hard enough to what she’s telling me about her problems. Perhaps I haven’t hit on the way that would do something to help herself. Because of the way she comes in like a ‘plop’ I tend to react against that. She’s one person I tend to be a bit authoritarian around. (Corinne)
Corinne was self-critical and honest enough to admit that she judged this patient on the basis of posture. She interpreted posture as not trying and caring to improve. She acknowledged personal feelings and reactions to patients. This increased awareness of her personal values transformed into a critical understanding and use of her professional power. Corinne tried to establish professional relationships based on her patients’ needs. She considered that some patients needed direction and clear prescription whereas others preferred guidance and collaboration.

There are some people that I would possibly never tell that I don't know [the diagnosis]. The people I wouldn't say that to are the ones who are fairly fragile. These people need some strength, they need to grasp hold somebody's strength. If I said to them I don't know what is going on here, it might be all too much for them. But then other people I feel I can be quite honest with. I am guessing it could be this, this or that. I suggest we are working through each one of the possibilities. (Corinne)

Corinne felt quite strongly that she wanted the choice of keeping or sharing control of her professional authority, even though she was self-critical and honest about that. She concluded:

I think physiotherapists need to know that they have the power and that they have the right to introduce or not introduce whatever treatment techniques or treatments they choose, whether to continue treatment, whether to stop treatment. I think they need to feel that they’ve got the right to do that. But the patient also needs to have a feeling that they have some power in this situation, and that they can say to physiotherapists that, you know, this is not working, I want some more [of this other technique]. (Corinne)

Corinne’s final quote on professional power portrays a critically balanced view. She was taking sides and she justified her position after careful self-critical reflection. To her, being critical implied taking sides; a critical approach implies being mindful of indecisiveness and chaos, but ultimately trying to overcome it. Corinne concluded that professional power rested with physiotherapists over patients. However, when keeping patients’ outcomes and interests in mind it was important for Corinne to have patients involved. Corinne was aware of her professional power, prejudices and assumptions. Her practice interest was to make patients feel part of the decision-making process even though they did not have ultimate control.

Zoe
Zoe was also aware of the complicated nature of being self critical about professional power use:

Yes so I am pretty good at reading what people think and need. Yet again I could use that to manipulate them; get them to do what I want (Zoe).

Zoe became more aware of her use of professional power. She started to wonder if she asserted her professionalism only to persuade patients to her way of thinking and acting.

You have to be conscious of the way you've been conditioned as a physiotherapist, even though you feel like you're on the patient's side, I think we have practices where we think we are making the patient [more] autonomous but we are not, we are just [in control] ... I think I'm more aware of it. (Zoe)

Zoe started to question the credibility of professional knowledge and physiotherapists’ well-intended practices. Professional knowledge could be interpreted as a misuse or a justification of professional power. She appreciated the complexity of critical interpretations of professional interests and patient expectations.

Jocelyn
Jocelyn also became more attentive to interests and her patients’ expectations of physiotherapy. She found that some patients had clear expectations and knew what they wanted. When comparing these with her professional expectations and goals Jocelyn found herself at times in conflict. She described an incident with an 80-year-old patient who could not carry her shopping home but otherwise was able to be fully independent. Jocelyn noted the decreased range of motion in her shoulder joint and she wanted to work first on increasing range of motion and then on strengthening muscles. However, her patient was not interested in increasing range of motion.
I could see that [this] patient was uninterested in my plan. I thought this wasn’t particularly functional [wanting to increase strength before increasing range of motion] but she was able to do everything: cook, clean etc. The only thing she couldn’t do was go shopping because she couldn’t carry anything. So, that was really glaring in my face. This is what she wants to do. I am not sure if I always pick that up. (Jocelyn)

In this particular situation Jocelyn appeared comfortable to go with her patient’s goals. Her decision was influenced by her patient’s age. Had her patient been younger she might have insisted on improving range of motion as well. Jocelyn made decisions in context and with a critical stance to self. She was willing to reconsider. However, generally speaking Jocelyn was not content to allow patients to lead treatment plans.

I am not so comfortable [with that]. I feel it takes away some of my authority or professional expertise when I say to them ‘what would you like to do in physiotherapy?’ because they don’t know physiotherapy technique and they say ‘I don’t know. You should know, you are the physiotherapist’. (Jocelyn)

Jocelyn could see that professional power is a flexible commodity. Simply handing it over was not a useful and critical approach. She would need to use it wisely and with critical awareness in each clinical situation. Some patients appreciated more democratic professional relationships whereas others did not. When patients showed initiative to participate in decision making Jocelyn welcomed their input and direction. She thought such patients often made very appropriate suggestions.

There are some patients that think of things that are really good; they have their own idea and I am very supportive of that. Most of the time it is really appropriate. They know their body better than I do. And I can’t think of an inappropriate suggestion that these patients have come up with and that is good (Jocelyn).

Jocelyn demonstrated critical awareness of her professional interests and her patients’ expectations, which enabled her to make more appropriate use of professional power and expand her skills to build professional relationships.

Alan
Across the participants, the more importance they placed on propositional knowledge, the more technical and rigid were treatment plans and the more authority was claimed by the physiotherapist. Alan provided a good example of this more therapist-centred approach:

I don’t like to give them [patients] a choice between stretching and strengthening exercises because I don’t think they can decide which one is more appropriate. I think it is a decision that is made with my assessment. I am clinically trained. I don’t think that they could do that. I guess I always decide what exercises to do. Then I let them work out how they are going to do that throughout the day. I wouldn’t think of giving them total control. I think it lies in their best interest to do what I say. I explain why the exercises need to be done, what they are trying to achieve. That makes a big difference. (Alan)

Alan was aware that he used professional power in clinical decision-making. He justified his decisions predominantly with his propositional knowledge. Alan kept a diary noting down how much control in their exercise programs he gave to his patients out of a scale from zero to ten. Zero meant no control and 10 meant full control. Alan reported on his diary:

The one [patient] I gave 10 out of 10 was actually a physiotherapist who came to me with neck pain. … Another one got 9 out of 10, she was pretty much managing herself. She was young and actually a law student. She was wanting to be independent and she was going very well. (Alan)

Alan shared control with patients who were complying and improving. Collaboration and working in harmony between Alan and his patients occurred only when patients shared his perspective. Alan did not change his perspective.

Across the participants the extent of critical dialogue and democratising professional relationships revealed the complexity of blending personal and professional authority with patient perspectives. All physiotherapists in the trialling phase were unwilling to unconditionally surrender their professional power. Corinne, Zoe, Louise and
Jocelyn were more able than the other participants to challenge their claim of professional power. In examining the participants’ interviews a number of indicators of their capacity to democratis professional relationships were evident:

- Appreciating patients’ perspectives (e.g. fear, lack of knowledge)
- Becoming self-aware of personal bias
- Being willing to reconsider treatment choices
- Exploring options with patients
- Establishing reciprocal relationships (being open and enabling the patient to be open)
- Recognising clearly the values that inform decision making

Physiotherapists working within a CSS would be skeptical and critical of taken-for-granted and automatically assumed professional authority. The four participants who fitted this description, Corinne, Zoe, Louise and Jocelyn, were flexible and chose to claim their professional power with some patients but not with others. They were able to justify their power use with critical reasoning.

5.3.3 Rethinking rationality and values that inform clinical reasoning

Rationality is often equated with objectivity in the physiotherapy context. Non-objective reasoning is seen as irrational, emotional or illogical. Traditionally, objective rationality is highly valued in clinical reasoning. Rationality, defined from a CSS perspective, is critical of purely objective and subjective reasoning. As described in chapter 3, critical rationality is a struggle against one-sided and one-moded reasoning. Reasoning that is based purely on one approach to knowing excludes the value of other ways of knowing. To consider and embrace diverse ways of knowing and reasoning with an intention to challenge the status quo and a willingness to reconsider goals and actions is a prerequisite for rethinking the rationale and values that inform one’s clinical reasoning. Professional values and clinical reasoning inform ways of knowing that underpin clinical practice knowledge.

There was no doubt that propositional knowledge was the foundation to practice within this trialling group. The core identity of being a physiotherapist originated in their technical propositional knowledge. However, with clinical experience the relevance of propositional knowledge in relation to personal and professional craft knowledge became less dominant.

Corinne

Corinne described professional practice knowledge with an analogy to music

I suppose the point is that we [clinical physiotherapists] need something solid to work from and the rest comes along with a good foundation. I always relate it to music. With music you need to have a solid foundation but the actual musicality is something different. It is a gift. So a musical performance is a combination of that rigid formation plus the musicality. So you can have all the rigid formation and give a technically correct performance without giving a musical performance. I think the same applies for physiotherapy. You can do it technically correctly. We have some physiotherapists who do prescriptive regimes in rehabilitation and we have had some feedback from patients that they did not fit into that prescriptive regimen and they have come to us feeling like failures. They couldn't fit in mainly because of their pain. They can't handle pain that they are trying to do what they are told to do to get rid of the pain. (Corinne)

Corinne spoke of the importance and benefit of using personal and professional craft knowledge rather than relying solely on propositional knowledge. She provided an example of how a prescriptive, technical approach to treatment can leave patients feeling alienated. Such an approach based on objective rationality could exclude patients’ knowledge of being and moving in a body and sensing pain or discomfort. Objective rationality had the potential to alienate patients from their bodies, as Corinne suggested in the quote above. Patients’ body awareness was an important criterion that could direct how to help patients learn about physical movements and exercises. She wanted to work better with patients’ perspectives rather than following rigid checklists.

The literature that you have given us [in the pre-implementation workshop] was talking about getting back to the idea of learning and I have sort of mentioned it a little bit [in discussing] the way people learn. In one of the papers it said people learn step-by-step and other people have a sense of it, they have a natural talent. I have been thinking whether my practice fits into that model. I would like my practice to be more fluent, creative and artistic - gut feeling sort of thing. But I know it has to be based on step-by-step initial learning and it has to be
based upon the evidence I suppose, correct assessment. I suppose I am trying to eliminate the unnecessary steps that we take sometimes in things like assessment. I am trying to fine-tune it to do only what is necessary. Am I getting to the point what it is all about or do I still plot all around the place?
F: So you are trying to hone in on cues faster?
Yes, that is what I mean. Looking for the things, fine-tuning to the cues the patients are giving us. One thing that I have noticed is that I don’t observe sufficiently. When they walk in what can I learn? I noticed frequently I have asked patients to come in and I haven’t even watched how they get up, walk in here. So I miss a lot of information. (Corinne)

Corinne was questioning how effectively she was actually applying professional craft knowledge. She valued a more inclusive approach to observation and she viewed each treatment as a learning process for herself. Corinne stated:

I wanted to learn from the patient so that I could improve my own skills. I think that every treatment session is a learning session for me. (Corinne)

Corinne did not see herself as the only expert or as the professional who should know all the answers. She could appreciate that patients had some relevant knowledge as well. Another aspect of rethinking rationality was the way therapists phrased questions to patients. Corinne felt that confronting patients with closed questions that require a yes/no answer could inhibit a trusting, open relationship. Instead, Corinne would try to engage patients in a dialogue by asking open questions concerning home exercises:

‘Have you been able to do your exercises? Did you have any problems with them? Would you like to show me what you’ve been doing.’ That allows them to come into it gently and not feel like they were a naughty kid because they haven’t done it. Because if I say ‘Have you done the exercises?’ they name me a dozen reasons why they couldn’t do them. A lot of our people are looking after elderly spouses or parents or even grandchildren. Those things come first before their own exercise. (Corinne)

Corinne was aware that not all patients valued exercising as highly as physiotherapists did. The values that underpinned Corinne’s reasoning were not exclusively located in objective rationality. She was mindful of and appreciated patients’ priorities and their values. Although she could see some merit in evidence-based approaches to practice she remained critical of them:

That whole scientific model in many ways is a very, very awkward way of trying to prove that what we do is effective. In fact, I think there must be better ways. I’m not sure how. ... I think it [evidence-based practice] has gone off on a tangent of its own. I think it’s taken on a momentum of its own that frequently is not really related very strongly to clinical work. That’s where I have problems. (Corinne)

Corinne alluded to the clinical reality where variables could not be controlled, patients presented a diversity of needs and perceptions, and physiotherapists added to this diversity. Corinne found it challenging to account for her practice epistemology within an evidence-based framework.

The problem is we cannot always prove that what we do works. We’re human beings, we’re not machines, that’s the problem. We are not machines, we are emotional, psychological, physical, physiological, spiritual beings and all of that affects the way we function, and it’s not possible, if we start treating people only like machines. (Corinne)

Corinne shared many stories to highlight how objective rationality and evidence-based practice were insufficient as the basis for her practice approaches. She felt that aspects of trust, humanity and a sense of how to work with patients’ fears and interests needed to be included in rethinking rationality and evidence in physiotherapy practice. One of these stories is presented below:

One of my patients at the moment was in a car accident four years ago. She has been passed from one first year graduate to the next one and the main course of treatment has been to say, you know, the problem is stiff neck and pain. And the first year graduates are saying, well, we’ve done all the exercises and it hasn’t improved, there’s nothing we can do to make it better
so we’re going to discharge you. She came back and she said ‘look, I want to make a complaint. I’m not happy with this. I really need to be able to drive the car’. Because at the moment she drives the car, but she can’t turn [her neck]. So her husband backs the car out for her and she always keeps driving till she finds a parking spot she can drive into. Her husband’s going away for a couple of months, she’s going to be left having to get the car out of the garage and she needs to be able to turn her neck to reverse the car. And I said ‘Well, let’s see what we can do’. I brought her back in and just with a bit more hands on stuff, a bit of massage, a bit more mobilisation, we’ve gained quite a lot, there’s been quite a bit of improvement. Sure, exercises should help but sometimes they don’t always help, you know, there are other things that sometimes need to be done. And maybe it is just her confidence in me, you know what I mean? I’m sure that that’s a part of it, too, so therefore she is prepared to stretch to the pain point, because I tell her it’s okay to, do you know what I mean? So we’re gradually improving the range of movement. (Corinne)

Outcomes and patient satisfaction improved with attention to this patient’s individual needs. Corinne’s technical approach did not differ from that of the more technically inclined junior colleagues, but in addition to the technical aspects Corinne included critical sensitivity towards the need for human touch and attention to detail. Her treatment was guided by her patient’s practical need to reverse her car and her emotional need to trust her therapist.

**Jocelyn**

Jocelyn had a similar encounter with a patient with a chronic condition:

> I do feel that what we do needs to have evidence behind it. But I think it will take such a long time to prove everything that I am happy to leave things that have been proven not to work but I feel that [this] woman [a patient of hers] really responded to massage. She really felt a lot better afterwards. Maybe only short-term, maybe only psychological [but] I didn’t mind devoting a small portion of my time to massage if that meant that she was going to do the exercises I prescribed for her. So if someone tells me they are 20% better or something, and largely so because I have listened to them and I talked to them and I have understood them, although it is not ideal in physiotherapy, I have made them somewhat better. And I like my patients to feel better. I feel I am doing a good job whether it is scientifically sound and measurable or not. If my patients are 20% better then that is something. (Jocelyn)

Corinne and Jocelyn both defended their use of massage. Jocelyn valued making her patients feel better. She did not favour measurable empirico-analytical epistemology over other ways of knowing. She focused on understanding patients even if her understanding was not scientifically measurable. Listening to and understanding patients was Jocelyn’s interest because she saw her practice as treating people within their wider context. Jocelyn did not isolate physical symptoms but integrated them to identify patients’ needs. Her interest was to make patients better from their perspective and not necessarily from a quantitative measurable perspective. Such attention to patients’ needs is testimony of Jocelyn’s emancipatory values.

**Petra**

Petra found it difficult to focus her treatments around her patients’ perceived needs. She had worked in acute settings for more than 20 years. She asserted that patients in acute, clinically unstable conditions could not make reasonable decisions due to pain, drowsiness and/or lack of awareness of their acute condition.

> I am ambivalent because I still really think that if patients did what they wanted to do really then they would only lie in bed all the time. It is a matter of explaining to them. It is a learning process. We are not really doing what the patients wants. We do have to do what I want. Not what I want personally but what is necessary for a speedy recovery. I will go as far as to say lying in bed is very dangerous. I explain what happens when people fly in the airplane, people get clots in their legs, or even in the brain or lungs. Patients then say ‘you are frightening me’. I am sorry to tell you this but you need to know, it is my responsibility to tell you this. I feel very anxious doing that [not treating due to patients’ wishes] in case the patient is developing a thrombosis or is going to start getting a chest infection. (Petra)

Petra would explain the biomedical condition and the reasons why patients needed to exercise and cooperate with treatment. She told them the medical facts and justified her treatment aims with objective reasons. She did not shy
away from frightening patients and disclosing risk and possible complications resulting from non-compliance. Petra
used these threatening tactics to feel better herself. If she listened to patients it could result in non-mobilisation and
she would risk being unprofessional and not fulfilling her duty of care.

It is nicer doing-with patients than doing-to patients. I feel less guilty towards patients if it is doing-
with but I also feel less guilty if it is doing-to if it is necessary for a speedy recovery. (Petra)

Petra could see some benefits in a patient-centred approach to working with patients but she felt it was not
necessarily an appropriate option in acute settings. She argued that patients did not know what to expect when they
underwent surgery, they did not know what they would feel. The immediate post-surgery period was a stage where
you could not reason with patients. ‘They are not their own expert’. Petra’s solution was thorough pre-operation
education, letting patients know what to expect and what had to be done to ensure a speedy uneventful recovery.

When it is abdominal surgery, day 1, [and the] patient has a temperature and grotty chest, I just go in
and do what I can. If somebody is in pain and they need to cough I assume I have to really make them
cough. (Petra)

Although Petra had a therapist-centred approach she discussed the need to see the human being in each patient. She
emphasised that she avoided rushing patients. She tried to consider their pain, how they had slept the night before,
their mental status, their fear of mobilising and their expectations of physiotherapy treatments. Petra weighed
patients’ perspectives with medical signs and symptoms. She judged if treatment was absolutely necessary or not. If
she decided that it was necessary and patients still refused after understanding the implications, then Petra felt she
needed to be therapist-centred.

People come for short-term only. They don't mind doing what you say for a couple of days. My job is
not about changing. I don't see that [sustainable change] in the short-term that I see patients. It
makes me feel kind of relieved that I don't have to do that. (Petra)

She confirmed herself as a short-term physiotherapist in an acute setting. Acute, short-term settings meant that there
was no perceived need and opportunity to develop professional relationships. Her practice values and clinical
reasoning were informed by the acuteness of clinical conditions.

Jacquie

Jacquie, who had worked in spinal rehabilitation for more than 10 years, felt that physiotherapists needed life
experience before they could treat spinal injury patients holistically. She claimed it was important to be creative and
work very closely with individual patients’ needs.

It's harder for a younger physiotherapist to do it [explore creatively], because maybe they haven't got
scope and vision yet in life, in order to be able to explore some of those things. But I guess they can
still look at ways and means, and often with occupational therapists, in how to be able to modify their
[patients'] environment. (Jacquie)

Jacquie saw a need for physiotherapists to draw from personal knowledge and life experience in order to work
effectively with patients. She also saw a need for collaboration with other health care professionals such as
occupational therapists. Jacquie was aware that there was little certainty in the speed and degree of recovery from a
spinal injury. She felt that hope, creativity and vision were important ingredients of professional practice
knowledge. Louise, who worked in the same practice setting as Jacquie, also shied away from closing off options
and telling patients the finality of their condition when there was still hope for further recovery of function.
Objective rationality was seen to smother hope. At the same time, keeping up hope could lead patients to
procrastinate about making decisions and plans for their future. Jacquie felt physiotherapists needed intuition and
creativity to guide patients in this very challenging time of early recovery.

During the trialling phase participants reflected on their perceptions of rationality and the values that informed their
clinical reasoning. However, their level of willingness to rethink their practice values, to challenge themselves in
what they were doing and thinking varied. In their dialogues with me, participants were eager to justify their
approach to clinical reasoning and to make sense of clinical situations and patient behaviour. They were interested
to explore how they arrived at clinical decisions but were reluctant to reconsider their decision-making approaches.
Willingness to be challenged on personal and professional values and to rethink professional practice knowledge
was not apparent in all participants. Some participants such as Alan had not questioned their clinical reasoning. He
placed most value on instrumental, objective clinical reasoning. He could appreciate that patients’ reasoning was

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different but he would not integrate it into his clinical reasoning if a patient’s reasoning was emotional. Jacque became more aware that she would decide in each clinical situation which reasoning approach she could take. Jocelyn appeared to be patient-centred with all patients. She reasoned her clinical decisions strongly from a patient perspective and displayed little focus on self and professional values other than making patients better. She did not question whether she helped patients help themselves. Her purpose was to be of service. Rethinking rationality in a direction of emancipating herself and her patients from non-egalitarian and unnecessary constraints was not her focus. She focused on patients. Taking a critical approach to rationality and clinical reasoning would require rethinking rationality for each situation and justifying decisions having emancipatory interests in mind.

5.3.4  Redefining professional identity and roles
Trialling CSS includes redefining one’s professional identity and role. Along with a capacity to critically reflect on one’s beliefs and actions comes the capacity to democratise professional relationships and to rethink rationality, practice knowledge and clinical reasoning. Clarifying professional identity and roles was another aspect discussed in the trialling phase of CSS.

 Alan
Alan planned to focus more on listening to patients: ‘It would be interesting to see what they say.’. He saw his role as the expert telling patients what needed to be done. Although he intended to, Alan did not focus on trialling greater listening to his patients. In his final interview Alan described his role:

    People who do not accept their condition are very unhappy people, and the pain and the drugs and everything. You can’t do anything for that person really. For that person they have to come to terms with it in their own way. And based on how they want to lead the rest of their lives. It is a personal thing, all their past experiences, all their things that made up their emotional being makes up how they do it, if they do it...  
F: Is it your role to help them change their perspective?  
(long pause). Yes, I think it is part of education. Especially when dealing with chronic things it is about managing, and you do not want the person coming to you every six months for a course of treatment. If you want the person to manage their condition themselves, well effectively, they have got to have a reasonable understanding of their condition and their perceptions have to be matched with their condition, so I guess if they have an arthritic knee and their perception is, if I do any exercise that makes the pain worse I won’t do it, then that is going to affect their health and lifestyle. (Alan)

Alan saw his responsibility as helping patients understand their biomedical situation. It was not his role to help them deal with and integrate the biomedical implications into personal perceptions and social contexts of patients. His patient education role was narrowly defined as providing biomedical explanations, not education that was inclusive of patient perspectives and had emancipatory interests. Professional identity was a therapist-centred affair for Alan.

 Carolyn
Carolyn worked in the cardio-thoracic department and especially with people living with chronic respiratory conditions. She coordinated an outpatient program for patients with chronic respiratory conditions in the community. She embraced the social and emotional issues that these patients faced when planning their educational program. She said the initial contact with prospective program participants was crucial but very time consuming because she had to listen and attend to all the issues and barriers before these people were able to attend the program.

    Once you open it up to say ‘ok what do you think?’ [can you physically get here?] and then discussion happens. For example that lady can’t come in the morning. Then I have to change the whole structure of the program to suit her somehow. Then it is about suiting her daughter who wants to go to a carer’s support group. So you spend another 45 minutes discussing how the daughter is coping. I ended up with 3-4 different jobs just from opening it up rather than saying, ‘this program starts on this day.’  
F: So the issues are that being open causes more different jobs that aren’t really physiotherapy jobs.  
You really refer them on. I spent the 40 minutes being a social worker. Validating the daughter’s concerns because her mother is developing pain and can’t leave the house so the daughter is trapped in the house. You spend that 40 minutes listening. But anyway you end up
being a mini social worker and mini speech pathologist because you are bridging that referral gap. (Carolyn)

Carolyn saw her professional role as enabling patients with chronic respiratory issues to attend a patient education program. She was mindful of the fact that people living with chronic conditions needed transport and generally support from carers. She saw family members and carers as part of the patient perspective. Carolyn discussed the issue of language barriers in the program. She had participants from non-English speaking backgrounds for whom she organised health care interpreters. The program was tailored towards diverse patient needs. She placed their needs above her own professional demands and needs, such as time. Time was a significant issue for all trialling participants. Carolyn was one who would consider patients first wherever she could.

Jacquie
Jacquie felt strongly about keeping professional boundaries but at the same time she did not want to lose her humanistic touch to patient care. She felt physiotherapists were in a strong position to work holistically with patients. She felt it was important for physiotherapists:

- to understand when something is a physiotherapy issue, when it’s a social work issue, when it’s an occupational therapy issue, when it’s an issue, when that other person is trained better than you are to manage that particular issue. Where it gets blurred and a bit difficult is with psychologists. They are often asked to give opinions or comment on patients’ behaviours or attitudes. Physiotherapists would spend probably two hours a day with the patient, occupational therapists probably two hours. A psychologist would be lucky to spend one hour or two hours in two months. Often psychologists think that they know something and yet we’ve got all this other time we’ve spent with this person and listened to their family and listened to them talk, listened to them generally interact with other patients and everybody else because we don’t have separate treatments here. There are all these people at the gym at one time. (Jacquie)

Jacquie’s professional identity as a physiotherapist centred on biomedical functions. Nevertheless, she included other functions that influenced her patients’ wellbeing. She used the gym environment, working alongside other health care professionals, to develop and treasure her personal and professional craft knowledge. She saw it as her role to deal with patients’ behaviours and beliefs. Practice knowledge included working effectively within a multidisciplinary team. She felt that rather than fragmenting patient care (leaving emotional issues to psychologists only) she wanted to promote inclusive, collaborative care. Such an approach to professional roles implies blurring professional boundaries, respecting each other’s expertise, and having a willingness to reconsider and listen to colleagues. Jocelyn shared Jacquie’s interpretations of professional identity as caring for the wider implications of wellbeing. However, she was worried and unsure about her chatty personality and her holistic approach to caring that went beyond caring for biomedical needs. Jocelyn wondered whether her ideas of caring were professional and the norm.

A lot of people laugh when I talk in case conferences. They [other health care practitioners] say ‘Jocelyn you should have been a social worker’. Because I often find out about their social situation. They see that as only the social worker’s problem. But sometimes it comes out at your treatment that there was an abusive mother or you know, an adopted sister. You can see that this affects your patients (Jocelyn).

Louise
Louise added another angle to the discussion of professional roles. She felt it was important to understand how her patients understood the physiotherapy role. Louise was not satisfied with knowing for herself who she was as a professional physiotherapist. She also needed to understand how patients interpreted her role as a physiotherapist. Some patients would automatically see her as the ‘enemy’ simply because she was a health care professional.

