Body politics: A Foucauldian discourse analysis of physiotherapy practice

By

David A. Nicholls MA GradDipPhys

Submitted in fulfilment of the requirements for the degree of Doctor of Philosophy, School of Health Sciences, Division of Health Sciences, University of South Australia

Submitted: 8th March 2008
TABLE OF CONTENTS

CHAPTER ONE - INTRODUCTION ............................................................................. 14
  The conditions that created the impetus for the study ..................................... 15
Situating this study within existing critical analyses of the professions .................. 17
Problematising physiotherapy and constructing a critical history .......................... 19
Developing the substantive foci for the thesis ....................................................... 22
Overview of the structure of the thesis .................................................................. 24
  Chapter Two – Methodological and theoretical approaches ............................... 24
  Chapter Three – From methodology to methods ............................................... 24
  Chapter Four – The quest for legitimacy in the practice of massage ................... 25
  Chapter Five – The pursuit of orthodox status .................................................... 25
  Chapter Six – Making breathing your business .................................................... 26
  Chapter Seven – Discussion ................................................................................. 26
In summary ............................................................................................................. 27

CHAPTER TWO – METHODOLOGICAL AND THEORETICAL APPROACHES .......... 28
Introduction ........................................................................................................... 28
Foucault’s toolbox .................................................................................................. 29
Critical history and physiotherapy practice ............................................................ 30
Analysing discursive formations archaeologically .................................................. 31
  Extending archaeological inquiry ........................................................................ 34
Governmentality ..................................................................................................... 35
  Liberal, welfarist and neo-liberal rationalities of government ............................... 36
Foucault’s interpretation of power ......................................................................... 39
Technologies of discipline ...................................................................................... 42
  Systematic observations ...................................................................................... 42
  Normalisation ....................................................................................................... 43
  The examination .................................................................................................. 44
Resistance .............................................................................................................. 46
Applying Foucauldian discourse analysis to the discursive construction of physiotherapy 48
  The methodological basis of genealogical analysis applied to this study ............... 49
  Foucault’s systems of exclusion ........................................................................ 50
  The rule of immanence ....................................................................................... 51
  The rule of continual variation ........................................................................... 52
  The rule of double conditioning ........................................................................ 52
  The rule of tactical polyvalence of discourse ...................................................... 52
  The principal of reversibility .............................................................................. 53
  The principal of discontinuity ............................................................................. 53
  The principal of specificity .................................................................................. 54
Foucauldian discourse analysis ............................................................................ 54
  First principle: Utilise a plurality of texts ............................................................. 55
  Second principle: Focus upon local, material practices ....................................... 55
  Third principle: Attend to the ruptures, fissures and tensions in the surface of discourses ........................................................................................................... 56
  Fourth principle: Drive the discourse analysis with extra-discursive elements ....... 56
In summary ............................................................................................................. 57

CHAPTER THREE – FROM METHODOLOGY TO METHODS ............................. 58
Introduction ........................................................................................................... 58
How my sampling strategy was constructed ......................................................... 58
  Placing limits on my texts .................................................................................. 59
Sampled texts ......................................................................................................... 62
  Texts sampled for the first moment ................................................................... 62
  How did my sampling strategy develop? .............................................................. 63
<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theorising documents as ethnographic texts</td>
<td>68</td>
</tr>
<tr>
<td>Texts sampled for the second moment</td>
<td>72</td>
</tr>
<tr>
<td>How did my sampling strategy develop?</td>
<td>73</td>
</tr>
<tr>
<td>Texts sampled for the third moment</td>
<td>76</td>
</tr>
<tr>
<td>How did my sampling strategy develop?</td>
<td>79</td>
</tr>
<tr>
<td>Theorising interviews as ethnographic texts</td>
<td>81</td>
</tr>
<tr>
<td>Theorising observations as ethnographic texts</td>
<td>83</td>
</tr>
<tr>
<td>Methods employed in reading and analysing texts</td>
<td>84</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>87</td>
</tr>
<tr>
<td>The recruitment of colleagues and peers for interview</td>
<td>87</td>
</tr>
<tr>
<td>Anonymity of participants cited within texts</td>
<td>88</td>
</tr>
<tr>
<td>The observation of clinical practice</td>
<td>89</td>
</tr>
<tr>
<td>Access to documents for analysis</td>
<td>90</td>
</tr>
<tr>
<td>In summary</td>
<td>90</td>
</tr>
<tr>
<td>CHAPTER FOUR – THE QUEST FOR LEGITIMACY IN THE PRACTICE OF MASSAGE</td>
<td>92</td>
</tr>
<tr>
<td>Introduction</td>
<td>92</td>
</tr>
<tr>
<td>Problematising massage</td>
<td>93</td>
</tr>
<tr>
<td>Responding to moral opprobrium: The formation of a massage profession</td>
<td>96</td>
</tr>
<tr>
<td>The development of rules to regulate masseuse's professional conduct</td>
<td>97</td>
</tr>
<tr>
<td>Courting medical patronage and the development of disciplinary alliances</td>
<td>101</td>
</tr>
<tr>
<td>Normalisation and the creation of examination systems</td>
<td>103</td>
</tr>
<tr>
<td>The registration of members as a technique of surveillance</td>
<td>106</td>
</tr>
<tr>
<td>The adoption of biomechanics as an ensemble of knowledge</td>
<td>109</td>
</tr>
<tr>
<td>Constructing the patient biomechanically</td>
<td>110</td>
</tr>
<tr>
<td>The cadaver</td>
<td>111</td>
</tr>
<tr>
<td>The model</td>
<td>115</td>
</tr>
<tr>
<td>The machine</td>
<td>118</td>
</tr>
<tr>
<td>Neurasthenia and the legitimisation of massage therapy</td>
<td>126</td>
</tr>
<tr>
<td>In summary: Returning to the problematisation of massage</td>
<td>131</td>
</tr>
<tr>
<td>CHAPTER FIVE – THE PURSUIT OF ORTHODOX STATUS</td>
<td>132</td>
</tr>
<tr>
<td>Introduction</td>
<td>132</td>
</tr>
<tr>
<td>The discursive formation of legitimate massage in New Zealand</td>
<td>133</td>
</tr>
<tr>
<td>The influence of the Society of Trained Masseuses</td>
<td>133</td>
</tr>
<tr>
<td>Adopting the ISTM’s examination framework</td>
<td>136</td>
</tr>
<tr>
<td>Relationships with the medical profession</td>
<td>139</td>
</tr>
<tr>
<td>Registering masseurs</td>
<td>142</td>
</tr>
<tr>
<td>Biomechanics in a New Zealand context</td>
<td>143</td>
</tr>
<tr>
<td>Welfare reforms and the formation of orthodox physiotherapy</td>
<td>146</td>
</tr>
<tr>
<td>Welfare legislation and the construction of physiotherapy in New Zealand</td>
<td>147</td>
</tr>
<tr>
<td>Analysing the emergence of physiotherapy in New Zealand through a welfarist lens</td>
<td>151</td>
</tr>
<tr>
<td>Refining the professional gaze – constructing respiratory physiotherapists</td>
<td>153</td>
</tr>
<tr>
<td>Managing the enclosure of the medical ward</td>
<td>156</td>
</tr>
<tr>
<td>Institutional influences on the formation of respiratory physiotherapy</td>
<td>159</td>
</tr>
<tr>
<td>The conduct of respiratory physiotherapists</td>
<td>162</td>
</tr>
<tr>
<td>In summary: Moving from legitimacy to orthodoxy</td>
<td>164</td>
</tr>
<tr>
<td>CHAPTER SIX – MAKING BREATHING YOUR BUSINESS</td>
<td>166</td>
</tr>
<tr>
<td>Introduction</td>
<td>166</td>
</tr>
<tr>
<td>The Formation of Breathing Works</td>
<td>168</td>
</tr>
<tr>
<td>Orthodox respiratory physiotherapy in the new millennium</td>
<td>171</td>
</tr>
<tr>
<td>Problematising breathing</td>
<td>173</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

Figure 1. Massage scandal report reprinted from the Evening News and Post, July 20th 1894 ........................................................................................................... 65

Figure 2. Students demonstrating symmetrical exercises on plinth. Source: Wellcome Institute archive ........................................................................... 70

Figure 3. One of a series of images taken of the interior of the Breathing Works clinic. .... 71

Figure 4. STM certificate showing rules of professional conduct. Source: Wellcome Institute archive ........................................................................... 98

Figure 5. Promotional photograph published by Harley Institute showing massage demonstrations being undertaken on male models from the Boy's Brigade. Source: Wellcome Institute archive ........................................................................... 100

Figure 6. Harley Institute promotional photograph showing mixed massage classes. Source: Wellcome Institute archive ........................................................................... 101

Figure 7. 'Flexing the thigh with the leg extended' from Despard (1916, p.358), showing the dispassionate gaze of the masseuse in practice ............................................ 112

Figure 8. A further illustration of the masseuse's dispassionate gaze. Source: Despard (1916, p.282) ......................................................................................... 113

Figure 9. Table of muscles of the upper limb from Palmer (1901, p.78) ....................... 114

Figure 10. Biomechanical representation of forces applied to the lower limb. Source: Guthries Smith (1952, p.158) ........................................................................... 116

Figure 11. Image and text showing starting positions from which all other positions were derived, from Kleen (1918, p.201) .................................................... 119

Figure 12. Derived position from Kleen (1918, p.241) .................................................. 121

Figure 13. Derived position from Kleen (1918, p.241) .................................................. 121

Figure 14. Illustration of derived positions applied to functional movements of the spine (Prosser, 1943, p.140) ........................................................................... 123

Figure 15. Image of austere discipline. Image shows a class of children being taught breathing exercises in a Physiotherapy Department, from Angove (1936, p.104) .... 124

Figure 16. Outdoor exercise by lake. Source: Bloch (1933, p.46) ...................................... 125

Figure 17. Common image of neurasthenia c.1900. Source Williams, et al (2004, p.8) .. 127

Figure 18. Child being treated in Physiotherapy Department, Rotorua, New Zealand c.1950. Source: Author's private collection ................................................. 138

Figure 19. Docile patient in Guthrie Smith sling suspension, from Wellcome Institute archives ........................................................................... 138

Figure 20. Gymnasium for returned servicemen, c.1916, from Wellcome Institute archives ........................................................................... 154

Figure 21. Rehabilitation class for returned servicemen, from Guthrie Smith (1952, p.143) ......................................................................................... 155

Figure 22. Rehabilitation class for returned servicemen, from Guthrie Smith (1952, p.144) ......................................................................................... 155

Figure 23. Postural drainage showing relevant lung segment being drained and appropriate patient position. Source: Thacker (1971, p.42) ............................................. 158

Figure 24. Postural drainage for a child with lung disease. Source: Ritchie Russell (1942, p. 45) ......................................................................................... 158

Figure 25. Physiotherapy Department c.1950 illustrating sterile, disciplined aesthetic of hospital ward. Source: http://www.keele.ac.uk/depts/pt/about_us/history.htm#scrapbook (retrieved 8th April 2005) ........................................................................... 163

Figure 26. View across Breathing Works' practice room showing domestic adaptations to interior ........................................................................... 169

Figure 27. Breathing Works' clinic interior showing strategic use of decor to balance domestic and clinical discourses ........................................................................... 184
Figure 28. Typical arrangement for physiotherapy treatment bed..............................185
Figure 29. View of interior of Better Breathing Clinic..............................................186
Figure 30. Breathing Works practice model...............................................................187
LIST OF TABLES
Table 1. Details of interviewees ................................................................. 77
Table 2. Syndromes associated with neurasthenia (Weir Mitchell, 1893, p. 9) .......... 128
**LIST OF APPENDICES**

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix One</td>
<td>Confirmation of ethical approval</td>
<td>239</td>
</tr>
<tr>
<td>Appendix Two</td>
<td>Invitation to participate letter</td>
<td>240</td>
</tr>
<tr>
<td>Appendix Three</td>
<td>Patient consent form</td>
<td>241</td>
</tr>
<tr>
<td>Appendix Four</td>
<td>Patient information sheet</td>
<td>242</td>
</tr>
<tr>
<td>Appendix Five</td>
<td>Participant consent form</td>
<td>243</td>
</tr>
<tr>
<td>Appendix Six</td>
<td>Participant information sheet</td>
<td>244</td>
</tr>
<tr>
<td>Appendix Seven</td>
<td>Outline of proposed research tools to be used in study</td>
<td>245</td>
</tr>
<tr>
<td>Appendix Eight</td>
<td>Breathing Works’ consent to use their names unaltered</td>
<td>246</td>
</tr>
<tr>
<td>Appendix Nine</td>
<td>Sample assessment sheet from Breathing Works with names removed</td>
<td>247</td>
</tr>
<tr>
<td>Appendix Eleven</td>
<td>Nijmegen Questionnaire</td>
<td>250</td>
</tr>
<tr>
<td>Appendix Twelve</td>
<td>Paper published in Social Science and Medicine, 2006;</td>
<td>251</td>
</tr>
<tr>
<td></td>
<td>62(9), 2336-2348</td>
<td></td>
</tr>
<tr>
<td>Appendix Thirteen</td>
<td>Poster presented at 7th International Interdisciplinary</td>
<td>252</td>
</tr>
<tr>
<td></td>
<td>Conference: Advances in Qualitative Methods, Gold Coast,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Australia, 2006</td>
<td>266</td>
</tr>
<tr>
<td>Appendix Fourteen</td>
<td>Paper submitted to New Zealand Journal of Physiotherapy,</td>
<td>267</td>
</tr>
<tr>
<td></td>
<td>2005; 33(2), 55-60</td>
<td></td>
</tr>
</tbody>
</table>
## GLOSSARY AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSMMG</td>
<td><em>Chartered Society of Massage and Medical Gymnastics.</em> The organisation formed in England by the amalgamation of the ISTM and a rival body – the Institute of Massage and Remedial Gymnastics – in 1920.</td>
</tr>
<tr>
<td>CSP</td>
<td><em>Chartered Society of Physiotherapy.</em> The professional body that has administered physiotherapy in England since 1944.</td>
</tr>
<tr>
<td>HPCA</td>
<td>‘Umbrella’ legislation enacted in New Zealand in 2003 to regulate ‘orthodox’ professions within the public health sector; one of which was physiotherapy. The Act repealed profession-specific legislation for 14 health professions, including the <em>Physiotherapy Act (1950).</em></td>
</tr>
<tr>
<td>ISTM</td>
<td><em>Incorporated Society of Trained Masseuses.</em> Organisation produced by the ‘incorporation’ of the STM in England in 1900. Incorporation was one of a number of strategies deployed by the STM to secure the legal and public status of a professional organisation.</td>
</tr>
<tr>
<td>MRA</td>
<td><em>Masseurs Registration Act.</em> Legislation enacted in New Zealand in 1920 to regulate all those that wished to become licensed masseurs.</td>
</tr>
<tr>
<td>MRB</td>
<td><em>Masseurs Registration Board.</em> Regulatory body created under the MRA to administer the registration and training of New Zealand masseurs.</td>
</tr>
<tr>
<td><em>Physiotherapy Act (1950)</em></td>
<td>Legislation enacted in New Zealand that became law on January 1st 1950 and replaced the MRA.</td>
</tr>
<tr>
<td>STM</td>
<td><em>Society of Trained Masseuses.</em> Founded in England in 1894. The forerunner of the ISTM and a major influence upon physiotherapy professional bodies throughout the Commonwealth.</td>
</tr>
</tbody>
</table>
SUMMARY

This thesis offers new insights into physiotherapy practice by asking ‘How is physiotherapy discursively constructed?’ Physiotherapy is a large, well-established, orthodox health profession. Recent changes in the economy of health care in developed countries, added to an increasing prevalence of chronic illness amongst aging populations, and growing public distrust for the established health professions, are now challenging physiotherapists to consider how best to adapt to the future needs of health care consumers.

Little is understood about the epistemological and ontological basis of physiotherapy practice and, to date, no research has been conducted to consider how historical conditions of possibility have made contemporary physiotherapy practice possible, or how some critical discursive formations have shaped physiotherapists’ subjectivity. To explore the discursive construction of physiotherapy practise, texts were generated for analysis to reflect the multiplicity of discourses emerging at particular moments in the profession’s past and present. Michel Foucault’s theorisation of governmentality was utilised as the theoretical framework underpinning the analysis of the texts, and provided the critical lens through which discourses, knowledge formations, relations of power, technologies of discipline and modes of resistance were explored.

My thesis is that the adoption of a biomechanical discourse enabled the profession of physiotherapy to establish a licence to touch people (positioned as patients) without fear of impropriety when the profession was established in late-Victorian England. This legitimacy then created the conditions necessary for the profession to establish its orthodoxy and become recognised as a principal provider of physical rehabilitation within the welfare state in the middle of the twentieth century. I argue that these rationalities, strategies and technologies were advantageous to the early development of the profession, but that they have now induced a state of torpor, ossification or stagnation among physiotherapists, precluding opportunities to engage in critical self-scrutiny.

Drawing on texts generated from the emergence of a new practice that appear to be operating at the margins of legitimate and orthodox physiotherapy, there is evidence of reform taking place within the profession; that a small number of practitioners are resisting the rationalities that have previously governed physiotherapy. In analysing the actions of a clinic, called Breathing Works, the practises of clinic staff reveal some of the previously taken-for-granted assumptions about the profession, whilst also providing valuable new insights into the future possibilities for physiotherapy practise.
In problematising contemporary physiotherapy practice, a space has been created to enable physiotherapists to think differently about physiotherapy’s future as a recognised provider of state-sponsored health care. Physiotherapy is a discursive construction, and a critical history of the profession – informed by the work of Michel Foucault – has much to offer physiotherapists, other health professions, health policy advisors, and sociologists of health care.
DECLARATION

I declare that this thesis presents work carried out by myself and does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university.

To the best of my knowledge it does not contain any materials previously published or written by another person except where due reference is made in the text; and all substantive contributions by others to the work presented, including jointly authored publications, is clearly acknowledged.

David A. Nicholls

Date: 8th March 2008
ACKNOWLEDGEMENTS

I would first like to acknowledge the deep debt of gratitude I owe to my supervisors; my principal supervisor Professor Julianne Cheek, Doctor Kay Price and Professor Jo Ann Walton. I am indebted to you for all your hard work, support and care, and for giving me the encouragement to ‘write against myself’. A student could not have three better supervisors. I hope this thesis goes some way to repay you all for the hours you have put in to nurturing me to the conclusion of this project.

To Tom and Alice. Thank you for letting me do this without ever asking why. Thank you for making me laugh when I was pulling my hair out, for being my playmates and my confidantes. I love you both dearly. To Charlie and Ella, for being there every morning at five to see in the new day with me. To Irene, my mother, who told me a long time ago that I had the wherewithal to do this, and gave me most everything I needed to believe in myself. And to Michael, my father, who taught me that dedication and perseverance are valuable commodities indeed. I wish you could have been here to see this.

To , Tania Clifton-Smith and the staff at Breathing Works for giving me the subject for the study, the chance to work with you, and to learn from you. Thank you for your support, encouragement and kindness.

I would also like to acknowledge a few friends and colleagues who have supported me throughout my study; Greg Coyle, Erik Dombroski, Bridget Garnham, Peter Larmer, Tony MacCulloch, Professor Kath McPherson, Dr Debbie Payne, Julie Reeve, Duncan Reid, Nicola Saywell, Dr Liz Smythe, Caroline Stretton, Dr Marie Williams and the staff at the University of South Australia, and Rachel Vickery. I owe you all a stiff drink.

And finally, to Sue, my soul mate and constant companion through all of this. This is for us.
CHAPTER ONE - INTRODUCTION

‘The most difficult thing about majorities is not that they cannot see minorities but that they cannot see themselves.’

- Glenn Colquhoun

Physiotherapy has been practiced throughout the world for more than a century, and in that time it has established itself as one of the largest professions allied to medicine (Du Toit, 1995; L. Williams, 2005). Physiotherapy is recognised in more than 100 countries and practised by more than a quarter of a million clinicians (Moffatt, 2007). However, unlike other comparable orthodox health professions within public health care (medicine, nursing, occupational therapy and psychology, for example), there has been little scholarly interest into the theoretical basis of physiotherapy practice (De Souza, 1998).

Contemporary physiotherapy practice is defined by a body of scholarship that is almost entirely directed towards the efficacy of assessment and treatment techniques and the biophysical bases of practice. What is more, a brief trawl through the physiotherapy literature reveals that little has changed in the profession in the century since the first ‘legitimate’ masseuses defined the focus of the profession as the application of massage, electrotherapy and remedial exercise. Some authors have commented recently that this lack of critical depth makes the profession vulnerable; particularly given the changes taking place within contemporary health care (Reid & Larmer, 2007; Struber, 2004), and that what is needed is greater theoretical insight into the profession’s past and present ‘situation’, in order that it might be better prepared for the future (Nicholls & Larmer, 2005).

This research study is, in some ways, a response to that call, and in it I have utilised the work of Michel Foucault and other ‘Foucauldian’ scholars to problematise physiotherapy practice and critically analyse the conditions that have made it historically possible. The focus of my thesis is upon the discursive construction of physiotherapy, and I have drawn on Foucault’s notions of governmentality, discipline, power/knowledge, resistance and discourse to guide my analysis. In this study I present material from three distinct critical moments in the history of the profession; the first explores the discursive construction of legitimate massage through the actions of the Society of Trained Masseuses in England towards the end of the nineteenth century; the second considers how
legitimate massage practices created the necessary conditions for orthodox physiotherapy to emerge during the welfare reforms of the middle of the twentieth century in New Zealand; and the third explores how discourses of legitimacy and orthodoxy are now being problematised by a small New Zealand practice, and how the actions of the practitioners at this clinic might provide insights into the future possibilities for physiotherapy in the changing marketplace for health care.

The primary question I address in this thesis is therefore, ‘How is physiotherapy discursively constructed?’ And from this question I have drawn a number of subsidiary questions:

- What have been some of the main discursive influences upon the construction of physiotherapy?
- How have the discourses that have guided the conduct of physiotherapists transformed throughout the profession’s history?
- How have particular relations of power governed the forms of knowledge that are privileged, and those that are marginalised in physiotherapy?
- How have governmental influences guided the formation and transformation of physiotherapist’s subjectivities throughout the profession’s history?
- How might the surface of emergence of new practices at the margins of orthodoxy create the possibility of new physiotherapy subjectivities that resist established subject positions?
- What opportunities and possibilities do these new subjectivities create for physiotherapists seeking to adapt to the demands of contemporary health care?

In the following chapter I reveal the main substantive, methodological and practical issues addressed by this study. I begin by outlining how the research came about, before unpacking the problem posed by the lack of relevant theoretical work within physiotherapy. From here I situate my research within the existing comparable literature, before moving to explore the theoretical basis for the study. I then unpack the guiding framework for my analysis before considering why I believe this study raises some relevant and important questions. I close the chapter by setting out the structure of the remainder of the thesis. To begin with, therefore, I explore how the study came about, and how the key questions posed by my thesis were developed.

The conditions that created the impetus for the study

This study began with a series of questions that arose from my work with a boutique private physiotherapy practice in Auckland, New Zealand, where I worked between 2001 and 2004. The practice, called Breathing Works, is a small private clinic.
on the edge of one of Auckland’s most affluent suburbs, which specialises in the assessment and treatment of breathing pattern disorders (BPDs). I came to work at the clinic for a few hours each week, as a way of maintaining some clinical experience, after emigrating from England to take up a university teaching position in 2000, and quickly came to realise that the practices of the clinic were different from anything I had been used to before. It seemed to me that the clinic was attempting to offer a quite different form of ‘respiratory’ physiotherapy from that which I was used to (as a clinician with more than 15 years experience, and as an experienced educator). I was enthralled by the way the clinic’s founders had sought to redefine traditional physiotherapy problems, clients and environments; and with it, redesign clinic spaces, practices and relations with other health professionals. Much of what they did struck me as a radical departure from the traditional, orthodox forms of practice I had been used to within the public health and education sectors.

My experience at Breathing Works therefore prompted me to consider how the physiotherapists at the clinic were operating differently from conventional physiotherapists? How had the changes made by the clinic been historically possible? What new forms of knowledge, relations of power, systems and concepts were they constructing? What actions brought about these changes and, in turn, what practices resulted from them?

It became clear that to gain an appreciation for the transformations taking place at Breathing Works, I would have to define the orthodox forms of practice that they were resisting. This approach would serve two related purposes; firstly, it would make visible some of the discursive formations that constituted orthodox physiotherapy; and secondly, it would show where some of the boundaries to contemporary physiotherapy practice lay.

Both of these issues were of value to this study, since they would provide much needed insight into the discursive construction of orthodox physiotherapy practice and the present tensions at the margins of its operations. These insights, in turn, held real possibilities for those interested in the future directions for physiotherapy, since they would highlight some of the historical conditions that had made contemporary practice possible; and, in so doing, open up a space to explore new possibilities for physiotherapy practice from a firmer philosophical footing than has been available to date. The

---

identities, given that I refer repeatedly to a number of publications that bear their name. Both Dinah and Tania agreed unreservedly to my request, and a sample of the consent form used has been included in Appendix One. Note, all other therapists included in this study have been given pseudonyms.

Breathing pattern disorders will be explored in great detail later in the text.
possibilities offered by this study therefore extended beyond a narrow analysis of a small boutique physiotherapy clinic, to consider how physiotherapy might be imagined differently in the future; how it might respond to the changing economy of health care, and the changing needs of patients, health care purchasers and policy analysts. This study then is one not only for physiotherapists, but for anyone who has an interest in the changes taking place within health care and the place physiotherapy might occupy within it.

**Situating this study within existing critical analyses of the professions**

The first association one might make between this study and the existing literature, relates to what has become known as the sociology of the professions (Macdonald, 1995). The latter half of the twentieth century has been marked by the emergence of a discrete branch of sociology that traces its origins to the functionalist studies of Emile Durkheim and Talcott Parsons (Durkheim, 1933; Parsons, 1937). Since then, a number of subdivisions in the field have emerged as interest in the socio-political role of the professions has shifted. Since the 1960s, a growing dissatisfaction with the ‘idealized conception of the characteristics of the archetypal professions’ (Abbott & Meerabeau, 1998, p. 4), has led to a number of authors exploring the ways professional groups achieved status and maintained it over time (N. Parry & Parry, 1976). Key among these ‘processual’ frameworks was Elliot Freidson’s early work around the notion of ‘market shelters’ and the occupational control of work (Freidson, 1970, 1983). These in turn have been the subject of criticism from Marxist and feminist scholars who launched ‘Critical attacks on professions in general as powerful, privileged, self-interested monopolies’ (Evetts, 2003, p. 401). In recent years these various structural critiques have themselves come in for criticism focusing, as they do, on re-interpretations of Durkheim and Parson’s original functionalism (Johnson, 1993). In their place, a concern for postmodern and poststructural analyses predominate, and these provide an iconoclastic counterpoint to the rather ideologically driven analyses of the professions evident in the latter half of the twentieth century. Chief among the works cited by postmodern scholars of the professions are those by Foucault, Derrida, Deleuze, Guattari and Lyotard. In this study, the works of Michel Foucault frame my analysis.

Approaches informed by the work of Michel Foucault have been utilised extensively over the last two decades to explore the discursive construction of professions as diverse as medicine, psychology, nursing, occupational therapy and podiatry. Studies by David Armstrong, Dave Holmes, Sarah Nettleton, Nikolas Rose, Claire Ballinger and others have highlighted the contingent circumstances that have made these professional
disciplines historically possible (Armstrong, 1983, 1995, 2002; Cheek, 1995, 2000; Cheek & Rudge, 1994a; Holmes, 2002; Holmes & Federman, 2003; Holmes & Gastaldo, 2002; Nettleton, 1992, 1994, 2001; Rose, 1985, 1997, 2003). There are now plentiful examples of how Foucauldian discourse analysis might be applied to physiotherapy practice. Physiotherapists remain reluctant, however, to engage with this theory, as Ballinger and Payne argued; ‘With a few exceptions, discourse analysis has been little used by researchers within the disciplines of occupational therapy and physiotherapy’ (Ballinger & Payne, 2000, p. 569). This point is reinforced by Williams, who argued that;

Much has been written from a sociological or political perspective about medicine and, increasingly, nursing. This is not surprising since doctors largely control the health system and nurses comprise approximately two-thirds of the health workforce. By contrast, allied health professions have been largely overlooked in the literature, which reflects their relatively small numbers and less than powerful position within the health system. Perhaps more surprising, is the fact that the allied health professions themselves have not demonstrated a critical perspective…most of the professions align themselves with medical science, largely neglecting to develop a culture that encourages criticism of their own development (L. Williams, 2005, p. 350).

Only a few studies exist within physiotherapy that approach the question of the profession’s ontology and epistemology. Ruby Heap’s critique of Canadian physiotherapy and Anne Parry’s brief writings on English practice, for instance, illustrate how feminist analyses may be applied (Heap, 1995a, 1995b; A. Parry, 1995). Lynne Dixon’s thesis on the rules that have governed physiotherapy in England shows one way in which discourse analysis may be used (Dixon, 2003). Lise Kjølsrød and Eline Thornquist’s study of physiotherapy and welfare reform in Norway also offers some insights into the linkages between physiotherapy practice and governmental imperatives (Kjølsrød & Thornquist, 2004). Added to this, works by Joy Higgs, Sally French and Pia Jorgensen offer some robust forms of critiques of physiotherapy in different domains of practice, but beyond this there are few examples of institutional epistemologies to draw on within the profession itself (Corker & French, 1999; French & Sim, 2004; Higgs, Refshauge, & Ellis, 2001; Higgs, Richardson, & Abrandt Dahlgren, 2004; Higgs & Titchen, 2001; Jorgensen, 2000; Swain, French, & Cameron, 2003a, 2003b; Trede, Higgs, Jones, & Edwards, 2003).

In recent years, a number of authors have begun to call for greater insight into physiotherapy’s theoretical ‘foundations’ (Bassett, 1995; Bithell, 2005; Bowerbank, 2000; De Souza, 1998; Nicholls & Larmer, 2005; Reid & Larmer, 2007; Roskell, Hewison, & Wildman, 1998; Tyni-Lenne, 1989), and a number of practice ‘models’ now exist which attempt to define physiotherapy practice (Bassett, 1995; Broberg et al., 2003; Cott et al.,
1995; Hislop, 1975; Noronen & Wikström-Grotell, 1999; P. Roberts, 1994). These models are limited, however, to functionalist, trait-based approaches, and fail to address many of the social, political or economic questions pertinent to physiotherapy.

Similar limitations exist within the historical accounts of physiotherapy written in recent years to celebrate the centenary of the profession in various countries (Barclay, 1994; Bentley & Dunstan, 2006; Cleather, 1995; Murphy, 1995). Whilst providing narrative accounts of critical events in the profession’s past, these texts fail to explain how physiotherapy became historically possible; preferring instead to address only the events themselves. Thus a gap exists for a study that explores the historical conditions of emergence of particular practices of physiotherapy and their discursive construction. The approach I have taken to this question in this study foregrounds the problematisation of physiotherapy practice.

Problematising physiotherapy and constructing a critical history

My thesis is, first and foremost, that physiotherapy is discursively constructed. Taking a Foucauldian perspective to this analysis, it is my view that the event known as physiotherapy is the product or effect of the actions and practices of the physiotherapists that perform it. Following Foucault, these actions and practices are themselves the products of discourses that compete to create certain knowledges, whilst marginalising others. Working on the premise that all knowledges carry different levels of significance for different people at different points in time; what comes to be understood as ‘contemporary physiotherapy’ at any one point in the profession’s past or present, is the result of competition and contest between different knowledges. The resulting ‘truths’ are therefore the product of power relations which operate throughout all levels of society; not hegemonically, but as a microscopic matrix acting on each and all across multiple nodes, in a myriad of often unseen ways (Foucault, 1977a).

In this study, Foucauldian discourse analysis is used to expose these matrices of power, and to scrutinise how they create particular knowledges that physiotherapists believe represent the truth about their practice. While these truths may be accepted by some as absolute, Foucauldian discourse analysis exposes the contingent social and political circumstances that make this knowledge historically possible; connecting the resulting truths to the agents whose interests may serve. Of particular concern are the connections between knowledge formations and those institutions that have come to represent governmental imperatives. Authors that have used Foucault’s writings over the last two decades, have often approached the analysis of these institutions through
Foucault’s notion of ‘governmentality’ (Borthwick, 1999a; Clinton & Hazelton, 2002; Fullagar, 2003; Hazelton, 1995; Holmes & Gastaldo, 2002; Nettleton, 1991; Petersen, 2003; Pryce, 2001; Winch, Creedy, & Chaboyer, 2002).

Governmentality refers to ‘the complex of notions, calculations, strategies, and tactics through which diverse authorities – political, military, economic, theological, medical, and so forth – have sought to act upon the lives and conducts of each and all in order to avert evils and achieve such desirable states of health, happiness, wealth and tranquillity’ (Rose, 1997, p. 152). Governmentality provides a theoretical lens through which we may hold professional disciplines such as physiotherapy up for critical scrutiny. Through this lens, we can explore the tactics and aspirations of physiotherapists, and the contingent economic, political and social conditions that have made the formation and transformation of their subjectivity possible over time. Governmentality, therefore, provides the critical purchase for my analysis of the way in which knowledge about physiotherapy has been constructed at different moments in the profession’s history.

This approach to Foucauldian discourse analysis challenges the notion that physiotherapy (or any other professional discipline) can be understood as a fixed entity; as a body composed of stable ideologies, unchanging attributes or qualities. Instead, my argument is that the complex of knowledges, relations of power, disciplinary tactics, strategies and technologies that make up physiotherapy at any point in time, might be best understood by analysing the actions of the physiotherapists themselves; by exploring its performative qualities (Fournier, 2002; Lyotard, 1984); and through this, revealing the historically contingent discourses that have made certain forms of physiotherapy amenable to practitioners, whilst making others seem undesirable.

Problematising physiotherapy in this way, demands a particular attention to;

- the emergence of problems in relation to particular moral, political, economic, military, geopolitical or juridical concerns, or within the operation of particular practices or institutional sites (courts, armies, schools, prisons…); the authorities who define phenomena as problems (educational, legal, religious, political…); the criteria in relation to which certain persons, things or forms of conduct come to be seen as problematic (institutional norms, military requirements, legal regulations…); the kinds of dividing practices involved (sickness from health; madness from criminality; normality from pathology…) (Rose, 1999, p. xi).

To problematise physiotherapy is to conceive of it as an ‘event’ rather than an entity (Foucault, 1972); to see it as a historically contingent phenomenon and one without the traditional substantialisation of historiography. As Nikolas Rose argues;
Like other historians of the present, I think we would be wise to avoid substantializing either the present or its past. Rather than conceiving of our present as an epoch or state of affairs, it is more useful, in my own view, to view the present as an array of problems and questions, an actuality to be acted upon and within by genealogical investigation, to be made amenable to action by the action of thought... This is not merely because of a general prejudice that one will learn more about our present and its past by studying the minor and everyday texts and practices, the places where thought is technical, practical, operational, than by attending to the procession of grand thinkers that have usually captivated historians of ideas or philosophy of history. It is also because, so often in our history, events, however major their ramifications, occur at the level of the molecular, the minor, the little and the mundane (Rose, 1999, p. 11).

Rather than viewing physiotherapy from the perspective of its established definition; ‘the treatment of injury, disease, or pain by physical methods, such as manipulation, massage, exercise, and the application of heat, light, etc., rather than by drugs or surgery’ (Simpson & Weiner, 1989), my thesis is that physiotherapy may be understood best by approaching ‘a range of more local conceptual device[s]...strategies, technologies, programmes, techniques’ that make physiotherapist’s actions possible (Barry, Rose, & Osborne, 1996, p. 4). As Barry, Rose and Osborne argue; ‘These concepts do not serve to sum up the present historical “conjuncture”; rather they are tools for understanding some of the contingencies of the systems of power that we inhabit – and which inhabit us – today’ (Barry, Rose, & Osborne, 1996, p. 4). This study therefore approaches physiotherapy as an array of questions in which the ‘received fixedness and inevitability of the present is destabilized, shown as just sufficiently fragile as to let in a little glimpse of freedom – as a practice of difference – through its fractures’ (Barry, Rose, & Osborne, 1996, p. 5).

This study is grounded firmly in the writings of Michel Foucault (particularly Foucault, 1973, 1977a, 1979a, 1979c), and Nikolas Rose (Rose, 1993, 1996, 1997, 1999), and draws on the work a growing body of researchers who have utilised Foucault’s methodological imperatives to scrutinise other health professional institutions. Of particular note are David Armstrong (Armstrong, 1983, 1994, 1995, 2002), whose work on the sociology of medicine informed my analysis of physiotherapy as an orthodox health practice; Sarah Nettleton (Nettleton, 1989, 1992, 1994), whose work on dentistry provided a template with which to undertake an analysis of physiotherapy as a technology of discipline; and Dave Holmes (Holmes, 2002; Holmes & Gastaldo, 2002), whose work in nursing sat alongside the writings of Nikolas Rose, Mitchell Dean and others as I grappled with the complexities of governmentality (Dean, 1999; Evetts & Dingwall, 2002; Larner, 2000; Lemke, 2000; Rose, 1997, 1999; Turner, 1997). Having defined the main theoretical
focus for my study, I move now to unpack how the substantive focus for the study developed, and how this informed the structure of the upcoming chapters.

**Developing the substantive foci for the thesis**

In analysing the discursive construction of physiotherapy, my main focus is upon the practices of physiotherapists and the historical conditions that have made these practices possible. Consequently, I have concentrated my analysis upon three distinct historical moments in the history of physiotherapy. The first concerns the birth of the legitimate massage profession in England following the 1894 massage scandals. The second concerns the construction of orthodox physiotherapy during the welfare reforms of the middle of the twentieth century in New Zealand. And the third concerns the emergence of Breathing Works, as a private practice, challenging the conventions of contemporary physiotherapy.

In this study, each moment is given a separate chapter, and they run in chronological order. This is the reverse of the process by which they were devised, since I began by reflecting on my experiences at Breathing Works, and questioning how the clinic was resisting orthodox practices. These questions led me to explore the welfare reforms of the middle of the twentieth century in New Zealand, and the formation of respiratory physiotherapists as a professional sub-discipline. It became clear in exploring the texts surrounding the establishment of the profession’s orthodoxy, that this was in turn, constructed around discourses of legitimacy that had been the pursuit of masseuses some years earlier in England, in response to the massage scandals which threatened to impugn their conduct. My attention therefore turned to the actions of the founders of the Society of Trained Masseuses (STM) to see how legitimacy had been achieved.

Thus I explored three historical moments that each presented different images of how physiotherapy practice could be thought. In addition to tracing the practices of masseuses and physiotherapists within these moments, I also pursued the socio-political context in which their actions operated. Significantly, each of the moments corresponded with a different governmental rationality; thus the birth of the STM related to the height of liberal reforms in England at the end of the nineteenth century. Similarly, the second moment concerning the construction of orthodox physiotherapy, related closely to the emergence of welfare state reforms in New Zealand in the middle of the twentieth century. And the most contemporary practices seen at Breathing Works connect closely with the emergence of recent neo-liberal reforms.
For each of the moments detailed in the three chapters of ‘findings’, there is, therefore, a conjoint concern for the way that practices of physiotherapists are historically contingent upon governmental rationalities that have framed physiotherapist’s conduct. The overlap between these two rationalities makes it possible to explore a wide range of practices and actions, discourses, knowledge formations, relations of power and disciplinary strategies, and in so doing, come to some realisation about the types of subjectivity being constructed.

This study is relevant, timely and significant, therefore, because little work has been done into what might be called the critical sociology of physiotherapy from either within the profession or without. It is also timely because there is a perception within the profession that physiotherapy has stagnated; that it has become ossified; fixed in its ideas and comfortable in its position as the preferred orthodox provider of rehabilitation services for people with physical impairments (Nicholls & Larmer, 2005; Reid & Larmer, 2007; Stewart & Haswell, 2007). In recent years, concerns for the pace of change taking place within health care are making many orthodox health care disciplines consider their present and future roles (Alexander, Ramsey, & Thomson, 2004; Larkin, 1983). Aging populations, increasing demand for rehabilitation services, future workforce shortages, increased availability of health care information, and the increased commodification of health care are expected to play an increasingly important part in the future demand for traditionally established health care services – particularly in the maintenance of physical activity, and the consequent reduction in dependency, in old age (Nancarrow & Borthwick, 2005; Struber, 2004). Physiotherapy will not be immune to these changes, and commentators within the profession are beginning to question whether physiotherapy, in its present form, will be able to maintain its privileged status within the orthodox health care system, or whether it will need to explore new markets for its skills and commodities (Hao & Tan, 1999; A. Jones, 2006; Katavich, 1996; Nicholls & Larmer, 2005; Struber, 2004; Tan, 1998; Walker, 2002).

This study is important, therefore, because it focuses on equipping those interested in the future possibilities for physiotherapy with a critically robust analysis of the discourses that have made contemporary physiotherapy possible. It situates the profession within the changing economic and political landscape of postmodern health care, and explores how new practices are emerging at the margins of orthodox practice that give us insights into the possible future(s) for physiotherapists. Further, it offers a counterpoint to
the historical narratives of the present accounts of physiotherapy’s past. I now conclude
the chapter by setting out how the remaining chapters of this text have been organised.

Overview of the structure of the thesis

The linear structure I have imposed on this document belies the fact that the
process involved in arriving at this point has been far from linear. As is often the case with
extended texts of this sort, they present an organised representation of what has been a
process of constant movement between reflection and observation, text generation and
theory, contemplation and analysis, reading and writing. The act of engaging with the
complex task of completing a doctoral thesis is multifaceted, and yet the finished
document has to obey accepted conventions and present a readable textual insight into
what has otherwise been a messy, sometimes chaotic process. What follows is a brief
overview of each of the chapters covering the project’s theoretical and methodological
framework, its findings and discussion.

Chapter Two – Methodological and theoretical approaches

In Chapter Two I define the theoretical and methodological framework employed
in this study. Building on the introduction to Foucauldian discourse analysis set out in this
chapter, I explore Foucault’s notion of governmentality, and provide an outline of the
governmental facets that form the underpinnings of my theoretical lens; power/knowledge
and resistance, discourse, technologies of discipline and subjectivity. I also explore how
my approach is both archaeological and genealogical in its design, and expand on
Foucault’s notion of the ‘toolbox’ to explore the key principles and methodological
imperatives necessary in conducting a Foucauldian discourse analysis. Finally, I briefly
consider the hazards inherent in discourse analysis for those that drift towards what Derek
Hook has called ‘the turn of the text’ (Hook, 2001a). With these theoretical ‘definitions’ in
place, I move to Chapter Three where I distil my methods of text generation and analysis.

Chapter Three – From methodology to methods

In Chapter Three I outline the methods of text generation and analysis used in this
study. I explore the use of the three historical ‘moments’ outlined in Chapter One and
show how texts were generated and analysed for each moment. I consider how texts were
sampled and the ethical questions that arose in the study, before opening the first of my
chapters of findings.
Chapter Four – The quest for legitimacy in the practise of massage

The first of the three chapters that outline my findings, concerns the events that surrounded the inauguration of the Society of Trained Masseuses (STM) in England in 1894. The STM was the forerunner of physiotherapy professional bodies that established the legitimacy of massage in the years leading up to the First World War, and the disciplinary model the founders of the Society established was copied throughout the Commonwealth in the early years of the twentieth century. The chapter focuses upon the actions taken by the founders of the STM in responding to the ‘massage scandals’ that threatened the legitimacy of their nursing and midwifery practice. The focus for the chapter is the way in which the founders constructed their professional identity in relation to the discourse of legitimacy, and how this pursuit influenced the kinds of practices that they promoted, and the kinds of activities they identified as licentious. At the heart of this chapter are the conjoint concerns for a disciplined surveillance of legitimate masseuses and the need to adopt a biomechanical discourse to allow the masseuse to touch with impunity. These tactics and strategies form the main theoretical thrust of the chapter.

Chapter Five – The pursuit of orthodox status

In the second of the ‘findings’ chapters, the focus shifts from moral questions of legitimacy to political questions of orthodoxy and the pursuit of state recognition for physiotherapy services. My emphasis is upon the ways in which masseuses pursued orthodox status within the welfare state by building on the legitimacy achieved by British masseuses some years earlier. Central to this pursuit were the actions of masseurs in negotiating the tensions and opportunities offered by the New Zealand welfare reforms of the 1930s and 40s. At the heart of the profession’s quest for state recognition was the drive for greater autonomy in the education, legislation and practice of masseurs, and it was in the public health sector, and the profession’s relationship with medicine, that these tensions were exercised. Consequently, one of the main focal points for the chapter is the emergence of a professional sub-specialty within physiotherapy that made use of the security offered by the public health system to secure a monopoly provider role within the enclosure of the medical ward. Respiratory physiotherapists represent a ‘paradigm case’ (Silverman, 1997), in that they connect governmental imperatives with an array of disciplinary discourse; some of which made it possible for physiotherapists to gain orthodox status and greater professional autonomy, whilst at the same time becoming more enmeshed within the matrices of ‘the state’. I explore this dynamic in Chapter Five and
consider how the emergence of respiratory physiotherapy illustrates how important legitimacy and orthodoxy have been for physiotherapy practice in the past.

Chapter Six – Making breathing your business

In my final chapter of findings, I reflect on the importance of legitimacy and orthodoxy for physiotherapy practice, and question whether these potent discourses still hold the same significance for the profession today. The focus of this chapter is upon the practises of the physiotherapists at Breathing Works. I argue that these practitioners are exercising a form of resistance to the legitimacy and orthodoxy valued by twentieth-century respiratory physiotherapists, and that, in challenging the discursive construction of physiotherapy, the staff at Breathing Works are exploring the possibilities of different kinds of practice in the future; different governmental technologies; different knowledges, affiliations and relations. In exploring this domain of practice, I investigate the ways in which the clinic is problematising physiotherapy through its use of the media, its colonisation of particular language, and its design of the practice environment. But most especially, I focus on its commodification of breathing and the innovative marketing of ‘good’ and ‘bad’ breathing as a way of tapping into neo-liberal economies of health, which valorise the freedom and responsibility to consume services with which to optimise one’s form and function. I explore how the actions of the physiotherapists at Breathing Works connect with changing governmental rationalities of health, and show how their actions are so markedly different from those practiced by ‘traditional’ physiotherapists.

Chapter Seven – Discussion

In the final chapter, I return to the research questions I posed in Chapter One and discuss how my study offers some insights into the discursive construction of physiotherapy. I reflect back on the lack of critical scholarship in physiotherapy and speculate as to whether the adoption of particularly enduring discursive constructions early in the profession’s history, has been a barrier to ‘other’ ways of viewing health and illness for physiotherapists. In considering this question I ask whether the emergence of new practices like Breathing Works resist these constraints and open up new possibilities for physiotherapists. Finally, I consider how my study contributes to our understanding of physiotherapy, and how these findings might be utilised by other professional groups. I situate my research within the growing areas now known as the sociology of the professions and the sociology of the body, and consider the part that Foucauldian discourse analysis may play in the critical analysis of professional subjectivities. Finally, I explore
what I perceive to be the study’s limitations and how I would like to take my research forward.

**In summary**

Returning to the quote that began this chapter, I feel, as a practising physiotherapist, lecturer and researcher, that a study exploring the discursive construction of the profession would make a timely contribution to our understanding of our practices; but more than that, I feel it would shine a light into a profession that has, until recently, given little thought to the conditions that guide the conduct of its practitioners. As the thesis develops I will unpack some of these conditions, and also speculate on why I feel physiotherapy has been so reticent to engage with philosophy and the social sciences in the past.

One of the consequence of this study has been that it has forced me to reflect upon the practices that are most intuitive to me; stable practices that have been used by physiotherapists for decades; practices that I have myself taught to undergraduate and postgraduate students; practices of touch, massage, manipulation, and movement. Undertaking this study has forced me to engage in the practice of ‘writing against myself’; developing a critical attitude towards those things that seem most familiar to me (Butler, 1993). Consequently, this study has been both challenging and transformative.

This thesis represents the first study to problematise physiotherapy discursively using an approach informed by the work of Michel Foucault. In many ways it is an ambitious work, not least because physiotherapists are commonly not exposed to these ways of thinking in gaining their education, and these approaches do not come naturally to professionals who are far better equipped to analyse someone’s gait pattern than analyse the discursive construction of their profession. This, in itself, returns us to the fundamental questions posed by this study; how is it that physiotherapists’ conduct can be guided in this way? In addressing this question, I have asked how is physiotherapy discursively constructed? And, with reference to the quote that began this chapter, how might physiotherapists better know themselves by analysing their practices discursively?

In this introductory chapter I have explained how this research study came into being; the questions that formed the basis for the study; and the broad theoretical approach I took in addressing my thesis. I have also outlined why I think this study is important, and where it sits within the current body of works utilising Foucauldian discourse analysis. In the following chapter I provide a detailed overview of my theoretical approach.
CHAPTER TWO – METHODOLOGICAL AND THEORETICAL APPROACHES

Introduction

In the opening chapter of this text, I stated my thesis that physiotherapy is discursively constructed, and I explained that my theoretical and methodological approach had been informed by the work of Michel Foucault and a number of other authors who had made use of his writings. In this chapter I set out, in much more detail, the theoretical lens I applied to my data, and the methodological approach I took towards text generation and analysis.

I begin the chapter by dealing with one of the idiosyncrasies of a Foucauldian approach to discourse analysis; that being the lack of a formal method. Foucault stated that his works were a ‘toolbox’ from which readers, researchers, and practitioners were all free to draw (Foucault, 1994). I begin then by outlining how I have used Foucault’s work as a toolbox. From here, I explore Nikolas Rose’s notion of critical histories (Rose, 1997) before moving on to what Foucault called his archaeological and genealogical approaches. In the past, these have been dealt with separately by some researchers, who have seen them as representative of different phases in Foucault’s writing; with archaeological inquiry relating to his earlier interest in discourse; and the production of knowledge, and genealogy relating to his interest in power and ethics of the self (McHoul & Grace, 1993). While this may help categorise and organise Foucault’s work in the mind of the researcher, I found it became a hindrance to have to work with them separately when, in my experience, there was considerable overlap between them. Consequently, I brought them together in this document.

I move from addressing these approaches to considering the substantive questions of governmentality, power, technologies of discipline and resistance. These are the main theoretical approaches I employ in this study. There are also methodological complexities in undertaking a Foucauldian discourse analysis that must be considered however, and in the latter part of the chapter, I set out how I have applied Foucault’s methodological imperatives and principles to my data. To begin with, I explore Foucault’s belief that his works represent a toolbox.
Foucault’s toolbox

I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area… I would like [my work] to be useful to an educator, a warden, a magistrate, a conscientious objector. I don't write for an audience, I write for users, not readers (Foucault, 1994, pp. 523-524).

Throughout his writings, Foucault maintained a constant criticism of those modes of scholarship that lent truth status to knowledge; that promoted the notion of existential truth or historical fact; that defined singular methods of enquiry or formulae for students to follow. It is not surprising then, that Foucault promoted the idea that his own works should be used as a sort of ‘toolbox’ from which practitioners could draw.

Foucault’s notion of a toolbox has been used extensively in recent years, and it has encouraged research which has taken a wide variety of forms (see, for example, Fraser, Hopwood, Treloar, & Brener, 2004; C. Graham & Neu, 2004; Manias & Street, 2000b; Szakolczai, 1998). In some studies, it may be argued, it has been misappropriated by authors, who have used it to justify a laissez-faire approach to Foucauldian discourse analysis (Hook, 2001a, 2001b). This may be the result of a misreading of Foucault’s intentions, or a lack of clarity on the part of the researcher. What is clear, though, is that despite Foucault’s methodological pluralism, he was not advocating an ‘anything goes’ approach to research, and as Ballinger and Cheek assert, discourse analysis in keeping with Foucault’s methodological intentions is anything but vague or indeterminate;

A fundamental principle of discourse analysis is that texts are analysed in a systematic and explicit fashion. One of the problems in some reports of studies purporting to use discourse analysis, is that neither the underpinning approach, nor the way in which it has been used have been clarified. The rather vague epistemological position of the researcher and non-specific mode of analysis then tend to be equated with difficulties with this methodology itself, rather than viewed as an example of poor scholarship (Ballinger & Cheek, 2006, p. 202).

Foucault’s intention was to provide broad rules, general principles, examples, instances and perspectives that others could draw from. Foucault’s suggestion was that his books should be regarded as ‘experience books’ rather than ‘truth books’ (Foucault, 1991, pp. 30-31).

Gary Gutting has argued that;

Foucault’s work is at root ad hoc, fragmentary and incomplete. Each of his books is determined by concerns and approaches specific to it and should not be understood as developing a theory or a method that is a general instrument of intellectual progress (Gutting, 1994, p. 2).
In keeping with this view, Mitchell Dean argued that Foucault never sought to ‘allow his own heuristics to congeal into a fixed, formal method’ (Dean, 1994, p. 14). It is more accurate, therefore, to refer to a set of ‘guiding principles’ when making use of Foucault’s approach to discourse analysis, rather than a single, defined methodological approach. These guiding principles provide a framework, or set of lenses, with which one may view one’s data.

In this study, I have made use of those tools best suited to my research question. These predominantly emanate from Foucault’s earlier works; especially Discipline and Punish, The Birth of the Clinic, the first volume of The History of Sexuality, and Archaeology of Knowledge (Foucault, 1972, 1973, 1977a, 1979c); and focus on those archaeological and genealogical tools relevant to particular facets of governmentality; namely, technologies of discipline, power/knowledge, discourse and resistance. Each of these will be explored in more detail later in the chapter. My first concern, however, is to define how I have approached physiotherapy practice from the perspective of a critical history.

**Critical history and physiotherapy practice**

In recent years, a number of historical accounts have been written about the physiotherapy profession to commemorate the centenary of the formation of different national professional bodies (Barclay, 1994; Bentley & Dunstan, 2006; Cleather, 1995; Murphy, 1995). These studies provide important insights into the profession, and a number of them have been used in this thesis as texts in their own right. They differ, however, from the approach to critical history that I have taken in this study. I have resisted the desire to understand the history of physiotherapy as a chronological account rooted in historical fact; or the linear, progressive drive towards enlightenment; and instead, I have approached historical moments as the result of particular, unique, discursive conditions. I have concentrated upon ‘the diversity of strategies and tactics of subjectification that have taken place and been deployed in diverse practices at different moments and in relation to different classifications and differentiations of persons’ (Rose, 1997, p. 37). As Rose goes on to argue;

> Critical history disturbs and fragments, it reveals the fragility of what seems solid, the contingency of that which seems necessary, the mundane and quotidian roots of that which claims lofty nobility and disinterest. It enables us to think *against* the present, in the sense of exploring its horizons and its conditions of possibility. Its aim is not to predetermine judgement, but to make judgement possible (Rose, 1997, p. 18, emphasis preserved).
Rather than documenting the history of physiotherapy as a collection of events or historical ‘facts’, I have emphasised the contingent, often accidental and incomplete process of knowledge formation that has taken place in the practice of physiotherapy at three distinct points in the profession’s history. Critical histories become a process of local excavation, of interrogation and scrutiny, and bring the discursive conditions that make the formation of knowledge possible into the foreground. Foucault described the analysis of critical histories as ‘archaeological’ (Foucault, 1972), and it is to this notion that I now turn.

**Analysing discursive formations archaeologically**

Studies that utilise Foucault’s archaeological principles, frequently take as their starting point a diverse array of texts. These texts are not confined only to physical documents that bear what Derek Hook called the ‘markings of textuality’ (Hook, 2001b), but include any utterance or form of expression that plays a role in forming or moderating what can be thought, said or done at any one time (Foucault, 1972). Texts are composed of statements, or utterances which make some claim to truth and are ratified by particular knowledges (Mills, 1997). The particular knowledge that passes as truth at any particular moment is the product of a discursive formation, which describes a variety of statements, subjects, objects, concepts and thematic choices (Foucault, 1972). Discursive formations define a discursive field, or the ‘totality of all effective statements (whether spoken or written)’ (Foucault, 1972, p. 27), and a discursive field encompasses every form of practice that systematically forms the objects of which it speaks (adapted from Foucault's definition of discourse, cited in Foucault, 1972, p. 49). These various definitions highlight the interplay between texts, statements and discourses that are central to Foucault’s archaeological approach to text analysis. In this study, I have utilised this approach to explore the statements (written, spoken or enacted) inherent in the practices of physiotherapists.

Statements form the basic unit of analysis in archaeological enquiry because they make objects, subject positions, strategies and tactics visible, and consequently they become amenable to analysis. At the same time, in exploring these statements, we learn something about the ways in which they are made visible in the first place; the matrices of power relations that make certain forms of knowledge authoritative (and thereby acceptably expressed as statements), and other forms unacceptable (and thereby suppressed). The rules that govern the visibility of statements, and their subsequent effect on the formation, correlation and transformation of discourses, were set down by Foucault
as guiding principles for understanding the interplay between statements and discourses, and they, therefore, provide a useful vehicle with which to approach the analysis of texts.

Foucault’s first rule he called the ‘Rule of Discursive Formation’, and this concerns the way in which some discourses are formed by particular statements and not others. Foucault encourages scholars to explore the ways that certain objects, subjects, strategies and concepts make particular thoughts, actions and behaviours possible, and the ways this related to the construction of knowledge and the formation of texts. Taking each of these in order, Foucault explored the formation of discursive objects, for example; massage, touch, treatment beds; those objects that embodied statements that legitimately bore the markings of particular discursive constructions. Foucault explored the surface of emergence of these objects, the authorities that gave weight to these discursive constructions (what Foucault called the ‘authorities of delimitation’), and the ways in which the objects are classified, organised, divided and regrouped (‘grids of specification’) (Foucault, 1972). One object that features prominently in my analysis is the object of the treatment bed. Throughout physiotherapy’s history, the treatment bed has been the site of tension for those who wished to legitimise touch. The treatment bed/couch/plinth bore certain ‘statements’ about its purpose as a way of expressing particular discourses of legitimacy and orthodoxy. In Chapter Six I explore how these discourses are now being subverted by an array of new statements about the discursive construction of the treatment bed.

Foucault also spoke of the formation of subject positions. Here, his concern was to explore the ways in which discourses made certain subject positions possible. In this study, for instance, one of my major analytic focal points has been the formation of particular physiotherapy subjectivities: who is speaking; whose authority carries legitimacy; who is allowed to provide commentary on particular objects? In this thesis, areas of major interest are the authorities of expertise that promote particular discourses as important for physiotherapists. In Chapter Four these are identified as the founders of the STM; in Chapter Five it is respiratory physiotherapists; and in Chapter Six it is the therapists at Breathing Works. Physiotherapists may occupy different subject positions that place them in differing relations to particular objects; for example, they may be orthodox health workers; conducting established biomedical assessment and treatment practices; or they may adopt new subject positions at the margins of orthodox practice. These positions enable objects like the clinic environment, the tools of measurement and assessment, or even patients/clients, to be approached from different subject positions.
These changed subject positions are significant for my analysis of the changes instituted by Breathing Works.

Foucault also spoke of the formation of concepts and strategies. Concepts and strategies such as ‘good’ or ‘bad’ breathing are important in this thesis because they group statements around particular notions of breathing which, in turn, situate physiotherapists in relation to the objects that these statements construct. The rule of discursive formation, therefore, plays a pivotal role in the construction of meaning for physiotherapists, and hence, their subjectivity.

Foucault’s second rule, the ‘Rule of Discursive Correlation’, focuses upon the fluid inter-relationship between discursive formations. This rule concerns the way discourses intersect, abut, compete, overlap, dominate, marginalise or negate one another (Hook, 2001b). Foucault argued that these interactions between discourses needed to be explored at a microscopic level (between subjects, objects, strategies and concepts), and at a macroscopic level (between discursive formations, competing knowledges and power effects), and so this rule encourages us to focus on the relational qualities of discursive formations.

In this study, the correlations between discursive formations play an important role because they provide a means for interpreting the changing context in which physiotherapists operate, without recourse to historical progressivism. In other words, by exploring the correlations between the discourses of legitimacy; across three historical moments, I can analyse the changing context in which physiotherapists’ actions have operated; whilst avoiding the tendency to write physiotherapy history as a linear narrative.

