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**A GOOD PHYSICAL THERAPIST WOULD COPE: GENDER AND
CLASS CONTROL IN A WOMEN'S PROFESSION**

by

Carole Miles-Tapping, B.Sc.R., M.A.

A dissertation submitted to the Faculty of
Graduate Studies in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

Department of Sociology and Anthropology

Carleton University

Ottawa, Ontario

July 1, 1987

1987 Carole Miles-Tapping

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ISBN 0-315-39354-8

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GENDER AND CLASS CONTROL IN A WOMEN'S PROFESSION

submitted by

Carole Miles-Tapping, B.Sc., M.A.

in partial fulfillment of the requirements for
the degree of Doctor of Philosophy

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ABSTRACT

The dissertation is a sociological case study of the labor process in an employed women's profession. Archival and published data supplied the background and historical information, but most of the data were collected by participant observation in facilities where many physical therapists are employed. Analysis of how class and gender control are structured, experienced, and expressed shows that control of the labor process in women's professional work is achieved by a combination of formal and informal techniques. Formal control of physical therapists' work is achieved by a system of recording and talking about interaction with patients that emphasizes concrete physical techniques and ignores the negotiated social interaction. Informal control of therapists is achieved by "helping each other," by "organizing and setting priorities," and by the expectation that "a good therapist would cope" with whatever is required. Ideas of service and subservience related to the gender and class origins of the profession underly the informal control system and support the acceptance of the formal techniques.

ACKNOWLEDGEMENTS

I would like to acknowledge the contribution to this work made by my supervising committee, Bruce McFarlane, Wallace Clement, and John Cove. David Coburn, Victor Marshall, Merrijoy Kelner, Marie Campbell, and Karen Yoshida contributed in various ways, at various times, to the final product. Alison Griffith and Roger Redwin were there from field work to final draft, providing practical advice, social support, and, from Alison, a determined sociological perspective. The staff at the Canadian Physiotherapy Association, the Ontario Physiotherapy Association, and the Board of Directors of Physiotherapy in Ontario shared statistical information with me. I would also like to thank all the faculty, students and staff in the Department of Rehabilitation Medicine at the University of Toronto, and particularly the physical therapy staff and patients at the two hospitals and one clinic where observational field work was conducted. I would like to acknowledge them personally, particularly some who have provided ongoing support to this project and whom I now consider friends, but to name them would violate the conventions of confidentiality.

This research was supported in part by the National Health Research and Development Program through a National Health Fellowship to Carole Miles-Tapping.

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A GOOD PHYSICAL THERAPIST WOULD COPE: GENDER AND CLASS CONTROL IN A WOMEN'S PROFESSION

Preface

This is a study about the labor process in an employed women's profession. It is a study partly from the inside, because I had worked many years as a physical therapist before the research began. It is also a study from the outside, because sociological knowledge was added to the stock of physical therapy knowledge to discover and make sense of what was happening to physical therapy work. The study can be regarded as an attempt to understand what it means to be a professional in a women's caring occupation. On a more practical level, the question asked is "what makes physical therapists work so hard?"

This preface explains the point of view taken by the research, and traces the changes that took place to arrive at the current perspective. As such, it is an account of seemingly unrelated events. Any coherence they appear to have in this account was achieved retrospectively, through reflection, struggle, and sociological analysis.

In 1980, before beginning graduate studies in sociology, I worked on the Physiotherapy Quality of Care Project. This

project, funded by Health and Welfare Canada and supported by the Canadian Physiotherapy Association, was to develop a nation-wide quality of care assurance system for physical therapy. It was my last full-time job as an ordinary physical therapist, and it raised the questions that eventually formed the basis of this research.

The Physiotherapy Quality of Care Committee, composed of prominent physical therapists, advised by a sociologist from Health and Welfare Canada, decided physical therapists needed to measure the health status of patients receiving treatment. A health status rating form, they said, would enable them to measure and compare outcomes from physical therapists and physical therapy facilities. The committee engaged a consultant in design, measurement and evaluation, and a researcher to develop a measurement form. I was a physical therapy manager temporarily between jobs. I became the researcher.