Sometimes people perceive you automatically as the enemy, including the patient’s family. You are part of the establishment and part of the system of telling them that they can’t function the way they would like to. No matter what you are trying to do. (Louise)

In these situations Louise saw it as her professional role to help patients trust her, not by sharing her propositional knowledge but by applying her professional craft knowledge. Louise saw her role as building her patients’ capacity.
She felt it was important to build their confidence in themselves, help them identify goals and work together towards them.

I used to say that I am patient-centred. I am not sure if I would use that term now. I suppose the role evolves getting patients to feel as comfortable as possible with me and with the rehab process, getting to trust me, my theoretical knowledge, trust that I am going to tell them the way it is and not trying to make them believe they can't do something just because I think so. I get them to understand what is happening and have confidence in their judgment there. I want to advocate for them if they are being discriminated against in any way by any one member of the team. Sometimes they are scared. People do not realise their full potential. For example, we are not doing this with this person because he is an x-type of a person. If you believe they are physically capable of doing something you advocate for it. You negotiate with the patient and on behalf of the patient with the team. In relation to the patient, that is why we are here. It is the whole patient. If patients don't have a goal then we are trying to identify one. It might be very small, but it is important to have goals. (Louise)

Louise saw it as her role to help patients advance in their journey towards better health. She felt that nurturing patient self-confidence, having goals and self-efficacy in achieving them, were important aspects of physiotherapy treatment. This is in contrast to treating physical deficits with the goal of bringing function back to ‘normal’. Building full potential and working towards patients’ capacity has emancipatory interest at the core.

Corinne

Corinne would define her professional role beyond improving physical functions. She reasoned that therapeutic approaches to biomedical issues included hands-on as well as hands-off interventions. She used supportive listening as part of her treatments.

I got totally caught up with someone [patient]. We ended up doing very little actual treatment but she has got huge problems at home because of her husband who has had a stroke. I obviously hit the spot when I said something to her and we spent the whole time talking about this and I couldn't stop her. She obviously needed to tell someone and I felt this is just as good, just as therapeutic, you know, allowing her to express it, as engaging in physical treatment that she is here for.

F: Did you feel uncomfortable wondering about your role?
No I didn't feel that. That was OK.
F: You didn't say 'hang on we are here for physiotherapy, stop talking and we do the treatment!'
No (laughter) but don't forget I am a lot older. (Corinne)

Corinne judged treatment situations individually. She did not elaborate why she felt ‘OK’ beyond saying that she was older than some of her colleagues and she could justify herself with her age. There are many potential explanations of this. Using her age discriminated against younger physiotherapists. The affinity in age between Corinne and her patient built rapport. This patient might not have shared her concerns with a younger, unmarried therapist. In saying she was older, Corinne implied that she might be wiser. She used her clinical experience to develop her professional craft knowledge and rethink her professional role as physiotherapist.

Zoe

Zoe shared a similar redefinition of her role as a professional. She would judge individual patients’ needs and respond to what she thought was most appropriate for her patient.

I see the patient is unhappy, sad, etc. so I let her go back to the ward. I was thinking about this and I am aware that I am a senior and I should know what I am doing. It was my choice to send her back to the ward. I can justify it. If I was younger I would have thought 'no that is my job, I have to work with her now'. (Zoe)

Appropriateness in this incident was understood in the clinical context, considering professional identity and role as well as considering patient need. However, Zoe was not totally convinced of her justifications and she remained skeptical. She compared herself with other physiotherapists and wondered if she was ‘professional’ enough as a physiotherapist.
Patients invite me to play golf, go to a BBQ etc. and that should not be happening. But it often does. Some patients are pretty knocked off frontally so that might explain some of it. I am just too friendly and I can't help being global. I think I am appropriate, I am professional but I still think I give too much as a person as opposed to as a therapist. The workshop made me think if I use me as a person to manipulate my patients. So I probably do a little bit. I should not be this nice girl to get what I want out of this. I am still thinking about this. I am very pro patient and anti system by nature. (Zoe)

Zoe hinted at the complexity of justifying her professional identity. She explored and challenged the motivation behind her patient-centredness and her clinical decision-making. She was aware of peer pressure and her resistance to complying with generalised systems that were not sensitive to diverse situations. Zoe felt that patients’ interpretations of their physical conditions had

**a lot to do with their background, their friends and family. And that fascinates me and that’s why that patient part of physiotherapy is important to me.** (Zoe)

Zoe saw a connection between being respectful, paying attention to detail and giving more than routine treatments to patients.

It [routine physiotherapy treatment] is all very black and white, impersonal, and one dimensional. Whereas this approach [CSS] is good. I like to give them [patients] something: more knowledge about their body, their lifestyle. You know, meet them on their level. I feel I am quite flexible and I give them some respect. (Zoe)

Zoe focused on her patients but realised that she needed certain information and clues to treat patients appropriately.

When we first talked in the workshop I thought maybe I am too equal and I won’t get my patients [to do] what I want them to do. But now when we are talking I think I need to feel comfortable and I need certain things, I need the information from them to combine what I think is best for them. So the patient needs to feel free to communicate. It is also about finding out how they think about their body, how they move. How much do you walk around? Oh well I don’t know. You know that gives me an idea about a patient’s relationship to her/his body. (Zoe)

Zoe challenged her interpretation of the role of physiotherapists. She was not always comfortable in her patient-centred role. She alluded to the need to be authentic, and for her being authentic meant feeling comfortable and confident herself. During the CSS trialling period confidence emerged with critically knowing what motivated her. She rethought her understanding of patient-centredness and emancipated herself from hidden manipulative motivations of being patient-centred.

The discussion of professional identity raised issues of questioning the physiotherapy norm and how broadly to define the role of physiotherapy. Time, seniority in the clinical hierarchy, personal development of professional craft knowledge and confidence in justifying one’s clinical reasoning were all influential factors in rethinking professional identity and professional roles. The trialling group was consistent in raising the time factor as a potential obstacle to operationalising CSS. Participants who valued CSS approaches justified their time spent listening carefully to patients, arguing that this led to ensuring appropriate, acceptable, sustainable and time-efficient treatments and discharge planning. All these actions fostered patient emancipation. Participants who worked with patients for longer periods of time were more ready to redefine their professional identity and broaden their role than those who worked in acute settings.

**5.3.5 Rethinking the practice context**

The practice context of physiotherapists can be understood on various levels. In its narrowest sense it could be interpreted as physiotherapists treating biomedical symptoms such as clearing a bronchus or strengthening a muscle. In its wider sense it could be interpreted as physiotherapists working within a multidisciplinary team facilitating patients’ learning to improve their biopsychosocial wellbeing within their community environment. Physiotherapists develop different working definitions of the term practice context. One of the CSS dimensions determined in section 3.9 was rethinking the practice context, rethinking biomedical conditions within the social context of patients.
Zoe

Zoe worked in a rehabilitation setting where she could treat patients in the ward and in the gym. However, she routinely treated all patients in the gym. During the trialling phase she questioned her reasoning behind this choice, because she felt patients were not well prepared for physical activity. She tried to familiarise patients with their new physiotherapy environment at a slower pace.

People [patients] have to feel comfortable with you. On Friday afternoons, if there are new patients I used to get them down to the gym and assess and treat them. But now I go up to the ward. They have only arrived that day. They are in a new environment. I have a chat and a quick look. And then on Mondays they come down to the gym.

F: So the first agenda is to introduce yourself?
Yeah, and make them feel comfy. I had two ladies that arrived on Fridays. And when they came on Monday to the gym they recognised my face. It is too much information when they just arrive. You know it is all new. Initially I let them talk to me on a Friday. On Monday I get them on the plinth and ask them to do things. Because I had that chat to them you know there is a certain amount of rapport. Patients feel comfortable. They trust me. They feel that I don’t impose. (Zoe)

Zoe became mindful that what she did routinely was not routine for her patients. Meeting patients in the ward first, before treating them in the gym, helped build rapport. Apart from meeting patients in ‘their’ territory first, Zoe started to be mindful of how patients would feel in a gym environment. The gym can have connotations of sports, training and competitiveness. Zoe loved the gym environment and its physical competitiveness. She used the gym to create a competitive environment to entice patients to exercise. She compared patients’ physical performance and tried to motivate the less willing to exercise as hard as the more willing. Zoe became aware that she had imposed her interpretation of a gym environment onto her patients. She felt she was using the gym as her ‘little school’, disregarding patients’ interpretations of a gym and their need for privacy. She also doubted whether the gym environment could improve self-motivation of patients to exercise and be physically more active. Zoe recognised that her approach was not emancipating patients but rather manipulating or even dominating them.

Petra

Petra reasoned that her short-term and acute practice context was not conducive for building professional relationships with patients. She provided an example: Patients might be were scheduled for an operation on Fridays, have a pre-operation session on Thursday with one physiotherapist, then see the night physiotherapist on Friday after the operation, see two different physiotherapists over the weekend and by Monday they would be discharged. These patients would not see the same physiotherapist twice. Petra felt that such a practice context was not conducive to getting to know patients and working appropriately with them on their terms.

Shared decision-making is not workable. People come for short-term, they don’t mind doing what you say for a couple of days. (Petra)

Petra felt that building rapport and including patient context were not feasible in acute settings.

Corinne

Corinne considered a wide range of patients’ perspectives such as age, fitness, attitude towards exercising, perception and fear of pain, gender and cultural backgrounds. She was aware that some patients were more uncomfortable about getting undressed than others. Corinne incorporated patients’ contexts into her professional working framework and responded to their needs.

Jacquie

Jacquie embraced both physiotherapist’s and patients’ contexts. She considered it important to be aware of the complex dynamics of young female physiotherapists working longer-term with male spinal injury patients.

I know when you’re a young physiotherapist, when you just start out, you have your specific little questions that you ask people and you tend not to vary too much from those questions. As you get older, especially with spinal injuries, you know that you have got to know the person a lot more. You absolutely have to know the person a lot more. You have to know the history, how they think. You have to have all their background in order to be able to work out your goals with the person because you get very, very close to the patient. People are so completely shattered by this life-altering event in their life that it’s not like treating an outpatient.
person a lot of the time. It’s not just, ‘I’ve got a bit of a sore shoulder’ or ‘there’s something a bit wrong with my knee’. It’s fairly catastrophic. The timeline is different as well. It’s not that you’re just going to treat the patient for six weeks because that’s all the time that you’ve got for an outpatient because your list is so long. You usually have the patient for six months and probably up to twelve months. (Jacquie)

Longer hospital stays in rehabilitation made the practice context very different from that of a short-term stay. The longer the timeline, the more opportunity exists for patient-focused practice and a wider interpretation of practice context. A narrow practice context with a clearly defined framework was warranted in acute life-threatening situations that called for a technical, therapist-centred approach. Jacquie stressed the importance of patients following strict bowel, bladder and skin care procedures. She was very certain of the importance of setting boundaries with patients.

I tell my young staff the first thing that will kill a spinal injury patient is non-compliance. It kills them because unfortunately the one thing that a spinal injury does to their life is give them a regime and unfortunately they have to stick to it. They can’t be a free body any more, there’s a lot of time constraints put on them, like bowel regime, bladder regime, looking after their skin. Physiotherapists have to get them to understand how important it is and they [patients] have to live their lives within that. Then, how they live their lives within that is totally up to them. Like I said, you go back to do what you were doing, we help you if you want to do that, we help you change if you want to change and obviously we, you know, if they’re just stuck in some sort of depressive state, well we try and help them out of that. (Jacquie)

Jacquie set up a biomedical framework within which practice context and negotiations with patients could occur. She rejected the notion of unconditional freedom for patients just as she rejected unnecessary domination over patients. Her clinical framework operated with the goal of preventing life-threatening complications first and then attending to wider issues of patients’ concerns.

Some participants did not like patients arriving late for treatment. They dismissed these patients as unreliable and labelled them as not motivated to do physiotherapy, whereas others tried to check why patients were late. Louise admitted becoming annoyed but she was mindful of her patients’ circumstances. Patients with a disability might need to wait for a wheelchair accessible bus, or they might depend on a carer who is less reliable. Nevertheless Louise set boundaries and made it clear to her patients that it was their responsibility to be on time.

Carolyn
Carolyn, who booked outpatients for an education program, perceived her practice context as beyond the actual program. She considered transport issues, timing of the day, and carer needs, as well as checking for appropriate referrals to this program. She had found that specialists made inappropriate referrals. Carolyn queried referrals because she had a clearly defined program context established and her goals were long-term. She reasoned that spending a lot of time at the beginning identifying and encouraging appropriate program participants to attend her program potentially reduced hospital readmission rates in the long term.

You get much better results and more content customers. I suppose if I can fix up these people in a six week program it saves a whole year of readmissions and worry. And I suppose it saves time at the end but initially it takes a lot of time. (Carolyn)

Although Carolyn had patients’ interests in mind she argued her practice context from a cost-effectiveness perspective. Reducing hospital readmissions was argued as a benefit for the health system. Carolyn did not argue from an emancipatory perspective where reducing readmissions could be seen as patient emancipation from dependency on health care system.

There were diverse interpretations of what constituted a practice context for physiotherapy practice. These interpretations ranged from intra-personal micro- to community macro-contexts. Some participants did not question their practice context beyond the intra- and interpersonal micro level. Others explored the wider practice context, such as working with people who lived in the community, considering their family support structure and employment needs. Others discussed their own working context such as the hospital gym environment, or their work in context of being a supervisor or senior physiotherapist. Another context raised was that of working with colleagues and other health care professionals and their expectations and assumptions of health care practice.
Patient context can best be understood by appreciating their diverse background and by being critically aware of influential social forces. Within a CSS model, situations would not be analysed in isolation, and patients would not be solely blamed for unhealthy behaviours. Rethinking practice context means critically understanding the meanings, beliefs and behaviours underpinning practice. The practice context needed to be defined within emancipatory terms. Widening the practice context and responding to sensitive issues of patient concerns enables physiotherapists to emancipate themselves from narrow professional roles. Social interpretations of health, wellbeing and responsibility for health serve to widen the scope of professional practice, the capacity to work effectively in multidisciplinary teams, and the role of patient advocacy. In traditional physiotherapy the tendency to reduce the practice context to the immediate, biomedical symptoms reduces physiotherapy practice to treating isolated aspects of people’s health needs.

5.4 Transformations of individual participants in the trialling CSS phase
In this section each participant’s journey of trialling CSS is portrayed, with a focus on shift in perception and/or practice. Although most participants could not operationalise all the five dimensions of the preliminary CSS model at a complete level, some participants were able to operationalise fragments of CSS. In general, participants used the first in-depth interview after the pre-implementation workshop to question themselves, their approach to clinical reasoning and their clinical decision-making processes. In subsequent interviews participants appeared to be integrating their critical thoughts and their new learning into their practice. Some were more forthcoming about practice tensions and dilemmas that they had encountered. They became clearer about their approaches to practice. Final interviews had a less self-questioning character. Participants appeared to have formed conclusions and opinions about CSS. Table 5.6 highlights each participant’s journey of trialling CSS in terms of the insights, shifts or transformations they had undergone throughout this trialling phase. External influences on practice transformation could be realised only in conjunction with internal self-reflection. The largest shifts that occurred related to participants’ reasoning, their internal influences. Most participants concentrated on self. Their reflections influenced their thinking. Few could transform these internal shifts to practice transformations within this action learning phase.

5.5 Prototypes
In this thesis various perceptions of physiotherapy practice models are explored in relation to CSS. To assist the reader in maintaining clarity about these diverse interpretations, prototypical descriptions are being used. These prototypes are not intended to generalise or categorise models of practice; instead, the prototype descriptions present clusters of themes and should be viewed as preliminary versions of physiotherapy practice models.

5.5.1 The first prototype, The Uninformed
In Chapter 4 Physiotherapy Status Quo, one CSS practice prototype was discussed, which I shall term ‘the Uninformed’ (in relation to CSS). In the following sections three journeys of trialling CSS are discussed. These reflect CSS prototypes 2, 3 and 4. A fifth prototype of CSS is discussed in Chapter 6.

The second prototype group (the Unconvinced) had little time for and/or set low priority on engaging with this project, demonstrated little capacity for critical self-reflection, and remained unconvinced of CSS as a model for physiotherapy practice. Dorothy and Alan best symbolised this prototype.

The third prototype group (the Contemplaters) demonstrated some capacity for critical self-reflection. They identified inconsistencies and tensions in their clinical reasoning and they questioned their professional identity. They trialled transforming aspects of their practice and saw some advantages in a CSS approach. However, they were not fully convinced. Jacquie and Petra best represented the third prototype.

The fourth prototype group (the Transformers) trialled grounding their practice in CSS dimensions. They were actively reflective and critical of their clinical reasoning. This group transformed aspects of their practice and started to shift their practice frameworks. Corinne, Carolyn, Zoe, Jocelyn and Louise best represented the third prototype.
<table>
<thead>
<tr>
<th>Participants</th>
<th>Topic of actual shifts</th>
<th>External -internal influences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alan</td>
<td>In general not really a shift just behaviourist reflections: From asking questions about what he does to why he does it: What is the range of flexibility he can allow patients within a biomedical model? Alan is not challenging his reasoning itself.</td>
<td>No change: accepting the biomedical model</td>
</tr>
<tr>
<td>Dorothy</td>
<td>No shift; patients don’t know what physiotherapy is so they cannot identify their own goals</td>
<td>No change: reinforced in the status quo of her practising</td>
</tr>
</tbody>
</table>
| Carolyn      | In general not really a shift just reflections; no clinical stories shared  
  • Questioning the system more  
  • Confirmed that barriers to CSS lies in the system first, then in individual qualities                                      | External influence due to jury experience                                                       |
| Corinne      | Challenging herself: reflecting how she makes judgments, aware of own power use  
  • Commenting on external influences eg EBP, undergrad training  
  • More aware and mindful of her observations and assumptions and starting to act on them in practice                                                      | Internal/transformative                                                                          |
| Jocelyn      | Critical of her chatty style but now using chatting for the purpose of identifying patient-centred treatment plans                                                                                                    | Internal/transformative                                                                          |
| Jacquie      | Clarifying her thinking and then focusing on how better to help patients. A critical thinker but not a self-reflective critical thinker                                                                                 | internal                                                                                                                                                  |
| Petra        | No change in behaviour but reflecting upon meaning of patient centredness: seeing the human side in patients. Being flexible whenever biomedical aspects allow it. Is more relaxed when she doesn’t need to push the physiotherapy agenda. | Internal                                                                                                                                                  |
| Louise       | She probably made most changes but had to adjust to external changes.  
  • Promotion to grade 2, now more managing, now feels more responsible and can do her thing  
  • From geriatrics to spinals, different contexts and patient needs therefore asking self different questions  
  • Meaning of patient-centred approach is about facilitating empowerment. It is not anarchy or total autonomy to patients but it is flexible, fluid, it is give and take  
  • Understanding and responding to patient’s needs at the time |
| Zoe          | Appeared to be honest critical self-reflective thinker.  
  • Critical self-reflection leading to changing practice and feeling more comfortable and confirmed in her role  
  • Less emotional about her difference and more thoughtful of it. Understands herself better       | Internal and transformative                                                                       |
5.5.2  The second prototype, the Unconvinced: Trialled CSS but remained unconvinced and unchanged

The Prototype 2 group started the trialling phase by reflecting back on professional practice. During the first interview, statements and claims were made about patients that were based on unreflective assumptions. Statements were not substantiated with incidents from practice. Prototype 2 participants did not question assumptions and values. Clinical reasoning and decision-making processes appeared to be a linear, cause-and-effect exercise. For example, patient motivation for exercising was judged by their compliance with home exercises, and unmotivated patients ‘needed a more therapist-centred approach’. This group did not consider diverse reasons for not exercising at home. Their ability to explain home exercises appropriately to individual patients was not challenged. Prototype 2 participants assumed that obese patients disliked exercising, without testing this assumption with patients first. Participants in this group did not critically reflect but rather described and declared decisions. Reflecting back on practice confirmed existing practice approaches. Patients who shared values of exercising and physical fitness with the therapist were given decision-making privileges.

Democratising physiotherapist-patient relationships was not really feasible for this prototype group. They found that control could be handed over only to patients who could be trusted to comply with treatment plans. They identified these patients as well-educated, young and physically fit. These physiotherapists were not aware that these patients were people like themselves and that their approach was reinforcing the status quo of power relations. There was limited ability to engage with patient diversity. There was a belief that practice needed to be flexible and responsive to each clinical situation, but flexibility was firmly limited to remaining within the biomechanical framework. Prototype 2 therapists understood the importance of setting realistic goals but felt it was up to patients to comply. This group became aware of the difference in treating patients with chronic conditions because they could not be easily persuaded of the efficacy of exercising. Even though this prototype group acknowledged patients’ experiences of living with a chronic condition, the biomedical model prevailed. The following quotes sum up succinctly this prototype group:

I think it is a decision that is made with my assessment. I am clinically trained. I don't think that they could do that [make appropriate clinical decisions]. I guess I always decide what exercises to do. Then I let them work out how they are going to do that throughout the day. I wouldn't think of giving them total control. I think it lies in their best interest to do what I say. I explain why the exercises need to be done and what they are trying to achieve. (Alan)

My goals were to get the patient to tell me what they want to do; to make it [treatment decisions] more open to them; asking them what they think they need to do which is not easy for the majority of patients. Because a lot of the time they don't know what physiotherapists do. They think it is massage. They don't actually associate it with getting up and walking and all those sorts of things that we perform. Asking patients has not really worked. Especially the older ones. If you say to them ‘what do you want to do today?’ of course they don't want to get up and go for a walk. They don't think about that. They think they are in hospital and need to rest for a week. (Dorothy)

Prototype 2 therapists did not venture outside the biomedical framework of physiotherapy practice. Their reflections did not embrace a critical approach. At the end of the trialling phase they felt more aware of and confirmed in their own practice.

I don't think anything has changed the way I practise. No I don't think I have changed anything but I think it has been reassuring for me that my reflections show me consistency in my decision making. It is not ad hoc, it is not at a whim but I had never thought about why I do it. It fits and it feels comfortable. (Alan)

I don't think this whole exercise [trialling phase] has changed my practice. I think it made me more aware. (Dorothy)

Prototype 2 physiotherapists’ intentions were to adhere to empirico-analytical qualities such as consistency and getting patients to do what their physiotherapists wanted them to do. Reflection without a critical element reinforced the status quo and did not lead to transformation and certainly not to patient emancipation. The practice framework was not challenged, and therefore practice could not be transformed.
5.5.3 The third prototype, the Contemplators: Identified some advantages of CSS but remained skeptical

The third prototype group had many years of clinical experience and felt that their practice had transformed over time rather than just as a result of this trialling phase. Prototype 3 physiotherapists displayed a willingness to reflect on and question their practice. They also asked questions and were often not so sure about their own practice statements. Contradictions and dilemmas were raised and critically discussed from multiple perspectives. As the trialling phase progressed the Prototype 3 group appeared more assertive and clearer as to their clinical reasoning. Skepticism faded. This group of therapists struggled with the concept of patient emancipation in acute settings. They concluded that patient-centredness meant ‘making practice suitable to patient’s background, as much as biomedical acuteness allowed’, and

trying to turn the patient concern around to mine, I guess that is what I would like so that we are working together. So it is educating them [patients] what they need to do. (Petra)

Prototype 3 physiotherapists understood patient-centredness as persuading patients to adopt the physiotherapist’s perspective. It was not based on egalitarian, equal terms and the biomedical perspective prevailed unchallenged. Practice values remained firmly grounded in the acute medical model despite appreciation of patients’ individual fears and needs. The third prototype group allowed more flexibility then Prototype 2. For example, they would respect patients’ requests to come back for treatment at a later time. This group sought to identify individual traits in each acute case and wanted to incorporate patient needs as much as was deemed possible. For example, several patients might all need percussion, cough, suction and mobilisation, but the timing, the sequence, the length of each treatment component would be likely to vary. Prototype 3 therapists believed that once patients were familiar with their acute conditions they could be empowered to take more control and determine their own treatment routine in consultation. The following quote succinctly describes the third prototype:

Doing-to patients saves lives and prevents complications. Doing-to is simple and straightforward. It means following my duty of care. In acute [settings] you focus on biomedical signs and you cannot always develop a relationship with the human being. In chronic settings you have time to develop a professional/personal relationship. In long-term rehabilitation you need to consider the human being more. It is more relaxing, working slower with patients. (Petra)

The prototype 3 group could see advantages of a CSS approach. These therapists stated that a more patient-centred process made them feel better as therapists and probably achieved more satisfaction for their patients as well. On the other hand they felt equally good choosing a therapist-centred approach in acute situations because complications needed to be prevented.

5.5.4 The fourth prototype, the Transformers: Operationalised aspects of CSS with practice success

The fourth prototype group of therapists focused on patient education and its role in helping patients deal with their trauma including anger, fear, shock, denial, and frustration, and coming to grips with understanding the processes they were going through. Prototype 4 therapists assumed that the practice context included the emotional aspects of patient care. Some patients were very assertive and provocative, and they challenged physiotherapists, whereas others needed encouragement to talk. Fourth prototype therapists felt that patient education should be open, detailed and answering patients’ questions. It was important to go into detail and explain issues in depth if necessary. This group was willing to analyse the complexity of physiotherapy practice. Reasoning was not seen as a logical, linear thought process. It was appreciated that diverse interpretations and influences had to be considered before emancipatory practice could be implemented. The fourth prototype group realised that many assumptions were made about what patients had and had not learned from patient education. They emancipated themselves from taken-for-granted assumptions by checking with patients, and they started exploring what patients thought and how they made sense of information they received. Now non-compliance appeared to be the wrong term and was rephrased as ‘patients not taking something on board’. This group avoided setting up confrontational situations where patient perspectives were opposed to physiotherapists’ advice. These therapists would first check what patients were thinking, how they understood their body⁸ and its function, and then work with patients starting from their perspective. This approach confirmed the value of better collaboration and dialogue with patients but fell short of consistently confirming emancipation.