The ‘Rule of Discursive Transformation’ – Foucault’s final archaeological rule, encourages us to explore how discourses shift and change over time. Where are shifts occurring? What changes are happening ‘internal’ to the discourse? What effect are these changes having on the relationships with other discursive formations? Importantly, our task becomes one of mapping the transformations in these discourses over time and exploring the changing contexts that make certain discourses possible and deny others.

Foucault did not consider that discourses could be ‘defined’ – since this might reinforce the view that they were monolithic entities warranting description – instead, he argued that their relationships, tactics, operations, oppositions, etc. should be ‘mapped’ across a broad terrain of events (Davidson, 1986). In this study, I have sought to map an array of discursive formations, rules, knowledges, structures and systems, some of which are immensely stable over time, and others that are entirely transitory. One such discursive
formation is biomechanics, or the discourse of the ‘body-as-machine’. This discourse has been reported extensively in relation to medicine in recent years (Samson, 1999), but has never before been applied to physiotherapy practice. The argument that I will develop in this thesis is that a biomechanical discourse has played a vital role in defining physiotherapist’s subjectivity and it continues to have an enduring effect on the statements that are produced by practitioners as they assert their authority. Importantly, Foucault argued that our task was to disturb that which was previously considered immobile; fragment what was thought unified; and show the heterogeneity of what had been considered consistent (Kendall & Wickham, 1999). And so in this thesis, I have attempted to make visible the various statements that cohere around the discourses of critical importance to physiotherapy, and in so doing, explore the relations of power that make these statements visible in the first place.

Extending archaeological inquiry

Foucault called the rules that govern the formation, correlation and transformation of discourses an ‘archive’. This is a very different interpretation of the term from that found in historical research, since Foucault utilised his understanding of the term as the basis for genealogical inquiry, by exploring systems of ‘domination, subjugation, the relationships of force’ (Foucault, 1980, p. 85). Thus, an exploration of the archive focuses on the relations of power that make it possible to promote certain statements and not others. When we shift our attention away from the intimate relationship between statements and discursive formations, to the relations of power that govern how that knowledge is created, we move towards a more genealogical approach. This is not, however, the same as saying one replaces the other; as Maria Tamboukou argues;

Genealogy was often promoted by Foucault as a kind of successor to archaeology. Despite this, genealogy maintains many of the essential ingredients of archaeology, including, paradoxically, the examination of bodies of statements in the archive. However, Foucault added to it a new concern with the analysis of power, a concern which manifests itself in the ‘history of the present’ (Tamboukou, 1999, p. 202).

In this thesis, archaeological approaches are employed as a ‘methodology [for the] analysis of local discursivities’ (Foucault, 1984c, p. 351), whereas genealogy refers to ‘the tactics whereby, on the basis of the descriptions of these local discursivities, the subjected knowledges which were thus released would be brought into play’ (Foucault, 1984c, p. 351).

According to Tamboukou, genealogical analysis reflects upon ‘the nature and development of modern power’, and works on the assumption that ‘truth cannot be
Genealogical analyses, therefore, target three specific foci;

First, a historical ontology of ourselves in relation to truth through which we constitute ourselves as subjects of knowledge; second, a historical ontology of ourselves in relation to a field of power through which we constitute ourselves as subjects acting on others; third, a historical ontology in relation to ethics through which we constitute ourselves as moral agents (Halperin, 1995, p. 18).

Thus, the first focus of my genealogical inquiry is upon the role of knowledge in the construction of physiotherapists’ subjectivities; the second focus relates to what Foucault called ‘technologies of discipline’ through which physiotherapists’ conduct is governed; and the third focus refers to the ‘technologies of self’ that defines the ethical conduct that allows physiotherapists to govern themselves. As I stated in Chapter One, in setting out this thesis, I made the pragmatic decision to focus only on the first two theoretical foci. This was not because the questions of our ethical self-formulation are not important or relevant; it is merely that I had to place some boundaries on the breadth of this particular study.

In summary, I believe it is possible to undertake an analysis that combines archaeological and genealogical principles to explore the relations of power that govern our conduct, whilst also considering the ways in which physiotherapists are subject to, and object of particular discourses which compete to construct particular knowledges about physiotherapy practice. This then was the basis for theoretical approach I took in this study. I will now turn to the various theoretical constructs that formed the cornerstone of my analysis. The first is governmentality, which formed an overarching theoretical framework for the thesis.

**Governmentality**

Governmentality is critical to this study because it brings together the historical, political and social strategies employed by physiotherapists, with the technologies that they put in place to ensure the health, wealth and happiness of the population. Mitchell Dean defines governmentality as;

Any more or less calculated and rational activity, undertaken by a multiplicity of authorities and agencies, employing a variety of techniques and forms of knowledge, that seeks to shape conduct by working through our desires, aspirations, interests and beliefs, for definite but shifting ends and with a diverse set of relatively unpredictable consequences, effects and outcomes (Dean, 1999, p. 11).
Governmentality combines Foucault’s interest in the archaeological interrogation of statements and discourses, with his genealogical concern for the ways in which power constructs knowledge and subjectivities (Foucault, 1979a). Governmentality was used by Foucault to focus attention on the ways in which knowledge formations were historically contingent. In other words, Foucault used governmental analyses to show that the acquisition of knowledge was not progressive, but often haphazard and contextual. Foucault’s particular interest was the nature of political rule in western states between the seventeenth and twentieth centuries, and he attempted to show how shifting relations of power had made certain forms of political rule possible. Thus, Foucault created the conditions for a great deal of subsequent scholarship into the development of what he called technologies of government; i.e. sovereign power, discipline and technologies of the self (Barry, Rose, & Osborne, 1996; Dean, 1999; Foucault, 1979a).

In this thesis I have concentrated upon the technologies of discipline as one form of governmentality, and explored how disciplinary discourses have connected physiotherapy with broader political imperatives. Returning to the questions I set up in Chapter One, I asked, ‘How have governmental influences guided the formation and transformation of physiotherapists’ subjectivities throughout the profession’s history?’ I have attempted to address this question by exploring physiotherapy practices at three moments which have three quite different governmental imperatives; the first moment situates physiotherapy within liberal rationalities of late-Victorian England, the second locates physiotherapy within the welfare reforms of the mid-twentieth century, and the third locates physiotherapy within contemporary neo-liberalism. Each of these governmental rationalities are discussed in more detail below.

**Liberal, welfarist and neo-liberal rationalities of government**

At the end of the nineteenth century, when the Society of Trained Masseuses was being formed, liberalism was the dominant governmental rationality in the developed world (Barry, Rose, & Osborne, 1996). It reflected a governmental interest in ensuring the health, wealth and happiness of the population, while at the same time, recognising that there were some aspects of society that were beyond the reach of government;

Liberalism, in this respect, marks the moment when the dystopian dream of a totally administered society was abandoned, and government was confronted with a domain that had its own naturalness, its own rules and processes, and its own internal form of self regulation (Rose & Miller, 1992, p. 179).

Social citizens were ‘assigned their social duties, accorded their rights, assured of their natural capacities, and educated in the fact that they need to be educated by experts in
order to responsibly assume their freedom’ (Rose, 1996, p. 49), and a new sphere of ‘social’ politics emerged in which ensuring an effective ‘society’ became a new political objective.

According to Eric Paras, liberalism involved a ‘calculated leaving alone…Rather than a tightening of the reins of social control’ (Paras, 2006, p. 103). It described a ‘kind of slackening: a power that functioned with precision inasmuch as it let natural processes pursue their course, inasmuch as it let individuals follow their inclinations’ (Paras, 2006, p. 103). One such manifestation of this ‘calculated leaving alone’ was an explosion in the numbers of professional authorities, who claimed expert status over particular facets of social life. In health care, previously established health practices flourished as professionals, now afforded government recognition, took on the duties of governing the conduct of conduct. Liberalism, therefore, personified a separation of the state from the citizen subject, and an increased dependence on the actions of professional experts;

Liberalism, as Foucault presented it, was precisely that kind of power within which the center comes to recognize that it cannot control all of the nodes, and that, in fact, the life of the nation is made up of a number of processes that are not only independent of the central authority, but which augment the force of the nation only to the extent that they are left alone to run their course (Paras, 2006, p. 106).

Crucially, the institutions that now constituted this expanded social infrastructure were required to pay attention to the goals of the state and ensure that they maintained disciplined surveillance over each location where there existed the possibility for irregularity or variation. Thus, in every corner of social life, new experts appeared whose intrusions were justified on the premise that they were helping citizens achieve greater prosperity, longevity, and personal fulfillment (Rose, 1993). As Burchell argues, governments no longer needed to take punitive action to discipline the conduct of its subjects; expert authorities acted on their behalf, instigating a raft of disciplinary technologies that operated at innumerable points to observe, normalise and examine conduct, and maximise the use of time and labour for the betterment of the nation as a whole (Burchell, 1993).

By the early decades of the twentieth century, the freedoms espoused by liberal forms of government, that had resulted in the proliferation of experts and authorities, had begun to create their own problems, and solutions were pursued that sought to rationalise particular forms of expertise and bring these selected authorities under closer government

---

3 I use the term expertise in the manner of Nikolas Rose’s definition which states that it refers ‘to a particular kind of social authority, characteristically deployed around problems, exercising a certain diagnostic gaze, grounded in a claim to truth, asserting technical efficacy, and avowing humane ethical virtues’ (Rose, 1997, p. 85).
scrutiny (Rose, 1993). The trade-off for expert authorities that had prospered under liberal governments, but now envisaged their freedoms being constrained, was government patronage in the form of discipline specific legislation; collective bargaining over pay and terms and conditions; freedom from competition; public kudos; and access to an enormously stable clientele, organised within institutions designed by the experts themselves (Bertilsson, 1990). Consequently, in many European and Commonwealth states, welfarism came to dominate the political landscape and replaced the minimally regulated freedoms of liberalism, with access to state sponsorship becoming the priority for legitimate health providers like physiotherapy (Dew, 2003).

While Foucault himself never spoke directly about welfarism, he recognised the significance of the political period in which welfarism reached its zenith;

In my opinion, the years 1940-1950 should be chosen as dates of reference marking the birth of this new system of rights, this new morality, this new politics and this new economy of the body in the modern western world. Since then, the body of the individual has become one of the chief objectives of State intervention, one of the major objects of which the State must take charge (Foucault, 2004, p. 7).

By the end of the twentieth century, welfarism had come under repeated attack for the bureaucratic and institutional constraints it placed upon individual citizen subjects. Welfarism was seen as stifling, and a more aggressively market-driven form of neo-liberal government was championed as its replacement. Grounded in a partial return to the liberal notion of freedom from state intervention, neo-liberalism brought about a dramatic re-evaluation of western welfarist projects that had dominated much of the twentieth century (Pierson, 1991; Rose, 1993). New rationalities of government emerged as a result of changing economic and governmental priorities (Rose, 1996). Following the bureaucratic, centralising motives of welfarism, a new process of ‘hollowing out’ government established new relationships between public and private services, increased flexibility in service delivery, and reduced expenditure on public health care (Carter & Rayner, 1996).

This notion of neo- or, as Nikolas Rose calls it, ‘advanced’ liberalism4, heralded a re-evaluation of the relationship between the state, the established orthodox professions, and citizen subjects, in which;

Citizens have been redefined as individual consumers of newly competitive public services and citizen rights have been re-defined as consumer rights; the public sector has undergone considerable downsizing as successive governments have pursued the privatization agenda; management has been delegated or devolved while executive power has been concentrated even more at the centre…There has

---

4 No distinction between these two terms is made in this thesis. I have used neo-liberalism unless specifically citing the work of Nikolas Rose.
been a clear shift away from universality to a “modest safety net”. The old welfare goals of participation and belonging have been abolished (Fitzsimons, 2000, p. 1).

Advanced liberalism places the emphasis upon ‘the market’ as the primary tool of wealth distribution, and it valorises the development of an enterprise culture that gradually unravelled the welfarist relationships between the state, expert practitioners and citizen consumers (Burchell, 1993; Larner, 2000). At the heart of this reform is the creation of the consumer as a vital cog in the machinery of government. According to Rose, advanced liberalism affords ‘vital political value to a certain image of the human being’ as the ‘enterprising self’ (Rose, 1997, p. 151, emphasis preserved); a self that aspires to autonomy and ‘personal fulfillment in its earthly life, it is to interpret its reality and destiny as a matter of individual responsibility, it is to find meaning in existence by shaping its life through acts of choice’ (Rose, 1997, p. 151). The significance of this political shift will become more apparent in Chapter Six where I discuss the emergence of the Breathing Works clinic and its move to commodify breathing and market solutions for breathing problems beyond the traditional boundaries of the medical ward.

In focusing on three different epistemes in the history of physiotherapy, I have also sought to align these with key shifts in the political economy of government taking place in England and New Zealand since the end of the nineteenth century. A Foucauldian approach makes it possible to see the emergence of particular practices, discourses and knowledges of physiotherapy as intimately related to broader governmental rationalities, and I have chosen to explore those events in physiotherapy’s history that broadly correspond with liberal, welfarist and advanced liberal rationalities. I will now move from governmentality to briefly consider Foucault’s analysis of power and its role in constructing knowledge and subjectivity.

Foucault’s interpretation of power

An understanding of Foucault’s analysis of the role of power in the construction of discourse, knowledge, truth and the subjective relations between oneself and others, and oneself and oneself, forms a central plank of Foucauldian discourse analysis (Dean, 1999; Rose, 1999). This stems from Foucault’s assertion that power operates not hegemonically (as seen by some structural ideologies), but as a matrix operating from multiple, dispersed points, in myriad ways and emanating from any number of nodes. To talk of power as being only repressive or negative, therefore, vastly understates its possibilities and positive effects. Power, according to Foucault, is creative – it creates knowledge – and this knowledge, in turn, folds back on itself to create new forms of power and new
subjectivities. In the case of physiotherapy, for example, I argue in Chapter Four that the power embodied in the discourse of legitimacy, gave masseuses the right to define the forms of conduct that constituted morally respectable practice. This knowledge further enhanced the masseuse social standing, which became vitally important as they pursued state recognition a few years later.

Power, for Foucault, is not based particularly upon coercion or violence, but on the ability to bring about desirable actions in the subject of power without the need for oppression or force, and in this way it becomes a vital tool for the conduct of government under the liberal states that began to emerge from the eighteenth century onwards (Foucault, 1977a). Foucault argued that because power operated from many different points, creating microscopic relations throughout society, it must be seen as relational; exerting its influence in many directions and at all times (Foucault, 1977a). It is possibly more accurate, therefore, to talk of ‘relations of power’ rather than to imply that power possessed monolithic qualities. Further, Foucault argued that these relations of power are exactly the forces that create discourses, and construct our notions of truth;

In a society such as ours, but basically in any society, there are manifold relations of power which permeate, characterise and constitute the social body, and these relations of power cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation and functioning of a discourse. There can be no possible exercise of power without a certain economy of discourses of truth which operates through and on the basis of this association. We are subjected to the production of truth through power and we cannot exercise power except through the production of truth (Foucault, 1980, p. 93).

The truths that are generated by these power relations are, like power itself, neither fixed nor impermeable, but rather, they shift repeatedly depending upon the social and historical context in which they operate. This is particularly true for the human sciences that do not share the same epistemological rigour of the pure sciences of mathematics and physics. These, therefore, depend upon the ‘densest and most complex field of positivity’ (Foucault, 1978, p. 20) to sustain their social and historical significance. Inevitably, they are less stable and more difficult to control, and so demand an array of tactical operations to maintain them. Among these tactical operations are disciplinary technologies, employed by actors within groups of human science professionals, that are deployed to stabilise professional subjectivities around particular sets of values, principles or beliefs. These tactical operations are used to ensure that members of particular professional groups conform to accepted standards and demonstrate the moral values of that group in their practices (Foucault, 1977a). In keeping with Foucault’s analysis of power, however, this is not achieved through force, but through the maintenance of a web of visibility, the
promotion of norms and the identification of aberration, the examination of conduct, and microscopic attention towards the minutiae of movements.

Foucault developed his understanding of these operations of power through his writings on the historical emergence of different forms of criminal justice in Europe from the seventeenth century onwards (Foucault, 1977a). In *Discipline and Punish*, for example, Foucault wrote about the panopticon as a metaphor for the emergence of a more ‘humane’ form of justice than had been exercised by sovereign rulers prior to the eighteenth century in Europe\(^5\). The panopticon served to illustrate that attitudes towards criminal justice changed over time and that these changes reflected shifting societal attitudes towards the humane treatment of prisoners. It also served to illustrate how new ‘technologies’ of government emerge as a result of these shifts. In the management of the criminal conduct, for example, Foucault showed how the emergence of statistics, epidemiological studies and the field of mental health occurred concurrently with a societal shift away from the summary punishment of the ‘bad’, towards the more humane care of the ‘mad’ (Foucault, 1977a). Equally, the panopticon connected operations of power with the development of modern forms of government, and it connected power with a certain number of defined tactical operations.

These issues are important to the discursive construction of physiotherapy because they connect the historical conditions of emergence of particular practices with particular governmental imperatives, and as McHoul and Grace argue, ‘The very existence and development of the ‘human sciences’ constitutes a historical event peculiar to our society, and one that must be accounted for’ (McHoul & Grace, 1993, p. 59). It also shows that many of the disciplinary tactics that ensue are the result of particular operations of power, and so to analyse the construction of particular knowledge and practices within a profession like physiotherapy requires consideration of the ways in which power is operating through the profession. I have chosen to focus on disciplinary technologies in this thesis since as Derek Hook argues; ‘…the emergence of the human/social sciences is contemporaneous with, and indivisible from, the development of disciplinary power’ (Hook, 2003, p. 609), and so I will explore these technologies in more detail below.

---

\(^5\) The panopticon was a circular prison designed around a central guard tower. Prisoners were arranged in cells around the outside of the prison and were constantly visible. The purpose of this was to induce an awareness of being continuously under surveillance, which would induce a state of docility in the prisoner. The metaphor of the panopticon has been written about extensively elsewhere in recent years; particularly in the fields of health, education and criminal justice (Cheek & Rudge, 1994b; Goodlad, 2003; Holmes, 2001; A. McKinlay & Starkey, 1998).
Technologies of discipline

Foucault used the notion of technologies of discipline as a way of defining the multitude of tactics, strategies and techniques whose purpose was the governance of the population (Foucault, 1977a). Because of Foucault’s interest in the historical conditions that made these technologies possible, technologies of discipline also imply certain relations of power between citizen, the machinery of government and the various authorities who are situated to deploy the various strategies involved; they are what Dean called the ‘contact point’ between the state and the citizen subject (Dean, 1999, p. 12). Thus, in my analysis of the discursive construction of physiotherapy, I have paid particular attention to the way physiotherapists have used technologies of discipline and how these have situated the profession in relation to the machinery of government. My particular focus has been on the deployment of disciplinary technologies by physiotherapists upon themselves. It is my contention that this engagement with technologies of discipline has been very important in defining aspects of physiotherapist’s subjectivity, and these technologies feature repeatedly within my analysis.

Foucault focused on a number of different disciplinary strategies. In this thesis I have concentrated on three of the most significant to physiotherapist’s subjectivity. I chose to focus on these three particularly because they resonated with the disciplinary practices I saw emerging repeatedly within my texts. They are systematic observations, normalisation and the examination.

Systematic observations

Systematic observations are one of the earliest technologies of discipline deployed by governments, being seen in texts from as early as the seventeenth century (Foucault, 1977a). This discipline became necessary with the growth of large urban populations in European cities, and led to the development of population statistics and surveys. In an effort to govern against the infinite ‘unforeseeable and contingent circumstances’ (Foucault, 1977a, p. 191) that nation states faced, governments developed sophisticated systems of surveillance. What was crucial about these forms of observation was that they targeted hierarchies within the population that had previously been ignored. Governments deemed that it was necessary to have detailed knowledge of every citizen, in order to know their needs, their wants, and the dangers they posed to the state (Rose, 1996). Foucault called this ‘descending individualism’ (Foucault, 1977a);

For a long time ordinary individuality – the everyday individuality of everybody – remained below the threshold of description. To be looked at, observed, described
in detail, followed from day to day by an uninterrupted writing was a privilege… [disciplinary methods] reversed this relation, lowered the threshold of describable individuality and made of this description a means of control and a method of domination… This turning of real lives into writing is no longer a procedure of heroization; it functions as a procedure of objectification and subjectivication (Dean, 1999, p. 119).

While Foucault traced the historical significance of these techniques and explored their emergence as governmental strategies, he was also clear that these forms of observation needed to be adopted by all sectors of society, such that each of us became enmeshed in a matrix of observations involving each other. Of greatest significance here were the professions whose expertise was, in part, defined by their ability to gather increasingly refined information about the populace. In some aspects of health care (for example general practice, community nursing, dentistry and public health), systematic observations of the population form a vital component of the professional’s role. My focus in this thesis was upon the ways in which these technologies played a role in the conduct of physiotherapists. How important, for instance, was systematic observation in legitimisation of touch and massage? How was this technology deployed by physiotherapists who moved into the public health system? How relevant are these forms of observation to contemporary physiotherapy practices that operate in a neo-liberal context?

Importantly, I am concerned with how systematic observations create individuality and more clearly define difference; how, by a process of systematically categorising and identifying each and every facet of human difference, can we reveal deviations in order that they may be amenable to ‘therapy’? Foucault’s interest was in how systematic observations (and the technologies of discipline that were allied to them) constructed our notions of criminals, schoolchildren, soldiers, and the sick, as deviant. In a similar way, I am interested in the contribution systematic observations make to the construction of physiotherapist’s subjectivity, and this forms an important aspect of my analysis.

Normalisation

The second technology of discipline explored here is normalisation; ‘Normalisation, simply put, is the ultimate goal and effect of disciplinary technologies – ‘the elimination of all social and psychological irregularities and the production of useful and docile subjects through a refashioning of minds and bodies’ (Best & Kellner, 1991, p. 47). Mitchell Dean argued that, ‘A norm creates an equivalence in that all are comparable in relation to it; but it also creates differences and inequalities in so far as it enables each to be individualized and hierarchically ordered in relation to it’ (Dean, 1999, p. 119). Thus,
in any social system based on the systematic ordering of the population, normalising
judgements play an important role in establishing the ‘benchmark’ against which each and
all are judged;

Foucault argued that, in recent times, practices of division, classification, and
ordering around a norm have become the primary means by which to individualize
people, who come to be understood scientifically, and who even come to
understand themselves in this mode (Tremain, 2005, p. 6).

Moreover, as the gaze of the observer (expert) becomes more refined – constructing
progressively more detailed topographies of specification and more sophisticated systems
of differentiation – people become increasingly identifiable (Dean, 1999).

Foucault’s interest in normalisation focused upon the institutions from which these
disciplinary technologies emerged, but also, importantly, why people allowed themselves
to be ‘programmed’ in this way in the first place. Foucault asked, ‘How were people made
to accept the power to punish, or quite simply, when punished, tolerate being so’ (Hoy,
2004, p. 65)? In attempting to answer this question, Hoy argues that ‘In general,
individuals are complicit in the process of their self-formation and they learn to normalize
themselves. Indeed, normalization does not suppress individualization, but produces it’
(Hoy, 2004, p. 65). Therefore, normalisation is not necessarily sinister or negative, but, in
keeping with Foucault’s entire construction of power, normalisation has real, positive
consequences for those who submit to it. Thus, in analysing the actions of
physiotherapists, it is important to explore how normalisation has operated to construct
physiotherapist’s subjectivity; the institutions that have defined particular norms for the
profession; norms that include the way the body may be viewed; what constitutes
professional practice, or moral legitimacy; and how physiotherapists have related to
normalising practices historically.

The examination

The examination combined the exercise of surveillance, the application of
normalising judgement and the technique of material inscription to produce
calculable traces of individuality. The examination’s mechanisms each provided a
mechanism for rendering subjectivity into thought as a calculable force. The
examination not only makes human individuality visible, it locates it in a web of
writing, transcribing attributes and their variations into codified forms, enabling
them to be accumulated, summated, averaged and normalized – in short,
documented (Rose, 1999, p. 7).

Foucault’s notion of the examination was a conflation of micro-technologies of
power including techniques of surveillance, hierarchical observation and normalising
judgement (Nettleton, 1992; Rose, 1997). Foucault’s use of the notion of the examination
considers how agents ‘codify’ technologies of discipline within systems whose purpose is to measure individual conduct against agreed norms. Examination holds ‘its subject in an ineluctable gaze. It thus transforms the ‘economy of visibility’ into the ‘exercise of power’’ (Foucault, 1977a, p. 190).

The examination functions as a model of disciplinary technology requiring the collection of detailed documentation of the status and progress of each subject. Complex assessment and evaluation processes are then put in place to measure the subject against a defined norm; much like the way a sample of tissue is brought under microscopic visibility, the examination refines the object of surveillance and situates it in an environment of illuminated contrast. These processes not only create specific subjectivities but allows the subject to be compared with others as a way of calculating the gaps between individuals. Each individual becomes a ‘case’ that demands scrutiny;

The case in many ways forms the quintessence of disciplinary practices, in that it is the point of intersection between power/knowledge, it simultaneously constitutes its object as a branch of knowledge and also as a branch of power (Nettleton, 1992, p. 120).

As with all expressions of power/knowledge, the examination is always incomplete; always requiring refinement and sophistication, since there are always minute aspects of the observable phenomena, that elude the gaze of the examiner. The examination contributes more than any other technique, however, to the ideal of a regulated, disciplined body, and the examination is the most effective site for the operation of surveillance and ‘forms the central site for the functioning of power/knowledge’ (C. Gordon, 1980, p. 156).

The examination is ‘a machine in which everyone is caught, those who exercise a power just as much as those over whom it is exercised’ (Hindess, 1996, p. 100). Thus, in a Foucauldian sense, to expose a system of examination demands that I pay attention, in this thesis, to a wide variety of tactics designed to maximise the effectiveness of disciplinary technologies. Thus I have explored various curricula, examination systems, surveys, tests, measures, observable capacities, systems of screening, regulations and systems of surveillance, monitors of progress and attainment, modes of assessment, check-lists and outcome measures. These have been explored as a way of analysing how physiotherapists have established monads of contact, where examination systems interact with other disciplinary technologies, that are themselves designed to maximise the ‘effectiveness’ of the physiotherapists, and make them subject to particular disciplinary technologies.
These various disciplinary technologies connect matrices of power effects and the forms of knowledge that they produce, with governmental interests in maximising the health, wealth and happiness of the population. Characteristically for a Foucauldian approach to these systems, we can say that they are often productive – not least because they create individuality and subjectivity;

Foucault’s analysis of the disciplines shows how a way of speaking the truth of individuals was conditional upon practices that contributed to a significant increase in their real capacity to transform and produce things, acquire skills, develop forms of conduct or ways of acting, and so on. But it also shows how this was at the same time at the cost of an intensified and more efficient hold of power on their bodies and actions, of an intensification of relations of domination at the level of their individual existence (Rose, 1999, p. 279).

Foucault saw that governmental attempts to control the conduct of citizens would always be failed projects (Foucault, 1977a). Foucault’s analysis of power asserts that it can never be absolute or total – since this would imply that the object of discipline had no choice but to obey, and Foucault vehemently rejected this hegemonic notion of power (Foucault, 1977a). Instead, he argued, every instrumental act of power is accompanied by the possibility of acting against the way the instrument seeks to direct people; that with every restatement of power, there emerge new ways in which the power can be resisted or subverted. Thus, every novel instrument employed as a disciplinary technology introduces new ways in which our subjectivity can be fashioned. In this study, therefore, I must not only analyse the application of various disciplinary technologies, but also the forms of resistance that they make possible, in order to understand something of physiotherapists’ subjectivity. My focus, therefore, turns to the Foucauldian notion of resistance, as the final analytic device I will be using in this thesis, and to considering how this forms an important feature of my analysis of the profession.

**Resistance**

Foucault’s notion of power is prefaced on the belief that ‘where there is no possibility of resistance there can be no relation of power’ (Hindess, 1996, p. 101). By this, I understand Hindess to mean that it is the ability to achieve one’s ends without resorting to violence or force that best explains the operation of power in modern society;

To insist, as Foucault does, that the exercise of power requires a degree of freedom on the part of its subjects is to say, first, that the effective exercise of power need not imply the removal of liberty. On the contrary, in Foucault’s view, where this is no possibility of resistance there can be no relations of power. It follows that the exercise of power will normally be at risk from the recalcitrance of its subjects: it will always involve costs and its outcome will often be far from certain. Resistance, evasion and the costs of dealing with them may provoke refinement or
modification of the techniques of power – and these, in turn, will provide conditions under which new forms of resistance and evasion may be developed (Rose, 1997, p. 35).

An understanding of resistance as the ‘opposition to a particular regime for the conduct of one’s conduct’ (Rose, 1997, p. 35) assumes a particular view of our subjectivity; one that is not based on a ‘coherent regime of some government that produces persons in the form in which it dreams’ (Rose, 1999, p. 279); i.e., not in monolithic, immovable terms; but rather as the result of multiple, contesting discourses – lives that are in constant movement; shifting subjectivities under the influence of host of discursive forces, each of which presupposes our uniquely individual responses to changing circumstance.

Foucault argued that resistance functions most effectively when it is directed ‘locally’ towards the techniques and material effects of power closest to us, rather than being directed towards a vaguely abstract notion of power in general (Foucault, 1982). This implies that one may expose acts of resistance where new knowledges are being created – particularly at the points of tension and rupture – at the locations where new surfaces or emergence appear. As Hunt and Wickham state;

Resistance is a technical component of governance, a component heavily involved in the fact that governance is always subject to politics. Resistance is part of the fact that power can only ever make a social machinery run imperfectly or incompletely…In Foucault’s words, resistance is the ‘counter-stroke’ to power, a metaphor with strong technical, machine-like connotations. Power and resistance are together the governance machine of society, but only in the sense that together they contribute to the truism that ‘things never quite work’ (Hunt & Wickham, 1994, p. 83).

Foucault argued that it is the ‘strategic codification of points of common resistance’ (McHoul & Grace, 1993, p. 86) that make radical change possible. It follows, therefore, that resistance may assume a relationship not only to the present exercise of power, but also to events that have framed one’s subjectivity in the past. Thus, methodologically speaking, resistance must be analysed locally, at points of rupture and tension, and with reference to the historical conditions that made the present modes of resistance possible (Hoy, 2004).

In this thesis, the concept of resistance plays an important part of my analysis, particularly in Chapter Six where I explore the emergence of Breathing Works as a possible mechanism of resistance directed towards some of the discourses and disciplinary technologies developed by earlier physiotherapists. I view Breathing Works as a surface of emergence for new rationalities and knowledges about physiotherapy, and, therefore, an
event that creates the conditions of possibility through which physiotherapists can explore new subjectivities.

In Chapter One I asked; ‘How might the surface of emergence of new practices at the margins of orthodoxy create the possibility of new physiotherapy subjectivities that resist established subject positions?’ Because I believe resistance, and its relationship with power and the construction of knowledge; its historical and governmental reference points; and its connection with discourse and the production of truth, become a critical focal point for this thesis.

Having explored the main theoretical foci for my thesis, I now move on to consider the methodological approaches that I have adopted from Foucault’s toolbox in conducting the study. These approaches are based on a number of methodological imperatives, principles and rules that Foucault constructed in a number of conceptual texts (notably, Foucault, 1970, 1972, 1981a, 1981b), but also in Foucault’s substantive writings already mentioned (Foucault, 1973, 1977a, 1979a, 1979c). It should also be noted that I have drawn on the writings of a number of authors who have sought to interpret Foucault’s methodological tensions. But even here, there is a great deal of disagreement over the most suitable way to interpret Foucault’s writings. I have chosen to follow the guidance set down by Derek Hook, Sarah Nettleton, James Ransom, Nikolas Rose and Maria Tamboukou, who all take a strong view of the drift towards linguistics and semiotics that can often appear in the works that interpret Foucault’s writings (Hook, 2001a, 2001b; Nettleton, 1992; Ransom, 1997; Rose, 1997, 1999; Tamboukou, 1999). The approaches they advocate are set down in the following section.

**Applying Foucauldian discourse analysis to the discursive construction of physiotherapy**

Just as it is possible to draw upon Foucault’s toolbox of writings for ways to approach one’s texts theoretically, so it is possible to draw on Foucault’s works for methodological guidance. Foucault outlined rules to guide the interrogation of statements and discourses (the archaeological rules of formation, correlation and transformation, discussed earlier); a number of methodological priorities; and a range of methodological precautions and limitations. These various principles were promoted by Foucault as an approach that retained the necessary flexibility, whilst being clear enough in their intent to ensure that the researcher did not lead their research in the direction of structuralism (by analysing power only as domination or oppression), hermeneutics (by valorising the primacy of the author), or historiography (by pursuing historical truths and progressive
notions of history). Having already addressed Foucault’s primary archaeological principles, I move on now to consider the ‘cautionary prescriptions’ that Foucault articulated in some of his later writing (particularly Foucault, 1979c, 1981b) as a guide to the genealogical analysis of power/knowledge, technologies of discipline and governmentality.

The methodological basis of genealogical analysis applied to this study

In The Order of Discourse, Foucault articulated four methodological ‘injunctions’ that helped address the nature of genealogical inquiry (Foucault, 1981b). These injunctions were concerned with regulating one’s analysis, so that one is placed in the best position to view the conditions that delimit discourses and bring about their circulation (Foucault, 1984d). Firstly, genealogical enquiry demands an attention to the historical context in which one’s study is situated (Hook, 2001a). Here the researcher takes on the role of ‘cartographer’ (Deleuze, 1992), mapping the study across a broad socio-political terrain. Secondly, the researcher must explore the social, historical and political conditions under which statements come to count as true or false (Hook, 2001a). How, for instance, are certain discourses valued and others not? Consequently discourses need to be explored not only as the effect of particular forms of knowledge, but also in their own right as the things that knowledge contests. Thirdly, the researcher must consider the materiality and conditions of possibility inherent within discursive formations (Hook, 2001a). In addition to studying discourses as objects in their own right, it is important to consider what discourses make possible; what practices and actions do they facilitate, for instance, and which do they foreclose? And finally, one must move in and out of the text using the extra-discursive to ‘drive the analysis of the discursive’ (Hook, 2001b, p. 543)⁶.

These methodological injunctions guide the development of genealogical analysis. These were supplemented by a range of broader principles that Foucault developed to ensure that relations of power, knowledge, discourse and subjectivication could also be approached genealogically (Rose, 1997). The first set of principles are encompassed by what Foucault called ‘systems of exclusion’, which explore those systems that seek to constrain what can be thought, directly through relations of power (Hook, 2001a).

---

⁶ By ‘extra-discursive’ Hook is referring to the material practices and actions that result from the formation, correlation and transformation of discourses, rather than suggesting that there is anything necessarily ‘beyond’ discourse. Foucault himself, used the notion of a dispositif to express this point; a dispositif is a system of relations that can be established between heterogeneous elements, discursive and non-discursive practices; ‘the said as well as the unsaid’ (Foucault, 1980, p. 194).
Foucault’s systems of exclusion

Systems of exclusion function to define what can be thought, known, or said at a particular time (Foucault, 1972). Foucault constructed three main forms of exclusion; internal, external and philosophical. Internal systems of exclusion concern our belief that we are the instigators of new knowledge, rather than the effect of the recirculation of older, primary discursive constructions – particularly those pertaining to religious, scientific or juridical matrices of power. This belief in our originality has led to us overstating the importance of the author of this newfound knowledge (Foucault, 1972). Foucault actively pursued an alternative view of the author function by reversing the nature of the question: rather than asking what discursive formations the author imbues, he asked how is the author formed and transformed as a consequence of the actions of discourses (Foucault, 1972)?

External systems of exclusion include all overt attempts to prohibit certain ways of thinking (often through the suppression of ideas and ways of speaking). These include the binary differentiations between what is considered reasoned and what is unreasoned or madness; and the differentiation between what is truthful and what is false (Foucault, 1972). These systems function as effective mechanisms of differentiation that enable us to normalise certain ways of thinking, speaking and being, whilst marginalising others. What comes to count as practically truthful, just as what comes to count as practically reasonable within a political system, is less about pure knowledge or truth, and more about the function of truth as a constantly mutating, fluid expression of an array of power effects (Foucault, 1972). Foucault emphasised that the analysis of these systems represents his unrelenting scepticism towards the ‘material conditions of possibility…the multiple institutional supports and various social structures and practices underlying the production of truth’ (Jessop, 2006, p. 3), or as Jessop recently argued;

The study of power should begin from below, in the heterogeneous and dispersed micro-physics of power, explore specific forms of its exercise in different institutional sites, and consider how, if at all, these were linked to produce broader and more persistent societal configurations. One should study power where it is exercised over individuals rather than legitimated at the centre; explore the actual practices of subjugation rather than the intentions that guide attempts at domination; and recognize that power circulates through networks rather than being applied at particular points (Jessop, 2006, p. 36).

The third system Foucault called the philosophical systems of exclusion (Foucault, 1972). This concerns the ways in which power effects are effectively concealed behind

---

7 By author, Foucault is referring to the author of a particular statement, discourse or text rather than the author of this research document.
idealised notions of truth or ‘universal logos’. Foucault was concerned with how these various forms of exclusion collude to create an idealised notion of truth within western society. In doing so these systems effectively conceal the power effects of discourse which comes to ‘occupy only the smallest possible space between thought and speech’ (Tamboukou, 1999, p. 209). Power effects become invisible behind an array of rules, rituals, systems and procedures that then project truth as taken-for-granted or obvious, implying that truth is stable and immutable (Hook, 2001a). The effect is to obscure from view the operations of power. Foucault’s interest was therefore directed towards destabilising the taken-for-grantedness of truth claims; exposing the matrices of power effects at the material level where discursive and extra-discursive practices appear to present a uniform, uncontested face (Foucault, 1972).

These systems of exclusion have important implications for this study, because they focus on the conditions that constrain how statements construct physiotherapists’ subjectivity. By exposing these systems to scrutiny, they are problematised, and it becomes easier to see how they constrain how physiotherapists can legitimately think and act. They also allow me to explore the kinds of knowledge about physiotherapy practice that are valorised and those that are marginalised. I have used these principles to scrutinise the ways in which physiotherapists have sought to colonise particular ways of speaking about their practice, in order that it is afforded legitimacy and orthodoxy; and I have exposed the power effects that were previously concealed beneath the mass of technical operations, disciplinary technologies and material practices of physiotherapists. These issues are addressed in more detail in Chapters Four, Five and Six.

The second set of principles designed by Foucault to ensure that relations of power, knowledge, discourse and subjectivication could be approached genealogically, are grouped here under the moniker of ‘methodological principles’. These address the relationship between discourse and power and guide the researcher to analyse the material conditions of possibility, and the power effects that govern the operation of discourses in the construction of physiotherapy subjectivities.

The rule of immanence

The rule of immanence reminds us that power operates as a microscopic/local network that enmeshes people rather than being exercised over them (Hook, 2001b). The focus for analytic enquiry should therefore be the local centres of operation of power; the places where objects are defined, subject positions negotiated and concepts and strategies are exercised (Foucault, 1979c). In this study, the focus has been upon the local
construction of knowledge about legitimate massage practice through a range of disciplinary strategies (Chapter Four), the practices that defined orthodox physiotherapy in the enclosure of the medical ward (Chapter Five), and the modes of resistance exercised at the Breathing Works clinic (Chapter Six).

The rule of continual variation

This rule emphasises the importance of resisting the tendency to analyse power and knowledge as static entities (Hook, 2001b). Foucault’s assertion was that power/knowledge and the subjectivities that ensued can never be seen as static (Foucault, 1979c). My focus in this study has been on capturing the moment at which particular operations of power/knowledge have made certain physiotherapy subjectivities possible. The emphasis is upon ‘matrices of transformation’, rather than who has power and who does not.

The rule of double conditioning

Here, my focus is upon the relationship between local material practices of physiotherapists and their connection with more ‘global’ questions, such as changing health priorities and public attitudes towards orthodox health professionals. Foucauldian approaches commonly emphasise ‘ascending’ analyses of power rather than the downward flow of power from above (Hook, 2001b). Thus, analyses often begin with local material practices, but seek to connect these practices with broader governmental concerns.

The rule of tactical polyvalence of discourse

This rule encourages the researcher to consider the possibility that discourses may occupy a number of different positions for practitioners that extend beyond the simple binaries of enabling and constraining, dominating and dominated (Foucault, 1972, 1977a). Instead, Foucault argues that ‘a multiplicity of discursive elements come into play in various strategies’ (Foucault, 1979c, p. 100). In analysing the various subjectivities utilised by physiotherapists, for example, I have rejected the idea that these are in any way totalising; accepting only that they explain a limited number of relations of power and discursive formations, since as Foucault argues; ‘there can exist different and even contradictory discourses within the same strategy and they can, on the contrary, circulate without changing their form from one strategy to another, opposing strategy’ (Foucault, 1979c, p. 102).
Having offered an overview of some of the genealogical rules that Foucault articulated as part of his methodological priorities, I now turn to three important methodological principals for the analysis of discursive formations. These are the principals of reversibility, discontinuity and specificity.

The principal of reversibility

Foucault’s principal of reversibility encourages us to change the way we view the relationship between discourses and power. Foucault argues that we should look for the ‘numberless beginnings’ of particular events (Tamboukou, 1999), rather than consider that our present originated from one primary source. Here, power is not the result of this process, but rather the force that defines how discourses operate; ‘our present is not theorised as the result of a meaningful development, but rather as an episode, a result of struggle and relations of force and domination’ (Foucault in Burchell, Gordon, & Miller, 1991, p. 77). In this way, discourses are seen as ‘events’ rather than the creative force from which we derive meaning. Critical histories of this sort therefore, reverse the relationship between power and discourse seen in other theoretical approaches. In Chapter Five, for example, I explore the material conditions of power associated with physiotherapists’ pursuit of orthodox status. Orthodoxy becomes the goal, and in the chapter I expose the political conditions of possibility that give orthodoxy meaning for physiotherapists. This act of reversal exposes the machinery of power to scrutiny, and reveals, for example, what is concealed in historical accounts of physiotherapy practice.

The principal of discontinuity

Foucault’s principal of discontinuity asserts that discourses should not be seen as trans-historical, unified or homogeneous (Hook, 2001b). Instead the work of the discourse analyst should be directed towards an awareness of the mobile, fragmentary and historically contingent nature of discourse. This approach troubles the idea that discourses possess any particular linearity or causality. It also encourages us to focus on discourses in series rather than in a linear, progressive form. The principal of discontinuity encourages us to take a broad, ‘horizontal’ view of text generation and analysis, rather than applying a more hermeneutic approach to the excavation of a deep, but relatively narrow field of enquiry. Hook argues that these hermeneutic forms of analysis risk reinforcing ‘exactly those forms of power that were initially being critiqued in the first place’ (Hook, 2001b, p. 63). Foucauldian discourse analysts, on the other hand, seek to ‘map discourse, to trace its
outline and its relations of force across a variety of discursive forms and objects’ (Hook, 2001b, p. 63). Or as Tamboukou describes it:

Instead of going deep, looking for origins and hidden meanings, the analyst is working on the surface, constructing ‘a polygon or rather a polyhedron’ (citing Foucault, in Burchell, Gordon, & Miller, 1991, p. 77) of various minor processes that surround the emergence of the event’ (Tamboukou, 1999, p. 208).

In Chapter Four, for example, this principal features in the breadth of data sampled to obtain a broad appreciation for the actions taken by the founders of the STM in establishing the legitimacy of physiotherapy practice. The same is true in Chapter Five and Six where the actions of distinct groups of physiotherapists are explored with the emphasis upon the mapping of power effects and discursive constructions rather than upon physiotherapists as the author or sole arbiters of truth (and thus exerting absolute power over what becomes possible discursively).

The principal of specificity

The third principal under consideration is the principal of specificity, which reinforces the importance of not placing too much emphasis upon the linguistic and representational power of language when conducting discourse analysis (Foucault, 1972). Derek Hook argues that Foucault’s work gains a ‘unique epistemological strength’ (Hook, 2001a, p. 59) when one considers the importance placed upon the discursive effects of the material, and the material effects of the discursive (Foucault, 1970). In undertaking a Foucauldian discourse analysis, we should place a great deal more emphasis upon the physical and material circumstances of discourse rather than a purely linguistic interpretation. Hook goes as far as to say here that these extra-discursive elements should be the main driving force for our discourse analysis, and in this way, we are less likely to slip into a narrow, linguistic analysis of our subject (Hook, 2001b).

Collectively, these methodological imperatives, principles and rules represent the guiding principles that govern the archaeological and genealogical analysis of the discursive construction of physiotherapy. In the final section of this chapter, I will bring these together to outline the practical schema I utilised to connect my methodological and theoretical approaches with the methods of text generation and analysis set out in Chapter Three.

Foucauldian discourse analysis

If one is thus attempting to engage critically with discourse, as Foucault understands it, then those forms of analysis based on the ‘turn of text’, that define discourse as ‘a system of statements that construct…an object’ (Parker, 1992, p. 5),
as ‘forms of spoken interaction…and written texts’ (Potter & Wetherell, 1987), that consider discourse to refer to a set of meanings, representations, images, stories and statements (Burr, 2001), will remain woefully limited in their attempts to apprehend discourse in the fullness of its capacity (Hook, 2001b, p. 5).

Having explored the various theoretical and methodological imperatives underpinning this thesis, I return finally to summarise my approach to Foucauldian discourse analysis. As I stated at the beginning of this chapter, Foucault’s methodological intentions are contained within a wide variety of texts, and are often hard to interpret. That being said, however, there has been a large body of work conducted in recent years to supplement Foucault’s original intentions, some of which has been more useful than others in constructing my own analytic framework. I would like to close this chapter, therefore, with a succinct summary of the principles I have followed in conducting my text generation and analysis. After this, I will move on to consider the practical aspects of my approach to the data that I used in this thesis.

First principle: Utilise a plurality of texts

‘Genealogy…requires patience and a knowledge of detail, and it depends on a vast accumulation of source material’ (Foucault, 1977b, p. 76)

In undertaking historical enquiry, Foucault argued that one should look to ‘map’ the terrain upon which knowledge was formulated; explore its contours, and locate its many ruptures, fissures, formations and transformations (Jessop, 2006). Foucault used geological metaphors to emphasise the importance of focusing, in the first instance, upon the ‘surface effects’ that brought about new knowledge (Foucault, 1972). Extending this metaphor, Foucault spoke of archaeological inquiry as a way of excavating beneath the surface of these emergent discourses (Foucault, 1972). In practical terms, this means using of a wide range of texts, spread over a broad horizon, made up of different textual materials, from a diversity of sources. Thus, in this thesis, I have drawn on texts from different countries, ranging over more than 110 years of physiotherapy history; including documents, interviews, observations and reflections. The documents alone include a diverse array of materials, including: first hand accounts, historical records, legislation, publicity materials, photographs, self-help guides and correspondence, and they concentrate on a number of critical events in the history of physiotherapy that represent, what might be called ‘ruptures’ on the surface of physiotherapy knowledge.

Second principle: Focus upon local, material practices

Rather than seeking the effects of discourses, knowledge and power in grand theories or ideologies, Foucault argued that one should locate and explore texts in the
locations where oppression, forms of discipline, regulations and constraints, binaries of separation, claims of originality and self-evident truths were present (Foucault, 1981a). As well as employing a plurality of texts, I have focused on the immanent events in the conduct of physiotherapists, as well as those records that document the conduct of physiotherapy in its immediacy. I have identified the locations where physiotherapy knowledge is produced at the places where power relations are enacted. I have sought out places where the material practices of physiotherapists are inscribed, documented or stated, and, most especially, I have concerned myself with the practices that seem taken-for-granted, as much as those that loudly proclaim their disciplinary tendencies.

**Third principle: Attend to the ruptures, fissures and tensions in the surface of discourses**

Foucault argued that rather than looking for continuities, which only reinforce our progressive image of history, we should explore the surface of emergence of new discursive forms by problematising tensions, emersions, fissures and ruptures in what might otherwise appear to be continuous discourses. Thus the choice of historical events made in this study was not based on the notion of physiotherapy as a smooth, unruffled surface – a linear history of progression towards enlightenment – but rather, an attempt to show how physiotherapy is contingent upon particular local discursivities; that it is discursively constructed.

The organising framework for this study is based on three historical ‘moments’ in the history of the physiotherapy. Each of these represents a significant surface of emergence in the practices of the profession, and the local, material practices that form the starting point for my analysis are used to provide clues to the tactics, strategies, instruments and effects that have made the ‘event’ known as physiotherapy possible.

**Fourth principle: Drive the discourse analysis with extra-discursive elements**

Foucault’s objections to linguistic, interpretative and historiographic analyses have been articulated throughout this chapter. Derek Hook, in his analysis of Foucault’s methodological approach, reinforced the importance of driving the generation and analysis of texts through their extra-discursive elements to avoid the mistake of placing too much emphasis upon the textual relativism (Hook, 2001a). According to Hook, Foucault is partly to blame for this tendency to misinterpret his own methodological intentions (Hook, 2003). Hook argues that Foucault sought to collapse the boundaries between textual/material divisions, and between discursive/extra-discursive; to complicate and problematise this artificial separation (Hook, 2001a). This has, however, led to some
authors seeing every action, operation, technique or strategy only in linguistic terms. Hook re-draws this distinction and encourages us to ‘substantiate critical textual assertions on the basis of materially-focused analyses, and vice versa’ (Hook, 2001a, p. 59). In this thesis, practical operations, material conditions, strategies and actions are analysed for their ability to provide clues to the material implications of power; some of which include the formation of discourses, the creation of knowledges, and the development of an array of disciplinary technologies, which all shift over time and act in relation to overarching governmental imperatives.

**In summary**

Having defined the purpose of my study to examine the discursive construction of physiotherapy, I have turned in this chapter to the theoretical and methodological bases for the study. I have given an overview of my main theoretical focus; namely governmentality, and within that an understanding of my conjoint approach towards archaeological and genealogical investigation. In unpacking the principles that I have used to guide these approaches, I set out how I have approached the issues of power, knowledge and discourse in the construction of physiotherapist’s subjectivities. The latter part of the chapter focused on the imperatives, principles and rules that guided my approach to Foucauldian discourse analysis. In the upcoming chapter, I outline how I sampled and generated texts for analysis, using these principles set out above as my guiding framework.
CHAPTER THREE – FROM METHODOLOGY TO METHODS

Introduction

In the opening two chapters of this text, I established that my purpose in conducting this research was to analyse the discursive construction of physiotherapy. I chose to scrutinise my data governmentally; focusing on the technologies of discipline, relations of power and forms of knowledge that defined physiotherapists’ subjectivity at three particular moments in the history of the profession. In exploring these particular theoretical questions, I chose to be guided by Foucault’s methodological imperatives, which emphasise the importance of attending to the local, material practices of physiotherapists; to a wide range of textual sources; and to the subjects, objects, strategies and concepts of physiotherapy conduct. In this chapter I will show how these various imperatives, principles and rules guided the way I sampled, generated and analysed the local texts that formed the basis for the analytic chapters that follow.

I begin the chapter discussing my text sampling strategy and consider how texts were sampled in to this study. Firstly, I reflect on how I constructed my sampling strategy, before considering the limits I placed on the texts that I utilised. From here, I begin the major section of the chapter by outlining the texts I utilised in each of the three historical moments. For each moment, I provide a descriptive summary of the texts that were utilised, before explaining how my sampling developed as my reading and analysis progressed. I follow this with an overview of the theoretical basis of my three main methods of text generation; documents, interviews and observations. Having established which texts I utilised in the study, I then set out how they were ‘read’ and analysed, before considering the ethical questions raised by the study. To begin with, I will detail the texts sampled for each of the historical moments.

How my sampling strategy was constructed

In Chapter One I rationalised my choice of three historical moments as the focal point for text generation and analysis in this study. Having made this choice, I took the first step towards placing limits on what could be explored in conducting my analysis of physiotherapists’ discursive formation. Between 2004 and 2006, I defined the boundaries of my study further; by reviewing and re-appraising those texts that were, to use Martin Heidegger’s term, ‘ready to hand’ (Heidegger, 1962); those texts that were being obscured and marginalised; and reflecting on those texts that simply did not exist.
In keeping with Foucault’s methodological imperatives, I wanted to make use of a broad range of texts, from a variety of different sources: historical accounts, personal correspondence, legislative acts, observed practices, promotional literature, etc.; and so, with every text, I oscillated between the new openings that they offered, and the need to delimit the scope of the study and foreclose certain questions. I faced this tension continually throughout the conduct of the study. For example, in dealing with my analysis of the emergence of legitimate massage that is detailed in Chapter Four, I was forced to debar those statements that spoke of the actions of the founders of the STM from a gendered perspective. Although I realised that these were substantive questions that warranted scrutiny, I was developing the thesis of my thesis; delimiting its scope; making firm decisions about what I felt made a coherent argument, and what deserved considered opinion elsewhere.

The sampling that I undertook in this study was therefore more than merely an exercise in grouping together comparable texts. The process of text sampling was pivotal in guiding the process through which I unwrapped my thesis. The texts that were chosen were done so partly because I had an intuitive sense of their value to the study (even though I was sometimes slow to realise it). Otherwise they were chosen because, in their reading, I gained some new insight into the possibilities they offered my analysis. In every case, my thesis – in both the sense of it being an argument and also a substantive body of work – grew from the texts I sampled. It could be said then that the sampling of my texts formed and transformed the discursive construction of my thesis.

Placing limits on my texts

By the time I had made the decision that the thesis would focus upon three historical moments, I had already decided that I wanted to explore the discursive construction of physiotherapy governmentally. Given that I was drawn to my research question through my experiences working with Breathing Works, it seemed reasonable to explore the actions of the clinic’s physiotherapists, and use this as an exemplar for practices at the margins of physiotherapy’s orthodoxy. I sensed Breathing Works’ practices were unorthodox because I myself had trained as a respiratory physiotherapist, and recognised how radically different their practices were to those I was familiar with. The second moment I selected was therefore one that explored how this orthodoxy had become possible (rather than particularly what orthodox practice was; which would have leant itself more to an ethnographic study of physiotherapy practices). I wanted to explore orthodox respiratory physiotherapy practices in a New Zealand context, because I believed
this was the reference point from which Breathing Works had been extrapolated. This led me to study the decade immediately prior to 1950 when enormous change took place within the physiotherapy profession in New Zealand. Most importantly, at the time, the 1949 *Physiotherapy Act* gave the profession a secure legislative platform to accompany its consolidation within the public health system. From here, I felt I needed to unpack how physiotherapy’s orthodoxy had been made possible by the actions of (primarily British) masseuses. And so, a third historical moment emerged that explored how physiotherapy’s orthodoxy had been made possible. My focus became the actions of the founders of the first legitimate massage profession in England in 1894, and particularly what became known as the ‘massage scandals’. Once again, however, I was less concerned with the historical accounts of what the founders did, and more with what their actions made possible.

Naturally, I could have added other historical moments; the enactment of accident compensation legislation that shifted the profession from being a largely public sector-based practice, to being dominated by private musculo-skeletal providers; or the exploration of the practices of remedial gymnasts, electrotherapists and masseurs, who predated the formation of the STM. Both of these would have made valuable additions to my analysis. They did not become important focal points for the thesis, however, because they only played a peripheral role in the focus of the discourse analysis that is documented in the subsequent chapters.

My sampling strategy developed alongside my exploration of the data, and I moved continually between the texts themselves, my theoretical framework, and Foucault’s methodological imperatives. I came to realise that I had chosen three historical moments that shared some coherent discursive formations, and that also posed a relatively defined set of questions that could be explored governmentally. The interplay between the discourse of legitimacy explored in Chapter Four, and the development of orthodox physiotherapy in Chapter Five, was made more transparent by my decision to focus upon technologies of discipline, which led, in turn, to my exploration of Breathing Works as a form of resistance to these discourses. This emphasised the importance of power in the construction of particular knowledges about physiotherapy, and also allowed me to more adequately situate my analysis within a historical context. Statements that embodied the different forms of knowledge that were emerging became my focus for analysis which, in turn, fed back into my sampling strategy, and guided which texts to explore, and which to discard. Returning to the methodological approach I identified in Chapter Two, this
process made the various subject positions, objects, strategies and tactics more visible and more amenable to scrutiny, and in so doing, exposed the conditions that make it possible for these statements to become visible in the first place.

The analyses that developed from this process connected the various emerging discursive formations with shifting governmental imperatives. It was possible therefore to see how the actions of physiotherapists were not isolated historical facts, but contingent responses that connected physiotherapy with its social and political context. It was easy then to see how the actions of physiotherapists had become possible. My choice of three historical moments was therefore a decision that became refined through a process of testing, rationalising, re-engagement with the data, and a constant refinement of my thesis.

The texts that informed my analysis were sampled into the study if they fulfilled the following criteria:

1) The text problematised physiotherapy
2) The text pertained to the actions and practices of physiotherapists
3) The text could be associated either chronologically or thematically with one of the three historical moments
4) The text related to one or more of the discursive formations developing in the study
5) The text included statements that resonated with me as a reader, regardless of whether I understood their value to the study at the time

In organising my analysis into a format that would be advantageous to the reader, I decided to reverse the order that I had taken in establishing my three historical moments, and place them in chronological order. There are inherent risks in doing this; not least that I indicate to the reader that I am constructing a linear history, or ‘projecting backwards from the present the concepts that [my] analysis will ultimately reveal’ (Hook, 2001a, p. 533). Neither of these are my intention however. Instead, the organisation of this document balances the need to make a readable text with the need to ‘interrogate the present, to examine its values, discourses and understandings with recourse to the past as a resource of destabilizing critical knowledge’ (Hook, 2001a, pp. 533-534, original emphasis).

---

8 Of particular note are those texts that exposed a point of tension or rupture in the surface of the profession and, in so doing, made the subjects, objects, disciplinary strategies and concepts amenable to scrutiny.
9 In a few examples, texts were utilised that fell well outside the broad chronological period defined by each moment. In the case of the treatment of neurasthenia, for example, texts were utilised that predated the formation of the STM by nearly 40 years. The substance of the text though determined that it was proper to include within this moment (see Chapter Four).
10 ‘Relating to’ a discursive formation included those texts that offered statements in opposition to the emerging discourse – to negative cases as much as those that affirm the developing formation.
Having outlined how I placed limits on my texts, I now outline the rationale for text sampling employed in this study.

**Sampled texts**

In this section, I describe my rationale for sampling, generating and analysing the texts that were deployed in this study. This section has three distinct, yet inter-related components:

1) A brief description of the texts utilised, how they were sourced and some of the practical aspects of their sampling
2) A reflective account of the development of my sampling strategy that shows how my strategy developed in parallel with my reading and analysis of the texts
3) An overview of the theoretical basis for the three main ethnographic approaches to text generation utilised in this study. These are undertaken as close as possible to the relevant historical moment; therefore, the theory pertaining to sampling documents is dealt with after discussing the texts deployed in the first moment. Interviews and observations are addressed after the third.

There is a small amount of unavoidable repetition between the first and second parts of this section. This is necessary to maintain some continuity, and has been kept, wherever possible, to a minimum.

**Texts sampled for the first moment**

The texts sampled in exploring this moment derived from the actions of the Society of Trained Masseuses (STM) in England and their response to the massage scandals of 1894. The sampled texts were from a wide variety of sources including proceedings of meetings, personal correspondence, photographs, examination papers, scholarly articles, media reports, published manuscripts, historical records, and other assorted ephemera (including certificates, badges, uniform items, etc.). These texts were sourced either directly from an extended visit to the Wellcome Institute¹¹ in London during the summer of 2004, or subsequently through private collections and library archives.

The Wellcome Institute collection included works that related either directly or indirectly to the actions of the founders in setting up the STM, and my initial reading of the collection concentrated on filtering those texts that related either to the events surrounding the ‘massage scandal’, or the subsequent actions of the SMT’s members. Thus, a number of media reports pertaining to the massage scandals were analysed (Garner, 1895; Maltby,

---

¹¹ The Wellcome Institute has held the complete collection of texts from the records of the Chartered Society of Physiotherapy in England for over several years. Much of the work involved in collating the collection was conducted leading up the CSP’s centenary in 1994.
1895; Reynold's Weekly, 1894; South Wales Times, 1894; St. Paul's, 1894; The Morning, 1894a, 1894b; The Nursing Record, 1895; The People, 1894; The Star, 1894; Whitehall Review, 1894), alongside the original reports of the massage scandals published in the British Medical Journal (British Medical Journal, 1894a, 1894b, 1894c), (see Figure 1). Two historical accounts that provide historiographic records of the early years of the STM were also scrutinised: Jane Wicksteed’s history of the Society, published in 1948 to mark 50 years of the profession (Wicksteed, 1948), and Joan Barclay’s more substantial centenary commemoration, published in 1994 (Barclay, 1994). Both of these texts provided commentaries on the massage scandal and confirmation of the historical records available in the CSP’s collection.