The consultant helped draft and pre-test a rating form which assessed movement, self care, basic communicative ability and social interaction in patients. Several physical therapy departments offered to field test the form. Only the consultant and I were paid. Staff physical therapists pre-tested the form and met several times to improve inter-rater reliability. They used the newly developed form to assess every patient they treated, both when they started and when

they finished treatment. For therapists who had rapid turnover in their caseloads this meant filling in ten or more forms a day. The physical therapy department's assistant directors collected and completed the forms. Between September and December 1980, admission and discharge forms were completed on 396 patients, 70% of the entire caseload of the department. If anyone complained about the extra work, they were quickly hushed by their peers and supervisors who told them it was for the good of the profession.

These physical therapists spent hours, many of them unpaid overtime, developing a form for an outside group. The consultant was surprised; he was used to paying people five to ten dollars to complete one questionnaire. I wasn't surprised. It was "for the good of the profession." Without question, I thought that anything that was good for the profession was good for patients. We had become physical therapists to help people, and this was part of our work, even if it meant working hours of overtime without pay.

During the field trials of the Health Status Rating Form, another problem became apparent. We were trying to fit patients, with all their human variability, into categories which could be counted, measured, and compared. No matter how we rearranged the boundaries of the categories in the attempt to make them comprehensive but mutually exclusive,

some patients did not fit. Frustrated therapists wrote comments in the margins of the form, explaining why the categories did not apply! The information in the comments was at least as useful and necessary as the information from the questions was to understand the health status of the patient. Realizing that physical therapy always deals with human dimensions, I began to search for a research method that could deal with them, both for physical therapists and patients. This led to sociology and especially to interpretive methodology.

When the Physiotherapy Quality of Care Project was complete, my physical therapy colleagues continued their search for objective ways to make comparisons among therapists and therapy programs, and I continued to wonder about what it means to be a professional, what makes physical therapists work as hard as they do. Sociology courses provided ample access to both quantitative and exploratory research methods, and to substantive and theoretical knowledge in fields which had been unknown to me as a physical therapist. Marxist theory was confronted as a whole new way to look at the world. At first, it seemed to offer all the answers to my questions. Marxist theory, especially its analysis of the labor process, deskilling, intensification of labour and the like, seemed to offer an explanation for the sense of stress, overwork and frustration

physical therapists so often experience.

For the first time, it began to seem as if feeling overworked was not only normal, as it is for most physical therapists most of the time, but explainable in terms other than individual laziness or inadequacy. I had learned, early in my physical therapy training if not before, that "a good physical therapist can cope with whatever comes along" and "if I were better organized I could finish this work within the working day." Like other physical therapists, I had been thinking that if the work load seemed to be growing it was because we were personally inefficient. Sociology, and particularly Marxist studies of the labor process, suggested that there were other reasons. Looking for social, rather than personal or physical explanations we might find, not just that in some objective sense we were overworked, but that there were more satisfactory explanations for this than blaming ourselves or our immediate supervisors. We could look to the social structure and the labor process for explanations.

This shift in perspective provided a new way to look at the Health Status Rating Form trial, among many other things. It raised a new set of questions. At the most concrete level, the question became "why do physical therapists work so hard?" More abstractly, it became, "what does it mean to be a physical therapist?" As the research progressed, it

became clear that the questions could be generalized to "what makes women professionals work so hard?" and "what does it mean to be a woman professional in our society?"

During the development of the Health Status Rating Form, staff and supervising therapists had worked long hours without pay to develop and test a measurement instrument that had no immediate practical application. Furthermore, it had the potential to measure and control their practice, limiting their professional freedom. Yet these therapists willingly, even eagerly, participated in its development. Why?

The rating form trials were not an isolated example. They typified a physical therapy attitude. Physical therapy treatments are expected to improve human functional ability, that is ability to look after oneself, to earn a living, and to have a normal family life. Physical therapists are educated and professionally socialized into a culture which values accurate measurement, and expects proof in facts and figures. Physical therapists continually try to measure human functional ability, despite the evidence that it is infinitely variable and always depends on the circumstances. Working hard for the good of the profession is part of the occupational culture of physical therapy. Professionalism, according to the vulgar Marxism I learned first, was simply a false ideology. That explanation, however, was far from

satisfactory. Sociologists look at the world from different perspectives. Still a qualified physical therapist, and occasionally returning to work as one, I found myself asking questions differently in the light of my new knowledge.