The fourth prototype group had the capacity to critically assess each clinical situation from more than just professional perspectives. It was important for this type not to abuse professional power and dictate what had to be

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⁸ Physiotherapists, as movement therapists, are principally concerned with the patient's functional/bodily disorders/disabilities
done. They had the ability to democratise professional relationships. On the other hand, this group asserted that it was detrimental if patients took over power completely. Patients could subtly manipulate. Prototype 4 therapists adopted the role of providing information and strategies and helping patients to clarify their attitudes, their thinking and understanding of their physical condition and beyond. The relationship needed to remain professional, no matter how informal it was. At times these therapists had to be assertive, at other times they needed to listen and let things happen. Some patients needed to go through experiences of failure before they understood what was happening. The fourth group felt that talking and cognitive reasoning may not help all patients. Flexibility of practice approaches was guided by patients’ needs. Prototype 4 therapists provided a practice environment that allowed patients to explore their physical abilities and their emotions. They felt that taking calculated risks had better long-term outcomes than protecting professional accountability by excluding patients’ emotions. The following quotes describe the practice transformation of this group:

Before [the trialling phase] I gave really simplistic explanations and leave it at that. And as they [patients] achieve and start to understand talk more. Now I want to encourage more 'why' questions. I want them to understand more complex things. They have got to be their own agent. These are the big changes. Changing patient education processes, giving them support but not pushing it; giving them control so they can come back to me. (Louise)

I don't think I reject any of it [CSS approach]. I think definitely through doing these exercises I am more aware of, particularly short-term goals helping long-term goals and to constantly re-referring to those with the person. To keep the process online rather than initially saying this is what you can achieve and they say 'good'. But to actually keep resetting the goals and have goal posts, working towards that. And also being quite aware of which things have been really good as my workload has gotten heavier to still stay patient-focused. Sometimes it gets really busy, other physiotherapists asking you questions, the phone ringing, to patients wanting an explanation, and to realise this is really an inappropriate way of dealing with inpatients, and they are the whole reason why we are doing this. So they should be our focus, despite the other stresses. You can be quite inefficient that way. So now it means that I have to stand back and treat people. I have to make that choice. It has not always been the case. (Louise)

If you are too authoritarian patients lose trust in you. If you are too patient-centred your goals, your aims, treatment and everything can just get totally sidetracked.

Some people you would hand them a lot more power than other people, you would be more authoritarian, and I'm recognising in myself when I'm doing these things. (Corinne)

The fourth prototype therapists were able to challenge themselves, their professional values and professional power claims. Being able to embrace multiple perspectives, being flexible and willing to readjust treatment goals and strategies were examples of CSS in operation. This group was willing to reconsider and trial changes. They journeyed forward. Reflections were used to inform future actions. This type transformed practice towards a CSS approach.

Summary

None of the trialling group participants fully realised a CSS model. CSS was not placed at the centre of their practice. Biomedical definitions of health and human movement remained largely at the centre of their professional identity, of practice frameworks and of practice knowledge definitions. Prototype group 2 explored CSS in a limited way but did not move towards a CSS model for practice. They reflected on their practice for a short-time period only due to leave or heavy workloads. Prototype 3 group were critical of self in certain aspects but did not legitimise or choose moving to CSS practice. Prototype 4 group were self-critical and trialled transforming aspects of their practice. They were moving towards CSS but did not centre their practice in CSS. Figure 5.1 illustrates these journeys. In the next chapter a fifth prototype is added to represent therapists whose practice is grounded in CSS.
5.6 The participants’ critical reflection on the exercise of trialling CSS

In this section the participants’ reflections on trialling CSS are discussed. All participants valued the experience of trialling CSS. At the most basic level, all reflected on their practice. Some concluded that they felt reinforced in their practice, others explored more deeply questions that they had been grappling with for a while, and yet others used the trialling phase as a means and justification for transforming their practice. Alan’s and Carolyn’s final reflections on the trialling phase depicted opposing ends of the CSS trial appraisal:

**Alan:**

*It makes me feel comfortable continuing this way.*

**Carolyn:**

*It [trialling phase] reassured me to try something different.*

Alan displayed a sense of relief that his approach was consistent and logical to him whereas Carolyn welcomed trialling CSS as an opportunity to legitimise transforming her practice. Participants who challenged their practice and had an interest to grow and transform did so. Others asked questions and reflected on practice in a way that did not provide the scope for any significant transformation. Questions that focused on explaining what was happening and searching for causes and uniform patterns replicated the status quo of practice.

Corinne concluded her interviews with the reflection that she had embarked on a journey that involved her personal as well as professional development:

**Corinne:**

*It [the trialling phase] has been really good for me because it’s sort of started me on the road to thinking. The interesting thing is it [CSS] actually goes beyond practice. It’s a part of your life skills too. I notice when I’m doing things with even other members of my family, how I’m interacting with them.*

Jocelyn became a physiotherapist because she wanted to help people. She valued good rapport with patients. However, she avoided raising sensitive issues. During the trialling phase Jocelyn transformed her superficial, chatty behaviour with patients to purposeful dialogue to inform shared goal setting and decision making.
I feel I am treating them [patients] more holistically. I get to know the person and I get to know what they want. And I still have my goals in mind but I try to merge them or kind of turn them. You know, instead of going straight I might turn a little bit to the left and right, if I know that makes them more interested and it might help me with my job and also to facilitate their goals as well. (Jocelyn)

It appeared that participants were poles apart concerning readiness to trial something new. Participants who were less willing to critically reflect on their practice did not advance to trialling any real change in their practice. Critical self-reflection fosters a need for change. Before people are ready and able to change they need to perceive a need for change.

The critical appraisal workshop concluded the trialling phase. Only four of the nine participants attended: Corinne, Jacquie, Petra and Zoe. One was on maternity leave, one was on annual leave, and three apologised for being too busy at work. They had engaged in some cultural appraisal of their trialling experience during their interviews with me. The aim of the workshop was to critically self-reflect on their journeys and to appraise CSS as a model for physiotherapy practice:

What insights had participants gained?
What did participants see as strengths and weaknesses of CSS?
What final questions did they want to pose and continue to explore?

Participants valued the opportunity to reflect. They had had little opportunity in their heavy schedules to do so. Reflective practice was not seen as core business of physiotherapy practice. All participants said they were rushed in their work, their department was often short-staffed, and they saw themselves predominately as ‘doers’ rather than as ‘thinkers and reflectors’. This confirmed that reflection is unusual in the workplace (Mezirow 1990). All felt that they had learnt something about themselves, and that they thought and practised at a level where they had not been before.

5.6.1 Perceived strengths of a CSS approach

Participants could see value in CSS. They felt that listening to patients and working with them in collaboration was more satisfying for both physiotherapist and patient. For the prototype groups 3 and 4 it was an easier approach that took less effort. Prototype 4 felt that CSS enabled them to achieve a more authentic practice approach because professional boundaries were blurred and the focus was on patients and better health outcomes. Opportunities that drove a CSS approach as identified by participants are shown here.

Transformation of practice was facilitated by:
• Workshop (pre-implementation phase and critical appraisal workshop)
• Allowing time for reflection
• Critical companionship with the researcher: validating experiences and thoughts
• Learning from experiences: clinical as well as outside of clinical
• Identifying tensions in self, towards patients, other staff
• Identifying contradictions in practice, in own reasoning
• Promotion: change in required competencies, increased autonomy in job
• Changing clinical areas as a trigger to comparing different clinical contexts and how they influence practice
• Readiness to change,
• Self-selection for this project
• Curiosity, seeking professional [and personal] development

Not all participants openly discussed the personal values that underpinned their professional values and informed their practice. It was easier for them to identify external factors that triggered transformation such as promotion and physically changing practice areas. It was interesting to note that none of the participants felt liberated or indeed emancipated during their trialling phase. They might have had some insights and changed aspects of their practice but in general they all remained cautious and somewhat wary of completely losing professional authority over patients.

5.6.2 Limitations of trialling CSS

This trialling of CSS occurred on a micro level. The focus was on participants, their perceptions of themselves, their patients and their immediate work environment. Only a few participants mentioned their physiotherapy department, professional norms, hospital policies and the health care systems as an influence to their practice. These were
predetermined boundaries for this study. Limitations to exploring CSS that participants raised focused on their immediate work environment. These limitations included:

- the acute workplace setting
- their patient profile
- their own readiness to transform.

In acute workplace settings, where patients were in acute pain, in life-threatening situations or not fully conscious, participants perceived CSS to have little relevance. Petra wanted to continue to explore how she could be patient-centred and emancipatory in an acute setting. Practice parameters were clearly defined within biomedical terms. Participants felt that they did not have the choice to explore alternative approaches. They had to comply with their duty of care and prevention of life-threatening complications in relation to the patient’s condition. There was no time to develop professional relationships. Even within acute settings Petra continued trying to transform her professional relationship with patients to develop more democratic relationships. She did not interpret acute settings as a legitimisation of the biomedical model and of her professional power over patients. Petra felt that CSS was much more relevant in chronic settings where patients received physiotherapy over a longer period of time.

Participants reported that patient profiles varied and not all patients wanted to be emancipated. Operationalising CSS depended on patients’ personality as well. Many patients chose the passive patient role of receiving advice and following instructions. Participants felt that emancipation did not need to be black and white. They felt there was a place to increase patient participation to a certain level, for example after familiarisation with physiotherapy routines. All participants preferred patients who participated or at least actively agreed with treatment plans and clinical decisions. Although participants mentioned patients’ backgrounds and how those influenced how patients saw their role, no participant questioned this passive role as being imposed by social norms or whether their approach fostered such a passive role.

Many participants told me that they were overloaded at work and did not have sufficient time to devote themselves to this study. Other priorities took precedence. Prototype 2 and 3 participants were not ready to move beyond their practice comfort zones. Challenging their own values was seen by the prototype 2 group as questioning their common sense. This unconvinced group was not ready to challenge their professional practice identity. CSS was not incorporated into existing practice and critical self-reflection was not part of their practice. Prototype 3 therapists were skeptical of their current practice and could appreciate potential in the CSS approach but they could not truly operationalise CSS in their own practice. Emancipation was not placed in the centre of their practice.

At the critical appraisal workshop participants concluded with questions they each wanted to continue to pursue. Their final questions were deeper and more refined versions of their initial action plans, and were closely related to what had concerned these participants at the beginning of the trialling phase. These questions reflected their practice identity. Table 5.7 lists the initial and final action plans of the four participants in the critical appraisal workshop:

<table>
<thead>
<tr>
<th>Participant</th>
<th>Initial Action Plan</th>
<th>Final Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zoe</td>
<td>To increase my understanding of my role as a physiotherapist and how this increased understanding has changed my practice.</td>
<td>Is setting up a competitive environment in the gym improving my patients’ longer-term physical activity?</td>
</tr>
<tr>
<td>Jacquie</td>
<td>When do I use a didactic approach compared to an emancipated patient-centred approach?</td>
<td>I will ask my [spinal injury] patient, what he will think and what he will do if no more improvement occurs?</td>
</tr>
<tr>
<td>Corinne</td>
<td>To achieve more patient (client) centred outcomes commensurate with their world view, and to learn from my patients in any areas that empower me to improve my skills as a therapist.</td>
<td>What is the relationship between improvement and empowerment. Does this idea of empowering people still leave us as practitioners with the sense that we are really the power and how far do we have to continue to look at this aspect of power and who is wielding it?</td>
</tr>
<tr>
<td>Petra</td>
<td>In a situation where patients are at a higher risk of developing complications and they do not want to do physiotherapy how can I help them to sort of still feel in control of the situation?</td>
<td>How can I provide treatment that is respectful to patient while still urging them/insisting that they are to undertake a treatment imperative to their health improvement</td>
</tr>
</tbody>
</table>
All these questions were related to aspects of a CSS perspective. These inquiries were personal and particularised. These four participants started to own their interpretations of CSS and make it relevant to their thinking of physiotherapy practice.

From the trialling phase the following values were identified in prototype 3 and 4 participants that facilitated a journey towards emancipation. These values were:

- Ability to see multiple perspectives
- Inclusion of emotion, hope, fear and uncertainty into clinical reasoning
- Focus on patients rather than on conventional professionalism (which was skewed towards power and decision making being the province of the distant, objective expert)
- Comprehensive application of professional practice knowledge including life experiences
- Ability to work effectively in changing work contexts: shift in thinking and willingness to reconsider dynamic professional relationships.

Most of the participants did not discuss their values openly. These remained largely hidden in the participants’ arguments and reflections. A critical lens on physiotherapy practice would critique all aspects of physiotherapy practice. Participants who were self-critical and honest about the prejudices and values that informed their thinking and practising were then in a position to make more conscious decisions to emancipate themselves from their prejudices. This aspect is explored further in Chapter 6 with the prototype 5 group from the next study. Participants who were critical with patients but not with self were still guided by their existing prejudices, socialisation and unreflected values. Underpinning practice with normative values means complying with these values even if they are hidden or unknown to the physiotherapist. Participants felt restricted by professional expectations to assess, diagnose and treat as the primary agent in the therapeutic relationship. Their desire to fulfil these expectations reinforced their compliance with the norm rather than emancipating them from the norm. Participants who were firmly based in an empirico-analytical framework could not see the relevance of CSS. Professional authority and conditioned belief in the superiority of propositional knowledge over other dimensions of practice knowledge made a CSS model seem inappropriate to them. They considered that patients were less knowledgeable and in need of advice and direction, and unable to participate in treatment negotiations.

5.7 Reflections on my journey of trialling CSS

My journey of trialling CSS did not start with proposing this thesis. The values and assumptions that underpinned my research questions were a natural progression from studying drama and movement in therapy in London. I was studying Karl Jung’s philosophy of the unconscious and Rudolf Laban’s philosophy of movement and behaviour. I was convinced prior to my physiotherapy studies that human movement and behaviour were influenced by individual emotion as well as biomedical, social and cultural forces. Movement was an expression of cultural values. Practising physiotherapy through my lenses confirmed my assumptions. I felt that the conventional physiotherapy approach to functional movement was simplistic and limiting. An exclusively biomedical approach could not emancipate patients to be more in control of their health and the quality of their lives because it did not reach the core of a person, the meaning and intentions behind their physical movements and behaviour.

Exploring the relevant CSS literature and working as diversity health coordinator made me realise that policies on access, equity, and patient rights etc. existed. These policies could potentially underpin emancipation from the medical model and its implied power relations. However, the reality of clinical practice taught me that this was not readily the case. The factors constraining emancipation were multifaceted and pervaded all levels of the health care system. For example, not all patients wanted to actively participate in clinical decision-making. I chose not to always involve patients in decision making. Multidisciplinary teams did not operate on democratic, critically thinking bases; they often needed to be pragmatic and succumbed to economic limitations and other forces of the hospital organisation. Policies were interpreted mainly with values of the medical model in mind. Ultimately, medical teams had power over patients regardless of patient-centred policies and rights.

In my journey of exploring the scope for CSS I became aware that clinicians did not necessarily see any value in reflecting and debriefing about critical incidents. Some were content identifying their clinical work as technical procedures. Improving practice was viewed as emphasising quantity and efficiency for the organisation, not necessarily quality and effectiveness for patient health outcomes. I came to realise that practice is just as complex as human beings. Some participants in this study could be convinced; others remained unconvinced, yet others started to be curious. The factors that influenced their reasoning were not based in professional, ethical, clinical or any other way of reasoning. I believe they made sense of CSS based on their personal backgrounds. I learned that humanising practice had to start with humanising professionals. Since professional ethos is against humanising and personalising professional practice, there is no available support system for CSS practice. In my journey of trialling CSS I understood that without a mandate for CSS in the physiotherapy practice framework and the wider health
care system, I had to reason for CSS starting from the status quo of physiotherapy practice which remains predominantly located in empirico-analytical approaches to professional practice. However, solely critiquing the medical model would not do CSS many favours. Critique could easily turn into a comparison between the medical and CSS models.

Studying CSS philosophy set me on a journey of abstractly imagining emancipation from all humanly imposed restrictions, laws, guidelines and policies. This visionary concept of CSS led me to imagine what CSS physiotherapy could look like. I developed skills to critique current situations and practices and I argued for transformation based on CSS values. But I became critically aware that my arguments were quite abstract and at times inaccessible to my audience. CSS was only a theory that was not based in clinical reality. I learned that imagining CSS could become frighteningly similar to the ideology of evidence-based practice based in the empirico-analytical paradigm of the natural sciences. Both were exclusive: CSS excluded power relations and distorted reasoning, while natural science excluded self-critique and interpretive reasoning; and both rejected relativism. I realised that the strength of CSS is located in self-critique that informs realisations towards a visioned CSS practice model.

Listening to my participants and their critique of my CSS vision privileged me to gain greater insight into their interpretations of their clinical reality. My initial interpretations of their interpretations of reality were harsh because I focused on critiquing their practice reality. It was easy to challenge them and point to their unreflected, taken-for-granted professional identities. It was much harder to challenge self. Some participants detected these unreflective tendencies to accept normative values themselves. On many occasions I was made aware of my bias towards CSS. I realised that the capacity to take a skeptical stance towards self-identity borders on losing self-identity. I felt lost studying the CSS literature and finding its relevance to physiotherapy practice. I understood at a deeper level how Horkheimer had run into a cul-de-sac. Self-critique could be self-destructive. Critique of conventional physiotherapy practice frameworks could transform physiotherapy to an extent where it was unrecognisable. Habermasian communicative theory rescued critical theory but reduced its transformative scope due to its focus on communication. This study also had a limited scope, focusing on the physiotherapist and the patient, and their professional and communicative relations.

When I revisited my initial interpretations three years later I was self-critical of my initial critiques. I noticed that there were fine nuances to being critical. Criticism could be underpinned by values and intentions to reinforce current power relations and it could be underpinned by values and intentions to advance emancipation. My critical interpretations had shifted. There was a difference in critiquing the literature and critiquing practice. It is easier to challenge the dominant voices of the literature than to challenge practice that is grounded in context and exposed to social forces. I could appreciate my participants’ reasoning more and I could analyse their underlying values more clearly.

I explored my values that informed my interpretations of participants’ interpretations. At times I had not been truly critical but only judgmental. The more strongly I argued for CSS the more strongly I needed to critique myself. I agree with Webb when he writes:

The more strident the claim to represent the good, the oppressed, the disempowered; the natural order of things; the divine, the keener the need for criticism (Webb 1996, p.138).

It is easy to be critical of current practices. It is harder to be critical about one’s own perspective. I value relativeness when it is used to appreciate diversity and complexity of interpretations. However, when it comes to decision-making and in clinical settings, physiotherapists and patients have to make decisions that go beyond respecting their difference, they have to come to some conclusions and act. I believe clinical practice is about taking standpoints, and these positions should be critically scrutinised for bias, authority and other issues that may unnecessarily restrict CSS values.

I learned on my CSS journey that CSS means understanding your values, questioning them with the initial aim of appreciating where they would lead you and what professional identity they would develop. It was crucial for me to understand that I first had to be clear as to my values and direction, and then based on those values I would be in a better critical position to interpret interpretations. Emancipation was no longer an abstract ideal state. It was concerned with asking ‘have things become better and more liberated’? and knowing what ‘better’ and ‘liberated’ meant or adjusting what ‘better’ and ‘liberated’ meant.

Trialling CSS has taught me to continue trialling. The completion of this thesis will be a completion of one critical dialogue. Its findings and implications will open the next cycle of critical dialogues.
Chapter 6

VISIONING AND EMBODYING CSS: Text 4

I think that an enormous part of anybody’s professional practice is learning from your own experiences and being critical of your own performance even when you are in a single room without witnesses and very poor tools of communicating. It is my experience that physiotherapists who are self-reflective and willing to examine their own results without fear of the outcome and without fear of the answer are brilliant clinicians and become more so with each passing year. (Paul)

In this chapter I discuss the interpretation of the fourth text, visioning and embodying CSS. I discuss the critique, vision, and embodiment of (emerging) CSS by the third participant group, the CSS champions, and my reflections of CSS as a practice model arising from my own practice and research journeys. The aim of constructing the fourth text was to engage in a critical dialogue with a group of physiotherapists who had already operationalised CSS values in their practice or could visualise a CSS framework, whether they used this terminology or not. I was in search of clinical stories that gave CSS principles concrete form and that clearly and tangibly portrayed CSS in clinical practice.

The (emerging) champion group enriched and expanded my insights into my CSS model development because they brought to the discussion an envisaged, deeper and more embodied understanding of what CSS was to them as a practice framework and could be to others. The term champion here implies the essence and the support for CSS. This particular group did not fully realise and embody CSS. Such people and practices are yet to fully emerge in this profession, which was one of the starting points of this research. The first participant group had little or no knowledge of CSS. Members of the second group, the trialling group, were asked to explore CSS and comment on their experiences. The third group (portrayed in this chapter) was informed of the essence and principles of CSS, how I related them to physiotherapy practice, and of the findings from the first and second participant groups. Their task was to critique CSS based on these findings and in comparison with their own practice philosophy and clinical practice. They provided interpretations of their clinical reality and discussed how it could hinder or foster the full realisation of CSS in physiotherapy practice. In essence, they were engaging in a critical transformative dialogue. Each of the three reported their experiencing of self critique, greater awareness of how their practice conformed to mainstream physiotherapy and a greater understanding of CSS and its current manifestation in their practice and its potential for further enriching and strengthening their preferred (critical emancipatory) practice approach.

This fourth research cycle placed my emerging CSS model for physiotherapy practice from text 2 and text 3 into its fourth critical transformative dialogue (see Figure 6.1, relating the three research groups and the four critical transformative dialogue cycles).

6.1 Constructing Text 4

It was anticipated from previous cycles of the research that few physiotherapists would be identified who (currently) knowingly embody CSS in their practice. I could not readily ask physiotherapists if they identified with a CSS practice model because CSS is not part of the mainstream physiotherapy discourse. However, I discussed my thesis and my vision with physiotherapy colleagues and asked if they knew of physiotherapists who were heading towards this direction in their practice. Through my physiotherapy network I had been advised of some physiotherapists whose practice models and experiences could make them good candidates to relate to and critique my emerging CSS practice model. Several academic physiotherapy friends, independently of each other, mentioned Raymond and Paul to me. Jill, who was part of the first participant group, was invited back to participate in this research cycle because her practice framework appeared to be very closely aligned with CSS principles. The participant group that comprised the fourth text consisted of these three chosen physiotherapists; their demographic details were provided in Table 6.1.

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9 Pseudonyms are used throughout this chapter
Figure 6.1  The three research groups and the four critical transformative dialogue cycles

<table>
<thead>
<tr>
<th>Products</th>
<th>Text interpretation</th>
<th>Critical transformative dialogues</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSS Model</td>
<td>Text 1: Conceptual CSS model</td>
<td>Dialogue with CSS theory and CSS-related pedagogy and health literature</td>
</tr>
<tr>
<td>Dialogue with Group 3: critiquing, Visioning, realising and embodying CSS in practice</td>
<td>Text 2: Critique of status quo</td>
<td>Dialogue with physiotherapy literature and Group 1 work</td>
</tr>
<tr>
<td>Implications for practice, research</td>
<td>CSS Components: Critical self-reflection, identity, professional relations, rationality and context</td>
<td>Recognising dominance of the empirico-analytical paradigm Prototype 1: The Uninformed</td>
</tr>
<tr>
<td>CSS Components: Critical self-reflection, identity, professional relations, rationality and context</td>
<td>Visioning and embodying CSS</td>
<td>Prototypes 2,3,4: The Uninformed, The Unconvinced, The Contemplaters, The Transformers</td>
</tr>
</tbody>
</table>
These participants practised in a way that I considered embodied CSS in action. I determined that this living practice was more necessary and pertinent than whether they could name CSS as their practice model. Initial contact with each participant was made via telephone. I described my thesis to them and disclosed who mentioned their name to me. I explained that I was seeking to conduct a critical dialogue with each of them if they agreed and felt that their practice appeared closely aligned with CSS principles. For ease of understanding I used key terms for CSS, to convey the core principles. It was more important to recognise the broad labels than detailed descriptions. These core CSS principles included critique and action based on this critique. Critique was explained as exploring the interests, assumptions, intentions and motivations of self and others. Actions were explained as responding to critique with negotiation, participation and collaboration with patients in all aspects of their treatments. All three physiotherapists could identify with these values and felt that this was the way they were practising. They agreed to participate in critical dialogue with me. Raymond said that he was amazed that there actually was another physiotherapist in NSW who appeared to share his practice values.

I conducted individual, deeply reflective and critical interviews with each participant. Each participant was given two of my publications (Trede and Higgs 2003; Trede et al 2003) as background reading prior to the interview. The aim was to familiarise them with CSS language, values and dimensions, and with how CSS could inform physiotherapy practice. The reading provided the platform for the interview, because no specific physiotherapy literature was available to describe a practice model based in CSS theory.

At the beginning of the interviews I described the process and findings of my thesis thus far, using a hand-out (refer to Appendix 3). The core of CSS was explained as critique of interests, assumptions and motivations, and acting on this critique in a patient-centred frame of reference. The assumptions that underpin CSS were described: (1) that knowledge is related to interests, (2) that interests, ideology, prejudice and assumptions inform the theory and education underlying practice, and (3) that theory and education influence clinical physiotherapy practice. The CSS principles were explained as (a) critiquing self, (b) being critically aware of patients’ needs and interests, and (c) acting on this critique by negotiating and collaborating with patients. I described the four prototypical groups identified thus far: the uninformed, the unconvinced, the contemplators and the transformers. The five key dimensions of CSS identified were described: capacity for critical self-reflection, democratising professional power relationships, rethinking rationality and values that inform clinical reasoning, redefining professional identity and roles, and rethinking the practice context. The three participants were each invited to critique my draft CSS model and my reasoning behind it by relating it to their clinical practice model.

The interviewees were asked to discuss their practice and share ideas about whether (and if so how) the dimensions and principles of CSS I had developed related to their practice. They were also asked to reflect on their own professional experiences that could critique and illuminate this CSS model further. Their examples had the potential to endorse, criticise and expand my emerging CSS model. They were asked to conclude with what they liked and disliked about this CSS model for physiotherapy practice. Each of these participants related strongly to the principles and dimensions of practice that I presented. They reported that they experienced and sought to implement many of these ideas in their practice.

It was stressed at the beginning of each interview that the prime purpose of the interview was to give me as the researcher a “reality check” of the CSS model I was developing. I was looking for their critique as practising physiotherapists on my model, as well as a self-critique on their own practice models. I explicitly requested participants to feel free to critique and challenge my research and to speak openly about their practice dilemmas. The interviews lasted between 60-90 minutes.

The discussion in this chapter is further informed by my work as a diversity health coordinator, where it is my brief to build the capacity of the organisation to provide appropriate and accessible service to address the diverse needs
of all patients and communities served by my organisation. The discussion is also informed by a workshop I conducted at the 2005 ANZAME conference (Trede et al 2005). At the workshop I presented the CSS draft model and facilitated a critical discussion that drew out strengths and weaknesses of applying this model in clinical practice (see summary of key points of feedback from this workshop in Appendix 4).

