The three-way health partnership between the Accident Compensation Corporation (ACC), the musculoskeletal physiotherapist and the client analysed through critical theory and postmodern lenses

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ABSTRACT

The purpose of this paper is to employ critical theory and postmodern world views to investigate and critique aspects of physiotherapy practice. The paper initially focuses on the power balance within the three-way health partnership between the Accident Compensation Corporation (ACC), the musculoskeletal physiotherapist and the client. Next, it addresses the concepts of knowledge and truth within practice and identifies the epistemological hierarchy that exists between discourses. The paper finds that stakeholders in health care are stratified in a hierarchical system dominated by an established order. However, although tiered, all stakeholders are co-dependently linked and rely on one another to achieve health-related goals. Furthermore, as well as oppressing, power is used positively to educate members of society regarding good health practices. Currently, medical models are driven by a scientific epistemology, crowning evidence-based practice (EBP) as the gold standard approach to healthcare. But, conversely, physiotherapy's large subjective component cannot be overlooked. Ultimately, physiotherapists need to recognize the dominance of EBP and learn to shape knowledge from a wide variety of sources above and beyond statistically significant health science.

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INTRODUCTION

As a physiotherapist, my job is to help rehabilitate the physical problems that my clients present with. However, treating physical problems requires a lot more than a physical approach (Foster and Sayers 2012, Lindquist et al 2006). To succeed in this endeavour, I must enter into a three-way health partnership with the client, and with the Accident Compensation Corporation (ACC), the funding body that 'provides comprehensive, no-fault personal injury cover for all New Zealand residents and visitors to New Zealand' (ACC 2012) and, thus, subsidizes injury-related physiotherapy services. Each partner brings to the health partnership unique offerings and plays a significant role in aiming to achieve a high standard of client-centered care.

As well as providing therapy, as a physiotherapist, I must act as a spokesperson and present to ACC on behalf of the client. This occurs whenever any ambiguity exists surrounding the client's initial injury claim or when, as often happens, a client needs further treatment above and beyond what has already been allocated. As treatment progresses and the partnership evolves, all three members adopt a role and engage in a complex political, economic and cultural production involving power-plays, dominance, morality and truth.

In a Utopian world, this partnership would be efficient, fair and just. Each member would behave accordingly and all would come from the interaction feeling well-treated, valued and respected. However, thanks to a catalogue of societal structures, inter-subjective factors and the unpredictability of human nature, this is not always the case. If corrective steps are to be taken here, these phenomena need to be analyzed and addressed.

Critical theory is a social theory that aims to understand critique and change society by liberating those who are enslaved by social circumstances through the hegemonic operation of power (Stanford Encyclopedia of Philosophy 2008). Thus, in an attempt to develop theoretical explanations regarding this three-way health partnership, I shall examine the actions and societal roles of ACC, the physiotherapist (me) and the client through a critical lens.

Next, I will explore the groundings of the resources that help guide my physiotherapeutic practice. In doing so I will investigate the concept of different world views as 'narratives' and how their hierarchical arrangements dictate what is accepted as 'knowledge' and 'truth'. My intention here will be to support the postmodern viewpoint that any one perspective of the world can only ever be a fragmented part of a larger reality (Loughlin 2008). I will also demonstrate how subjectivity and opinion manifest themselves in health science objectivity; questioning validity claims and current gold standards.

Critical Theory

Critical theory provides both descriptive and normative platforms for social inquiry, with the intent of decreasing domination and increasing freedom across society (Stanford Encyclopedia of Philosophy 2008). According to Duchscher and Myrick (2008), proponents of critical theory argue that an awareness of oppressive social structures is inseparable from the pursuit of emancipatory social action. Therefore, if physiotherapy as a field of practice aspires to contribute to greater social equality, its stakeholders must view it through this philosophical lens; thus analysing how care is delivered and how vested interests and power balances within the system affect the ultimate outcomes.

When the client presents for physiotherapy the aforementioned partnership begins. From the outset, with a variance in ways of acting (habitus), all the stake-holders mentioned above enter into a social space or health field where, according to Bourdieu (1998) they are distributed according to economic and cultural principles of differentiation. As the governing body, it is easy to assume that ACC dominates this field. However, the inter-relationships and co-dependencies between the aforementioned parties are complex.