The knowledge from sociology, however, could not be applied like a formula. It did not fit my experience or the knowledge of my physical therapy colleagues. Braverman (1974), Edwards (1979), Burawoy (1979), Clement (1981) and other authorities who wrote about deskilling of the workers, bureaucratic control, and shop floor pressure to increase production were convincing, and seemed to be partly applicable, but their findings did not fit physical therapy. They did not explain why the idea of profession seemed so important, why therapists attribute a sense of overwork to personal inefficiency, and why physical therapists gossip about their superiors and about some doctors instead of openly defying them. Labor process studies did not provide any explanation for the ambivalent relationship between physical therapists and doctors. It was necessary to select eclectically from sociology literature, to evaluate what was learned in terms of what I already knew about physical therapy work, and to combine theoretical knowledge with an exploratory research approach. Instead of asking "how can we prove that . . ." we needed to ask "what is going on here?"

Research seldom follows a straight path from problem

through methods to conclusions; this was no exception. As the papers included in a recent collection about doing social research (Bell and Roberts 1984) amply show, the interactions among problem, method, and personal circumstances are variable. Apparently, however, few now dispute that personal circumstances and characteristics of the researcher shape the research question, the research methodology, and the results. The theoretical stances taken by this research report are feminist, Marxist, and phenomenological. They were not chosen at the outset of the research; rather they developed by struggle with various academic, occupational and personal influences and ideas throughout the research process.

The research was done from the position of physical therapist-becoming-sociologist. This dual perspective was at the same time helpful and uncomfortable. It facilitated access to data but denied access to other data. Developing rapport with physical therapists was easy, but it sometimes led to confidences which could not be used because the information might embarrass or upset the people studied, might be used for purposes not intended by the researcher, or might place the credibility and even the jobs of some of the researched in jeopardy. The observations vacillated between a physical therapy and a sociological perspective. Overall, however, during the research the viewpoint shifted from the stance of "distanced sociological observer" to "involved

physical therapy participant and analyst." While at first the direction might seem surprising, the shift reflects increasing understanding of and comfort with the research process and the problem of investigating human questions.

The physical therapist - becoming - sociologist is beset with struggle over what counts as data, what observations are valid, and how research should be done. Research to develop a body of knowledge that is the art and science of physical therapy is an important professional goal. The idea of doing research is attractive in the physical therapy community. Until now, however, physical therapy research has been almost entirely in a natural sciences framework, with physical therapists - becoming - engineers, kinesiologists, and physiologists applying their disciplines to problems of practice in physical therapy. Consequently, to physical therapy academics and leaders of the profession, the "science" of physical therapy, narrowly defined as that part which is measurable and replicable, has assumed far more importance than the art. Even the psychologists, epidemiologists, and educators who have contributed to the physical therapy literature have employed positivist approaches, which has the effect of making social factors appear "scientific." These investigators have documented trends, but have not captured or explained most of what physical therapists know.

Social science methods, particularly interpretive and phenomenological approaches, are unfamiliar and tend to be dismissed as "unscientific" or "mere opinion" by physical therapy educators, doctors, and other important members of the research settings. Methodological justification was required at every stage in the research. The theoretical-methodological struggles reflected on the research process and modified it. They are inextricably linked with the research topic and with the results. To pretend otherwise would be to indulge in academic fiction, and would impair readers' ability to follow the logic of the study to its conclusions.

The academic justifications for human sciences research, and in particular for a phenomenological approach, made sense when they were encountered in graduate courses in sociology and anthropology. At the same time, studies in the labor process¹ promised to provide answers to physical therapists' sense that work was speeding up, that there was never enough time.

Braverman's (1974) ideas of deskilling, which related workers' sense of alienation and frustration to management's assumption of control of the labor process, seemed on first examination to be applicable to the problem of why physical therapists worked, and thought they were working, so hard. Braverman's book was about male craft workers, not female

professionals, and reflected an idealized version of the organization of skilled craft work. In the naive enthusiasm of an inexperienced sociology student, however, all the difficulties and objections to the deskilling hypothesis were resolutely put aside, so that I might write a formal proposal specifying the research I wished to do.