6.2 Visioning CSS principles in context and action

Major findings of the trialling phase illuminated five CSS dimensions. In this chapter, the deeper refinements of these CSS dimensions and embodiments of the CSS principles arising from Text 4 are presented. The critical dialogues with Text 4 participants about enacting CSS in physiotherapy practice helped to clarify and make more explicit the complexity and diversity of my CSS practice model.

6.2.1 CSS is not part of the physiotherapy discourse

Emancipatory learning, critical self-reflection and emancipation are terms that are not part of mainstream physiotherapy discourse and physiotherapy literature. Throughout the project none of the participating physiotherapists had heard of CSS, let alone thought about its relevance to their practice. Physiotherapy discourse appears to be preoccupied with the performance and scientific rationale of practice rather than reflecting on practice philosophy and the realisation of humanising and emancipating practice. In my experience, physiotherapists are socialised into the medical model with its task and technique orientation as well as its technical-rational approach to practice. The participants were not familiar with CSS terms. They did not enter the discussions describing themselves as emancipated and critical self-reflective physiotherapists. These terms had to be explained in their abstract meanings and then translated to practice meanings. For this third group, it was challenging to identify suitable participants who could provide informed critique on CSS philosophy and its applicability to physiotherapy practice. My decision in the end was to focus on reports from colleagues (subsequently checked with the three participants over the phone) about the nature and priorities of their practice.

A CSS practice framework is based on emancipatory interests. My CSS model, in addition, emphasises the dimensions of critical self-reflection, along with issues of power and professional authority in physiotherapy practice. These dimensions are not captured by the empirico-analytical illness model; nor are they the focus of the interpretive wellness model. A major difference is that these two models largely take their own ideologies for granted and do not explicitly discuss them or lay them open to critique. Clinicians who follow Foucault’s (1980) philosophy about power are suspicious of any individual emancipation. They would see emancipation as a form of manipulation in disguise. By comparison, all three participants of text 4 had critically reflected on their practice assumptions. They were aware of power imbalances in practice contexts and the tensions between their practice ideology and the practice context norm/reality.

Jill worked as a community physiotherapist attached to a teaching hospital, and she continued to speak out against medical power and fight for patients’ quality of life. Raymond had worked in private practice but had to retire due to illness and was now working in a public hospital. He was quite stressed about the tension between his practice ideology and that of his department but he felt he had no choice but to continue work there. Paul chose to leave the public system early in his career in order to be able to develop his own practice approach. He felt he could realise his chosen/authentic practice approach away from the “public service mentality” and expectations.

The (emerging) champion group stated that the five CSS dimensions I had identified resonated with them in their practice and were realisable to some extent in practice i.e.; list. None felt that the dimensions were either utopian or readily adopted in regular workplace settings. However, the five dimensions were realised in diverse ways and to varying degrees by this group, as outlined below. They appreciated the prototypical groups that I had identified (i.e. the uninformed, the unconvinced, the contemplators and the transformers), and Raymond especially thought that the majority of physiotherapists would fall into the second prototypical group, the unconvinced.

6.2.2 Complexity of interpreting meanings in language

This fourth text was constructed by clarifying and challenging interpretations of CSS terms and of practice. For Raymond it was obvious that interests and assumptions informed professional knowledge and practice. He liked Habermasian knowledge and interest theory and felt an affinity to it without having read any of Habermas’ works.

Habermas sounds good but I have not read him. (Raymond)

Raymond worked in a multidisciplinary team with pain patients and found it very important to define pain. He claimed that the way pain was defined determined how clinicians would treat it. Jill also mentioned pain and how

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10 The Prince of Wales Hospital, Sydney.
important it is to describe and define it in detail in order to provide meaningful treatments. Jill volunteered her services at the Paralympics games in Sydney in 2000.

I saw different athletes all the time and we didn’t follow one up. So you pick up their notes and there would be written ‘pain’. How can you describe someone else’s pain in one line? And then prescribe ice, interferential, massage, hot pack and so on. No one ever found out which one worked best. (Jill)

Jill alluded to the issue of reducing particularities of pain to generalisations about pain that resulted in multiple treatment interventions. She was “appalled that the instructions for physiotherapists were not more specific and detailed”. She was “astounded that these athletes were not in tune with their bodies and did not appear to know what treatment modality worked best for them” or show an interest in more particularised treatments. Jill realised that her approach to critically interpreting the meaning of pain and carefully planning personalised interventions was not shared by her volunteer colleagues at the Paralympics. She was left wondering if these colleagues had a similar generalised “one size fits all” practice approach in their “normal” workplaces.

Exploring definitions, assumptions, interests and motivation determined how my three participants in this text 4 stage related to their patients, how they identified themselves as practitioners, and what comprised their knowledge base and approaches to professional practice. All three participants had the ability to engage in philosophical discussion thinking deeply about their practice interests.

They were articulate and able to discuss in fine detail their clinical reasoning and decision making. An example is the way they described and qualified patient-centred care. Paul was clear what patient-centred care meant to him:

It certainly is important to negotiate; after all so many people don’t know what you can offer. Most people in Australian society have a very unclear idea about what my capabilities as a physiotherapist are. It is often the case when someone has a headache and they come in for back pain and I say ‘Can we could look at your neck, it is probably the source of your headache’ and they say ‘Oh I didn’t know that you can offer that’. It is often for that reason that people have limited goals, limited ideas of what you can help with and so part of the negotiation is what they need to change in their life, what is the problem stopping them or what would you like to be able to do and to say what I can actually offer them. (Paul)

Paul mentioned patients’ lack of knowledge of physiotherapy, and how to facilitate learning, negotiate goals and work within open professional relations. He saw overcoming these barriers was an important dimension of his patient-centred care. The interests and assumptions behind claims of patient-centred care needed to be made explicit. Most physiotherapists would say they want to provide the best care for their patients However, a distinction needs to be made between caring for people that involves providing treatments to and for them, and working with them to achieve the best health management outcomes. The latter is more consistent with CSS and patient-centred care. Best care for patients is interpreted very differently depending on which perspective and with what interests it is viewed. The capacity to articulate these interests and describe clinical reasoning in depth is part of realising the theory of communicative action (Habermas 1981/1984) in practice. At present there is little stimulus or expectation for physiotherapists to build this capacity of critiquing interest and acting on this critique. Further, a language needs to be established within the profession that speaks of the notions of critical self-awareness, value clarification and emancipatory practice.

6.2.3 Critical self-reflection as a crucial but also most demanding tool for realising CSS in practice

This group felt that critical self-reflection was the most crucial aspect of the CSS model. It was easy for them to identify with critical self-reflection. They were willing to be self-critical and skeptical of their assumptions and practice. All three participants had developed their practice models using critical self-reflection. They developed their own authentic practice over time, as they gained professional experience, by asking questions, thinking for themselves, and maintaining a skeptical stance to truth claims and their own practice. They saw critical self-reflection as an important attribute to improve clinical reasoning, patient rapport and outcome effectiveness.

Raymond considered that the strength of a CSS model was that it allowed physiotherapists to think for themselves, not just about the tasks of physiotherapy but also about its rationale and frame of reference. Increased self-awareness clarifies motivation and interest, facilitating more authentic and sincere decision-making. Raymond felt he was a critical self-reflector:

I am constantly self-evaluating. Sometimes it is very negative. (Raymond).
Raymond critically assessed his treatments. When the intervention did not produce the expected positive outcome he questioned himself and first checked that he had applied the correct techniques. Then he would evaluate his choice of technique. He would not stop there but also questioned his choice of technique in relation to its appropriateness for the individual patient. In practising critical reflection, Raymond stepped out of his comfort zone by questioning his reasoning and motivations in relation to his patients’ perspectives. He included patients in exploring treatment outcomes. Raymond had many books and peer-reviewed journal articles on his desk when I interviewed him and he referred to them during our interview. He was not ashamed to admit in front of his patients that he did not know everything. He acknowledged the challenge of critique in questioning himself and including patients in this challenge. It was not always comfortable to be challenging himself but he felt that this was the way he could improve his professional practice techniques as well as his patients’ participation and outcomes. The goal of critical self-reflection was to expand clinical reasoning and treatment effectiveness beyond his learned physiotherapy perspective. The value of this critique was heightened when it resulted in subsequent action based on this critique. Although Raymond found critical self-reflection at times negative (e.g. tearing down certainties, critiquing truths and challenging his confidence) he was able to see the advantages of viewing himself from outside his own practice (and self) framework.

Paul also stressed the value and importance of critical self-reflection. He said that physiotherapists often work in cubicles, alone with patients and without witnesses. Such a situation makes critical self-reflection essential for ethical professional practice. He stated that all professional practice should embrace critical self-reflection.

> I think I am critical from minute to minute. I guess I have a healthy skepticism that the interventions are not the only cause of change when patient symptoms subside. (Paul)

Paul developed his practice approach from professional experience based on critical self-reflection. He actively exposed himself to a diversity of practice approaches in order to develop his own approach:

> I made it a point in my career to work with different clinicians to see different models of treatment and thought. I have noticed that I could never really exactly match anybody's treatment [approach]. Often bosses said to me 'if you could only treat exactly how I do'. I was trying but I think this will never be possible. I did a lot of examining of my knowledge base and challenging completely different knowledge bases, and putting the two together has a lot to do with self-criticism. Working in a new environment challenges all of that what you had. (Paul)

He felt that critical self-reflection was a key ingredient that all leading expert clinicians possess.

> I think that an enormous part of anybody's professional practice is learning from your own experiences and if you are not critical of your own performance when you are in a single room without witnesses and with very poor tools of communicating [then this is a problem]. It is my experience that physiotherapists who are self-reflective and willing to examine their own results and without fear of the outcome and without fear of the answer, are brilliant clinicians and become more so with each passing year. (Paul)

Paul realised that critical self-reflection was an important tool to advance his practice. He saw critical self-reflection as the primary tool for improving clinical reasoning, effective treatment choice and better health outcomes for patients. Although it might involve taking risks, being confronted and feeling uncertain at times, critical self-reflection enables physiotherapists to emerge as more mature, authentic and expert practitioners.

Critical self-reflection was seen as important because each practice situation has to be considered on its own merit. Information from evidence-based research and propositional knowledge was no substitute for critical thinking that questioned the participants’ motivations, values and modes of working with people, not just the efficacy of their interventions where the principal focus is on treatment evaluation within the medical model.

### 6.2.4 The need to assess treatment outcomes with critical skepticism and mutuality

Paul’s critical attitude was evidenced when he said he wanted to determine to what extent his interventions made patients better compared with other influences. He was humble and reluctant to claim that his physiotherapy treatments were the exclusive cause for patient improvements. He was aware that disease presentations are complex. He felt it was impossible to think of all the variables that could influence disease progression, let alone control them. Paul was content to approximate success due to physiotherapy and place it into context. Raymond
saw assessing outcomes as even more problematic. He wanted to be able to measure improvements biomedically but also subjectively from patients’ reports.

There was this patient who came back for years and said each time ‘I am slightly better’. Well after a year I thought this guy must be better than anybody else in this world. But he was still on a walking stick, not doing any more things. Perhaps this is wrong but I feel I have to analyse what I am doing and listening to what they are saying and marrying the two together. That is the hardest thing. (Raymond)

Raymond alluded to the grey area of determining improvement. Before physiotherapists can negotiate with patients they need to know what their aims for the negotiations are. There is a danger in justifying all decisions by physiotherapists on critical thinking if this thinking is not really critical. Raymond felt that if he was too direct with patients and if he was skeptical of patients’ intentions and agendas he would ruin the open and trusting professional relationships.

I put the patient outcome much higher than the research. That might not be very scientific and it [my practice] is getting into a social science model, a qualitative model rather than a quantitative model. Patients’ self reports seem to fluctuate. You do not get the scientific rationalism that you get in a quantitative approach. (Raymond)

It is the collaboration and participation of both therapist and patient that can ensure sincere reporting, realistic goal setting and mutual evaluation of outcomes. As soon as critique is lost, so is emancipation. Critique enhances trust because feeling safe to critique something means trusting somebody. Raymond defended his approach from his personal experience as a patient. He had not been taken seriously and as a result he had been misdiagnosed. He provided an example where a similar situation happened to a patient of his.

That doctor said the other day ‘that little lady only had a little whiplash. She only wants compensation money’. A four-wheel drive car hit her at 80km/h and she was parked at the lights. That is not a little whiplash. I think generally people come to consult professionals because they have a valid reason. They do not come here for their secondary gain and if they do they do not have a consistent report. You soon pick up a pattern when people are not honest with you. That is my philosophy. I am always trusting, looking to find out what caused their condition and understand the pathology. (Raymond)

Listening to what patients are reporting and experiencing is important. However, their experiences may need to be clarified. The feelings and the motivations behind their reporting could be elicited. Patients could be helped to put into clear language what they are initially unable to express. Because neither the patient nor the physiotherapist knows what information is important initially, patients’ stories need to be explored rather than accepted at face value. Jill had mastered critical skepticism about treatment outcomes. She was interested to learn which of her physiotherapy intervention modalities worked best, but at the core of her evaluation was reintegrating patients into their social life so that they saw meaning and value in physiotherapy treatments. Jill sought not to alienate patients from their bodies but to work with them to regain physical function and greater control over their function. Jill entered the discussion of evaluation by talking about the process. It is important to recognize in this discussion that skepticism does not mean starting from a superior, disbelieving position that challenges everything a patient says. Rather it refers to avoiding complacency and superficiality by looking beyond and beneath the apparent (the causes, motivations effects, etc) of behaviour, actions and outcomes of practice, to understand these factors deeply and critically and use them to richly inform practice. Also it is important in CSS-informed practice that it is the patient as well as the practitioner who should have the right and opportunity to be critically skeptical of practice parameters and be involved in a mutual evaluation of outcomes.

6.2.5 A pragmatic yet critical professional practice identity
The champion group presented as professionals who had in mind the process of developing professional relations as well as the desired outcomes. They were practical doers yet critical thinkers. They intended to use correct and appropriate actions to achieve the best outcomes for their patients. They relieved pain and increased physical functions and facilitate patient self-management. They drew from their biomedical knowledge of movement, from patient perspectives and from their practice experience based on critical self-reflection. These participants were able to articulate their self-understanding as physiotherapists. Their professional purpose to treat efficiently and evaluatively was underpinned by their practice philosophy. Their intentions were to make a difference in patients’ lives and to assist in improving quality of life. They were mindful of the value of considering empirico-analytical,
socio-cultural influences and values as part of treatment outcomes. All three participants described themselves as ultimately pragmatic because they were practitioners working with people in the real world.

Jill discussed how she used tactile and listening techniques to assess her patients. She mentioned practical collaborative elements that made up her practice identity:

> Until you've actually got the hands on you are not absolutely definite about anything. It is very difficult to understand a clinical situation over the phone. Talking over the phone is quite different from actually seeing someone. I am a really visual and practical hands-on physiotherapist. (Jill)

The visual aspect included assessing patients’ emotional expressions and how their body posture could reveal attitudes. Paul described his intentions as a practitioner as follows:

> I say to my patients that 'the most important thing that you are going to get from coming here is a better understanding of how you can look after yourself. I can help you with making you feel better now; I can use my hands to make it feel better probably and that will hasten your recovery but ultimately what I can teach you in knowledge and skills is the thing that you are really getting from this.' (Paul)

Teaching patients how to self-manage their physical complaints was a core aspect of these participants’ practice. The aim was to work with patients so that they could take control of their health. Paul developed his clinical skills by questioning the effectiveness of his treatment interventions and maintaining a critical attitude towards learning from his professional experiences.

> I think it [my professional identity] is [based on] self-reflection on a minute-to-minute and year-to-year basis and certainly over a career. I remember in my career after about 5 years experience that I got an enormous sense of joy that on the whole I was able to tell people what they could expect from treatment. I remember that as a quite rewarding milestone in my career. (Paul)

Paul was mindful that many factors influenced recovery in patient symptoms. He wanted to know what part he played in this recovery but at the same time he did not assume that his treatment interventions alone improved physical symptoms. This openness towards other influences and humility about claiming treatment success characterised Paul’s practice ethic and is consistent with the critical stance that is a core characteristic of CSS. Convinced that it was impossible to control all variables, Paul included all the variables he could think of, but he was sure he could not imagine all the variables that actually influenced patient recovery. Despite this skeptical and inclusive attitude he wanted to identify his contribution to patient improvement. He did not lose sight of his critical professional identity.

> I certainly have enjoyed patients coming back saying 'I am better'. 'That feels great'. Then I usually explore what part of that was my role. That is important to what decision is made next. 'Do you think you got better because of your anti-inflammatories or because you stopped playing football or because of the stretches?' So I know that we are on the right track and we know what is the single most important thing in that half an hour. (Paul)

Practitioners using a biomedical approach would treat according to the available evidence-based information and would attribute success to that intervention. Practitioners using a postmodern approach would use diverse treatment techniques and would be reluctant to attribute success to any one of those techniques. Practitioners using a critical approach would, after critical reflection and open negotiation with patients, select techniques based on broad-spectrum evidence (research and practice-generated knowledge) and patient information and interests. This mindfulness of the complexity of human needs (e.g. for health care) and what could address them is central to a CSS perspective. Recovery cannot easily be attributed to physiotherapy intervention alone. Other obvious influences, as mentioned by Paul, are taken into consideration, but he would also consider the possibility that factors he had not even taken into account could influence outcomes. Paul would make his success claims carefully, critically and in collaboration with his patients.

In Chapter 4 the current trend of physiotherapy practice was critiqued as over-reliant on quantitative approaches to practice. Such approaches build a professional identity that is technical, certain, uniform, predictable and in control of outcomes. The participants of this fourth text were skeptical and not willing to constrain their professional
identity within these quantitative values. All said that empirical-analytical approaches to knowledge were important and necessary for the physiotherapy profession but they did not exclusively identify with these approaches in their practice.

The current quantitative research models that are dominant within our profession have a tacit belief that they are closer and closer moving towards the truth. [These models make us believe] that with each new fragment of information we are eventually going to come to the truth and although that is a long way off many of my colleagues see it as a progression and I have a definite impression that it is quite circular (Paul).

Paul did not consider himself an evidence-based physiotherapist. He did not believe that you could ever reach the truth. He believed in learning and developing deeper insights and revisiting questions from different perspectives. Exploring a phenomenon within one paradigm may generate more knowledge, but the same phenomenon explored through a different paradigm places different emphasis and interest and generates different type of knowledge. Paul developed his professional identity by observing many different approaches to physiotherapy practice and by learning through that, underpinned by skepticism, which matches a critical hermeneutic approach to knowing.

I think the EB11 literature contains so many uncontrolled variables it contains so much assumptions that are not measured in the experiment that it is not really very different in many ways [to what I practise]. If you document carefully enough what you do then anybody else can reproduce it. But there is a very good chance that you did not realise what [variable of your treatment] was important. We all bring a whole bunch of ideas to an environment. I bring this idea that I am going to make this person better and they [patients] bring the idea that they are not going to get better. Or visa versa. (Paul)

Paul acknowledged the complexity, attitudes and uncertainties that are brought to the clinical encounter. His practice identity was very much based in critical self-reflection and self-awareness.

Jill’s practice identity was people-centred and involved thinking for self. When she felt “out of her depth” she would consult the physiotherapy literature, which she equated with the EBP literature. Propositional knowledge comprised only a minor part of her practice identity.

The more you read randomised control trials the more you see what hasn’t been done. And you look and you say ‘Oh no that is not applicable. Why haven’t they asked other questions? Why have they done this intervention?’ There was a trial with hip protectors. Someone came and encouraged people to wear them. The study found that hip protectors gave people more security. They didn’t say that the fact that someone came around and encouraged them had any effect. Maybe I am just too critical but many of the controlled trials are flawed and exclude important factors. But it is really good as a complementary tool. (Jill)

Jill was familiar with EBP, and she could articulate how she used EBP knowledge in her practice. She did not reject it; neither did she use it exclusively. Jill identified with a practice approach that developed with practice experience and critical self-reflection. She spoke with conviction about her way of practising and clinical reasoning. She identified as a physiotherapist who facilitated change in her patients’ lives:

I would like my patients to say ‘This has changed. I made a change in my life because of what you suggested and for some reason it worked’. I want to give patients goals beyond doing their exercises. (Jill)

Jill’s practice identity can be described as a facilitator of emancipatory learning which reaches beyond being a caring, pragmatic movement expert.

Raymond saw himself as a scientist, critical self-reflector and a patient-centred clinician.

Is physiotherapy a social science? To me it is, and my colleagues will hit me over the head. I think there are the arts and the sciences. It is somewhere between the two. You have to oscillate all the time to facilitate an outcome for the patient. So I have this pulling force in me
all the time. I value the scientific [approach] and searching for the evidence but I am worried about the patient. (Raymond)

Raymond perceived himself as an outsider within the physiotherapy community. He saw himself as a facilitator of integrating biomedical facts with patient perception. He defined his practice as doing qualitative medicine. CSS does not exclude propositional knowledge but it places non-propositional knowledge in emancipatory context with propositional knowledge. At the core of these participants’ practice identity was thinking for self in a critical way about one’s practice. They did not adopt practice techniques without constantly checking their effectiveness with individual patients. Patients were regarded as social, cultural and political human beings.

You cannot tell a teenager to stop smoking. You need to look at their social issues. I practise physiotherapy like that. First [I consider] scientific knowledge and then social beliefs and patient knowledge. (Raymond)

It is safe to say that each of these physiotherapists identified as an expert of human movement, as a professional who relieved pain and provided advice on exercise and self-management. What distinguished their practice identity from that of other practice models was that they used their human agency to facilitate change in their patients. Change was larger than physical improvement because change was initiated in collaboration with patients, so that treatment interventions were appropriate and meaningful for both physiotherapist and patient. These three participants were pragmatic in that they worked within the external framework they practised in but they were critical in that they were aware of this framework and sought to maintain a balance between authenticity to their practice model and the constraints of the context framework. Their identity appeared critically authentic because they were convinced of what they were doing, through critical reflection on self and patient.

In order to define a CSS identity, the values and ideology that underpin professional identity need to be illuminated. Although these participants could not articulate their identity explicitly in terms of detailed practice theory they demonstrated it implicitly in terms of their values and what motivated them to practise the way they did and used their own words and concepts to describe and authenticate their practice. Their words were compatible with CSS philosophy. They stood up for their practice, knowing that it did not currently reflect mainstream practice. A CSS practice identity is underpinned by critique and acting on this critique. Identifying with critique manifests itself in critical self-reflection, responsiveness and openness to patient perspectives, skepticism about treatment outcomes and an awareness of the wider context within which practice occurs. Participants of this fourth critical dialogue demonstrated such a CSS-centred professional identity.

6.2.6 Open yet skeptical professional relationships

Participants of this fourth text were self-critical, and this attitude transferred to their practitioner-patient relationships. These participants would explore their patients’ expectations of physiotherapy. They would create a safe environment for patients to express their concerns freely and tell their stories. The safe environment consisted of allowing time for patients to talk actively, listening in order to understand patients’ perspectives, and collaborating about acceptable treatment aims.

An important aspect of critical and emancipatory practice is recognising the readiness and capacity of patients for different levels of direct participation in such activities. Jill did not establish the same quality of openness with all her patients. She made distinctions informed by her critical judgment of what type of professional relationship was appropriate for each patient. When patients were familiar to her she did not go to the same length of participatory assessment.

I ask patients what they are actually feeling when I assess them hands-on and what they think the problem is. That is quite revealing I find. I relay back to them what I think the problem is and why they were right or maybe I am seeing something different but we are leaving this quite open. I start to negotiate what I think should happen and ask them what they expect of me. (Jill)

Jill invited patients to be involved and participate in the assessment and goal-setting process. She withheld her judgment prior to inviting patients’ opinions and input. She listened to patients with a critical focus. She did not take their perceptions or her own on face value, but facilitated a dialogue so that they arrived at a shared assessment. Jill was open yet skeptical. She saw her professional relations as a process that developed with each visit getting to know patients better. It was important for Jill to collaborate with patients. She shared her clinical reasoning processes to some extent with them.
I would always say on the first visit ‘look this is what I expect I am able to achieve, I don’t know if we are going to do it, what do you think?’ Get feedback from them if you can about what their goal would be. We get closer to the goals as visits are increasing. I don’t have my aims established in the first treatment. I see it as a process. I would always establish with them what I found. You may get quite assertive at the first visit. Especially if it is a chronic condition and you know the patient. (Jill)

Paul keenly aimed for open relationships with his patients. He commenced his treatments by establishing treatment goals from a patient perspective.

I think it is important in the first session that patients express themselves and say what they want to achieve. [I ask them] ‘When would you think that we have done a good job?’ (Paul)

He sought to understand the meaning behind what patients were saying or hinting non-verbally. Paul was mindful that most patients did not have a clear understanding of what physiotherapy services entailed. He often needed to educate them on what they could achieve through physiotherapy. Patients would want to be pain-free but that was not a sufficient goal for him. He wanted to agree on goals that were based on physical function as well as on patients gaining increasing independence and self-management skills. Paul believed that in some cases the expectation of wanting to be pain-free was idealistic and not realistic. He made patients partially responsible for negotiating realistic goals. He harnessed the openness in negotiations within a realistic and professionally informed framework. Paul would facilitate the goal setting process to derive joint goals.

There is a grief involved in morbidity so when people say ‘I don’t want to have any more pain’ I am usually not happy with that as a joint goal. I usually follow up with ‘In what way does the pain affect you?’ because I find it more measurable. Quite often people will say I am 99% better. I think I am wasting their money because I don’t need it to be pain free. Often they change their idea and they say ‘It is better than it ever was and now I know how to manage it so much better and I am more functional than I have been.’ (Paul)

Paul taught his patients to think in functional and tangible terms. He was not skeptical about what patients were saying but was aware of the inadequacy of language as a good communication tool. He tried to make communication as undistorted as possible by listening carefully to patients, taking them seriously and not doubting but rather exploring their agendas together with them.