With no physiotherapeutic knowledge and in need of help, the client is instantly dependent on the physiotherapist. But instead of liberating the client from the oppressive structures that characterize, normalize and perpetuate unequal relationships (Duchscher and Myrick 2008), it could be argued that I, as the physiotherapist, augment domination through concrete cultural forms, such as technical language, that, as Giroux (1985) states actively silence people.

There are obvious financial interests for me as the physiotherapist regarding my relationship with the client but Foster and Sawyers (2012) uncover the caring and emotional aspects that also drive the bond. These complex and contradictory emotions that are integral to physiotherapy (Foster and Sawyers 2012) demonstrate some of the positive aspects of power. Foucault (1980) discusses how, in this type of situation, through education, power productively traverses to produce knowledge and discourse.

However, as education is often a representation of the dominant culture (Giroux 1985), it could be argued that the physiotherapist is abstracting from complex and problematic social structures. This, Waitzkin (1989) states, reduces the effective critique of such structures; the nullification of the patient's social complaints. For instance, relieving back pain someone has acquired from continuous lifting in a poorly paid manual job remedies the painful symptoms, but not the labour-related cause.

As the physiotherapist, I also act as a bridge between the client and ACC. Bourdieu (1998) has labelled agents in this immediate location, between polar extremes as the 'petit-Bourgeoise'. ACC, as the funding body provide structure. But, although potentially productive, imposed structures often limit progress through prescribed behaviours (Duchscher and Myrick 2008). The funding regimes that enforce structure also act as a source of tension and detract from the physiotherapist's primary focus; i.e. serving the client (Foster and Sawyers 2012).

Part of ACC's structure includes administration, a process I undertake on behalf of the client. However, the client, without the correct technical vocabulary, according to Barry (2002), remains isolated in this interaction and relies fully on my communicative action and validity claims. Here I am in a powerful position, as an influential person, able to use persuasive mechanisms in reaching an understanding at a higher level (Habermas 1989). Such practices, in turn, create what Foucault (1980) calls a 'medico-administrative knowledge' which further disempowers the client and can be viewed as a hegemonic practice.

A greater understanding of the power balance between ACC and myself, as a physiotherapist, can be gained by returning to Bourdieu's (1998) concepts of habitus (social structure) and field (a social arena). Habitus, described by Bourdieu (1998), includes principles of vision and a unity of style and practices. There is, therefore, an overlapping between the parties. Both ultimately want to rehabilitate injuries acquired through accidental damage and maintain a healthy population.

But, as a physiotherapist, the methodologies and processes I use to achieve the uniting vision often vary dramatically from ACC's praxis. Without emotional ties to the client, ACC are more likely to be concerned with the financial implications of ongoing treatment, be ideologically driven by the notion that a healthy person produces economically (Waitzkin 1989) and focus on the immediate physicality of a problem. In contrast, as discovered by Foster and Sawyers (2012), emotional connections often draw the physiotherapist to continue with the client, even after the physical treatment goals have been achieved.

The possession of capital is another area of conflict. Using Bourdieu's model of field, Mooney et al (2008) identify the different types of capital owned by the physiotherapist and other agents – in this case ACC – and how these weighted possessions give rise to tension. With the ability to grant or deny treatment, ACC are the established order and have what Bourdieu (1998) terms economic capital. Conversely, as the physiotherapist, with clinical knowledge, I am viewed as a healthcare authority and thus possess cultural capital.

This creates a strange symbiosis, where both need one another to help rehabilitate the client. But differing praxis and capital values (cost efficiency for ACC and holistic care for the physiotherapist) can damage the relationship. Then there is the client, bereft of both cultural and economic capital in this context and, thus, dependent on the physiotherapist. According to Mooney et al (2008), this separation or 'distinction' between ACC and the client further perpetuates levels of tension.

Initially the client can apply to ACC for treatment by filling in a treatment request form (ACC45). This requires no technical knowledge or healthcare acumen, but only grants the client with a limited number of consultations. If the client's problems have not resolved within the 'trigger' number, I must apply for a treatment extension by filling in a request for further treatment form (ACC32). In this instance the client relies on my ability as a speaker to influence the addressee (ACC). Habermas (1989) suggests this is done by persuasive power manifested in 'communicative achievement of consensus' and an acceptance that rationality and knowledge are linked (Habermas 1984).