I wanted to gain some insight into the massage practices that were in existence at the time of the formation of the STM, and so I also explored existing published manuscripts and massage texts produced for practitioners that were available at the time of the STM’s intervention (Creighton-Hale, 1893; D. Graham, 1884; Hyde, 1890; Nissen, 1889, 1905; Stretch Dowse, 1887; Symons Eccles, 1895). These texts, and an additional group of texts written by the founders of the Society of Trained Masseuses as guides for students studying the Society’s registration examination, were not available at the Wellcome Institute and had to be sourced separately (Despard, 1916; Ellison, 1898; Mennell, 1920; Palmer, 1901; Zander, 1918).

To situate the actions of the STM in a broader cultural and socio-political context, I sourced background material from the historical, socio-political, cultural and economic literature pertaining to the period, including cultural histories of late Victorian England (Bashford, 1998; Brimblecombe, 2003; Maxwell, 2000; L. S. May, 1998; Morus, 1999; Vicinus, 1977; Walkowitz, 1992), analyses of health care practice and public health medicine (Bashford, 1998; Behlmer, 1990; Corderoy, 1995; L. S. May, 1998; Tomes, 1997; Wainwright, 2003), texts on the changing roles for Victorian women (Vicinus, 1977; Walkowitz, 1977), and questions of Victorian sexuality and morality (Barry Smith, 1977; Hall, 1999; Mason, 1994; Trudgill, 1976; Urban, 2004).

How did my sampling strategy develop?

The first texts I read in relation to the actions of the STM, were the accounts of the massage scandal published by the BMJ and subsequently reported by the in the popular press. I was struck by how vehemently all of the texts promoted a moral outrage. In Figure 1, for example, the press report speaks of the ‘grossest immorality’ of those who engaged in licentious massage. These accounts were read closely and returned to
frequently as I began to explore the actions of the founders of the STM and, in many cases, it seems the founders acted directly upon the recommendations of the popular press (the suggestion in Figure 1, for instance, that women should only massage women, was a common recommendation).
Figure 1. Massage scandal report reprinted from the Evening News and Post, July 20th, 1894
From here, I began to ask what these various statements about immoral massage practice made possible, and my focus shifted to those texts that documented the actions and responses of the women who founded the STM. I read each relevant text with the question ‘how are these actions predicated on a concern for the moral conduct of massage?’ As I read the various texts, I began to see a number of discursive formations taking shape. These discourses began to cohere around a number of disciplinary technologies; the examination of students (and the curriculum that this imposed on massage tutors around the country); the creation of a professional body to regulate contact with patients; the disciplining of contact between males and females; the use of medical referrals as the only source of patient contact. Each of these technologies was based on the active and ongoing definition of legitimate massage; the normalisation of certain practices, attitudes and forms of knowledge, and the marginalisation of forms of touch associated with licentiousness, sensuality and pleasure. As Valerie Fournier writes in her account of the discursive construction of aromatherapy; the creation of orthodox medical practice in the late nineteenth century was prefaced on the notion of an ‘other’ – a binary opposite to orthodoxy, that was necessary for medicine to be able to distinguish itself from the quack and the charlatan (Fournier, 2002). Thus medicine created the notion of the quack and the charlatan – it did not exist before medicine needed it as a means to define its own orthodoxy. As I read the actions of the STM’s founders in legitimising morally-appropriate touch, I was sensitive to this same discursive strategy, and the deliberate creation of the licentious masseuse: the prostitute, the magdelena (Trudgill, 1976), the poor unfortunate ‘woman of fallen virtue’ as some reports called her (South Wales Times, 1894; The Morning, 1894a).

My focus then turned to the various subject positions that these disciplinary strategies created for ‘legitimate’ masseuses, and the objects, concepts and strategies that were deployed. I began to consider how touch, the contact between patient and masseuse, the treatment bed, the masseuse’s hands, her uniform, her demeanour, and her techniques, all became objects of scrutiny for the STM. And so my attention turned to those texts that differentiated legitimate forms of these objects by defining the ways in which they could be corrupted (BMJ, 1895; Ellison, 1898; Incorporated Society of Trained Masseuses, 1912; Musser & Kelly, 1911; Nissen, 1905; Palmer, 1901; Stretch Dowse, 1906; Symons Eccles, 1895). Most striking were the early manuscripts produced by members of the STM which acted as early curriculum texts (Ellison, 1898; Palmer, 1901); early examination scripts which conflated practical and technical questions with questions of the masseuse’s moral character (Incorporated Society of Trained Masseuses, 1911, 1914); and texts
pertaining to the ISTM’s dispute with rival organisations who were challenged on the basis of their credentials, but were forced to close because of their use of male models to train female masseuses (Incorporated Society of Trained Masseuses, 1894-1912, 1912).

As my appreciation for the disciplinary technologies employed by the Society grew, I began to ask questions about the epistemological basis of the massage training promoted by the STM. I came across repeated references to the training of anatomy, physiology and pathology that were striking, partly because I recognised the same emphasis in my own experience as a physiotherapist and educator. I began to ask questions about the seemingly purposeful attempt by the Society to conflate a particular approach towards the body with legitimate massage practice. It was clear from my reading that the STM was working assiduously to align itself with the medical profession (Barclay, 1994; Grafton, 1934b; Incorporated Society of Trained Masseuses, c. 1912), but this, in itself, did not adequately explain the vigour with which the STM promoted a biomechanical view of the body. I therefore focused on the types of knowledge that this view of the body constructed; the antecedent conditions that had made the adoption of this approach possible; and the subjectivities that resulted from these discourses.

The discursive construction of a biomechanical discourse and its relationship to the Society’s quest for legitimacy makes a major contribution to my analysis in Chapter Four. But, in itself, it is only one of a number of disciplinary strategies employed by the Society to establish its notion of legitimate touch, and I was keen to situate the emergence of the STM within a broader socio-political context. My reading for this moment therefore culminated in a broad analysis of texts that explored the cultural, economic, social and political context in which the STM emerged. My focus fell upon texts that explored the emergence of expert practitioners in health and welfare at the height of English liberal reforms (Barry, Rose, & Osborne, 1996; Burchell, 1993; Goodlad, 2003; P. Miller & Rose, 1990; Osborne, 1996); the developing role played by women in the caring professions (Bland, 2001; Brimblecombe, 2003; Brumber & Tomes, 1982; Donnison, 1977; Durbach, 2000; Hannam, 1997; Heap, 1995b; Jordan, 1999; A. Parry, 1995; A. Summers, 1988, 1998; Vicinus, 1985a, 1985b, 1977); and Victorian attitudes towards sexuality, intimate contact, touch, and physical activity (Barry Smith, 1977; Ehrenreich & English, 1978; Fields, 1999; Golden, 1992; Hall, 1999; Haney-Peritz, 1986; Kantola & Squires, 2004; McLaren & Kuh, 2004; Mewett, 2003; Miles, 1999; Morus, 1999; H. E. Roberts, 1977; Spitzack, 1987; Vertinsky, 1995; Walkowitz, 1977; K. Williams et al., 2004). These texts helped situate the actions of the STM in a broader governmental context.
Theorising documents as ethnographic texts

Written and photographic documents formed a large part of the texts I gathered within this study, and the entirety of the texts sampled for this moment. Documents are one of the most common texts employed by Foucauldian discourse analysts in researching health care, with researchers utilising a wide range of materials including health care records, health care policy documents and the professional and popular media (see, for example Gilbert, 2001; Nettleton, 1991; Petersen, 2003; M. Roberts, 2005). In those studies that adhere to a Foucauldian approach to discourse analysis, a wide variety of documents are scrutinised\(^{12}\). In addition, measures are taken to avoid reading the text purely as a linguistic expression of signifiers and the signified (Titscher, Meyer, Wodak, & Vetter, 2000). These measures were addressed largely in Chapter Two, but will be reprised towards the end of the chapter. In essence though, documents are deployed for their ability to provide text and context. Thus I approached each of the document used in this moment for its ability to provide clues to the relations of power, knowledge formations, disciplinary technologies and governmental rationalities interwoven in the discursive construction of physiotherapist’s subjectivity.

Text and context were interwoven in the reading of documents utilised in this study. Hence, when I read a new document for the first time, I approached it with questions directly about the text; ‘what is the scope of this document?’; ‘What forms of knowledge are being valorised, what is hidden?’ ‘How are subject positions described in the document?’ ‘What objects are made visible, which are silenced?’ etc. At the same time, I asked questions about the context in which this document operated and how the document made new contexts possible. I asked, for instance, ‘What relations of power are making it possible for this document to function discursively?’ ‘What disciplinary systems are functioning here?’ ‘What governmental rationalities are informing the knowledge/truths promoted and marginalised by this document?’ Prior explains this dual role for documents as follows;

…when documents are put forward for consideration they are usually approached in terms of their content rather than their status as ‘things’. That is, the focus is usually on the language contained in the document as a medium of thought and action. Yet…it is quite clear that each and every document stands in a dual relation to fields of action. Namely, as a receptacle (of instruments, commands, wishes,

\(^{12}\) The reader is referred back to Chapter Two where I cited Tamboukou, Burchell, Gordon and Miller who argued that ‘the analyst is working on the surface, constructing ‘a polygon or rather a polyhedron’ (citing Foucault, in Burchell, Gordon, & Miller, 1991, p. 77) of various minor processes that surround the emergence of the event’ (Tamboukou, 1999, p. 208).
reports, etc.), as an agent that is open to manipulation by others, and as an ally or resource to be mobilised for further action (Prior, 2004, p. 91).

One of the primary reasons for including a plurality of documents in one’s trawl of the available texts, is to make available negative cases – those that dispute, contradict or undermine assumptions that one might be making about the discursive constructions that may be emerging from the texts. As Derek Hook argues; ‘Discourse analysis should hence busy itself not merely with the search for a plenitude of meaning, but rather with a search for the scarcity of meaning, with what cannot be said, with what is impossible or unreasonable within a certain discursive locations’ (Hook, 2001a, p. 527). To search for negative cases does not have to involve the search for texts that refute one’s developing analysis however. In this study, there are any number of different ways in which one might interrogate the documents that I sampled. I have mentioned, for instance, that an analysis of the actions of the founders of the STM through a gendered lens would yield some interesting findings – not least because I make a great deal in the upcoming chapters of the importance of biomechanical discourses to the profession; discourses that are strongly associated with androcentricity, embodied by a profession made up largely of women. Negative cases that present different possibilities for discursive construction are important, therefore, not least because they allow the researcher to examine the boundaries of his/her thesis and establish the limits of their study.

In addition to sourcing written texts, a large volume of photographic material was also read. Most of the photographs analysed in this study were drawn from textbooks or historical records, and often presented a partial, yet deliberate scene. As such they provided rich material for analysis. Most of the images were staged ‘narratives’, used to represent, publicise or promote particular views about massage or physiotherapy practice (See Figure 2 below), in which ‘The person behind the camera is selective and biased towards information that may serve to illustrate a particular interpretation of a situation’ (Grbich, 1999, p. 137). Once again, the image can therefore be analysed as both text and context. It is possible to view the image as a narrative text – explaining, in the example below, the way to use suspended slings in passively extending the gleno-humeral joint; the use of symmetry; or the uniforms of the student masseuses. It is also possible to trouble the image’s narrative qualities and ask how was it possible for this image to be framed in this fashion in the first place? What discursive constructions are being promoted here? What subject/object positions does this image make possible? Similar questions were directed at each image that was scrutinised for the thesis. The images therefore provided valuable narratives of physiotherapist’s actions and practices, whilst also prompting us to
ask ‘how had these actions been made possible?’ And the task of the reader is to problematise what is being said as well as how it is being said.

Figure 2. Students demonstrating symmetrical exercises on plinth. Source: Wellcome Institute archive

The discursive analysis of photographic images exposes the narrative and contextual qualities of the image to scrutiny, and so it is possible to ‘read’ the image for its values, meanings, discursive possibilities, etc., in the same way as one reads a written document (Riley & Manias, 2003). In this study, I analysed images that were presented in a wide variety of physiotherapy texts. Most of these images were created by others. There were, however, a number of images created by me to record the practice environment at the Breathing Works clinic (see Figure 3 which shows the clinic's imposing reception desk and the adaptations that were made to the interior of the building to convert it from a domestic residence to a functioning clinic). These images served a number of purposes; they provided a narrative representation of what one might see if one visited the clinic; they show a particular perspective – the use of particular angles, light, etc. to frame the image – that helped me explore the discursive influences that informed my framing of the image; and further, in generating these images, I was able to explore the discourses that I was attempting to problematise in framing the images in certain ways. Thus, in taking this
picture and not another, I was able to reflect upon the discursive formations I was seeking to convey, and in doing so, problematise my own developing analysis, my own situation in relation to the image, and my role as physiotherapist and researcher. This latter issue became important when I considered how my analysis had been informed by my experiences, values, assumptions and beliefs. In considering, for example, the difficulties I faced in ‘write against myself’, the framing of particular images became an important way to problematise the phenomenology of my own experience and expose my innate assumptions to scrutiny.

Figure 3. One of a series of images taken of the interior of the Breathing Works clinic

The above figure shows the interior décor of the reception area at Breathing Works. To capture the image I needed to stand just inside the front doors of the building and take the photograph when the desk was temporarily cleared of people. When I examined the image later, I asked myself why I had taken that image and framed it in that way. I had wanted to illustrate the plush confidence of the clinic through its use of bold colour; the broad sweeping reception desk; the clinic’s deconstruction of what was once a domestic space; etc. I asked questions of the structures within the image; how, for instance did this create particular subjectivities for the client, the receptionist and the physiotherapists – each of which had different uses for, and different rights of access to the desk. I explored
the various objects within the image; the spot lights, pot plants, products placed on the reception desk; as promoting particular messages about the clinic. And I considered how these subjects and objects reflected disciplinary technologies that I had seen embodied in images of physiotherapists in other historical moments. These various analyses were then fed into my analysis of each of the moments and used to inform my writings.

**Texts sampled for the second moment**

The texts sampled for the second moment surround the establishment of orthodox physiotherapy within the New Zealand public health sector in the years immediately prior to the enactment of the 1949 *Physiotherapy Act*. The sampled texts were from an equally wide distribution as those sampled for the first moment and included a similar variety of source materials, including professional journal articles, minutes of meetings, correspondence, photographs, curricula and examination papers, published manuscripts, historical records, and assorted ephemera. These texts were sourced either directly from visits to the Hocken Library, the Otago Medical School, or the School of Physiotherapy, all of which are in Dunedin, New Zealand. These visits were conducted in May 2005 and a subsequent visit to the offices of the Physiotherapy Board in Wellington, New Zealand was conducted in February 2006.

The Hocken Library is the official repository of the New Zealand physiotherapy archive, but is much less well ordered than that of the Wellcome Institute in London. The collection was organised initially to assist Enid Anderson write her golden jubilee history of physiotherapy (Anderson, 1977), but little work has been done to organise the collection since and it is considerably more difficult to navigate. My focus, however, was upon the texts that pertained to the period leading up to the enactment of the *Physiotherapy Act* (Ministry of Health, 1949). These included reports from the Massage School (M. L. Roberts, 1938), examination papers (Masseurs Registration Board, 1940, 1941) minutes of meetings from the Masseurs Registration Board (Masseurs Registration Board, 1942, 1945, 1946, 1948, 1949), correspondence from divisions within the association (Wellington Provincial Masseurs Association, 1922) minutes and commentary from the New Zealand Trained Masseurs Association (McGrath, 1950; New Zealand Society of Physiotherapists, 1950a, 1950b; New Zealand Trained Masseurs Association, 1948, 1949), commentaries on the importance of the legislation pertaining to physiotherapy practice in New Zealand (Bremner Abel, 1950), and the acts of legislation themselves (Ministry of Health, 1920, 1949).
As with the first moment, I also sought to understand how massage practices in New Zealand related to practices elsewhere. What was striking was the degree to which New Zealand texts mirrored those in England. This was partly due to the large number of English masseuses who emigrated to New Zealand between 1900 and 1950 (Anderson, 1977). The insistence of the Dunedin Massage School that all its tutors train as massage and electrotherapy teachers under the CSMMG in England before taking up a teaching position in New Zealand, may also have influenced the uptake of English texts in New Zealand. These tutors would have exposed their students to the latest English massage practices and introduced them to a number of established English texts (Angove, 1936; Cash, 1951; Copestake, 1920; Despard, 1916; Jensen, 1932; McMillan, 1932; Mennell, 1920; Musser & Kelly, 1911; Prosser, 1943; Rawlins, 1930; Tidy, 1937). These texts appeared repeatedly in hospital physiotherapy departments and private collection during my trawl for manuscripts.

To situate the actions of New Zealand masseurs in the broader governmental context, I sourced background material from the period, focusing particularly on accounts of the emergence of welfare state reforms in New Zealand and elsewhere, and their impact on the delivery and organisation of health care (Belgrave, 1985; Bertilsson, 1990; Carter & Rayner, 1996; Cheyne, O'Brien, & Belgrave, 2005a, 2005b; Fitzgerald, 2004; Fitzsimons, 2000; Fougere, 2001; Goodlad, 2003; Haworth, 1945; Katavich, 1996; Kelsey, 1997; Labrum, 2000; Pierson, 1991; Rose, 1993; Sutch, 1966).

As my focus moved towards the construction of respiratory physiotherapy within the public health system, I also explored the literature pertaining to the practices of respiratory physiotherapists, and once again, I found the dominant influence of English masseuses upon practices in New Zealand (Angove, 1936; Askew, 1971; Cash, 1951; A. Donaldson & Gandevia, 1963; Glendenning, 1979; D. J. Gordon & Clague, 1958; Grant, 1975; Guthrie Smith, 1952; Hanan, 1970; Hawes, 1968; Johnsen, 1976; McKenzie & Glendenning, 1975; Prosser, 1943; Ritchie Russell, 1952; Ross, Gandevia, & Bolton, 1958; Simcock, 1964; Staff of Greenlane Hospital, 1968; Storey, 1958, 1959; Thompson, 1973; Thompson & Thompson, 1968; B. A. Webber, 1973; Wood, 1972; Wood & Nye, 1970).

How did my sampling strategy develop?

My initial trawl of the texts pertaining to the second moment was piecemeal because the various materials were widely distributed and poorly organised. Material pertaining to this period was considerably less well catalogued than that within the Wellcome Library and lay, where available, in only partially catalogued order. However,
unlike the material pertaining to the birth of the STM, there was more un-catalogued material in the collections of hospital physiotherapy departments and hospital libraries, and in people’s own private collections. This may have been due to the fact that the CSP in England had celebrated its centenary in 1994 and gone through an exhaustive process of gathering and cataloguing its resources. Whereas New Zealand physiotherapists celebrate their centenary in 2013 and, at the point of writing this thesis, have yet to go through the same process. Consequently, the process of text collation for this study extended over a longer period than had been the case with the texts held at the Wellcome Institute, and involved a more diverse set of investigative systems including word of mouth referral, Internet searching, notices in the Society’s newsletter, and at the biennia physiotherapy conference.

Interrogating the data that became available through these means, it became clear that many of the reforms taking place in New Zealand, in the years between the inception of a massage school in Dunedin in 1913 and the enactment of the Physiotherapy Act in 1949, mirrored changes taking place with the CSMMG in England. These synergies related to school curricula and systems of examination, professional regulations, the training of teachers, relationships with medicine, and the pursuit of state ‘recognition’. So striking were the parallels between the two countries that I briefly explored the historical accounts of physiotherapy systems in other developed countries (Bentley & Dunstan, 2006; Bowerbank, 2001, 2004; Cleather, 1995; Murphy, 1995) to see if the same discursive influences applied. Although there were many comparable events and actions; particularly those within the Commonwealth countries where the influence of the ‘English’ experience was strong, I was unable to find such synergies between any of the other major physiotherapy organisations that I explored. This immediately struck me as interesting, given that the two countries are on opposite sides of the world, and would have seemed even more distant in the early part of the twentieth century without the convenience of modern communication.

I concentrated my early reading, therefore, on the linkage between the developing systems of regulation, curriculum and examination in New Zealand and England, and considered the conditions of possibility that these ‘shared’ discourses created. What was clear was that the ‘English’ system was being adopted almost wholesale in New Zealand, indeed one might even say that the CSMMG’s disciplinary technologies were almost ‘transplanted’ into a New Zealand context. In exploring these connections, my focus fell upon the practical arrangements that maintained strong connections between New Zealand
masseurs and their counterparts in England. These included the adoption of the STM’s systems and operations; the extensive use of English massage texts by New Zealand masseuses; and the stipulation that all teachers at the Dunedin School should train as massage and electrotherapy teachers in England before teaching at the Dunedin School.

By interrogating the various practices of masseuses in both countries, it was possible to see how readily the STM’s quest for legitimacy translated to New Zealand. In many ways it was possible to see the same disciplinary strategies, forms of knowledge, and relations of power (particularly between the masseurs and the medical professionals) enacted out in New Zealand as in England. There was, however, a subtle shift in the statements that emerged in New Zealand texts after World War One. Texts began to focus less on the practice of women massaging men, and spoke instead of the need for professional recognition; they began to question the dominance of the medical profession in the early, pre-clinical teaching of massage students, and began talking more of autonomy; and they began to speak less of massage, and more of physiotherapy.

These issues then began to guide my reading, and while many of the texts focused upon relatively mundane matters of curriculum planning, complaints from registered members, and the financial support for the NZTMA’s newsletter, there was a growing interest in how the profession might best align itself with the welfare state. These ‘threads’ of statements began to cohere around a small number of discursive formations that would ultimately result in the overarching discourse of orthodoxy presented in Chapter Five.

The statements that linked the masseurs’ practice with broader governmental imperatives were rarely overt; indeed, in many respects, they were hardly visible at all on my first reading of the texts. Their presence was very noticeable, however, when I began to bring together statements and consider the forms of knowledge that were being constructed, and the subject positions these created for the New Zealand masseurs. Thus, I initially read the arguments put forward by the Society for its own profession-specific legislation in the decade prior to the 1949 Physiotherapy Act, as an attempt to gain some autonomy from the medical profession and wrest some control over the conduct of the profession’s own affairs. Reading this in the context of the broader economic, political and social reforms taking place in New Zealand following the 1935 election – which introduced many of the social welfare reforms adopted in other countries in the middle of the twentieth century (Fitzsimons, 2000) – I began to read the actions of the masseurs as an attempt to take advantage of the opportunities offered by the welfarist reform; especially those offered to health professions that had already established their legitimacy.
Consequently, my interest moved from historical accounts of policy decisions, curricula and massage practices, to the emerging discourses of orthodoxy that culminated in the enactment of the 1949 *Physiotherapy Act*.

My ‘paradigm case’ for this discursive drive towards orthodox status was the emergence of respiratory physiotherapy as a discreet professional sub-specialty. I was drawn to the conditions that had made this surface of emergence possible. I was interested in the historical conditions of emergence of respiratory physiotherapy, and the particular choices made by the physiotherapists that established the professional sub-specialty. Of these, the move into the medical ward; the acceptance of its various disciplinary regimes and environments; the enforced relations of power between the nurses, doctors, physiotherapists and patients; the consolidation of the profession’s biomechanical focus around the problem of organic lung disease; and those aspects of practice that these disciplines valorised, were all important focal points for my trawl of the literature.

I found the practices of therapists documented in textbooks designed to instruct practitioners in the appropriate assessment and treatment of respiratory diseases instructive (Angove, 1936; Bott, 2000; D. J. Gordon & Clague, 1958; Guthrie Smith, 1952; Krusen, 1942; Ritchie Russell, 1952; Ross, Gandevia, & Bolton, 1958; Storey, 1958, 1959; Tidy, 1937; Ward & Helmholz, 1997). These texts gave me the critical purchase to examine how the pursuit of orthodox status had informed the actions of respiratory physiotherapists. I considered the historical conditions that had helped establish the sub-specialty: the field injuries of WWI; the epidemics of polio, tuberculosis and influenza; the discovery of penicillin; and the development of anaesthetic and surgical techniques that made thoracic surgery possible; focusing on the practices of the physiotherapists themselves as they engaged in their practice within the enclosure of the medical ward. The medical ward itself became a focus for my analysis of the various disciplinary technologies employed, and some consideration was given to its structure and working arrangement (Armstrong, 1995, 2002; Innocenti, 1996; Ward & Helmholz, 1997; West, 2004). The texts I explored focused on how it had become possible for respiratory physiotherapists to established themselves as a necessary technology of the medical ward whilst at the same time addressing the profession’s desire for orthodoxy, and by the middle of the twentieth century, establishing the discipline as one of the largest sub-specialties within physiotherapy (Barclay, 1994; Billings, 1979).

Texts sampled for the third moment
Sampling for this moment involved a somewhat more diverse strategy than had been employed in the previous two historical moments. In addition to a profusion of documents pertaining to the Breathing Works clinic, including media reports, press releases and book reviews (for example, L. Donaldson, 1999; Doyle, 1999; Du Chateau, 1999; Griffin-Wilson, 2002; She Magazine, 2000; Tolerton, 1999); self-help guides and publications directed at practitioners produced by the two founders of the clinic (Bartley & Clifton-Smith, 2006; Bradley, 1992, 1998, 1999, 2002a, 2002b; Bradley & Clifton-Smith, 2004, 2005; Bradley, Gracewood, & Henley, 2001; Bradley & Lum, 2001; Chaitow, Bradley, & Gilbert, 2002; Clifton-Smith, 1999, 2002); I was able to generate texts from interviews with the Breathing Works staff, observations of their practices, and photographic images of the clinic.

As I read the literature produced by, and about Breathing Works, I reflected on my own experience both as a respiratory physiotherapist and as someone who had earlier worked at the clinic. I utilised these reflections as the basis of a set of questions I posed about the function of the clinic, which were incorporated into the field notes I used when I subsequently interviewed the staff at the clinic and observed their practices (see Table 1). These observations and reflections became important both in the analysis of the practices of the physiotherapists at Breathing Works, but also as a way of reflecting upon the practices of masseurs in the previous two moments.

Table 1. Details of interviewees

<table>
<thead>
<tr>
<th>Participant</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tania Clifton-Smith</td>
<td>Co-founder of Breathing Works in 1999. Written and presented extensively for professionals and public.</td>
</tr>
<tr>
<td>Erin</td>
<td>Part-time clinician at Breathing Works.</td>
</tr>
<tr>
<td>Denise</td>
<td>Part-time clinician at Breathing Works.</td>
</tr>
<tr>
<td>Julie</td>
<td>Clinician specialising in the treatment of BPDs at large regional centre in North Island of New Zealand. Previously worked for just over one year in Auckland founding a specialist clinic which briefly rivalled Breathing Works but has since ceased operation.</td>
</tr>
<tr>
<td>Fiona</td>
<td>Clinical specialist at large regional centre in North Island of New Zealand. Works periodically with patients with BPDs but specialised in the management of chronic lung diseases.</td>
</tr>
<tr>
<td>Angela</td>
<td>Clinical specialist at one of Auckland’s largest hospitals. Treats patients with BPD periodically, specialises in pulmonary rehabilitation and the treatment of chronic obstructive pulmonary diseases.</td>
</tr>
</tbody>
</table>
To gain some critical purchase for my reflections on the differences between the approach to respiratory physiotherapy offered by Breathing Works, and that which predominated in orthodox respiratory physiotherapy, I juxtaposed the literature pertaining to the clinic, with existing, large circulation texts that discuss the contemporary role of respiratory physiotherapy (Bott, 2000; Bott & Singh, 1998; Enright, 2003; Holloway & Ram, 2005; Hough, 2001; Pryor & Prasad, 2002). These were supplemented by texts that evaluated the changing face of respiratory physiotherapy in the twenty-first century (Bott, 2000; Roskell, 2002; Roskell & Cross, 2001, 2003). In addition, I also sought out texts concerned with the management of breathing pattern problems, written by physiotherapists with no allegiance to Breathing Works, to see if they shared the same approach to the assessment, treatment and organisation of their practice (Emtner, Hedin, & Stalenheim, 1998; Holloway & Ram, 2005; Hough, 2001; Innocenti, 1996, 1998), and further, to those texts that spoke about the management of breathing pattern problems from the perspective of medicine and psychology (Bass, 2000; Gardner, 1996; Gardner & Bass, 1989; Lum, 1977).

While there were many similarities in the definition, assessment and management of the breathing problems in these texts, I was unable to find any discussion of the possibilities these practices held for extending the boundaries of professional practice and opening up new opportunities to market these technologies in the community, in the way that Breathing Works had explored. To understand the conditions that had made Breathing Works' actions possible, I turned to the writings of Andrew Barry, Nikolas Rose, Mitchell Dean, Wendy Larner, Thomas Osborne, Alan Petersen and other, who have offered commentaries in recent years on the emergence of neo-liberal rationalities in health care (Barry, Rose, & Osborne, 1996; Clarke & James, 2003; Dean, 2002; Fusco, 2006; Galvin, 2002; Larner, 2000, 2005; Osborne, 1993; Petersen, 1996; Petersen & Lupton, 1996; Rose, 1996, 1997).

These texts provided insights into the changing marketplace for health care commodities (Frank, 2002; Henderson & Petersen, 2002; Irvine, 2002; Seale, Cavers, & Dixon-Woods, 2006), but did not explore how Breathing Works might be engaging in these shifts, and what they might mean for their changing subjectivities as physiotherapists operating at the margins of orthodox practice. To explore this question in more detail I returned to my reflections on my experiences as a respiratory physiotherapist, lecturer, researcher and practitioner at Breathing Works and looked to the literature to provide some
guidance on the changing roles for health professions (Evetts, 2003, 2006; Evetts & Dingwall, 2002; Fournier, 1999; Kuhlmann, 2004; Larson, 2005; Light, 2000, 2001; Nancarrow & Borthwick, 2005; Riske, 2005), focusing particularly on the effect of governmental reform on the possibilities for resistance, or ‘countervailing power’ as Donald Light calls it (Light, 2000). These texts brought me back to the conditions that had made physiotherapy possible in the first place, and my analyses of the historical conditions of possibility for orthodox and legitimate physiotherapy that had provided the discursive formations that Breathing Works was now testing.

How did my sampling strategy develop?

As with the second moment, I gathered and read the various texts that pertained to Breathing Works alongside my reading of texts from the other two moments, so that I was able to maintain a fluid interplay between them and use one set of emerging discursive constructions as a way of bringing clarity to another. At times this process was chaotic and difficult to manage, but as my discursive formations began to emerge, I found it much easier to contextualise the contrasting subject positions, objects, concepts and strategies being presented than might have been possible otherwise.

In reviewing the texts that I generated from my initial observations, interviews, reflections and readings, it became increasingly clear that the physiotherapists at Breathing Works were promoting discourses of resistance towards many of the disciplinary technologies that had been instrumental in establishing the profession’s legitimacy and orthodoxy. Frequently statements that were embodied by these discourses of resistance were directed at the actions of physiotherapists themselves, their practice environments, their approach to assessment and treatment, and their relationships and alliances. And yet, in many of these statements, the notions of legitimacy and orthodoxy still remained; in the relationship between Breathing Works and the medical profession; with biomechanical discourses; with systems of examination and registration; with recognised physiotherapy curricula and organisational practices. What I found, however, was a desire to trouble the practices and explore the possibility of operating otherwise.

Many of the discourses of resistance promoted by the clinic were directed towards the disciplines, systems, operations, strategies and tactics of the medical ward. I began exploring this by analysing the differences between the utilitarian, disciplined environment of the medical ward, and the boutique practice environment at Breathing Works. This analysis led me to consider how these environments valorised certain practices. I explored these drawing on methods of photographic ethnography (Harper, 2003; Riley & Manias,
using this data to construct statements about the subject positions, objects, strategies and concepts embodied by the various spaces. I explored the various statements made about the nature of the practices at Breathing Works through the use of particular environmental objects; large pot plants, domestic wooden furniture, soft décor; and through practices designed to distance the clinic from the biomedical; concealing biomedical assessment and treatment equipment within the clinic space and down-playing the clinic’s association with orthodox physiotherapy. These were approached as contingent responses to disciplines embodied by the medical ward and statements of the clinic’s attempt to subvert its technologies.

A primary example of this resistance came when I focused on the clinic’s particular approach to their treatment bed. I was struck by how different the bed appeared from that which I was used to in physiotherapy departments and clinics in orthodox physiotherapy. Unlike the beds familiar to earlier physiotherapists and masseuse that were deliberately austere, the beds at Breathing Works made some concession to the need to be a relaxed place for their clients. They were draped to conceal their workings, they were placed away from the centre of the room, and they were well lit with natural light from large bay windows. The importance of these statements about the bed’s form and function, and the role physiotherapists played in constructing their subjectivity and the subjectivity of their clients in relation to it, did not become clear to me until I interviewed one of the staff at the clinic and she betrayed some reservations about the status of the clinic’s beds/plinths/couches: What to call them; how to use them; how to situate them within the room; and how to negotiate touching patients now that the obvious discourses of legitimacy and orthodoxy had been destabilised.

The tensions that arose with the clinic’s attempts to ‘trouble’ previously stable discourses were repeated in numerous other texts; from the format and content of the clinic’s client records, to the conversations with the staff, and the way their practices were reported in the media. Having explored a number of tangible objects within the clinic, and considered the discourses that embodied the various statements that they made, I began to focus on breathing as the primary target of Breathing Works’ attention.

The clinic’s actions appeared to be targeted towards problematising the biomechanical/pathological discourse of lung disease that predominated in the medical ward; replacing it, instead, with the notion of the ‘bad breather’ (Bradley, 1992; Doyle, 1999; Lawrence, 1999; Woodward, 2002). This problematisations was interesting because it demanded a reconsideration of the conception of breathing functions as a natural,
automatic, homeostatic mechanism that becomes corrupted by pathology or trauma. Instead, Breathing Works were promoting statements that breathing problems were being experienced by a large percentage of the population; people with no organic lung disease. Further, they argued that our breathing was at the mercy of our moods; our work-life balance; our attitudes, stresses and anxieties. In response to these challenges, Breathing Works argued that for these maladaptions to be repaired, expertise would be required, and that this expertise could be developed as a business venture.

My focus therefore shifted to the way that the staff at the clinic created a demand for their services by defining the parameters of this problem, and approaching their practice as a business supplying remedies for problems that had previously been ignored. My attention focused, therefore, on the strategies and tactics employed by the clinic in defining ‘bad breathing’ as an object worthy of problematising. From here, I was able to consider how these problematisations created new subject positions for the physiotherapists and clients at the clinic, and how, in turn, these subverted many of the technologies of discipline that had been so fundamental in the construction of legitimate and orthodox respiratory physiotherapy.

Theorising interviews as ethnographic texts

In recent years, interviews have become the focus of much debate and discussion in the social sciences (Holstein & Gubrium, 2004). Interviews have come to occupy an important place in western society as a way of understanding the views of consumers, voters, viewers and listeners. They have become the conduit, par excellence, for cultural expression within postmodern society; as a potent means of democratising thought; and as a vehicle for increasing our awareness of the complexity of human society;

Today, interviewing is more popular than ever as a means of generating information. In our postmodern “interview society”…the mass media, human service providers, and researchers increasingly generate data by interviewing…it has been estimated that 90 percent of all social science investigations use interviews in one way or another. Interviewing is undoubtedly the most widely used technique for conducting systematic social inquiry, as sociologists, psychologists, anthropologists, psychiatrists, clinicians, administrators, politicians, and pollsters treat interviews as their “windows on the world” (Holstein & Gubrium, 2004, p. 140).

Interviews have evolved as a means of obtaining information about our selves and given us insight into our private thoughts, or as Gubrium and Holstein state; ‘The category of “the person” now identifies the self-reflective constituents of society; if we want to know what the social world is like, we now ask its individual inhabitants’ (Holstein &
Interviews have become ubiquitous in qualitative research as a vehicle for apprehending the ‘agency and responsibility’ of individuals (Garland, 1997), or as a ‘pipeline for transporting knowledge’ (Holstein & Gubrium, 2004, p. 141).

In this study, I have used interviewing as an active process of construction, whereby my participants and I engage in a creative dialogue and mutual exploration of the experience of physiotherapists actions, following the premise that, ‘Both parties to the interview are necessarily and unavoidably active. Meaning is not merely elicited by apt questioning, nor simply transported through respondent replies; it is actively and communicatively assembled in the interview encounter’ (Holstein & Gubrium, 2004, p. 141).

Interviews are used extensively by researchers that follow Foucault’s approach to discourse analysis (see, for example, Fraser, Hopwood, Treloar, & Brener, 2004; Hau, 2004; Manias & Street, 2000a; Nettleton, 1991; Purkis, 2001). A number of authors however caution the reader to pay attention to the function and power of interviews (Ayllon, 2003; Gilbert, 2003). The interview, they argue, is neither the neutered, context-free creation of the positivist social sciences, nor an authentic representation of subjective experience. Texts generated by interview viewed without the ‘extra-discursive’ context in which they reside, become ‘meaningless beyond the context in which they occur’ (J. Miller & Glassner, 2004, p. 125). Therefore, interview transcripts alone are insufficient if one wishes to expose the complex interplay of forces that make our current understandings of social reality possible.

Foucault himself never utilised interviews as a method of data collection; a point that gave me significant cause for concern when I was planning my approach to text generation. Given the exposure Foucault gave to the confessional as a technology of power, it seemed disingenuous to use interviews as a primary means of data collection. Foucault stated that ‘western man has become a confessing animal’ (Foucault, 1979c, p. 59), and I was concerned that I might be perpetuating these confessional practices in my own study. While I do not feel that I have been able to satisfactorily resolve these concerns, my heightened awareness of the problem did bring me to the realisation that there are many forms of confessional present in the texts and images I was exploring, other than those I elicited directly through interview. The self help books, clinical records and training manuals of the Breathing Works clinic; the curriculum documents of the physiotherapy schools; the images of proper massage technique; etc., all bare confessional elements to them, in that they are all seeking to project particular subjectivities to others.
and have these accepted as normal, or emphasise their truth status. This point then became vital in my appreciation for the function of discourse analysis. In analysing these texts I was attempting to expose these subjectivities; to explore the relations of power that had made them possible. And thus, using the confessional basis of knowledge formation as a focus for analysis. So, while I was not able to entirely reconcile particular problems I faced in generating new confessional texts with my interviews at Breathing Works, I did, come to some realisation about the role of confessional practices in the generation, and subsequent discursive analysis of all texts.

Theorising observations as ethnographic texts

Observations are also a common method used in ethnographic research allowing the researcher to apprehend the world firsthand (Silverman, 2001). In this study I used a non-participant, unstructured observation technique to gather texts;

In this holistic approach, the researcher is guided by prior knowledge and experience and ‘sees’ through the unique lens of her own socio-culturally constructed values dependent upon life history and factors such as gender, ethnicity, social class and disciplinary and professional background. Broad decisions are usually made in advance about the kinds of things to be recorded, either on the basis of analysis of other data already collected (e.g. interviews or questionnaire data) or derived from the focus of the research (L. Jones & Somekh, 2005, p. 140).

I chose to adopt this approach because it allowed me to view events, actions, norms, values, etc., from the perspective of the people being studied (Bryman, 1988). This approach, like many other forms of ethnographic research, depends upon the sensitivity of the researcher to the things they are observing. Observations are frequently documented in a field journal; ‘a product of choices about what to observe and what to record, made either at the time of the observation, in response to impressions, or in advance of the observation in an attempt prospectively to impose some order on the data’ (L. Jones & Somekh, 2005, p. 138). Therefore, the texts that are generated from observations are a partial account of one’s experiences. They do however provide rich material; particularly the extra-discursive elements that may be used to challenge the texts generated from interview.

The dynamic interaction between the observer and the participants, or situation being observed, not only raises questions of ‘partiality’, but also relations of power. Early approaches to observation that developed in ethnography situated the researcher as a ‘documenter of culture’ (Grbich, 1999), but many authors have argued since that this position is now untenable in contemporary ethnographic research. Feminist researchers, for instance, have attempted to decentre the role of the researcher, seeking instead to apply...
dialogical, polyphonic voices to their research (Keddy, 1996; Weedon, 1987). Others have been critical of the detached neutrality of earlier forms of observational research, arguing that the researcher is so intimately interwoven with the construction of the text that they cannot be an unbiased conduit between the data and its analysis (Silverman, 1993).

Foucault, for his part, was critical of methods that placed too much emphasis upon research that either ignored the power relations at play, or saw the power relations between the observer and the observed as only one of dominance. Instead, adopting a Foucauldian approach, one should view observations as a way of exploring the various subject positions, objects, concepts and strategies at play throughout the discursive field one is exploring. Where traditional ethnographies have therefore sought to reconstruct social realities from the ‘inside’, focusing on the value of observation for its ability to recreate a representation of a particular social reality, a more Foucauldian approach uses observation to explore the dynamic interplay of individual practices as they form and transform social reality;

Discursively focused research on social settings…emphasizes how social realities are always under construction. It considers how setting members continually assemble and use the interactional and interpretive resources “provided” by social settings to construct defend, repair, and change social realities. Hence the emphasis by discursively orientated ethnographers in observing…the actual ways in which setting members construct social realities by making sense of practical issues (G. Miller & Fox, 2004, p. 38).

A number of authors have utilised data obtained from observations in developing Foucauldian analyses of health and illness. Manias and Street (2000) for instance, undertook an ethnographic case study of nurses working in critical care (Manias & Street, 2000c). The study used observations to explore the power relations between doctors and nurses during periods of handover. Purkis, on the other hand, used observation to explore the political role home-care nurses played in governing the behaviour of their patients (Purkis, 2001), while Irving used observations as part of a Foucauldian approach to the discipline of patients through the use of physical restraints (Irving, 2002).

Methods employed in reading and analysing texts

I will now move on to consider how the various texts were read. Thus far I have explained how texts were sampled into this study, and the theoretical basis for each of the methods of text collation and generation. What I will now show is how my approach to Foucauldian discourse analysis was operationalised in the reading of my texts. This section therefore brings together the questions and problematisations from Chapter One, and the theoretical and methodological framework outlined in Chapter Two, with the

The methodological framework established in the previous chapter emphasised a number of guiding principles; the use of a plurality of texts; the focus on local, material practices; the need to attend to the ruptures, fissures and tensions in the surface of discourses; and the focus upon driving the discourse analysis with extra-discursive texts. These methodological imperatives and guiding principles ‘framed’ the way each text was ‘read’.

I employed a number of different approaches to my reading throughout this study. At times this allowed me to focus on texts that formed natural groupings; texts pertaining to the biomechanical construction of the body, for instance, were read in a period when I focused almost entirely on this body of work. At other times, I read texts in a piecemeal fashion; finding some quite surprising insights coming from serendipitous encounters with documents, images, and reflections. This happened with my reading of some of the texts that appear in Chapter Five, for instance. Reading was sometimes purposeful, but at other times I was quite unaware as to why I had chosen to explore a particular text. Rarely, however, did I ever find my reading had taken me down a completely blind alley; I was always able to glean some insight or other from the text I was scrutinising.

The first step I took in analysing each of the texts, individually and in series, was to write a commentary of my first impressions of the text. What statements were evident? What was said and not said? What was being conveyed? What was in the text? What was the context surrounding the text? What subject positions were evident? What objects were available for analysis? What strategies and systems were at play? Why had I chosen it? What was the date and time of my reading? After undertaking this ‘ naïve’ commentary on each text’s various statements, a further series of questions were posed of the text that moved ‘beyond’ the confines of the text itself; I asked: what is the terrain upon which this text seeks to exert its influence? What discontinuities, ruptures and tensions does this text expose? How does this text seek to respond to these tensions? How does this text connect with other texts and discourses that have emerged so far?
With an outline of the key discursive influences pertinent to my study emerging, I then turned to Foucault’s rules of discursive formation, transformation and correlation, and explored each of the discursive formations in parallel with one-another. This exercise revealed some normative and theoretical ‘bridges’ that spanned my historical moments. Bridges such as the STM’s focus on neurasthenia that emerges towards the end of Chapter Four, and its normative connection to the actions of Breathing Works discussed in Chapter Six illustrate this point. Equally, theoretical connections between the disciplinary actions of the STM and their correlative equivalents in contemporary practice, highlighted the potential for further theoretical depth when discourses were seen less as stages of development towards enlightenment, and more as contextual responses to local conditions that have some transformative qualities over time.

Having articulated a number of critical questions, a process of culling and conflation then took place, whereby different statements and questions were brought into opposition with one another. This process resulted in the dismissal of a vast number of statements and a large volume of data, but generated a number of new discursive themes that tentatively held a number of statements in a loose collective. These rudimentary discursive themes were sketched onto mind-maps with textual references locating the various originating statements.

Having sketched naïve discursive themes, I then returned to the theoretical literature to locate examples and issues from other people’s work to challenge my emerging themes. I began, at this point, to explore the forms of knowledge that these statements were seeking to normalise and the power relations that made this possible. My focus was upon the actions and practices of physiotherapists made possible by governmental rationalities over my three moments. In particular, I considered the ‘positive knowledges’ (Foucault, 1973) constructed around physiotherapy practice that related to the discourses of legitimacy, orthodoxy and resistance. The process of moulding, refining, documenting, comparing and testing the emergent discursive themes continued until a primitive structure began to emerge, that began to suggest a cohesive system for reporting the findings. Thus, as a thematic structure began to appear, a new series of questions began to be considered, that revolved around how best to present this amorphous matrix of discursive effects in a linear fashion necessary for this research document. This process, from text generation through to reporting ran at different stages with different discursive themes. In some cases I had well-formed arguments from the first reading of the text. At other times, the inductive process took many weeks to sediment. In all cases, the process
of textual analysis remained a ‘re-iterative’ process in which the text I was generating went through constant revision until my analysis had been refined to my satisfaction.

The resulting research text presented here is, in some ways, a compromise; a ‘best fit’; being neither a complete or total analysis of the discursive construction of physiotherapy, nor necessarily the best way of presenting the nuance and complexity of my findings. It has been my intention throughout the process, however, to construct a narrative that retained a sense of linearity, without imposing a sense of progression upon the history of the physiotherapy. I have sought to maintain, for the reader, a sense of coherence, without losing the heterogeneity, complexity and breadth of the texts. Therefore, the structure that I chose to adopt stays close to the idea of three historical moments in the history of the profession, but makes no claim about the profession’s assumed drift towards enlightenment and progressive refinement of purpose.

In Chapter Two I articulated a number of strategies deployed by Foucauldian scholars in conducting discourse analyses. These included four guiding principles:

1) Genealogical enquiry demands an attention to the historical context in which one’s study is situated.
2) The researcher must explore the social, historical and political conditions under which statements come to count as true or false.
3) The researcher must consider the materiality and conditions of possibility inherent within discursive formations.
4) One must move in and out of the text using the extra-discursive to ‘drive the analysis of the discursive’ (Hook, 2001b, p. 543).

In setting out the process I followed in reading my texts, I have retained these in the forefront of my mind and attempted to remain true to Foucault’s theoretical and methodological imperatives.

**Ethical considerations**

Ethical approval for the study was granted by the Auckland Regional Ethics Committee, and the University of South Australia Ethics Committee on 30th July 2004 (see Appendix One). Two ethics committees were consulted because my doctoral thesis was lodged with the University of South Australia, but the data collection was undertaken in the greater Auckland region. The committees considered a number of issues in approving the study and these are outlined below.

**The recruitment of colleagues and peers for interview**
New Zealand has a relatively small population of practicing physiotherapists – in 2007 there were only 3,481 registered practitioners for a population of over four million people (The Physiotherapy Board of New Zealand, 2007). In practical terms, this means that most specialist practitioners are well known within the community; particularly if they have produced eight books in recent times and promote themselves aggressively.

Breathing Works therefore, is a well-known organisation amongst physiotherapists in New Zealand and its founders; and Tania Clifton-Smith, are recognised for their innovation, enthusiasm and commitment to the treatment of breathing pattern disorders. I have known the staff of Breathing Works well for over 5 years, and so, an important ethical question that I have had to address is whether it is possible for me to engage with Breathing Works with the objectivity necessary to produce meaningful texts for analysis?

My relationship with Breathing Works has certainly made it easier to access texts produced by the clinic, but there is naturally the possibility that this relationship might be abused in order to obtain the data that I required. I took the following steps to mitigate against this:

1) All participation in the study was voluntary and based on informed consent
2) My relationship with the Breathing Works staff was transparent
3) I did not work for, or with, anyone from the clinic during the period of my data collection
4) All participants in the study would be anonymous with the exception of and .

Anonymity of participants cited within texts

Throughout this document, I refer to Dinah Bradley and Tania Clifton-Smith by their real names. This was a decision arrived at after a great deal of discussion between my supervisors, the Ethics Committees and Dinah and Tania themselves. I wanted to use the real name of the clinic – Breathing Works – rather than a pseudonym, because all attempts to find a suitable alternative failed to capture the significance of the name for the operation of the clinic. I tried a number of alternatives, but none of them were satisfactory. Indeed in a paper written about the clinic that is currently in preparation, we have avoided the subject of naming the clinic entirely, given that we did not have enough space to justify our argument for its use in the paper. After discussing the use of the clinic’s proper name in this text however, I first discussed the issue with my supervisors, then I approached the ethics committee to work through a solution, and I only then did I approach the founders of

---

13 One of the staff became a postgraduate student of mine during the latter part of my data collection, but her work exploring the development of a breathing self-efficacy scale, and our relationship had no bearing on this study.
the clinic to gain their verbal and written consent to use the name of Breathing Works in this document.

At the same time, I wanted to use the founders’ real names within the text. This made perfect sense to me since I refer so much to their writings; their names are used widely in quotations, and their identities are made obvious by repeated reference to their works in this thesis. It seemed ludicrous therefore that I should maintain a pretence about their identity. I therefore followed the same process in gaining their approval to use their real names in the thesis. Examples of the ethical approval forms that were developed are included in Appendix Nine.

The observation of clinical practice

As a practising respiratory physiotherapist and lecturer, I have a working relationship with all the participants in the various study sites within New Zealand; I know each of the participants well, and have worked with them over several years on a number of different occasions. The possibility that conflicting interests might have interfered with the conduct of the study therefore needed to be addressed. And while my relationship with the participants in the study made it easier to negotiate access to different research sites, it also generated an additional layer of uncertainty about my dual role as researcher and practitioner/colleague. In attempting to address this uncertainty, I developed explicit guidelines that set out the goals of my study and the role as the principal researcher during my period of observation. These guidelines articulated the boundaries between appropriate and inappropriate expectations and interactions, between the therapists and the researcher, and established mutually acceptable roles. Further, decisions about the conduct of the researcher at the research site were formalised between the researcher, the research supervisors, and the research sites prior to the development of these guidelines:

1) The researcher will have no clinical role within the clinic during the period of data gathering
2) The researcher will not be asked to offer a clinical opinion
3) In the unlikely event that the researcher’s position is compromised by requests from the research sites, or because of a threat to patient safety, the researcher will deal with this sensitively by communicating his concerns to the research participant (service manager or therapist). If the matter is not resolved, the researcher may withdraw from the site and report his concerns to the supervisory team or a more senior manager, but will not intervene in the care of patients unless their health and safety has the potential to be compromised
4) Policies and procedures will be established and modified in consultation with key stakeholders (principally key staff at research sites and my supervisory team) at all times.

5) No payment will be received by the researcher at any time during the study from any of the research sites, nor any inducements given to any of the sites to take part in the study.

In making observations of clinical practice, I sought the approval of both the therapist undertaking the work and the patient engaged in assessment and treatment. Patients who were due to enter the clinic room were asked by the clinic’s receptionist on arrival if they were happy to be observed. If they verbally consented, they were given a consent form to complete (see Appendix Three). This consent form established boundaries, rights and restrictions upon the observations and made it clear that the observations could be terminated at any time if the patient so wished. The consent form also made it clear that the patient was not the object of the observation, but that this did not affect their rights. In the same way, each of the therapists who agreed to be observed consented verbally, then in writing, to the same rights.

Access to documents for analysis

A large number of documents were accessed in conducting this study. Of major ethical concern were those that included personal details of patients and surviving participants identified within documents. Records of the New Zealand Society of Physiotherapy, the Physiotherapy Board of New Zealand and the Chartered Society of Physiotherapy all contained references to surviving individuals. In each case, the anonymity of the individual was ensured throughout the text generation and reporting processes. No original names, locations or other identifying features were used that might draw attention to, impugn or otherwise identify any person or persons cited within the text.

In summary

In this chapter, I have provided a detailed description and critique for the various methods of text generation and analysis employed in this study. I began by outlining the limits I placed on my texts, before providing detailed accounts of my sampling strategy; including the criteria that I used to govern my strategy, details of the sampled texts themselves and a comprehensive overview of the way in which my strategy developed through the course of the study. I provided a theoretical rationale for each of the main ethnographic texts (documents, interviews and observations) before defining how I interpreted Foucault’s methodological imperatives in reading and analysing my documents. And finally, I addressed the main ethical questions that arose in this study.
The preceding three chapters therefore provide the context, theoretical and methodological frameworks that have been applied to my primary research question – how is physiotherapy discursively constructed? To make use of an approach informed by Foucauldian discourse analysis, it is necessary to construct a robust set of theoretic imperatives and methodological principles in order that the findings of the study stand up to external scrutiny. The preceding chapters have set out these principles in relation to my study, so that the following chapters can more adequately address the various questions posed by the texts generated in the study. What follows is an analysis of a range of texts that, as previously stated, does not offer the definitive answer to my primary research question, but offers one response – informed as it is by a robust theoretical and methodological critique.
CHAPTER FOUR – THE QUEST FOR LEGITIMACY IN THE PRACTICE OF MASSAGE

‘We will make massage a safe, clean and honourable profession, and it shall be a profession for British women’ (Grafton, 1934a, p. 229).

Introduction

In the first three chapters of this thesis I set out to examine how physiotherapy might be discursively constructed, how it might be examined governmentally – paying particular attention to Foucault’s notion of technologies of discipline – and how I might conduct such a study methodologically. No research study can provide a complete account or analysis of a profession’s history of the present, and I do not set out to do so here. My purpose over the next three chapters is to explore the events that correspond to three critical junctures in the profession’s history and explore how the actions of masseuses and physiotherapists at these moments inform our understanding of the discursive construction of physiotherapy.

The first of my three chapters of ‘findings’ focuses on the strategies, tactics, instruments and procedures deployed in forming the Society of Trained Masseuses. It is my contention that the event now referred to colloquially as the ‘massage scandal’ induced a number of significant responses in a small group of nurses and midwives, and that these have had an enduring effect upon physiotherapists’ subjectivity. My critical focus is the quest for legitimacy, and the desire to distinguish the actions of legitimate masseuses from the ‘sensual’ massage practices of prostitutes14. My theoretical focus is upon the actions of the masseuses rather than the events themselves; I am concerned with how it became possible to legitimise massage practices; what disciplinary technologies were deployed in pursuing legitimacy; and what subjectivities were made possible by these actions.

I have interwoven evidence from a wide variety of texts into my analysis, in the hope that I can relate something of the fascinating story of these events surrounding the formation of the STM to the reader. This has been a problematic process in many respects, since, as I have already stated, I do not want to imply a sense that this text is a historical narrative. Instead, I have sought to make use of those texts that were available to me to tell a story, but only as a convenient device around which I have structured my analysis. I

14 In this chapter, I refer almost exclusively to masseuses (the female derivative of masseur). In later chapters I utilise the words masseur and physiotherapist because of their historical and political connotations. The reasons for this will become clear within each chapter.
begin the chapter by problematising massage and setting out why I believe the STM felt it necessary to legitimise massage practices. From here the focus of the rest of the chapter is upon how the STM responded; the actions they took and their discursive significance. I have grouped these responses under five main subheadings – each with a particular disciplinary focus. Central to my argument is the STM’s use of biomechanics as a disciplinary technology, and the subsequent effect this had upon masseuses’ approach to the body of their patients. This forms much of the latter part of the chapter. I close the chapter considering the paradigm case of neurasthenia – a syndrome with a relatively short-lived, but significant role in the history of the profession – and its role in the question of legitimacy.

In addressing these issues, I pose the following questions:

1) What discursive formations informed the actions of the founders of the Society of Trained Masseuses?
2) What actions resulted from these influences?
3) What new knowledges about massage practice were promoted by the STM and what was marginalised?
4) What relations of power developed through the actions of the STM?
5) How did liberal governmental reforms influence the formation of the Society?
6) What subject positions were created with the construction of the legitimate masseuse?
7) How did the actions of the STM create new possibilities for legitimate masseuses?

To begin then, I explore how massage became a problem that instigated the actions of the STM.

**Problematising massage**

In the summer of 1894 the following article appeared in the British Medical Journal:

**IMMORAL “MASSAGE” ESTABLISHMENTS.**

We have received communications suggesting that an association should be formed for those who have gone through a proper course of instruction in massage and obtained certificates of proficiency, and asking our assistance in the preparation of a list of good and satisfactory workers. The suggestion is, however, beset with difficulties. We understand that a good many “massage shops,” the advertisements of which are frequently inserted in one or two of the fashionable daily papers, are very little more than houses of accommodation…Many of the girls [employed by the massage parlours] have certificates, but they, as a rule, have spent their last penny in getting instruction, and, little by little, drift into a mode of life which is often most distasteful to them. The men are often not much better, and it has become a fashionable fad for certain ladies of position to frequent the rooms of a young and good-looking masseur…Certificates in “massage” are given, even by
qualified medical men, after the most perfunctory course of instruction…Our impression is that the legitimate massage market is overstocked, and that no woman, unless she has a private connection, has the slightest chance of getting a living by massage alone – at all events in London. We are afraid that nothing could be done in the way of registration unless the ground could previously be cleared of what is undoubtedly a great social scandal. It would be difficult, at all events at first, to refuse a place on the list to any woman who has a certificate from a legally qualified practitioner, and yet in many cases such recognition would mean neither more nor less than a recognition of prostitution (British Medical Journal, 1894b).

This article led to a number of further investigations by both the BMJ and journals of the popular press which, over the remainder of the year, published further details of their enquiries (South Wales Times, 1894; The Morning, 1894a, 1894b). The reports that followed highlighted the resurgence of interest in massage as both a leisure pursuit for the middle and upper classes, and as a new career for women (Reynold's Weekly, 1894). They also drew attention to the fact that the training of masseuses had become shambolic, with a number of stories emphasising the poor working conditions experienced by masseuses (British Medical Journal, 1894a; St. Paul's, 1894). A number of articles, for instance, recognising that the scarcity of work was driving down labour costs, spoke of how this was exposing women to unscrupulous practices in which the masseuse received no ‘wages’, but depended on the ‘tips’ of patrons – to which they were expected to make themselves ‘agreeable’ (Reynold's Weekly, 1894; The People, 1894) (See Figure 1).

Training in massage was most often provided by doctors or supposedly ‘qualified’ masseuses, but there were clearly no standards governing training, and many accounts came to light in the months following the BMJ’s article, that exposed a trade in meaningless certificates and unreliable qualifications (British Medical Journal, 1894a). The women drawn into the brothels and bagnios of England’s large metropolitan areas received no protection from the law because the authorities were unable to distinguish legitimate massage from prostitution; as soon as the police threatened to close a suspicious practice down, the proprietor claimed that it was a massage parlour and the police were unable to take further action (British Medical Journal, 1894a). This lack of differentiation between massage and prostitution caused a vexed response in the media, who openly reported their frustration – and that of ‘the authorities’ – that even the most well known brothels in London’s West End were unable to be closed down (The Star, 1894).

To make matters worse, it became clear that it was the ‘aristocratic portion’ of society that was frequenting the illicit massage parlours (Reynold's Weekly, 1894), and, worse still, women were attending in considerable numbers, as the fashion for massage
reached its peak in the 1890s (British Medical Journal, 1894a). The following quote captures the moral opprobrium that accompanied many reports within the popular press;

…immorality is not…an offence against the law. If it were, indeed, the law would have its hands full, and we should find peer and peasant rubbing shoulders in the dock. In our opinion something far more dreadful than the existence of these immoral massage establishments is the thought that they are extensively patronised by persons who, in spite of rank and education, are a proof that man is, after all, the most disgusting of all the animals (Whitehall Review, 1894).