I am skeptical about our communication. I am always skeptical of what two people are saying in a single conversation. I tend to ask the same question in different ways to verify that I have interpreted them properly. If I am in any doubt I say ‘Do you mean to say that …’. I am not skeptical of patients at all. I am skeptical of our ability to communicate a multitude of issues that come up. (Paul)

Paul was able to integrate patients’ perspectives with his own. He appreciated that most patients were not fully informed of what physiotherapy could offer them. He also was aware that he did not know the patients. Rather than working solely on patient or physiotherapist terms he would establish a process that facilitated collaborative, realistic goal setting. He felt patients often had lower expectations than he had because of their lack of information and knowledge of physiotherapy and understanding of the human body. Paul strongly supported establishing open relationships so that he could provide an effective service that was acceptable for both parties in the professional relationship. His reflexivity and intention to establish open relationships is evident in the questions he posed himself:

Have I really identified the patients’ problem? Have I given them a clear indication of what part of their problem I can help them? And [am I aware that] their expectations are different to mine? I think that [clarifying expectations] takes a lot of patient discussion and rephrasing. (Paul)

Another important attribute to open relationships is honesty, which is embedded in critical self-reflection. By showing honesty and self-critique physiotherapists are modelling open relationships. This makes it easier for patients to open up, be honest about their expectation, be willing to listen and speak up. Paul took treatment evaluation seriously. He wanted to determine how effective his treatments were. He did not take patients’ reports
about treatment effectiveness on face value. He wanted to ensure as much as possible that the evaluation was sincere.

I can really only learn by trying to be as honest as possible with my clients about outcomes of treatments. Every time a patient walks into the room I ask them 'How do you feel today compared to last time I saw you? If they are looking vague I ask them 'Do you feel better or worse or about the same?' I try to ask open questions and secondly to give them options and free them to say 'Well, I actually feel worse. I know you do not want to hear that but I feel worse or I feel the same'. (Paul)

Paul would not base his treatment evaluation purely on what patients initially reported. He clarified their reporting and he conducted physical tests to compare patient report with actual physical signs. Paul was a physiotherapist and not a psychologist. If there was a match between physical tests and reported history he was quite certain to have established treatment outcomes. If there were a mismatch then he would explore the reasons. Patients would participate in finding out why there was a mismatch, and at this stage other issues would emerge that influenced outcomes.

That [patient participation] might often bring up what is actually bothering them like 'I am upset about my mother being sick'. So I help to identify their issues and what part of the problems I can help with. (Paul)

Instead of excluding the wider context of practising, Paul included it and then set clear boundaries as to what his interventions could achieve and where patients would need to be referred to other professionals. Participation helped patients to make decisions, clarify their own situation and understand what physiotherapy could offer. Paul realised democratic open relationships with his patients.

Raymond thought he was sensitive to his patients’ expectations and felt he was quite an exception to the norm. He thought most physiotherapists did not develop open relationships but rather detached, authoritarian professional relationships with their patients, and he suspected that most patients went along with it.

These physiotherapists dominate the cubicle, question the patient, harass them, and at the end of the day they turn the patient’s opinion around to theirs. The patient might think they are bastards but when these physiotherapists say 'This is what's wrong with you. I am going to manipulate this joint and you are going to get better', patients will think 'Oh this is the best physiotherapist I have been to'. They are the sort of patients that fit your prototype two physiotherapist group, the unconvinced. They do dictate their patients but they do get respect and they get an interpersonal relationship going via that respect they generate. (Raymond)

This type of patient response is typical of the community’s expectation and (often) forced acceptance of expertise and domination in illness roles. This is part of the reason that some health care practitioners remain unconvinced that they need to change. Raymond was aware that some physiotherapists took advantage of these taken-for-granted assumptions about passive patient and expert therapist roles to claim patients’ trust. However, consumer expectations are changing towards greater expectations of collaboration. Raymond described his professional relations with patients as practical and contextual, because each depended on the unique clinical situation. Raymond wanted neither to confront nor to silence his patients.

6.2.7 The delicate balance of power distribution

CSS provides an opportunity for physiotherapists to understand why they practise the way they do, and why patients bring certain expectations to physiotherapy. Open professional relationships facilitate patient collaboration and enable physiotherapists to act on shared understanding. Physiotherapists who have not questioned their professional identity, their expectations of patients and the effectiveness of their interventions may be ignorant of power relations. Physiotherapists who have limited self-awareness also have limited awareness of their professional authority and its impact on patients. It was challenging to approach the topic of professional authority. Participants found it difficult to articulate how they used their professional authority.

Paul did not overtly discuss power. His discourse was about collaboration and negotiation, which implied a process of democratising professional relations.
Establishing goals is a two-way thing. I have to explain where I am coming from and my own prejudices and I need to have that at the back of my mind and so do patients in a professional relationship. (Paul)

Raymond, on the other hand, was very explicit about power relations. He had examples of how he as a patient was dominated by clinicians. Here is one example he provided of physiotherapy dominance over patients:

Continence physiotherapists say to women ‘you have weak pelvic floor muscles because you had babies’. ‘But I had no babies’. ‘Oh, you just have a weak pelvic floor’. Physiotherapists dominate patients about what it is that is right with them and why. (Raymond)

Raymond, like Paul and Jill, was skeptical about physiotherapists knowing all the causes of presenting symptoms. He felt that other physiotherapists claimed to know the causes of dysfunctions without knowing or checking them. His experiences as a patient made him sensitive and conscious of power relations. Raising critical self-awareness by challenging one’s reasoning was necessary in order to become conscious of the power discourse. Raymond returned to university for further study because he wanted to make his practice approach more scientific, after a colleague had challenged his practice claiming that he had no evidence for what he was doing.

I felt, hang on, I haven't got a handle on this [scientific evidence]. That is when I went back to do a postgraduate course to become a lot more scientific and dominate the cubicle. And do you have a handle now? No. (laugh) I have not because I have this pulling about being empathetic. I value the scientific and searching for the evidence but I am worried about the patient. (Raymond)

He accepted that practice could not be strictly rationally determined and justified. He was critical of empirico-analytical approaches to practice, preferring to determine his interventions based on the individual clinical situation. He was aware that reliability amongst clinicians was poor and that clinical as well as laboratory tests were interpreted differently. Raymond provided an example of observer reliability and how poor it was:

There was a study done on asymptomatic patients and the average reporting of neurosurgeons reporting on CAT scans. There was only a 15% reliability in reporting. (Raymond)

Raymond was skeptical of test reporting. Raymond felt that clinicians who are not willing to accept diverse interpretations simplify their practice and may unknowingly overuse their professional authority thus avoiding critical thinking. Raymond gave an example of professional dominance with doctors over-using their authority over physiotherapists as well as patients:

The doctor seems to gloss over what the patient says and what they find and e.g. we [physiotherapists] do a straight leg raise and pain comes in at 15 degrees. Then we do the same in side lying and the patient can straighten the leg much further pain free. From this the doctor assumes the patient is not telling the truth. [They resolved to] accept the pain, don’t treat pain. (Raymond)

Raymond felt disempowered to educate doctors about the difference in straight leg raises in different positions. His practice knowledge did not match that of his clinical team. Within the team he had less power than doctors and psychologists, and he felt silenced in relation to evidence and definitions.

If I brought evidence of tissue damage, he [psychologist] would bring evidence of fear avoidance and say that the patient is fearful of pain and it is pain behaviour. I do not have the range of knowledge to argue with that. I have been thrown into a different field here. Pain is now [defined as] an emotive experience. Pain is emotional. You live and die by evidence. (Raymond)

Discussing which evidence is truer is futile if this discussion is not critical of the assumptions that inform the interpretations of the evidence. In Raymond’s experience, the assumptions which were based on a pathology and a psychology perspective were accepted as a given and were not questioned. The patient perspective was assumed to be unreliable or even counterproductive. Raymond was unable to critically question his colleagues and bring the patient perspective into a discussion of evidence. He was unable to take the discussion to a deeper level, to question
what underpins all these beliefs in evidence. Raymond would have liked deeper discussion but he did not have the
critical self-reflection and skill to do so with his medical and psychology colleagues.

Physiotherapy discourse continues to debate whether physiotherapy is a science, or an applied science and is largely
silent on exploration of physiotherapy as a critical social science (Parry 1997, Richardson 1999). This debate also
occurs at an interdisciplinary level (Skelton 1998). If practice frameworks are predetermined and there is no
environment for critical debate to challenge statements and clarify assumptions and definitions, then the practice
environment fosters hegemony. Excluding the perceptions of other colleagues and patients runs the risk of silencing
and therefore dominating them. Raymond took a biomedical pathology perspective on pain whereas the
psychologists took a behaviourist and self-efficacy perspective. Patients were mistrusted as people who lacked
motivation or complained of pain for secondary gains. It is patients who suffer in these power struggles between
clinical disciplines.

I feel sorry for this poor bugger [the patient] and it is wrong to say ‘You’ve got to force your
arm or you have no quality of life’. They [psychologists and doctors] are trying to force that
patient. (Raymond)

Raymond made careful distinctions between patients who were fear- and pain-avoidant and those who were not. He
provided an example of a patient who would not move her knee after surgery due to fear of pain:

This young lady could not straighten her leg after knee surgery. So she was not allowed to go
home. The surgeon shouted at her and she cried. The surgeon asked me to get that leg moving
so she can go home. I talked to her and then suggested to lie on her side and straighten the leg
that way. She said ‘That did not hurt’. I said ‘That is all the doctor wanted you to do’. ‘But I am
not on my back’. So she rolled on her back and could do it. She was totally fear avoidant. So I
am self-reflecting about which patient is fear avoidant and which one is not. (Raymond)

As long as patients’ emotions are excluded and not even confronted, treatment plans are dominated by the more
powerful clinician. The powerful clinician is one who conforms to hegemonic systems and structures. These
structures or hidden practice frameworks restrict the ability of individuals to adopt different approaches.

Jill discussed how she carefully balanced the way she used her professional power. She would approach each case
with an open, non-judgmental attitude and give patients the benefit of the doubt. She felt diagnosing could be
dangerous as it had a definitive quality about it. Although she provided patients with diagnoses she would ensure
that she phrased diagnoses as tentative, and she was prepared to change them as treatment and the professional
relationship developed.

You don’t really know [a diagnosis] until you get to know the person. You can have preconceived
ideas like a diagnosis but then you get there and it is not at all that and then you change ... it is
a lot of negotiation. (Jill)

Jill was willing to collaborate and democratise her professional relations with patients. However, she would not lose
control of treatment situations either. She knew when to set boundaries and when not to. She gave an example of
not collaborating with patients who made inappropriate requests:

‘I want you to massage me once a day’. ‘I cannot do that’. I am not prepared to meet all my
patients’ expectations. It depends on the degree of their expectation. I would become more
assertive and if necessary actually confront their expectations. (Jill)

Jill listened and then made informed critical decisions on how to balance the decision-making process. She would
collaborate if patients’ expectations were appropriate and led to constructive treatment plans that would foster their
accepting at least part of the responsibility for improving. Wanting daily massages was not a self-liberating,
constructive suggestion. Jill would explore and discuss expectations with patients with the aim of liberating them
from dependent, passive approaches to treatment. She seized her professional power in a critical way, which means
she used it with emancipatory interests in mind.

Professional identity that has critique and transformation at its core would be inclusive and skeptical, shifting the
debate onto a different platform. Neither patients nor clinicians should dominate, but both should collaborate. The
CSS platform encompasses collaboration and participation with democratic and sincere intentions.
6.2.8 The influence of the practice environment on practice models

Jill worked as a community physiotherapist and her practice environment was her patients’ homes. She thought this made her practice immediately more patient-centred. She felt privileged to enter patients’ homes because it reminded her that patients are people and it gave her so many cues about her patients’ values in life which she incorporated into developing treatment plans. Raymond, on the other hand, felt restricted and dominated in his pain clinic practice environment. The three participants felt that the private physiotherapy practice environment was more conducive to developing an authentic professional identity than public service physiotherapy. The former provided the perceived freedom to negotiate with patients and work in an emancipatory way on a one-to-one physiotherapist-patient level. The participants felt that working in public hospitals smothered their personal professional identity.

Larger organisational systems such as hospitals currently appear to operate with a limited capacity to support emancipatory professional practice. In my experience as a senior clinical physiotherapist and diversity health coordinator, I have found that organisations establish uniform practice standards, construct hierarchical lines of accountability, and most of the time privilege the medical voice over the voices of other health care professionals. Organisations have to provide services within budgets dictated by governments, which is a different situation to the private practice environment, where physiotherapists are self-employed and the consumer pays for direct services. However, none of these participants worked in a profit-dominated private practice. Participants did not perceive their public hospitals as learning organisations that encouraged critical thinking, rigorous professional debate and particularised practice. The emphasis in hospitals was to provide quick and cost-efficient rather than human services.

Even when participants were able to create emancipatory environments with their patients and even when they practised critical self-reflective practice, they encountered barriers to widening this type of practice beyond their interpersonal micro-practice level with patients. These interpretations of practice environments by these participants can be challenged. Not all community physiotherapists facilitate emancipatory learning in their patients as Jill did; not all pain clinic physiotherapists feel dominated by others as Raymond did; and not all physiotherapists feel liberated in their private practice. The way the environment is perceived and used to inform practice is important. The values, interests and assumptions that physiotherapists bring into the environment make a difference. The environment is not passive, static and unchangeable. These participants engaged differently with their environmental influences.

As discussed above, Raymond had worked in his own private practice and due to injury was forced to relocate to a public hospital. He provided insights into the differences between the two environments and how they influenced the way he now practiced. At the core of his practice identity stood his firm belief in patients’ sincerity about their health conditions and reporting back on improvements, and their desire to get better. In his current position Raymond felt that his department, a chronic pain clinic, advocated a model of care that was suspicious of patients’ desire to get better. In his department, patients’ physical pain perceptions were actually disregarded, on the assumption that lack of movement and increased pain was due to pain avoidance at a cognitive level.

**This gives me a lot of stress because I am practising what I do not believe. My practice is scientific methodology modulated to fit into the social sphere.** (Raymond).

Raymond felt that his department did not acknowledge patients’ perspectives. He felt patients were forced to comply with their given treatment regimen or leave. Another physiotherapist in his department had left recently because she did not agree with this practice approach. Rapid turn-over of staffing, difficulty replacing vacancies in short leaving the system rather than resolving differences with critical debate at all levels of practice is emerging as a common theme in the public health care system. Raymond felt disempowered to realise his preferred practice model in the public system. He argued that the main barrier for advancing particularised practice was the battle between professional disciplines and the bureaucracy.

**I do not think this [CSS practice] is ever going to happen [in public hospitals] because they [health care professionals and the health bureaucracy] have a terrible battle. I did not have that in my private practice. [There] I do not give a damn what everybody said. If I talked for an hour with patients and they said it is working [I was satisfied]. If it was not working I asked what their motivation was. I put it in the notes that we were treating but no having results** (Raymond).

He was aware of power struggles and dominance of one practice model over another. He identified a lack of critical debate and advocacy for patients in the public system. However, he did not identify his own limitations in these matters. He did not want to question his patients. He took their reports seriously because he felt uncomfortable
challenging them. It is important to accept that critical thinking and particularised practice cannot be realised in a CSS sense if they are not negotiated with patients. Negotiations with patients would need to have a democratising character that was free of coercion and manipulation, and strove towards ideal speech communication situations. Further, negotiations with patients are based on the assumption that patients are emancipated debaters with a willingness to participate and a desire to cooperate towards better health outcomes. Raymond took these assumptions for granted, without checking them with his patients individually. He was happiest working in private practice where the practice influences could be more easily reduced to his professional relationship with his patients. Working in a multidisciplinary team environment challenged his perspective. He felt his social qualitative voice was marginalised. Raymond felt that patients were excluded from judging the value of treatments. It was senior clinicians who had the power to judge accountability and treatment effectiveness. He provided an example where a doctor who had passed all the theoretical tests had failed a practical examination on several occasions.

*Accountability is judged by your peers not by science. I know of a doctor who passed all the written exams but he failed his vivas nine times. His peers thought he could not do it [clinical practice].* (Raymond)

Commanding propositional knowledge does not make a competent clinician. Raymond agreed with this statement but questioned who and how it was decided what made this clinician fail. He suspected that he failed because his colleagues did not accept his practice approach including his interpretations of propositional knowledge in practice. Colleagues who had the most power acted as gatekeepers of what was good, acceptable clinical practice and what was not. Raymond’s quote provides an example of the difference between propositional knowledge and non-propositional knowledge. A doctor who passed all the propositional knowledge (written) tests may not have been fit to practice for a variety of reasons. These may include difficulties in applying medical knowledge appropriately in clinical practice, failing to draw upon non-propositional practice-based knowledge to supplement theory and research knowledge, not using appropriate interpersonal communication skills and not fitting into the informal medical culture.

Clinical practice is a social construction, not a law-like phenomenon. It is transformed by new propositional knowledge but even more so by social political forces. Evidence-based practice is underpinned with the assumption that propositional knowledge should inform practice as the superior way of knowing. The aim of evidence-based practice is to guide practice approaches and differentiate effective from non-effective treatment techniques, regardless of the practice context. Critical debates that build the capacity to question practice and self within given practice contexts are tools to emancipate clinicians from unnecessary and seemingly frozen prejudices and assumptions. These assumptions may be based on empirico-analytical, interpretive and critical values. Critical debates ultimately result in better outcomes for patients (Barry et al 2001). However, critical debates about practice models are only critical when practitioners have the capacity to take the risk to embrace evidence and arguments that are outside the current practice paradigm. Internal debates on practice models that remain within a practice model and exclude other values may fine-tune and develop a focused practice model within its paradigm, but the paradigm cannot readily be sustained outside its own practice parameters. The limitations of such internal debates are their narrowness and loss of connection with outside-of-paradigm ideas and thoughts. As long as patient evidence and social-political influences are not embraced in the physiotherapy discourse a CSS model for physiotherapy practice remains at the margins.

Physiotherapists do not work in isolation. CSS can only be realised when the interests of individual physiotherapists, their multidisciplinary teams and their patients are aligned, and the system is supportive. Public health care systems are challenged to create an environment that fosters democratising professional relationships. Such relationships need to start with an awareness of professional authority, one’s own spheres of influence and power as well as those of others. This research examined only in part the professional power of physiotherapists within the wider context of health care practice. It was beyond the scope of this research to explore the wider practice contexts in depth. This group of participants discussed the wider context more than other participant groups. Physiotherapists who practice within a CSS framework need to constantly remind themselves that power relations between therapist and patient are unequal from the start. But even when emancipatory environments can be created at the one-to-one micro-level they cannot be sustained if macro levels (departments, hospital organisations, health insurance companies) do not foster emancipation. Jill provided an example that showed how little support there was for democratising professional relationships in the wider context.

*When patients come to public hospital they are told to have nine treatments before they are reassessed. The physiotherapists may know that it would take less than nine treatments but patients want the nine sessions because the doctor had said so.* (Jill)
Power relations are complex and do not stop at the physiotherapist-patient level. Physiotherapists need to deal with medical power as well. Jill struggled with the public system and concluded that the private system worked better for physiotherapists because they were self-sufficient and practiced independently of doctors’ orders. She felt the issue of over-treating patients had a lot to do with doctors using prescribing power. Jill felt strongly that the number of treatments that are required to help patients gain control over their health condition should not be regimented. Regimentation silences individual care and critical thinking. All interviewees mentioned the issue of acceptable number of treatments. Determining an acceptable number of treatments that patients should receive is influenced by many factors: current biophysical and biomedical knowledge, medical insurance policies, hospital policies, individual doctors’ prescriptions, patients’ willingness to pay, and, last but not least, physiotherapists’ perspectives (see Figure 6.2).

Determining the acceptable number of treatments is located within a messy force field of diverse interests. The interests of therapists, patients and the external working environment determine the acceptable number of treatments. It is rarely determined at the interpersonal micro-level between therapist and patient alone. It is equally rarely determined by evidence-based information alone.

![Figure 6.2 Influences and interdependence of perceived number of treatments required for physiotherapy](image)

6.2.9 Hidden practice cultures
Each physiotherapy department develops its own ways of providing physiotherapy services. The interests and values of leading senior physiotherapy positions have considerable influence on these cultures. Jill noted that senior physiotherapy positions in public teaching hospitals are increasingly more occupied by physiotherapists with limited professional experience. She felt that this situation contributed to the development of a hidden culture that
valued empirico-analytical approaches more than practice-based approaches grounded in deep practice knowledge and wisdom. It also led to a focus on technical procedures rather than patient engagement and participation. Cultural knowledge was being bypassed by strictly scientific knowledge. Jill felt that physiotherapy training neglected critical thinking skills and a patient-centred approach to practice.

Jill felt such “scientisation” of practice was due to the dominance of empirico-analytical approaches, as evident in the new generation of physiotherapists who predominantly applied treatment techniques when there was evidence of their effectiveness, without any room for critical interpretation of this evidence or variation related to the particular clinical situation. Scientising physiotherapy practice fits the current trend of hospital systems that value fast through-put of patients and marginalise patients’ perspectives.

Raymond felt his way of practising physiotherapy was not valued because it did not conform to the evidence-based framework.

You have to come to a definition of what is physiotherapy, haven’t you? Because if I practise physiotherapy that is not evidence-based here in a public hospital then I am considered a charlatan. (Raymond)

Raymond asserted that most practice was in fact not evidence-based, but to openly admit that was not acceptable. He felt that his colleagues were deluding themselves when they claimed to work in an evidence-based framework. He argued that the real issue of contention should be what underpinned their assertions and convictions, rather than the assertions themselves. Raymond believed that his clinical team members were hiding their real values behind evidence-based practice.

Paul worked in private practice and was able to realise an emancipatory approach in his practice. He felt that the public system and his physiotherapy peers did not fit his practice approach.

I worked in the public system for one year, my first year. I did not consider staying at the time. Socially and politically I would prefer to do that. But at the time I felt the system had a bad influence on me. I just thought I learnt a bad work ethic. (Paul)

Paul gave an example of a bad work ethic: planning sick days when one was not sick but simply wanted time off. He developed his own practice model which was based on critical self-reflection, scientific physical tests to measure treatment effectiveness, democratic patient collaboration, skepticism, clear communication and intentions to create ideal speech situations. He was aware of the diverse interpretations of language and he clarified his understanding of patients’ needs by checking what patients and he himself were trying to say. He collaborated about treatment plans and goals with critical awareness of his professional authority, which he endeavoured not to misuse. He had sincere intentions to work towards independence and quality of life of his patients. He felt that his private practice environment allowed him to realise his espoused practice model.

It is not surprising that like-minded physiotherapists end up in the same departments, applying the same practice techniques and approaches. Eliminating tensions between personal and organisational values and ideology may produce harmony and self-confidence within physiotherapy departments. Such a harmonious balance increases a sense of belonging and may provide security for staff and improved productivity (Wenger, et al 2002). However, cultivating communities of practice by attracting like-minded physiotherapists who lack challenge and critique may hinder practice development. To develop a CSS framework physiotherapists must constantly challenge their clinical reasoning and maintain a critical stance to current practices. This critical stance to self and others can only be sustained within a supportive environment that facilitates such emancipatory learning. Neither Raymond nor Jill felt well supported in their emancipatory practice attempts, and such lack of support was one of Paul’s reasons for leaving the public system.

6.3 Critical reflections on the three participants’ practices

The participants of this fourth text had developed their own professional practice approaches. Each of these approaches embodied a variation of the CSS themes, critique and emancipation. Raymond struggled to moderate and integrate his practice philosophy with that of his workplace setting. The dominant culture in his practice setting was the strongest influence on his practice, followed by his assumptions of what patients expected from physiotherapy. His personal motivation and the propositional knowledge underpinning his practice philosophy were least influential, as illustrated in Figure 6.3.

Raymond did not moderate these competing influences critically. He conformed predominantly to the setting culture and secondarily to patients’ perspectives. He did not feel supported by his practice environment to question
and challenge dominant practices. He was able to have scientific discussions but no value clarifying debates within his multidisciplinary team.

I am not emancipated (by my workplace). I am a public servant. (Raymond)

Raymond disliked mainstream systems that disregarded patient perspectives, especially in the context of a pain clinic. He felt disempowered in his workplace and could not see a way to change his situation. Raymond would have liked to practise CSS but he could not realise the critical self-reflective quality and the capacity to critique the interests of his team that were required.

Figure 6.3 Influences of Raymond’s practice (thicker arrows indicate stronger influence)

Paul chose to work in private practice so that he could realise his practice philosophy. The one year that he worked in the public system context made him realise that he could not develop his own practice approaches there. Before establishing his own practice, Paul worked for other physiotherapists in a private practice setting, observing their approaches. He adopted aspects that he liked and avoided others. He avoided engaging in critical dialogues with colleagues by opting to work for himself in private practice. He chose this path in order to develop his authentic practice approaches, and he achieved this. He mentioned that he could work in the public system if he had to. This could be interpreted as feeling ready to have critical dialogues and test his practice approaches in the diverse interest-driven public system world. At present, however, Paul realised CSS only at the interpersonal level with his patients. He did not appear to experience interest clashes and he did not have a critical companion, as described by Titchen (2001), who could facilitate critical dialogue and continuing practice development. Paul worked as his own boss with few interdependent professional relationships with colleagues. His practice was critically patient-centred and realised CSS at the therapist-patient level.

Jill was the participant who was most self-critical and reconsidered her practice values based on her patients’ aspirations and aims. She checked her judgments with patients openly. She was also consciously aware of the political and medical forces of the public system. She did not allow these forces to hinder her emancipatory practice at the interpersonal level within the public system. She felt that the main barrier to emancipatory practice was the
medical profession. She sought dialogues with general practitioners (GPs) to critique their prescriptions for and educate them about physiotherapy. Jill was driven to do that based on an emancipatory interest for her profession as well as for her patients. Jill rang GPs individually; she did not have the skills to approach the Division of General Practice at a systems level.

Jill had been driven to critical self-reflective practice through a critical incident she had with an amputee patient. This experience affected the way she thought and the way she practised physiotherapy. Her values were grounded in humanity, listening to patients, understanding them and working with them to improve their situation. Raymond discussed several critical incidents that made him stop and think critically about physiotherapy knowledge, definitions of symptoms and the complexity of working with diversity. His experiences as a patient influenced his somewhat uncritical acceptance of patient-centred approaches to physiotherapy practice. Paul had had no critical incident with patients, but he remembered a senior physiotherapist who consistently had overwhelmingly positive results with her patients. This physiotherapist, however, was unable to explain and put into words what she was doing. This lack set Paul on the path of wanting to be able to articulate his clinical reasoning and wanting to communicate sincerely and clearly with patients.

A summary overview of each participant in text four is displayed in Tables 6.2 and 6.3 to illustrate the core ideas of CSS and how far these participants had entered and embodied interest critique and emancipation in their current practice.