I decided to study deskilling in physical therapy, and several research proposals were developed, all variations on the theme of deskilling, but with a methodology which was variously described as participant observation, observational field work, and ethnographic field work. One of the proposals appears in an appendix to this work.

When the research was being planned, I was completing a term as a visiting graduate student in Behavioural Sciences at University of Toronto, and working as a part time faculty member in the School of Rehabilitation Medicine at the same university. In Behavioural Sciences, I was exposed to a critical, sociologically oriented view of medicine and health, while my teaching duties in a physical therapy education program involved me in the process of producing physical therapists. The dual role created tensions between a populist, critical view of the health care field and a practitioner view. The tensions became less uncomfortable after both sociology course work and physical therapy

teaching duties came to an end, but they are still present. They appear in the dissertation.

The dissertation starts with the simple question, why do physical therapists work so hard? The straightforward reasons, which have to do with techniques for controlling labor power and using it efficiently, are dealt with first. Even in those chapters, however, it becomes clear that compliance with techniques of control is secured because of a complex of ideologies and material conditions which surround work in a women's profession. Thus, the dissertation goes from the particular, shop floor based inquiry about why therapists work hard, to a more general question about the meaning of professional. The meaning of professional, for this example of employed women workers, is explored using historical sources and documents. From an examination of the interaction of the state, the medical profession, its competitors, and the physical therapy profession, we can see how class and gender dominance are expressed, experienced, and perpetuated in this women's profession.

The dissertation examines the experience and expression of the physical therapy profession from the practitioner viewpoint. That inquiry is worthwhile, because it has not been done sociologically before, and because it adds systematic data to the growing literature which examines the relationship between class and gender. Another sociological

viewpoint, however, asks about the consequences of various trends for patients and for society in general. Lines of inquiry which could not be explored fully in this report merit, and should receive, further investigation and future research.

The field investigation began with a proposal to study deskilling in the physical therapy labor process. The hypotheses stated that physical therapists, like all workers, would be deskilled by having their work delegated to less expensive workers and by having machines used to extend their labor power. The proposal was accepted by the supervising committee at Carleton University, but rejected by the Physiotherapy Foundation of Canada, to which it was submitted for funding assistance. One physical therapy manager, a reviewer for the Physiotherapy Foundation, disagreed so strongly with the hypotheses that she contacted me to tell me I was wrong. Her department had developed a new way to deal with the pressure to produce, she said, and her therapists were not deskilled at all, but rather had increased their knowledge and were now acting like true consultants. Further investigation and a great deal of reflection convinced me that she was right in what she said, her staff have not been deskilled, and they are working like consultants.

I am still uneasy, however, with the consequences of the

pressure to produce, and much of this dissertation revolves around that concern. I have tried to present a fair view of the facts about physical therapy. We all must recognize, however, that all "facts" are open to various interpretations, and our interpretations of what is happening to work in physical therapy may differ depending on our perspective. Even if we disagree, however, it is useful to have examined the other perspectives.

Although the deskilling hypotheses must have made them very nervous, physical therapists overcame their misgivings and agreed to be observed at work. Their enormous contribution to this thesis should be acknowledged, but to name them or the managers who facilitated entry to the field work settings would violate the convention of confidentiality. They know who they are, however, and will recognize their words even though names are changed in the notes and quotes included here. I am also in debt to other staff and especially to the patients who so freely shared their views on physical therapy and their views on the problems that brought them to physical therapy. Unfortunately, because this is an academic dissertation, because I never knew their names, and because most of them are now well past their physical therapy, treatment, I cannot contact them and they likely will never hear what came of the research in which they willingly participated. Where I

deemed it necessary to protect confidentiality, I have assigned fictitious names.

Victor Marshall reviewed sections of handwritten field notes from the early observation period. He made many helpful suggestions, some of them technical and some about possible lines for further inquiry.

Colleagues and faculty in both Physical Therapy and Behavioural Sciences programs at University of Toronto read papers, commented on drafts, and were excellent sounding boards for the ideas as they became tentative hypotheses, were further explored, and discarded or incorporated into the end product. I would like to thank David Coburn for his comments on an earlier draft. Karen Yoshida not only contributed some historical references, she discussed with me the tensions between medical and sociological analyses of the history of physical therapy clarified many of the issues presented in the last section of the dissertation.