There were no restrictions on who could advertise their massage services; where the adverts could appear, or the nature of the claims made. Thus a prospective client would not know whether the person advertising themselves as ‘Miss Nightingale’, for example, was a ‘therapeutic’ masseuse or a prostitute (Incorporated Society of Trained Masseuses, 1894-1912). Concern was raised on behalf of the ‘legitimate’ masseurs and masseuses by practitioners writing in to the newspapers, to complain about their situation; In a letter to the St. James’s Gazette announcing the formation of the British Massage Association, for instance, T. Garner wrote, ‘Unfortunately there are hundreds of most intelligent and useful men and women whose prospects have been well-nigh ruined by reported malpractice of unscrupulous persons’ (Garner, 1895).

Thus the popular press sought a response, and it was through the organ of the British Medical Journal that action came. The journal first appealed to the government to close the brothels down, regulate the advertising of masseuses, and formulate a system of training to legitimise the profession (British Medical Journal, 1894a). But failing in this endeavour, the BMJ (under its editor and pioneering social reformer Ernest Hart) turned to the medical community to provide its own solution, and it was in this climate of scandal and moral outrage that four nurses and midwives organised themselves into a small society, with the explicit purpose of legitimising massage practice (Robinson, 1994).

The ‘massage scandal’, as it was subsequently referred to (South Wales Times, 1894; The Morning, 1894a, 1894b), illustrates how massage was problematised as a moral corruption. In keeping with other discourses of moral decay, pestilence, dirt and disorder – particularly those that pertain to the health and vitality of the population – massage presents an additional analytical focal point for a growing body of scholarship that is taking as its target Victorian attitudes towards sexuality (Bashford, 1998; Behlmer, 1990; Briggs, 1968; Brimblecombe, 2003; Harrison, 1990; Higginss, 2000; L. S. May, 1998; Tomes, 1997; Wainwright, 2003; Walkowitz, 1977, 1992). Foucault argued that the Victorians had an obsessive interest in defining norms of sexual conduct, and in so doing, created many forms of deviance that previously did not exist (Foucault, 1979c).
descending individualism (Rose, 1997) reinforced the need to attend to every individual’s sexual morality, and nowhere was this more important than in those locations where sensual contact between people passed under the guise of therapeutic practice. How then did the promotion of massage scandals serve to create the necessary conditions in which the Society of Trained Masseuse might act to legitimise massage practices?

**Responding to moral opprobrium: The formation of a massage profession**

The following is an extract from Jane Wicksteed’s 1948 account of the moment when the idea for the Society of Trained Masseuses was envisaged:

A summer afternoon in the year 1894, two anxious young women in earnest conversation. Rosalind Paget, the elder, tall slight and distinguished, is dressed in the close-fitting bonnet and dark uniform of the Queen’s Nurses; Lucy Robinson, the younger, round-about in build, is enveloped in the huge circular cloak designed for midwives, so designed that they can walk safely through the rain clasping under this cloak the precious basket from which the juvenile mind of the period believes the baby will emerge.

These two nurses, so unlike in appearance, so alike in their aspirations, are seated in the club-room of the Midwives’ Institute and Trained Nurses’ Club; they talk in hushed and awed voices, for life is very serious just then. The air is thick – or so it seems to them – with the breath of noisome rumours; not only in the halfpenny press, but also the revered medical journals, are publishing articles on what have come to be known as the “Massage Scandals”. Unsavoury establishments are cropping up under the guise of nursing homes, and to these places unsuspecting nurses are enticed on the pretext of being needed to give massage to patients. Rosalind and Lucy are both practising massage or ‘medical rubbing’, a form of treatment now finding way into the armamentarium of the medical profession; both are immersed heart and soul in their work and cannot endure this cloud that is rising; rising as they fear to envelop their profession, to saturate it with evil practice, and finally to drive it entirely outside the pale of medical science.

But what can they do? Two young women up against a great and growing evil. Suddenly Lucy exclaims: “Let’s form a Society” (Wicksteed, 1948, p. 9).

Thus begins Jane Wicksteed’s history of the first 50 years of the physiotherapy profession in England. In portraying the urgency and desperation of Lucy Robinson and Rosalind Paget’s quest\(^\text{15}\), I believe Wicksteed is attempting to express the moral outrage of the Society’s founders, and set their earnest intentions apart from the ‘cloud that is rising, threatening to envelope their profession’. The founders of the STM had no such profession to turn to, however, and certainly not in the sense that there was a recognised single body around which legitimate masseuses could assemble. When I first read this account I was

---

\(^{15}\) Rosalind Paget made a significant contribution to professions for women during her lifetime. She was made as a Dame of the British Empire in 1934 for her pioneering work with nursing, midwifery and massage. As well as being a founding member of the STM, she was a founder of the British Midwives Institute that played a major role in influencing the Royal College of Midwives in England.
struck by its breathless enthusiasm, but also by its triumphal celebration of the founders’ actions in *rescuing* massage from the slur of debauchery. What I didn’t glean from the text, nor from the other historical account of this period in the profession’s history (Barclay, 1994), was a sense of how legitimacy had been achieved, and how this had framed the subjectivity of the masseuses who practiced under the disciplinary apparatus established by the STM.

My reading of the texts pertaining to this event led me to conclude that disciplinary technologies played a vital role in separating the STM from licentious massage, and that it defined an enduring discursive framework around which physiotherapy developed as a profession. To understand the subjectivities that emerged, therefore, I felt I needed to explore the disciplinary technologies that had made them possible. These have been grouped into five distinct sections. Each section deals with a particular set of actions and practices and the disciplinary technology that these actions revealed. They are as follows:

1) The development of rules to regulate masseuses’ professional conduct
2) Courting medical patronage and the development of disciplinary alliances
3) Normalisation and the creation of examination systems
4) The registration of members as a technique of surveillance
5) The adoption of biomechanics as an ensemble of knowledge

Each of these will now be considered in turn.

**The development of rules to regulate masseuses’ professional conduct**

Defining rules of professional conduct for members of the Society was one of the first actions undertaken by the founders at their inaugural meeting in December 1894. These rules ‘protected our members from unpleasantness and have given the doctors a feeling of security that our rubbers [a colloquial name for masseuses] are not prescribing quacks, and the general public a feeling of trust that our members are masseuses of irreproachable character’ (Nursing Notes, 1900).

The rules stated that:

1) No massage to be undertaken except under medical supervision.
2) No general massage for men to be undertaken but exceptions may be made for urgent and nursing cases at a doctor’s special request.
3) No advertising in any but strictly medical papers.
4) No sale of drugs to patients allowed (Society of Trained Masseuses, 1895).

These rules were reproduced on the bottom of every graduate’s certificate (see Figure 4), which suggests that the STM saw them as visible evidence of the Society’s
principles; principles that elevated the masseuses above the mass of unqualified hacks and charlatans practicing massage at the time. I believe these rules were designed to address a number of intersecting problems raised by the massage scandals; firstly, they established the massuese’s relationship with the medical profession by formalising their subservience to the referring doctor; they addressed the problem posed by the necessarily intimate contact between male patients and masseuses, by forbidding the massage of men by members of the STM; and they defined more clearly how the profession should position itself in relation to those masseurs who advertised in the popular press.

![Image of a STM certificate showing rules of professional conduct.](https://wellcomecollection.org/collection/ds-4bc2278a-8b6c-4015-92cf-8418b4e09db2)
In themselves, these tactics are unremarkable, particularly since it was common practice within the health field for new professional groups to establish rules of professional conduct for their members (Cordery, 1995). Not surprisingly, many of the competitor organisations that were seeking to offer legitimate solutions to the massage scandals at the same time as the STM, also offered (sometimes quite extensive) rules of conduct. But by 1914 most of these rival organisations had folded. Organisations like the British Massage Association (BMA), the Incorporated Society of Trained Masseuses and Masseurs, and the Harley Institute, all published rules of professional conduct between 1895 and 1898 (Barclay, 1994) as part of their quest for legitimacy, but all ultimately ceased operating and disappeared.

Rules alone, therefore, cannot explain how the STM prospered. It is my contention that the rules do provide some clues, however, to the matrix of disciplinary technologies that encircled the Society’s masseuses, and two or these are of particular significance: The first is that the STM published only in nursing and medical journals; and the second is that the STM forbade men from entering the profession.

Publishing only in the nursing and medical literature served two purposes; it showed the Society’s intent to promote the profession within the medical community, and it targeted the particular class of women who were now being attracted to nursing and midwifery – an aspect of the profession’s identity that Rosalind Paget was most anxious to assert (Hannam, 1997). The ability to publish exclusively in the nursing literature was greatly enhanced by the fact that Ms Paget was the proprietor of the journal *Nursing Notes*, which subsequently carried reports of the Society’s business and advertised the profession to nurses and midwives throughout Britain (Barclay, 1994).

Excluding men from the Society was a position the STM maintained until 1905, when men were finally allowed to sit the Society’s examination\textsuperscript{16}. They were not allowed to register with the Society, however, until 1920 (A. Parry, 1995), and were thus prevented from receiving medical referrals – a vital component of the STM’s pursuit of legitimacy. Finally, in 1920, the newly named Chartered Society of Massage and Medical Gymnastics relented and allowed men to register, but only after the women of the ISTM had shown

---

\textsuperscript{16} Men were forbidden from sitting the STM’s exams until 1905 when the War Office approached the Society to examine Royal Army Medical Corps orderlies. Thornton explains that; ‘This raised an interesting problem. The Society’s rules clearly state that women must not give general massage to men or vice versa, nor were women allowed to examine men in practical massage. As men had been excluded from the Society, mainly because membership gave rights of access to the Nurses’ Social Club, an exclusively female organisation, there were no male examiners. The problem was resolved by asking a son of one of the members, himself a trained masseur, to examine the practical component for the Society (Thornton, 1994, p. 12A). (This begs the question – how was it decided that his massage was up to standard in the first place)?
themselves to be the pre-eminent providers of massage treatments for returned servicemen. By contrast, all other massage organisations were open to both male and female masseurs from the outset, and placed no restriction on contact between the sexes. This failure to grasp the importance of excluding men from registration became a potent weapon in the STM’s attempts to marginalise its competitors.

Anne Parry argues that the exclusion of men from the profession in its early years was motivated as much by the desire to protect the reputation of nurse- and midwife-masseuses during the massage scandals, as much as it was an attempt to create a new niche for women professionals (A. Parry, 1995). While this may be the case, it is clear that the Society’s fervour to legitimise its practice saw the STM deploy its heteronormative moral superiority to hasten the demise of its rival organisations. The Harley Institute, for example, was accused of charging too little for treatments, giving false credentials, providing inadequate training, but ‘worst of all, allowing young women to receive instruction from men and to work on male models (albeit from the Boy’s Brigade)’ (Barclay, 1994, p. 37) (See Figure 5 and Figure 6). As a result, the STM petitioned the London County Council to refuse the Harley Institute a license to practice, and it was subsequently closed down.

Figure 5. Promotional photograph published by Harley Institute showing massage demonstrations being undertaken on male models from the Boy's Brigade. Source: Wellcome Institute archive

17 This pre-eminence was recognised in 1920 when the Incorporated Society of Trained Masseuses gained Chartered status when it merged with the Institute of Massage and Remedial Gymnastics to form the Chartered Society of Massage and Medical Gymnastics (CSMMG).
The rules established by the STM were only one aspect of a broadly disciplinary approach taken by the Society to regulate the conduct of its members. The rules were normalising in that they established a benchmark, or an ‘equivalence’ as Mitchell Dean calls it (Dean, 1999), against which those within the profession, and those outside, could be evaluated; they also offered a tentative definition of legitimacy by stipulating that advertising in the popular press and treating men was beyond the boundary of decency; and significantly, they defined the profession’s relationship to the medical community. This relationship was significant because it established a strategic alliance with the professional body that provided access to patients. It is to this relationship that I turn next.

Courting medical patronage and the development of disciplinary alliances

The relationship the STM sought to establish with the medical profession took a number of forms. Firstly, the Society made it clear that the masseuse should not, in any way, overstep her authority by making her own diagnoses of the patient’s problems. This was strictly the domain of the physician, who had acquired newfound respectability.
towards the end of the nineteenth century with the discovery of germ theory, and the rise of what David Armstrong has called ‘surveillance medicine’ (Armstrong, 1995). The masseuse therefore, treated only as directed by the doctor who, it was assumed, knew more about the conditions requiring massage, and the suitable modalities of treatment, than the therapist.

Secondly, the Society insisted that only patients referred by a recognised doctor were to be seen. This was not difficult to enforce in the hospitals and nursing homes, where many of the early members were already working as nurses and midwives, but a growing number of masseuses were practising in private homes, and so an additional level of regulation was needed here. The STM formed itself into a ‘gate keeping’ agency; taking referrals from doctors, and passing them on to registered and approved masseuse. Through this mechanism, the STM was able not only to vet the referring doctor, but also to control the work of its registrants.

A third strategy employed by the founders was to seek medical patronage for their organisational endeavours. Texts from the Wellcome library suggest that the STM went to quite considerable lengths to recruit medical support for their campaign to legitimise massage. The founders worked assiduously to obtain medical signatories to the Society’s principles, and to promote them in the Society’s advertising to the public. Signatories included Surgeon-General Sir Alfred Keogh, Robert Knox M.D., James Little M.D., Sir Frederick Treves, and the retired Past President of the Royal College of Physicians - Sir Samuel Wilks (Incorporated Society of Trained Masseuses, c. 1912).

Finally, if further recognition of medicine was needed, the founders made it clear that the knowledge that would form the basis for legitimate massage practice would be defined by biomedical, or more accurately biomechanical, reasoning. Early texts used by Society members leant heavily on the writings of doctors who had specialised in massage, exercise, electrotherapy, and other physical remedies (Bennett, 1902; Creighton-Hale, 1893; Ellison, 1898; D. Graham, 1884; Nissen, 1889; Palmer, 1901; Stretch Dowse, 1887). In some ways the STM’s timing was opportune, since it was clear that medicine was losing some interest in massage, preferring instead more detached, technical specialties emerging under germ theory (Stretch Dowse, 1887). A professional organisation prepared to take doctor’s place, that was complicit with medicine’s dominance, and indeed eager to seek the patronage of physicians, was therefore an ideal solution to the vexed problem of who should take on the practice of massage in the future.
Some authors have argued that the early founders of female-dominated professions, like physiotherapy, hindered their professional progress by deferring so readily to medicine which was dominated by an androcentric bias (Heap, 1995a; Witz, 1992). But I believe that this argument, based on a feminist interpretation of the profession’s history, fails to account for the success these women had in legitimising their practice. Without the patronage of the medical community, it is possible that the STM would have gone the way of the Harley Institute and others, who disappeared, in part because of their inability to obtain medical cooperation and support. And while this does not deny that the ‘trade-off’ for the profession, as Lynley Katavich calls it, was the acceptance of biomedicine as its guiding epistemology (Katavich, 1996), it does allow for the positive effects of power in creating the conditions necessary for the STM’s pursuit of legitimacy.

Normalisation and the creation of examination systems

Having developed two inter-related disciplinary technologies that helped to establish the legitimacy of the Society’s masseuses, I now turn to the systems of normalisation that were embedded in the STM’s examinations. In my view, the examination system established by the Society is the most ‘liberal’ of all the strategies mentioned in this chapter, since it involves the enfolding of authority into the machinery of the professional body (Dean, 1996). By this I mean that the examination system reflects the desire of liberal governments to govern the conduct of its citizens through the functions of particular authorities, who are themselves remote from the direct hand of the state. The examination system set up by the Society served this purpose by regulating who could enter legitimate practice without the need for direct governmental sanction. It is interesting to note, therefore, how the examinations were used by the STM and what functions they served.

Examinations were deemed necessary because; ‘Massage is a scientific method of treating disease by means of systematic manipulations, and is very different from the ordinary shampooing or medical rubbing, which can be acquired without any definitive training’ (Ellison, 1898, p. 1). This quote highlights the STM’s view that training in the complexities of legitimate massage demanded testing, and this testing needed to be sufficient to convince the medical profession particularly, that the STM was graduating suitably qualified practitioners. We can be confident that this was the view of the STM because M. A. Ellison was one of its founding members, and alongside Margaret Palmer, published one of the first texts specifically for STM registrants.
The significance of examinations to the STM’s purpose was highlighted by Barclay, who states that while the first objective of the Society was to ‘improve the status and training of masseuses’, the second was to ‘hold examinations and grant certificates’ (Barclay, 1994, p. 31). The first council of the Society recognised that it had limited resources and was small in size, and so decided against setting up a training school or defining a curriculum that would need to be policed around the country. Instead, it devised a registration examination that everyone who wanted to become a member of the STM had to pass. In this way, the Society could police the qualities and capabilities of the masseuses it registered. The effect of these changes was to establish a curriculum ‘at a distance’, since teachers would need to comply with this to be able to submit students for examination. This liberal approach to training and examination was in many ways an ideal solution for the Society, since it gave them the authority to discipline its registrants without being seen as being punitive or domineering.

Students attempting to register with the STM sat a national examination – written, approved and delivered by the Society’s Examination Committee. Training was offered by tutors dispersed around the country, many of whom were themselves STM members. Miss Manley, for example, was a leading massage teacher at Guys Hospital from 1888 to 1913, while Miss Palmer and Miss Despard were actively involved in training students in their own practices. Both of these tutors would go on to develop ‘curriculum texts’ for their students which included information on the important facets of practice necessary to be an effective masseuse (Despard, 1916; Palmer, 1901).

To qualify for registration, students had to demonstrate theoretical and practical competence in massage, medical gymnastics and later, medical electricity. These three domains were prefaced on the student’s knowledge of anatomy and physiology, kinesiology, rudimentary pathology and elementary physics, including biomechanics. Importantly however, the examinations also acted as a barometer of the student’s attitude towards their work and as a vehicle to reinforce the Society’s beliefs in ‘professionalism’. In 1908, for instance, 18 students under the tutelage of Miss Manley were reported as performing ‘useless massage; were painfully slow; knew few movements and had a casual attitude’ (Barclay, 1994, p. 39). The following year the examiners criticised nurse candidates whose ‘short petticoats, high heeled shoes, and transparent stockings, and an exceedingly obnoxious style of hairdressing’ went ‘extremely ill with a print dress, bonnet and veil’ (Examination Committee minutes 23 Feb, 1909 reported in Barclay, 1994, p. 42).
Every examination straddled the mutual concerns for the students theoretical knowledge, practical proficiency and professional demeanour. The first written examination conducted by students in 1895, for example, included the following four questions:

1) How would you treat a case of constipation?
2) What symptoms occurring during massage of a sprain, strain or recent fracture would cause you to send for the doctor?
3) Give the position, origin and insertion and use of four leading muscles.
4) You receive a letter from a would-be patient asking if you can undertake a case. What would you do? (Thornton, 1994, p. 11A, emphasis added).

By the written examination of June 1911, some of the attention to anatomy and kinesiology had changed, the students were still asked to demonstrate ‘How may the personal habits of the masseuse be responsible for success or failure in her profession?’ (Incorporated Society of Trained Masseuses, 1911, emphasis added), and in the November paper of 1914, the first five questions concentrate on anatomical, clinical and practical issues, while the last question asks ‘As a member of an honourable profession what do you consider to be your duties and obligations to that profession and to your fellow members?’ (Incorporated Society of Trained Masseuses, 1914).

It seems that the function of these ‘professional’ questions was to reassure the Society that the appropriate moral standards were being instilled in the students, with the students needing to demonstrate the right answer to these questions to register as a legitimate masseuse. Thus the questions in this examination served to test a set of normalised moral precepts about the proper conduct of the masseuse. Importantly, these precepts were based not on either the masseuse’s practical or technical ability – these were tested elsewhere – nor were they examining the masseuse’s knowledge of anatomy, pathology or treatment techniques. They were explicitly directed at measuring the registrants against the STM’s definition of legitimacy. They made the student subject to the gaze of the STM and, at the same time, the Society became an object of authority and expertise. They conflated those practices that gave students pass grades with legitimacy and normalcy, and marginalised all practices that hinted at incompetence, licentiousness or a casual attitude to work (Society of Trained Masseuses, 1895).

Foucault argued that discipline was a ‘type of power, a modality for its exercise, comprising a whole set of instruments, techniques, procedures, levels of application, targets; it is a “physics” or an “anatomy” of power, a technology’ (Foucault, 1977a, p. 215). For the STM, the examination was a principal disciplinary technology that served a number of purposes; it helped define the epistemological boundaries of legitimacy for
students and for the Society, and it differentiated legitimate masseuse from unregistered (and therefore illegitimate) practitioners. Access to registration carried some significant benefits for massueses – not least the access to patients referred by orthodox medical practitioners. Thus registration was an important corollary to examination, and it is to this that I now turn.

The registration of members as a technique of surveillance

The three disciplinary strategies already mentioned were effective in their own right as tactics designed to regulate the conduct of the Society’s members, they achieved particular significance for the Society, however, when they operated together ‘in concert’; when one strategy correlates with another to form a web of power effects. Foucault argued that ‘the product of the various forces is increased by their calculated combination’ (Foucault, 1977a, p. 167). For the STM, their ability to define legitimate professional conduct relied on their close relationship with the medical profession. Through this relationship, the Society was able to gain reflected legitimacy – hanging on to the coat-tails of the medical profession. The medical profession, however, needed to be convinced that the STM was earnest in its endeavour and offered a legitimate solution. Hence the Society’s deployment of rules of professional conduct and examinations as disciplinary devices. It seemed this was not enough however, because the STM went further in trying to ensure that its actions were seen to be well intentioned, and it did so by coalescing the other strategies around one common purpose; the registration of its membership.

Professional regulation of members is not, in itself, unusual in the history of the conduct of the established health professions, as Davies argues;

Professional regulation, in essence, is a state-supported power to place names on a register. Nineteenth and early 20th century legislation in the UK gave the right to doctors, pharmacists, midwives, dentists, nurses and others to maintain registers, and to make decisions about entry and about removal. Legal restriction of title to those on the register separated sheep from goats and enabled regulators both to set standards for entry to practise [sic] and to remove those who failed to meet those standards (Davies, 2007, p. 234).

Registration offers certain privileges to members of the professional group, but also levies obligations upon them. For the STM, the privileges offered to members included the patronage of the medical profession, the advocacy of a legitimate professional body, a recognised examination system that provided a certificate that people trusted, standardised rates of pay and conditions of service, and some degree of protection from the vagaries of

---

18 This reference to sheep and goats also appears frequently as a way of delineating legitimate and licentious masseuses (see for example the text of Figure 1).
an overstocked massage marketplace. For their part, to gain membership of the Society, the student was required to pass a stringent examination, subscribe to the STM’s rules, practise only in ways prescribed by the Society, register with the organisation and only take on patients that were provided by the Society’s employment agency.

For many this arrangement was mutually advantageous. For instance, it allowed the Society to trumpet that;

We do not recommend any from our Institute unless they undertake only to attend cases under medical supervision. We never recommend masseuses to male patients for general massage. We have the name and directions of a few excellent masseurs whom we can recommend for such cases (Reprinted from Nursing Notes, 1894, cited in Young, 1969, p. 271, original publication no longer available).

For the masseuse registration provided some guarantees of work, but most importantly it provided guarantees of a particular type of work. The employment agency established by the Society established a registration process that filtered all referrals and only took on cases that it knew to be legitimate. It no longer accepted requests for ‘general massage’, nor requests from men, unless referred by a doctor, and only then if they were ‘nursing cases’ (i.e. invalids) (Incorporated Society of Trained Masseuses, c. 1912).

The appeal of these guarantees appears to have been a strong influence upon the growth of the Society in its early years, since members were happy to endure shortages of work and poor rates of pay in order to benefit from the legitimacy that the STM offered. The competition within the market could not be ignored by the Society however and its council was ever vigilant to masseuses who were practicing unscrupulously. This was particularly important when masseuses sought to supplement their income by trading off their legitimate status to offer ‘other’ treatments to clients.

Unlike most of the founders; who as affluent single women were able to develop their interests in the Society largely as a philanthropic gesture – for which they received no financial reward – most newly registered masseuses struggled to live on the wages prescribed by the STM. Consequently, in the overstocked market for masseuses, the Society was repeatedly drawn into action against its own members, who found it necessary to offer beauty, chiropody and nursing services as a way of supplementing their income. In 1908, for example, one member complained that she had earned only 2 shillings a week from massage (at a time when the massage examiners were charging 21 shillings an hour for their services). At other times the Society recorded instances where registrants had changed their names to make their beauty treatments more appealing to women. Clearly training in massage, exercise and electrotherapy was perfectly suited to this line of work.
It was however deemed to be too close to an aesthetic of pleasure or luxury for the STM to countenance its practice.

Registration created mutually advantageous possibilities for the Society and its members, and in doing so, entrenched a set of disciplinary procedures based on the panoptic surveillance of the membership. The STM needed to police the margins of its operation continually to ensure that no single individual brought the profession’s legitimacy into disrepute. To aid this process, the STM appointed an Inspector (at significant cost to the personal wealth of the founders), whose job it was to visit each of the schools that prepared students for the registration examination, and ensure that they were upholding the Society’s standards.

The inspector’s role was of critical importance, and was only ever awarded to a masseuse of peerless principles and an unblemished professional career. Its first appointee, for example, was Miss Anne Gibson ‘a nightingale protégée, who had recently retired as Matron of Birmingham’s huge Poor Law Infirmary’ (Nursing Notes, 1st December 1895, p.161, cited in Barclay, 1994, p. 34). Not only was Miss Gibson an experienced nurse and masseuse, but also an early graduate of the STM and a therapist well schooled in the Society’s founding principles. The STM was a small organisation however, and the appointment of an Inspector was a costly undertaking in the quest for legitimacy. Despite this, the appointment added a further layer of legitimacy to a growing portfolio of disciplinary technologies.

Where the Inspector focused on the quality of students and the various training institutions, the registered membership was reached through the publication Nursing Notes which, from June 1887 through to WWI, provided information for nurses, midwives and later, registered masseuses, as a supplementary magazine to the large circulation Woman magazine. Through Nursing Notes, the STM was able to broadcast not only the administrative functions of the Society, but also its aspirations, requirements and principles. In one example, Miss Wilson commented on the need for personal dignity as a vital quality in the ‘making of the profession’; ‘a masseuse with a fussy manner who was not sure where to put her cloak and bonnet made a nervous patient worse, and demeanour was important as servants recognized the standing of the doctor and the trained nurse but were unable ‘place the masseuse’’ (Nursing Notes, 1900). These opinion pieces reinforced the more authoritarian rules and guidance notes produced by the Society and sought to enhance the standards of practice that were built in to the STM’s examinations.
The environment the STM created for its practitioners acted as an ‘enclosure’ in which registered members operated. While this gave members freedom to practise without fear of scandal, it demanded a disciplined approach to constantly police its boundaries and limits. These boundaries and limits were vigorously scrutinised in the early years of the society and the normalised practices defined by the STM’s examinations constituted a form of ‘moral orthopaedics’ (Rose, 1999, p. 221). This moral orthopaedics was based on the desire to make masseuses accountable for their actions and inculcate the Society’s values into their own systems of self regulation.

These arguments have been made elsewhere in analyses of the history of medicine, dentistry and nursing (Berghs, Dierckx de Casterlé, & Gastmans, 2006, p. 118). Berghs et al argued, for example, that discipline was the ‘essence of moral training’ in nursing, and that ‘a nurse’s character was more important than theoretical knowledge and more important than education’ (Berghs, Dierckx de Casterlé, & Gastmans, 2006). I believe this same argument holds true, in many respects, for the early massage profession. It is surely no coincidence that the motto carried on the badge of the Society from 1900 onwards was ‘Digna sequens’, or ‘Follow worthy things’. Where I disagree with Berghs et al however, is in the significance of particular aspects of the masseuse’s theoretical knowledge. What I will go on to argue now is that a particular facet of the profession’s epistemology was of primary importance in defining the masseuses’ subjectivity, and served as a form of knowledge on which the profession was based, as well as a disciplinary technology. What follows then is a detailed analysis of the role played by a biomechanical discourse in the legitimisation of massage.

The adoption of biomechanics as an ensemble of knowledge

The notion of the body as a machine has a long history in sociology and philosophy (Nettleton, 2005). In postmodern scholarship the body has taken on particular significance as a site of disciplinary practice (Foucault, 1977a); as a vehicle for destabilising ideologies (N. J. Fox, 2002), and as a proving ground for new rationalities of health, wellness and quality of life (N. Fox, 1999; Turner, 1996; S. J. Williams, 2003, 2006). In this study, I wanted to explore how a particular view of the body became a vehicle for disciplinary technologies, and as a means of legitimising the conduct of masseuses. The tactics and strategies mentioned thus far (examination, registration, normalisation, etc.), help to explain how the STM was able to discipline the general conduct of the masseuse, but they fail to address the specific problem posed by the masseuse’s need to touch the patient’s body and perform techniques that were closely associated with sensuality and eroticism.
How could the STM ensure, for instance, that when the masseuse touched the patient, they did so dispassionately?

The focus for my research fell upon the deployment of biomechanics as a discursive formation. References to the body-as-machine abound in the STM’s literature and yet, surprisingly, there has been no interest from within physiotherapy or elsewhere as to why this might be. My contention is that biomechanics served a greater purpose than simply providing an epistemological focus for the profession. My argument is that a biomechanical discourse played a vital role, alongside the other disciplinary technologies, in constructing masseuses’ subjectivity by governing how the masseuse was to view their patient’s body, and vitally, how they were to touch it.

**Constructing the patient biomechanically**

One only has to skim briefly through any of the early texts used as curriculum documents by the STM to see that anatomy, kinesiology and biomechanics make up a considerable proportion of the text’s content (Palmer, Despard, Stretch Dowse, etc.). Each text begins with an extensive treatise on structural and surface anatomy. In some cases this material spans well over half the book (Ellison, 1898, p. 3, original emphasis preserved). Details cover the origins and insertions of most major, superficial and deep muscles, the principles of movement and locomotion, and to a lesser extent, the major organ systems.

The STM were determined that student’s should have a comprehensive knowledge of human anatomy, as M.A. Ellison argued; ‘The *theoretical* part [of training] should include an elementary but sound knowledge of anatomy, with special attention to the position of the organs and the superficial muscles’ (Ellison, 1898, p. 2). The function of such detailed understanding of anatomy appears to have been normative; providing students with a body of knowledge that would inform their practice. But there is also the suggestion that this knowledge serves a more pragmatic function, as Margaret Palmer argues;

> The shampooing done in a Turkish bath is not massage; it is pleasant and useful, but it is not scientific, and is done by persons who have no knowledge of anatomy; nor is it necessary they should have, but to do massage properly and to be able to follow intelligently the directions of the medical man, some knowledge of anatomy is essential (Palmer, 1901, p. 3).

This quote illustrates that a sound knowledge of anatomy was thought to elevate the practice of the legitimate masseuse above the level of untrained ‘hack’, who operated without any real scientific rationale. Similarly, knowledge of anatomy aligned masseuses more closely with the medical profession – something that had a considerable bearing on
the profession’s pursuit of medical patronage. It would be reasonable to argue then that while a biomechanical view of the body provided a solid epistemological foundation for the manipulations, movements and exercised performed by masseuses, it also served to normalise certain knowledges of the body, and it helped create a disciplinary alliance with medicine.

Biomechanics cannot be analysed effectively therefore, in the context of its role within the STM, unless one considers it as the strategic deployment of particular knowledge in the service of particular ends. Biomechanics must be seen as both a particular set of normalised knowledges, and as an effect of a number of relations of power. Taken together, these rationalities affect the subject positions available to masseuses in their practice. To explore these subject positions in more detail, I have considered how different ‘bodies’ were constructed in the STM’s texts. Each of these places a biomechanical discourse at its core. They are ‘The Cadaver’, ‘The Model’, and ‘The Machine’, and each will be considered in turn below.

The cadaver

The metaphor of the cadaver is used here to illustrate how many of the early masseuses’ texts described the body of their patients as an inanimate object; a vessel containing muscles, bones and joints; passive moving parts that needed to be scrutinised and named. Representations of the body in this way appeared repeatedly in photographs and line drawings, descriptions and analyses. In all cases, the body was defined by accepted anatomical conventions and taxonomies, but only those parts of the body that were deemed suited to the work of the masseuse were described. Thus the texts focused exclusively on the superficial layers of the skin, the muscles, bones, and joints.

Although the body of the patient was frequently represented in this way, it seems clear that the author of the text knew that it was only a convenient device with which to express certain capacities possessed by the body, as this quote from the Swedish Institute in London indicates; ‘The results of massage being essentially vital, we must at the outset devote our best attention to the marvellous mechanism of the frame and tissues on which we operate’ (The Swedish Institute, c. 1918). Importantly, the cadaver allowed the massage teacher to strip away the ‘vital’ effects of massage, and focus instead on the body as an inert, unemotional vessel. Thus massage could start to be seen as a technical operation removed from its aesthetic connotations.
The cadaver represents a metaphor for the body as a depersonalised body-with-organs (Deleuze & Guattari, 1987), an anatomical atlas, or surface to be ‘mapped’ (Foucault, 1973). Repeatedly, texts used by early Society members detail increasingly complex and abstract notions of the physical body – a body available to the detached, neutral gaze of the therapist; one that can be seen without itself seeing – a panoptical gaze trained on bodies without regard for their inherent ‘humanity’ (see Figure 7 and Figure 8).

Figure 7. 'Flexing the thigh with the leg extended' from Despard (1916, p.358), showing the dispassionate gaze of the masseuse in practice
In the above images, for example, we see how the STM had to grapple with complex tensions over the body; the need to be naked in order that due regard for the individual’s surface anatomy could be given, and the need to touch and give relief. We also see indications of how the STM dealt with some of these tensions; allowing only women to massage other women; emphasising the technique of touch rather than its communicative or emotive effects; gowing the patient to maintain their decency, but also to ‘disembody’ the patient; obscuring the identity of the therapist; etc. Each of these micro-technologies further enhanced the masseuses dispassionate gaze upon the body of their patient.

Students were expected to have a detailed working knowledge of the anatomical conventions of naming and organising the body. For instance, in one of any number of examples from Margaret Palmer’s text, written for STM registrants in 1901, students were exposed to a degree of anatomical detail possessed by few outside of medicine (and certainly not within the nurses training curriculum at the time – an important point of differentiation for STM members, particularly those already trained in nursing and midwifery). In this example, the degree of description matched that found in medical texts at the time;
**Connective tissue**, also called areolar, fibrous and elastic tissues, is the most widely diffused of all the tissues of the body; besides enveloping all the muscles, it forms a sheath for each (p.32)...The lymphatics of the right arm, of the right side of the head and upper part of the trunk, take up the lymph from these parts and carry it to the **right lymphatic duct**, which is a short vessel about an inch long, emptying into the innominate vein (p.45)...The muscles chiefly concerned in producing movements of the joints of the upper limb are as follows: **Shoulder**:

- Flexion: pectoralis major, anterior fibres of deltoid; Extension: latissimus dorsi, posterior fibres of deltoid, teres major; Abduction: deltoid, supra-spinatus (p.72) (Palmer, 1901).

These descriptions were justified by the authors who argued that it was necessary for the masseuse to be able to operate on the patient’s body with a similar degree of understanding to the referring doctor. The descriptions were problematic in many ways because they could have been seen as a threat to doctor’s authority; particularly since the descriptions of the body’s movement systems and biomechanics exceeded that found within texts used by student doctors (Despard, 1916). Thus, knowledge of the biomechanics of the body had to be accompanied by professional rules and teaching on the relationship between the two professions, to ensure that the masseuse knew her place (but also to ensure that doctors knew that the masseuse knew her place).

Frequently, the students attended medical school dissection rooms where they learnt to recognise the various muscle origins and insertions, bony prominences and anatomical landmarks first hand. Complex systems of categorisation were required to organise muscles into functional groupings that facilitated understanding (see Figure 9).

**Figure 9. Table of muscles of the upper limb from Palmer (1901, p.78)**
As the above table shows, detailed layers and hierarchies of muscle functions were developed, and with each layer came greater anatomical sophistication. The more sophisticated this abstract notion of the body became, the further the masseuse moved away from viewing their patient with aesthetic eroticism or fantasy. The body could become entirely corporeal, and in so doing, detached the therapist from any association with intimacy and licentiousness.

Elegant in its simplicity, this model made it possible to instil a neutered attitude in the masseuse; one that found favour with the medical community and elevated the profession above the uneducated ‘rubber’. This view immeasurably advanced the Society’s licence to touch without fear of approbation – assuming, of course, that the STM was assiduous in its ability to instil these values in its students. This disciplined approach to the body created a distinct subjectivity for the masseuse – a regulated, practical, dispassionate subjectivity applied to an otherwise sensual object; disciplined, objective and value-neutral. It was however, a model with limited utility, since bodies were clearly not static, disengaged or motionless. Thus, the metaphor of the cadaver had clear limits for the masseuse who needed to engage with a body enlivened with the capacity for movement, expression and display. Here then the metaphor of ‘the model’ serves to illustrate the ways in which the founders were able to address the potential hazards posed by the moving body.

The model

In the latter half of the nineteenth century, at the height of industrialisation, mechanisation discourses became commonplace (Jackson-Houlston, 1999; Morus, 1999). Some explored the way that the population as a whole could be seen as a ‘machinery of production’ (Morus, 1999), while others explored the mechanistic properties of individual bodies (Brauer, 2003; Synnott, 1992). There was a shared concern in all of these discourses, however, that brought together political questions of how best to govern individual freedoms (whilst maximising the efficiency and effectiveness of individual bodies), with ethical and moral questions of how best to conduct oneself (Armstrong, 2002). These discourses focused, to some extent, on the body’s relationship with nature, its capacity for movement and, most importantly, its ability to engage with other bodies. As David Armstrong argues, the body was slowly ‘brought into movement’. Whereas earlier social theorists had been concerned with the minutiae of correct posture and its associations with poor health and a poor ‘attitude’, attention now shifted to the capacity for
movement in the body, and the capacity for bodies to engage with one another (Armstrong, 2002, p. 44).

For the STM, understanding the inanimate body of the cadaver was only partially satisfactory. As with the physical training movement that ‘became emblematic of the twentieth century concern to take the still, inanimate body of the nineteenth century and give it movement’ (Armstrong, 2002, p. 44), the texts produced by writers for the STM’s students concerned themselves with how to govern the moving body. My belief is that this was not based on a conscious awareness of the need to discipline the actions of the masseuse with regard to the patient’s capacity to move, but rather an awareness that the moving body was problematic for the profession since it carried with it aesthetic qualities that could be used for licentious or immoral purposes.

The solution offered by those who wrote for the STM’s students; M. A. Ellison, Margaret Palmer, Louisa Despard and others; was to place a strong emphasis upon the study of the physical properties of movement; particularly the mechanical properties of forces, levers, motions and moments. The STM had available to it a large number of texts that explored, in increasing detail and complexity, the physics of the moving body (Creighton-Hale, 1893; D. Graham, 1884; Nissen, 1889; Stretch Dowse, 1887; The Swedish Institute, c. 1918). It was possible then, to take the image of the static, passive body, and animate it through the abstract categorisation of movements, and represent to students of massage a body that was entirely devoid of culture, gender, age, or other subjectifying characteristics (see Figure 10).

![Diagram of biomechanical representation of forces applied to the lower limb](image)

**Figure 10.** Biomechanical representation of forces applied to the lower limb. Source: Guthries Smith (1952, p.158)
In these images the body represented is of indeterminate sex, age, race or ethnicity. It is a body whose movements mimic a machine. In this way, the cadaver was mobilised and represented in abstract form as a functioning model. In numerous examples throughout early STM texts, the body was represented first as a ‘cadaver’ – a body with tissues that attach in one place and insert into another, and then as a model – a set of structures bearing the capacity for movement. These ‘actions’ were largely separated from everyday functions – thus the arm could be flexed at the elbow with biceps brachii, brachialis and brachioradialis, but these movements are abstracted from the reason for having the muscles in the first place; to eat and drink, gesture to another person, or fire a gun, for example. This more functional view was to follow, but only after the body had been completely denuded of its capacity for aesthetics.

The model was the basis of an important point of difference for masseuses that the later physiotherapy profession would need to problematise. The model gave the massage student the ability to focus on the body of the individual patient that presented to them. Each body was a unique adaptation of the anatomical map presented to them in their training, and needed to be scrutinised in fine detail. The model gave the massage professional the view that each body was a uniquely distinct entity that could be understood without the need to consider the cultural associations of societies. Thus unlike medicine, nursing, dentistry, psychology and most other professional organisation of the early twentieth century, the massage profession spurned the opportunities offered by population-based medicine. While doctors were developing mass inoculation programs and the British Dental Association were encouraging everyone to take regular dental check-ups (Nettleton, 1992, 1994), masseuses only considered the body of their patient as a unique, individual entity. This legacy would have important implications for the future development of physiotherapy as a profession and will be discussed in subsequent chapters.

The model therefore served to situate the masseuse in relation to the object of their gaze; as a dispassionate witness to the intimate differences between each person’s body. The model, with its capacity for movement, enabled the masseuse to regard the body as a system of levers and biomechanical forces. This was the closest the massage profession came to viewing the body as a composite of mechanical parts. This remained an abstraction however, and the authors of the masseuse’s texts knew that they had to address the problem of the body that could engage in leisure pursuits, enjoy exercise, join with
others in play, interact, etc. I have used the metaphor of the machine to explore how I feel these authors addressed this problem.

The machine

The metaphor of the machine brings together and amplifies the shared concerns expressed by the metaphors of the cadaver and the model, in that it explores not only the capacity, but also the actuality of bodily movement. The texts available to the STM’s registrants deconstructed the body’s movement and exposed it to critical scrutiny through a detailed process of classification and division. In a move that was replicated throughout the early actions of the STM, these rationalities were borrowed from the Swedish Institute in Copenhagen, who had, in turn, developed a rigid system of classifications in the early nineteenth century under the tutelage of Per Henrik Ling (1776-1839) (Calvert, 2002; Roth, 1851). The system stabilised the social body by imposing upon it rigid definitions of normalised movement patterns. Thus the therapist was trained to consider the moving body by defining an array of ‘starting positions’; or positions from which movements were derived (see Figure 11). These starting positions were divorced from everyday social activities such as walking, sitting on the bus, or leaning at the bar. They were ‘fundamental’ positions from which all other movements, and importantly muscle actions, could be derived:
The above text shows one of many dozens of pages devoted to the definition of ‘fundamental’ and ‘derived’ positions that became the unique province of masseuses and physiotherapists. These positional descriptions were first used in teaching in the first decade of the twentieth century and were still being taught in England and New Zealand in the 1980s. In that time, they remained almost entirely unaltered. What they show is the position a patient must adopt, and instructions that the masseuse must give, to make a specific muscle group function.

These fundamental positions formed the basis for the masseuse control of patients’ movements. All movements began with a defined starting position, and as the example below indicates, these starting positions were prescribed and regulated by the masseuse;

**I. STANDING FUNDAMENTAL POSITION**

- Heels together.
- Feet forming an angle of not more than 45°.
• Knees fully extended.
• Hips fully extended.
• Head erect and chin slightly drawn in.
• Shoulders held well back and drawn down.
• Arms hanging by the sides.
• Fingers not fully extended.
• Palmar surface of the hand in contact with the lateral side of the thigh.
• This position innervates all the muscles of the back of the neck, the back, extensors of the leg and thigh, and others. It expands the chest and maintains the pelvis in a correct position (Despard, 1916, p. 226, emphasis preserved).

Starting positions such as these provided the template from which a number of ‘derived’ positions and subsequent movements could be performed. Thus, every functional movement could be defined by categories of body position – every action could be analysed for its ability to locate the body in space, and the body work involved in each movement could be calculated as a sum of forces. In the example below, the fundamental starting position has been adapted to allow the masseuse to examine the movements working the extensor muscles of the hip. What is striking for me about these disciplines is how they are directed at the conduct of the masseuse, rather than the direction given to the patient. It is the masseuse that is being instructed here; it is the masseuse that is being disciplined into learning these ritualistic patterns of movement; and it is the masseuse who becomes subject to the gaze of tutors and examiners who can glean from their performance how well they have learnt to adopt the proper gaze of the dispassionate therapist;

MOVEMENTS WORKING EXTENSORS OF HIP JOINT
HIGH – RIDE – SITTING TRUNK – BENDING – BACKWARDS, AND TRUNK RAISINGS belong to this group
BACK-LEAN-STANDING LEG-FORWARD-DRAWING
Patient stands with back against rib-stool or wall, generally on a stool. Gymnast stands in front and fixes one hand over ant.sup.iliac spine, the other hand grasps leg immediately above heel.
Gymnast draws leg forward while Patient resists, whereupon Patient carries it back to Position while Gymnast resists.
Repeat 4 to 6 times.
It is most convenient for Gymnast to stand on inner side of leg.

WORKING MUSCLES
Extensors of hip (excentrically [sic] and concentrically)
Draws blood from Pelvis. Move takes place in hip joint (The Swedish Institute, c. 1918) (see Figure 12 and Figure 13).
Figure 12. Derived position from Kleen (1918, p.241)

Figure 13. Derived position from Kleen (1918, p.241)
The disciplines that were embodied by these texts were also drawn in figures that represented the movements being performed. Perhaps unsurprisingly, the representations used were frequently either naïve, childlike stick-figures (see Figure 14), or carefully framed photographs of actors designed to portray austerity and functional discipline (see Figure 15). The representations of the patients performing functional movements in Figure 14, show a person (neither male nor female) as a stick figure – stripped back only to the muscles, bones and joints that need concern the massage student; a stylised head incorporated only to indicate the direction the body is facing. This represents, for me, the author’s attempt to define the machinery of movement in its most rationalised form; movement as purposeful function; devoid of pleasure, sensuality or eroticism. In Figures 12 and 13 two students, dressed uniformly, demonstrate how to perform the derived positions and movements. The austerity of their surroundings, and the coverage offered by their clothing, contrasts dramatically with the European tradition that was developing at the same time. In Alice Bloch’s text ‘The Body Beautiful’ (Bloch, 1933), almost identical exercised to those found in English masseuse’s texts are performed by models, but with an entirely different aesthetic (see Figure 16). Throughout the text, the models are connected with the natural world, by being positioned at the side of a lake, and most strikingly, completely naked. This tradition for a more relaxed attitude towards the contact between bodies was replicated in the Scandinavian approach to physical therapy called Mensendieck (Mensendieck, 1937). In this system, students learnt the structures and functions of the body without the restrictions of clothing – very much in contrast to the repressive practices of Victorian and Edwardian masseuse.
Figure 14. Illustration of derived positions applied to functional movements of the spine  
(Prosser, 1943, p.140)
My contention here is that the actions of the authors of these texts, in representing the aspirations of the STM, were a contingent response to the context in which the founders operated. The disciplines they instigated reflected Victorian heteronormative attitudes towards the body and the risks posed by unfettered contact between the sexes. The construction of the body as a machine allowed the masseuse to touch the body of the patient without fear of impropriety, which lent the profession respectability and legitimacy in the eyes of the public and the medical profession. These disciplinary technologies cannot, therefore, be seen as purely oppressive or constraining, since they made it possible for masseuses to adopt subjectivities that furthered their cause and promoted their interests.
Figure 16. Outdoor exercise by lake. Source: Bloch (1933, p.46)

The adoption of biomechanics addressed the ‘political’ problem of licentiousness by removing it ‘from the domain of political discourse, recasting [it] in the neutral language of science (or that of its associated applications), and transforming [it] into [a] technical problems for the sole attention of specialists and experts’ – in this case, the legitimate massage profession (Hook, 2003, p. 610, emphasis preserved).

I believe the metaphor of the body-as-machine helps explain how the founders were able to formulate a way of teaching students to touch patients’ bodies without the association with prostitution, and in this regard, it must be considered a successful strategy. By 1925 the Society’s membership had swelled to 5,600 practitioners, it had achieved Chartered status, and had secured its pre-eminent position within the public health system through its work during and after the First World War. Much of this success, I argue, owes itself to these tactics and strategies and the subject positions they created.

Up until this point, I have not considered the application of these tactics to a particular health problem. This is primarily because this was how the metaphorical body-as-machine was introduced to students of the STM. Clearly, however, massage practitioners worked with people with an array of health problems. The masseuse had little
say in the kind of patient they were to treat since the decision was entirely in the hands of
the referring doctor. Indications in the literature suggest however that massage referrals
concentrated on the degenerative musculoskeletal, neurological and ‘hysterical’ conditions
that failed to respond to pharmaceutical intervention (Beard, 1869; Creighton-Hale, 1893;
Ellison, 1898; D. Graham, 1884; Palmer, 1901; Stretch Dowse, 1887; Weir Mitchell,
1893). Of these conditions, one stands out as a paradigm case for the early massage
profession. Neurasthenia was a condition that the medical profession had little interest in
treating itself, but one that plagued a good many of the ‘leisure classes’ of Victorian
England. The emergence of the STM coincided with a newfound interest in treating these
‘sympathetic’ nervous complaints, and with the Society’s conjoint interests in massage,
movement, electrotherapy and nursing, it found itself in the ideal place to exploit the
doctor’s desire for a skilled, respectable worker to take on the task of rehabilitating these
patients. I will argue in the next section that neurasthenia gave the massage profession the
ideal population with which to demonstrate its legitimacy; to practise its disciplinary
technologies; and to prove its worth to medicine and the population at large.

Neurasthenia and the legitimisation of massage therapy

In the chapter thus far, I have defined a set of disciplinary practices enacted by
masseuses for the regulation of their practice, and in the pursuit of professional legitimacy.
These practices included rules of professional conduct, disciplinary alliances with the
medical profession, and systems of normalisation, examination and registration. Most
recently I have argued that biomechanics played an important role in defining the
masseuse's professional subjectivity. In the following section I will argue that these
technologies found their most potent form of expression in the management of the patient
with neurasthenia.

Neurasthenia, otherwise known as anxiety neurosis, muscular exhaustion, or a host
of other pseudonyms (Gardner & Bass, 1989), was a well-known condition in late-
Victorian society. Portrayed as a condition of the idle rich, neurasthenia was associated
with a class of women, or ‘sofa wives’, who were prone to nervous exhaustion. Parallels
have been drawn between the illnesses experienced by these women and the rigid social
structures that contributed to their ill health (Golden, 1989; Haney-Peritz, 1986). These
women were literally and metaphorically bound to a set of rigid social practices that
demanded strict codes of decorum, the avoidance of physical (especially paid) work, the
governance of a household (often including servants), and attention to a bewildering array
of displays of dress. Enormous pressure was put upon these middle and upper class
'women of standing’ to display certain postures in public that demanded pinched waists and heavily boned corsetry (H. E. Roberts, 1977; L. Summers, 2003). The use of corsetry, common between 1860 and 1920 had remained in vogue for many of these women, and images from the end of the nineteenth century show an almost fetishistic interest in acquiring a thin waist (Fields, 1999; H. E. Roberts, 1977; L. Summers, 2003). Girls as young as 5 were corseted such that by the mid-teens they were unable to sit or stand unsupported.

The lack of free movement and the restrictions on breathing and circulation, caused many of these women to become ill (although this was frequently denied by advocates of corsetry), and the physical disorders that ensued were compounded by psychological anxieties that developed from the enforced docility that many of the women had to endure (see Figure 17). Most were well educated women who found the constraints on their activities tiresome (K. Williams et al., 2004). Some engaged in minor philanthropic work where it was possible, while others took the bold step to defy convention and move into occupations (like nursing, midwifery and massage), where they were offered the opportunity for useful work and a greater freedom of movement (Fields, 1999). These professions were only feasibly alternatives, however, if they were accepted as socially respectable.

Figure 17. Common image of neurasthenia c.1900. Source Williams, et al (2004, p.8)
The massage texts used by the STM’s registrants dealt extensively with the correct management of neurasthenic patients (Despard, 1916; Ellison, 1898; Palmer, 1901; Stretch Dowse, 1887). The preferred treatments were enforced rest, passive exercise, massage, electrotherapy and strict attention to the diet. These treatments formed the basic competencies examined by the STM and so the nurse-masseuse was ideally positioned to provide treatment for patients with this condition. Added to this, the patients were mostly women (which was therefore no barrier to massage and legitimate touch) and of a similar age and social standing to the masseuse. Thus the masseuse could enter the patient’s household, hold down a position within the house for the period of the woman’s confinement (appointments were frequently residential for six to eight weeks); attend to her personal nursing care, whilst also offering recuperative treatment with the skills provided by her massage training.

Neurasthenia was a well known condition in the latter half of the nineteenth century thanks to the work of one of its greatest proponents – Dr. Silas Weir Mitchell. Weir Mitchell, a controversial figure at best, was considered to be the foremost American neurologist of the nineteenth century, and his book ‘Fat and Blood: An essay on the treatment of certain forms of Neurasthenia and Hysteria’ (Weir Mitchell, 1893) became a pivotal work in the recognition of a condition to which there was no obvious organic basis. The condition, first named by George Beard (Beard, 1869), identified a syndrome of symptoms that had been known by a variety of other names (see Table 2). The condition could be identified by the presence of fatigue and malaise, transitory clouding of consciousness and a feeling of ‘other-worldliness’, restless sleep, agitation, localised sympathetic symptoms including cold hands and feet, flushes and sweating, palpitations and pseudo-anginal attacks (Encyclopaedia Britannica, 1911).

Table 2. Syndromes associated with neurasthenia (Weir Mitchell, 1893, p. 9)
Frequently the condition was diagnosed in people who, it was said, lacked the constitution to sustain a busy productive lifestyle\(^\text{19}\). In this way the diagnosis served to connect the common eugenic notion of ‘weaker’ individuals, with a veiled critique of the ‘pace of life’ that left some women with the capacity to retain ‘repose’ (K. Williams et al., 2004). In the description below, Weir Mitchell defines the ‘common complaint’ seen by the physician.

The cases thus treated have been chiefly women of a class well known to every physician, - nervous women, who, as a rule, are thin and lack blood. Most of them have been such as had passed through many hands and been treated in turn for gastric, spinal, or uterine troubles, but who remained at the end as at the beginning, invalids, unable to attend to the duties of life, and sources alike of discomfort to themselves and anxiety to others (Weir Mitchell, 1893, p. 9).

The ‘duties of life’ that Weir Mitchell refers to here, were almost certainly those of domesticated middle- and upper-class women. The lives of these women have been the focus of a great deal of scholarship to date (Gijswijt-Hofstra & Porter, 2001; Neve, 2001; K. Williams et al., 2004), indeed Charlotte Perkins Gilman’s account of her diagnosis and treatment under the Weir Mitchell Rest Cure method, first published in the New England Magazine in 1891 and later in print, became something of a rallying point for feminist scholars who used this account to illustrate the oppressive nature of social, and particularly brutal medical practices used to subordinate these women (Haney-Peritz, 1986; D. Thomas, 1998).

Weir Mitchell’s methods were certainly oppressive. His remedy, detailed in numerous early massage texts used by students of the Society, involved a rigid system of discipline, force feeding, and the ritualised administration of a range of passive therapies. The woman had her movements completely restricted by the nurse-masseuse during a period that could last as long as 8 weeks. For much of this time the woman was confined to bed. She was prevented from writing or reading letters, communicating with the outside world or reading the newspaper. She was even denied access to family and friends. Indeed all external stimulants were removed. Weir Mitchell then insisted that the women undergo a course of force feeding; Margaret Palmer’s book for massage students gives an indication of the disciplinary approach taken towards patients with neurasthenia under Weir Mitchell’s prescription;

**Feeding** - The patient is gradually put on a milk diet, one quart (two pints) daily in divided doses of 3 or 4 ounces. It may be warm or cold, and barley, rice or lime water added to aid digestion. A cup of black coffee without sugar, is given in

\(^{19}\) The notion of neurasthenia was co-opted during the first world war to explain shell shock. In some locations this was also called ‘Soldier’s Heart’, see Table 2.
the early morning to regulate the bowels. In a couple of days the milk is increased
to two quarts, in doses of 5 ounces; later on, 10 ounces. Within a week the patient
has soup and a light breakfast. Later on a mutton-chop at mid-day, then thin bread-
and-butter three times a day (Dr. Weir-Mitchell advised butter to be used freely).
Within a fortnight the patient has three full meals daily, besides two quarts of milk.
Fluid extract of malt is given before each meal (Palmer, 1901, p. 218, original
emphasis preserved).

Recognising the patient needed exercise to improve ‘her blood’, but not allowing
her to move beyond the confines of the room, Weir Mitchell’s approach relied on the
assistance of masseuse who could perform the necessary massage and electrotherapy – two
passive devices ideally suited to the patient’s enforced docility. Perversely, the Rest Cure
became a popular symbol of social status for therapists and patients alike, such that to have
ones own ‘live-in’ therapist became its own symbol of status;

So fashionable did the Rest Cure become among the gentry that many women,
including some with no discernible medical complaints, engaged personal
masseuses daily in their homes as a form of preventive medicine. Gentlemen did
much the same, also ostensibly for medical reasons, though usually taking
treatment at one of the comfortable and clubby west End massage “parlours”
(Murphy, 1995, p. 17).

Neurasthenia offered the Society the opportunity to demonstrate its legitimacy, and
from the evident popularity of the treatment, and the growth in membership numbers, they
were successful. The condition allowed the Society to utilise its treatment skills in an
environment that was ideally suited to its work. The patients were predominantly female,
or otherwise required nursing care, and since many of the Society’s first members were
nurses or midwives, they were well able to care for the patient’s personal needs. The
patient’s confinement required the masseuse to show mature discipline and act entirely in
accordance with the doctors wishes, and what is more, to detach themselves from the
personal concerns that had caused the patient to labour in the first place and, instead, instil
a new discipline in the patient. The neurasthenic patient also allowed the STM to maintain
close personal surveillance over the conduct of the masseuse, who acted against anyone
who transgressed the narrow constraints of their scope of practice; they distributed work
only to those who complied entirely with the STM’s systems and structures, and they
constantly reinforced the importance of a biomechanical discourse in managing the contact
between therapist and patient. Thus the STM secured a lucrative and mutually
advantageous relationship with medicine that was based, in the first instance, on the local
problem posed by the massage scandals. It is my belief then that neurasthenia was pivotal
in helping the Society establish its legitimacy. The question of neurasthenia returns later in
the thesis, when I juxtapose it against the new practices of Breathing Works. I now return
to the question that began the chapter and summarise some of the critical points I have made thus far.

**In summary: Returning to the problematisation of massage**

Problematisations refer to the ‘everyday practices where conduct has become problematic to others or oneself’ (Rose, 1997, p. 26), and in exploring the actions of the STM, I have attempted to show how the Society ‘render[ed] [the problem of massage] intelligible and, at the same time, manageable’ (Foucault, 1977a, p. 193). In attempting to address the problems posed by the massage scandals, the society developed disciplinary technologies whose purpose was to legitimise the actions of masseuses. The practices that these disciplines made possible resulted in the development of rules, alliances with the medical profession, examination and registration systems, and a particular view of the body that allowed the therapist to touch the patient without fear of impropriety.

When we consider how these actions relate to the questions I posed at the start of this study, I have shown that technologies of discipline were of pivotal importance in the establishment of the Society of Trained Masseuses as a legitimate solution to the problems posed by the massage scandals. I have also shown that the actions and practices that were tied to the discourse of legitimacy created certain knowledges about the way a patient’s body should be regarded, but also, how a masseuse should conduct herself. These actions and practices therefore reveal aspects of the emerging professional subjectivity that was being constructed by the STM. Finally, I have shown that this subjectivity was inextricably linked to governmental questions in that it arose from a set of concerns for the moral conduct of the population that was particular to late Victorian England. What I will show in the following chapter is how the emerging subjectivity of the legitimate massage profession in England correlated with, and was transformed by the massage profession in New Zealand, which took on the English concern for legitimacy and used it as the basis for its claims to orthodoxy.
CHAPTER FIVE – THE PURSUIT OF ORTHODOX STATUS

At the time of the founding of the Society massage was used as a luxury of the well-to-do, and regarded as a substitute for healthy exercise. Today it is serving an infinitely nobler end in soothing nervous wrecks, and in helping to save limbs shattered in many a grim battle fought for the country and for freedom (Palmer, 1917).