<table>
<thead>
<tr>
<th>Interest</th>
<th>Critique</th>
<th>Self-critique</th>
<th>Critique of patient</th>
<th>Critique of colleagues</th>
<th>Critique of environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raymond</td>
<td>(X)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Paul</td>
<td>X</td>
<td>X</td>
<td>(private practice)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jill</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSS</td>
<td>XX</td>
<td>XX</td>
<td>XX</td>
<td>XX</td>
<td></td>
</tr>
<tr>
<td>champions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 6.3</th>
<th>Emancipation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acting on Critique</td>
<td>Transforming self</td>
</tr>
<tr>
<td>Raymond</td>
<td>(X)</td>
</tr>
<tr>
<td>Paul</td>
<td>X</td>
</tr>
<tr>
<td>Jill</td>
<td>X</td>
</tr>
<tr>
<td>CSS champions</td>
<td>XX</td>
</tr>
</tbody>
</table>

It can be seen that none of the three participants comprehensively reflected CSS in their practice. Rather than being true CSS champions they were emerging CSS champions. However, it could be argued that since they had all developed their practice models through personal insights, reflections and critique, without the benefit of CSS teaching, role modelling or mentoring, and had done so “against the grain” of dominant and socialised practices, their practice development was a remarkable achievement of authenticity and the realisation of emancipatory interests. Table 6.4 illustrates the essence and core aspects of the practice of Jill, Paul and Raymond, and their critique of CSS.

Although each participant was reflective and self-critical to a degree, none of them took up an activist emancipatory role that had an influence beyond themselves and their patients. An activist role includes engaging and challenging established systems. None of these participants saw it their role to advocate for democratising structures or to reform clinical decision-making processes at multidisciplinary levels. Jill and Raymond did not discuss these issues with their managers. Being his own boss, Paul did not have a manager at all. The potential for such an activist role was not contemplated, despite the fact that these participants each critiqued current hierarchical structures. It is increasingly difficult in the current climate to hear a critical voice (Newman 2006). The current climate does not foster a supporting environment for thinking critically for oneself and having rigorous debate on values and interests. Instead of experiencing support from peers and engaging in critical dialogues, these participants had resolved their critical stance of the status quo individually.
### Table 6.4 Essence and core aspects of the fourth text group participants and their critique of the CSS model

<table>
<thead>
<tr>
<th>Name</th>
<th>Essence of their practice</th>
<th>Core aspect of their practice that realised CSS dimensions</th>
<th>What they liked about the CSS model</th>
<th>What they disliked about the CSS model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raymond</td>
<td>Trusting patients and their reports without questioning them, addressing patients’ needs</td>
<td>Being aware of the power relations in his current practice context, placing evidence-based and patient knowledge into a critical dialogue</td>
<td>Including patient values</td>
<td>Feeling I have to accept patients’ views that I know to be misguided</td>
</tr>
<tr>
<td>Jill</td>
<td>Working with patients towards meaningful collaborative goals</td>
<td>Using critical self-reflection to improve treatment and collaborative goal setting</td>
<td>Including patients</td>
<td>My practice model not being appreciated and valued by peers</td>
</tr>
<tr>
<td>Paul</td>
<td>Bringing an attitude to the clinical encounter that wants to contribute to patients becoming better</td>
<td>Being critically aware of the complexity of communication, continually critiquing and developing own practice</td>
<td>Being critically self-reflective makes brilliant clinicians</td>
<td>Needing to be skeptical</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lacking a tool to access critical self-reflection</td>
</tr>
</tbody>
</table>

### 6.4 Potential limitations, constraints and costs

The following discussion is a dialogue between my voice and participants’ voices. It is the critical interpretation of participants’ interpretations of their practice and of my CSS model for a physiotherapy practice. During my journey of completing this thesis I discussed my research with many colleagues, academics and clinicians. I engaged in critical dialogue with critical peers in writing three journal papers (Trede and Higgs 2003, Trede et al 2003, Edwards et al 2004). I presented papers on CSS at conferences to clinicians, academics and educators, at quality management seminars to department heads and nurse unit managers, and at research symposia to peers. I had not met one practising physiotherapist with whom I could have an informed conversation about CSS theory in practice. Indeed, I had not been familiar with the Gadamer-Habermas and the Foucault-Habermas debates prior to my research journey. Critical discussions involved translating CSS into my conversation partner’s context and language, focusing on key ideas rather than complexities. To an extent their critique and concerns were a reflection of their ideology, ignorance, positioning in the system and/or fear regarding CSS.

The concerns, constraints and costs that were raised in these dialogues are summarised into seven categories:
1. CSS assumes that patients want to collaborate and be emancipated
2. CSS does not fit the current political health care practice climate
3. There is a danger of misusing critical self-reflection
4. CSS is strongly located in Western culture emphasising self-reflection and self-confidence to negotiate. This does not easily fit with all cultural values
5. CSS lacks evidence to measure outcomes of critical self-reflection
6. CSS is difficult to criticise because it would mean taking sides with the so-called oppressors
7. CSS-related practice could be alienating

Rather than defending CSS and refuting these limitations, I discuss each of them here by illuminating the ideologies behind these perceived weaknesses of CSS.

#### 6.4.1 CSS assumes that patients want to collaborate and be emancipated

There are patients who for various reasons do not want to be included in the decision making process. Maybe the very reason they seek help from physiotherapists is that they want to hand over responsibility for “curing their ills”; knowingly or unknowingly they are thus handing over their self-determination and control. One needs to be cautious about assuming that patients want collaboration and participation. Some patients may feel uncomfortable or simply do not wish to question their physiotherapist. Patients may want simply to trust the physiotherapist and comply with advice or instructions. If physiotherapists invite patients to participate in treatment decision-making, patients may get the impression that the physiotherapist is incompetent. Patients may assume that physiotherapists should be able to “fix” them. And even if patients wanted an open professional relationship they may not have the skills to negotiate such a relationship, especially with non-CSS physiotherapists who have not sought to learn the skills of emancipation or collaborative decision making. Collaboration with patients may also be limited when no
common ground can be found. Physiotherapists need to have the liberty not to collaborate with patients who have unreasonable expectations or unacceptable behaviour.

These are all potential rather than absolute limitations of CSS. However, other restrictions to collaboration include acute life-threatening conditions, language barriers, lack of cognitive ability, mental health problems, and age-related issues. One of the key principles of CSS is to not take patients’ assumptions and expectations for granted. The first step in critiquing the status quo is to find out patient expectations. Practising CSS does not imply coercing patients to participate. Patients who choose not to participate can be asked why they do not want to do so. There may be sound reasons for not wanting to participate and physiotherapists should respect patients’ wishes, but these wishes are best explored and understood without any sense of coercion to collaborate. Often physiotherapists assume non-participation of patients without checking it out with them. Here it is important to make a point about the therapeutic culture. Patients may not want to participate because they have been acculturated into accepting expert advice and adopting a submissive role. CSS challenges this taken-for-granted role of a passive patient. CSS starts with critical self-reflection and exploring assumptions for the very reason of not assuming, coercing or acting on untested assumptions. A CSS perspective builds on goodwill and a desire to collaborate. Depending on what interests influence the individual, this goodwill can be interpreted as a limitation or a promising potential.

6.4.2 CSS does not fit the current political health care practice climate
The current political health care climate still values power being vested with practitioners and the system rather than with patients (Duckett 2004). Control, prediction and measurable outcomes are more valued than attending to diversity, complexity and uncertainty. The most prominent physiotherapy journals publish predominantly quantitative studies that disseminate propositional knowledge of physiotherapy generalisations and are outcome-oriented. The bulk of physiotherapy journals are grounded strongly in the medical model and the empirico-analytical paradigm. Concepts of patient-centred care and practice-based knowledge have limited exposure and meaning. The Australian Physiotherapy Research Foundation funds quantitative more often than qualitative research grant applications. As long as the health care system and physiotherapy bodies endorse empirical-analytical approaches and quantitative outcomes and evaluation of clinical practice, physiotherapists will not easily relinquish their professional power. It is uncomfortable to have one’s professional authority compromised by listening to patients, by being open and honest about uncertainty. Patients have less professional knowledge and often do not know what part of their story is relevant and what is irrelevant. Allowing patients to talk requires patience and good listening skills to detect relevant information. It is a more complex way of engaging with patients and it might involve taking risks. The professionalisation process for graduate physiotherapists reinforces non-democratic relations with patients and less engagement, in favour of efficient practice and professionally detached relations. The narrow vision of current health hegemonic care practice models marginalises CSS.

Indeed, it is much easier to be part of the mainstream and to profit from a supportive environment than to challenge, question and display skepticism, which result in marginalisation and non-recognition. However, the consumer rights voice is a persistent but not as powerful as the voices of the proponents of the biomedical model, and it continues to critique clinician power and the biomedical model. The Frankfurt School has taught us a historical lesson concerning conforming and silently accepting rather than resisting unwarranted power use. Adopting a CSS perspective made this lesson of resistance accessible at the interpersonal level and makes it relevant for current post-modern times. Conforming and fitting in do not necessarily assist development, improvement and certainly do not promote emancipation and self-determination. It is the self-reflective sciences that mature and transform with post-modern times. Conforming and fitting in do not necessarily assist development, improvement and certainly do not promote emancipation and self-determination. It is the self-reflective sciences that mature and transform with post-modern times. Conforming and fitting in do not necessarily assist development, improvement and certainly do not promote emancipation and self-determination. It is the self-reflective sciences that mature and transform with post-modern times. Conforming and fitting in do not necessarily assist development, improvement and certainly do not promote emancipation and self-determination. It is the self-reflective sciences that mature and transform with post-modern times. Conforming and fitting in do not necessarily assist development, improvement and certainly do not promote emancipation and self-determination. It is the self-reflective sciences that mature and transform with post-modern times.

6.4.3 There is a danger of misusing critical self-reflection
It has been argued that it is difficult to determine when critical self-reflection is mastered well and when it is not really practised. Who else but the self could be the judge of critical self-reflection? Critical self-reflection should not be given such strong emphasis because physiotherapists may be reinforcing their prejudices rather than challenging them. Critical self-reflection could lead to taking the moral high ground (Wilson and Beresford 2000). Any professional judgments and clinical decisions could be presented as being the result of intensive critical self-

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reflection. Critical self-reflection can be misused to acquire increased power and authority. The paradox of misusing critical self-reflection was discussed in Section 3.2.2 (Critique of Instrumental Reason). Reflection and negotiation are vulnerable to distortion and manipulation (Horkheimer and Adorno 1944/1972).

Critical self-reflection requires questioning one's reasoning. It is an ability to be skeptical with oneself. For professional physiotherapists this a demanding exercise, especially when professional authority and decision-making powers are accorded to them. But this makes it more important to be able to critique and monitor oneself so that these powers will not be misused. The decision to use this professional power wisely is strongly advocated in the practice of CSS.

6.4.4 CSS requires self-confidence and assertiveness
Patients interpret their roles in diverse ways, depending on their background and what influences them most. Some patients want to be taken care of without having to accept responsibility and participate in clinical decisions. Patients may lack confidence to question their physiotherapist. There are many reasons for adopting passive patient roles but in some cultures passivity is expected and it is even regarded as inappropriate to negotiate with health care professionals. In some cultures, responsibility is placed with families or communities and not with individual patients. Some indigenous cultures, for example, where most value is placed on the community and not on the individual, have a tradition of collaborating collectively. Critical self-reflection was also seen as being an uncomfortable, and potentially an identity-destroying exercise. Raymond and Paul both found the self-critical aspect of CSS most difficult, although Paul found it also the most crucial aspect for practice improvement. It is important to remember that too much skepticism can lead to self-doubt and indecision.

CSS originated from German philosophers of the Enlightenment movement and from Western European critical theory philosophy that focused on critiquing capitalism. In the present thesis the focus was on physiotherapists rethinking their professional identity and recognising that they commonly have more power than do patients and communities in clinical situations. CSS provides a perspective that allows the practitioner to question and seek to transform clinical practice. Before physiotherapists can provide culturally appropriate care they need to become aware of the diversity of their patients as well as their own diversity, including their professional power use. With increasing critical self-awareness, the possibility of providing culturally appropriate and person-centred care is heightened rather than lessened.

6.4.5 CSS lacks evidence to measure outcomes of critical self-reflection
CSS places emphasis on critical self-reflection. While logic suggests that this should enhance practice, there is little research evidence as to how critical self-reflection leads to better health outcomes. Tools need to be developed to describe what critical self-reflection is and to assess its effects. Criteria for sound critical self-reflection have not been established. Physiotherapists may think that they are critically self-reflecting when in fact they are simply reinforcing their thinking and existing knowledge and practice.

Critical self-reflection was discussed particularly in Chapter 5 (Trialling CSS). It is a complex and demanding task for a number of reasons: beyond reflecting on the basics of practice (the actions, roles, knowledge), critical reflection asks the reflector to question self and explore ideology. Ideology is so ingrained that it is difficult to make it explicit. Difficult though it may be, it is the very task of CSS to undermine the impact of ideology – to undermine ideologies that limit freedom. Questioning oneself entails questioning self-identity and professional identity. Critical self-reflection requires reflectors to think in increasingly deeper action-reflection cycles. The current lack of progress indicators for critical self-reflection can be overcome by further research into critical self-reflection.

6.4.6 It is difficult to criticise CSS because it would mean taking sides with the “so-called” oppressors
CSS stands for all the “good things” such as social justice, democracy and freedom, making it difficult to criticise (Wilson and Beresford 2000). Any critique of CSS could be interpreted as favouring fascism, oppression and hegemony. The unconvinced physiotherapists criticised CSS values. They argued that they have no time to engage with patients, no skill or desire to facilitate emancipatory learning, no measurable evidence to prove that this hegemony. The unconvinced physiotherapists criticised CSS values. They argued that they have no time to engage with patients, no skill or desire to facilitate emancipatory learning, no measurable evidence to prove that this hegemony. The unconvinced physiotherapists criticised CSS values. They argued that they have no time to engage with patients, no skill or desire to facilitate emancipatory learning, no measurable evidence to prove that this hegemony.
6.4.7 CSS-related practice could be alienating

Pursuing their authentic practice had come at a cost to Jill, Paul and Raymond. All three interviewees felt they were marginalised within their profession:

- My colleagues will hit me over the head. (Raymond)
- Quantitative researchers would say that my analysis is incredibly skewed. (Paul)
- My peers would not approve of my way of practising. (Jill)

They felt unable to have a meaningful critical discussion with physiotherapists who embodied the medical model and believed in evidence-based practice. Maybe this was due to insecurity, unsupportive environments, lack of language and articulation of practice values and inability to conduct constructive critical debates beyond their practice paradigm. None had tried to change dominant practice values. They refrained from public debate for many reasons, including that they did not see it their role, they were not encouraged or supported to do so, and they had no skills in conducting public debates. They realised their practice philosophy as much as they felt able to within each of their practice contexts and spheres of influence.

6.5 Concluding remarks

The participants in Text 4 had transformed their practice towards emancipation, independently of this study, as a result of critical self-reflection and critique of conventional physiotherapy practice. They had challenged accepted practice through questioning and understanding its origins (in CSS terms, its socio-cultural, historical and political constructions), and had moved towards a self-critical and emancipatory framework for practice. They claimed to have gained confidence, better patient health outcomes and professional satisfaction from acting on their self-critique. These physiotherapists were aware of distortions in communication and of the inadequacy of language as a sincere communication tool. They were aware of power relations and manipulations and sought to avoid these practices. This group democratised their relationships with patients as far as possible, as long as no external influences required them to do otherwise. They felt isolated and poorly supported in their practice approach but remained convinced of their practice values. These values included a commitment to listening to patients, being self-critical and working flexibly in negotiation with patients. Their practice philosophies were based on relational experiences (being able to see connections between various variables and aspects to human movement), creating positive and authentic interactions with others, valuing professional practice knowledge that was developed with critical self-reflection on professional experiences, and critically and consciously making value judgements about different practice perspectives. They shared a vision of CSS but felt they could not realise it completely.

Reflecting on their interpretations and how closely they related to my CSS model enabled me to address the question, “Is this something that already exists in some similar form or shape and is this something that realistically can be attempted in practice?”. Jill, Paul and Raymond demonstrated that essential features of my CSS model had been envisaged, realised and embodied to some extent in their practices. Their stories of marginalisation led me to believe that there might be many more physiotherapists trying to practise a CSS mode of physiotherapy without support and without a strong voice. I have hope and conviction that this is a viable and achievable model for physiotherapy practice.

My conviction is based on the following arguments:

(a) These three participants each enacted a mode of CSS related to my CSS model.

(b) Facilitation of trialling CSS and education about this practice demonstrated that there is the potential for the uninformed, the contemplators, the transformers and the (emerging) champions to be moved to realise CSS principles in their practice. Educational opportunity can facilitate change in physiotherapists who are ready to change.

(c) My own journey and struggle in transforming my practice provided me with a broader vision and depth of understanding that enabled me to reflect more critically on physiotherapy practice.

(d) Physiotherapy workplaces that provide local managerial support can overcome economic rationalist systems and build islands of democratic practice (Newman 1994, p.82).
Chapter 7

CONCLUSIONS:
CRITICAL PHYSIOTHERAPY PRACTICE

In this concluding chapter I present a series of propositions concerning the value, applicability and features of physiotherapy practice informed by CSS. I present CSS as a critical approach to physiotherapy and a potential practice model. Although my thesis is based on the philosophical theories of Habermas, its emerging relevance to practice lies also in the educational theories (especially critical pedagogy) that are informed by CSS. Therefore I will put aside the theoretical term *CCS model* and introduce a simpler more practical label, *critical physiotherapy practice*. In doing so I also align my work with educators who have researched the challenge of teaching critical thinking. In his latest book to be published this year, 2006, Mike Newman describes eloquently what critical thinking means from a critical perspective:

> It is common enough these days to hear people say that we should teach critical thinking, but this injunction has become a platitude. There was a time when critical thinking derived from critical theory. This kind of critical thinking involved separating out 'truth' from 'ideology'. It meant analysing human activity in terms of power, and refusing to take the words, ideas, injunctions and orders of others at face value. It meant not letting other make up our minds for us. It meant abandoning the search for some fixed set of principles, and adopting a stance of informed and continual critique. Critical thinking was not a neutral activity. Like the critical theory from which it sprang, critical thinking was associated with the pursuit of social justice (Newman 2006, p. 14).

Like Newman I derive ‘critical’ from traditions of critical theory. Like Habermas I started from a position of ideals of what practice should be like, and like Habermas my ideals were critiqued in critical dialogues with others. I learned and transformed my ideals to make them more applicable and realistic. The aim of my research was to spell out what critical physiotherapy practice could be. I commence with an overview of the journey from CSS theory to clinical practice applicability.

7.1 Overview of the journey from CSS theory to clinical practice applicability

The research questions posed in this thesis were What is the value of CSS for physiotherapy practice? and What are the uses and limitations of CSS as a framework for physiotherapy practice?

In Chapter 2 I discussed the philosophical background of CSS. I described the ontological, epistemological and methodological persuasions that guided me to develop an integrated hermeneutic research design. This design comprised four research cycles combining interpretive and critical methods to explore my research questions.

In Chapter 3 I explored the question *What is CSS? What are the relevant themes of CSS that could inform physiotherapy practice?* I discussed the historical developments and theoretical foci of CSS from the Frankfurt School to the theory of communicative actions developed by Habermas. Historically, the Frankfurt School opposed and rejected positivism outright. It created a dichotomy between technical scientific knowledge and critical social knowledge. Such comparison narrowed options and burned bridges, creating barriers to dialogue. It alienated the Frankfurt School rather than bringing it as a viable option into mainstream discussion. This dichotomous thinking, however, gave rise to CSS (Agger 1998). Jürgen Habermas, one of the most prominent proponents of CSS, directed the focus to a critique of interests that inform knowledge generation (1968/1972) and communication theory (1981/1984, 1981/1987) that was based on reason and critical rationality. He claimed that different types of knowledge can be generated, based on three different interests (technical, practical and emancipatory). Each type of knowledge serves a different purpose. Rather than placing these different types of knowledge on a ranking scale he argued that they are equally important. His theories of human knowledge and interests, and communication made CSS easily accessible to aspects of clinical practice theories that relate to professional practice knowledge, clinical reasoning and therapist-patient relationships.

Habermas categorised interests into technical, practical and emancipatory. In this thesis these interest categories were contemplated in the physiotherapy context. Technical interest underpins a therapist-centred practice model built on empirico-analytical research and theory, propositional knowledge and notions of empirically-based, provider-determined best practice. In this model physiotherapy practice is interpreted as a technology, detached from emotions and free of bias. A technical focus involves determining what technique is the best choice and how
this technique should be performed to effect appropriate measurable outcomes. On the other hand, practical interest underpins a bio-psycho-social practice model with a focus on professional judgment, communication and functional outcomes. Practical interest is equated with functional interest entailing listening to and appreciating patients’ perspectives, and helping patients to cope and to adapt to existing social norms. Finally, emancipatory interest underpins a liberated, critical practice model. This model was explored in this thesis. Emancipatory interest strives to liberate practice from unreflected, taken-for-granted professional judgments, functional goals and distorted communication that constrain rather than facilitate patients’ participation and learning. Table 7.1 illustrates how technical, practical and emancipatory interests influence practices.

<table>
<thead>
<tr>
<th>Interest</th>
<th>Technical</th>
<th>Practical</th>
<th>Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context</td>
<td>Exclude</td>
<td>Build on</td>
<td>Critique</td>
</tr>
<tr>
<td>Traditions and norms</td>
<td>Reinforce</td>
<td>Grow on</td>
<td>Liberate from</td>
</tr>
<tr>
<td>Power</td>
<td>To control</td>
<td>To consent</td>
<td>To democratise</td>
</tr>
<tr>
<td>Reasoning for</td>
<td>Prediction</td>
<td>Agreement</td>
<td>Emancipation</td>
</tr>
<tr>
<td>Interpretations are</td>
<td>Objectified</td>
<td>Interpreted</td>
<td>Critiqued</td>
</tr>
</tbody>
</table>

Habermas (1981/1984) theorised the ideal situation and conceded to Gadamer (1960/1992) and Foucault (1969/1982) that the ideal was not always realisable in the present. These debates about refining concepts of knowledge, power and practice were also played out in the literature of related health professions. Drawing on this literature I propose that three key concepts of CSS have primary relevance for physiotherapy practice:

- Physiotherapist *empowerment* by redefining and liberating their professional identities and roles
- *Critical pedagogy* in facilitating patient empowerment
- *Critical rationality* and the critique of taken-for-granted practices by rethinking professional reasoning and practice epistemology

These concepts imply a focus on critique of self, others, systems and frameworks (practice frameworks and frames of reference), and they also imply agency in emancipatory learning.

In Chapter 4 I posed the question *What do current physiotherapy practice models look like?* Physiotherapy literature does include a discussion of professional practice with accountability to self, explorations of practice ideology, use and misuse of professional authority, and collaborative clinical decision-making. But a theorising about a critical physiotherapy practice that derives from CSS is noticeably absent. Physiotherapists who participated in this cycle of my research portrayed physiotherapy as being predominantly grounded in technical interests, with some level of practical interests, consistent with their medical model socialisation.

In Chapter 5 I led an action-learning exercise with physiotherapists who were interested to engage with ideas derived from CSS. The questions I posed were *What would trialling a CSS model in practice be like? What are the strengths and limitations of these CSS applications?* Some participants did not engage in critical self-reflection. Their focus was on patients’ physical wellbeing, with little consideration of what patients might contribute to the professional relationship and decision making. These participants were unconvinced of the relevance or value of CSS and were reinforced in their technical-practical approaches. Others were intrigued by CSS values and its relevance to their practice, and although they contemplated potential applications of CSS in practice, they did not significantly change their current practice. Yet others could see uses and applications of CSS to their practice, and they transformed their practice to incorporate these new insights and approaches. Critical dialogue in this CSS practice trialling phase of my research highlighted the complexity of practice and its context and identified that critical self-reflection is a key aspect to starting the journey of transformation.

In Chapter 6 I explored with my third participant group how physiotherapy might already be applying CSS in practice. I posed the question *What might CSS-informed physiotherapy practice look like? What are the pros and cons of such a CSS approach to physiotherapy practice?* I found that this participant group, without the theory, learning and labels of CSS, had unknowingly realised aspects of CSS in their practice. They endorsed the values and merit of CSS and discussed challenges and barriers to its implementation in practice.

From these four texts and their critical interpretations I theorised the following set of propositions.
7.2 Propositions arising from text interpretations of this study

**PROPOSITION 1** Critical practice requires practitioners to be willing to question self, their professional identity and their chosen model of practice

Self-critique includes questions such as *Who am I?*, *What do I do?* and *What is my role?* Participants who engaged in self-critique became aware of competing interests between self and their profession, self and patients, as well as self and work-place. Self-critique was a starting tool for personal and professional development that could set critical practice in motion. Participants who critiqued themselves developed their ability to shift their thinking, thereby becoming more flexible, creative and adaptable in practice, and able to liberate themselves from unreflected assumptions. Their thinking became more consciously person-centred (as opposed to therapist-centred).

Many clinicians have conceded to me that the biomedical model is flawed and have agreed that we should all take a more patient-centred approach. When these clinicians could not see an alternative to the didactic, technical approach and simply continued to critique without identifying emancipatory actions, they displayed cognitive critical appreciation of CSS but did not own it. Cognitive-critical appreciation is a mental state that does not necessarily manifest itself in practice transformation. Petra exemplified cognitive-critical appreciation when she said, ‘It is much nicer working with patients than doing to patients’. Her justifications for needing to do to patients were grounded in medical model values. Questioning self that extended to critical clinical reasoning included:

- Avoiding making generalised judgments about patients
- Seeking critical self-understanding
- Being honest, open, sincere, and curious
- Paying attention to detail

Critical practice means moving away from a situation where patients are unaware, disempowered and expected to be patient and compliant. The ‘comfort’ of this system and situation is that patients are (relatively) not ‘difficult’ because they are largely constrained into a position of passivity and compliance, and authoritarian practitioners can practise satisfactorily within hegemonic practice environments and systems. In my study, the physiotherapy participants did not identify (name) themselves as either oppressed people or oppressors. Many felt uncomfortable discussing their professional identity and authority, let alone questioning them. From my research I concluded that physiotherapists do not want to complicate their practice. They prefer to be practitioners that ‘do’ as opposed to ‘reflect’. We see here the inherent and powerful effects of hegemonic practice which sets out behaviour expectations and rewards those who comply. Also, it was evident that the unchallenged acceptance of socialised norms was a strong part of this tertiary health care work environment. Without other models to consider, and without education about the interests underlying their practices, there was no stimulus or critical dialogue to generate a revision or rejection of the status quo. The research project itself brought such alternatives and questions to the minds of some participants, particularly in the later cycles of the study, prompting critique and alteration of the status quo.