Ultimately the client must assume the role of actor here, forsake lifeworld contexts and adopt formally organized domains of action (Habermas 1989). With ideological power deemed greater than material power (Barry 2002), the onus is then on me, as the physiotherapist to express cultural capital by requesting further treatment. As well as earning further care for the client, the form can also be viewed as a critical tool that interrogates power and challenges the dominant definitions of knowledge (Giroux 1985). From here though, in judging the legitimacy and validity of further treatment claims, a key question is, how do ACC rule on what constitutes a truth?

POSTMODERNISM

Postmodernism recognises that knowledge is constituted by power and its interests (Fox 1991). It also recognises the competition between discourses; the epistemological

frameworks wherein specific cultural attitudes are expressed and practised (Dybicz 2011). In medical and healthcare realms, (Loughlin 2008) highlights that a hierarchy of discourses exists dominated by scientific evidence, in the form of randomised controlled trials (RCT). But the personal and subjective nature of healthcare and, in particular, physiotherapy demands a critique of this dominance.

When assessing human behaviour, (Goding and Edwards 2002) pertinently point out that a scientific, positivist criterion of validity and generalisability is wholly inadequate; failing to factor in societal complexities and a chaotic lifeworld. What is more, when decision-making, as a physiotherapist, I must take into account many non-scientific factors such as patient goals, contexts and perspectives, views of colleagues and different forms of published research; the subjective variables that impact on the merits of evidence (Loughlin 2008).

Ultimately, though, I have to make a diagnosis for the benefit of everyone involved; the client so they can develop coping strategies and learn about the problem, and ACC so they can assess the claim, provide funding and collect statistics. When applying to ACC on behalf of the patient for ongoing treatment, I must provide evidence to 'validate ongoing treatment'. But what exactly constitutes evidence and can evidence ever be labeled as the truth?

In expressing assessment findings, I provide an interpretation of a condition. But according to (Habermas 1984) an interpreter understands only certain assertions, values and norms and, therefore, constructs a personal understanding of a context. With the feeding of intellectual, moral and aesthetic judgments into explanatory structures (Fox 1991), it could also be argued that a subjective component to any diagnosis I produce is unavoidable. Furthermore, considering medical or scientific knowledge announces itself in the form of a narrative (Lyotard 1994), it is easy to see how bias in the form of my subjectivity can infiltrate theoretical structures. Even the most stringent empiricists and evidence-based practitioners would, thus, struggle to deny that all professional judgments lack complete objectivity and are merely educated 'opinions' (Loughlin 2008).

Accepting the errors of modernity and recognising the mistakes of deriving ideal objectivity from a decentred world (Habermas 1984), encourage me to follow discourse dialectic and ask philosophical questions. Regarding practice, is it possible to combine high quality scientific evidence with inter-subjectivity and personal beliefs when planning rehabilitation programmes?

Although the gold standard status of evidence-based practice (EBP) devalues other epistemic currencies (Loughlin 2008), the findings of well conducted treatment studies arm me with treatment options and are still integral to physiotherapy. As demonstrated above, scientists and the conductors of research may be no more logical or objective than others, but Rorty (1999) commends, with praise, the institutions they have developed and proposes them as 'models for the rest of culture'.

But, alongside this scientific knowledge bank and EBP, there stands my physiotherapeutic intuition. I have to understand that the client can only refer to a personal, subjective world, thus, I must accept a lifeworld bounded by the totality of interpretation (Habermas 1984). Considering this human complexity in an ever-changing environment, I may only be able to view quantitative research as statistically significant but clinically superficial (Goding and Edwards 2002) and in need of support from health professional interactions, interpersonal skills and intuitive judgments.

In considering these points, it would seem that, as a physiotherapist, I can happily unite medical science and narrative discourse to successfully practise. But there still remains a theoretical incommensurability (Okasha 2002) and (Lyotard's 1994) claim that the validity of narrative knowledge cannot be judged on the basis of scientific knowledge and vice versa. To me, this seems the ultimate parody considering science relies on narratology to make known its findings, and philosophy to question the assumptions that scientists take for granted (Okasha 2002).