From the field work right through the many drafts of the thesis, Alison Griffith and Roger Redwin listened to my musings, grumbling, and speculation. In addition to the social and material support they provided, Roger provided a practical viewpoint to balance the endeavor; Alison steadfastly insisted that I search for sociological explanations instead of the personal or physical therapy

explanations favored by my physical therapy training. She further insisted that I view the effort to find those explanations as "work", and stop fretting because it was taking so long.

Because the research was conducted, and the dissertation was written, in Toronto and not in Ottawa, my Carleton University supervisors, Bruce McFarlane and Wallace Clement, have had to deliver their input (except for smoothing the path through the bureaucracy) during my short visits to Ottawa. Much of the work, however, to establish interpretation, to link the data to theory, and to write it in acceptable academic form was conducted in a sort of imaginary dialogue and/or struggle with them. John Cove has been my advisor since I began graduate studies in 1981; many long rambling conversations with him have helped to sort out the whole experience of research, field work, writing, and especially reflecting. Early in the project he suggested I keep notes not only about what I observed, but about the research process itself. In accordance with anthropological tradition, I did. These notes were interspersed with observation notes during the field work period, and were continued, even during an eleven month "break", while working on a project to assess the health and social service needs of the aged, disabled and chronically ill in the Northwest Territories. These notes contain my reactions to field work,

problems and roadblocks along the way, speculations and tentative hypotheses, notes about things that need further investigation, and reactions to the culture shock of landing in an entirely different society in which "women's work" is openly assigned to women and recognized as equally important with other subsistence and cultural activities. The notes on the research process do not appear in the final form of the thesis, but were an important tool for retracing the development of the research question and the perspective from which it is now viewed.

The research that led to the final form of the thesis was supported partly by periods of paid employment in which the observation and thinking about the topic was not formalized, but still carried on. Thus, the therapists, patients, faculty and students with whom I worked all contributed to this research and I would like to thank them. A Carleton University scholarship, an award from the Physiotherapy Foundation of Canada, an Ontario Graduate Scholarship, and a National Health Research and Development Program Fellowship also supported the full time graduate student phases of this work.

PART I
TAKING UP THE THREADS.

CHAPTER ONE
Introduction

This dissertation is a case study of an employed women's profession. It has three main purposes. It studies physical therapy as an occupation and profession, because that has never before been done sociologically. It fills a gap in the work on class and gender, because the theory has advanced to the point where more case studies are needed to explore the fit between theory and what can be observed. Finally, this study explores the relationship between structure and how it is experienced, expressed, and reproduced.

Physical therapy is an employed women's profession. There are about seven thousand physical therapists in Canada. Over ninety per cent of them are women. Most work in publicly funded general hospitals and rehabilitation centers. They have standards of education and employment, and provincial statutes which guarantee them exclusive right to title (no-one else may call her or himself a physical therapist or physiotherapist, and no-one else may call what he or she practises physical therapy or physiotherapy¹). Physical therapists are taught to think of themselves as

professionals; and the idea of professionalism is connected with the way they work.

In this study, the work is guided by the sociological literature on work and professions and by the labor process literature. In the sociology of work literature, the emphasis has been on work for pay, and furthermore on work men do for pay. Although all of the pronouns and some of the assumptions must be changed when such literature is applied to women who work for pay, there is little theoretical difficulty applying the sociology of work literature to physical therapy. The problem, however, is that this literature is almost atheoretical. It proceeds on the basis of functionalist assumptions without specifying what they are.

The Marxist sociology of the labor process literature sets out to remedy the omissions of the sociology of work literature by using Marxist theory of the labor process in explicit conjunction with studies of the way work is organized for production. Marxists introduce theories of class and class relationships as a way to understand and predict dominance, subordination, and change in the labor process. While this approach gives a much stronger theoretical basis for a sociological case study it, like the sociology of work literature, lacks a theory or method for

seeing and analyzing gender differences and for looking at gender, as well as class, as a principle that organizes the labor process.

Feminist theory examines and attempts to explain theoretically why patriarchy, or the dominance of women as a group by men as a group, exists as a structure which cuts across all societies and historical periods. In contrast with Marxism, feminism makes gender central to the analysis, and has a consequent tendency to downplay differences structured by class.