Introduction

In Chapter Four I analysed the discursive formation of the Society of Trained Masseuses in late-Victorian England. At the heart of my analysis were the technologies of discipline that were used by the Society to promote a legitimate response to the problems posed by the massage scandals of 1894. The chapter focused on the responses of the Society’s founders to the association between massage and licentiousness, and the effect these responses had on masseuses’ subjectivity. In developing rules of professional conduct, the patronage of the medical community, systems of examination and registration, and most especially, an epistemology based on a biomechanical discourse, I argued that the Society rendered the problem of legitimate massage intelligible and manageable. In the following chapter I explore how the welfare reforms of the middle of the twentieth century created a new problem space for the massage profession, and draw on the actions of masseuses in New Zealand to explore the discursive formations, tactics, strategies, concepts and technologies that they employed to respond to these issues.

The substantive focus for the chapter is the formation of a legitimate massage profession in New Zealand, and its transformation into an orthodox health profession known as physiotherapy. The chapter is divided into three sections. The first deals with the conditions that made the birth of a legitimate massage profession in New Zealand possible, and here I reflect upon the influence of the STM’s discursive construction of legitimacy in framing the subjectivity of masseurs in New Zealand. In this section I revisit the disciplinary technologies developed in Chapter Four, and ask why these had such a profound effect upon the massage profession in New Zealand. In the middle section of the chapter, I explore how the question of legitimacy was transformed in New Zealand by the desire to establish masseurs’ orthodox status and take advantage of the opportunities offered by the emerging welfare state in the two decades after 1930. This section deals primarily with the pursuit of greater governmental recognition and professional autonomy,

20 The collective noun ‘masseur’ will be used throughout this chapter to refer to massage practitioners in New Zealand. The rationale for this alteration from the convention used in Chapter Four will be explored later in the chapter.
and considers the role played by discipline-specific legislation in creating new possibilities for the profession. The final section of the chapter considers how the physiotherapy profession in New Zealand exploited these new-found opportunities by establishing clinical sub-specialties within the public health system. I focus here on the paradigm case of respiratory physiotherapy. I argue that this sub-specialty is of particular interest because it represents the conjunction of a number of relevant theoretical and substantive questions raised by this study: the discourses of legitimacy and orthodoxy; governmental concerns for the rehabilitation of people with respiratory disease (a major health problem during the period); and disciplinary technologies that framed respiratory physiotherapists’ subjectivity. These conjunctions are brought together to explore how the masseuse’s pursuit of legitimacy was transformed into the physiotherapist’s pursuit of orthodoxy.

In returning, therefore, to the questions that I posed in Chapter One, the questions I pose in this chapter are:

1) What discursive formations informed the actions of the founders of legitimate massage practices in New Zealand?
2) How were these actions informed by the discursive formations and disciplinary technologies developed by the Society of Trained Masseuses?
3) What actions resulted from these influences?
4) What new knowledges about legitimate massage practice were promoted by masseurs in New Zealand, and what was marginalised?
5) What relations of power developed through the actions of orthodox, respiratory physiotherapists?
6) How did the development of welfarism influence the transformation from a concern for professional legitimacy to orthodoxy in the physiotherapy profession between 1930 and 1950?
7) What subject positions were created with the construction of the orthodox masseuse?
8) How did the actions of New Zealand masseurs create new possibilities for legitimate, orthodox for the massage profession in New Zealand?

I open this chapter by addressing the first of these questions and considering the conditions that made the discursive formation of legitimate massage possible in New Zealand.

**The discursive formation of legitimate massage in New Zealand**

**The influence of the Society of Trained Masseuses**

Before 1913, New Zealand, like England 20 years earlier, had no formal system of training or registration for practicing masseurs. Reports from the period indicate that this caused many of the same problems experienced in England;

The so-called masseur or masseuse who goes about the country with a certificate which is simply a receipt for money paid is an abomination and has been the means of bringing a legitimate mode of treatment into disrepute. For this reason we have
been shy of giving encouragement to unknown persons desirous of practising massage at Rotorua [a spa town in the North Island of New Zealand]. We have long recognised the desirability of having a thoroughly competent masseur established here. The difficulty has been to secure the services of a man who had the necessary training and experience (Department of Statistics, 1894).

The above quotation suggests that the question of legitimacy was closely tied, in the minds of the officials that wrote this account, to the education and experience of masseurs. It also seems clear that the officials recognised that New Zealand possessed no standardised system of training in massage that was recognised as bona fide. Notwithstanding these concerns, little was done to develop a training school or regulate the practice of masseurs until a number of doctors employed at the University of Otago Medical School, returned from England having observed the work of pioneering orthopaedic surgeons like Robert Jones, and his use of masseuses as a profession closely allied to surgery (Taylor, 1988).

The pressure exerted by the doctors of the Otago Medical School was almost certainly matched by complaints from the rapidly increasing numbers of trained masseuses that emigrated to New Zealand from Britain in the first decades of the twentieth century (Anderson, 1977). Many of these masseuses had been involved in legitimising massage in England, and knew of the benefits to be had by formalising curricula, examinations, systems of registration, etc. It is clear that in the years between 1900 and 1920, there was large-scale migration of professional masseuses from England to all corners of the Dominion; to Australia, Canada, India, New Zealand and South Africa, and that the arrival of these immigrants heralded the formation of legitimate professional bodies and protective legislation (Taylor, 1988).

Many of the regulatory systems and curricula that developed in these colonies bore a striking resemblance to the STM’s professional model, and this was no more evident than in New Zealand. Here, the actions and practices of the ISTM had a profound influence upon the conduct of masseurs. The most potent symbol of the ISTM’s early influence was upon the founding curriculum of the Dunedin Massage School. The school, founded in 1913, was devised to provide a training in massage that was acceptable to the medical community in New Zealand. The school’s curriculum was heavily influenced by the input of doctors and tutors from the Medical School, and in its early years all the facilities, resources, and most of the teachers employed to deliver the content were doctors. Doctors

---

21 To assist the reader with the often confusing abbreviations used by the early massage profession in England, I have briefly documented the chronology of their change here. The changes are as follows: 1894-1900 Society of Trained Masseuses (STM); 1900-1920 Incorporated society of Trained Masseuses (ISTM); 1920-1944 Chartered Society of Massage and Medical Gymnastics (CSMMG); 1944-present day Chartered Society of Physiotherapy (CSP).
from the Medical School delivered all the ‘pre-clinical’ content of the course; the anatomy, physiology, pathology, and physics (Taylor, 1988). However, it was the input of the two ‘massage teachers’ appointed to teach the ‘practical skills’ components of the course; techniques of massage, movement, gymnastics, and ‘therapeutics’ that brought the ISTM’s principles to bear on the course (Taylor, 1988).

The first of these teachers, Miss L.E. Armstrong, was a masseuse who had trained under the ISTM, and she applied many of the principles, resources (including a meagre collection of key texts), and systems from her training in developing the course in Dunedin. Her first concern was to develop strong synergies between the priorities of the Medical School and the practical components of the massage training. Like her English counterparts, this was achieved, in part, by situating the teaching of anatomy and physiology at the heart of the curriculum. In the early draft of the school’s programme of teaching, detailed below, it is possible to see the central importance given to a biomechanical discourse, and the effect this might have had on cementing the massage school’s relationship with their medical colleagues;

1) Lectures and demonstrations in Anatomy for Six Months, covered by 60 lecture demonstrations.
2) Lectures in Biology and Physiology for Six Months.
3) Instruction in Massage and Medical Gymnastics for Three Months, running concurrently with the latter part of Medical School Lectures.
4) Ten Lectures in Theoretical and Practical Medical Electricity.
5) Instruction in Massage and Medical Gymnastics in a Public Hospital for Twelve Months.
6) A course of Clinical Lectures on Applied Massage and Medical Gymnastics (M. L. Roberts, 1938, p. 28).

Interestingly, this curriculum plan looks almost identical to an early ISTM curriculum, suggesting that Miss Anderson’s influence upon the design of the curriculum was considerable. The synergies that developed between the two schools were so stable that some years later, Miss Roberts, one of the first school principals (referenced above), wrote in her school report of 1938 that; ‘The course, still only for two years’ duration, as in Great Britain, is modelled in the ruling of the C.S.M.M.G. The same syllabus is used, and, as far as possible the same number of hours in theoretical and practical work’ (M. L. Roberts, 1938, p. 28).

Curriculum content was primarily derived from those texts published by prominent members of the ISTM and the later CSMMG. Utilising these texts, the tutors at the

---

22 Of these, Tidy and Guthrie Smith appear to have been utilised the most (Guthrie Smith, 1952; Tidy, 1937). Both were prominent members of the CSMMG. Tidy was a former Sister-in-Charge of an army massage.
Dunedin School constructed a practical teaching curriculum that mirrored the English training almost exactly (New Zealand School of Physiotherapy, c.1949). Students were taught the history of legitimate massage, professional etiquette, the theory and practice of massage, remedial exercises, electrotherapy (the use of small amounts of electricity to stimulate muscles), and actinotherapy (the use of light). Kinesiology (the study of the moving body) made up the vast bulk of the practical component of the course, and introduced students to some of the fundamental principles of the biomechanics of movement (what I referred to in Chapter 4 as the metaphors of ‘the model’ and ‘the machine’). Classes of instruction, for instance, were provided in:

1) Principles of exercise
2) Passive movements
3) Active movements
4) Relaxation
5) Breathing exercises
6) Examination and assessment of the patient
7) Group exercises
8) Teaching
9) Prevention of accidents
10) Games
11) Apparatus and equipment (Anderson, 1977)

These classes culminated in an examination that was also drawn directly from England.

The significance of the close ties between the English and New Zealand curricula lies not only in the substantive content of the course, but also in the ensemble of knowledges that accompanied it. I shall show later, for instance, how a biomechanical view of the body was co-opted by masseurs in New Zealand. The theoretical significance of this cannot be understated since, there can be few other rationalities of health that can be translocated so readily - without any regard to the local culture and social context in which they are deployed. Thus, the adoption of the STM’s curriculum, carried with it discursive practices that governed many aspects of the New Zealand masseurs’ conduct, and framed them with a particularly English lens. Over the following pages, I will explore some of the other ensembles of knowledge and consider their implications for New Zealand masseurs’ subjectivity.

**Adopting the ISTM’s examination framework**

From the outset, the Dunedin School adopted the examination system of the ISTM, and, with a short delay, changes to the English examination system were reflected in department, and Guthrie Smith was Principal of the Swedish Institute that developed the fundamental and derived positions for rehabilitation exercises in physiotherapy described in Chapter Four.
changes in New Zealand (Masseurs Registration Board, 1942). In 1942, for instance, students on opposite sides of the world sat written and viva voce examinations in Anatomy and Physiology, the Theory of Massage and Remedial Gymnastics, Treatments, Pathology and General Knowledge, Medical Electrotherapy, and Actinotherapy (Masseurs Registration Board, 1940). In the ‘Theory of Massage and Remedial Gymnastics’ paper of 1940, New Zealand massage students followed an examination drawn directly from the CSMMG in England. This examination asked the students to;

Describe the following:

1) Active movements.

2) Passive movements. Comparing their effects and uses.

3) Give four exercises, two passive and two active, which you would use in treatment of simple left Dorsal scoliosis.

4) What are the probable complications and irregularities in posture, in after years, when a child is born with one leg shorter than the other?... (question truncated for brevity)

5) Give an advanced table of exercises for a patient suffering from asthma and state the general rule for compiling such a table.

6) Give the muscle action effects and uses of:
   a) Stoop, stride sitting, back raising and head support.
   b) Wing leg forward lying holding.

Apart from the issue of the synergy between the examination papers, the paper illustrates a number of shared discursive influences upon the students’ training; the centrality of anatomy and biomechanics to their system of reasoning; the marginalisation of social, cultural, spiritual, and other discursive influences on their approach to massage and remedial exercise; the technical rationalism of the masseur’s conduct; the passive docility of their patients (represented frequently in the textual images from the period – see, for example, Figure 18 and Figure 19); and the use of fundamental and derived positions discussed in Chapter Four.
Figure 18. Child being treated in Physiotherapy Department, Rotorua, New Zealand c.1950. Source: Author's private collection

Figure 19. Docile patient in Guthrie Smith sling suspension, from Wellcome Institute archives
These images highlight how the metaphors of the model and the machine operated in practice to situate the patient in an entirely passive relation to the physiotherapist, and while the actions of the therapist may be viewed as defining the patient’s subjectivity, my focus here is upon how the therapist’s actions ‘wrote’ their own. In Figure 18, for example, the austere environment that makes no concession even for the treatment of a child, is used to re-state the distance that the profession has gained from its association with licentiousness, whereas in Figure 19, every effort is made through the use of passive technologies (sling suspensions, uniforms, assessment techniques, etc.) to project a notion of orthodox, biomechanical practice back on to the physiotherapist.

One possible explanation for the synergy between the examinations in New Zealand and those in England, may be found in the decision of the Dunedin Massage School to insist that every massage teacher receive their training in England under the auspices of the CSMMG (Anderson, 1977). Thus, to become a recognised teacher of massage in New Zealand, one had to endure an eight-week round trip to England by boat, and an 18-month long course of study, unpaid, to become registered as an English trained Teacher of Massage and Medical Gymnastics (TMMG) or Medical Electricity (TET). Training was, therefore, daunting for many, and a considerable expense for most.

The effect of the training was to inculcate in the trainee tutor not only a level and depth of curriculum knowledge, but also the requisite disciplinary zeal promoted by the Society. When qualified teachers returned to New Zealand, they brought with them news of curriculum changes, systems of examination and registration, texts used by English masseuses, and a particularly English attitude towards legitimacy which had, at its heart, a close working relationship with the medical profession (Anderson, 1977) – something the New Zealand masseurs were initially only too happy to encourage, but would later seek to destabilise.

Relationships with the medical profession

If the medical profession played an important role in legitimising the massage profession in Britain, its role in New Zealand was possibly even more significant. As well as teaching much of the pre-clinical programme at the school, doctors were also intimately involved in the organisation and administration of the profession. The enactment of the Masseurs Registration Act (MRA) in 1920 reflected this influence. In the years between 1913 and 1920 – when there was a recognised school of massage, but no legislation to enable the students to be officially registered, the school was only able to attract a handful of new applicants. This was made worse by the First World War that took many New
Zealander’s overseas to serve with the dominion forces. It was the lack of official legislation, however, that primarily undermined the value of formal training, because it gave the School’s masseurs no formal advantage over their competitors, and only served to burden them with the expense of unrecognised training. The Act was necessary therefore if the profession was to be able to monopolise legitimate massage and, like in England, exclude anyone unsuitable for registration. When the act finally came into effect, the Dunedin school became the monopoly provider of legitimate massage training in New Zealand.

The Masseurs Registration Act created a governing body for the profession called the Masseurs Registration Board (MRB). Members included a representative of the Hospital Board, the Anatomy Department, the Medical Superintendent, a representative from a member of the hospital’s orthopaedic staff, and the officer in charge of the school (Taylor, 1988). Thus, all but one of the members on the governing body for massage training in New Zealand was a doctor (Taylor, 1988).

This was a far greater direct involvement in the administration of massage training than had been the case in Britain. It is possible that this was due to the relatively small number of masseurs in New Zealand compared with Britain23, their lack of material resources (money, facilities, equipment, textbooks, etc.), and the drive of doctors like W.E. Herbert and T.H.A. Valentine to promote the profession in New Zealand (Taylor, 1988). Although the dynamics of the relationship are not made clear in the texts, what is clear is that there was a strong bond between masseurs and the medical profession that was cemented by the act which gave doctors ‘executive authority’ over training and registration, whilst providing masseurs with the patronage and resources of the Medical School.

The close bond between the two professions was considerably enhanced by the doctor’s familiarity with the treatments being offered by masseurs in New Zealand. Massage, the use of electricity, actinotherapy, and, to a lesser extent, therapeutic gymnastics, had all been within the armamentarium of medicine for much of the nineteenth century (P. Roberts, 1994). Medicine’s interest in these physical modalities had waned however, just as the interest of nurses, midwives and independent practitioners had increased, and this was as true in New Zealand as it was in Britain. It suited masseurs therefore to receive the patronage, support, tuition and resources of the medical profession,

23 In 1920 300 variously trained masseurs registered with the first cohort of MRA members. In Britain at the same time there were more than 6,000 practicing masseuses (Anderson, 1977; Barclay, 1994).
while the masseurs themselves took on the subordinate duties that the medical profession no longer wanted direct involvement in.

Some have, in recent years, reflected on the close bond between the two professions; particularly considering the subordinate role massage played to medicine in the first half of the twentieth century. As Lynley Katavich states;

Physiotherapy has played a subordinate role to medicine throughout its history, adopting the biomedical model as a theory base, and so aligning itself with the medical profession. Roberts (Chartered Society of Massage and Medical Gymnastics, 1930) states that doctors were able to subordinate the emerging physiotherapy profession, which could have otherwise posed a threat to their own dominance of health care. The payoff for physiotherapists was the patronage of one of the most powerful groups in society. However, medicine dominated the practice, management and theory of physiotherapy. The result has been the development of physiotherapy theory, which seeks to explain its practice in terms of the medical model. This has led to the moulding of physiotherapy to meet the needs of the medical profession (Katavich, 1996, p. 11).

While others have trumpeted the adoption of the discourse of biomechanics as fundamental in helping physiotherapists achieve their professional subjectivity;

The solid underpinning of the biomedical sciences has provided the basis for physiotherapy to evolve into what it is today, a clinical movement science with practitioners who have the capacity to work from first principles, possess strong problem solving skills, and who are able to advance their clinical management based on a growing body of evidence and a individual analysis of the effect of particular techniques on individual patients (Nall, 2006).

My own view is that the masseur’s relationship with the medical profession in New Zealand was pivotal in establishing the legitimacy of the profession. In this sense, I disagree with Katavich’s sentiment that medicine has had a repressive influence on the development of the physiotherapy profession, since I believe there is considerable evidence that medicine and massage constructed positive relations of power between themselves that worked to their mutual advantage. Equally, I question the implication in Nall’s paper that the centrality of biomechanics for physiotherapy should be accepted without question. I believe the deployment of biomechanics was a contingent response to the needs of the profession – not least in gaining the patronage of the medical profession. As an early editorial in the CSMMG Journal stated; ‘We were looked upon not with a little suspicion…and could not relax efforts in educating the doctors. But we have arrived in every sense of the word’ (Chartered Society of Massage and Medical Gymnastics, 1930). In this regard, the massage profession in New Zealand mirrored many aspects of its sister profession in England. In other respects however, there were some striking differences.
Registering masseurs

One of the noticeable differences between the massage profession in New Zealand and Great Britain lies in the different approaches towards registering men. As I showed in Chapter Four, the STM was adamant that the Society was a profession for women (Grafton, 1934a, p. 229), and that no men would register as masseurs, or be touched by the Society’s members unless specifically directed by a doctor. Indeed, men were not formally allowed into the ISTM at all until it became the CSMMG in 1920 – some 25 years after the profession’s inception (A. Parry, 1995). In New Zealand however, men were accepted into the Massage School from the very outset, and when the MRA came into force in 1920 it was named the Masseurs Registration Act in recognition of the fact that men and women should be able to enter into training together.

The origins of this deviation from the original rules of the STM may lie in the strong influence men played in the formation of the massage profession in New Zealand; a notable contrast to the situation in Britain. Masseurs, for example, made up a significant number of the more than 300 massage therapists that registered under the MRA (Anderson, 1977). Some of these were emigrants from England who had found it almost impossible to gain work as male masseurs without ISTM recognition, while others were interested medical men and untrained practitioners working in rural communities, who wished to maintain their practices (Anderson, 1977). Male doctors also made up the majority of the teachers at the Dunedin School and had a significant influence on the students accepted for training (Taylor, 1988). They showed this influence by appointing a man – Mr D. Edwin Booth – to one of the first two massage teacher positions at the school – a situation that would have been unheard of in England at the time.

In some respects then, the Dunedin Massage School worked contrary to some of the STM’s founding principles, but this appears to have been the case only where the medical profession had its influence over the training. Elsewhere, where English trained masseuses held sway (in the design of the curriculum and conduct of examination, student selection and the practical arrangements of the course itself), the disciplinary technologies of the CSMMG and the discursive influences of biomechanics remained paramount. Here, I believe, the same heteronormative interpretation of legitimacy, and the same disposition towards disciplinary norms of the body and touch prevailed.

Despite its supposed openness to male and female masseurs, only three men trained at the Dunedin Massage School between 1913 and 1927 (Anderson, 1977). Even as late as 1944, when the first ex-servicemen were being recruited as a way of finding useful
employment for men wounded in war, only applicants in pairs were accepted (Anderson, 1977). This policy ensured that massage could always be practised in class between men rather than across the sexes. Single male applicants were only accepted for training under special circumstances. For instance, the only single male applicant to pass through the school before 1921 was Vincent C. Pike who, because of his experience working in his father’s massage business, was allowed to study a truncated course and graduate as a postgraduate student. Another applicant, Mr Clifton Weedon, applied for admission with his wife, who was then deemed a suitable practice partner, and the two remained together in all practice classes for the entirety of the course (Taylor, 1988, p. 36).

Whether this attitude towards masseurs reflected broader heteronormative values, or whether it was a policy imposed by the CSMMG from afar, is hard to say. There are no existing records available to specifically address this question. My belief is that the medical profession, which was largely responsible for drafting the legislation that governed massage in New Zealand, and administering massage in its early years, was broadly happy to allow men into the profession. It was the medical profession, after all, that provided the greatest support for the drafting of the Masseurs Registration Act. There is evidence that male doctors had a strong interest in massage practices and physical rehabilitation and saw no reason to exclude men from its further training as a new discipline (Belgrave, 1985). I believe, however, that when it came to the delivery of a massage curriculum at the Dunedin School, the CSMMG’s influence took priority. British masseuses had a powerful influence over the course of training in New Zealand. So great was this influence in fact, that at one point the New Zealand Trained Masseurs Association (or NZTMA; a social network of masseurs set up to promote the interests of the profession) applied to become a branch of the newly formed CSP (New Zealand Trained Masseurs Association Executive, 1947, p. 2), and further; ‘In the late 1940s, the NZTMA sought to change its name to the CSMMG (New Zealand)’ (Anderson, 1977, p. 37). The discursive influence of the Society can be felt no more powerfully however, than in the acceptance of biomechanics as the massage profession’s practice epistemology in New Zealand.

**Biomechanics in a New Zealand context**

Students at the Dunedin School studied the bones, joints, muscles, ligaments, tendons and nerves of the entire motor systems of the body in exactly the same level of detail as their English peers. The same attention was paid, for instance, to the study of the inanimate, acultural, ahistorical body of ‘the cadaver’, the living anatomy of ‘the model’ –
where the emphasis was upon the ‘recognition of structures in the living body by inspection and palpation’ (New Zealand School of Physiotherapy, c.1949), and the discipline of movement seen in the discourse of ‘the machine’ discussed in detail in Chapter Four. In the example below, from a 1940 New Zealand anatomy examination, we see these discourses embodied in the questions set for the students;

1) Describe the course of the ulnar nerve from the elbow downwards, mentioning the muscular and cutaneous distribution.
2) Describe the knee joint and the actions moving it.
3) Describe a complete lesion of a motor nerve including the manner in which recovery takes place.
4) Describe the systemic circulation of the blood.
5) Discuss the function of the following muscles:
   a) Biceps brachii
   b) Tibialis anticus
   c) Supraspinatus
   d) Trapezius
   e) Brachialis anticus
   f) Muscles of anterior abdominal wall
6) Write a short note on:
   a) Parathyroid glands
   b) Intervertebral discs
   c) The triangular fibro cartilage of the wrist
   d) Ligamentum Nuchae (Masseurs Registration Board, 1940, p. 30).

Here the cadaver is represented by the inanimate structures that the student is asked to locate (question 1); the model is revealed in the actions, systems and structures associated with movement (questions 2, 4, and 5); and the machine in the way that illness or injury impairs movement and affects the person only at the level of their deranged anatomy (question 3). As I argued in Chapter Four, these discursive formations remove the body from the domain of politics, and envisage it only as a technical problem (Rose, 1997). In doing so the masseuses normalised biomechanical knowledges of the body, and marginalised social, cultural, metaphysical, and other knowledges. These knowledges, for their own part, provided limits on the subject positions available to the masseurs, and these delimited subjectivities, in turn, defined the practices that the masseurs chose to deploy. Thus, the adoption of biomechanics must be seen as a strategic decision – either knowingly taken or otherwise – and as a contingent response to the need to establish the profession’s legitimacy.

The adoption of biomechanics by the masseurs in New Zealand also reveals the absolute (trans)portability of a biomechanical discourse; its ability to transcend cultural, geographical, historical and social differences, and impose upon the massage profession of two different, and geographically remote countries, a particular attitude towards the body;
a professional gaze that operated regardless of its local context. What is more, biomechanics was an ideal vehicle with which to export the Society’s values throughout the Commonwealth countries, whilst, at the same time, it proved a perfectly suitable solution to the New Zealand massage profession’s quest for legitimacy. Biomechanics therefore presents a rather interesting, paradoxical position. On the one hand, it is an apolitical, acultural, ahistorical discourse that ignores individual and social differences. On the other hand it is intimately connected with the profession’s moral quest for legitimacy, and political quest for orthodoxy. My argument, therefore, is that biomechanics is both apolitical in its approach to the body, and yet also intensely political in the way it served the massage profession’s desire for recognition.

This recognition came to the fore in my reading of texts from the 1930s; when a shift appears to have taken place in the examination systems in England and New Zealand that suggests a different political purpose for biomechanics than the pursuit of legitimacy. Copies of ‘State Examinations’ began appearing in the appendices to Noel Tidy’s text ‘Massage and Remedial Exercise’ (Tidy, 1937), and the examinations began to concentrate less upon basic pre-clinical sciences, and more upon ‘functional’ anatomy, kinesiology and therapeutics; the ‘machinery’ of movement. ‘Professional questions’ disappeared from the examination papers, and a new-found interest in the work of the masseur as part of a health care team began to emerge. It is my view that this move reflected a strategic shift away from the need to constantly restate the professions legitimacy, towards the need to establish its orthodoxy24.

As the massage profession grew in size in England and New Zealand, and the opportunities for consolidation within the emerging welfare state became more apparent, masseurs began to push for greater professional autonomy, a more ‘mature’ relationship with doctors, and legislative recognition of a new profession with a new name (Bremner Abel, 1950). Less emphasis was placed upon the testing of the student’s ‘attitude’ towards touch and the body, and more was given to the student’s ability to analyse, regulate and prescribe rehabilitative strategies as part of a health care team. The simple rhetoric of the body-as-machine was supplemented by a regard for the body as a more complex array of systems more amenable to specialist practitioners. Tacit acknowledgement was given to the profession’s legitimate status, and new relationships were formed between various state enterprises in social security and health care. New therapeutic strategies emerged that required special knowledge and training, and as the need for greater expertise became a

24 As stated in Chapter One, I am referring here to orthodoxy in the sense that it implies recognition of specific services and professional disciplines by the state.
factor in the training of graduates, the profession began to call for greater control of its governing board (Anderson, 1977).

From 1938, when the *Social Security Act* heralded the formalisation of Welfare State in New Zealand, the profession began to call for new legislation to give masseurs their own identity, professional autonomy and state recognition. The 1930s and 40s therefore marked the shift from the search for legitimacy (characterised by the profession’s reliance upon the CSMMG and the medical profession), to the demands of orthodox professional status (characterised by autonomy and state recognition).

What I have shown thus far, is that the legitimate massage profession in New Zealand owes much to the influence of the CSMMG in England and the medical profession in Dunedin. These authorities provided the masseurs with the ensembles of knowledge necessary to establish the profession’s legitimacy. In this thesis I have argued that the discursive construction of physiotherapy must be understood governmentally, and in the following section I attempt to illustrate why this is necessary. It is my contention that a shift that took place in the massage profession between 1930 and 1950 that reflect the move from a concern for legitimacy to orthodoxy; from massage to physiotherapy; and that these cannot be separated from the shift from liberalism to welfarism. Having addressed the question ‘How did the discursive formations and disciplinary technologies developed by the Society of Trained Masseuses inform the developing subjectivity of legitimate masseurs in New Zealand?’ I now turn to the question ‘How did the development of welfarism influence the transformation from a concern for professional legitimacy to orthodoxy in the physiotherapy profession between 1930 and 1950?’

**Welfare reforms and the formation of orthodox physiotherapy**

In Chapter Two I briefly explored some of the theoretical work that has been undertaken to define the role welfare reforms have had in developed countries during the twentieth century. In this next section I will relate some of this theory to the emerging physiotherapy profession in New Zealand. I have focused on the legislative reforms that took place between 1920 and 1950, because I believe that these acts operate at the interface between the profession and broader governmental imperatives. What I mean by this is that I believe there was a dynamic interplay between the emerging massage profession in New Zealand and the state, and that at this interface physiotherapists have actively constructed their role as orthodox health professionals.
I will explore this construction first by providing some background to the three important pieces of legislation to affect the massage profession, then relate these to concurrent changes taking place in England (always a potent influence on the massage profession in New Zealand). I will then briefly explore how I feel the NZTMA began to interact with the state, through its pursuit of autonomy and greater state recognition, and follow this with an analysis of the implications of this interaction, before ending the section relating this analysis back to broader theoretical issues of pastorship, expertise and subjectivity.

The developing relationship between the massage profession and the state is central to this chapter because I believe it provides a context for the actions of masseuses in New Zealand in the years between 1930 and 1950, and it created the conditions necessary for massage to achieve orthodox status. The massage profession moved rapidly from being a small group of un-registered practitioners, adhering slavishly to an ‘English’ model of practice in the early 1920s, to an independent, autonomous, orthodox health profession by 1950. How this became possible, and what impact it had on physiotherapist’s subjectivity is the focus for this section.

Welfare legislation and the construction of physiotherapy in New Zealand

During the first half of the twentieth century, New Zealand was ‘at the head of the Western world for the scope and liberality of its social security scheme’ (Sutch, 1966, p. 236). With the enactment of the Social Security Act (SSA) of 1938, the pioneering Labour government developed state institutions that collectivised social relations between industry, farming, health, education and social security, and instituted a radical policy of public works, state housing and the institutionalisation of health care. Its health care policy alone established fixed salaries and terms and conditions for state employees, and created the necessary conditions for a small number of legitimate professional disciplines to monopolise the provision of health care. The SSA had a significant impact upon the massage profession, as it provided the basis for subsidised treatment, guaranteed salaries and stable terms and conditions for public sector workers. It failed, however, to adequately differentiate between registered and unregistered masseuses, and so instigated a decade-long campaign by the NZTMA for a single piece of discipline-specific legislation to give registered masseuses sole access to the public health system (Anderson, 1977).

In England, similar developments in welfare reform were taking place, with the Beveridge Plan of 1942 establishing new state-sponsored authorities with new responsibilities for governing the health, wealth and happiness of the population. These
were charged with addressing what Beveridge called ‘the five giants’; five major causes of social disorder, discontent and disaffection; ‘Want, Disease, Idleness, Ignorance and Squalor’ (Beveridge, 1942). These authorities included the Chartered Society of Physiotherapy (CSP) – which in 1944 changed its name to acknowledge its recognition within the welfare state.

The National Health Service Act had a profound effect on the newly named Chartered Society of Physiotherapy (CSP) when it was enacted in 1946. The CSP was courted by Aneurin Bevan – the chief proponent of the legislation – who assured members that; ‘it is my function, as Minister of Health, to try to see to it that the achievements of specialised science are made readily and universally available to the whole population’ (Bevan, 1946). The act gave physiotherapists privileged access to the National Health System which included, amongst other benefits, secure income for its members, a ready supply of patients, and state recognition.

This recognition was exactly what was desired by masseurs in New Zealand as they sought greater autonomy in their professional decision making, profession-specific legislation to promote and protect their interests, and a secure role within the public health system. In essence, the NZTMA and the massage teachers at the School, sought to take more control over the governance of their own affairs by obtaining greater representation on the Masseurs Registration Board (which, since 1920 had been dominated by doctors), and in the management of the school (Anderson, 1977). This desire was further supported by moves within the profession at large to play a greater governance role within the public health system created by the Social Security Act. This desire was expressed by Enid Anderson, long-time principal of the Dunedin School, who illustrated the change in the relationship between the massage and medical professions in the following way;

…the climate had changed so much that it was possible for one Branch…to submit a remit ‘that the term para-medical be replaced by the term “health sciences”. The reason was that the latter term, it was hoped, would foster an attitude of team-work WITH rather than WORKING UNDER the medical profession (Anderson, 1977, p. 81, original emphasis preserved).

The change that the profession wanted was fraught with difficulty however; the profession did not want to lose the patronage of the medical profession, but it did want greater autonomy. Equally, it wanted to retain biomechanics at the heart of the profession’s epistemology, but accepted the impact of new expertise and the public’s waning interest in massage (New Zealand Trained Masseurs Association, 1949; New Zealand Trained Masseurs Association Executive, 1947). The journey towards the resolution of these tensions was a tortuous one for masseurs in New Zealand.
The NZTMA and the Dunedin Massage School maintained a constant nagging criticism of the limitations of the 1920 Masseurs Registration Act after the enactment of the 1938 Social Security Act. The profession sought to consolidate its position as the single recognised state provider of massage and physical therapy services, whilst having its ability to manage its own affairs enshrined in legislation. These goals were achieved after more than a decade of campaigning with the enactment of the Physiotherapy Act on 1st January 1950, as the newly formed New Zealand Society of Physiotherapy stated;

‘The long-awaited Physiotherapy Act has at last become law, giving us very strong representation on the Board and placing most of the control of the profession and its ethics in the hands of its own members’ (New Zealand Society of Physiotherapists, 1950b, p. 3).

The act featured a number of significant revisions to the MRA. Firstly, it defined a new profession under the name ‘physiotherapy’; mirroring changes that had taken place throughout the colonies, America and Europe (Remondiere, 2003). The significance of this name change was highlighted by the NZTMA who argued that; ‘The change of name for our profession in this country will bring us into line with other countries who have also recognised that the term “Masseur” does not explain the present range of our professional activities’ (New Zealand Trained Masseurs Association, 1949, p. 3). The Act also defined a new scope of practice for the profession. Under this new identity it defined physiotherapy as;

The use by instruction or application to the human body of remedial exercises; or
The use by external application to the body of massage, being the manipulation of the soft tissues of the body, passive movements, electricity, heat, light, water, or other physical agents; or
The use of any other method of treatment for the time being declared by the Governor-General in Council to be an approved method of performing physiotherapy
-for the purpose of curing or alleviating any abnormal condition of the body, or of alleviating any obstetrical condition, or of promoting health and well-being during pregnancy or the puerperium [the time period immediately after childbirth during which time the woman’s body returns to its normal physical state - OED]; but does not include the internal use of any drug or medicine or the application of any medical or surgical appliance except so far as the application of that appliance is necessary in the use of massage, passive movements, remedial exercises, or any such physical agent or other approved method as aforesaid: (Ministry of Health, 1949, original formatting preserved).

25 Although there is debate about its etymology, the first use of the word ‘physiotherapy’ appears to have been in a letter in the British Medical Journal dated July 15 1905, which referred to the abuses caused by healers who pretended to treat by therapeutic products. The name was not commonly adopted in the Commonwealth until the 1930s however.
What is interesting about this definition is that it bears striking similarities to the practices that were identified as ‘massage’ in the texts of the STM (Despard, 1916; Ellison, 1898; Mennell, 1920; Musser & Kelly, 1911; Palmer, 1901; Prosser, 1943; Tidy, 1937); The emphasis upon the biomechanics of the body is retained, as are the recognised modalities of treatment and the defined relationships with the medical profession. What is different, however, is that previously these epistemologies, relations, knowledges and discursive constructions were defined only in the texts of the profession itself, which required a diverse array of disciplinary technologies and relations of power to maintain its status as the primary provider of rehabilitation services. With the enactment of the Physiotherapy Act, New Zealand masseurs had achieved a degree of state recognition that provided them with the space to grow and the security to diversify.

The Act defined a new Board structure, which some argued was, ‘The most important clause in the Bill’ (New Zealand Society of Physiotherapists, 1950a, p. 3). The Board was constituted by the Director General of Health as Chairman, the Inspector of Physiotherapy, the Principal of the newly named School of Physiotherapy, three practicing physiotherapists (one of whom was to be a private practitioner, one working in the public health system) to be nominated by the NZTMA, and a registered medical practitioner (Bremner Abel, 1950). The new act therefore fulfilled its promise by greatly increasing the representation of physiotherapists on their own governing body.

One of the most satisfying aspects of the new legislation for physiotherapists was, however, its protection of title. The new act made it an offence ‘for any person to infer [sic] by name, initial, or abbreviations that he (sic) is qualified to carry out such treatment’ as was otherwise licensed only to physiotherapists (Bremner Abel, 1950, p. 18). The titles of physiotherapy, physiotherapist, massage, masseur and masseuse became protected by the Act, thus preventing others from legally performing massage that had not registered with the Physiotherapy Board, and by extension, undergone training at the only recognised training school in New Zealand. Thus, the profession (like the CSP) secured an effective monopoly on the training and registration of all legitimate and orthodox masseurs.

Interestingly, the practices and modalities that were codified in the Physiotherapy Act as ‘belonging to’ physiotherapy, were not, in themselves, the exclusive provision of physiotherapists. Indeed, the birth of the STM in England had not corresponded with the invention of a new device or approach to practice, as was the case with some other professions (radiotherapy, for instance). Instead, the STM corralled together and colonised
a particular set of methods and techniques that were already in circulation and widely used amongst orthodox and alternative practitioners.

Swedish massage, remedial gymnastics and electrotherapy were colonised by the Society because they functioned well as vehicles for promoting a particularly disciplined approach to physical rehabilitation; an approach that could then be used to assert the profession’s legitimacy. These methods were not necessarily the only way to rehabilitate illness or injury, but they allowed the STM to create an ‘enclosure’ around the modalities, techniques and strategies of assessment and treatments that it colonised, and use this enclosure to promote its legitimacy. Massage professions throughout the Commonwealth, most especially in New Zealand, drew on the lead taken by the STM, constructing almost identical practice epistemologies, as can be seen in the clauses defining the limits of physiotherapy practice in the *Physiotherapy Act*.

**Analysing the emergence of physiotherapy in New Zealand through a welfarist lens**

As I outlined in Chapter Two, the welfarist reforms that were pioneered in New Zealand prior to World War II concentrated upon the centralised coordination of services for the population, and the creation of a modest ‘safety net’ based around services such as education, health care, security and social welfare (Fitzgerald, 2004). Welfarism was considered a suitable response by many governments in developing countries to the vagaries of liberalism that had developed at the end of the nineteenth century, and a more ‘pastoral’ approach to welfare was developed which emphasised the need to shift the focus towards the wellbeing of the citizen rather than the prosperity of the state (Beveridge, 1942). Health, for instance, was transformed into ‘an object of State concern, not for the benefit of the State, but for the benefit of individuals…the concept of the healthy individuals in service of the State was replaced by that of the State in service of the healthy individual’ (Foucault, 2004, p. 6). Thus we see in New Zealand, for example, the emergence of social security legislation that was described as ‘applied christianity’ by the pioneering Labour leader Michael Joseph Savage (Foucault, 1979b, p. 302).

Central to the organisation of the welfare state was the rationalisation of services around governmental imperatives; a tacit criticims of the laissez-faire attitude of liberal governments that had allowed the expansion of professional authorities and service providers with few constraints. By contrast, welfarist reformers undertook to organise

26 The three therapeutic ‘cornerstones’ of the profession – massage, remedial exercise and electrotherapy – were all methods widely practiced by orthodox and alternative practitioners for many years before the formation of the STM, and they have never been the sole province of the profession.
health and social welfare services around a small number of (legitimate) state-supported providers. To be included within this grouping was clearly something that many professions aspired to, but few achieved. What are now considered the orthodox professions, owe this status in part to their ability to occupy the secure ‘enclosure’ created by welfarism.

In *Discipline and Punish*, Foucault spoke of the use of ‘exile enclosures’ during times of plague as a way of confining a population within a particular space (Foucault, 1977a). The need to monitor the movements and activities of the population within the exile enclosure was used as a justification for heightened surveillance and the particular focus upon disciplinary technologies. I believe this metaphor offers some useful insights into the conduct of physiotherapists as they policed the margins of their professional boundary. The *Physiotherapy Act* created a Physiotherapy Board to replace the MRB whose function was to register members and ensure that no-one acted beyond their scope of practice, and that no-one was allowed to claim to be a physiotherapist that was not officially registered (Bremner Abel, 1950). Thus accepting the opportunities offered by the welfare state, was also to submit to becoming part of a network of surveillance. As with Foucault’s panopticism, heightened visibility was ‘written into’ the system, such that the state monitored the profession to ensure it was still serving its social purpose, the profession monitored its practitioners to ensure that they were acting in accordance with its rules, and the practitioners maintained their gaze upon the patient. The enclosure created by the welfare state therefore enmeshed the physiotherapy profession within a matrix of power relations, maintained by an array of disciplinary technologies – the most potent of which was surveillance.

It is my view that the massage profession wilfully submitted itself to the enclosure of the welfare state. It had no fear of the disciplinary restraints that this imposed. The massage profession was well used to the exercise of disciplinary technologies, having enfolded these into its professional identity in its pursuit of legitimacy. Rather than seeing these as being repressive, I believe that it saw instead how the welfare state could open up possibilities for the profession; how it could create a secure enclosure within which it could prosper; how it could protect its margins from other professions that sought access to the rehabilitation market created by the state.

In many ways, the argument I am making here is similar to that which I made earlier with regard to biomechanics. I argued that it is possible to regard the profession’s adoption of biomechanics as a form of constraint upon the practices of masseurs. That
biomechanics restricted the ability of masseurs to see other ways of viewing health and illness, and in so doing, confined their practices to a narrow set of dispassionate, technical competencies. In the same way, the adoption of the welfare state may be seen as a form of constraint; its constant unremitting gaze; its emphasis upon social welfare provision; its forced alliance with other orthodox health care providers, for instance. In both cases, however, I believe the argument misses one vitally important point that derives from Foucault’s view of power. That is that these changes were *positive*, in the sense that they created new subject positions for masseurs and physiotherapists; they defined new objects of scrutiny, and new knowledges; they cemented stable relationships, and made new discursive constructions possible; in essence they created physiotherapist’s subjectivity. In the following, and final section of this chapter, I de-construct the new subjectivities created for physiotherapists by the welfare state, focusing upon a sub-specialty within the profession that emerged as a direct result of the welfare reforms. Respiratory physiotherapists, I believe, embody much of what welfare reforms were attempting to achieve, and they act as a paradigm case against which I set Chapter Six. This final section considers the construction of respiratory physiotherapy.

**Refining the professional gaze – constructing respiratory physiotherapists**

The first forty years of the twentieth century were marked by a number of events that created the conditions of possibility for the emergence of respiratory physiotherapists within the welfare state. Inhalation injuries and developments in thoracic surgery during the First World War; epidemics of tuberculosis, polio and influenza in the years immediately following; and the advent of antimicrobial therapy from the 1920s onwards, all heralded the aggressive treatment of lung disease, with the resulting effect of creating thousands of survivors of what would have earlier been fatal lung conditions. The presence of large numbers of acute and chronic suppurating lung conditions created a need for health workers who could manage the physical consequences of lung disease and trauma (Angove, 1936; Ward & Helmholtz, 1997).

Registered masseuses and masseurs were ideally placed to take on this work because they were accepted by the medical profession, and they had in their armoury, an array of ‘massage’ techniques which could be adapted to the treatment of suppurating lung diseases. Thus, the chest clapping, postural drainage, rib-springing techniques, breathing exercises, stretching and manipulations of the chest wall deployed by early masseurs, were all adaptations of Swedish massage and remedial gymnastic techniques already well established within the profession.
Masseurs were also ideally placed to work on these patients because many had established massage departments within the grounds of local hospitals following the First World War. These departments were ostensibly designed for the rehabilitation of returned servicemen (see Figure 20), but they were easily adapted for the physical rehabilitation of chest complaints (see Figure 21 and Figure 22). Given the nature of the complaint, however, most respiratory techniques were practised on the wards where the patient resided. This was necessary since many patients had communicable lung diseases, while others were so ill that moving them to the massage department was out of the question. Thus, during the 1930s, a small body of masseurs began to specialise in the treatment of patients with respiratory disease on the medical ward – away from their host department (Angove, 1936).

Figure 20. Gymnasium for returned servicemen, c.1916, from Wellcome Institute archives
Figure 21. Rehabilitation class for returned servicemen, from Guthrie Smith (1952, p.143)

Figure 22. Rehabilitation class for returned servicemen, from Guthrie Smith (1952, p.144)
The use of masseurs specialising in respiratory care increased exponentially in the 1930s, such that by the outbreak of World War II, they made up almost one-third of all registered practitioners in England (Barclay, 1994). Masseurs were an ideal adjunct to respiratory medicine and surgery; physicians treated the pathogen allopathically, while the therapist worked physically; surgeons dissected the lung tissues, while the physiotherapist restored the patient to normal physical function. This mutually supportive arrangement was described by Storey as follows:

In those ‘early days’, i.e. 1930-40, the surgical patients were suffering from suppurations in the lungs and the pleural cavities, from carcinoma of the bronchus and pulmonary tuberculosis. The deformities which these diseases and the operations in vogue produced could be largely coerced and controlled by post-operative treatment and physiotherapy. But this was not the only contribution. Anybody who has worked in this branch of surgery knows that many of the patients require long periods of investigation before an operation can be done, and the post-operative treatment can be tedious and exacting. By constant attention to every detail of the patients’ trial and discomforts, they were encouraged to get back to a normal life in the competitive outside world (Storey, 1959, p. 9).

The constant attention demanded of the masseur/physiotherapist was enhanced by the organisation of the medical ward, which offered a model of surveillance medicine (Armstrong, 1995). In the medical ward, the vulnerability of the patient provided the justification for constant monitoring of the patient’s well-being. Respiratory physiotherapists were very much part of this technology.

Managing the enclosure of the medical ward

As well as being ideally positioned to take advantage of the advances in respiratory medicine and thoracic surgery, the rise of the respiratory physiotherapist also owes much to the public’s enduring fear of contagious diseases – particularly those borne in the air and on the patient’s breath (Cordery, 1995; Hurt, 2004). Respiratory infections were known to cause debilitating illnesses and death, and the pursuit of an effective cure for diseases like tuberculosis, played an important part in twentieth century medicine (Lane, 2001). Robert Koch’s discovery of mycobacterium tuberculosis in 1882, for instance, contributed greatly to the demise of miasmic theory, which espoused that noxious, ‘bad air’ caused illness (Cordery, 1995). Likewise, Konrad von Rontgen’s discovery of X-rays in 1895 made it possible to ‘see’ a two-dimensional image of the disease within the lungs. These discoveries accompanied the development of antimicrobial therapies in the 1920s which had a profound effect on function of orthodox medicine (Brieger, 2004).

Innovations in medicine such as these were inextricably tied to the emergence of respiratory physiotherapy. The sanatorium movement, for instance, emphasised fresh air
and exercise for patients with TB (Hurt, 2004), X-rays made it possible to identify the specific segment of the lung affected by the infection and use postural drainage techniques to drain the affected lobe (see Figure 23 and Figure 24) and antimicrobial therapy killed the pathogen within the lungs, which then needed to be removed physically. This work was ideally suited to the manual techniques of the respiratory physiotherapist.

Figure 23. Postural drainage showing relevant lung segment being drained and appropriate patient position. Source: Thacker (1971, p.42)
The therapist’s primary concern was for the removal of the patient’s sputum; the foul, sometimes putrid smelling physical manifestation of the patient’s lung disease. Sputum was distinctly unsanitary and unpleasant. It was the cause of embarrassment for the patient, and of pathological interest for the physician, nurse and physiotherapist. The colour, smell, texture, viscosity and contents of sputum samples became the subject of much scholarly interest from the 1930s onwards, and a number of clinical pathologies became dependent on its accurate diagnosis (for instance, bronchitis, cystic fibrosis and bronchiectasis) (Seaton, Seaton, & Leitch, 1989). The ‘management’ of sputum became important not only for those on the medical wards with recognised lung diseases, but also for those within the confines of the hospital who might be vulnerable to respiratory infection. Respiratory physiotherapists therefore joined the nurses and doctors of the medical ward in applying the principles of sanitary inspection to the confinement and disciplining of patients with lung disease within the hospital (Brimblecombe, 2003).

When a respiratory infection had been diagnosed, the patient was often removed from their surroundings and placed within the ‘exile enclosure’ (Foucault, 1977a) of the

Figure 24. Postural drainage for a child with lung disease. Source: Ritchie Russell (1942, p. 45)
medical ward. The ward became the site of panoptic surveillance, and the patient became subject to a disciplined set of observations and investigations. The degree of confinement, and the extent to which patient’s movements needed to be constrained reflected the anxieties over the contagious nature of the patient’s illness. Those with TB were barrier-nursed in private rooms for the duration of their treatment, while those with chronic bronchitis were managed in the open ward; the risks posed by their lung disease being deemed to be less (Ward & Helmholz, 1997).

To remove the secretions from the patient’s lungs, the respiratory physiotherapist brought the infected sputum out into the atmosphere, and so there were inherent risks in the therapist’s techniques. Sputum removal carried with it the danger of cross-infection – not least from the therapist themselves – who might transmit pathogens from one patient to the next as they moved around the ward. Strict rules on hand-washing, the use of protective clothing, the removal of infected sputum, procedures for obtaining sputum samples, and the use of various pieces of equipment needed to be followed (Angove, 1936), and the therapist, as much as the patient, became the object of panoptic surveillance.

Nikolas Rose argued that ‘Schools, hospitals, prisons, reformatories, and factories acted as apparatuses for the isolation, intensification, and inscription of human difference. They played not only the part of microscope but also that of laboratory, for they were simultaneously locales for observation of and experimentation with human difference’ (Rose, 1997, p. 232). My argument here is that this laboratory was as much a place for the formation of respiratory physiotherapists’ subjectivities as it was for the patient.

Institutional influences on the formation of respiratory physiotherapy.

Armstrong has argued that the hospital ward that emerged in the twentieth century made it possible for a form of surveillance medicine to replace bedside medicine (Armstrong, 1995). Surveillance medicine affected the organisation of work patterns on the ward, the layout and design of the buildings, and the relationships between the patient and the staff. Not least, it helped reinforce the patient’s subservience to medicine, and placed those with medical authority in a position of dominance (S. J. Williams, 2003). Thus patients could be confined in the exile enclosure of the ward; supervised and surveilled; handled, moved, assessed, scanned, and documented; and treated entirely passively. At the same time, the ward’s staff were enmeshed in a web of surveillance, with their movements, actions, and thoughts exposed to scrutiny. The ward was a potent expression of panopticism and disciplinary power (Foucault, 1973, 1977a).
It is my belief that respiratory physiotherapists flourished in its regulated order of the medical ward; with its functionalist aesthetic and regimented routines. In the first instance, the therapists were familiar with close professional scrutiny – having made the notions of observation and scrutiny the cornerstones of their quest for professional legitimacy. They were, as Cheek and Rudge say, ‘panoptic connoisseurs’ (Cheek & Rudge, 1994b). Secondly, they sought to attain orthodox status, and so a close working relationships with the other orthodox health professions of medicine and nursing was both necessary and desirable. Thirdly, respiratory physiotherapists were keen to apply their own dispassionate, clinical gaze to the patient, and the medical ward was the ideal environment in which to bring together these various interests.

The medical ward was the product of an array of ‘dividing practices’ (Foucault, 1977a) – practices that divided normal lung function from pathological; contagious from non-contagious; between those requiring surgery and those not; between the old and the young. The organisation of the medical ward reflected this by making possible a clear division of roles, and it was the physiotherapist’s job to manage the physical dimensions of the patient’s rehabilitation. Angove, for instance, defined the physiotherapist’s role as the removal of sputum, the recovery of normal lung volumes, the restoration of normal function, and the adoption of good posture (Angove, 1936, pp. 124-125). Later, Storey defined the role of the respiratory physiotherapist in much the same way:

1) The maintenance of correct posture
2) The increase of respiratory efficiency
3) Coughing and expectoration
4) The maintenance of mobility and the restoration of the function of all parts of the body (Storey, 1959, p. 47).

These definitions once again illustrate the prevalence of a biomechanical discourse, a privileging of physical discourses of health and illness over other discourses, and a primary focus on returning the patient to normal function – pivotal to the aspirations of welfarist reforms.

This work of the respiratory physiotherapist complemented the physician’s biomedical approach to the patient’s lung disease to such an extent that by 1950, the aspirations of the two profession’s were considered by some to be almost inseparable;

We have come to realise that the achievement and maintenance of health, the conduct of serious disease and injury, and the rehabilitation and revocation of disabled persons are, none of them, a one-man job. Success can only be achieved by team-work, and in this team there are no two members more important than the doctor and the physiotherapist. Each has his separate functions to fulfil, yet neither can fulfil it adequately unless he works in harmony with the other (From Dr F.D.Howitt's forward in Cash, 1951, p. 7).
Institutional practices within the medical ward, however, also reinforced the separation between physiotherapy, nursing and medicine. Each profession maintained separate professional records with their own design and nomenclature. Respiratory physiotherapists kept their records with them and returned them to the physiotherapy department at the end of the day. They did not remain on the ward (Billings, 1979; Storey, 1958). This may have been because the physiotherapist was not ‘resident’ on the ward like the nursing staff; they moved between wards, occasionally removing recovering patients from the ward and treating them in the physiotherapy gymnasium, and unlike the medical records (which was the ‘executive’ record of patient care and the sole province of the doctors that visited the ward), physiotherapy notes were not essential for the day-to-day care of the patient. Where medical notes gave instructions for patient care and provided information that might be conveyed to the nurses, patients or their relatives, the physiotherapy notes were deemed subsidiary.

Respiratory physiotherapists also separated themselves from their nursing and medical colleagues by only operating a normal service between 8am and 5pm. Nurses were continually resident on the ward, and doctors maintained a 24-hour service. Physiotherapists, on the other hand, came into the ward in the morning, took a ward report, organised their priority patients, and began working through their lists which were completed by 5pm, at which point an ‘extended’ skeleton service sometimes operate for a few hours into the evening, until the ‘on-call’ physiotherapist came on duty. If a patient needed to be seen by the ‘on-call’ physiotherapist, they were called in by the resident doctor (the nursing staff were rarely, if ever, allowed to do this), and brought in from home.

This may seem, on the surface, to be a small procedural matter, but I believe it illustrates how respiratory physiotherapists responded to competing tensions in the formation of its subjectivity; on the one hand, it was successfully integrating its practices into orthodox health care and finding a niche within the medical ward; while on the other it could not let go of the profoundly influential tensions that had framed the profession in the first place. It is my view that respiratory physiotherapists adhered to a ‘normal working day’, for example, because this was one of their early responses to accusations of licentiousness – by working during the day they could separate themselves a little from the work of prostitutes whose work was always associated with the night (Nicholls, 2006). Thus we see the revision and re-presentation of discourses of legitimacy even in the
regulated practices of the medical ward. How then did these discursive influences on the respiratory physiotherapists affect their actions and practices?

The conduct of respiratory physiotherapists

As I have already outlined, the role of the respiratory physiotherapist on the medical ward concentrated upon the assessment and treatment of the patient’s presenting lung disease; particularly its physical dimensions, and the greatest concern of all was the removal of infected sputum. Of the treatment techniques developed by physiotherapists, most were adaptations of the massage and manipulation practices of earlier ‘orthopaedic’ therapies. Thus a number of competing discursive influenced informed the actions of the therapist and guided their practices. These included;

1) A biomechanical focus on the body of the patient as a machine whose ‘engine’ (represented by respiration) had become dysfunctional
2) A discourse of legitimacy that emphasised the need for proper conduct in the physical handling of patients
3) A disciplinary discourse evident in the organisation and environment of the medical ward
4) An discourse of orthodoxy which created particular relations of power between the therapist, the nurse, the doctor and the patient
5) A governmental discourse which sought to align the goals of physiotherapy with the needs of the state – specifically for the rehabilitation of people with respiratory disease

These discourses found their expression in the local, material practices of the respiratory physiotherapist. In the following account of the treatment of a patient with bronchitis from the late 1930s, for example, Hester Angove illustrates the passive docility of the patient; the attention to ‘the machine’ metaphor from Chapter Four; and the use of derived positions as a bodily discipline;

1) Lying – deep breathing.
2) Half-lying – arm kneading and forearm bending and stretching (about 6 times).
3) Half-lying – deep breathing, and vibration.
4) Half-lying – leg kneading, followed by knee bending and stretching).
5) Right side back lying – vibration and shaking.

Here we see the same referents to the body-as-machine that were central to the construction of legitimate massage profession. What is different here though is that the focus has shifted from the musculoskeletal system, to the patient’s diseased lung.

Respiratory physiotherapists focused on the patients lungs in the same way that dentists

---

27 Hester Angove was the first physiotherapist to write an account of respiratory physiotherapy. She was Sister-in-Charge at the Guy’s Hospital Massage Department and a prominent member of the CSMMG.
focused on the mouth and podiatrists attended to the lower limbs, and in much the same way, respiratory physiotherapists were actively engaged in constructing the lungs as a field of intense visibility (Borthwick, 1999b; Nettleton, 1992, 1994). Respiratory physiotherapists were, for the first time, able to focus their observations and interventions upon a defined object of scrutiny. Previously, masseurs had concentrated upon the body as a relatively undifferentiated machine, but now the attention to lung function could refine this approach and begin to create new forms of knowledge about breathing, the lungs, and their effects on the person’s well-being. Thus, although the ‘tools’ for defining the patient remained the same, their focus became much more refined.

The expression of a biomechanical discourse can be found throughout the profession’s texts leading up to 1950; in its anatomical focus on the thorax (Cash, 1951; Storey, 1958; Tidy, 1937); in the design and organisation of the physiotherapy department (which drew heavily on the sterile ward practices of the medical ward, (see, for instance, Figure 25); and in the assessment strategies and treatment regimes which concentrated entirely on physical function (Billings, 1979; Storey, 1958). The underlying tone of this discourse, when applied to respiratory physiotherapy, was one of austerity, functionality, and a constant, unerring professional gaze upon a passive patient.

Figure 25. Physiotherapy Department c.1950 illustrating sterile, disciplined aesthetic of hospital ward. Source: http://www.keele.ac.uk/depts/pt/about_us/history.htm#scrapbook (retrieved 8th April 2005)
I argued in Chapter Four that the masseuses’ deployment of biomechanics contributed greatly to its quest for legitimacy. It is my belief that the same discourse – applied to a new context, and in conjunction with the other discursive influences outlined above – helped respiratory physiotherapists in their pursuit of orthodoxy. The deployment of these discourses in the rehabilitation of patients who possessed specific lung diseases that were a considerable burden to the welfare state; within the exile enclosure of the medical ward; in alliance with other orthodox health professions of nursing and medicine, served to identify respiratory physiotherapy firmly with the governmental imperatives of welfarism and secured its status as an orthodox health profession.

**In summary: Moving from legitimacy to orthodoxy**

Kuhlmann recently argued that ‘Health care systems [were] one of the main arenas for the transformation of welfare state systems and social citizenship issues with the health professions as the key players and professionalism as the social order’ (Kuhlmann, 2004, p. 2). I have attempted to show in this chapter how the massage profession engaged with the changing governmental imperatives of welfarism, and in so doing, constructed new, orthodox, professional subjectivities. I set out in the chapter to explore the practices of respiratory physiotherapists and consider how physiotherapists had come to embody a ‘neutrality, authority and skill in a wise figure, operating according to an ethical code’ (Rose & Miller, 1992, p. 187), such that Bach could state that;

> It is probably safe to say that there are today few general hospitals in which there is no physiotherapy department. Medical practitioners in many special fields have come to regard the physiotherapist as an integral part of the health team, alike in preventative, rehabilitative and palliative fields…The physiotherapist must be equipped not only with scientific knowledge and a sound technique, but must also be able to shoulder responsibility, for no one else can undertake the treatment of the patient as a thrice weekly duty or twice daily routine. Even if he would or could, the specialist in physical medicine has not the time at his disposal (Bach, 1950, p. 458).