Placed between the client and ACC, I am faced with a political dilemma. Incorporate all the elements of the client's story to biopsychosocially diagnose what I believe to be the client's problem and risk not meeting ACC injury criteria; or pigeon-hole a condition to fit ACC's limited diagnostic tags and risk limiting my scope of practice. In this dilemma, I have to accept that even though a physiotherapist attempts to break down psychological and physical barriers (Foster and Sayers 2012), I may lack the education, understanding and the experience to do so. Conversely, it can only be assumed that ACC play down the uncomfortable supposition that neatly fitting, whole stories suppress information to sustain an appearance of unity (Fox 1991). Ultimately, it is important that both parties recognise that serious flaws are made in practice when objectivity and rationality are considered to be antithetical alternatives to thinking that is subjective and personal (Loughlin 2008).

In granting treatment, ACC consider my diagnostic claims and evaluate the professional and theoretical knowledge within. To do this, the organisation uses guidelines, but (Loughlin 2008) exposes the embarrassing fact that such guidelines are increasingly produced by those removed from the work contexts they regulate. None the less, to control budgets, care has to be standardised and ACC will make decisions based on my clinical 'rationality'. As (Habermas 1989) points to, knowledge is embodied in normatively regulated action, thus a physiotherapist will be considered rational by producing a strong argument with reference to existing normative contexts.

Although subject-laden, by using professional technology and strategies, the physiotherapist produces what (Habermas 1989) terms objectivicated knowledge. Again, we return to the fact that expression or, in this case, writing as a method of 'knowing' nurtures a researcher's voice and allows the unknown into healthcare (Corroto 2011).

CONCLUSION

My aim, in this paper, has been to gain a better understanding of, and critique the three-way health partnership between ACC, the musculoskeletal physiotherapist and the client. To achieve this goal I have used critical theorist models and a postmodernist questioning of truth. In the process I have shown that stakeholders and groups in health care are stratified; tiered in a hierarchical system that is dominated by a power-yielding, established order and regulated according to the ownership of capital, whether it be political, economic or cultural.

A critical approach has also helped me demonstrate that power, as well as constraining and oppressing, can be used

positively to educate members of society regarding their health. Furthermore, even though healthcare is manipulated by dominant powers, all stake-holders are all co-dependently linked and rely on the others to achieve health related goals.

The current medical model, implicit by the use of simple physical diagnoses, continues to be driven by a scientific epistemology. However, while physiotherapy demands an evidence-based underpinning, the profession must not devalue subjectivity, intuition and qualitative research as sources of knowledge for the clinician. With the help of a postmodern approach, I have also shown that medical science requires subjective actions such as interpretation and reporting to make known its findings.

It can be said that incommensurability exists between scientific and normative discourses (Okasha 2002). However, for physiotherapists, it is of paramount importance that they learn, from postmodernism, the importance of shaping knowledge from a wide variety of sound sources and not solely relying on statistically significant health science.

In understanding, critiquing and improving physiotherapy, critical theory and postmodernism analytically stand shoulder to shoulder. They both commonly believe that sociological analysis is required to grapple with the value laden character of knowledge (Fox 1991, Lyotard 1994). Sadly though, in writing this essay, I have discovered that physiotherapy has so far under-utilized critical theory and postmodernism as tools for critique and improvement of the profession.

Ultimately, for physiotherapy to recognize its full potential, it must learn to embrace the subjective variables that impact on client management while still recognizing the strength of randomised controlled trials and quantitative research. To recognize my full potential as a physiotherapist, I must not take the structure of the health system I practice within for granted. I must learn to critique the practices that disempower and isolate people and question the sources and value of knowledge and truth.

KEYPOINTS

- Stakeholders in healthcare are stratified in a hierarchical system which is dominated by a powerful established order.
- All stakeholders possess capital (economic, political and cultural) and are, therefore, co-dependently linked in achieving health-related goals.
- Medical models are driven by a scientific epistemology that is statistically significant but often fails to account for the inter-subjective, chaotic nature of life.
- Physiotherapists need to recognize the subjective component of their practice and learn to combine professional intuition and other knowledge sources along with scientific evidence to practise successfully.

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