Efforts to combine Marxist theory with feminist theory in the analysis of paid work have faltered, perhaps mainly because there were not sufficient systematic data from which to build theory, and with which to test it. This case study will complement others that have been completed recently (e.g. Ganange 1986) and are now in progress, to help fill that lacuna.

With a few notable exceptions, such as Lowe's (1982) historical study of clerical work and the transfer of office tasks from men to women, labor process case studies, like most of the sociology of work that went before them, have concentrated mainly on the work that men do and on work that fits neatly into the productive sector of the economy. Very few explicitly labor process studies of jobs in the

reproductive sector, those jobs which either ensure the day to day reproduction of a work force able to labor, or the reproduction from generation to generation, have been done. There is a need both to theorize the relationship of reproductive work to the overall relations in society, and to study jobs in which reproductive work is done for pay.

Housework has been studied, and the relationship of housework to the productive process (see, for example, Malos 1980, Kuhn and Wolpe 1978, Luxton 1980, Fox 1980) has been discussed. Women's wage labor has not been studied intensively; there is a need for studies which make gender as well as class central to the analysis.

With the exception of studies of nursing, which perhaps because it was labelled a "semi-profession" tended to remain in the female ghetto of nursing literature rather than taking their place in the mainstream of sociological literature, the sociology of the professions has concentrated almost exclusively on the traditional men's professions such as medicine, law, and the clergy. The studies which have addressed employee professions (e.g. Larson 1977, Johnson 1977, Prandy 1975) have addressed primarily professions such as engineering and accounting whose incumbents had a simple and obvious connection with the forces and relations of production. We need studies of women's professions to right the imbalance and to examine closely the role of wage labor

in reproduction.

Debates on the proletarianization of professionals (Saks 1983, Coburn et. al. 1983, Freidson 1984) center on the dominant male professions, especially medicine. Except for noting as Etzioni (1969) did, that occupations such as nursing, teaching, and social work are each subordinate to other occupations and can not correctly be called professions but rather semi-professions, sociologists have been silent about the constellation of professions that employ women to perform tasks that support all members of society. While he explored fully the implications the employed status of these professionals had on their autonomy and freedom to make decisions, Etzioni merely noted that women predominated in these occupations. It remained for studies almost twenty years later to explore fully the implications of gender on the work of these occupations.

Cockburn (1985) on the other hand, provided an example of work studies guided by feminist theory and concerns. She performed case studies of ladies' garment making, mail order houses, and technical work in hospital X-ray departments to examine the impact of technological change on women's work. Her objective was to account for women's disadvantaged position with respect to men in the paid work force. This disadvantaged position, Cockburn showed, has persisted

despite equal opportunity legislation and government policies of affirmative action, And despite the introduction of technology which reduced the physical strength needed to perform the work. In the case study of the radiographers, particularly, Cockburn showed that men retained control of the technology, using arguments about women's innate ineptitude with machinery. With control of the technology, Cockburn maintained, goes control over the pace of work and greater relative autonomy in the labor process. While she did use Marxist categories and terminology, Cockburn made gender central to her analysis, slighting an account of the experience and expression of class in the day to day work.

While sociologists created a sociology of work, and others with a Marxist perspective studied work from a different angle and called it labor process, or were concerned with class and labor market segmentation, most feminists concentrated on patriarchy, and especially on women's domestic labor in the home. Feminists who engaged with the phenomenon of professions focussed mainly on the impact of the traditional, male dominated professions such as medicine on women recipients of services. Participants in what is now called "the domestic labor debate" argued that women's work at home contributed to the accumulation of capital by consuming goods and services, and that housework reduced the reproductive cost of labor for capital by

feeding, clothing, and healing the workers in the family. The family, these sociologists also argued, ensured that the class structure continued from generation to generation. By raising their children with attitudes and habits appropriate to their own social class, educating them, and preparing them for work and marriage, women ensured the next generation was ready when the older generation could no longer work. Such work they called "reproductive labor."