I have shown that these actions must be understood as the effect of a number of competing discourses and disciplinary technologies. I have also shown that the pursuit of orthodoxy must be seen as a response to the opportunities provided by the emergence of the welfare state. Without the legitimacy created by the actions of masseuses in England and New Zealand, however, acceptance as an orthodox health profession would not have been achievable. Finally, I have shown that the development of respiratory physiotherapy represents the creation of new forms of knowledge, relations of power, discursive formations and subjectivities for physiotherapists, and that these were made possible by the profession’s ready acceptance of the disciplines of the medical ward.
My focus now shifts to the present day, and the practices of the Breathing Works clinic which, I will argue, present some innovative responses to the discourses and disciplines that have been so important in establishing respiratory physiotherapy as a legitimate, orthodox health profession.
CHAPTER SIX – MAKING BREATHING YOUR BUSINESS

If there’s one thing humans can do without thinking it’s breathing, right? Sure. But what if we told you that improving the way you breathe could transform your life, give you more energy, improve your health, reduce your stress, help you sleep better and even improve your sex life? Leading New Zealand breathing specialists Dinah Bradley and Tania Clifton-Smith say breathing is the key to success in all aspects of life – from work to health, love to leisure and fitness (She Magazine, 2000, p. 6).

Introduction

In Chapters Four and Five I analysed the discursive construction of physiotherapy in two historical moments; the first gave an account of the actions of the founders of the Society of Trained Masseuses in England, the second concerned the emergence of respiratory physiotherapists within the welfare state in New Zealand. The theoretical foci for these chapters have been the actions and practices of physiotherapists as technologies of discipline, and the connection between these practices and broader governmental imperatives. What I have shown is that the discourses of legitimacy and orthodoxy have played an important role in the construction of the physiotherapy profession. I have also shown that physiotherapists’ subjectivity is heavily influenced by a biomechanical discourse that guides their conduct; particularly in regard to their view of the body. I have argued that these discourses created certain conditions of possibility that allowed the profession to establish itself as the principal provider of rehabilitation services within the public health system, but also argued that in achieving this, respiratory physiotherapists submitted to the particular conditions imposed on them by the disciplines of the medical ward.

If one traces through the respiratory physiotherapy texts published in the half-century since the enactment of the Physiotherapy Act, one would find that little has changed (Gaskell & Webber, 1973; Hough, 1991, 2001; Pryor & Prasad, 2002; Roskell & Cross, 2001; B. Webber & Pryor, 1991, 1993). The same curriculum of study is offered; the same focus upon the body of the patient as a dysfunctional machine; the same emphasis on pulmonary function at the exclusion of other discourses of health and illness; the same strategic alliances with the other orthodox health providers; and the same practice environments. Technological advances have brought new modalities of treatment to respiratory physiotherapy, but these have not fundamentally altered the therapist’s focus. On the one hand, this may be seen as the mark of a profession that is perfectly adapted for its environment; a profession entirely habituated to its surroundings. On the other hand,
one might argue that respiratory physiotherapy has stagnated; that it has become ossified; found itself to be comfortable in its surroundings, and become entrenched in its approach to health care.

In this chapter I explore this question by focusing on the conduct of a small group of physiotherapists that are problematising the conditions that have made respiratory physiotherapy possible and, in so doing, offering a critique of the ossified practices of respiratory physiotherapists. In testing the conventions of respiratory physiotherapy, I believe that Breathing Works is challenging the discourses of legitimacy, orthodoxy and biomechanics that have, for many years, guided the conduct of physiotherapists.

This final ‘findings’ chapter therefore holds to Foucault’s maxim that; ‘My point is not that everything is bad, but that everything is dangerous’ (Dreyfus & Rabinow, 1983, pp. 231-232), since I am not arguing that legitimate, orthodox physiotherapy is necessarily bad; quite the opposite in fact; since without the discourses and disciplines set in place by earlier physiotherapists, it would be hard to imagine any form of physiotherapy emerging – let alone becoming one of the largest allied health professions in the developed world.

What I am arguing however, is that these developments in the profession should not go unchallenged; that by exposing the conditions that have made physiotherapy historically possible, we might see the possible futures for the profession more clearly (Nicholls & Larmer, 2005). Therefore, the analysis of the surface of emergence of Breathing Works; its rationalities and the actions and practices of the physiotherapists that have made it possible; serves to provide critical purchase for a discussion about how one might imagine physiotherapy differently from the disciplined order of the medical ward.

The questions that form the focus for this chapter are as follows;

1) How have the physiotherapists at Breathing Works problematised legitimate, orthodox respiratory physiotherapy?
2) What discursive formations informed the actions of the physiotherapists at Breathing Works?
3) How were these actions informed by the discursive formations and disciplinary technologies developed by orthodox respiratory physiotherapy?
4) What actions resulted from these influences?
5) What new knowledges about physiotherapy practice were promoted by Breathing Works, and what was marginalised?
6) What relations of power developed through Breathing Works’ actions?
7) How are neo-liberal governmental rationalities informing the practices of the physiotherapists at Breathing Works?
8) What subject positions were created through Breathing Works’ actions?
9) How do Breathing Works’ actions create new possibilities for physiotherapy practice?
I begin the chapter by briefly describing Breathing Works, before reflecting on the practices that constitute contemporary respiratory physiotherapy. From here, I explore how the clinic’s staff are problematising breathing through their attention to breathing pattern disorders (BPD), and reflect on the significance of their construction of ‘good’ and ‘bad’ breathing. The main focus for the chapter is then introduced when I turn my attention to the enterprising practices developed by the clinic (Rose, 1997) through its commodification of breathing. This focus on the economic imperatives of physiotherapy is followed up by a discussion of Breathing Works as a neo-liberal practice. In the final section of the chapter I revisit the neurasthenic patient discussed in Chapter Four, and consider how the practices of the physiotherapists at Breathing Works represent a peculiar revision of the early goals and aspirations of the profession. To begin with, however, I will outline the organisation, structure and design of the Breathing Works clinic.

**The Formation of Breathing Works**

Breathing Works was created in 1999 by two physiotherapists, Dinah Bradley and Tania Clifton-Smith, who had worked for a number of years in New Zealand and England refining their approach to the treatment of breathing pattern disorders. Dinah and Tania met for the first time at a talk Dinah was giving on the treatment of hyperventilation syndrome in Auckland in 1998. She had already published her first patient guide to hyperventilation syndrome seven years earlier (Bradley, 1991), but was largely unknown outside of her immediate professional colleagues. When Tania realised that she shared a mutual interest in the treatment of HVS, they began to consider the possibility of working together. Early in their conversations they realised that their plans extended beyond the boundaries imposed by the public health system, and began looking for suitable partners and locations to launch a specialist private clinic, and by the end of 1999 ‘the first specialist breathing pattern disorder clinic in Australasia’ (Bradley & Clifton-Smith, n/d) was created in Auckland, New Zealand.

The clinic opened in a large, single-storey, suburban house at the end of the main street in one of Auckland’s more affluent suburbs. It occupied the front of the house, and shared the building with a busy gymnasium, a separate physiotherapy clinic, podiatry and masseur’s practice. The house is imposing, but still comfortably domestic. A few obvious signs of its conversion to a clinical practice exist: the large arc-shaped reception desk in what used to be the house’s reception room (see Figure 3), the bench seats along the wall where waiting patients sit, the state-of-the-art gymnasium, and the display cases showing products for sale, but otherwise the building retains its residential feel.
Dinah and Tania’s rooms are the largest and most domestic looking in the building. The rooms are subtly decorated in earthy pastels and they resemble a living room more than a sterile clinical space (see Figure 26). Apart from the small half-moon sink near the door, there are few indications that this is a treatment room in a medical practice. Clearly, enormous efforts have been made to move away from the traditional austerity of the hospital clinic; there are large pot plants, luxurious carpets, domestic furnishings, and framed pictures on the wall. In Dinah’s room, for instance, a framed picture of Lion Rock – a local landmark on Auckland’s west coast – rests in the line of site of patients talking with the therapist. The photograph shows a large rocky outcrop, surrounded by waves breaking on the shore (the image can be seen on the home page on the Breathing Works website). The waves, Dinah explained to me, represent the gentle, tidal flow of breathing, and the shape of the rock resembles the curve of a normal lung function test. Dinah and Tania explained though that the image is a metaphor for the kind of relaxed easy breathing that becomes corrupted, in some people, by worry, stress and overwork.

Figure 26. View across Breathing Works' practice room showing domestic adaptations to interior
Patients come to the clinic for its reputation in treating breathing pattern disorders. Originally known as hyperventilation syndrome, BPDs refer to a collection of symptoms that occur in people whose breathing has become disordered, usually as a result of anxiety or stress, but always resulting in a breathing pattern that is in excess of metabolic demand (M. Thomas, McKinley, Freeman, & Foy, 2001). Patients are generally free of other organic lung problems – bronchitis, emphysema or infection, for instance. It is not uncommon however for patients to present with asthma, and there is a long history of association between these two conditions (Chaitow, Bradley, & Gilbert, 2002; Holgate, Boushey, & Fabbri, 1999). Patients are referred to the clinic either by their general practitioner or medical specialist, or self-refer having heard about the clinic’s work from a friend or relative. Patients are seen for one hour at the first appointment and pay what is, by comparison with other private physiotherapy practices, a premium rate for their treatment. They commonly attend four to six sessions over the course of three to six months before being discharged, in many cases fully relieved of their symptoms.

As well as Dinah and Tania, an array of part-time physiotherapists have worked at the clinic in the years since its creation. Though not all trained in respiratory branch of physiotherapy, they all receive training in the ‘Breathing Works Method’. Dinah and Tania are not at all protective of their approach to the assessment and treatment of BPDs, in fact they have spent a great deal of time and effort in recent year promoting their methods within the profession. It is their belief that all physiotherapists should be incorporating their methods, and at the time of writing this text, Dinah and Tania are finishing a comprehensive manual that will include their accumulated wisdom from the first decade of Breathing Works. The manual will include their philosophy and approach to practice; practical advice on assessment and treatment techniques; systems of clinical management, and interactions with other colleagues.

Patients spend much of their initial appointment at Breathing Works talking about the signs and symptoms of their breathing problems. Breathing Works has its own assessment forms which follow many traditional respiratory physiotherapy lines; asking about the history of the patient’s presenting complaint, their relevant past medical history and medications (see Appendix Ten). But unlike orthodox respiratory physiotherapists, the Breathing Works staff also ask about alcohol, caffeine and illicit drug consumption; diet, leisure and sleep habits; personal relations, work stress and occupational roles, and a wide

---

28 The charge for treatment at Breathing Works is roughly comparable with the cost of a specialist medical consultation, or boutique complementary therapist.
range of seemingly unconnected symptoms; headaches, depersonalisation, anxiety and tension, musculoskeletal pain, tingling fingers, upset stomach, phobias and other irrational fears, palpitations and chest pain. The therapist often measures the patient’s oxygen levels, heart and respiratory rates, and lung function, before checking on the patient’s breathing pattern and posture. Unlike conventional physiotherapy in the medical ward though, this is done without removing the patient’s clothing. The emphasis here is less upon the anatomy, physiology or pathology of a person’s breathing, and more to do with the connection between their work, home life, relationships, rest, activity and personal fulfilment and their symptoms, and as such, the gaze of the therapist shifts from one of an intimate interest in the pathological evidence of abnormal lung function, to a less corporeal interest in the social context of the person’s breathing problems. This is a much more involved view of the breathing patient, and is designed to locate any deviation from ‘good’ breathing\textsuperscript{29}. How then do these practices differ from legitimate, orthodox respiratory physiotherapy?

**Orthodox respiratory physiotherapy in the new millennium**

The crux of my argument in this chapter is that Breathing Works is resisting many of the discourses that have constructed physiotherapist’s practices in the past; that it is seeking to transgress traditional assumptions about orthodox physiotherapy, and challenge the disciplinary strategies and tactics that won the profession its legitimacy. This resistance works no more clearly than when we contrast the operations of Breathing Works with orthodox respiratory physiotherapy, which, I will show, remains tied to many of the subjectivities constructed during the early years of the twentieth century. I will explore later how neo-liberal, economic and political reforms have created new possibilities for health professionals, but my contention is that respiratory physiotherapy has been largely insulated from these effects within the enclosure of the medical ward. It is my belief that the constraints imposed by this enclosure acted as a stimulus for Dinah Bradley and Tania Clifton-Smith, and encouraged them to transgress traditional, taken-for-granted assumptions about legitimate, orthodox practice, and create new possibilities for physiotherapy – in this case, in the shape of the Breathing Works clinic.

Present-day respiratory physiotherapy is substantively unchanged in New Zealand from that which developed at the height of the welfare state in the 1930s and 40s. Despite some minor organisational re-arrangements, it still relies heavily upon the same

\textsuperscript{29} The notion of ‘good’ breathing, so prevalent in Breathing Works’ writing will be discussed at length later in the chapter.
philosophical approaches to the body, the same daily routines and conventions, and the
same pathologies and structural relationships with doctors, nurses and allied health staff
(Hough, 2001; Pryor & Prasad, 2002; Roskell & Cross, 2001). And while scientific
advances have brought new techniques into the profession (i.e. non-invasive ventilation,
positive expiratory pressure, inspiratory muscle training), respiratory physiotherapists
remain tied to a biomechanical, pathologically-centred view of lung disease (Hough, 2001;
Pryor & Prasad, 2002). In the treatment of chronic obstructive pulmonary disease for
example – one of the major causes of morbidity and mortality in the western world
(Halbert et al., 2006) – the role of the respiratory physiotherapist remains one of sputum
clearance and maximising physical function (Hough, 2001). In the two most widely used
respiratory physiotherapy texts, the focus remains squarely on the problems of sputum
retention, increased work of breathing and reduced lung volumes, while the therapist is
encouraged to understand the innate complexity of breathing in purely mechanistic terms
(Hough, 2001; Pryor & Prasad, 2002). Little has changed in the conduct of respiratory
physiotherapy. Even pulmonary rehabilitation – a relatively new approach to the
management of chronic lung disease; which emphasises exercise as a way of maximising
independent functioning in the community (Bott & Singh, 1998), operates according to
principles of remedial gymnastics made popular in Europe at the end of the nineteenth
century and later colonised by the ISTM as a part of legitimate massage practice (Kleen,
1918; Zander, 1918).

The last 30 years have been difficult for respiratory physiotherapists in New Zealand. Despite the fact that it remains the primary public service provider of physical
rehabilitation services to patients with lung disease (Bott, 2000), the numbers of
physiotherapists practicing the sub-discipline have declined. By contrast, the number of
private practitioners in New Zealand has increased exponentially; In 1960 fewer than 5%
of graduates were employed as private practitioners, by 2000 this number had risen to
more than 55% of the physiotherapy population (Reid & Larmer, 2007). A combination of
changing societal attitudes towards the orthodox health services and the creation of no-
fault accident compensation legislation has created new possibilities for physiotherapists
which some in the field of musculoskeletal physiotherapy practice have been eager to
exploit (Fahy, 1982; Reid & Larmer, 2007).

By contrast with the changes taking place in musculoskeletal private practice,
respiratory physiotherapy has stagnated. Since it established itself within the medical
wards in the first half of the twentieth century, it has ossified professionally. The
discipline has retained its interest in lung disease, and has largely ignored social and political changes that have encouraged health professionals to view health and illness through interpretative or postmodern lenses (Bott, 2000; Roskell, 2002). Even changes to the structure and organisation of public health care have had little effect on the delivery of medical respiratory physiotherapy; the move towards purchaser/provider divisions, the creation of GP fundholding, the emergence of health promotion strategies as a way of countering the growing cost of health care, the changing demographics of the population, and the advent of public health medicine, have had little effect on the material practices of respiratory physiotherapists.

One shift in the delivery of health care which has caught the profession’s attention, however, is the emergence of evidence based practice (EBP). For many years, respiratory physiotherapists have been calling for better research to promote the profession (Bott, 2000). With the advent of EBP, and the consolidation of physiotherapy teaching within the university sector from the 1990s onwards, far more graduates have been equipped with the requisite knowledge, skills and attitudes to promote and engage in research. Not unsurprisingly, given respiratory physiotherapy’s concentration on the biophysical aspects of lung disease, the focus for much of the evidence based research to date has been directed towards the question of the efficacy of treatment (Roskell & Cross, 2001; Ward & Helmholz, 1997). Evidence based practice is considered by some to be the necessary accompaniment to future professional practice in respiratory physiotherapy, and it is clear thus far, that the profession wishes to continue its positivistic approach to lung disease and remain in close proximity to the medical profession within the public health sector. It is also clear that, for some, this represents a rather limited view of the future for respiratory physiotherapy, and one such practice is Breathing Works. I will now go on to explore how Breathing Works is formulating its own solution to the problem of respiratory physiotherapists’ increasing isolation within the medical ward, and the way that the founders of the clinic are problematising breathing as a way to imagine future physiotherapy practice differently.

**Problematising breathing**

The B R E A T H I N G W O R K S method is a unique way of approaching health problems in the 21st century. The drug free method is a way of self regulating through skilled information where people are able to restore homeostasis that has often been lost because of the stress levels we live under. The method is a unique and effective application of physiological and musculoskeletal principles (Bradley & Clifton-Smith, n/d).
The above quote illustrates Breathing Works’ bold statements about the potential benefits of its approach, and many of the discursive influences upon the design of its practices; its focus on contemporary health care; its promotion of alternatives to conventional medicine; the benefits of gaining control over one’s own breathing (and, by extension, one’s life); with the solid foundations in orthodox science as the basis for its claims. These claims form the basis of my analysis in this chapter as I seek to unpack the various subject positions adopted by Breathing Works in its pursuit of new opportunities beyond the confines of the medical ward.

Breathing Works deviates from legitimate, orthodox respiratory physiotherapy in many ways. Firstly, the object of its attention is no longer an organic lung disease, but rather a syndrome of symptoms more akin to a lifestyle complaint. Secondly, the clinic’s operating environment is a radical departure from the austere surroundings of the medical ward and physiotherapy clinic. Thirdly, its problematisation and commodification of breathing has created the possibility for an entirely new lexicon of language and practices at the margins of orthodoxy. I will explore each of these forms of deviation as the chapter unfolds, but to begin with, I will consider how Breathing Works is problematising breathing.

The term breathing pattern disorder is a relatively recent invention (Gardner, 1996). It is a term that first appeared in the medical literature as a way of resolving some of the complexity inherent in the more familiar phrase ‘hyperventilation syndrome’ (Gardner, 1996). BPD allowed doctors, physiotherapists and psychologists to explain the variations between people who presented with symptoms that indicated breathing problems in the absence of organic lung disease, and at the same time address the widely differing clinical presentations that HVS could not (Chaitow, Bradley, & Gilbert, 2002). It had been thought, for instance, that the cause of the symptoms associated with HVS was as a result of lowered levels of carbon dioxide in the blood; but many people with HVS do not have lowered blood CO₂ levels (Bradley, 2002b; Lum, 1977). It was thought that others visibly breathed deeper or faster; but again many did not. No-one to date has managed to isolate a single physiological variable shared by all patients, therefore it is possible to argue that the term ‘hyperventilation’ presented a misguided view of the problems presented by patients. ‘Breathing pattern disorder’, on the other hand, was broad enough to capture all of the problems associated with its presenting symptoms.

While the terms HVS and BPD were not invented by Breathing Works, Dinah Bradley and Tania Clifton-Smith have been determined in their attempt to promote the
terms as legitimate problems worthy of investigation. Indeed the clinic’s prosperity depends on its ability to locate ‘bad breathers’ within the community and treat them. The notion of good and bad breathing is a striking one and one that appears repeatedly in the clinic’s promotional literature, as this excerpt illustrates;

Good breathers take about 10-14 breaths a minute, inhale through the nose and use their diaphragms to expand their lungs. Dinah is co-founder of an Auckland clinic called Breathing Works where she retrains bad breathers, turning them into good breathers – with remarkable results (Atterbury, 2002, p. 68).

I will return to the moral questions posed by this notion of the good and bad breather later, because it is my belief that it has important connotations for physiotherapy; not least because it displaces respiratory physiotherapist’s earlier focus upon ‘bad lungs’ which emphasised many of the anatomical and physiological reference points utilised by massage practitioners to demonstrate their legitimacy and orthodoxy; the emphasis on the biomechanics of breathing and the objective measurement of oxygen saturations and peak expiratory flow rates, for instance. Breathing Works has supplemented these with a much broader view of the breathing patient. Breathing problems no longer serve merely to differentiate a person who is ill from one who is healthy. Instead they introduce the notion of optimal health; of a world in which we could all breathe better. In doing so, Breathing Works is troubling what had previously been thought of as a universal constant. Breathing. As Tania explains;

‘Instead of looking at someone who’s got something wrong and making it better, we’re taking someone and saying “hey, do you want to be even better?” You’re starting from a neutral position versus an unwell position. Traditional physiotherapy, as it has evolved, looks at someone and says “oh, your knee’s not so good” or “your breathing’s bad”. We’re changing that and instead saying ‘hey, you can do this if you want to enhance your wellbeing’, so it’s a change in the mindset. We’re not just treating people who’ve got a disorder.’

This quote illustrates how it has been possible for Dinah and Tania to create new subject positions for the physiotherapists at Breathing Works by defining a new domain of objects centred around the breathing client. These new objects demand new expertise to interpret the new knowledges of breathing that emerge. Unsurprisingly then, authorities in the treatment of breathing pattern disorders make much of the fact that patients may appear on the surface to be breathing perfectly normally (Chaitow, Bradley, & Gilbert, 2002; Lum, 1977, p. 232), and highlight the need for experts to interpret clients’ fatigue, anxiety, heightened stress levels and poor productivity as indicative of breathing problems. As Tania stated in an early interview about the clinic;

30 By way of clarification, parentheses have been used in this chapter to denote directly quoted speech, and citations less than 40 words in length.
“If you stood on the street and asked members of the general public,” says Tania, “eight out of ten people would tell you that they’re tired. They may not be experiencing anything other than fatigue and low energy, but they might also have things like sore neck and back muscles, headaches, general anxiety and panic, gut problems, insomnia, chest pain, and pins and needles (Atterbury, 2002, p. 68).

The article goes on to state that;

‘Tania, Dinah, and many other health professionals believe that symptoms like these have a common source; they say that many of us are not breathing properly, and are putting enormous pressure on our bodies as a result’ (Atterbury, 2002, p. 68).

It has been known for many years that breathing is an automatic response to our environment, activity levels and state of mind (Proctor). Breathing has also been known to be one of the few automatic bodily functions that occasionally comes under voluntary control. Thus, it is unlike the function of the heart, liver, spleen, or digestive system, per se, which are automatic bodily functions over which we have almost no voluntary control. Breathing is more like blinking; an automatic reaction that can be controlled at will. Unlike blinking however, breathing is essential to life. Breathing, therefore, is the only body system essential to life that is under automatic and voluntary control, and as such it is prey to our moods, as well as our environment and our metabolic demands.

The implications of this paradox were tentatively explored by Claude Lum in 1977, when he stated that;

each one of us can, and does, learn an habitual manner of breathing which may differ markedly from that of our neighbour, and we may adopt certain mannerisms of breathing of which we are quite unconscious but which may, in fact, be definitely harmful (Lum, 1977, p. 232).

For their own part, Breathing Works has emphasised the fact that the diaphragm is the only skeletal muscle in the body that we cannot live without, and so argues that the profession (with its intimate knowledge of skeletal anatomy and physiology), is ideally placed to optimise people’s breathing, particularly when it is not functioning optimally.

Texts produced by the founders of Breathing Works make much of the supposed naturalness of breathing and our mistaken belief that we all breathe automatically; ‘It’s something we can’t survive without, but as many as 350,000 New Zealanders are doing it wrongly’ (Bartley & Clifton-Smith, 2006). The clinic has also promoted the idea that BPDs are far more common than we might have imagined;

Tired all the time? Yawning too much? Unrefreshing sleep? Sore chest wall and other aches and pains? Are you feeling spaced out, stressed to the max, light-headed and anxious? You may be amongst the one in eight healthy New Zealanders who suffer from breathing pattern disorders or chronic over-
breathing…Using simple techniques we can literally breathe our way to improving our health and performance (She Magazine, 2000).

At other times the ratio of bad breathers to good seems to shift, but the emphasis remains firmly upon a natural body system corrupted by our moods and lifestyles;

Most of us don’t breathe properly, says Ms Clifton-Smith. We start breathing perfectly from the time we are born to the age of four. But as life changes us, it changes the way we breathe – often for the worse and bad breathing patterns can lead to all sorts of related health disorders…But says Ms Clifton-Smith, one in 10 New Zealanders have some form of breathing pattern disorder (Beck, 2003, p. 39).

Thus far then I have argued that Breathing Works has actively constructed the notion of the ‘bad breather’, and linked this to breathing patterns that are shared by all of us; rather than only those with pathological lung disease. I have also explored Breathing Works’ belief that the naturalness of breathing makes it difficult to perceive, and that it takes an expert practitioner to diagnose it. (Interestingly, this expertise is gleaned, for the large part, from knowledge of anatomy and physiology; two very orthodox physiotherapy epistemologies).

Some of the ‘causes’ of ‘bad breathing’ have recently been identified by Clifton-Smith and Dr Jim Bartley in a publication titled ‘Breathing Matters: A New Zealand Guide’ (Bartley & Clifton-Smith, 2006). The authors state that increased workload, home stressors, perceived pressures, poor posture, static positions, held breath, hormones, menstruation, menopause or pregnancy, poor diet or overdosing on caffeine, represent a range of ‘stimulants’ that can alter people’s breathing patterns (Bartley & Clifton-Smith, 2006). What is notable here, and what is consistent throughout Breathing Works’ publications, is the emphasis upon the working age population, and the moral questions surrounding the notion of bad breathing.

The clinic’s message appears to target the adult, predominantly female consumer. Of the more than 50 interviews and promotional pieces run about the clinic since 1999, over three-quarters appear in adult ‘women’s interest’ magazines. They are often accompanied by pictures of models in meditative states, with headlines that proclaim; ‘Breathe better…look younger in an instant!’ (Beck, 2003, p. 39); that tell the readers about ‘redeeming your airways’ (in which Tania is described as a ‘breathing evangelist’) (L. Donaldson, 1999, p. 48); and that ‘Better breathing improves living’ (Woodward, 2002); and, in virtually every case, the clinic ensures that the reader understands that bad breathing is a complex, often hidden medical problem, requiring expert medical attention if it is to be located, assessed and treated;
Don’t waste time and money with amateur “breathing experts.” Many unqualified practitioners are setting themselves up as breathing experts. Changing the way you breathe can be dangerous – so make sure you see a practitioner who has expertise in this field. Look for professional medical qualifications – specialist physiotherapists have led the field in treating breathing pattern disorders since the mid 1960s (She Magazine, 2000, p. 7).

The above quotation is interesting because it is one of the few occasions in the texts produced by, or for the clinic, that mention is made of the fact that the founders and all the practitioners are physiotherapists. It seems at times that the founders of Breathing Works feel uncomfortable about the clinic’s association with orthodox physiotherapy – a point I will return to later. In their self-help guides, for example, mention of physiotherapy is rarely made (Bradley, 1991; Bradley & Clifton-Smith, 2004, 2005; Clifton-Smith, 1999, 2002). My belief is that the physiotherapists at Breathing Works are attempting to straddle orthodox and alternative practice; making use of biomechanical discourses and their alliances with the medical profession to establish their credibility in a competitive marketplace; but developing new knowledges, subject positions and objects of scrutiny that are also amenable to a contemporary audience of health care consumers.

Breathing Works, in this regard, may be viewed as an ‘enterprising technology’ (Rose, 1997), in which;

the well-being of both political and social existence is to be ensured not by centralised planning and bureaucracy, but through the ‘enterprising’ activities and choices of autonomous entities – businesses, organizations, persons – each striving to maximise its own advantage by inventing and promoting new products by means of individual and local calculations of strategies and tactics, costs and benefits (Rose, 1997, p. 153).

Enterprise is therefore firmly rooted in the political and social aspirations of neo-liberal democracies. It is directed at developing ‘enterprise technologies’ that facilitate people to become enterprising; in the case of Breathing Works, developing technologies that allow people to pay for strategies that seek to optimise their health; demonstrate their ‘virility’; or overcome their own barriers to efficiency and effectiveness in work and life; what Rose called ‘striving for fulfillment, excellence, and achievement’ (Rose, 1997, p. 154).

The notion of enterprise technology comes into stark relief when we consider how the message promoted by the Breathing Works clinic’s staff transcends the strictly orthodox, biomechanical discourse of the respiratory physiotherapist. Rather than being constrained by the same dogmatic approach to the body-as-machine, the physiotherapists at Breathing Works are aware that their message is targeting an affluent, working age, predominantly female population, and speaking to their anxieties and guilt about bad breathing. In doing so, Breathing Works, is actively focusing on a paradox; the
incongruous problem of why women who would appear to be living otherwise ‘perfect lives’ – with all the accoutrements and luxuries of consumer culture at their disposal – should be suffering widespread, largely invisible symptoms, and feeling guilty because their lives remained troubled by illness. In the following quote, for instance from a conversation with Dinah, we see the conflation of the notion of guilt with the image of the affluent adult woman, and the corresponding effect her state of mind has upon her breathing:

‘Well you would feel guilty. Imagine you’re a lovely middle class happy woman, lovely children, rich husband. Not happy, not well. And to actually put it into a…you know, she’s actually been doing too much Pilates and it’s buggered up her breathing.’

As opposed to an orthodox respiratory physiotherapy approach which simply ignored non-biomechanical discourses surrounding lung disease (I am thinking here, for instance, of the social discourses surrounding the notion of contagion, interpretative discourses exploring people’s lived experiences of lung disease, and metaphysical discourses around living with and dying from lung disease), Breathing Works uses its orthodox status to make a virtue of the anxiety and guilt associated with bad breathing, and makes it a feature of their new approach to the breathing patient, as Erin pointed out in one of our interviews when she stated that ‘There is enough science to say to someone…if someone comes in, there is enough science to reassure them, to remove any guilt from it, to remove anything psychotic from it; there is enough science to be useful for that.’

This ‘play’ on the notion of anxiety and guilt has been reflected in Valerie Fournier’s work into authority and expertise in neo-liberal health care. In the following quote, for example, she argues that it is in the interests of the expert to engender a culture of anxiety in their target population;

Professional authority needs to be established and reinforced through symbols which make the public conscious of its dependence on the professions. The professions may create this pattern of dependence by playing on the weakness of the clients, their vulnerability, helplessness and general anxiety, which in turn are generated, or at least exacerbated, by professionals’ cultivation of an atmosphere of crisis or emergence in which they both create work for themselves and reinforce their authority by intimidating clients (Fournier, 2000, p. 80).

When applied to Breathing Works, and the newly emergent neo-liberal context in which Breathing Works is operating, this approach reflects a form of resistance to the dogmatic orthodoxy of respiratory physiotherapy. It seems that Breathing Works is taking a different view of breathing – one that focuses upon the breathing client, rather than the patient’s lung disease – and in so doing, it is constructing an array of alternative
approaches, languages and practices. This is encapsulated in the way the clinic turns the innate vulnerability of breathing into a virtue. I stated earlier that breathing was the only body system essential to life that was under automatic and voluntary control, and that we were consequently at the mercy of our busy lifestyles and fluctuating emotions. According to Breathing Works, breathing, unlike all other homeostatic bodily functions, makes us constantly vulnerable and prone to illness, and this is particularly true if our anxieties, passions or stresses cause our breathing to become excessive. The list of symptoms associated with HVS is diverse and impressive: chest pain, depersonalisation, blurred vision, palpitations, upset stomach, tingling fingers, poor sleep, etc., and the list of clinical features equally so: disordered breathing patterns, overuse of accessory muscles of respiration, elevated saturation of oxygen in the blood, altered blood pH, etc (Bradley & Lum, 2001; Chaitow, Bradley, & Gilbert, 2002; Clifton-Smith, 1999). But it is my belief that this same vulnerability has been turned on its head by experts in breathing pattern disorders like Dinah and Tania, who have realised that this vulnerability also provides a window into the systems that regulate basic bodily functions, and treat the person ‘from the inside out’ – intervene in the most fundamental bodily functions and restore the person from within (Chaitow, Bradley, & Gilbert, 2002). The ability to artificially manipulate one’s breathing means that those patients that have ‘buggered up their breathing’ – to use Dinah’s phrase – can be restored to health by the manipulations of expert practitioners at Breathing Works. Breathing becomes the ‘portal’ through which Breathing Works is able to treat all manner of non-specific symptoms of busy lives and over-wrought emotions. Physiotherapy need no longer focus only on the mere physical dimensions of lung disease, now it can broaden out to issues of one’s lifestyle, habits, emotions, thoughts, loves, hates, attitudes and beliefs. I believe then that Breathing Works is creating an entirely new object of scrutiny for physiotherapy, and in doing so it is problematising breathing.

Foucault defined problematisation as ‘the ensemble of discursive and nondiscursive practices that makes something enter into the play of the true and the false and constitutes it [as] an object of thought (whether in the form of moral reflection, scientific knowledge, political analysis or the like)’ (Foucault, 1984a, p. 18). Breathing Works is actively reconfiguring the naturalness of breathing, constructing new truths about ‘good’ and ‘bad’ breathing, and creating new ways in which knowledge of its deleterious effects can be disseminated throughout the community. Breathing is no longer the natural bodily response we thought it was. This approach is not, in itself, that unusual, particularly in health care, where the ‘invention’ of new categories of illness underpins many features of life that are now considered medical conditions (depression, alcoholism, ADHD and
autism, for example) (Netleton & Bunton, 1995). What is relevant here though, is the way that Breathing Works has framed breathing in a neo-liberal context; where natural capacities of the body become objects of commodification. Nikolas Rose argues here that;

There is thus a certain reversibility of relations of expertise. What begins as a norm implanted ‘from above’, such as the universal obligations of literacy or numeracy, or the adoption of appropriate patterns of conduct in child rearing, can be ‘repossessed’ as a demand that citizens, consumers, survivors make of authorities in the name of their rights, the autonomy, their freedom (Rose, 1999, p. 92).

This act of reversal creates its own market for commodities that people come to believe are essential for the expression of their personal freedoms. Good breathing becomes one’s right, and it is each person’s responsibility to pursue it. Breathing – such a natural, previously un-thought facet of our experience of selfhood – now becomes a potent commodity that people can acquire in the neo-liberal pursuit of freedom.

Commodifying breathing

Contemporary respiratory physiology teaching is based on the belief that breathing plays a vital role in maintaining one’s homeostasis. The acidity and alkalinity of our blood is balanced largely by the rate and depth of our breathing, and this is managed by an acutely sensitive region of the brain stem which continually monitors the amount of circulating carbon dioxide in the blood and alters breathing accordingly (Chaitow, Bradley, & Gilbert, 2002). Respiratory physiologists talk about breathing being an example of a negative feedback loop – a system that provides an immediate response to a chemical imbalance within the body (Bartley & Clifton-Smith, 2006). The same respiratory physiologists have, however, been slow to accept that breathing might itself become maladaptive; that instead of being a reflex response to a change in blood pH, breathing might actually be the cause. In recent years, a growing body of literature has shown that altered breathing patterns may be the reason for illness, not merely a response (Bass, 2000).

As the literature has emerged problematising the assumed normality of breathing, Breathing Works has concentrated its practice approach on this emerging body of evidence. Indeed, one of Dinah’s books is a collaborative venture between herself, an osteopath and psychologist, documenting the clinical evidence supporting a number of breathing pattern disorder treatments (Chaitow, Bradley, & Gilbert, 2002), and recently, Tania has co-authored a book with a local Ear, Nose and Throat surgeon looking at BPDs and the function of the upper airways (Bradley, 1991). Breathing Works has done as much
as anyone to date to legitimise the treatment of HVS and BPDs, and has sought to gain the support of the medical community for their practices.

Their efforts have not been met with universal support however. Within their own profession, Breathing Works is viewed with some suspicion. Despite their success in promoting a new form of physiotherapy practice, there is an anxiety about the way that the practice is challenging the conventional wisdom about breathing. Their publications are viewed with some suspicion by physiotherapists, and the College of Physiotherapy in New Zealand thus far refuses to recognise the Breathing Works courses offered to physiotherapists by Dinah and Tania. In an interview with Dinah, she explained her frustrations with this lack of recognition;

David: You’ve published extensively haven’t you.
Dinah: Yes. It’s all pop though, I’m not recognised, I mean I’m a laughing stock in physio, you know in the College and things like that… I may be exaggerating but it’s of no importance to them… My books are pop books.

The reason for this anxiety on the part of the profession may lie in Breathing Works’ unorthodox approach to breathing. As I mentioned earlier; while the clinic maintains one foot firmly within orthodox health care, it is also developing an entirely new approach to respiratory physiotherapy – one that operates very close to the margins of orthodox practice. The most tangible example of this is the clinic’s commodification of breathing. Breathing Works operates successfully as a private enterprise only as long as it continues to convince the public and its medical colleagues that bad breathing exists, affects people adversely, and can be recognised and treated by experts in the ‘Breathing Works Method’. Bad breathing is no longer seen only in pathological terms; differentiating the healthy person from the ill patient. Now breathing operates on a different axis of specification which rejects the simple binary of healthy/sick. Without the need to identify an underlying pathology characteristic of orthodox medicine, the emphasis falls upon our breathing pattern, and any number of ‘affectations’ may be considered problematic: breath holding, sighing, yawning, breathing into the upper chest, overusing the accessory muscles of respiration, etc. Respiratory physiotherapists no longer need to recognise pathological changes on X-ray, pulmonary function test, or auscultation. They no longer need to approach the lungs of the patient empirically. Instead they need to be able to connect the various breathing patterns with an array of diverse symptoms associated with stress and overwork, and in one short step, they have created an entirely new market for their expertise. Nigel Malin explored this dynamic in considering how
neo-liberal market rationalities had created new possibilities for consumers and practitioners alike;

Consumers are no longer passive, simply accepting the authority of the professional and consuming what is on offer. Consuming is transformed into an enterprise project through which people assemble their chosen lifestyle by taking responsibility for, and making informed choice about, the acquisition of appropriate goods and services. The so constituted consumer shares very little with the passive, philistine and dependent client. This newly found independence of the customer is a challenge to the relationship of dependence between client and practitioner central to the establishment of the professions. The sovereign consumers question the authority of the professions and the value and cost of their services, they ply around for alternatives within and outside the profession. This constitutes another pressure on professionals to locate their activities in the market: they have to sell their produce or service (Malin, 2000, p. 80).

Breathing Works is making bad breathing its business, and following Zigmunt Bauman’s assertion that ‘The freedom to treat the whole of life as one protracted shopping spree means casting the world as a warehouse overflowing with consumer commodities’ (Bauman, 2000, p. 89), it is constructing its practice with a view to its consumer appeal – an approach to respiratory physiotherapy unseen before. In the design and layout of its clinic space, the creation of a new lexicon of therapeutic language, and its use of popular media, Breathing Works is firmly straddling orthodox and alternative/complementary practice.

The clinic’s environment is a striking illustration of its consumer-mindedness. Turning its back on the austere, sterility of the medical ward and hospital physiotherapy department, Dinah and Tania have created a clinic space that resists many of the functionalist constraints imposed on orthodox practitioners. Their treatment rooms are painted in soft greens, they have warm, rich-coloured carpets, their treatment couch is draped in fabrics that match the décor, and in one of the clinic spaces, a large pot plant breaks up the regular contours of the room. Clearly, attention has been paid to the aesthetics of the environment and the need to project an alternative image than that found in the public sector. As Fiona, a physiotherapist treating patients in a large district general comments;

Fiona: If you want to market yourself similar to the chiropractors and physicians then your rooms have got to give that perception that you are...good. It’s all part of the marketing package isn’t it. If you go into a cruddy old place you’re not going to expect great treatment – that’s just human psyche, human motivation and all that sort of stuff.

David: So where do you treat your patients?

Fiona: In a private room, or at the YMCA (laughs).
David: The private room – is that within the physio department?
Fiona: Yes it is.
David: And what’s the room like?
Fiona: It’s pretty cruddy. But it’s better than a cubicle which it used to be. It’s got a hospital bed in it; it’s got a window with some natural light which is nice, got a couple of chairs, so it’s better than what I would have had to treat five years ago.

The patients entering Dinah and Tania’s rooms at Breathing Works are given subtle clues about the clinic’s practice philosophy; a small half-moon sink suggests cleanliness, but unobtrusively; therapy equipment (wall bars, sling suspensions and electrotherapy devices) has all been removed, and the few pieces of equipment used by the staff are concealed behind warm-coloured wooden furniture. Only a stethoscope, hanging from the corner of a display unit, reminds the patient of the clinic’s respiratory roots (see Figure 27).

Figure 27. Breathing Works’ clinic interior showing strategic use of decor to balance domestic and clinical discourses

Even the treatment couch; the symbol of orthodoxy and passivity for physiotherapists for many years, is draped to conceal the austerity of its design. But it is clear that such subtle acts as these challenge some of the critical discourses that underpin the profession’s professional identity. In the case of the treatment couch for instance, the
clinic’s use of soft furnishings, its movement of the bed away from the centre of the room (as is often the case in orthodox practice), and its location within a warm, aesthetically pleasing clinic space, destabilises one of the profession’s anchor points in its ongoing pursuit of legitimacy. It is my belief that the treatment bed served a very important function in earlier moments of the profession’s legitimacy and orthodoxy; projecting an image of decency and ‘comme il faut’ to the patient. A treatment couch was designed to look nothing like a bed that you might find at home, or worse still, in a brothel. It was not meant to be luxurious, comfortable, relaxing or pleasing to the eye. It was meant to be functional, sterile, manipulatable, and it was meant to situate the patient in a passive relation to the therapist – with sections that could position the patient’s legs, head and torso as the therapist wished (see Figure 28). The beds in the Breathing Works clinic however, are covered with sheets to conceal their inner workings. The patient is made comfortable with soft pillows and warm blankets, and while they clearly remain a reasonably firm, rather uncomfortable surface to lie on for any length of time; the clinic has done as much as it can to make it a more aesthetically pleasing experience (see Figure 29).

Figure 28. Typical arrangement for physiotherapy treatment bed
In destabilising one of the most important technologies used by orthodox practitioners to demonstrate their legitimacy, Breathing Works is testing the margins of orthodox practice. This tension came to the surface in an interview with Erin:

Erin: That’s the other thing. I never know what to call it.
David: What, a bed?
Erin: A bed. I call it a bed but I feel hmmm (uncomfortable)
David: What’s wrong with ‘bed’?
Erin: Too personal; ‘lying on a bed’. ‘Lying on a plinth’ – too clinical…
David: Treatment couch?
Erin: Sounds too ‘psych’
David: Mmm,
Erin: It’s very hard, especially something like this, to keep it appropriately clinical but not too clinical.
David: What do you mean by appropriately clinical?
Erin: Erm, the patient has to feel safe. They have come to see a health professional, I think I can say that, they expect to see a health professional, so they have expectations, and if you move beyond that…
David: To what?
Erin: Well they have to be comfortable with that.

The redesign of the clinic space is not the only way in which Breathing Works is challenging conventional approaches to orthodox practice. In its guidance notes for new staff, for example, it promotes an alternative model of physiotherapy practice called the ‘Breathing Works Model’ (Figure 30). In addition to this, the clinic also promotes such innovations as ‘the relaxation ripple’, ‘mind stopping’, the ‘green dot method’, and ‘baseline calm’ (Bartley & Clifton-Smith, 2006; Bradley, 1998; Bradley & Clifton-Smith, 2005; Clifton-Smith, 1999, 2002). Clients are encouraged to progress from the ‘Breathing Works apical deactivation technique’ to the ‘Breathing Works lateral deactivation technique’ (Dekker, 1999) – essentially altered breathing patterns that have been used by respiratory physiotherapists for many years, commodified and colonised by Tania and Dinah, and promoted in their various self-help guides.

![Breathing Works practice model](image)

Figure 30. Breathing Works practice model
Dinah and Tania’s advice on breathing often appears in the form of easy-to-remember slogans and homely advice that anyone can understand. These catch-phrases appear repeatedly in their promotional interviews;

They are a bit like the advice from your mother to you as a child to count to 10, and can be summed up in one key phrase: “If in doubt, breathe out” (Hill, 1999). “The main thing is,” she chants, “breathe nose, low and slow, when in doubt, breathe out...” Her solution [to the problem of breath-holding while concentrating at work] is to put a green dot on the computer and whenever you see it, breathe out and ensure your jaw, tongue and shoulders relax. Breathe into your belly, let go, pause – and without feeling too new-agey – feel the calm. It's a micropause (Dekker, 1999).

I believe these simple aphorisms serve a number of purposes; firstly, they are meant to be memorable. They are meant to be phrases that people will retain and remember throughout their day, and act as a constant reminder to self-monitor one’s own breathing. Secondly, they are meant to remind the person that breathing is a critical function that, when done correctly, can induce a state of blissful calm in an otherwise busy day. Thirdly, Dinah and Tania constantly reinforce the positive benefits of good breathing upon one’s lifestyle and work performance, and so rather than addressing the structural causes of stress at home and in the workplace, they remind the individual of his or her responsibilities to keep an even temper. And finally, these punchy phrases serve to identify Breathing Works and separate it from its competitors – thus these become Breathing Works’ phrases, and the language itself becomes a marketable commodity.

Although there are phrases and patterns of breathing used by Breathing Works that have been used by physiotherapists since Bernice Thompson and Diana Innocenti began working on encouraging patients with asthma to exhale and reduce their depth and rate of breathing in the 1960s (Innocenti, 1996, 1998; Thompson & Thompson, 1968), Breathing Works also draws heavily on language from a number of alternative health practices. In recent years, Tai Chi, Yoga, Buteyko, meditation, and a host of other approaches have gained popularity with mainstream practitioners (Du Chateau, 1999). Breathing Works offers a secular, western variation on these methods of altering one’s state of mind through breathing – an approach grounded in physiotherapy’s orthodox history, but one very much at the margins of contemporary practice.

It is possible to argue that the Breathing Works’ approach to breathing taps into a growing disaffection with orthodox, mainstream health care and an increasing appetite for boutique, consumer-orientated approaches to health and wellbeing. According to Rob Irvine, this approach responds to ‘patient disaffection with public institutions and decision-making processes’ which, he argues ‘was impelled in no small part by the belief that
service provision was dominated by self-referential professionals, inattentive or apathetic to the interests and preferences, both material and moral, of patients individually and collectively’ (Irvine, 2002, p. 32). Breathing Works’ ‘boutique’ approach to treatment certainly represents one response to these concerns.

Much as Breathing Works is throwing off the constraints of the enclosure of the medical ward, it is also challenging the biomechanically-orientated, single-body-system approach favoured by physiotherapists for the last 100 years. In the strikingly generous way it dispenses advice and guidance to readers and practitioners alike on how to breathe better, it mimics many of the ways that Nikolas Rose has spoken about the democratic ‘generosity of expertise’ (Rose, 1999, p. 92) of the ‘psy’ disciplines in their dissemination of ‘psy’ language;

The key to the transformations in our present wrought by the expertise of human conduct lies in the way in which certain knowledgeable persons – lawyers, doctors, psychologists, criminologists and so forth [and to this list we might add a few select physiotherapists] – have lent their vocabularies of explanation, procedures of judgement and techniques of remediation ‘freely’ to others…on the condition that these ‘petty engineers of human conduct’ think and act a bit like experts (Rose, 1999, p. 92).

Thus the message in Breathing Works’ self help books is that through better breathing techniques, one can help oneself to a better life. The democratisation of these truths lends status to Breathing Works as the instigator of this liberating knowledge, whilst arming its readers with more tools with which to govern their own conduct. In the following quote, Dinah talks about the universal appeal of this message and the possibilities it holds to transcend all interactions between therapist and client;

‘We’ve worked out assessment things that can radiate out into all aspects of physio, whether its orthopaedics, or neuro or anything. If you do this fundamental things first to get the homeostasis before you do anything, then I just feel sure, so deeply, that it’s such an important part of a curriculum that isn’t being addressed as well as it might be’…‘I see carbon dioxide looming over the whole physiotherapy world, both in neurology, cardiology, pain, everything, everything. If that’s not looked at, then you’re not being a good physiotherapist’...‘We’ve got such a unifying principal which is our ‘method’ that, whichever aspect of health you go into, there’s a place for it; whether it’s corporate health, whether its hospital-based or whether it’s physios in private practice.’

The notion of a unifying principle is apt when one speaks of breathing since breathing is common to us all. Consequently, there is much to be gained by problematising and commodifying it, since it can be something with enormous marketable possibilities. This re-imagining of physiotherapy and its relationship with breathing emphasises, for me, how Breathing Works is resisting many of the discourses that have informed the profession in
the past. In this section I have explored how Breathing Works is destabilising the assumed normality of breathing and how setting out to offer alternative forms of practice it has colonised new language that separates it from conventional respiratory physiotherapy. These approaches have created new markets for health care consumers interested in, not only resolving perceived health problems, but optimising their work/life balance, relationships, moods, work performance, etc. Finally, I have explored how the democratic generosity of Breathing Works in disseminating its model of practice, assessment and treatment techniques, has created a niche for the clinic beyond the confines of conventional physiotherapy practice. I now move on to consider some of the governmental conditions that I believe are informing the actions of the physiotherapists at Breathing Works.

A sign of the times – breathing in a neo-liberal age

Breathing Works is a truly modern practice’, and ‘Although hyperventilation has been around since the Middle Ages, it’s become more relevant in the technological age – a real, living, and breathing sign of the times (Du Chateau, 1999).

In the following section I will explore the notion that Breathing Works is a ‘truly modern practice’ by considering the impact of neo-liberal reforms in New Zealand’s health care system, and the possibilities these reforms created for Breathing Works.

Dinah and Tania have been called ‘health consultants’ (Lawrence, 1999), ‘renowned breathing-pattern disorder experts’ (Winter, 2003), ‘leading authorities’, ‘breath evangelists’ (L. Donaldson, 1999), and even ‘breathing divas’ (Watkin, 2002). At no time before, in the history of respiratory physiotherapy, has anyone written about physiotherapists this way. But then respiratory physiotherapy has never been exposed to the same market conditions and consumer possibilities before. I believe that Breathing Works is, in part, a contingent response to a set of tensions and opportunities created by the shift in recent years from welfare-dominated approaches to health care, to postmodern, neo-liberal philosophies of optimal health and wellness. The emergence of the Breathing Works clinic, and the tactics and strategies employed by its founders, represents for me a rupture, a surface of emergence, a flowering of a new form of practice; located at the very margins of orthodox physiotherapy; testing, as it develops, how far orthodox physiotherapy will extend to accommodate it. I believe that the conditions that have made this emergence possible owe something to the shift in the political environment in which physiotherapy is now operating. In the same way that physiotherapist’s practices benefited in the 1930s and 40s from welfare reforms, I believe we are now seeing the emergence of a number of new ‘boutique’ practices, like Breathing Works, as a direct response to neo-liberal economic reforms affecting the health care systems of the developed world.
Over the last 20 years, there has been a dramatic ‘hollowing out’ of the welfare reforms that dominated New Zealand’s health care landscape for much of the twentieth century (Jessop, 2006). This re-evaluation of the systems and structures of the public sector has created new problem spaces between state institutions, professions and consumers (Taylor-Gooby, 1999). A new, much more fluid relationship now exists between public institutions and newly created private market (Evetts & Dingwall, 2002), and professional bodies like physiotherapy have been exposed to legislative reform that has made a shift in the focus of practice delivery possible.

I have already briefly mentioned how the ACC legislation of the late 1970s created new market opportunities for physiotherapists to develop private musculoskeletal physiotherapy, but it is the recently enacted Health Practitioners Competence Assurance (HPCA) Act (2003), that I believe will have the most profound effect upon the profession in its efforts to create new market opportunities, blur professional boundaries, and make possible diversification from traditional, orthodox health care practices.

Repealing the 1949 Physiotherapy Act, the HPCA Act removed profession-specific legislation, replacing it with a statute that governs physiotherapists’ registration and ongoing professional development. The act has allowed the 14 established public sector disciplines to define their scopes of practice, and made it easier for other organisations to enter public health care. The legislation also emphasised the need for ongoing knowledge and skills-development, and focused on the need for health professionals to be more accountable to the public for their education and practice.

The language written into the Act emphasised the responsibilisation of the individual practitioners and the need for professional bodies to tighten their systems of surveillance, to avoid cases of malpractice which have been so damaging to public trust and wellbeing in recent years; as one of the Members of Parliament that enacted the legislation, herself a physiotherapist, explained; ‘The principal purpose of the HPCA Act is to protect the health and safety of the public by ensuring practitioners remain fit and competent to practice within a defined 'scope of practice’’ (Roy, 2004). The responsibility for enacting the legislation fell upon the various professional bodies, and in physiotherapy this is the Physiotherapy Board. The Board is a variation of the same body created by the 1949 Physiotherapy Act, that in turn replaced the Masseurs Registration Board created in 1920 under the Masseurs Registration Act. The Board, now made up entirely of physiotherapists, welcomed the HPCA Act, stating that;
the introduction of new legislation…better reflects the environment in which a statutory authority has to operate in terms of scientific advance, medico-legal change and consumer expectation (The Physiotherapy Board of New Zealand, 2004a, p. 4).

This new legislative environment provides the governmental context for the emergence of Breathing Works as a resistance to conventional physiotherapy. It is constituted by a public scepticism of orthodox practice, a desire to open up welfarist institutions like public health care to economic reform, and a rolling back of governmental control over individual rights and responsibilities (Clarke & James, 2003; Larner, 2000; Osborne, 1993). This reform has had a profound and ongoing effect upon the problem space in which expert professions like physiotherapy have traditionally operated. The neo-liberal economic reforms that provided the spur for changes in legislation in New Zealand in recent years have ‘detach[ed] the substantive authority of expertise from the apparatuses of political rule…relocating experts within a market governed by the rationalities of competition, accountability and consumer demand’ (Miklaucic, 2003, p. 328). They have ‘create[ed] a distance between the decisions of formal political institutions and other social actors’ (Rose, 1996, p. 155), with the emphasis firmly on responsibilisation, conceptualising and anticipating risk, increasing individual autonomy and choice, and re-emphasising the importance of individual freedom to act and choose health care services that best suite one’s needs (Rose, 1996). This is particularly true in New Zealand where, according to Fitzsimmons;

a distinctive strand of neo-liberalism has emerged as the dominant paradigm of public policy: citizens have been redefined as individual consumers of newly competitive public services, and citizen rights have been re-defined as consumer rights; the public sector itself has undergone considerable downsizing as successive governments have pursued the privatization agenda; management has been delegated or devolved while executive power has been concentrated even more at the centre…There has been a clear shift away from universality to a “modest safety net”. The old welfare goals of participation and belonging have been abolished (Fitzsimons, 2000, p. 1).

New Zealand represents an ideal population upon which to engage in neo-liberal experimentation. With its preference for a ‘thin’ democracy (one judicial house and a strong executive), and a small population concentrated around four major cities, New Zealand also has a history of pioneering social reform and has been described by some as a ‘social laboratory’ (Maidment, Goldblatt, & Mitchell, 1998, p. 118). New Zealand was one of first countries to pioneer liberal, welfarist and ‘third way’ governmental reform and it was the first country in the world to give women the vote (Fitzsimons, 2000). It has a history of social experimentation that has created a climate of innovation and reform.
Breathing Works represents a small exemplar of this – a small social experiment in the reform of a previously entrenched professional orthodoxy.

Not everyone agrees that the neo-liberal economic and political reforms that spurned the HPCA legislation have resulted in greater freedom however. Terry Johnson, for instance, argues;

What is clear today, however, is that despite the rhetoric of ‘deregulation’ employed by the government, there has been little ‘deregulation’ in practice. Markets in professional services may have been reconstructed; they have not been freed. The state has been rolled back, only to be reconstructed in another, equally pervasive form (Johnson, 1993, p. 140).

Evidence for this rhetoric of deregulation can be seen in the conditions imposed on individual practitioners under the HPCA Act. While it seems that professional bodies have been given greater autonomy (embodied in the freedom to define scopes of practice, for instance), the legislation has also imposed much greater responsibilities upon practitioners for self-surveillance, risk management, and a constant vigilance on the part of each and every professional. The Physiotherapy Board, for instance, argues that the Act serves to;

- Provide consistent accountability across the health professions. All previously regulated professions…will all be covered by the same legislation. This will make it easier for the public to understand.

- Establish the mechanisms for determining scopes of practice for each health practitioner. This is so the public can understand what health service each registered practitioner provides.

- Provide systems to ensure that health practitioners don’t operate outside their own scope of practice (The Physiotherapy Board of New Zealand, 2005b).

For the first time, every health professional has to re-register annually and demonstrate their ongoing professional competence to their professional body. The Physiotherapy Board has decided to comply by randomly sampling five percent of all registered members on an annual basis (The Physiotherapy Board of New Zealand, 2004a). Selected members have to demonstrate evidence of on-going professional development and competence to practice. The random nature of the selection process, and the extensiveness of the portfolio of evidence required, are clearly the strategies chosen by the Physiotherapy Board to remind each individual practitioner of the Board’s constant remote surveillance of their conduct. Each physiotherapist, we are told;

will need to assume greater personal responsibility for maintaining your relationship with the Board. The penalties for non-compliance are much higher
under HPCA. For example, practicing without a current APC is a disciplinary offence for which you may be charged (The Physiotherapy Board of New Zealand, 2004b, p. 3).

Further, the importance of self-surveillance is reinforced as the principal mechanism of professional responsibility;

A rigid system applied to all physiotherapists that is not relevant to current practice situations is not preferred. Imposition is not favoured either. Ideally there should be a strong element of self-commitment to continuous professional development that maintains competence. Practitioners should be encouraged to identify areas where further training, peer review etc. are required (The Physiotherapy Board of New Zealand, 2004b).

These mechanisms of self monitoring, and the constant vigilance of the Board have also been supplemented by an extension in the networks of surveillance that further reinforces one’s individuality. The Board, aware that it cannot police every act, every patient assessment, every treatment, encourages physiotherapists to monitor each others actions and, where appropriate, report non-compliance or sub-standard practice;

If you have a concern about the performance of a colleague (whether in your discipline or not) you may inform the registrar or that person’s authority...Recently several physiotherapists have been found working when they don’t hold a current APC. We strongly recommend employers sight an original APC before allowing any potential employee to commence working (The Physiotherapy Board of New Zealand, 2005a, emphasis preserved).

Analysing Breathing Works in the context of this recent shift in physiotherapy’s governmental environment, I believe that it is possible to see the clinic as an exemplar for many of the tensions confronting the larger physiotherapy profession; the present constraints of orthodoxy (evidence-based practice, legislative compliance, professional surveillance, etc.) versus the possibilities offered by alternative and complementary therapy and the emerging markets for consumer health care, health promotion and population-based medicine. Breathing Works is, I believe, one illustration of the way that some sectors of orthodox physiotherapy are attempting to negotiate these tensions by exploring the discursive margins of legitimate and orthodox practice. The marginal nature of Breathing Works may be seen in the way Dinah and Tania speak about the future of their clinic;

David: You mentioned earlier on that if this kind of work continues to expand and develop it might not be physiotherapy any more…

Tania: It depends. If physiotherapy wants to own it they can, like the Breathing Works work, if physiotherapy says “Yes, we want to be a part of this” it would be great and we’ll teach physiotherapists everywhere and we’ll keep it within our profession, but I think the way I’ve been thinking clinically, everything I’ve
observed over the last 15 years, if the profession doesn’t want anything to do with it, that’s fine. It will just carry on as Breathing Works

This question of ownership has occurred elsewhere in recent physiotherapy literature. For instance, in Gardiner and Wagstaff’s recent paper on the emergence of extended scope of practice, the authors considered the problems of how to be identified in their new roles as ‘consultant physiotherapists’. The authors asked; ‘did we overtly want to be known as physiotherapists? Would this undermine our authority in clinic or would we lose our physiotherapy identity’ (Gardiner & Wagstaff, 2001, p. 3)? This illustrates, for me, the tensions inherent in operating at the margins of legitimate, orthodox physiotherapy practice, and as a result of these tensions, Breathing Works faces a real dilemma; does it relent and return to the orthodox practices established by successive generations of masseuses and physiotherapists; does it pursue its reformist agenda taking physiotherapy with it as it colonises new territory beyond the limits of currently accepted practice; or does it leave physiotherapy altogether and join the masses of newly emerging alternative/complementary ‘breathing therapies’?