**PROPOSITION 2** Critical practice necessitates challenging models of practice, practice cultures and taken-for-granted practice interests

A critical approach asks health care professionals to critique interests and practices. Some participants were not ready or willing to critique themselves, their interests and what predominantly influenced the way they practised. This could be the outcome of professionalisation and practice circumstances. In this thesis I identified as oppressed people those physiotherapists who were unaware and unreflective, and adopted practice approaches without questioning them. I identified that the interests underpinning physiotherapy practice were largely taken-for-granted, and that there was a lack of perceived need to challenge the status quo. I am speaking here of the impact of interests on practice. There were many aspects of practice (e.g. staffing levels, workloads), which were not entirely satisfactory for the participants. Such discussion is not the focus of this study. This lack of interest in critique of the basis for or the nature of the hegemonic practice model is a key barrier to democratising and humanising practice. Table 7.2 highlights how technical, practical and emancipatory interests influence practice.
Table 7.2  Influence of interests on aspects of practice

<table>
<thead>
<tr>
<th>Practice aspects</th>
<th>Critical interests</th>
<th>Practical interests</th>
<th>Technical interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional identity</td>
<td>self-awareness</td>
<td>awareness of others</td>
<td>scientific awareness</td>
</tr>
<tr>
<td>Critique and clinical</td>
<td>starts with self,</td>
<td>starts with patients,</td>
<td>starts with technique,</td>
</tr>
<tr>
<td>reasoning</td>
<td>with the aim to</td>
<td>with the aim to</td>
<td>with the aim to</td>
</tr>
<tr>
<td></td>
<td>transform</td>
<td>empower</td>
<td>master</td>
</tr>
<tr>
<td>Clinician power</td>
<td>equalising power</td>
<td>clinician may share</td>
<td>clinician has power</td>
</tr>
<tr>
<td></td>
<td>sharing</td>
<td>some power</td>
<td></td>
</tr>
<tr>
<td>Patient power</td>
<td>empowered in a way</td>
<td>empowered</td>
<td>disempowered</td>
</tr>
<tr>
<td></td>
<td>that can be</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>sustained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus of disease</td>
<td>political</td>
<td>practical</td>
<td>technical</td>
</tr>
<tr>
<td>Practice knowledge</td>
<td>propositional-technical, experiential and critical</td>
<td>propositional-technical and experiential</td>
<td>propositional-technical</td>
</tr>
<tr>
<td>Questioning technique</td>
<td>open, strategic</td>
<td>open questions</td>
<td>closed, explanatory</td>
</tr>
<tr>
<td></td>
<td>questions</td>
<td></td>
<td>questions</td>
</tr>
<tr>
<td>Context of decision-</td>
<td>historical-political</td>
<td>in psycho-cultural context</td>
<td>out of context</td>
</tr>
<tr>
<td>making</td>
<td></td>
<td>(definitely not political)</td>
<td></td>
</tr>
<tr>
<td>Clinicians helping</td>
<td>to empower and</td>
<td>to cope</td>
<td>to survive and</td>
</tr>
<tr>
<td>patients</td>
<td>liberate</td>
<td></td>
<td>comply</td>
</tr>
<tr>
<td>Identifying treatment</td>
<td>based on self-</td>
<td>based on clinical</td>
<td>based on RCTs</td>
</tr>
<tr>
<td>options</td>
<td>determination and</td>
<td>complexity and diversity</td>
<td></td>
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<tr>
<td></td>
<td>liberation</td>
<td></td>
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</tbody>
</table>

Physiotherapists in this study predominantly identified themselves as caring people, which they interpreted as having an interest in helping people by improving their biomedical function. Caring was thus objectified and largely reduced to caring for biomechanical aspects of human performance.

**PROPOSITION 3**  Critical practice requires accountability to self as well as accountability to those influenced by one’s professional practice

Critical practice in the health care system is challenging because it requires accountability to self. Practitioners are happy to be accountable to regulating bodies and patients, but not necessarily to self. Being accountable to critical self-introspection is a fragile undertaking, especially when practice occurs in a system and with patients and colleagues who predominantly equate professionalism with technical accountability, objectivity and detachment from self.

**PROPOSITION 4**  Critical practice requires practitioners to analyse what is valuable practice knowledge

CSS offers a useful way to conceptualise different beliefs about what constitutes valuable practice knowledge. Habermas suggested a typology with technical, practical and critical knowledge. Technical propositional knowledge has explanatory value, experiential knowledge has practical value, and critical knowledge has emancipatory value. Some clinical situations may require special attention to technical knowledge, whereas in other situations the focus needs to be on practical or emancipatory knowledge. All three are needed to inform practice and ground it in the strengths and needs inherent in the three interest areas.

**PROPOSITION 5**  Critical practice requires practitioners to critically and responsibly exercise choice about courses of action

Setting goals for treatment is one thing; achieving them is another. The goal may be to care for patients and achieve better health outcomes with them. However, judging what actions will best achieve this necessitates recognising system constraints such as the acuteness of patients’ conditions, staff shortages and long patient lists. The choice might be to engage with one patient only or to attend to the urgent needs of 10 patients. In other situations the management plan may require instruction for patients about what they need to do, because this is the best response to patients’ expectations of them and to their preferred learning styles. At times a technical or pragmatic approach may be the best way forward. Through critique, practitioners are enabled to make thoughtful judgments and decisions.
PROPOSITION 6  Critical practice requires critical pedagogy

Teaching (of patients and novices) and learning about and through critical practice cannot be prescriptive and didactic because learning is not about the objective world; neither can it be purely experiential because learning is not about practical interest in social relationships (Cranton 1996).

Critical reflection is central to learning if personal and professional growth are both included in the development. This is not to say that instrumental and communicative learning about teaching are not a part of becoming an educator, but rather that development requires moving beyond the acquisition of new knowledge and understanding, into questioning our existing assumptions, values, and perspectives (Cranton 1996, p. 76).

Facilitating learning about practice through critique and critical dialogues can lead to critical practice. The action learning phase of this research resembled critical pedagogy in that the participants learned about CSS and critically appraised it by trialling it in their own practice.

PROPOSITION 7  Critical practice requires practitioners to engage patients (and carers) in transformative dialogue

Having an open, sincere and honest engagement with others is an approach that applies critique and emancipation at the interpersonal level. Open transformative dialogues foster learning for all people involved in the dialogue. It is a reciprocal process and potentially transforms the thinking and acting of all involved. Participants in my research who learned from their patients and made changes to their practice approaches as a result of this learning were able to acknowledge and address diversity of patients and complexity in treatment choices. In open dialogues, communication partners acknowledge that language is an imprecise communication tool and they are therefore open to and mindful of diverse interpretations. Adopting a critical perspective in communication creates an inclusive dialogue in order to expose assumptions and interests that create dichotomies and misunderstandings and result in distortions and dominance in practice. Such dialogues are not rhetorical but are based on critical thought, which means that dialogue partners are willing to listen, to reconsider and to identify what informed their assumptions and values. Readiness for action is underpinned by an awareness of interests, by a flexibility that enables communication partners to consider options and choice, and by a strong conviction that through critical dialogues, interpretations of situations are transformed to knowing what actions are needed. The success of open and critical dialogues requires instigation by physiotherapists and willing participation of patients (and carers secondarily) in partnership.

PROPOSITION 8  Critical practice invites its participants to imagine alternatives

Critiquing the status quo through a CSS lens enables people to rethink their practice and imagine how it could be practised differently, and invites patients to imagine different treatments and health outcomes. Such imagining creates visionary thinking, fostering self-determination and liberation from past oppressive practices.

PROPOSITION 9  Critical practice can start with a small degree of change

Emancipation may mean that only a small aspect of practice is (at first) transformed, such as the way therapists greet patients, the types of questions they ask patients, how they make clinical decisions, or how they interpret physiotherapy literature. During my research, the term *emancipation* conjured up interpretations that were aligned with gender issues, and attitudes of resistance to accommodate others. Some participants imagined that CSS needed to affect all aspects of themselves, their practice and the system within which they worked. CSS can sound complex and difficult, which may prevent people from considering and trialling it.

PROPOSITION 10  Critical practice has variable relevance and potential across the range of physiotherapy practice contexts

It is important to note that the critical practice approach is not the most relevant and appropriate in all practice situations. Critical practice is not a panacea. The process of critique facilitates making conscious and informed decisions about when and how critical practice is relevant and appropriate. Critical practice as a process can begin with reflection, applied as a precursor to transformation that opens up other possibilities.

Critical practice is not relevant in all situations and contexts. For example, in acute settings where patients are comatose, drowsy from medication, in extreme pain or showing cognitive impairment it is not universally appropriate to engage in critical dialogues and ascertain patients’ expectations. In these situations practitioners must
primarily use their professional authority and act on their patients’ best-deduced interests. Practice models that enable physiotherapists to take control and help patients cope and adjust to their given situation could be more appropriate in many situations. However, even in these situations where technical knowledge normally prevails there remains the possibility for dignified, humane treatment approaches.

Physiotherapist participants in my study had diverse positions and opinions about critical practice. It depended on who they were, where they came from, what priorities they brought to their work, where they worked, what system they worked in, who they worked with, and who their patients were. Practice approaches can result from socialisation and may be unconsciously unchallenged, or consciously critiqued and self-owned, or a mixture of these. Physiotherapists in general have to decide for themselves if this model is useful in practice or for their way of being and relating with others in the world. Physiotherapists need to determine and trial for themselves the transferability of my findings into their individual practice situations.

**PROPOSITION 11** Critical physiotherapy practice is the practice model of choice in situations of emancipatory need, predilection and support

Critical physiotherapy practice is an accessible and acceptable choice when three situations coincide. First, when there is a perceived need of patients and physiotherapists to collaborate in clinical decision making and liberate practice; second, when it is preferred practice model of a practitioner (or group) who is a champion of critical practice; and third, when other physiotherapists or multidisciplinary team members are on side, embodying authentic critical practice, and where management and organisational systems avoid hegemonic structures and support critical approaches. These three situations create an enabling and supportive environment for embedding a critical practice perspective in the existing discourse. Critical physiotherapy practice would be the practice model of choice because marginalised voices of patients and physiotherapists are heard and acted upon in a system-based environment that is sensitive, supportive and responsive to critique and liberation.

**PROPOSITION 12** The ultimate value of critical practice is its capacity to enhance the quality of life of its protagonists through critical appraisal, particularisation, empowerment and constructive collaboration in shared vision and actions

The value of critical practice for physiotherapy lies first of all in developing self-conscious, critical perspectives for physiotherapists. Its value and use are not limited to a simplistic choice of either/or (i.e. either this practice model (e.g. medical) or that (CSS)). Instead, adapting CSS can range from a tantalising glimpse of other possibilities that sheds light and doubt on the complacency of current practices, to adopting a flexible model of particularised care, to an authentic and deep embodiment of CSS philosophy in practice. Ultimately critical practice, where it is relevant, has the capacity to enhance the learning and quality of life of participants through critical transformative dialogues in the pursuit of the goal of empowering protagonists to collaborate in shared vision and actions to achieve quality, particularised health care.

### 7.3 Realising critical physiotherapy practice theory and philosophy in practice

Through a process of hermeneutic analysis of my four texts, I transformed the ideal, abstract theories derived from Habermas into concrete concepts and approaches that are applicable to clinical practice. Optimally, a critical practice framework is realised through critical transformative dialogues. These dialogues embody critical reflexivity and close the gap between theory and practice. Establishing open yet skeptical professional relations was one of these embodiments of critical reflexivity. On the one hand, open relations relate closely to Gadamer’s philosophical hermeneutics because relationships (in this study, physiotherapist-patient relationships, physiotherapist-other health care practitioner relationships, multidisciplinary relationships) are involved and embedded in a practice culture (Altenbernd Johnson 2000). On the other hand, establishing skepticism within these open professional relations relates closely to Habermas’ argument that relationships need to be appraised with skepticism and critiqued so they can be democratised and emancipated. Habermas saw the aim of critique as becoming aware of cultural dominance or scientised practice frameworks. He contended that critiquing from within would not show the distortions (what is concealed and what is disclosed) in practice. He saw it as a necessity to separate self from one’s framework in order to understand its influences by looking at it from the outside. Understanding, balancing, and appreciating could be seen as embodiments of illuminating and recognising the status quo, and negotiating consensus following notions of philosophical hermeneutics. However, understanding, balancing and appreciating transform into inherent actions of CSS embodiments when skeptical, challenging and critical attitudes are added. The CSS embodiments highlight how the tensions between the biomedical and patient-centred models can be overcome. It involves knowing your ultimate emancipatory vision of practice and at the same time working with the forces that influence clinical practice. Figure 7.1 illustrates the core elements of the Gadamer-Habermas debate translated into the physiotherapy practice context.
Figure 7.1 The Gadamer-Habermas debate in the physiotherapy practice context

<table>
<thead>
<tr>
<th>Gadamer</th>
<th>Habermas</th>
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<tbody>
<tr>
<td>open ---</td>
<td>yet ---</td>
</tr>
<tr>
<td>pragmatic</td>
<td>critical</td>
</tr>
<tr>
<td>cultural</td>
<td>as well as</td>
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CRITICAL PHYSIOTHERAPY PRACTICE
Based on balance, interest-moderation and critical ownership

The debate between Gadamer and Habermas differentiated between the critical and the practical aspects of hermeneutics. The critical transformative dialogues in this study illuminated the differences between being critical of practice within a given and accepted framework and being critical of practice by challenging given frameworks and transforming them. Gadamer saw the aim of critique in finding common ground and consensus and stated that we are immersed in culture (and practice); we are part of culture and cannot critique outside of culture. Habermas, by comparison, contended that we could critique culture from a detached, outsider position. The embodiments (described in Chapter 6) are a manifestation of the Gadamer-Habermas debate placed in clinical practice situations.

7.3.1 Levels of engagement with critical physiotherapy practice – Five Prototypes
Proposition 10 recognises the variability that it is logical to expect in relation to the relevance and level of adoption of CSS in physiotherapy practice. In this section I draw together the particular findings of my research that deal with levels of engagement of my participants with CSS. Each participant engaged differently with CSS concepts. I grouped the diversity of their responses to CSS into five modes or prototypes of engagement:

1. The Uninformed those who had not heard of CSS
2. The Unconvinced those who trialled CSS but did not change their current practice, which remained in a biomedical model
3. The Contemplators those who trialled CSS and thought that some aspects of CSS were convincing but encountered too many perceived barriers to transform their practice substantially
4. The Transformers those who were convinced of CSS and were transforming aspects of their practice
5. The Champions those who were convinced of the value of CSS and embodied CSS in their practice

The various modes of engaging with CSS are displayed in Table 7.3. It is my conviction that these prototypes have relevance beyond my participants and beyond physiotherapy.

The uninformed
Physiotherapists who had not heard of and were not informed or educated about CSS comprised the first participant group, the uninformed. They did not consciously engage with CSS. However, they might unknowingly engage in critique of interests, values and expectations and be agents of CSS and even embody CSS. Physiotherapists of the first research participant group were unaware of CSS and most fitted this group.

The next three modes of engagements with CSS emerged from the second participant group who trialled CSS in their practice.

The unconvinced
Two physiotherapist participants from the trialling group fitted this engagement mode. The unconvinced shared three characteristics: (1) they had minimal capacity to critique their interests and critically self-reflect, (2) they demonstrated no vision to consider options in their treatment, and (3) they emerged unchanged from the trialling process.

13 In this study the participants in this group were called impending champions, to recognise their adoption of CSS practices and their learning about CSS theory. They have come a long way from their traditional medical model backgrounds but have some way to go in relation to fully embodying CSS principles in their practice.
Their critique did not question the interests and assumptions that shaped their practice. The focus of their critique was predominantly on patients and their condition and the practice environment. Critique had a notion of placing responsibility on other factors than self. Reasoning and critical reflection were interpreted as linear cause and effect mechanisms that did not leave room to question other ways of reasoning. As a consequence, they could not see viable alternatives or variations to the way they related to patients and others in their workplace. During the series of interviews these participants did not report any new insights from their action plans. They found it hard to keep pursuing their action plans or rewriting their action plans, and they did not have further practice issues that they wanted to explore deeper. No new questions emerged for them.

Unconvinced practitioners argued that it was pointless asking patients what their expectations were and inviting them to collaborate in clinical decision making because patients did not know what physiotherapy could offer them. They considered that patients were ignorant about treatment options and needed to be told what to do, and physiotherapists were the experts who had authority to guide patients. Participants who were unconvinced about the CSS approach where convinced about their current approaches to practice. They already felt confirmed in what they were doing. There was nothing more to question about their practice. They did not engage in a critical transformative dialogue and exited the trialling phase without engaging in any real critique.

The contemplators
The contemplator group did go as far as engaging with the process of critical transformative dialogues. However, they did not realise that their reasoning about practice was informed by values and expectations. They started to explore their existing practice framework at a deeper level. They agreed in theory with the values of CSS but they could not visualise how to operationalise CSS in their practice. They reverted to their current reasoning and practice within the biomedical model. Nevertheless, through critical dialogues in the trialling phase, they came to appreciate at least some of the potential of CSS. The contemplators were limited to cognitive-critical appreciation of CSS. They were swayed towards a commitment to CSS and readiness to change aspects of their practice. Petra said that it would be much nicer working with patients because it created harmony and satisfaction rather than constantly persuading patients to exercise by acting like a salesperson. However, she found it difficult to share her power with patients and predicted that patients would take over power, which could lead to their not complying with physiotherapy treatments at all.

Contemplators were quick to point out limitations in realising CSS. They felt that they could practise CSS in settings where patients had less acute and more chronic types of conditions. They presented arguments in favour of the status quo such as, ‘In real life patients don’t want to collaborate’, ‘I need to follow doctors’ protocols’, ‘I am not sure how to justify this to my peers’. These comments could be interpreted in many different ways, such as excuses for not wanting to challenge current power distributions, not really identifying with a facilitation role, not wanting to defy the mainstream system-imposed practice approaches, not moderating the different interests that can be brought to clinical encounters, or not addressing the wider context of practice. Figure 7.2 illustrates the various prototypes of uncritical and critical practitioners projected onto a scale of critical practice. The contemplators would feature as the thinkers who start to appreciate the CSS concept but not as agents and doers of CSS.
<table>
<thead>
<tr>
<th><strong>Table 7.3</strong> Five prototypical engagements with CSS</th>
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<tbody>
<tr>
<td><strong>PRACTICE</strong></td>
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<tr>
<td>Definition</td>
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<tr>
<td>Practice Model</td>
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<tr>
<td>Interests</td>
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<td>Self appraisal</td>
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<td>Mode of critique</td>
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<td>Approach to reasoning</td>
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<td>Patient relationships</td>
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<tr>
<td>Power/authority</td>
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<tr>
<td>Context interpretation</td>
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<tr>
<td>Professional identity and role</td>
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<td>Goals</td>
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</table>
The transformers
The transformers critiqued their values, interests and expectations that informed their practice. They critically appreciated the potential and limitation of CSS. They were committed and convinced that they could improve their practice using CSS. They identified how they could change their practice by following their critical self-reflective insights. They were ready to empower themselves and transform their practice. Some used the trialling opportunity to legitimise changing their practice. They had not had the opportunity in the past to act on reflection. They tried out changes, were willing to take calculated risks by departing from their unreflected expectations and assumptions, and at times they succeeded and felt empowered through their actions and thinking.

Zoe, for example, changed the way she introduced herself and commenced treatment regimens with patients. Initially, Zoe wanted patients to equate physiotherapy with the gym. She started her initial treatment in the gym. Upon critical reflection she came to realise that the gym was her practice environment. She wondered if it was more patient-centred and less domineering at her initial assessment if she met patients in their room. She felt it was a much better way to establish democratising relationships with patients and allow patients time to get used to physiotherapy, ask questions and collaborate. Zoe transformed from an unreflective physiotherapist to one more aware of power distribution. She changed her sense of professional identity and accessed her capacity to bring her personal experiences into her professional practice knowledge.

Transformers developed a heightened awareness and control of their practice transformations. They started to exercise choice. Corinne developed her critical self-reflection capacity by becoming acutely aware of her power claims. She did not want to share leadership in treatment decisions with any patient. She understood that it was essential to treat patients differently according to their needs and priorities as well as her own.

The champions
The champions were physiotherapists who applied some version of a critical practice framework. They were more impending champions than actual champions of critical practice, in that they had not had any support for a critical practice, they had limited knowledge of CSS principles and theory, and the scope of their practice transformation had not been fully realised. The champions of critical practice in this study were physiotherapists whose practice was aligned with critical practice critique. Even though they had not heard of critical practice as a theory or practice model prior to participating in this research, they were skeptical of truth claims and generalisations that were made about existing practice. They were skeptical that improvements in patients could be attributed to purely technical interventions. They saw physical movements and their dysfunction or impairment as a result of complex interrelations that included emotions, hope, sense of control and attitudes towards self. They acted on critical self-reflection by facilitating emancipatory learning in self and others. Among all the participants, this group’s practice best reflected a critical, collaborative and shared practice. They included and responded to uncertainty, diversity and complexity in their practice, which are aspects of clinical practice that are marginalised in the biomedical model. The champions practised physiotherapy as a personal critical practice, while employing various aspects of the

14 The uninformed group was not placed on this graph because they were not informed about CSS
15 i.e. physiotherapy foci of health care
biomedical model for reasons of professional choice or contextual imperatives, such as knowing when to follow group expected practices.

The champions interpreted their desires and feelings about their practice. Raymond was patient-centred due to his experience as an oppressed patient. Paul had a desire to communicate openly and clearly with his patients and to facilitate emancipatory learning. Jill critically reflected on her professional experiences and continually transformed her practice. To some extent, all had freed themselves from preconceived ideas about physiotherapy practice and they had developed their self-owned practice approaches.

### 7.3.2 Relevance and value of critical physiotherapy practice

This thesis has answered the research question of the relevance of CSS for physiotherapy practice, because such a perspective

1. builds the capacity of physiotherapists for critical self-reflection as a tool for practice development
2. democratises professional relations and ensures inclusive, appropriate and ethical practice that empowers patients
3. raises awareness of interests and values that inform clinical reasoning
4. redefines professional identity within a constantly changing world to empower physiotherapists and liberate them from restrictive hegemonic practice rules
5. rethinks the boundaries and inclusions of the practice context.


My research provides examples of how the application of a critical perspective can unravel tensions, contradictions, gaps and opportunities, and create potential for enhanced practice processes, experiences and outcomes through emancipation. By critiquing their own practice my participants demonstrated that interest critique is relevant and useful for clinical practice development. It questions practice and prepares for transformation. Practice issues that were critically discussed in this study, as to the agendas that guided them, included

- professional culture and ideology
- informal departmental and ward cultures
- duties and responsibilities
- expectations and motivations
- boundaries of the practice context
- interpersonal communication
- personal backgrounds and experiences (of practitioners and patients)
- practice knowledge
- professional relations
- practice values
- clinical decision making
- diversity of disease presentations
- uncertainty of practice outcomes.

Starting to question and rethink the legitimacy of these practice aspects opens up opportunities for reflection, evaluation and choice for the future. The diversity of practice issues raised in this study draws attention to the need to operationalise a critical perspective for physiotherapy practice. It highlights physiotherapy practice as a cultural, relational and complex practice that has potential beyond empirico-analytical and solely interpretive approaches.
Many practice approaches are being developed without engaging in a critical dialogue of value clarification and interest critique. Unreflected assumptions of practice have a tendency to endorse fragmented, unarticulated practice and to neglect value clarification. Critique can mature the physiotherapy profession and its members by gaining awareness of professional practice values and responding and moderating diverse, ever-changing interests. The relevance of CSS as a framework for physiotherapy practice is that it endorses critical self-reflection and learning from the process of critical dialogues. Dialoguing, collaborating and participating in critical debates is a promising option to help physiotherapists mature in these complex, postmodern times. It is a safeguard against unreflected, disengaged and internalised monologues that do not reach beyond the professional boundaries of physiotherapy. The contribution that CSS can make to physiotherapy practice is to add critical transformative dialogues as a strategy to advance practice that is patient-centred and multidisciplinary in approach, inclusive of socio-political environments, mindful of professional power and open about professional values.

7.4 A critical practice model for physiotherapy

From my research I have produced a critical practice model for physiotherapy. In this model critical practice is described as a journey of critical transformative dialogues. It is a journey because it is a developmental process. It is critical because it is based on critique and reflexivity. It is transformative because it involves change that leads to liberation. It is a dialogue because it is a two-way conversation with self or others using critical reasoning. Figure 7.3 is a visual illustration of my critical practice model. This figure draws together the twelve propositions and the five prototypes discussed above.

The critical transformative dialogues are placed at the centre of this model to highlight this process as the core of critical practice. These dialogues provide the means of making choices and identifying requirements for realising this model in practice. The bottom left hand side of the figure identifies core decisions practitioners make, ranging from choosing a practice model and approaches to working with others, to deciding whether to challenge and change the status quo of one’s practice.

Physiotherapists can engage with critical practice at five different levels. They may not have heard of CSS and fit the uninformed prototype, they may learn about CSS, trial it but remain unconvinced of its relevance to their practice. They may adopt the third prototype, the contemplators, because theoretically they can appreciate aspects of CSS as beneficial to their practice, however, they perceive that there are too many barriers for them to transform their practice. They may start making changes to their practice and identify themselves as transformers or they might become champions because they are convinced of the value of CSS and develop their practice approach to the point where they embody CSS in their practice. Proposition 10 emphasises that professional practice involves choosing a practice approach grounded in the practitioner’s personal and professional frame of reference (including values, practice philosophy, interests etc) and recognises that critical practice is one practice model, not a panacea for all organisational, practitioner and patient contexts.

The top right hand side of the model comprises the requirements for realising critical practice in the real world of practice (Propositions 1-9). These propositions are analytical and explanatory findings that illuminate the requirements for operationalising and embodying critical practice. The bottom right hand corner comprise Propositions 11 and 12 identifying when critical practice is the optimal choice for practice and what value and relevance it has to self and others.

The four text constructions in this thesis are the four research cycles and critical transformative dialogues through which my critical practice model emerged. Each dialogue was an approximation towards this model.