Signs of this dilemma appear frequently in Dinah and Tania’s writings. As I have already mentioned, the founders of the Breathing Works clinic rarely advertise the fact that they are physiotherapists in their promotional texts, referring to themselves instead as ‘breathing experts’ or ‘specialists in Breathing Pattern Disorders’. This does not suggest to me that they are necessarily unhappy being called physiotherapists, but rather that they believe the association between physiotherapy and orthodox medicine is too strong at present to appeal to health consumers with an appetite for more ‘holistic’ approaches to health care. The notion of practicing ‘holistically’ however creates its own problems.

When I discussed whether Breathing Works was a holistic practice with Tania, she argued that physiotherapy should;

shine above [the language of holism] and say “Hey look, we’re looking at this thing that looks like a moving dynamic human being and these tools and techniques are great incorporating everything”, but it’s using a different word type. I think holistic is been and done…it’s had it’s day maybe. I think it’s a new time, it’s a new era and I think it’s a change to make it more positive, make it more, lighter I think.

While Tania talks about a ‘new era’, it is important to remember that Breathing Works is not offering a particularly new approach to breathing retraining. In Jeroen Staring’s recent biography of Frederick Alexander, for example (Staring, 2005), the author talks about Alexander developing his approach to the re-education of movement and posture, later known as the Alexander Technique, through close attention to breathing (particularly comparing the over-wrought tensions of Australians, New Zealanders and
Tasmanians with their local indigenous population in the early years of the twentieth century). Alexander promoted his approach to breathing thus:

The employment of the Alexander Method, under medical supervision, has shown that it restores the control over the entire Thoracic (sic) mechanism; prevents “Sniffing” and “Gasping” in breath-taking; ensures perfect Dilatation of the nasal passages; removes all strain in respiration and vocalisation from the region of the throat; prevents thoracic rigidity in physical effort; eradicates Mouth Breathing, and makes Nasal Respiration possible in vocal and physical efforts at all times, and under all reasonable circumstances; and renders a Rigid Thorax adequately mobile, thereby greatly benefiting the general health, and materially assisting the vital organs in the proper and full performance of their functional duties (Staring, 2005, p. 134).

This citation illustrates that colonising the language of breathing is not new, nor is the practice of attributing these ensembles of knowledge to a particular sobriquet (in this case ‘The Alexander Method’). What is different in the data from this study is the use of these techniques, strategies, devices and tactics in respiratory physiotherapy, and within the context of contemporary health care. These actions therefore draw on a number of precedents to offer insights into the ‘local’ analysis of the changing face of physiotherapy.

To illustrate this point further, similar precedents can be found in the work of twentieth century psychotherapists like Wilhelm Reich, Elsa Gindler, Frederick Perls’ Gestalt therapy (Johnsen, 1976), Alexander Lowen’s Bioenergetics; ‘a therapeutic technique focused on breathing, moving, feeling, self-expression, and sexuality’ (Lowen, 1976, p. 3), and outside western psychotherapies including Yoga, Feldenkrais, Qi Gong, Zen, Tai Chi and Pranayama (Chaitow, Bradley, & Gilbert, 2002). But what is truly striking for me, is that Breathing Works’ approach is not even new to physiotherapy. It is highly probable that the condition we now know as hyperventilation syndrome is a new diagnostic label for a condition we have seen before – neurasthenia. Neurasthenia was the disorder that made it possible for the English massage profession to establish its legitimacy by allowing them to combine their nursing and massage craft with the regulated discipline of the Rest Cure (see Chapter Four). I will now conclude this chapter by briefly outlining the similarities between these two conditions, and discuss how I believe they have been used by masseuses and physiotherapists for quite contrasting purposes.

Neurasthenia revisited

In Chapter Four I wrote about a condition that was characterised by fatigue and malaise, transitory clouding of consciousness and a feeling of ‘other-worldliness’, restless sleep, agitation, localised sympathetic symptoms including cold hands and feet, flushes and sweating, palpitations and pseudo-anginal attacks (Beard, 1869). Neurasthenia has
subsequently been given any number of vague diagnostic labels and has been associated with a range of ‘sympathetic nervous complaints’ including hysteria and neurosis, hysterical paralysis, chronic fatigue syndrome and fibromyalgia (Neve, 2001).

Today, hyperventilation syndrome is commonly diagnosed by a suggestive case history, evidence of abnormal blood gases, and a positive score on the Nijmegen Questionnaire (Appendix Eleven) (Bradley, 2002b). A suggestive case history would commonly show evidence of ongoing or persistent stress, poor sleep patterns, anxiety and worry often accompanied by panic attacks, and an altered pattern of breathing (predominantly this means breathing into the upper chest rather than the diaphragm) (Bradley, 2002b). The Nijmegen Questionnaire is an internationally validated tool for assessing 16 of the most common symptoms associated with hyperventilation syndrome (Vansteenkiste, Rochette, & Demedts, 1991). Symptoms include chest pain, anxiety and tension, cold hands and feet, palpitations, mental confusion and periodic blurred vision.

Not only then do patients presenting at Breathing Works often show the same clinical signs and symptoms as those women diagnosed with neurasthenia at the end of the nineteenth century, in many ways Breathing Works promotes the same causal factors – an inability to cope with the stresses of modern life, and the disabling habit of pulling in one’s stomach seen in women who endured a lifetime of corseting. It is more than mere coincidence that the vanity associated with a narrow waist is now once more the target of health practitioners like Breathing Works, as this excerpt illustrates;

For some people, bad breathing is a habit borne of vanity. Holding in the tummy gives rise to the bad habit of chest breathing, as opposed to abdominal breathing. Learning ballet as a child, having bad posture, hormone imbalance, tight clothes, viral sickness, coughs and colds, anaemia, over-working, experiencing trauma or suffering from a chronic disorder such as asthma – all can lead to bad breathing patterns (Woodward, 2002).

Tight clothing and a willingness to appear slim appears to be a particular concern to Dinah and Tania and reminds us again of the parallels between HVS and neurasthenia;

The causes of stressful chronic over-breathing are many and varied:

• It might result from something as simple as tight-waisted clothes. (Think of poor Nicole Kidman in those tight corsets in Moulin Rouge) (Clifton-Smith, 2002, original formatting preserved).

And as this account from one of the clinic’s patients who was interviewed as part of a review of the clinic infers;

I’d taken breathing for granted. But my tense back and abdomen were working like a 19th century corset, holding the air in my upper respiratory tract and stopping
it from getting down to my diaphragm, where it’s needed most. My breathing was adding to unhealthy fatigue (L. Donaldson, 1999, p. 48).

My interest here is not in the veracity of the claims made about the detrimental effects of corseting, Pilates, core stabilisation, or any other practice designed to give one a slim appearance. My interest is in how Breathing Works is using the same messages about slimness, breathing and ‘the pace of life’ in an entirely different way from the way that the founders of the profession used it more than a century ago. I am interested in how these parallels help us to understand something of the way Breathing Works is challenging legitimate, orthodox physiotherapy. How it is paradoxically using the same social phenomenon in an entirely different way to the founders of the Society, but one that is no less contingent upon the cultural, political and social context in which the profession has found itself.

I stated in Chapter Four that the early founders of the STM colonised the practices of massage, Swedish remedial exercise and electrotherapy and made these the basis of its claim to legitimacy. I also stated that in neurasthenia masseuses found the paradigm case upon which to practice. Neurasthenia presented the ideal vehicle with which masseuses could demonstrate that they could touch without licentiousness, follow the instruction of the referring doctor, adopt a biomechanical curriculum and examination system, and maintain disciplined surveillance over their professional body. Neurasthenia was one of the most potent illustrations of the profession’s ability to resist the discourses of vice and squalor that threatened the massage profession, nursing and midwifery, and promote an alternative that met with the approval of the public, the medical profession and the state.

It is my belief that HVS fortuitously provides Breathing Works with a similar opportunity for resistance, but now the resistance is directed inwards; towards the profession itself; towards the very same legitimacy and orthodoxy that neurasthenia helped to create. Breathing Works is, I believe, deconstructing the legitimacy and orthodoxy of the founders of the profession and attempting to reformulate new subjectivities for the profession. Thus the physiotherapists at Breathing Works are;

no longer explicit agents of a social code of moralizing instructions enjoined by superiors, but concerned professional seeking to allay the problems, anxieties and uncertainties engendered by the seemingly so perplexing conditions of our present (Rose, 1999, p. 87).

In an argument that has echoes back to Foucault’s belief that there are a finite number of primary texts, and that while physiotherapists think they are constructing something new, they are really rehearsing established discourses (Foucault, 1972), I believe Breathing Works is using HVS to situate the profession in a new problem space; in
a new relation with the public, its allies and competitors, and the state. My argument is that Breathing Works, like the STM before it, is demonstrating that it is sensitive to the governmental context in which it is operating, and responding accordingly.

I believe Breathing Works is a contingent response to the changing neo-liberal, consumer-driven marketplace for health care that is now well established in developed countries around the world. It is at the ‘bleeding edge’ of these developments partly because of New Zealand’s liberal attitudes towards political and social reform (Fitzgerald, 2004). But I believe that it is also a partial rejection of the biomechanical discourse that has dominated physiotherapy practice, and the material practices that have flowed from this rather austere, dispassionate discourse. In challenging the way that physiotherapy is practiced; by radically changing its environs, its institutions, its material practices, the physiotherapists at Breathing Works are allowing new forms of governmentality to work through the operations of physiotherapists. From a disciplinary perspective, Breathing Works is much more concerned with responsibilisation, the appraisal of risk, the promotion of optimal health, and the aesthetics of peace and repose, than any respiratory practice has been before. These neo-liberal rationalities have opened up new markets and new consumers for its services, and it is now no longer necessary for respiratory physiotherapists to be tied to the exile enclosure of the medical ward. The result of this shift is a fundamental revision of the relationship between the physiotherapist and the client. One no longer needs to be ill to come under the gaze of the therapist. It is no longer necessary to present with an underlying lung disease. Everyone, as normal breathing individuals, is open to having their most basic physiological functions scrutinised by ‘experts’ who are all too eager to label you as a ‘bad’ breather, and arm you with the tools to allow you to take greater responsibility for your own breathing. This clearly has striking implications for physiotherapy as a profession. Hence I have used Breathing Works as a paradigm case; as a metaphor for a range of physiotherapy services around the world that are beginning to explore the possibilities of new health care markets, new professional alliances, and new forms of governmentality.

In summary: Resisting legitimate and orthodox physiotherapy

[T]oday, the therapeutic culture of the self and its experts of subjectivity offer a different freedom, a freedom to realise our potential and our dreams through reshaping the style in which we conduct our secular existence (Rose, 1997, p. 164).

In this chapter I have presented an account of the practices, tactics, strategies, instruments and procedures developed by Breathing Works and contrasted these with the material practices found in contemporary respiratory physiotherapy. I have shown that
Breathing Works is operating at the margins of orthodox practice ostensibly by problematising breathing in what appears to be an entirely new way. I have explored the various texts produced by, and about the clinic, from a governmental perspective, focusing on the economic imperatives of neo-liberalism. Principle among the constructions I explored was the discourse of commodification, and I exposed the approach that Breathing Works takes towards ‘good’ and ‘bad’ breathing to critical scrutiny. I have also shown that there are remarkable parallels between Breathing Works’ approach to breathing pattern disorders and those seen in other, older practice approaches, and that in hyperventilation the profession has a clinical problem that almost exactly parallels the treatment of neurasthenia by masseuses some 110 years earlier.

In shifting breathing from its association with pathology, to its newfound status as a lifestyle disorder, the Better Breathing Clinic epitomises Rose’s notion of an enterprising technology; one that helps people who are ‘striving for fulfillment, excellence, and achievement’ (Rose, 1997, p. 154), and it is these technologies that ‘permit individuals to perfect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct and ways of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality’ (Foucault, 1988, p. 18).

My argument is that the actions of the physiotherapists at Breathing Works are distinct from the practices of legitimate and orthodox practitioners because they ‘no longer seek to discipline, instruct, moralize, or threaten subjects into compliance. Rather, they aspire to instil and use the self-directing propensities of subjects to bring them into alliance with the aspirations of authorities’ (Rose, 1997, p. 160). Instead they provide new fields of experience, that involve new objects and new subjectivities; new ways of speaking the truth about ourselves (Burchell, Gordon, & Miller, 1991). Thus in this study, the conditions that have made Breathing Works possible may be used to provide critical purchase for broader questions of how physiotherapy is discursively and governmentally constructed, and historically possible. An approach informed by Foucauldian discourse analysis is central to this process, and I have used this approach here to show how Breathing Works is resisting conventional discourses of legitimacy and orthodoxy within the profession, and in doing so challenging the subjectivities that have been critical in the profession’s growth and development over the last 110 years.
CHAPTER SEVEN - DISCUSSION

Introduction

For years physiotherapists were turned out skilled in the techniques of physiotherapy but with their minds quite untroubled by knowledge of the past (A. Parry, 1995, p. 310)

This study has attempted to shine a light onto the discursive construction of physiotherapy; to explore some of ways in which the actions of masseuses and physiotherapists have been guided historically by disciplinary technologies, governmental imperatives and discursive formations. In conducting the study I have explored the operation of a number of important discourses in the construction of physiotherapists’ subjectivity; legitimacy, orthodoxy, resistance and biomechanics. These discourses help explain how the event known as physiotherapy came to be practiced in certain ways and not others.

The point of entry for this thesis was the question, ‘how is physiotherapy discursively constructed?’ And from here I derived a set of questions that drove my analysis. These were as follows:

1) What have been some of the main discursive influences upon the construction of physiotherapy?
2) How have the discourses that have guided the conduct of physiotherapists transformed throughout the profession’s history?
3) How have particular relations of power governed the forms of knowledge that are privileged, and those that are marginalised in physiotherapy?
4) How have governmental influences guided the formation and transformation of physiotherapists’ subjectivities throughout the profession’s history?
5) How might the surface of emergence of new practices at the margins of orthodoxy create the possibility of new physiotherapy subjectivities that resist established subject positions?
6) What opportunities and possibilities do these new subjectivities create for physiotherapists seeking to adapt to the demands of contemporary health care?

During the course of Chapters Four, Five and Six, I addressed each of these questions in the text. I considered the quest for legitimacy and the pursuit of orthodoxy in Chapters Four and Five, and reflected on Breathing Works’ resistance of these discourses in Chapter Six. I explored how these discourses guided the conduct of masseuses and physiotherapists at each moment, and how these governed the forms of knowledge, objects of scrutiny, subject positions, concepts, strategies and tactics deployed by practitioners both in pursuit of their particular goal (legitimacy, orthodoxy, etc.), and also as an effect of the discourse itself. I also considered how these actions influenced the practitioner’s
professional subjectivity, and how this informed the relationships that masseuses and physiotherapists constructed (particularly with the medical profession) in attempting to assert their authority. And with the question of the profession’s claim to expertise in mind, I connected the governmental shifts taking place in the health care systems in England and New Zealand with physiotherapists’ changing political imperatives. Finally, I considered how new ‘boutique’ practices are destabilising the discourses that have constructed physiotherapy subjectivities to date – opening up a space, as they do, for thinking about physiotherapy differently.

In addressing the question; ‘How is physiotherapy discursively constructed?’ I have explored three main discursive formations with distinct, yet overlapping rationales. These are the discourses of legitimacy, orthodoxy and resistance. Each of these discursive formations anchors to a particular governmental episteme, and is organised around a set of disciplinary practices. And each makes an important contribution to defining the historical contingency of physiotherapist’s subjectivity.

Running through each of these discourses and historical moments is the discursive formation I have termed biomechanics. This formation represents a normative set of knowledges about the way physiotherapists assess bodily form and function; a set of substantive practices governing the conduct of masseuses and physiotherapists; a political technology creating relations of power between medicine and massage, for example; and a theoretical construct guiding the profession’s epistemological approach. Biomechanics has had an enduring effect upon the physiotherapy profession, and in the following section I will consider how its interaction with the discourses of legitimacy, orthodoxy and resistance carries certain implications and possibilities for the theoretical and practical development of my study.

Implications for theory and practice

I have coalesced the implications of this study around three themes that correspond to the study’s three moments. The first concerns the ongoing significance of legitimacy to physiotherapy practice and relates my study to the field of the sociology of the professions. The second concerns the discourse of orthodoxy and its role in contemporary physiotherapy practice, and here I explore the interface between this study and emerging sociologies of the body. Finally, I explore how resistance is problematising orthodox practice and consider how the findings of the study suggest that physiotherapy is analytically ‘thin’.
Victorian morality and destabilised bodies: the ongoing significance of legitimacy to physiotherapy practice

The question of legitimacy was the focal point for my analysis of the actions of the founders of the STM in Chapter Four. The data led me to approach masseuses’ actions as a discourse of morality, whose purpose was to establish a set of rules and prohibitions, disciplinary technologies, levies and obligations (Foucault, 1977a) to govern their individual and collective conduct. These strategies were necessary because massage had become problematic as a social practice in late-Victorian England. My argument in Chapter Four was that the actions of the founders of the STM must be understood as a historically contingent response to a wider set of cultural concerns than has not been represented thus far in the extant historical accounts of physiotherapists’ practice.

Massage was problematic for Victorians because it conflated the ‘embodied and experiential elements of human life’ (Van der Riet, 1997, p. 104); that is, it concerned the practical, functional and affective aspects of bodily experience. Victorians’ concerns to understand and to know every facet of human experience – particularly those related to sexual deviance, perversion and ‘otherness’ – inevitably led to an interest in practices of touch, since the association between massage as a therapeutic or sensual practice had not been clearly defined by earlier generations of social reformers, and this had led to ‘the widespread elision between massage and sex work’ (Oerton, 2004, p. 544).

In the second volume of History of Sexuality, Foucault turned his attention to the moral questions of sexual deviance and encouraged readers to ask ‘why are the activities and pleasures that attach to [sexual conduct], an object of moral solicitude’ (Foucault, 1985, p. 10)? Why have they become important at this moment in time? And why have the actions that resulted taken this particular form? In addressing these questions I was led to pursue the connections between the moral conduct of the STM and Victorian Christian values which held that one’s attitude towards the desires of the flesh, sensuality and eroticism are indicative of one’s subjectivity. My analysis indicates that the arbitrary distinction that existed between massage as a healing therapeutic practice, and massage as a sensual pleasure prior to 1894, became the focus for scrutiny by Victorian moral reformers like Ernest Hart of the BMJ and the founders of the STM. As with many of the Victorians’ concerns to distinguish good from evil, the distinction between these two poles needed to be problematised in order that moral standards of civility (taken here to mean moral conduct) could be reinforced (Rose, 1999). The STM’s pursuit of legitimacy was a feature of the outworking of this problematisations.
My argument in Chapter Four was that Victorian concerns to govern life through constraints on sexual conduct, joined with liberal social reforms designed to minimise the role of governments in the conduct of public citizens, by creating the conditions necessary for private individuals to govern their own conduct; in this case through the organisation of small interest groups – one of which was the STM. Thus it was that the masseuses within the Society ‘tracked down’ sexuality in all aspects of massage practice and, to paraphrase Foucault, suspected it of underlying the least folly (Foucault, 1979c, p. 145). Once exposed, licentious practices became the object of interference, discipline, surveillance and constraint. The result of these actions was an emphasis upon what Watson called ‘instrumental touch’ – or touch designed to assist in the performance of particular acts – and the exclusion of expressive touch (that which is spontaneous and affective) (Watson, 1975). The form of instrumental touch adopted by the Society emphasised a disciplined approach to the conduct of the masseuses.

At the heart of this disciplined approach to the moral legitimacy of touch was the profession’s approach to the body-as-machine. Biomechanics allied the masseuses to the medical profession by encouraging an overlapping approach to the body, and making it possible to defer significant parts of the professional curriculum to doctors. It also gave the masseuse a ‘lens’ through which to view the body dispassionately. Most importantly, it allowed the masseuses to touch the patient without fear of impropriety. Biomechanics created possibilities for those masseuses prepared to submit to the various disciplinary strategies needed to ensure that their conduct constituted the Society’s notion of legitimate practice.

I showed in Chapter Five how enduring biomechanics has been within the physiotherapy profession, and how easily it was translocated to a New Zealand context. The portability of biomechanics highlights how much this approach marginalises other discourses of bodily experience. This notion of the body has been reproduced throughout the entirety of physiotherapy’s history, and rarely has it been challenged, since one of the other effects of adopting a biomechanical view of the body is to limit the gaze of the therapist to the limits of the mechanical body. Thus physiotherapists have rarely engaged in the epistemological, ontological and socio-political debates that other orthodox health professions have engaged in (particularly over the last 30 years).

The recent development of a discrete branch of scholarship focusing on the sociology of the body highlights how divided and uncertain we now are about the various bodies that exist in society (Armstrong, 1994; Butler, 1993; Lawler, 1997; Mann, 1996;
Physiotherapists have yet to engage with these discussions, preferring instead to focus on technical rationalist questions of assessment and treatment efficacy (Bithell, 2005; Hough, 2001; Roskell, 2002). My belief is that the absence of physiotherapy commentaries amongst the growing body of literature pertaining to the sociology of the body is not borne of a wilful dismissal of these ‘other ways of knowing’ the body, but rather emanates from an ignorance of the possibilities offered by these alternative viewpoints.

This therefore explains, to some extent, why this study represents a novel approach to the critical analysis of physiotherapy as a profession, since physiotherapists are only now coming to realise what our sister professions of nursing, occupational therapy, psychology, the complementary therapies and, latterly, medicine, have realised for some time; that to engage with the possibility of other discourses of the body than biomechanics, offers fertile ground for alternative approaches to patient care and professional development. To develop these, however, I would argue physiotherapy has to engage with the discussion about its present and future relationship with the body of its clients, and problematise the historically contingent conditions that brought them to this point in the first place. This is where I believe my study makes a valuable contribution to understanding the relationship between physiotherapy and the discourse of legitimacy.

**Orthodoxy as a political discourse and its impact on the construction of physiotherapy practice**

The role of orthodoxy as a political discourse was the focus for Chapter Five. Texts drawn from the development of massage practices in New Zealand in the first half of the twentieth century, led me to explore how the profession responded to the development of the welfare state, and the opportunities made available to those professions that had earlier established their legitimacy. This chapter raised the issue of physiotherapist’s relationship with shifting governmental imperatives, and its focus was upon the shift from the conditions of possibility created by a moral discourse of legitimacy, to a political discourse of orthodoxy.

Orthodoxy, in this study, implies a formal relationship between the state, to the extent that the interests of the particular institution are ‘underwritten’ by government-sponsored legislation, collective terms and conditions of employment and national bargaining rights, government funding that confers favoured status on the authority, support for training and registration, and, in the case of the British and New Zealand health care systems, sole rights of access to a large population of patients requiring physical
rehabilitation (Larkin, 1983; Saks, 2001). In this chapter I sought to link the various disciplinary practices that had a bearing on New Zealand masseuses’ conduct, with forms of power that created, shaped and utilised masseuses as subjects of government (Rose, 1997, p. 151).

The relationship between the orthodox health professions and ‘the state’ has been an enduring feature of the sociological literature for more than 50 years, with the early functionalist accounts of Durkheim and Parsons, supplemented by Marxist and feminist critiques of the dominant health professions (Durkheim, 1933; Macdonald, 1995; J. B. McKinlay & Arches, 1985; Parsons, 1937; Witz, 1992). In recent years, a shift has taken place within the literature, and a space has been created for postmodern deconstructions of the traditional binaries of power that were seen to exist between professionals, the state and the public (Evetts, 2006; Johnson, 1995; C. May, 2007). Within this body of work, a number of scholars whose research is informed by the work of Michel Foucault, are problematising the governmental, technological and discursive construction of professional conduct (Borthwick, 1999a; Brownlie, 2004; Clinton & Hazelton, 2002; Holmes, 2001, 2002; Holmes & Gastaldo, 2002; Lupton & McLean, 1998; Nettleton, 1991; Perron, Fluet, & Holmes, 2005; Petersen, 1996, 2003; Petersen & Bunton, 1997; Rose, 1997, 1999; Turner, 1997). These studies scrutinise the ‘calculated transformation[s] of human conduct’ (Rose, 1997, p. 121) that are embodied by the organisations, institutions and practices that coalesce around the various human technologies – of which physiotherapy is but one event.

For the massage profession in New Zealand, I have shown that the emergence of the welfare state brought with it a number of competing tensions; on the one hand, the profession sought to gain greater professional autonomy, greater separation from the medical administration of massage training, and profession-specific legislation to formally associate the language of legitimate massage with the new profession called physiotherapy. On the other hand, the profession wanted to strengthen its relationship with medicine, which now almost completely dominated how orthodox health care could be thought (Armstrong, 1983); it also wanted to align itself with other health professions that were obtaining orthodox status; and it wanted to secure a niche within the public health system at the exclusion of other, alternative health professions (Dew, 2003; Fournier, 2002; Saks, 2001).

In the case of respiratory physiotherapy, I have shown in Chapter Five that the profession was successful in most respects by restating its affinity for a biomechanical
reading of the body, and by re-organising its practices around the configuration of such
disciplinary institutions as the medical ward. The practices that resulted from this
transformation showed that orthodox respiratory physiotherapists had adopted new subject
positions, objects of scrutiny, instruments, procedures, and regulatory practices. Despite
these changes, the profession retained its adherence to a biomechanical view of the body,
which was transformed from a broad strategy whose purpose was to achieve legitimacy, to
a focused attention on body regions that conformed exactly to the structural arrangements
of the hospital (Dent, 2003).

My analysis in Chapter Five focuses upon the emergence of orthodox respiratory
physiotherapists as a contingent response to changing governmental imperatives, and the
conditions of possibility that these created. This analysis is particularly pertinent when one
contrasts the security and stability offered by the welfare reforms of the mid-twentieth
century, with the ‘hollowing out’ of social welfare that has taken place in developed
countries since the 1980s (Rhodes, 2005; Taylor-Gooby, 1999). These changes,
highlighted in Chapter Six, support my assertions that physiotherapy can be understood as
a governmental rationality since I have shown that the deconstruction of the welfare state
and its various institutions was accompanied by a gradual deterioration in the fortunes of
respiratory physiotherapists.

Respiratory physiotherapists have argued for more than a decade that they have a
future within the public health system (Bott, 2000), but the rapidly changing face of
contemporary health care is unpacking many of the governmental structures that
previously provided surety for the profession, and the profession is unprepared for the
changes that are taking place; as Janet Struber argued; ‘The physiotherapy
profession…appears to have been caught unawares by the rapidly changing demography of
health services and now seems to lack a clear identity and vision’ (Struber, 2004). The
response from within the profession appears to have been to explore the possibility of a
unifying concept of physiotherapy – an ontological and epistemological core that
transcends socio-cultural and political boundaries (Bassett, 1995; Broberg et al., 2003; Cott
et al., 1995; Hislop, 1975). It is my view that such a unifying model of physiotherapy does
not, and cannot exist, and that the profession might be better served by analysing the
conditions that make physiotherapy practice possible.

One of the primary barriers to undertaking such an analysis, however, is the
profession’s adherence to a biomechanical rationality. This view marginalises other
discourses of health and illness and, consequently, limits physiotherapists’ ability to
imagine their profession ‘otherwise’. It is possibly not surprising then that philosophical or sociological analyses of physiotherapy practice are rare. In the changing economic climate of health care, and the increasing public dissatisfaction with orthodox health services, this leaves physiotherapists particularly vulnerable to scrutiny, since they have has little awareness of the profession’s role as a human technology (Rose, 1997).

The scholarship that now exists within the sociology of the professions is well enough advanced for physiotherapists to utilise the work of Evetts, Fox, Gabe, Johnson, Williams, and others (Evetts, 2003, 2006; Evetts & Dingwall, 2002; N. Fox, 1991, 1993, 1999; Gabe, Bury, & Elston, 2005; Gabe, Kelleher, & Williams, 1994; Johnson, 1993, 1995; Johnson, Larkin, & Saks, 1995; S. J. Williams, 1999, 2003), as Du Toit, Heap, Kjølsrød, Jørgensen and Williams, have recently sought to do (Du Toit, 1995; Heap, 1995a, 1995b; Jørgensen, 2000; Kjølsrød & Thornquist, 2004; L. Williams, 2005). A further avenue for future physiotherapy practitioners may be to explore the possibilities of practice at the margins of the stable institutions that have provided physiotherapy with support for so long. In Chapter Six I explored one such institution. Here again, my analysis centred around physiotherapy’s biomechanical heritage, but in this part of the study my attention was upon those practices that are resisting legitimate and orthodox practice, and exploring new conditions of possibility for the profession.

Resistance and the problematisation of orthodox physiotherapy

Breathing Works’ resistance to the practices of legitimate and orthodox physiotherapists was the focus for my final analytic chapter. Texts drawn from conversations with the clinic’s staff, documents generated by the clinic’s founders, and observations of practice, led me to explore the actions of the physiotherapists at Breathing Works as a form of resistance to the subject positions, objects, strategies and concepts established by conventional respiratory physiotherapists. My argument was that Breathing Works was operating at the margins of orthodox practice and, in so doing, was both revealing how orthodox physiotherapy was discursively constructed, and providing an exemplar for how it might be practised differently in the future.

The notion of resistance lies at the heart of Foucault’s idiosyncratic approach toward the analysis of power in contemporary society. According to Foucault, power embodies a degree of freedom that always allows for the possibility for resistance, as Halperin states; ‘Power, then, is everywhere. Resistance to power takes place from within power; it is part of the total relations of power’ (Halperin, 1995, pp. 17-18).
Foucault’s conceptualisation of power has been immensely problematic for many social activists, critical theorists, and left-wing scholars, who have argued that Foucault’s writings, ‘effectively robbed people of freedom and made successful political opposition impossible’ (Halperin, 1995, p. 16). If power was everywhere, they argued, how could it be resisted; ‘…if power is everywhere, according to Foucault, and if freedom – along with the possibilities of resisting power – is contained within power itself, then where shall we locate the pressure points, the fault lines’ (Halperin, 1995, p. 48)? Or as Sam Porter argues;

The problem with Foucault’s judgemental relativism is that, while it may well undermine the taken-for-granted certainties that currently animate health care, it can provide no grounding for alternative modes of knowledge, for they will be equally bereft of a firm epistemological territory upon which to stand (Cheek & Porter, 1997, p. 112)

Significantly for this study, Foucault’s conceptualisation of resistance was based on the premise that power exerted its disciplinary influence upon the body; arguing that the body was essentially constructed as an effect of power; ‘Nothing in man’, argued Foucault, ‘not even his body, is sufficiently stable to serve as the basis for self-recognition or for understanding in other men’ (Foucault, 1984b, p. 153). Thus the body was also the primary site for the exercise of resistance. Yet Foucault had the greatest difficulty articulating the relationship between resistance and the body (Dreyfus & Rabinow, 1983). If Foucault argues that the body is discursively constructed by power, then from where does resistance emerge? If there is no existential permanence to the body, what is it that resists that is not just a revision of discursively constructed power itself? Conversely, if Foucault accepts the existence of an existential ‘body’ that exists beyond power, does this not invalidate his assertion that the body is socially constructed?

Drawing on the work of Hubert Dreyfus, Felix Driver and Paul Rabinow, David Couzins Hoy’s suggested resolution to this problem has been to argue that Foucault was not denying the universality of the body, per se, only that the existential aspects of the body are of little use to researchers interested in the pressing questions facing contemporary society;

Even if there are bodily universals, and Foucault need not deny that there are, these universals may be too thin to serve as the basis of the more concrete criticisms and resistances (Hoy, 2004, p. 62).

From a Foucauldian perspective then, physiotherapy may be viewed as ‘analytically thin’, since I have shown that its complete reliance on the assessment and treatment of an existential body delimits its ability to view bodily experiences otherwise; it
precludes the profession’s attention to other discursive constructions, and induces an ignorance of other ways of knowing in the profession. Physiotherapists have chosen to construct a very narrow analytic lens through which to view activities of daily living, deformity, impairment, function, movement, pain, etc., but in my analysis of the actions of the physiotherapists at Breathing Works, I have explored new practices at the margins of orthodox physiotherapy which hold the possibility of new constructions of the body and new practices.

Central to Breathing Works’ resistance of conventional physiotherapy is its construction of new knowledges of breathing. These new knowledges have enabled the Breathing Works physiotherapists to completely re-imagine how their practices might function; their relations of power, their practice environments; and, most importantly, their relationship with contemporary governmental imperatives.

Neo-liberal rationalities of public health are fundamentally challenging institutional arrangements created under the earlier welfare reforms, and physiotherapists are not immune to these changes. The emphasis now placed on individual freedom to choose health care options within an increasingly open marketplace, and the emphasis placed on individual responsibility for one’s own conduct and wellbeing, has created the conditions of possibility necessary for ‘boutique’ practices to emerge that meet their local market conditions. Breathing Works is a radical departure from traditional respiratory physiotherapy in this regard, because it is actively creating a new market by problematising and commodifying breathing.

The ‘genius’ of Breathing Works’ strategy is that it is attempting to commodify an activity that is common to us all, and one that resonates closely with the desire of working-age adults for a better work/life balance. It is attempting to colonise particular ways of speaking and thinking about breathing that highlight its potential to become maladaptive under circumstances that are commonplace, and it is attempting to democratise its expert knowledge in order that we are all sensitised to the need to consume the appropriate remedy for our ‘bad breathing’. Breathing Works’ actions may be understood, therefore, as an act of resistance, within the context of neo-liberal reforms of the health care system, and as an attempt to push at the margins of orthodox physiotherapy and create the possibility of thinking differently about physiotherapy practice.

Mitchell Dean argues that;

The point of doing this is not to make the transformation of these practices appear inevitable or easier, but to open the space in which to think about how it is possible
to do things in a different fashion, to highlight the points at which resistance and contestation bring an urgency to their transformation, and even to demonstrate the degree to which that transformation may prove difficult (Dean, 1999, p. 36).

Recent changes in legislation in New Zealand – a country with a strong history of social reform – would suggest that the previously tightly constrained orthodox health disciplines are experiencing greater freedom of movement. This coupled with the changing demographic profile of the population in the developed world, advances in biotechnology, neo-liberal economic reform and a willingness to destabilise traditional constructions of health and illness, creates enormous possibilities for a profession with such a strong emphasis upon the moving body. This study, therefore, makes an entirely novel contribution to the debate about the future role for physiotherapy by problematising its discursive construction, and exploring practices that are seeking to imagine physiotherapy otherwise.

In addition to the substantive contribution made by this thesis to our understandings of the discursive construction of physiotherapy, I believe this study also makes a contribution to the growing body of theoretical work that is building on the writings of Michel Foucault. This study is one of only a small number that have constructed historical analyses of professional disciplines, and of these, it is part of a discrete body of work to combine an interest in governmentality, discourse and discipline (Armstrong, 1983; Borthwick, 1999b; Holmes & Gastaldo, 2002; Nettleton, 1992; Rose, 1997). The study contributes to our understanding of the possibilities offered by conducting archaeological and genealogical analyses in parallel, and it builds on an enlarging corpus of works that explore the interface between knowledge construction, power and resistance.

Having discussed the implications of this study for theory and practice, I now turn to the discussion of the limitations of the study and possible future directions.

Limitations and possible future directions

In this study, I set out to analyse the discursive construction of physiotherapy using an approach informed by the work of Michel Foucault. In doing so, I have had to reconcile a number of theoretical and methodological questions, and resolve a number of pragmatic decisions. Some of these questions are familiar to most researchers who have used a Foucauldian approach to discourse analysis, while others are idiosyncrasies of this study. There are two primary limitations to the study; the first pertains to the breadth of texts

31 The decisions made to limit the substantive scope of the study were highlighted in Chapter One, with those pertaining to the study’s theoretical and methodological scope addressed in Chapter Two.
utilised, their historical selectivity and the implications for the study’s generalisability; and the second concerns my choice to exclude certain theoretical constructs.

The data collected for this study was limited to three historical moments, and within that, to those texts that were accessible. My rationale for choosing the three moments across two different geographical locations was explored at length in Chapter One, but it is important to acknowledge that this approach has limited my ability to generalise my study’s findings to physiotherapy practices elsewhere. This limitation is further amplified by the rather limited range of texts available pertaining to some fields within my study. Surprisingly, this is not so much true of the ‘older’ material pertaining to Chapter Four and the formation of the STM, as it is for the emergence of orthodox physiotherapy discussed in Chapter Five. Here, I have had to find materials from a wide range of disparate sources, and I am sure that my analysis would have been immeasurably strengthened had other texts been available. This is particularly true, for instance, where I considered the conditions that made the formation of legitimate massage possible in New Zealand from 1913 to 1925, where I was reliant on only a few primary sources, since no other directly relevant primary materials from the period are thought to exist. Notwithstanding these limitations, it is still necessary to make pragmatic choices with one’s texts, and as Cherryholmes states, at some point the researcher must, ‘stop searching and settle on a stipulated meaning which serves, of course, as the point of origin for some later search’ (Cherryholmes, 1988, p. 37).

One could argue that these limitations adversely affect the study’s generalisability. I would argue though that I have been able to use the local, material practices explored in each of the historical moments to construct, inductively, a discursive analysis of the profession that has value across a number of different sectors. It has, for instance, value when we consider how physiotherapy might approach the juridical reform of orthodox health professions, or the demographic changes to western populations that some believe will radically shape health care reform in the twenty-first century. It has value for our understanding of the role of technologies of discipline, knowledge, power and resistance in the analysis of health professions, and as a governmental analysis of their histories of the present.

The fact that the texts I utilised in this study represent an incomplete account of events is less of a concern in Foucauldian discourse analysis than the ability to explore a breadth of texts within a particular discursive formation. I was not attempting to construct a ‘complete’ history of physiotherapy – even if one were possible. Rather I acknowledged
in Chapter One that my thesis would be limited, and attempted to ensure that these limits were reasonable and enhanced, rather than detracted from, the study. A Foucauldian approach ‘fully recognises the local, specific and contingent nature of critique’ (Pels, 1995, p. 1027), and the texts employed in this approach provide a purchase for critical thought, rather than the exhaustive catalogue of events required from a piece of historiographic research.

This is not to suggest that Foucault’s approach to historical research has not been without criticism; particularly by historians like Gareth Stedman Jones who have criticised Foucault’s thinly veiled ‘continuity with a now largely discredited 1960s structuralism’ and the assumptions and procedures that assume the ‘death of the author’ (Stedman Jones, 1996, p. 4). The same criticisms may be made of this study, particularly the association between the discursive construction of the profession and structuralist critiques which privilege the systems and structures that made it possible for physiotherapy to emerge. Foucault himself openly accepted the limits of his approach to the reading of texts when he stated that, ‘I am well aware that I have not written anything but fictions’. He was also quick to point out, however, that ‘[this] is not to say they have nothing to do with the truth’ (Foucault, 1980, p. 193). Thomas Flynn argued that;

Professional historians, for example, who specialize in the fields [Foucault] covers, have been quick to take issue with his list of historical facts. The price of being an historian *suo modo* seems to be that he is not entirely at home either with professional historians or with philosophers. His greatest influence to date appears to have been on scholars working in literature and in the social sciences (Flynn, 1994, p. 44).

And so it is in this study, which acknowledges that there are limits to Foucauldian discourse analysis but also considerable possibilities for analysis that no other theoretical or methodological approach can offer.

The second principal limitation of this study lies in my marginalisation of some aspects of Foucault’s oeuvre that would have almost certainly enhanced the breadth of my analysis. I am referring here to Foucault’s later works on ethics and aesthetics, technologies of self, and biopower.

I explained in Chapter One that I had made some strategic choices over the direction my study should go in, and that this involved the *deselection* of a number of important facets of the discursive analysis of professional conduct. Governmentality is a composite of a number of distinct approaches including the arts and mentalities of government, technologies of discipline, and the actions people undertake to govern their own conduct. In this study I have only been able to explore technologies of discipline in
any depth. Thus my study is limited in its ability to extrapolate my findings to larger questions of the function of government of the population, as works like Nikolas Rose’s *Inventing Our Selves* do (Rose, 1997). Likewise, I have hardly given any space to the question of the practices that individual physiotherapists undertook to govern their own conduct, preferring instead to focus on collective, institutional disciplinary strategies.

Foucault’s later works began his analysis of the aesthetics and ethics of sexuality – a subject of direct relevance to this thesis – but again I have only been able to give this subject cursory attention. And finally, I have bypassed almost completely, biopolitical questions which concern themselves with the governance of the individual, social institutions and the species body as a whole. It was this latter concern that made me decide that this was beyond the scope of this study. These various omissions are limitations, because they place artificial boundaries around the theoretical constructs I am proposing in this study. They are, however, necessary and certainly do not foreclose the possibility of undertaking additional work in these areas in the future.

Having explored the key limitations of the thesis and, earlier, set out some of the possibilities it offered, I would now like to articulate how I envisage my research developing in the future. I believe this study makes a valid contribution to the sociology of the professions; particularly those works that are increasingly making use of Foucauldian approaches to disciplinary practices and institutions (Borthwick, 1999b; Evetts, 2006; Holmes & Gastaldo, 2002; Johnson, 1993, 1995; Light, 2001; Nettleton, 1994; Perron, Fluet, & Holmes, 2005; Petersen, 2003; Rose, 1997). I am particularly drawn to the historical tensions and future possibilities offered by the interface between orthodox and alternative therapies (Dew, 2003; Fournier, 2000, 2002; Saks, 2001). I also believe that the emerging sociology of embodiment holds some important implications for the future development of physiotherapy, and warrants further attention. In recent years, writers such as Brian Turner, Simon Williams, Nick Fox and Chris Shilling have argued that the body needs to be ‘brought back in’ to sociology to counter the excessive determinism of naturalist scholars and the relativism of social constructionists. (Here Turner, Williams Fox, Shilling and others are critical of the work of Foucault and many other poststructural writers.) They argue that embodiment can reconcile the binary tensions that have existed within sociology, and they offer a more pragmatic view of the role of the body in, amongst other areas, health and illness, in health care and health economics (N. Fox, 1999; Shilling, 2003; Turner, 1996; S. J. Williams, 2003). Embodiment may help to draw together the determinism of physiotherapy and the relativism of Foucauldian discourse analysis to yield
an approach towards future practice that will be amenable to physiotherapists and social scientists alike.

Beyond this, I would like to explore the possibilities offered by the medical humanities and their potential to inform our understanding of physiotherapy practice, and consider comparative analyses of governmental influences upon the profession across other nation-states. There is, therefore, a fruitful body of work to follow from this study, and conducting the study has opened many new doors that I would never have even imagined existed before. It seems appropriate at the close of this text, that I reflect on its future possibilities. It has been a transformative experience and one which has taught me much; not only about my profession, but also about myself and the possibilities for our respective futures. I now begin to close the text whilst recognising that this in itself is a positive opening, because it creates the possibility for others to share in my experience and themselves experience something of a transformation.

Remarks at the point of departure

I set out at the start of this text to explore how physiotherapy was discursively constructed. Through my analysis I have shown that contemporary practices have been informed by historical conditions, and that these conditions have coalesced around a number of discursive formations; legitimacy, orthodoxy, resistance, and biomechanics. Utilising an approach to discourse analysis informed by the work of Michel Foucault and others, I have focused on the technologies of discipline that the profession put in place, and the effect these technologies had on constructing professional subjectivities around the event known as physiotherapy. In recent years, the emergence of practices which resist these disciplines and discourses have made it easier to briefly glimpse into the archaeological and genealogical conditions that made physiotherapy’s history possible, whilst also creating the possibility for thinking about physiotherapy otherwise.

This study makes an entirely novel contribution to a professional discipline that has, thus far, focused its theoretical and substantive gaze elsewhere. By dint of my own experience as a physiotherapist, conducting this study has involved a process of writing against many of the instincts that are familiar to me. The possibilities and limits of biomechanics as a discursive construction lie at the heart of the profession, as much as they do at the heart of this thesis, and it is here that I feel I have made my most significant contribution.
I set out not to write a history of physiotherapy, but to critically scrutinise the conditions that had made physiotherapy historically possible, since, to quote Foucault; ‘Maybe the target nowadays is not to discover what we are, but to refuse what we are’ (Foucault, 2000, p. 16). If ‘the most difficult thing about majorities is not that they cannot see minorities but that they cannot see themselves’ – as Glenn Colquhoun stated on the opening page of this thesis – then my hope is that I have contributed to the process of opening up physiotherapy for closer scrutiny, so that it is better placed to face the challenges of future health care. With this as my closing thought, I now open up my thesis for reading and critical debate.
Gaze House – Headquarters of the New Zealand Physiotherapy Board, Wellington.
References


Beard, G. M. (1869). Neurasthenia, or nervous exhaustion. Boston Medical and Surgical Journal, 80, 217-221.


Glendenning, S. (1979). The use of Fenoterol (Berotec) respiratory solution 0.5% in patients with severe asthma. New Zealand Journal of Physiotherapy, 8(2), 26-27.


Lawrence, C. (1999). *Breathing for the better*.
Masseurs Registration Board. (1942). *Minutes of the meeting of the Masseurs Registration Board - 17th November 1942*: Masseurs Registration Board.


New Zealand School of Physiotherapy. (c.1949). *Instruction course for physiotherapists and syllabus of subjects for examination under the Physiotherapy Act 1949*. Unpublished manuscript, Dunedin.


Roskell, C. (2002). More robust evidence needed on provision of respiratory care training... debate regarding respiratory care and university provision (Frontline, May 1 and June 5). *Physiotherapy Frontline*, 8(14), 27.


Roth, M. (1851). *The Prevention and Cure of Many Chronic Diseases by Movements: An Exposition of the Principles and Practice by These Movements for the Correction of the Tendencies to Disease in Infancy, Childhood, and Youth, and for the Cure of Many Morbid Affections of Adults*. London: John Churchill.


The Nursing Record. (1895, January 9th 1895). The Massage Question: Letter to the Editor. The Nursing Record.


Appendices

Appendix One – Confirmation of ethical approval

From: Vicki Allen Vicki.Allen@unisa.edu.au
To: 'David Nicholls'
CC: 'jo.walton@aut.ac.nz'; Julianne Cheek;
Subject: Ethics protocol P128/04 "A Foucauldian discourse analysis of physiotherapy practice".
Date: 7/30/04 2:47PM

Dear David
Re: Ethics protocol P128/04 " A Foucauldian discourse analysis of physiotherapy practice ".

Thank you for providing the amendments and/or additional information requested by the Human Research Ethics Committee (letter dated 5 July 2004).

I am pleased to advise that your protocol has been approved. However, I remind you that it is your responsibility to ensure that you obtain written permission from the organisations where the research will be undertaken before commencing your research in the same.

Please regard this email as formal notification of approval.

Ethics approval is always made on the basis of a number of conditions detailed in the attachment; it is important that you are familiar with, and abide by, these conditions. It is also essential that you conduct all research according to UniSA guidelines, which can be found at <http://www.unisa.edu.au/orc/ethics/index.htm>.

Best wishes for your research.

Regards, Vicki

Vicki Allen
Ethics Officer
Research Services
University of South Australia
Mawson Lakes Campus
Mawson Lakes Boulevard
Mawson Lakes SA 5095
Telephone: +61 8 8302 3118
Fax: +61 8 83023921
Email: vicki.allen@unisa.edu.au
Invitation to take part in PhD research study into the analysis of physiotherapy practice

Dear ***

I would like to invite you to take part in a research study looking at the physiotherapy management of breathing pattern disorders. The study is part of a PhD supervised by Professor Julianne Cheek and Dr Kay Price (University of South Australia) and Professor Jo Ann Walton (Auckland University of Technology).

The study is a qualitative discourse analysis of new forms of physiotherapy. It is not a clinical trial. Instead, it will involve interviews and observations of physiotherapy practice. Importantly the study focuses on the practice of physiotherapy, rather than that of individual physiotherapists.

In undertaking the research I would like to spend some time observing physiotherapy practice and interviewing practitioners. The data collection will be periodic and will not disrupt your clinical interaction with patients.

Before you can formally consent to take part in the study I would like to invite you to discuss the research study further. At that meeting you will have the chance to discuss the proposed research in much greater detail and ask any questions you wish about the study.

Please contact me to arrange a meeting time where we can discuss the project further. You can contact me by letter, email, fax or telephone, and all contact details are given below. Thank you for your consideration.

Yours sincerely

David Nicholls MA GradDipPhys
PhD Candidate
School of Physiotherapy
Auckland University of Technology
UNIVERSITY OF SOUTH AUSTRALIA
Faculty of Health Science

PATIENT CONSENT FORM

Please tick box if you require an interpreter

Project Title
A Foucauldian discourse analysis of physiotherapy practice

Researcher’s name
David Nicholls

Supervisor’s name
Julianne Cheek and Kay Price (UniSA), Jo Ann Walton (AUT)

- I am at least 18 years of age
- I have received information about this research project
- I understand the purpose of the research project and my involvement in it
- I give my permission to the researcher to access my personal/medical records held by my physiotherapist for the purposes of this research only
- I understand that I may withdraw from the research project at any stage

Name of participant: ÉÉÉ ÉÉÉÉÉ ÉÉÉÉÉ ÉÉÉÉÉ ÉÉ

Signed: ÉÉ ÉÉÉÉÉ ÉÉÉÉÉ ÉÉÉÉ ÉÉ ÉÉ Date: ÉÉÉ ÉÉ ÉÉ

I have provided information about the research to the research participant and believe that he/she understands what is involved.

I consent to allowing the researcher to access my personal/medical records from the respective physiotherapists YES/NO

Researcher’s signature: ÉÉ ÉÉÉÉÉ ÉÉ ÉÉ Date: ÉÉÉ ÉÉ ÉÉ
You are invited to take part in this research study which looks at the physiotherapy management of breathing pattern disorders. The study has been designed to analyze the role of new forms of physiotherapy using the work of French philosopher Michel Foucault. The study is planned to take place in hospital physiotherapy departments and private practices in Auckland, New Zealand.

In finding out how physiotherapy has come to work with people with breathing pattern disorders a number of different research methods will be used, these include; observations of physiotherapists assessing and treating patients, formal interviews and informal conversations with physiotherapists, reading practice and professional practice documents.

The study looks at physiotherapy practice in general, not the work of individual physiotherapists. Nor does the study involve you directly as a patient. Participation in the study is voluntary. If you choose to participate you will be asked to allow the researcher to observe you being assessed and treated by a physiotherapist. The researcher will also want to view your patient records. On occasions the researcher will ask to observe you for the entire period of your treatment session. The researcher will record observations in a research journal during the session.

All information provided by participants will remain confidential and no information will be released which could lead to your personal identification. None of the data gathered will be viewed by anyone other than the participant, the researcher and the study supervisors. Any dissemination of material will only be done with the consent of the participant and you will be able to view any final transcripts that include data pertaining to you. All participants will have pseudonyms, and details identifying the location of their practice will be masked. Data may be used in future related studies for which ethics approval will be obtained from a New Zealand accredited ethics committee.

If you consent to take part in the study, you have the right to withdraw from the study at any time without consequence. Your involvement in this study will not affect your physiotherapy treatment in any way.

Your consent to take part in the study will help develop our appreciation of the emergence of new forms of physiotherapy, how it has changed and the influences that have brought about that change. Your involvement in the study will allow the researcher to explore the influences that have led to the emergence of these new forms of physiotherapy.

There are no risks to you personally in taking part in the study. Your confidentiality and anonymity are assured. Your right to withdraw from the study at any time is guaranteed, as is your right to be informed about the management of data pertaining to you.
PARTICIPANT CONSENT FORM

Please tick box if you require an interpreter

Project Title  A Foucauldian discourse analysis of physiotherapy practice

Researcher’s name  David Nicholls

Supervisor’s name  Julianne Cheek and Kay Price (UniSA), Jo Ann Walton (AUT)

- I am at least 18 years old
- I have received information about this research project
- I understand the purpose of the research project and my involvement in it
- I give my permission for the researcher to access personal/medical information pertaining to patients under my care for the purposes of this research only
- I understand that I may withdraw from the research project at any stage
- I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential
- I understand that I will be audio-taped during interviews

Name of participant: ÉÉÉ ÉÉÉÉÉ ÉÉÉÉÉ ÉÉÉÉÉ ÉÉÉ

Signed: ÉÉ ÉÉÉÉÉ ÉÉÉÉÉ ÉÉÉÉÉ ÉÉÉ Date: ÉÉÉ ÉÉ É

I have provided information about the research to the research participant and believe that he/she understands what is involved.

I consent to my data being in future related studies for which ethics approval will be obtained from a New Zealand accredited ethics committee  YES/NO

Researcher’s signature: ÉÉ ÉÉÉÉÉ ÉÉÉ É Date: ÉÉÉ ÉÉ É
A Foucauldian discourse analysis of physiotherapy practice

David Nicholls MA GradDipPhys NZSP
PhD Candidate
00 64 9 917 9999 x7064

You invited to take part in this research study which looks at the physiotherapy management of breathing pattern disorders. The study has been designed to analyze the role of new forms of physiotherapy using the work of French philosopher Michel Foucault. The study is planned to take place in hospital physiotherapy departments and private practices in Auckland, New Zealand.

In finding out how physiotherapy has come to work with people with breathing pattern disorders a number of different research methods will be used, these include; observations of physiotherapists assessing and treating patients, formal interviews and informal conversations with physiotherapists, and reading practice and professional practice documents.

The study looks at physiotherapy practice in general, not the work of individual physiotherapists. Nor does the study involve any of your patients. If you participate in the study you will be asked to allow the researcher to observe and periodically interview you about the physiotherapy management of people under your care. You will be asked to let the researcher view practice files and patient records. Observations will last from a few minutes to a number of hours and interviews will vary from brief conversations to formal discussions lasting over one hour. Most of the interview data will be tape-recorded using a discrete hand-held audio-recorder, observations and practice notes will be written in a research journal.

The confidentiality or anonymity of participants and their practice is an important part of this study. All participants will have pseudonyms, and details identifying the location of their practice will be masked. None of the data gathered will be viewed by anyone other than the participant, the researcher and the study supervisors. Any dissemination of material will only be done with the consent of the participant.

If you consent to take part in the study, you have the right to withdraw from the study at any time without consequence.

Your consent to take part in the study will help develop our appreciation of the emergence of current forms of physiotherapy, how it has changed and the influences that have brought about that change. Breathing retraining is a very new form of physiotherapy and its emergence is a significant shift from traditional approaches to practice. Your involvement in the study will allow the researcher to explore the influences that have led to the emergence of these new forms of physiotherapy.

There are no risks to you personally in taking part in the study. Your confidentiality and anonymity is assured. Your rights to withdraw from the study at any time are guaranteed, as are your rights to be informed about the management of data pertaining to you.
CONSENT FORM FOR USE WHERE TAPE MATERIAL IS TO BE RETAINED

Project Title  A Foucauldian discourse analysis of physiotherapy practice

Researcher’s name  David Nicholls

Supervisor’s name  Julianne Cheek, Kay Price (UniSA), Jo Ann Walton (AUT)

- I have read the Information Sheet, and the nature and the purpose of the research project has been explained to me. I understand and agree to take part.
- I understand that I may not directly benefit from taking part in the project.
- I understand that I can withdraw from the study at any stage and that this will not affect my status now or in the future.
- I confirm that I am over 18 years of age.
- I understand that I will be audio-taped during the study.
- I understand that the tape will be stored in a locked cabinet in the office of the researcher and that it will not be accessed by anyone other than the researcher.
- I understand that the University shall not be required to make any payment to me arising out of its exercise of this right.
- I understand that wherever practical, the University will acknowledge my participation in the project in exercising this right.

Name of Participant É É ÉÉÉÉÉ É ÉÉÉÉÉ É ÉÉÉÉÉ É É

Signed É É ÉÉÉÉÉ É ÉÉÉÉÉ É ÉÉÉÉÉ É ÉÉÉÉÉ É É

Dated É É ÉÉÉÉÉ É ÉÉÉÉÉ É É ÉÉÉÉÉ É ÉÉÉÉÉ É É

I have explained the study to subject and consider that he/she understands what is involved.

Researcher’s signature É ÉÉÉÉ É ÉÉÉÉÉÉÉ É ÉÉÉÉÉ É ÉÉÉÉÉ É É
A Foucauldian discourse analysis of physiotherapy practice

David Nicholls MA GradDip Phys NZ SP
PhD Candidate
00 64 9 917 9999 x7064

Research tools

Theme list for formal interviews with physiotherapists:

- Organization of the clinic space and time
- Patient assessment and diagnosis
- Patient treatment
- Patient demographics
- Patient records
- Communication between patients, clinicians and other healthcare workers
- Rationality for physiotherapy as a valid form of therapy
- Views about breathing pattern disorders as a clinical condition – epidemiology and etiology of ‘bad breathing’
- Physiotherapy roles and scope of practice
- Thoughts about respiratory physiotherapy and the emergence of this new form of therapy
- Techniques for achieving desired patient outcomes
- Future for these therapies
- Economic considerations and service funding
- Promotion and advertising services

Theme list for observations of physiotherapy practice

- The therapeutic environment including the organization of clinic space, the room design and layout
- Organization and control of the physiotherapist’s and patient’s time – the booking system
- Patient demographics
- Episodes of patient assessment and diagnosis
- Episodes of patient treatment
- Resources employed by therapist during interactions with patients
- Use of observation, interrogation and touch
- Different practices between therapists and between patients
- Similar practices between therapists and patients
- Roles and relationships, interactions and communication between therapists and patients
- Recording patient data
- Communication with other therapists and healthcare workers
- Promotional material
- Patient information material
Appendix Nine – Breathing Works’ consent to use their names unaltered

Tania Clifton-Smith  
BREATHING WORKS  
437 Remuera Road  
Auckland 5  
Monday, 4 September 2006

Request to use Breathing Works’ names within publications

Dear Tania,

Following our conversation last week about using the name ‘Breathing Works’ in my thesis, and naming you and Dinah individually, I wrote to my ethics committee in Australia to enquire about the issue.

Their advice was as follows:

Provided you have the participants’ written consent to name them in an identifiable way (either by name of release of information which could lead to their identification) and the written permission from the CEO of the organisation to name that organisation along with releasing information about the organisation via your thesis and/or publications you may do so. You must keep the original signed copy of these “consents/permissions” in your file for your project/thesis and give the participants/CEO of organisation a copy for their records.

I am therefore writing to you to ask if you have any objections to me using the name ‘Breathing Works’ within my thesis and citing you and Dinah by name. My reasons for this are:

1. The clinic’s name; ‘Breathing Works’ portrays a great deal about the business and is a point of analysis that I cannot make if I have to change it’s name.

2. There is only one such clinic in Australasia, so it will be patently obvious to anyone with a modicum of knowledge within the field whom I am speaking about when I refer to it.

3. You are internationally recognised authors and experts in this field who are well known within the field. To give you false names would be a ludicrous deception. When I reference your books I will do so with your original name and thus give the game away somewhat.

4. From my conversations with you to date I believe that neither of you have any problem with me using your name or the name of the clinic and would, in fact, prefer this to be so.

Consequently, I would like to ask you to complete the attached form and return a signed copy to me if you’re happy to do so.
I, Terecia CiaronSmith, am happy that my name be used (rather than a pseudonym) in David Nicholls' PhD thesis and any subsequent publications that may result from it. I am aware that, in all likelihood this will result in my name, and the name of the Breathing Works clinic, being visible within the public domain.

This decision is made in good faith and, before any publications using my name goes to press, I will have the chance to alter any reference to me or the clinic without prejudice.

I have had the opportunity to discuss this before making my decision and am happy to support this proposal.

Signed

Yours sincerely

David Nicholls MA GradDipPhys
PhD Candidate
School of Physiotherapy
Auckland University of Technology
I, Dinah Bradley, am happy that my name be used (rather than a pseudonym) in David Nicholls’ PhD thesis and any subsequent publications that may result from it. I am aware that, in all likelihood this will result in my name, and the name of the Breathing Works clinic, being visible within the public domain.

This decision is made in good faith and, before any publications using my name goes to press, I will have the chance to alter any reference to me or the clinic without prejudice.

I have had the opportunity to discuss this before making my decision and am happy to support this proposal.

Signed: Dinah Bradley

Yours sincerely,

David Nicholls MA GradDipPhys
PhD Candidate
School of Physiotherapy
Auckland University of Technology
Appendix Ten – Sample assessment sheet from Breathing Works with names removed

**NAME:** Name removed

**ADDRESS:**

**TELEPHONE:**

**DATE:** 6/12/04

**REFFER:** Name removed

**G.P.**

### Diagnosis Given

<table>
<thead>
<tr>
<th>Diagnosis Given</th>
<th>Date</th>
<th>Referrer</th>
<th>G.P.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPD</td>
<td>6/12/04</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Presenting Problems

- Anxiety
- Fatigue
- Insomnia

### Previous Medical History

- C/O: Headache, Migrane
- Whiplash: 1 year, 12 months
- Hx: Glands, 6 yrs ago

### Social Occupation

- Live with partner
- Full time sales
- 8:30 - 7:30, 11 a week

### Other Alternative Treatments or Investigations

- Bloods - x 4

### Subjective Symptoms

<table>
<thead>
<tr>
<th>Subjective Symptom</th>
<th>Frequency</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent yawning/sighing</td>
<td>Habit</td>
<td></td>
</tr>
<tr>
<td>Nose/mouth breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disturbed Sleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscles ache / tremor</td>
<td>x2</td>
<td>Fever 25</td>
</tr>
<tr>
<td>Upset gut / nausea / reflux</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td>x2</td>
<td>Migrane</td>
</tr>
<tr>
<td>Panics / Phobias</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Objective:

- Respiration Rate: 18-20
- Patterns:
- Trigger Points:
  - PEPR:
  - Oxy Sat: 99%
Appendix Eleven – Nijmegen Questionnaire

**B R E A T H I N G  W O R K S**

**NIJMEGAN QUESTIONNAIRE**

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rare</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling tense</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blurred vision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizzy spells</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling confused</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faster or deeper breathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short of breath</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tight feeling in chest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bloated feeling in stomach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tingling fingers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to breathe deeply</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stiff fingers or arms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tight feeling around mouth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cold hands or feet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palpitations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feelings of anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>/64</strong></td>
</tr>
</tbody>
</table>
Appendix Twelve – Paper published in Social Science and Medicine, 2006; 62(9), 2336-2348
Physiotherapy and the shadow of prostitution: The Society of Trained Masseuses and the massage scandals of 1894

David A. Nicholls, Julianne Check

Abstract

In 1894 the Society of Trained Masseuses (STM) formed in response to massage scandals published by the British Medical Journal (BMJ). The Society's founders acted to legitimise massage, which had become sullied by its association with prostitution. This study analyses the discourses that influenced the founders of the Society and reflects upon the social and political conditions that enabled the STM to emerge and prosper.

The founders established a clear practice model for massage which effectively regulated the sensual elements of contact between therapist and patient. Massage practices were regulated through clearly defined curricula, examinations and the surveillance of the Society's members. A biomechanical model of physical rehabilitation was adopted to enable massage to view the body as a machine rather than as a sensual being. Medical patronage of the Society was crucial enabling the Society to prosper amongst competing organisations.

Using Foucault's work on power we explore the contingent nature of these events, viewing the massage scandals in context with broader questions of sexual morality, professionalisation and expertise in the late nineteenth century society. We argue that many of the technologies developed by the founders resonate with physiotherapy practice today and enable us to critically analyse the continued relevance of the profession to contemporary healthcare.

Keywords: Physiotherapy; History; Massage; Discourse; Foucault; Professions; UK

Introduction

Little has been written about the history of physiotherapy as a profession, and to date there have been no critical accounts of the events surrounding the emergence of one of the largest health professional groups in Western healthcare.

This is in contrast to the attention that has been paid to nursing (Gestaldo & Holmes, 1999), medicine (Armstrong, 1995), dentistry (Nettelton, 1997), psychology (Rose, 1985) and some of the allied health professions: chiropody (Dagnall & Page, 1992), chiropractic (Coburn, 1994) and podiatry (Borthwick, 1999).

Physiotherapy began as a profession in 1894, as a response to massage scandals promulgated by the British Medical Journal (BMJ). The formation of the Society of Trained Masseuses (STM) by four august Victorian women would lead, eventually, to
the creation of the first and largest profession allied to medicine, and to the formalisation of physical rehabilitation as a professional discipline.

It is surprising then that so little attention has been paid to the events surrounding the formation of the Society—particularly given that researchers and historians have concentrated so much scholarship upon late Victorian England—showing this to have been an exceedingly rich period in the history of social and political reform. Such events include the advancement of women’s emancipation, the development of germ theory and sanitary science, social problems of urban overcrowding, the effects of two foreign wars, and political questions of sovereignty and government, classical liberalism and legal reform.

The events surrounding the formation of the STM have been detailed twice before, in Wicksteed’s (1948) book, 'The Growth of the Profession: Being the history of the Chartered Society of Physiotherapy 1894–1945', and more substantially in Barclay’s (1994) book, 'In Good Hands: The History of the Chartered Society of Physiotherapy, 1894-1994'. Both of these texts present excellent accounts of the events surrounding the formation of the STM, but neither undertakes a critical analysis of the social and political context that influenced the actions of the Society’s founders.

One might ask for instance: why was there such concern to professionalise massage practice at this particular time, when massage had been practised for centuries, in many different societies and in many different ways? What circumstances conspired to bring the massage practices of a few disruptive London institutions into the spotlight and cause such moral outrage? What events allowed the formation of the STM to be seen as the appropriate response to these scandals? And how did the STM succeed in becoming the orthodox face of professional massage?

In this paper we attempt to address these questions by undertaking a genealogical analysis of the documentary evidence pertaining to the period. We have attempted to unravel some of the discourses that influenced the actions of the Society’s founders, and present our analysis in a social and political context. We are not attempting here to analyse physiotherapy practice per se, but rather the formation of the Society that sought to regulate the work of its members and, in so doing, colonise the notion of what it meant to offer legitimate massage practice.

This paper has two principal goals: to present a genealogical analysis of the discourses surrounding the massage scandals of 1894, and to write of these events in such a way that they have relevance for the contemporary and future histories of physiotherapy practice. As Foucault would put it, we aim to construct a history of the present.

Methodological approach

This paper represents part of a larger genealogical study into the emergence of new forms of physiotherapy practice. A genealogical approach to Foucauldian discourse analysis has been taken in order to explore those facets of physiotherapy, as a human science, that are 'inextricably associated with particular technologies of power embodied in social practices' (Smart, 1985, p. 48). Genealogical studies provide a framework through which we can explore 'the history of morals, ideals, and metaphysical concepts, the history of the concept of liberty or of the aesthetic life, as they stand for the emergence of different interpretations, they must be made to appear as events on the stage of the historical process' (Foucault, 1977, p. 152). From this, the historical events that led to the formation of the STM can be seen as a 'a cobbled patchwork of heterogeneous elements' (Rasmun, 1997, p. 88), rather than a set of self-evident truths that expose the 'essential' basis of physiotherapy practice.

Texts were generated for the study from primary and secondary sources; primarily from the archives of the Chartered Society of Physiotherapy held by the Wellcome Institute Library in London. These texts included business reports, correspondence, curriculum documents, minutes of meetings, newspaper reports, photographs and promotional materials. Textual material from 1894 to the outbreak of war in 1914 was sourced for analytical interrogation. Secondary sources focused on historical accounts of the emergence of the STM (Barclay, 1994; Grafton, 1934; Wicksteed, 1948).

Data were critically analysed in the context of other political, social and historical writings of the period. This reading focused largely upon the extensive literature surrounding Victorian sexual morality—since it is this that exercised the minds of the founders so profoundly.

A Foucauldian approach to data analysis was undertaken, utilising a combination of approaches that draw directly from Foucault (1980, 1981) whilst also drawing on strategies developed by Hook.
These approaches to discourse analysis reveal and trouble the nature of power. They explore the 'domination, subjugation, the relationships of force' (Davidson, 1986, p. 225) extant within society. These forces operating in history 'are not controlled by destiny or regulative mechanisms, but respond to haphazard conflicts' (Foucault, 1977, p. 155). It is the desire to manipulate and control these errant forces that constitutes the actions of government; working through various refined agencies to achieve political ends (Dean, 1999). One such technology is the professionalisation of expertise through which conditions of possibility are exercised. Organised professional expertise engages in the definition, creation, modification, constraint and liberation of discourses, through their ability to influence what can be said and what can not, what is normalised and what is marginalised.

In undertaking a genealogical analysis of the data, rather than trying to produce a definitive account of events, we have attempted to expose the sometimes hidden, ubiquitous and multi-dimensional operations of power that construct subjectivities and material practices around the notions of morality, expertise and professionalism in the emergence of physiotherapy.

Instead of applying our analytical lens to a narrow set of circumstances, we have tried to map the extra-discursive subjectivities, objects, strategies and regimes, so as to trace the outline of discursive formations acting upon the Society and its founders. For this reason, it would be fair to criticise the paper for ranging too far across a wide body of textual material. However, our intention was to explore ways in which the materiality of discourses were enfolded into social, political and historical realities, rather than to present a detailed historiography or hermeneutic interpretative analysis of all the textual elements present (Ransom, 1997).

Our critique comes at an early stage in development of scholarship within (and upon) physiotherapy, but draws on a burgeoning interest in the role of professionals in society from a wide range of authors who utilise an increasingly diverse array of social, political, economic, cultural and philosophical lenses (Auld & Lewis, 2004; Clarke, Doel, & Segrott, 2004; Gilbert, Cochrane, & Greenwell, 2003; Larkin, 1985, 1995; Perron, Fluet, & Holmes, 2005; Wear & Keesewski, 2004).

A Foucauldian approach to the socio-political analysis of a profession will be inevitably partial, selective and temporary. We recognise that this can only be one reading of the texts and we hope that many more will follow. Inevitably, there have been casualties in the process of sampling, refining and analysing textual sources, for instance: in addressing the relationship between the Weir Mitchell method and the Society's members, we do not draw on much of the extensive feminist critique that emerged from Charlotte Perkins Gilman's 'The Yellow Wallpaper'; nor do we spend a great deal of time tracing the history of the Swedish exercise movement, physical rehabilitation in medicine, the relationship between physiotherapy and emerging psychoanalytic theory (most especially Reichian bodywork), or the leisure spa culture at the end of the nineteenth century. All of these fields of scholarship are worthy of their own attention but are beyond the scope of this paper.

The conditions of possibility that allowed for the formation of the Society of Trained Massageists

There are many accounts of late Victorian political, social, governmental and economic life, and in recent years this period has received extensive critical commentary. Most notable are the texts which have considered the role of mass migration from country to city, the rise of a new class of urban poor, the legislative shift to governmental surveillance, the refinement of liberalism as a political and economic strategy, the development of public health (especially urban sanitation), the impact of the industrial revolution, the impact of war overseas and the pursuit of colonialism (Harrison, 1990). By the close of the nineteenth century, colonial governments wrestled with the enormous complexity of rule across diverse sectors of the population, and in some cases many miles from their own shores. The late nineteenth century is notable for the sophisticated proliferation of governmental technologies that sought to secure the effective exercise of classical liberalism (Rose, 1993). Most notable amongst these rationalities of government were those committed to the 'growth of mechanisms of power in relation to the ability to observe, measure and subsequently to know the details of a population' (Galvin, 2002). This conjunction of technologies of the body with matrices of social institutions and bio-politics concerned itself with the population 'in which issues of individual sexual and reproductive conduct interconnected with issues of national policy and power' (Gordon, 1991, p. 5).
Governmental concerns to ensure the health, wealth and happiness of the populace, which had been at the heart of earlier rationalities of rule, now grappled with the problem of maintaining positive knowledge of the population whilst reinforcing people's freedoms. Social welfare developed as an important vehicle for societal reform, and materialised in particular forms of philanthropic, moralistic and disciplinary regimes (Rose, 1996, p. 40). But the desire of governments to remove themselves from direct control over the conduct of individual citizens and social groupings enabled the emergence of professional organisations which acted as intermediaries between the citizens and their government.

Professions acquired powerful capacities to generate 'enclosures' (Rose, 1996, p. 50) which enabled them to implement disciplinary technologies, often with considerable freedom of expression, whilst maintaining a governmental rationality of rule. The individual and family were 'simultaneously assigned their social duties, accorded their rights, assured of their natural capacities, and educated in the fact that they need to be educated by experts in order to responsibly assume their freedom' (Rose, 1996, p. 49).

Thus the latter half of the nineteenth century saw the widespread development of new professional groupings, each with their own intimate relationship with government, and each problematising a section of the population. One such example is that of public health, which developed as a discrete governamental policy during the latter half of the nineteenth century (Brimblecombe, 2003). Public health exercised the attention of Victorian governments, partly from a concern for the welfare of the slum-dwelling population, but also because disease was a public issue in so far as it affected public finances, particularly with regard to the running of the Poor Law; but also because of the recognition that sectors of towns infected by disease and squalor could have effects on more salubrious areas (Osborne, 1996, p. 106).

More significantly for the development of massage practice though was the dramatic upswing in the nature and number of professional roles for women that developed between 1850 and 1900. While these occupations were often poorly paid, they provided new opportunities for women from the educated middle- and upper-classes. Key to this shift was the growing acceptance of professional roles as a morally acceptable alternative for the leisure classes (Vicinus, 1985), and as jobs in the most common professions of nursing and teaching became more scarce, women looked for opportunities to diversify within these roles.

Massage became an important feature of nursing work during the 1880s as medicine's interest in its practice waned. Massage courses were established by nursing schools and private concerns and were widely patronised, particularly by nurses looking to develop new therapeutic skills to complement their bedside nursing. Nurses were trained in rudimentary Swedish massage and movement often by men and women who had studied overseas or emigrated from Europe. Initially courses were unregulated and one's qualifications depended entirely upon the credibility of the tutor. By 1894 the market for masseurs and masseuses in the large cities was so overstocked that people were finding it hard to secure regular employment. This was compounded by concerns for the quality and suitability of some massage therapists, and it was known that many were operating under false qualifications in the absence of formal regulation.

Massage therefore developed at the confluence of a number of channels of resistance to the orthodox Victorian imagination. Firstly, it was closely allied to the development of professional roles for women that challenged medicine's domination of therapeutic modalities; secondly, it gave women a degree of professional autonomy and self-determination that had not been seen before; thirdly, it stimulated interest in a treatment modality that exposed Victorian social ambivalences to sexuality and touch.

Many authors have written about Victorians attitude towards sexuality and the roles played by women (Bashford, 1998; Bland, 2001a; Jackson-Houlston, 1999; Mason, 1994a; May, 1998; Trudgill, 1976; Vicinus, 1977; Wallkowitz, 1992) and many different perspectives exist. It is clear though that Victorian society was distinctly ambivalent about the relevance, function and potency of women's sexuality. The heavily androcentric literature of the time promulgated romantic notions of women as either unable to experience passion, or as weak-willed, impressionable and hysterical victims of their emotions, and all too frequently both at the same time. Further, the study of women's sexuality took on unprecedented levels of intrusion, justified on the basis that women occupied a pivotal role in the welfare of the state: as givers of life, promoters of healthy sexual practices, but passive in the face of their own sexual desires; 'Behind the veneer of the
dominant nineteenth-century ideal woman—the domestic 'angel in the house'—lurked the earlier representation of sexualized femininity: the Magdalen behind the Madonna' (Bland, 2001b, p. 58).

Rarely, throughout modern history, has there been such a concerted attempt to refine rationalities of sexuality around a population. Foucault, drawing extensively on the work of Nietzsche (1889), considered this an intensely productive period in the history of sexual morality (Foucault, 1979; Nietzsche, 1889). The confluence of an orthodox Christian morality; the economic necessity of a healthy, morally pliable population and increased domestic productivity; the increasing scientification of women's sexuality; and a concern for the effective management of a diverse population of urban poor, all contributed to the progressive development of a range of technologies around the sexual conduct of women. Added to this, women were now challenging professional roles previously occupied exclusively by men and openly showing resistance to forms of constraint that had previously operated effectively.

The actions of the founders of the STM must be seen therefore in the light of larger questions of women's professionalisation and their resistance to orthodox governmental rationalities (be they liberal economic reforms, orthodox religious beliefs or questions of idealised gender roles). Our analysis therefore focuses on the actions of a small number of educated late Victorian women who occupied the middle- and upper-classes and who pioneered the professions allied to medicine. It is clear that these women actively resisted many of the constraints on their activities and achieved remarkable success. However, it is also clear that their success was achieved with compromises—some of which served to reinforce the androcentric ideal of female subservience and deference to medicine. This is no more evident than in the development of physiotherapy as the oldest and largest of the Professions Allied to Medicine.

As Foucault argues, it is in the nature of these competing discourses, in their points of tension and conflict, that ruptures occur and shifts are enabled, and it is here that we can explore the dynamic interplay of material forces that helped to create a sense of alarm with the publication of 'Astonishing Revelations Concerning Supposed Massage Houses or Pandemoniums of Vice...' by the BMJ in 1894. This paper provided the catalyst for the actions of the founders, and provided the conditions of possibility sufficient to enable the birth of the STM. It is to the events surrounding this birth that we now turn.

The massage scandals of 1894

During the 1880s massage was undergoing something of a revival, as Swedish medical gymnasts and masseurs migrated to England. But in the absence of formalised training institutions, massage education was frequently provided on an ad hoc basis by nurse/midwife masseurs, trained Swedish masseurs and interested medical men. Prior to the formation of the STM, a diverse array of variously trained massage therapists were practising throughout the country. Programmes of instruction varied, from a few hours to full-scale apprenticeships. Salaries and working conditions also varied widely across the country and, by 1894, massage had become so popular as a vocation, it was largely felt that the market for therapists, particularly in large urban centres like London, was completely overstocked (British Medical Journal, 1894b).

In the summer of 1894, the BMJ published an editorial titled 'Immoral "massage" establishments' (British Medical Journal, 1894b, p. 83). This report led to widespread interest in the national press, and later that year drew comment in the House of Commons from the Home Secretary. The BMJ editorial of July 14th 1894 was couched in language of moral outrage, claiming that 'a good many "massage shops... are very little more than houses of accommodation"' (British Medical Journal, 1894b, p. 88). The editorial spoke of the ease with which women and men could establish and make use of massage parlours. The implication here was that many massage establishments were merely a front for brothels and many masseurs and masseuses were simply offering massage as a euphemism for prostitution.

Prostitution in Victorian London was clearly rampant, and the prevalence of sexually transmitted diseases had reached epidemic proportions amongst some sections of the urban population. Prostitution was, for many women, the only way of maintaining a subsistence income, but it was stories of women of the middle- and upper-classes lured into vice that exercised the minds of the BMJ most profoundly. Anecdotes of poor fallen women were published to illustrate the dangers of this new form of licentious expression. And while it was not unusual to read stories of these women in the
popular press, they were now being voiced by medical men rather than just men of the church and sensational journalists. But not all medical publications spoke with the same vehemence. The Lancet for instance—a very prominent medical voice at the time—took no interest at all in these revelations.

While it would be easy to criticise the morality of the BMJ in pursuing massage practitioners, rather than addressing the dangers experienced by prostitutes who were daily exposed to harassment, physical assault, rampant disease and police ambivalence (Walkowitz, 1992), it brings to our attention the contingent nature of the actions of the BMJ, and how successfully it targeted educated Victorian women.

The increasing interest in women’s sexual health led to a renewed interest in gynaecological medicine, and it was the female prostitute who bore the brunt of medicine’s surveillance. One side-effect of this interest though was the realisation of the degree and severity of disease endemic amongst the population of prostitutes. Gonorrhoea, chancroid and, worst of all, syphilis were widespread. The devastating effects of syphilis had been known for some time—by 1864 one out of every three sick soldiers in the army was ‘diseased’ (Trollope, 1994, p. 160), but the license given to medicine to establish the extent and nature of disease led to an almost unprecedented interest in the sexual mores of prostitutes (Walkowitz, 1977).

The consequences of syphilis were felt throughout society at a time when Britain was aggressively pursuing its military conquests, fighting insurgence in the colonies and driving industrialisation in its cities and towns. The country needed a strong, capable workforce, while syphilis brought shame, weakness and deceit. And the shame was not merely personal, but was felt at a national level when the country felt at its most vulnerable: ‘In these dens of infamy the worst passions of a man or a woman are excited by treatment they are pleased to call massage...We had thought that Christian England—especially the more aristocratic portion of it—could have given better illustration of her much-vaulted modesty for wicked France to peep at’ (British Medical Journal, 1894a). This moral outrage provided the BMJ with an opportune vehicle to promote moral messages about sexual practices and develop medicine’s role in sexual health medicine that would have far reaching effects in all spheres of healthcare practice.

Massage held the potential for the pursuit of sexual pleasure amongst the population (Coveney & Banton, 2003) aside from (or maybe because of) its association with prostitution. For many Victorians, unused to intimate physical contact, massage must have been a highly sensual experience. Possibly as a result, massage was believed to have profound effects on the body; something that the nurses who founded the Society would have sought to utilise in their nascent occupation. These effects could be harnessed to heal a diverse array of clinical conditions including curvatures of the spine, an array of nervous complaints and neurological pathologies, infectious diseases, cardiovascular, rheumatologic and skin disorders. But the sensual aspects of massage could not be denied and, as Victorian England grappled with the need to regulate against sins of the flesh, the power of massage became an obvious target for its regulation.

However, massage services were now widely felt to be a euphemism for prostitution, and massage could not rid itself of the association with licentiousness. Men and women advertised their services in the popular press in language that made it impossible to distinguish between the legitimate and the clandestine. One would not know with any certainty what ‘kind’ of massage was being offered or, indeed, was being sought. The BMJ reported that ‘there are only six out of the many advertised ... massage dens which can be counted as creditable’ (British Medical Journal, 1894a, p. 6).

Nurses had for some years tried to distance themselves from the association with prostitution (Bushford, 1998), and with medicine’s rapid shift into more sophisticated forms of healthcare, the opportunities (and dangers) of legitimising massage provided nurses with fertile ground to resist the social and professional restraints placed upon them.

Massage provided a link to medicine which, buoyed by the creation of ‘germ theory’, felt able to make progressively more influential societal commentary. Society was becoming aware of the body not as passive in relation to nature, but as a mobile vehicle for the transmission of contagions (Armstrong, 2002), a point highlighted by the belief that women—now more socially mobile—were the conduits for sexually transmitted diseases. Women’s mobility was a challenge that needed restraint. The emergence of refined disciplinary technologies of classed liberalism—particularly the professionalisation of expertise—proved a useful vehicle for achieving this operation.
Consequently, after publishing its concerns about the massage scandals, the BMJ recommended that '...an association should be formed for those who have gone through a proper course of instruction in massage and obtained certificates of proficiency' (British Medical Journal, 1894b). Within six months the STM was founded by four London-based nurse/midwife masseuses, concerned with the public's perception of their work, who sought to 'make massage a safe, clean and honourable profession, and it shall be a profession for British women' (Grafton, 1934).

The Society's response to the scandals

The actions of the Society's founders cannot be seen as a necessarily obvious, logical or inevitable response to the social and political climate of the time, but rather as contingent upon their interpretation of a series of interwoven events. The four principle founders; Miss (Mary) Rosalind Paget (who by now had ceased practice to concentrate on her pioneering work with the STM and gaining registration for midwives—a feat achieved in 1902), Miss Lucy Robinson, Miss Elizabeth Anne Manley (the only non-midwife) and Mrs Margaret Palmer (who would write the first text specifically for the STM), established the Society in a formal meeting in December 1894. At subsequent meetings theycourted medica l opinion, established examinations, and developed a curriculum and professional code of conduct.

The founders' first concern was to regulate the education, training, registration and practice of masseuses, through the formation of a Society. The founding rules of the society stated that no massage was to be undertaken except under medical direction, and no general massage for men was to be undertaken; but exceptions may be made for urgent and nursing cases at a doctor's special request. There was to be no advertising in any but strictly medical papers (Barclay, 1994).

These rules were reinforced by a code of conduct which guided the masseuses to dress plainly, avoid gossip about patients, refuse offers of stimulants at the houses of their patients, avoid recommending drugs to patients and charge fees in accordance with professional rules.

The Society, in turn, set up a training curriculum, paying particular attention to examinations—Rosalind Paget, whilst practising little massage herself, remained Chair and Director of Examinations for 20 years (Barclay, 1994). Students were examined on practical subjects and rudimentary anatomy, but also on questions of proper conduct. The written examination on massage contained a 'professional practice' question for over 20 years, until the Society had effectively established a monopoly on authentic and legitimate massage practice. For instance, students were asked; 'How may the personal habits of the masseuse be responsible for success or failure in her profession?' (Incorporated Society of Trained Masseuses, 1911b) and; 'As a member of an honourable profession what do you consider to be your duties and obligations to that profession and to your fellow members?' (Incorporated Society of Trained Masseuses, 1914).

By discouraging contact between masseuses and male clients (unless in exceptional circumstances), and by refusing to register male masseurs, the Society went a long way to reassuring the medical establishment of its propriety. But these gestures were nothing compared to the strenuous efforts of the founders to court medical patronage. It was recognised early on that the Society would not survive without the support of the British medical establishment since, with the advent of germ theory and the development of asepsis, medicine had become the principal voice in the political and social campaign to rid the population of illness and disease. The founders were active in garnering support from high profile doctors, including Surgeon-General Sir Alfred Koghl, Robert Knox M.D., James Little M.D., Sir Frederick Traves and the retired Past President of the Royal College of Physicians—Sir Samuel Wilks, who allowed the premises. In fact, so successful were the founders in courting medical patronage that they were soon able to list 79 members of the medical profession who had signed their approval of the aims and principles of the newly 'Incorporated' Society of Trained Masseuses within a Society prospectus (Incorporated Society of Trained Masseuses, 1912).

And yet, the association between massage and medicine was more than simply convivial. In developing its association with the medical fraternity, the Society adopted possibly its most profound technology in their battle for authenticity and respectability—that of the biomechanical basis of health and illness.

Biomechanical approaches to health and illness were nothing new. Physical rehabilitation had been a feature of medicine and healing practices for centuries. In England, any number of Swedish
movement practitioners, bone setters and orthopaedic surgeons were practicing. But the biomechanical basis of illness had never found such a useful purpose as in the fight for moral respectability.

The adoption of a physical rehabilitation model of practice served a number of highly significant functions for the Society's founders. It provided them with a vehicle to interact with their patients without any suggestion of impropriety. The therapist was no longer concerned with the person as a sensual, aesthetic being; more as a collection of mechanically orientated units. The therapist was now free to touch the patient with impunity—under the umbrella of medico-scientific respectability. The physical rehabilitation model brought the practice of massage in line with medicine and allowed the Society to be carried along by a much more buoyant, organised medical orthodoxy, from which it could borrow organisational systems and learn how to maintain 'appropriate' relationships of objectivity and distance from patients. And, as a pleasant side-effect, it gave Society members reflected respectability in the eyes of the public.

It was from medicine that the Society's members learnt to pay attention to the microscopic technologies of biomechanical assessment that would convey the right message to patients about the therapy that they were receiving. A curriculum developed which focused upon the correct 'attitude' of the therapist towards assessment. In the curriculum paper of 1911 on Swedish Remedial Exercises, the 'gymnast' was taught: 'How a joint or part near a joint are examined by a Doctor'. The notes went on to say that the 'Gymnast must be able to do it in order to treat intelligently, but is generally given history and diagnosis by doctor. In that case must be careful not to ask too many questions (sic)' (Incorporated Society of Trained Massuæuse, 1911a, p. 13).

Therapists were taught to conduct themselves in a particular way. They would dress in uniform—reflecting elements of the physical cleanliness learnt from medicine's advances with germ theory, the moral cleanliness of religious orders and the domestic attire of the middle-class housekeeper. They were encouraged to practise only during daytime hours and, in time, to organise their clinic spaces within the grounds of hospitals. Their clinic rooms would be free from adornment and conveyed a message of sterility, objectivity and detachment. Each of these steps, though innocently considered, represented a further refinement of the moral crusade to rid massage of its seedy connotations.

The STM established itself as both ombudsmen and agency for masseuses. It received and vouched all referrals from medical colleagues, it farmed out work to registered therapists, it established pay rates and imposed systems of regulation. From the rules of the Society it is clear that the policy of the STM was to register women only as masseuses, and to forbid contact with male patients in all but exceptional circumstances. It is also clear then that between 1894 and 1905 (when men first achieved registration with the Society) legitimate massage was a female-only affair.

In their professional infancy, the Society's members—all nurse/midwife masseuses—were employed by women who could afford extended massage treatments at home. They received a private therapist for many hours of the day, and some times for many weeks. The women patients were therefore likely to be of a similar social standing to their therapists. The therapist therefore came to represent a model of respectable, pioneering practice to many of their patients which only served to enhance the reputation of massage as a desirable professional career for young women. Massage provided fresh possibilities 'both for young women and, unlike physical education, for those of more mature years. Being an old-fashioned rubber1 carried little kudos but training in anatomy and physiology, working with the medical profession and treating women of good social standing were much more appealing to the 'new women' of the age' (Barclay, 1994, p. 18).

The liberation from redundancy for educated middle-class women was not the least of the benefits. Through the 1880s and 90s women's fashions had become increasingly restrictive:

That a woman should be prepared to suffer in order to be beautiful is not incomprehensible; but that she should put up with semi-strangulation of her vital organs in order to be fashionable would be past belief. Were it not demonstrable in the history of more than one century (and even in prehistory; witness the wasp waists of the Minoan period). To attain their seventeen-inch waists, the young ladies of the 'eighties and 'nineties submitted to a process of corseting so

1 A colloquial term for an early unskilled masseuse from the working classes.
severe that it required the assistance of another hand, stronger and more relentless than their own, to pull the laces tight enough. ... But many young women did irreparable harm to their health (Bott & Clephane, 1932, p. 192).

Correcting was justified on medical grounds as an excellent mode of support; however, it came with other significantly moral messages; 'The unrestricted body came to be regarded in this period as symbolic of moral license; the loose body reflected loose morals' (Turner, 1996, p. 191). As with much Victorian morality, the corset represented a paradox—enhancing an image of female beauty whilst visibly denying the woman's fertility (Kunze, 2004). Apart from its effects upon the woman's internal organs—inducing a severe form of liver disease from compression by the lower ribs—it caused immense pressure in the pelvis which affected menstrual flow in puberty, caused uterine compression, and occasionally foetal damage, restricted blood flow to the heart and major organs, deranged respiration and interrupted digestion. There were, of course, campaigners against corsetry who recognized its ill effects (Roberts, 1977; Summers, 2003).

The prevalence of symptoms associated with sympathetic nervous complaints in many women led to social labelling of those who had become numbness as a result of their practices (sofa wives), and the medical classification of a diverse array of symptoms for which there was no obvious physiological cause—neuromastia, irritable heart, anxiety neurosis, etc. (Gardner & Bass, 1989).

Of the less well reported clinical conditions associated with middle-class women of the time, neuromastia was unquestionably linked to their physical and metaphorical constraint. First described by American neurologist George Beard in 1869 (Beard, 1869), it existed as a discrete diagnosis until it came into the domain of psychiatrists in the early part of the twentieth century and mutated into neurasthenia partly as a result of earlier work on mesmerism (see, for instance, Romanishyn, 1989).

Neuromastia was a condition without an obvious underlying cause, that catered for a diverse array of symptoms of 'sympathetic' origin: malaise, nervous depression with functional disturbance, headaches, unrefreshing sleep, scattered analgesia, morbid heats, and cold extremities, dyspepsia and gastric atony (Gijswijt-Hofstra & Porter, 2001; Neve, 2001; Sicherman, 1977). In fact, neuromastia presented a perfect medical diagnosis for women made ill through correcting, lack of physical exercise and a dire need for liberation from mental drudgery (Gijswijt-Hofstra & Porter, 2001).

The founders of the Society were ideally positioned to understand the needs of those who felt because so many of the members were educated middle-class women of similar social upbringing. Not surprisingly it was in this area that the Society members first established a niche and early Society curricula placed a great emphasis upon treatment methods designed specifically for neuromastic patients.

Early texts used by the Society in training masseuses suggest the importance given to work with neuromastic women and the lengths to which nurse/masseuse were involved in the day-to-day care of the patient (Ellison, 1908; Palmer, 1901; Symons, 1895). Margaret Palmer, one of the Society's founders, writes:

At first the patient is not allowed to feed herself or to use her hands in any way. It is found that more food is taken if the patient is fed by the nurse. The nurse sponges the patient all over daily in bed.

After a fortnight the nurse is allowed to read aloud. Towards the end of the treatment, which may last six weeks or two or three months, the patient is allowed to sit up in bed and occupy herself with some light work; she may also feed herself, the food being cut up for her; then she is allowed to sit out of bed for a few minutes at bedtime (Palmer, 1901, p. 218).

This method of treatment was known as the Weir Mitchell method after its founder Dr Silas Weir Mitchell (1829-1914)—one of America's most eminent neurologists. Weir Mitchell's work, 'Fat and Blood' (Weir Mitchell, 1903) proved a powerful influence on the founder's early curricula. The mainstay of his approach focused on returning the exhausted patient to full active health. The rest-cure method lasted for between 8 and 12 weeks and involved a ritualised regime of confinement and enforced rest, excessive feeding with milk and beef juices, regular massage and occasional electricity to replace the need for exercise outdoors (Dowse, 1906).

Society members were the ideal candidates to administer these treatments because they were all women trained in massage with general nursing experience, and so could provide personal care to women confined for extended periods in their own
bedrooms. They were also women of similar age and social standing, and so could take over the woman’s household duties whilst projecting a model of efficiency and organisation. The therapist was taught to be firm with her patients – who was not allowed to rise from bed other than for brief trips to the toilet. The patient was not allowed to deviate from the prescribed programme, receive letters, read the paper or engage in conversation during the course of her treatment (Palmer, 1901).

In many ways it is ironic that the women who were liberating themselves through professionalisation should choose to engage in such ritualistic forms of constraint upon other women (Vertinsky, 1995). But this serves to highlight important facets of Foucaultian discourse analysis; that power is creative rather than simply repressive (whilst not denying that repression frequently takes place); that the material effects of power are always partial, demanding constant vigilance to guard against forms of resistances, and that power can never simply be seen as hierarchical.

The various responses of the founders to the massage scandals of 1894 illustrate an array of more or less collective intelligences around the construction of authentic, respectable practice in massage at the turn of the century. Many of the strategies employed by the founders were not designed from a conscious will to ritualise their practice, patronise medicine or influence the burgeoning independence of women, but these were its material effects. By exploring the material practices of the founders it is possible to glimpse the productive capacity of technologies of power to create subject positions for the Society members that remain in a constant state of flux. The founders’ actions may be seen as contingent upon the desire to offer a respectable solution to the problem of massage and its connotations with inappropriate sexual contact. In doing so, they created networks of meaning that resonate with practice today.

Discussion

In this paper we have constructed a genealogical analysis of the events surrounding the formation of the STM. Central to this argument is Foucault’s interpretation of the constructive capacity of power. Foucault encourages us to ask not who has or does not have power, or who is the author of power or subject to its influence, but rather how has power installed itself and created the conditions of possibility that allow for real material effects to occur; ‘Power is nothing more and nothing less than the multiplicity of force relations extant within the social body’ (McHoul & Grace, 1993, p. 84).

We argue here that power was a creative influence in the formation and transformation of the STM; the productive nature of power enabled biomedical, or, more specifically, biomechanical discourses to emerge as a way for the founders to attain social respectability for themselves and their work.

In privileging one set of discourses, other discourses, particularly those relating to aesthetics, pleasure and sensuality, were marginalised. This can be seen in the micro-technologies implemented by the founders to intervene and control the actions of massage graduates and qualified members of the Society (Dew & Kirkman, 2002).

Fundamental to the operation of power in society is its relationship with the regulation of bodies, social institutions and politics (or more succinctly ‘biopower’). Here, the development of registers and archives, methods of observation, techniques of registration, procedures for investigation and apparatuses of control become essential techniques in the organisation of society (Hacking, 1981, p. 22).

Power becomes widely dispersed and quickly incorporates a wide array of mentalities. It takes on the form of a capillary network of influence that both constructs and is constructed by the actions of the various agents. Hence Foucault’s belief that power relations are never a completed work, but always remain incomplete – constantly responding to the changing subject and object positions adopted by individuals (Peterson & Bunton, 1997).

It is our contention that physiotherapists adopted a biomechanical model of reasoning that was simply one discursive construction amongst many – and while it may have been a highly influential model, it was neither static nor immutable. It was clearly influenced by questions of morality, bodily discipline, discourses of sexuality and proper conduct. The actions of the founders also came at a time when new professional discourses were being explored, with new surfaces upon which to inscribe societal values.

Biomechanical discourses gave physiotherapists licence to touch patients, massage and manipulate them, interact with them and treat them, whilst at the same time addressing the vexed questions of legitimacy. They gave Society members a status that allowed them to marginalise other competing
organisations, such as the Harley Institute, which could not gain the necessary medical respectability (Chartered Society of Physiotherapy, 1894–1912). They also provided a framework around which further advances in physiotherapy could be assimilated. Electrotherapy, Swedish movement, hydrotherapy, manipulative therapies, respiratory and later neurological therapies all maintained a strong association with the biomechanical rationalities of human form and function.

Clearly, the adoption of a biomechanical discourse was highly significant for physiotherapists. One only has to look at the massage and movement texts utilised by physiotherapy schools to see the way in which physiotherapists utilised biomechanical discourses as disciplinary technologies. Most of the texts pay meticulous attention to starting positions and detailed specifications of movements, with a requirement to know the anatomical surface and deep anatomy, kinesiology and biomechanics, supplemented by a growing attention to pathology. Biomechanical discourses provided a basis to the profession and gave physiotherapists license to legitimise authentic practice.

Rather than seeing, as do some authors, the adoption of biomechanical discourses as evidence that physiotherapy ‘sold its soul’ to medicine (Katavic, 1996), it would be more useful to consider the formation of the Society as an active engagement with a specific network of force relations. These relations combined to reveal the capillary nature of power and its productive capacity to provide an authentic solution to the questions of morality, professionalism and expertise in the delivery of massage and movement therapies.

These dynamic, inter-connected, microscopic interests of power reveal a history of physiotherapy that is somewhat more vibrant than has been presented before. In dealing with social, political and economic questions of morality, bodily discipline, and discourses of sexuality and proper conduct, the Society forged a professional body that would successfully navigate a diverse array of power effects. In doing so, the profession created new discourses—in this case ways of viewing the body and interacting with it—that would come to represent orthodoxy practice in the field of massage and manipulation for many years to come.

Analysing the relevance of historical events to physiotherapy as a profession is not an esoteric exercise; it has important consequences for the way in which physiotherapists interpret the political, social, economic, governmental and practical milieu in which they function as a profession today and in the future. Physiotherapists’ claims to truth are no more stable or reliable than those of other professional groups, and the ability to remain a respected healthcare professional depends, to some extent, on their ability to understand that no professional orthodoxy has a monopoly on the truth. Physiotherapy is embedded within a dynamic network of truth effects that are always motivated by political ends. Whether this is a conscious process or not depends on our ability to recognise the contingent nature of our decisions, and Foucauldian discourse analysis provides a useful critical framework within which to develop this consciousness.

Conclusion

In discussing the events surrounding the massage scandals of 1894 we have attempted to offer a new perspective on the emergence of one of the largest professional groups within Western healthcare. Examination of the events leading up to the formation of the STM reveals the contingent nature of power relations at work in the discursive construction of the profession.

Any analysis of events will be a partial account. No socio-political construction based on historical archives can ever be absolute, and this paper does not set out to reveal the historical origins, or philosophical essence of physiotherapy. Instead we have tried to provide an alternative to the rather two-dimensional, transcendental histories of the STM that currently exist by asking how the emergence of the profession of physiotherapy became historically possible, what were the historical conditions of its existence, and what relevance does this hold for physiotherapy practice today?

Acknowledgements

Thanks to Leslie Hall, Kathryn McPherson, Kay Price and Jo Ann Walton for their invaluable help and support in developing this paper.

References


British Medical Journal (1894). A startling revelation concerning supposed massage boxes or pedicures of the feet, frequented by both sexes, being a complete expose of the ways of professional masseurs and masseuses. London: British Medical Association.


Sexual restraint in practice: Images of moral conduct in physiotherapy texts

David A. Nicholls, School of Physiotherapy, Auckland University of Technology, New Zealand

Introduction

In 1994, the Society of Traditionally Masseuses (STM) was formed in England by four nurses and midwives in response to the pressure exerted upon them by the British Medical Journal. The STM federation is now a network of practitioners whose primary concerns are to promote safe, effective, and ethical practice in the field of physiotherapy. The STM has a strong national and international presence, with members in over 40 countries. The organization's mission is to raise awareness of the importance of ethical practice in physiotherapy and to promote a culture of excellence in patient care.

Appendix Thirteen describes the poster presented at the 7th International Interdisciplinary Conference: Advances in Qualitative Methods, Gold Coast, Australia, 2006.

Images of disciplined contact

From a moral perspective, the STM has developed a framework to understand the nature of contact between physical therapists and their patients. This framework is based on the principles of ethical and professional conduct, and it is designed to ensure that the rights and well-being of patients are protected. The STM's guidelines provide a clear and comprehensive framework for practitioners to follow in their work.

Images of discipline through registration

The STM has implemented a system of registration for its members, which it believes is necessary to maintain high standards of practice. This system ensures that all members are registered and meet the requirements of the organization. It also promotes a culture of excellence and professionalism among members.

Images of resistance and deviance

In the context of physiotherapy, resistance and deviance are important concepts to consider. Resistance may take many forms, including patient resistance to treatment or therapist resistance to ethical considerations. Deviance, on the other hand, refers to behaviors that violate ethical standards. The STM's guidelines emphasize the importance of maintaining a balance between these two concepts in order to ensure ethical and effective practice.

Discussion

Physiotherapists have the unique ability to help clients attain wellness in a variety of settings. This unique position allows physiotherapists to play a crucial role in promoting health and well-being. The primary focus of the paper is to explore the role of physiotherapists in promoting health and well-being. The paper concludes with recommendations for the future development of the field of physiotherapy.

References


Appendix Thirteen. Poster Presented at 7th International Interdisciplinary Conference: Advances in Qualitative Methods, Gold Coast, Australia, 2006.
Appendix Fourteen – Paper submitted to New Zealand Journal of Physiotherapy, 2005; 33(2), 55-60
Possible futures for physiotherapy: an exploration of the New Zealand context

David A Nicholls* and Peter Larnert

ABSTRACT
This paper discusses how physiotherapists might respond to the challenges of health care reform taking place in New Zealand. We begin by outlining the health policy initiatives that are challenging our understanding of physiotherapy practice. We then outline a socio-political history of physiotherapy, using the “body-as-machine” as a metaphor. We then present four possible responses to New Zealand health reforms: watching and waiting, enhancing the body-as-machine, rejecting the body-as-machine and integration. These are then analyzed for their various advantages and disadvantages. We conclude by appealing to physiotherapists to reflect upon the significance of New Zealand’s health care reforms and to begin considering their responses.


Key Words: Physiotherapy practice, health reform, history

INTRODUCTION
The culture of health care is changing. Professional roles that were once distinct are being challenged by health workforce planners looking to develop new models of rehabilitation. The pressure to reform stems from a recognition amongst Western governments of the growing financial burden of an aging population and predictions of the cost of providing health care in the future.

We are told that health services cannot function along traditional lines, that service providers will have to rationalise, streamline, and organise better; that inter-professional communication will need to improve, and professional boundaries will need to be reconsidered.

In 2003 New Zealand’s Health Workforce Advisory Committee (HWAC) stated that ‘simply doing more of the same is not an option’ (p.21)... A major culture change (or paradigm shift) is required (p.2), ‘Some totally new roles and ways of working will emerge’ (p.53) (Health Workforce Advisory Committee, 2003).

New Zealand’s unique cultural context is also providing a strong drive to change the way traditional health care ‘silo’s operate. In 2002/3 the Māori Health Strategy and Implementation Plan (Whakatātika) built on the concept of whānau ora to challenge the classical liberal approach to health care which focuses upon the individual as the point of contact for health services. Whānau, extended social grouping and population-based approaches to preventative health care were signalled as the way forward, with the inevitable restructuring of systems and structures of health care delivery (Cunningham and Darie, 2005).

The Ministry of Health in New Zealand is at the forefront of attempts to improve the flexibility of health professionals in meeting the needs of its key stakeholders. For example, amendments have been made to the Medicines Act 1999 to allow the extension of prescribing rights to nurses and other health professionals, and work has been done to develop a scope of practice for a registered nurse practitioner. Initiatives such as these are justified on the basis that they provide twofold merits in that they improve the delivery of services and enhance career opportunities for health professionals which, in turn, improves retention rates (Ministry of Health, 2001).

Physiotherapy has been a buoyant, independent health service provider for over 100 years and in this paper we briefly trace the origins of this independence. We also argue that if these changes to health services come about, physiotherapy will face the biggest challenge to its autonomy since its inception, and that some hard choices will have to be made about the future direction of the profession. We provide a model that is intended to encourage readers to contemplate possible futures for physiotherapy and suggest some of the possible benefits and limitations of each approach.

TENSIONS FACING CURRENT PHYSIOTHERAPY

Practice
A number of Western countries have recognised the growing strains on the public health system. The Modernisation Agency, established by the United Kingdom government to refashion the National Health Service, recently identified 6 major challenges to the health workforce of the future:

1. An increasingly aging population.
2. The increasing burden of chronic illness.
3. The emergence of information and communication technology supporting new forms of care delivery.
4. A shift in emphasis from services centred on the healthcare professional to patient-centred services.
5. Technological advances in healthcare that will promote changes in the demand for services.
6. Issues in relation to education, training, regulation, accreditation, pay and reward (Alexander et al., 2004).

The New Zealand health care environment mirrors much of the United Kingdom's system. Both governments are both sympathetic to a 'Third Way' philosophy which emphasizes individual responsibility with moderated state intervention for areas such as health, social welfare and education. Health care reforms in these two countries have pioneered consumer-oriented models of health care that emphasize purchaser-provider participation, local community action groups and reduced state intervention which in turn have fostered a culture of wellness, self-surveillance and increasing responsibility for one's own health (Galvin, 2002).

In some ways health care educators have been slow to adapt to these changes and while major changes have taken place in the financing and provision of health care, the location and content of many health education programmes have undergone comparatively less change (Health Workforce Advisory Committee, 2002). While there are clear messages being sent out from the New Zealand government that it would like to see greater co-operation between organizations involved in health workforce education and training; to ensure that a strategic approach is taken to health workforce supply, demand and development (Ministry of Health, 2001), it is also clear that there is a great deal of inertia among professional bodies, tertiary education providers and consumers.

Initially the government appeared happy to see stakeholders make changes voluntarily, but patience with the rate of change is evaporating. Some totally new roles and ways of working will emerge. But, in large part it should be possible to evolve the required changes by working with existing occupational structures and workforce arrangements. The extent to which the existing workforce and its supporting structures are willing and able to evolve and meet new challenges will determine how assertive legislative and other measures aimed at promoting change will need to be (Health Workforce Advisory Committee, 2003, p.5).

The Health and Disability Strategy asserts that health professionals must learn to work more effectively to meet the needs of their communities. This will be achieved through greater professional collaboration, a stronger emphasis on population-based medicine, a preference for integrated primary care as the mainstay of health care delivery and greater emphasis upon participatory health care that values the involvement of community organizations, action groups, informal carers, and a health care professional with a greater scope of practice than currently exists (Ministry of Disability Issues, 2001).

Liam Donaldson, Chief Medical Officer for England reinforced this climate of change when he stated recently that, 'The need for health services to give priority to developing health professionals equipped to practice in new ways and thrive in new organization environments requires a rapid response to reshape curricula and training programmes' (Alexander et al., 2004, p.7).

These changes have the potential to radically alter the nature and scope of physiotherapy practice. Physiotherapy is an autonomous, discrete health professional group that has strong ties to biomedical reasoning. Moves to defuse or even remove professional boundaries challenges the philosophical and epistemological basis of physiotherapy. In the next section we briefly trace the origins of that basis before debating some of the possible future directions for physiotherapy practice.

The Emergence of Physiotherapy as a Profession

The physiotherapy profession we see internationally today emerged largely as a response to massage scandals in late-Victorian England. The Victorians, concerned with the moral turpitude of the population, were alarmed by reports of masseurs and masseuses offering massage as a euphemism for prostitution, and resolved to establish a professional body that would take massage out of the brothels and give it legitimacy.

In 1894 the Society of Trained Masseuses (STM) formalised a training and registration programme stating, 'We will make massage a safe, clean and honourable profession, and it shall be a profession for women' (Grafton, 1934, p.229). The Founders of the STM were able to achieve legitimacy for a professional body by curtailing medical patronage, but they were also scrupulous in their attention to the moral fortitude of the masseuses. These steps were designed to ensure that when a masseuse put her hands upon a patient, there could be no confusion with any sexual encounter. Principles that the Founders put in place included:

- The formation of a professional body with widespread support from the almost exclusively male medical establishment.
- The exclusive registration of women (men could train, but could not register or work under the auspices of the STM).
- Establishing standardised training programs to inculcate high standards of practice in graduates including the examination of practical skills, theoretical knowledge and a particular (pudendo-Christian) moral code.
- Locating practice within hospitals under the direct referral of medical practitioners.
- Organising clinic spaces to mimic medical clinics - enforcing high standards of cleanliness and efficiency. Rooms would be plain, with little adornment and little to 'stimulate' the patient.

And possibly most significant for today's professional:

Adopting physical medicine's approach to the body that focused upon anatomy, kinesiology, biomechanics, physiology and pathology as the core principles of practice.

In effect, physiotherapists developed an approach to the body that emphasised its form and function but detached the 'person', as a sensual being, from the underlying pathology. A person became a condition. Physiotherapists defined people by their condition (stroke patients) and classified them by their pathology mimicking the detached neutrality of medicine. This enabled the masseuses to legitimise their practice and offer a safe, recognisable alternative to the illicit practices of unprofessional masseuses.

At the same time, the United States of America, New Zealand, Australia, Canada and other colonial countries were grappling with the same need to provide a legitimate health care training that was recognised politically and socially. As Ethel Mary Cartwright warned on collegiate masseuses in 1923: 

Unqualified masseuses practising in our midst are a positive danger and risk which all new professions encounter; both the medical and nursing professions have suffered in the past from this. Therefore qualified workers must strive by every means in their power to demonstrate to the medical world and the public alike the difference between the work and standards of those belonging to a registered professional fraternity and the unskilled rubber (Cartwright, 1924, p.5).

Physiotherapists had demonstrated their ability to offer a respectable, trusted approach to treatment that met with approval from government, the medical establishment and the public – culminating in 1949 with the Physiotherapy Act which entrenched the right of physiotherapists to be the only legitimate practitioner of massage.

Within the public health system, physiotherapists competed with other professionals for the approval of medicine. Doctors considered physiotherapists to be more independent than nurses; they couldn't be bullied as much' (Cleather, 1995, p.10). But in many ways physiotherapy was different from many of the health disciplines evolving in the first half of the twentieth century: unlike medicine, nursing, psychology and dentistry for instance, physiotherapy never really adopted a population-based approach to health care. Physiotherapy programs never involved mass screening and treatment programmes like those for consumption, influenza, dental caries, vaccination, neuroses and hysteria (Armstrong, 1995; Nettleton, 1997).

Physiotherapists focused upon individual form and function. Stanton Rogers suggests that this attention to the biomechanical basis of health might be represented by the metaphor of the 'body-as-machine' (Stanton Rogers, 1991).

This legacy still persists in physiotherapy training. One only has to look at the emphasis placed on anatomy, kinesiology, biomechanics, physiology and pathology within physiotherapy curricula to see this. However a challenge to the traditional training has resulted with the move from the technical institutes to the universities (Mercer and Jones, 2002). Education based upon research may ensure that previously accepted norms are questioned.

In the latter half of the twentieth century we have seen a superficial shift in the physical, political and social 'space' occupied by physiotherapy. We have moved from care performed through technical rationalism (Schon, 1987) – under direct referral from medical practitioners, to research- and evidence-based practitioners working independently of medical referral. It is however a superficial shift, because it is clear that the body-as-machine still dominates much of the rhetoric of physiotherapy practice.

For these reasons, the future direction of the New Zealand government's health strategy poses some significant challenges for physiotherapy practitioners.

Possible futures for Physiotherapy

This paper suggests that the physiotherapy profession is at a critical juncture in its development. Several possible futures are open to physiotherapy; each presents its own potential benefits and concerns. We have attempted here to summarise them into four distinct domains:

1. Watching and waiting
2. Enhancing the body-as-machine
3. Rejecting the body-as-machine
4. Integration

Each of the domains is explored in Table 1. For each domain we have presented the rationale, possible advantages and disadvantages. What is clear from the table is that no one domain offers the best possible future for physiotherapy and all three models of change rely on some rejection of previous or possible future opportunities.

Many health and education reforms have come and gone and left a legacy of distrust amongst staff who would, broadly speaking, prefer to distance themselves from political decision making – historically speaking, physiotherapists are not politically motivated, but it would seem that the arguments we are hearing now are no fading. There appears to be a concerted attempt to reform health care, buoyed by an economic imperative to drive down the cost of health care services and increase efficiency. Maybe it is time for physiotherapists to give greater thought to their future within the new health care. As the HWAC report prompts:

Much can be done, and will need to be done, within existing resources but we should be thinking and planning now as to where and how new resources for health workforce development should be invested, should the opportunity arise. (Health Workforce Advisory Committee, 2003, p.7).
Table 1: Possible models for physiotherapy development

<table>
<thead>
<tr>
<th>Model</th>
<th>Rationale</th>
<th>Possible advantages</th>
<th>Possible disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Watching and waiting</td>
<td>No dramatic changes would be made to the direction, philosophy or strategies employed by physiotherapists. Political changes would be monitored for their potential impact upon the profession and significant change would be limited to material content and specifics of education and practice, without the major philosophical changes advocated by some new health policy rationalities. Changes would be permissible as long as they correlated with the philosophical tenets of the profession, namely the ‘body-as-machine’.</td>
<td>Watching and waiting would give the profession time to accommodate to changes in health care and decide its best course of action. This would allow for a period of critical reflection upon the influences of health care policy, both nationally and internationally. Physiotherapists have been reluctant to explore the philosophical basis of their practice – possibly because they have felt secure in their identity, and this would not be challenged by this option.</td>
<td>Cycles of change are slow (most notably in education) and change may happen without us. Legislative change may force us to be reactive, rather than proactive. Conversely, it could see the profession stagnate, appear intransigent or reactionary. We could become isolated and weakened by our lack of responsiveness and we could find others encroaching more and more on territory that we could rightfully claim as our own. We could easily be portrayed as having an ‘old-world’ view of health.</td>
</tr>
<tr>
<td>2 Enhancing the body-as-machine</td>
<td>This option would see a strengthening of the biomechanical base that established physiotherapy as a distinctive and highly regarded profession in the health sector. It would involve an outright rejection of one of the more flexible health policy initiatives in favour of a strengthening of the core physiotherapy values of ‘body-as-machine’. It would value the historical relevance of a profession that has remained relatively true to its founding beliefs in the face of major social and political change. It would argue that the profession will outage current health care policy predictions and offer an authentic model of professional practice built on over a century of health care experience.</td>
<td>It reinforces physiotherapy’s strong profile. Physiotherapists remain a visible presence and offer patients a service with distinct parameters. It builds on a health care philosophy that is well established. It reinforces a highly marketable, authoritative practice philosophy and it relies on a longer history than the current political opinion. It would be easy for physiotherapists to identify, market and position themselves in future health care services, and it would provide a clear message that health care practices need not be at the mercy of contemporary political rhetoric.</td>
<td>As a model of health the ‘body-as-machine’ is universally criticized for its ability to depersonalise health care. Physiotherapy has become diverse and is struggling to maintain coherent connections with its heritage; many colleagues may see a move back to body-as-machine as regressive. It may also be seen as conservative and intransigent in the face of strong evidence that the health care marketplace has changed. If contemporary political opinion becomes established, we will have been left behind or displaced by other health disciplines aggressively marketing for areas we have relinquished.</td>
</tr>
<tr>
<td>3 Rejecting the body-as-machine</td>
<td>Here physiotherapists acknowledge that the health care environment requires a new approach. The traditional technical rationalism of physiotherapy would be rejected, possibly for a new “holistic” approach, or one directly in line with prevailing health policy. Physiotherapists adopt a more flexible ‘generalist’s’ approach to rehabilitation and illness prevention. This acknowledges that the health care environment demands a new approach from physiotherapists. This would represent a renaissance for the profession – involving the adoption of practice philosophies entirely new to physiotherapy.</td>
<td>Things physiotherapy into line with other professions looking to develop population-based models of health and disability. It has the advantage of positioning physiotherapy as a responsive, proactive professional group able to respond to the new legislative and market environment. Physiotherapists would be confident in their ability to contribute effectively, and in many cases lead, rehabilitation services. It would open physiotherapy to new possibilities – social, political, cultural, environmental, psychological dimensions of health and illness that have been a problem for the body-as-machine to focus on. It would be more inclusive to the diversity of modern physiotherapy practice.</td>
<td>Physiotherapy would effectively lose its unique identity and becomes one of a number of generic health workers. It might hypothetically result in the disappearance of physiotherapy as a discrete profession. Physiotherapists would need to adopt philosophies previously alien to them. Inter-professional rivalry might be exacerbated due to the further blurring of boundaries between professions. It would also force us to separate the new profession from its discrete heritage. In effect, we would migrate to new territory. Physiotherapy might be seen as increasingly weak, in not resisting the current political fashion.</td>
</tr>
</tbody>
</table>
We have the luxury of taking time to consider our options. Physiotherapy education is buoyant—even though there has been a massive expansion in the options open to undergraduates, the increasing numbers of people entering higher education have buffered this effect. Physiotherapists remain a well respected health profession, and calls to reform are coming from a small sector of health care managers, policy analysts and political theorists. But they are also coming from government and non-governmental agencies, patients and their support groups and from within the profession itself and this may present the most significant incentive for reflection.

CONCLUSIONS

In this paper we have outlined some of the pressures to reform physiotherapy practice as Western health care systems become aware of the future economic burden of an increasingly diverse population.

We base our argument on an socio-political sketch of the emergence of physiotherapy at the end of the nineteenth century and in doing so highlight how the notion of body-as-machine has relevance for our practice philosophies today.

In considering the pressures on contemporary physiotherapy practice we have developed a number of possibilities for the future of the profession. These are by no means exclusive, but are employed to facilitate debate amongst physiotherapists.

Change happens slowly in health care, and even slower in education. So while we feel no real pressure to reform at the moment, it would be wise to have look-outs. Physiotherapy is a first class profession with a strong heritage and a distinctive 'brand identity', but it may not retain this status if it fails to address the challenges of health care reform of the future.

Key Points

- The New Zealand health care system will have to cater for an increasingly disabled, elderly population in the future.
- Health care reformers are looking to new models of therapy that emphasize interdisciplinary working and rationalized services.
- Physiotherapists have an established history as a specialist in the field of biomechanical therapies.
- Traditional models of physiotherapy are significantly challenged by these proposed reforms.
- Four ways for physiotherapists to respond to these reforms are proposed.

REFERENCES

273


CORRESPONDENCE ADDRESS

a David A Nicholls MA Grad Dip Phys, Senior Lecturer, School of Physiotherapy, Auckland University of Technology, Private Bag 92026, Auckland, New Zealand, Email: david.nicholls@aut.ac.nz. Tel: 09 949 7999 x7046, Fax: 09 949 9620.

ADDITIONAL ADDRESS

b Peter Larmee MPH, PhD Phys, Dip HF, Senior Lecturer, School of Physiotherapy, Auckland University of Technology, Private Bag 92026, Auckland, New Zealand, p.larmee@aut.ac.nz. Tel: 09 949 7999 x7322, Fax: 09 949 9620.

You’ll see it all when you work with us.

If you’d like to broaden your horizons and experience the adventure of a lifetime – while building on your professional skills and gaining invaluable experience of different working practices – you should be talking to us. Located just 50 miles away from London, we’re seeking physiotherapists to join us in a number of areas, including back and knee, women’s health, paediatrics, rheumatology and others.

As we’re so close to the capital, you’ll have easy access to the nightlife, tourist sites and cultural locations during your free time. And if you’re keen to explore the Continent for a weekend or longer, the Channel Tunnel and Kent International Airport are also nearby. Our flexible employment contracts give you the chance to take time out and go travelling, getting experience of new cultures and seeing the world.

We believe in making the application process as convenient as possible for you – we even have video-conferencing facilities, so you don’t have to leave home to find out if we’re right for you.

To find out more visit www.eastkentjobs.co.uk

60