7.5 Implications for physiotherapy education

There are different approaches to education: didactic, experiential and critical (Foley 2000). Each is important and legitimate and each contributes to the overall education of physiotherapists. The contribution that a CSS perspective makes to physiotherapy education is that it is based on critical dialogues to enhance critical self-understanding. Critical pedagogy is based on a commitment to shared leadership, patient participation, social justice and critical rationality (Cranton 1994). Critical pedagogy sees the purpose of education in learning to think for oneself by appreciating different perceptions and interests. A critical approach to physiotherapy education would establish the current order for practice and challenge this order. It would explore the assumptions, pre-judgments and ideologies of existing practice models and would state openly that a critical approach is opposed to power relations and communication practices that foster inequality, subjugation and oppression. The value and relevance of patient knowledge to treatment management would be emphasised. Physiotherapy education should include a clear description of what critical thinking (grounded in critical theory) is, and this would be modelled in all aspects of education including teaching, learning and assessment.
Critical physiotherapy practice is the practice model of choice in situations of emancipatory need, predilection and support. The ultimate value of critical practice is its capacity to enhance the quality of life of its protagonists through critical appraisal, particularisation, empowerment and constructive collaboration in shared vision and actions.

Self-critique
Challenging Status Quo
Accountability
Valuing Practice Knowledge
Critical Pedagogy
Transformative Dialogues
Imagining Alternatives

Critical Practice Requirements

CRITICAL TRANSFORMATIVE DIALOGUE(S)

Making Practice Model Choices

The Unconvinced
The Contemplators
The Transformers
The Champions

Choosing a Preferred Practice Model

Negotiating a Practice Approach with a Patient/Carers

Planning a Team Practice Approach

Maintaining Status Quo Approach

Figure 7.3
The list of educational implications includes:

- Critical thinking and self-reflection skills that focus on interests
- Communication and listening skills that focus on openness, clarity, sincerity and reciprocity
- Ability to interpret propositional knowledge appropriately to make physiotherapy interventions relevant to patients and to combine this with experiential knowledge relevant to practice
- Valuing of process as much as content and outcomes
- Critical definitions of what ‘health care practice’ is, and which definitions are rejected
- Promotion of self-knowing self and of understanding patients
- Input of patient knowledge to treatment management, including assessing, decision making and evaluating
- Skills of collaborative shared learning
- Cross-faculty teaching including other areas such as social science, economy
- An overt curriculum that clearly articulates what is meant by CSS, including value clarifications and critique of what underpins practice models
- Exposure to critical and interpretive learning
- Focus on experiences, reasoning skills, and critique of learners

Education in physiotherapy occurs at different levels and in different places such as undergraduate and postgraduate study, in-services, clinical placements, at conferences and with patients. Regardless of the type of setting and stage in people’s career, the principles of education are the same.

7.6 Implications for future research

The research design of this study indicates that there is potential to apply critical transformative dialogues as a research strategy. This study implies that there is value in exploring physiotherapy practice in collaboration with physiotherapist practitioners. This study endorses participatory action research that facilitates action learning and practice transformation. This design could be replicated in other practice settings (especially private practice and community settings, which were not the prime focus of this research) to explore further the relevance and value of critical transformative dialogues as a tool for maturing and emancipating practice. Critical physiotherapy practice could be advanced by studying the following topics:

- How influential is the practice context in realising critical physiotherapy practice?
- How is practice driven by human interests and contextual forces?

Future research could explore critical physiotherapy practice in different disciplines with different populations, such as paediatric physiotherapy. Working with children and their parents as decision makers would shed a particular light on professional authority and professional relations as well as on patient experiences and family perceptions with illness.

This study did not focus strongly on organisational and other environmental influences on practice. Future research could explore practice transformation in a more supportive environment, such as integrative practices (combining orthodox and complementary medicines).

The hidden informal practice cultures of physiotherapy could be explored, particularly with regard to what informs them and how current hidden cultures could be exposed and transformed. Research could be conducted at different levels of practice such as departmental, clinical educator or clinical team, to assess the influences of the practice settings on individual practice approaches.

Future research could test how effective the strategy of critical transformative dialogues is in making CSS a part of the physiotherapy discourse. In addition, future research could involve patients and their perceptions of critical physiotherapy practice. Such research could be illuminated by the cultural diversity of patients. Another area of research could be to test these research findings with other professions and multidisciplinary groups.

7.7 Final remarks

In this thesis the status quo of current practice models is critiqued and alternatives are provided. My research generated possibilities and presented opportunities for participating physiotherapists to critically self-reflect, understand their practice through critical lenses, trial CSS in their practice and emancipate themselves from current unreflected practices. This research provides a platform for further exploration of critical physiotherapy practice in education, practice and research settings.

Physiotherapy is not as simple as empirico-analytical approaches to practice suggest. Many different human interests collide in physiotherapy practice. The modern medical system is grounded in technical interest, which is overlaid by political and economic interests, while social and consumer rights movements are appealing to practical,
cultural and social interests. If physiotherapy wants to determine its own future it needs to engage in critical dialogues with all of these interests in practice.

Professional maturity will eventuate through the articulation of practice interests and being able to critically debate these interests. As long as political-social influences, emancipatory interests and patient evidence are not acknowledged in the physiotherapy discourse, a critical approach to physiotherapy practice will remain marginalised. However, if CSS were included as a possible practice model physiotherapists would gain the capacity to advance their profession by being articulate, emancipated practitioners willing to base their actions on critical thinking.

Physiotherapy practice operates in increasingly more complex, diverse and uncertain environments. Patients are better informed, technology is advancing and health care practice is constantly changing. The relevance of critique in such a dynamic environment is for physiotherapists to reclaim their human agency and critical self-reflective capacity. Critical thinking based on technical and practical interests is important but incomplete in meeting the challenging demands of current practice.
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APPENDIX 1

Information and consent forms

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An analysis of the uses and limitations of critical theory for physiotherapy practice
CONSENT FORM for Participants of Part 2

Project Directors:
Professor Joy Higgs, email J.Higgs@cchs.usyd.edu.au
Dr. Rodd Rothwell, e-mail r.rothwell@cchs.usyd.edu.au
Mr. Bill Brennan, e-mail brennanb@sesahs.nsw.gov.au
Ms. Franziska Trede, Email f.trede@unsw.edu.au.

I,………………………………………. voluntarily agree to participate in the study of the relevance of
critical theory to physiotherapy practice, directed by Professor Joy Higgs, Dr. Rod Rothwell, Mr. Bill
Brennan, and Ms. Franziska Trede.

I have been given an explanation of the project and I have had an opportunity to ask questions. My
questions have been answered to my satisfaction. I understand that by agreeing to participate, I will be
asked to participate in an in-depth interview. I give permission for taping of the interview and for these
tapes to be transcribed for use in this study.

I give my consent to participate in this project with the understanding that the interview is confidential
and that my identity or the identity of anyone I mention during the interview will not be revealed at any
time. I understand that the information from the interview, and any corresponding documents will only
be used for research purposes and that I may withdraw my participation at any time without penalty or
prejudice. I understand that all information collected will be stored in a locked filing cabinet or password
protected computer accessible only by the researcher(s). I understand that if I have any questions or
problems I may contact the project directors, as detailed above. I have read and understood the Subject
Information Statement and Consent Form and understand the purpose and risks of the study.

Complaints may be directed to the Research Ethics Secretariat, South Eastern Sydney Area Health
Service – Eastern Section, Prince of Wales Hospital, Randwick NSW 2031 AUSTRALIA (phone 9382
3587, fax 9382 2813, email brehenyk@sesahs.nsw.gov.au).

________________________________________  __________________________
Name (Printed)                                                                 Witness (Printed)

________________________________________
Signature
________________________________________
Date

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An analysis of the uses and limitations of critical theory for physiotherapy practice

CONSENT FORM for Participants of Part 4

Project Directors:
Professor Joy Higgs, email J.Higgs@cchs.usyd.edu.au;
Dr. Rod Rothwell, e-mail r.rothwell@cchs.usyd.edu.au,
Mr. Bill Brennan, email brennanb@sesahs.nsw.gov.au and
Ms. Franziska Trede, e-mail f.trede@unsw.edu.au

I,………………………………………. voluntarily agree to participate in the study of the relevance of critical
theory to physiotherapy practice, directed by Professor Joy Higgs, Dr. Rod Rothwell, Mr. Bill Brennan, and Ms.
Franziska Trede.

I have been given an explanation of the project and I have had an opportunity to ask questions. My questions have
been answered to my satisfaction. I understand that by agreeing to participate, I will be asked to participate in a
research project involving focus groups, in-depth interviews and reflecting on my clinical practice over a 6-9
months period. I give permission for taping of the discussions and interviews and for these tapes to be transcribed
for use in this study.

I give my consent to participate in this project with the understanding that the research is confidential and that my
identity or the identity of anyone I mention during this phase will not be revealed at any time. I understand that the
information and any corresponding documents will only be used for research purposes and I may withdraw my
consent at any time. I understand that all information collected will be stored in a locked filing cabinet or password
protected computer accessible only by the researcher(s). The data will be stored between 5 to 15 years and then
disposed of by shredding of transcripts and erasure of audiotapes. I understand that if I have any questions or
problems I may contact the project directors, as detailed above. I have read and understood the Subject Information
Statement and Consent Form and understand the purpose and risks of the study.

Complaints may be directed to the Research Ethics Secretariat, South Eastern Sydney Area Health Service –
Eastern Section, Prince of Wales Hospital, Randwick NSW 2031 AUSTRALIA (phone 9382 3587, fax 9382 2813,
email brehenyk@sesahs.nsw.gov.au).

Name (Printed) ______________________________________________________________________
Witness (Printed) _____________________________________________________________________
Signature __________________________________________________________________________
Signature __________________________________________________________________________
Date _______________________________________________________________________________
An analysis of the uses and limitations of critical theory for physiotherapy practice

Information Sheet for Physiotherapists in Part 2

This study explores the relevance of critical theory to physiotherapy practice. Critical theory in practice deals with analysing current practices by focusing on clinicians as educators, clinician-patient relationships, how professional knowledge is used in therapy, how the needs of patients are integrated into therapy and how treatment interventions and goals are negotiated. In this exploratory process clinical reasoning, assumptions, and professional as well as personal values will be explored. We are interested in the physiotherapy practitioners’ perspective on this topic and we will be speaking with physiotherapists from a range of physiotherapy settings.

If you agree to participate in this study, one of the researchers will invite you to participate in an in-depth interview. You will be asked for your permission to tape the interview to assist in the analysis of data. Your participation is voluntary. If you agree to participate, you are free to withdraw at any time. All information you provide will be confidential.

This project will be written up as a Ph.D. study, and excerpts may appear in journal articles or other academic documents. No identifying details will be used in the writing up of this study. Pseudonyms will be used to protect participants’ anonymity and where personal information is used, details will be changed, so those individuals will not be recognisable.

If you wish to have more information about this study, please contact:
♦ Ms. Franziska Trede, Email f.trede@unsw.edu.au
   Or Phone: (02) 9385 3629 or Fax: (02) 9385 1526.

Complaints may be directed to the Research Ethics Secretariat, South Eastern Sydney Area Health Service – Eastern Section, Prince of Wales Hospital, Randwick NSW 2031 AUSTRALIA (phone 9382 3587, fax 9382 2813, email brehenyk@sesahs.nsw.gov.au).
An analysis of the uses and limitations of critical theory for physiotherapy practice

Information Sheet for Physiotherapists in Part 4

This study explores the relevance of critical theory to physiotherapy practice. Critical theory explores current practices by focusing on clinicians as educators, clinician-patient relationships, how professional knowledge is used in therapy, how the needs of patients is integrated into therapy and how treatment interventions and goals are negotiated. In this exploratory process clinical reasoning, assumptions, and professional as well as personal values will be explored. We are interested in exploring factors, which could facilitate changes, and barriers, which could inhibit changes to physiotherapy practice associated with the application of critical theory. We particularly want to explore physiotherapy practitioners’ perspectives, and their clinical experiences and reflections on this topic.

If you agree to participate in this study, one of the researchers will invite you to participate in an exploration of critical theory in your own practice. This phase consists of three steps. First a pre-implementation workshop where we will explain what principles of critical theory could be relevant to physiotherapy practice. Second an implementation phase where you will be asked to apply principles of critical theory in your clinical practice, to keep a reflective diary on your experiences with the process, and participate in 2-4 interviews. The final step is a follow up discussion group where you will consolidate your experiences. You will be asked for your permission to analyse your reflective diary and to tape the interviews and workshops to assist in the analysis of data. If you agree to participate, you are free to withdraw at any time. All information you provide will be confidential. Your name will not appear in any publications of the collated research findings.

This project will be written up as a Ph.D. study, and excerpts may appear in journal articles or other academic documents. No identifying details will be used in the writing up of this study. Pseudonyms will be used to protect participants’ anonymity and where personal information is used, details will be changed, so those individuals will not be recognisable.

If you wish to have more information about this study, please contact:

♦ Ms. Franziska Trede, Email ftrede@unsw.edu.au
   Or Phone: (02) 9385 3629 or Fax: (02) 9385 1526.

Complaints may be directed to the Research Ethics Secretariat, South Eastern Sydney Area Health Service – Eastern Section, Prince of Wales Hospital, Randwick NSW 2031 AUSTRALIA (phone 9382 3587, fax 9382 2813, email brehenyk@sesahs.nsw.gov.au).
APPENDIX 2

(A) Pre-implementation workshop plan,
(B) Glossary of terms and references,
(C) Sample action plan

(A) PRE IMPLEMENTATION WORKSHOP PLAN

Aim:
To help physiotherapists getting ready to explore emancipatory practice in part 4 of the research project.

Objectives
4. to reflect on status quo, and participants’ current practice. Draw a picture of self-perception, of how physiotherapists practise now.
5. to think about patient-centred practice
6. to explore the notion of emancipatory practice
7. to understand what critical pedagogy is:
   - clinicians as facilitators of emancipatory learning
   - open clinician-patient relationship

Hand outs
Workshop outline with contact details on them.
List of definitions and terms.
Three journal papers
Further reading list and websites (upon request I will supply papers).
Paper for action plan (I would like to have a copy of those action plans).

Workshop Outline

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.30</td>
<td><strong>INTRODUCTION</strong></td>
</tr>
<tr>
<td></td>
<td>Welcome and thank you</td>
</tr>
<tr>
<td></td>
<td>Introduce ourselves</td>
</tr>
<tr>
<td></td>
<td>Outline of My interest as a clinician and academic</td>
</tr>
<tr>
<td></td>
<td>Outline workshop structure</td>
</tr>
<tr>
<td></td>
<td><strong>Conditions for participating – consent form - ethics</strong></td>
</tr>
<tr>
<td></td>
<td>Discuss and invite questions</td>
</tr>
<tr>
<td></td>
<td>Overview of participation commitments</td>
</tr>
<tr>
<td></td>
<td>Discussion of critical pedagogy</td>
</tr>
<tr>
<td></td>
<td>The aim of this workshop and indeed the entire study is not to tell you what to do and how to practice physiotherapy. The aim is to help you to reflect on your practice and explore various options over the next 6 months.</td>
</tr>
<tr>
<td>1.50pm</td>
<td><strong>Status quo: Describe the preliminary analysis of previous interviews</strong></td>
</tr>
<tr>
<td></td>
<td>(1) A big issue appears to be context. The way physiotherapy is practised depends on setting, stage of disease condition, personality of patient as well as physio.</td>
</tr>
<tr>
<td></td>
<td>(2) Three core themes are emerging: Professional identity Professional power Clinician-patient relationship</td>
</tr>
</tbody>
</table>
2.05 STATUS QUO and PRACTICE MODELS:

Describe the preliminary analysis of interviews [10 minutes]
How do they find out what patients need
What are their goals
What framework are they working in: practice knowledge, degree of collaboration?
Label
Biggest challenge
Draw practice models
Can you identify with some of these models? Is this you? If not in what way is this not you? What is missing, what did I get wrong?

2.30 SELF-REFLECTION [20 minutes]
Goal: increase awareness of how they are influenced.
What influences your way of practising? What has influenced your practice in the past? Discussion of critical incidents
What motivates physios
What are their goals
What are their interactions with patients like
Are physios exploring their practice?
Do they seek alternatives/other options, do they explore other choices?
Are they happy where they are?
How does this status quo impact on physiotherapists’ professional development?
Do they need more technical courses? Do they need a psychologist, educator, someone who helps them reflect?
Do they need management training to cope better with their work place?
Towards what direction/kind of physiotherapists are they heading?

3.05 CONCEPTS OF PATIENT-CENTRED CARE
Not being pre-occupied with technical task (diagnosing, searching for deficits). Especially when it is difficult to communicate and understand patients’ perspectives clinician would not misuse medical knowledge as defense mechanism and as the only best ‘evidence’.
Listening and understanding patients’ perspective
Control and power
Compliance is transformed to understanding
Role of clinician and patient: both are humane
Definition of health= social meaning
What counts as right, logical and good, and what is wrong, irrational and bad is assessed within the social and political and cultural context, not only the medical context.

3.40 EMANCIPATORY PRACTICE
What does emancipation mean
Freeing from frozen structures towards choice
Freeing from reglemented behaviour to self-determined action
Freeing patients from being dependent on
3.45 CLINICIANS AS FACILITATORS OF EMANCIPATORY LEARNING
Not doing things to patients but with patients.
Reflecting and being more aware of our thoughts and actions.
Open relationships, more group work, patients learning from each other.
An emancipatory educator would start with the patient. Such clinicians would ask questions that make patients
think/expand their horizon/question their own reasoning. The emphasis is on doing things with patients: helping
patients to help themselves.

Critical incidents:
Deficit thinking model, filling empty vessel, aim is to increase joint mobility and muscle strength. Treatment is
justified with you treat what is needed according to measurements. Treatment is technical, you ask your patients
yes-no questions.
Potential thinking model, building on patient’s potential, priorities and wishes, finds out that patient is housebound
due to stroke suffering husband, wants to be able to play bingo again at social club. Treatment plan is referral to
water exercises and referral to community respite care. This physio asks open-ended questions, gives choices,
incorporates the patient as a person.

4.10 WRITING ACTION PLAN
Write down your action plan: (1) what questions, insights emerged from this workshop. What do you think of this?
(2) What would you like to try out first? (3) What aspect of your practice do you want to think about first? (4) What
would you like to leave for later?

4.30 QUESTIONS, CLARIFICATIONS WHAT NEXT, CLOSE
(B) GLOSSARY OF TERMS AND REFERENCES

Practice knowledge
Practice knowledge is the knowledge that clinicians bring to the clinical encounter. Higgs and Titchen (2001) identified three forms of practice knowledge: propositional, professional craft, and personal knowledge.

Propositional Knowledge
Propositional knowledge is technical, theoretical or scientific. Propositional knowledge e.g. will help you understand etiology and prognosis. Propositional knowledge is formal, explicit and generalized.

Professional Craft Knowledge
Professional craft knowledge is generated from clinical experiences and from individual patients. Your working principles, the analogies you use, the practical aspects of your work are all embedded in professional craft knowledge. This knowledge can be unconscious to you or not. Professional craft knowledge is context specific and does not attempt to make generalized statements.

Personal Knowledge
Personal knowledge is derived from personal life experiences. “This kind of personal knowledge might be general in nature, uniquely conceptualized from the collective knowledge held by a community and culture in which the individual has been brought up.” (Higgs and Titchen, 2001, p.5).

Critical
The word critical can have various meanings especially in health care. Critical in our context has nothing to do with critical conditions of patients, critical pathways, and critical care. It is not about taking risks or something being crucial. To be critical is not about searching for deficits and mistakes. When we talk about critical we mean being aware of diverse aspects of something. Being critical is about understanding uses and limitations of something.

Critical thinking
Many books have been written about critical thinking. We supplied you with a journal paper titled ‘catching the wave’. Jack Mezirow is professor of adult education in America and he defines critical thinking as examining sources and consequences, recognizing assumptions and underlying beliefs that govern our thoughts and actions. Facione (quoted from the paper titled ‘catching the wave: understanding the concept of critical thinking’) summed it up succinctly as :

“The ideal critical thinker is habitually inquisitive, well informed, trustful of reason, open minded, flexible, fair minded in evaluation, honest in facing personal biases, prudent in making judgments, willing to reconsider, clear about issues, orderly in complex matters, diligent in seeking relevant information, reasonable in the selection of criteria, focused in inquiry, and persistent in seeking results which are precise as the subject and the circumstances of inquiry permit.” (1990, p. 2)

Critical self-reflection
Assessment of the way one has posed problems and of one’s own frame of reference. Critical self-reflection enables us to justify our ideas and actions.

Critical Theory
Critical theorists are people who question all aspects of life that is taken-for-granted. They challenge social structures, work hierarchies, mainstream culture and they would question physiotherapy practice as it is predominantly practiced today. The aim of such an inquiry is to transform current situations to a different future. Critical theorists explore what motivates people to act the way they act, the way they think and make sense of the world from a historical and social perspective. Critical theorists do not accept mainstream approaches, dominant ways of thinking and doing things, without reflecting upon them. By reflecting we mean understanding underlying driving human interests and needs. One might say that critical theorists are people that like to criticise and see things negatively. Indeed it would be easy to pull mainstream thinking and doing, such as mainstream physiotherapy, apart by identifying all the deficits, problems and illogical deductions that it might be based on. However, critical theorists use their critique of present situations to improve them. There is optimism about critical theory unlike other philosophical perspectives. One of its core themes is to emancipate individuals and society, to liberate them from seemingly frozen, unchangeable social laws. The ultimate goal of critical theory is to improve the status quo.

Emancipation
Emancipation means setting free from restraints. The act of emancipating leads to liberation and freedom.
Empowerment
This is a very popular word in our times. Literally it means to give more power to people who have less. In our clinical context this could mean that you empower patients by teaching them scientific facts and exercises based on evidence-based practice. However, you may empower patients by providing them with technical facts it is another question if patients are also empowered to act on this empowering knowledge.

Facilitating emancipatory learning
To help others to learn to think for themselves, act for themselves and feeling more in control over their lives. There is a distinction between helping patients to comply with what we as physiotherapists might think is best for them, and helping patients to find a self-management regimen that really makes them feel better and in control over their health problem. Emancipatory learning brings about an awareness of one’s capabilities and potentials. It invites the learner to use these capabilities and potentials in order to increase control over their health.

Collaboration
Collaboration implies clinicians and patients\(^\text{16}\) working together as mutually respected partners who negotiate a treatment plan that is acceptable for both partners

References


\(^\text{16}\) The term patient is used in this paper (even though ‘client’ or ‘customer’ could well suit the argument better). This is an intentional choice to prompt re-examination of how clinicians interact with their patients.
(C) SAMPLE ACTION PLAN

What aspects of my practice would I like to change or explore further?

What are my goals?

What are my strategies to achieve these goals?
APPENDIX 3 TALK ON CSS

Exploring visioning and embodying a CSS model for physiotherapy practice

Franziska Trede
Joy Higgs and Rod Rothwell
The University of Sydney

CSS Core
- Critique
  - self
  - patient
  - Action based on this critique
  - negotiation
  - collaboration
  - participation

Ideology and professional practice

Ideology Critique (Habermas)
- knowledge is linked to interest
- knowledge is perceived with skepticism
- not all interpretations are equally true
- not all traditions have equal authority
- power relations need to be made explicit

CSS physiotherapists are critically self-aware of
- assumptions and beliefs
- values
- professional practice knowledge
- social status and professional authority

CSS Physiotherapists are critically aware of their patients:
- Culture and diversity
- physical experiences and their meaning
- backgrounds
- needs
- hopes
- capacity and willingness to listen, learn and change

CSS Physiotherapists act on this critical awareness
- Establishment of scope and roles
- Patient participation
- Negotiation in determining health issues
- Collaboration in goal setting
- Flexibility and creativity

Three frameworks for professional practice models in health

<table>
<thead>
<tr>
<th>Model</th>
<th>Illness model</th>
<th>Wellness model</th>
<th>Capacity model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kind of interest</td>
<td>Technical</td>
<td>Practical</td>
<td>Emanicipatory</td>
</tr>
<tr>
<td>Approach</td>
<td>Clinician-centred</td>
<td>Patient-centred</td>
<td>Patient-democratised</td>
</tr>
<tr>
<td>Philosophical paradigm</td>
<td>Empirico-analytical</td>
<td>Interpretive</td>
<td>Critical</td>
</tr>
</tbody>
</table>
### Three frameworks for professional practice models in health

<table>
<thead>
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<th>Wellness model</th>
<th>Capacity model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus of Health</td>
<td>Technical</td>
<td>Practical</td>
<td>Political</td>
</tr>
<tr>
<td>Patient power</td>
<td>Disempowered</td>
<td>Empowered</td>
<td>Empowered in a way that can be sustained</td>
</tr>
<tr>
<td>Stance towards status quo</td>
<td>Taking things for granted, Accepting, Reinforcing</td>
<td>Being aware of taken-for-granted things</td>
<td>Challenging status quo and changing frameworks</td>
</tr>
</tbody>
</table>

#### Three frameworks for professional practice models in health

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<th>Model</th>
<th>Illness model</th>
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<th>Capacity model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of Clinician</td>
<td>Teacher</td>
<td>Listener</td>
<td>Facilitator</td>
</tr>
<tr>
<td>Context of decision-making</td>
<td>Out of context</td>
<td>In psycho-spiritual context (definitely not political)</td>
<td>And in socio-political context</td>
</tr>
<tr>
<td>Clinicians helping patients</td>
<td>To comply</td>
<td>To cope</td>
<td>To liberate</td>
</tr>
</tbody>
</table>

![Diagram](image-url)
### Summary of weaknesses and strengths of CSS model from ANZAME workshop participants

<table>
<thead>
<tr>
<th>Weakness</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs ability to identify which patient wants to collaborate; patient/community need ability to communicate well</td>
<td>Collaboration for quality life, life needs and expectations</td>
</tr>
<tr>
<td>Limited by narrow vision of HCP</td>
<td>Potential for change, attempts to breakdown authoritarian model</td>
</tr>
<tr>
<td>Current values lie with professional power-over patients, clinicians are reluctant to share power; pluralistic issues are not valued; CSS does not fit political, social environment</td>
<td>Rounded view of health, constructive and optimistic</td>
</tr>
<tr>
<td>It requires time; there may be not sufficient time to engage with patients according to CSS</td>
<td>Professional AND personal development is implied</td>
</tr>
<tr>
<td>Danger to over-emphasis personal values and disregard scientific evidence; too much diversity</td>
<td>More involved patient, better informed patients, less complaints</td>
</tr>
<tr>
<td>Not suitable for mentally ill, children, acutely ill</td>
<td>It democratizes systems, professional relationships</td>
</tr>
<tr>
<td>It assumes a lot about patients; what does the community really want?</td>
<td></td>
</tr>
</tbody>
</table>