Women were, and still are, often employed in occupations and professions which are an extension of the work they do at home. This work does not produce profit, but heals injured workers, takes care of those who cannot care for themselves, and reproduces the class structure. Not all reproductive labor in Canada takes place within the family; some of it is provided by state funded and a few privately run institutions which hire teachers, nurses, therapists, and the like. These occupations, which perform reproductive labor for society, are often called the helping professions.

The helping professions have many similarities. They developed at a time when women were entering wage labor in large numbers. Qualities considered desirable in a helping professional were the same qualities considered desirable in women. The helping professions developed roles that were ancillary to other, predominantly male occupations. Women teachers, for example, worked under the supervision of school

principals and superintendents, usually men. By agreeing to work "under the supervision of a doctor" nurses and therapists gained support and recognition for their professions. Gender as well as class relationships were specified in the helping professions from the time they began as professions.

The helping professionals themselves were mainly women. Many were employed; rather than independent practitioners. Some professions such as nursing and physical therapy began with independent practitioners who moved into employment in large organizations. At present, most women in the helping professions are employed, and most of these are employed by large state funded institutions.

Nursing and teaching developed as professions for women in Canada in the late nineteenth century. Other professions for women, for example social work and physical and occupational therapy, developed in the early years of the twentieth century. As professions, all these groups proceeded by setting standards for membership, setting codes of conduct, excluding practitioners who did not conform, acquiring the sponsorship of powerful groups in society and with their help, getting recognition in provincial statutes. The helping professions have continued to promote their members' interests, struggling to raise their status and

rewards. Even in the 1980's, with its movement of women into non-traditional occupations, women's professions persist. The women's professions are changing; they have upgraded educational requirements, they struggle for recognition as independent practitioners, some of them have organized collectively to upgrade their pay and their control over working conditions. Still, women's professions remain, shaped by the gender and class structures which influenced their development and constrain them. This case study contributes a theoretically informed body of knowledge about one women's profession, physical therapy.

Sociologists have a great deal of information about the labor process of working class men. Professions and professional workers, especially medicine and newer men's professions such as engineering, have also been studied extensively. In general, the analysis ignored the sex of the workers. Labor process literature sometimes included women in the analysis, either as a reserve army of labor who could be drawn into the work force to suit the requirements of capitalism, or as a group which could be recruited, like immigrants and other disadvantaged workers, into jobs which required less skill or which paid less. Women, therefore, were sometimes seen by organized labor and by employers as a group which could be exploited to moderate the wage demands of the male labor force. Even in studies of industries which

employ many women, there is little that links these women's experiences to their class or sex.

Industrial sociology often mentioned congruity with usual family roles and inborn feminine traits as reasons why women made such a tractable work force. Like the Marxists, these sociologists were silent on the way women workers were controlled and silent on women's experience of that control. At the end of a detailed and fairly creditable discussion of the literature on feminization, Thompson (1983:205) negates the whole debate by assuring us that male dominance is inevitable, but not important.

However, while it is important to acknowledge the complex sources of feminisation, it remains useful to distinguish between the stimulus of the capital accumulation process and the subsequent development of the sexual division of labour in the work place, which takes on a life of its own.

Women professionals, who surely share some traits with their professional male counterparts, some with skilled craft workers, and some with their working class sisters, seem to be missing. Feminist analysts, with the exception of Smith (1982) have not considered class in connection with women professionals. Smith suggested that helping professions; nursing, teaching, and the like, are specifically ancillary to the career structures of men in the dominant class, and they contribute to the maintenance and reproduction not only of class domination, but gender domination. Unfortunately,

Smith seems to have abandoned inquiry about the helping professions in favor of further studies of the family (e.g., Burstyn and Smith 1985). Some of Smith's students have used her Marxist ethnomethodology to explore issues of concern to women's professions. Campbell (1985) for example studied the way modern cost accounting methods produce an organizational structure which controls and constrains the professional work of nurses. Walker (1986), using an example drawn from social work, comments on the way in which the ideological practices of researchers, theoreticians, and scholars draw relationships between individual lived experiences of wife battering, and include them under a term, "family violence," which conceals who does what to whom.

These authors have considered some aspects of the women's professions. Campbell approached most closely to an examination of the labor process in a women's profession when she studied management practices in nursing. She laid the theoretical ground work which became part of the present analysis. Her work is discussed in connection with charting in later chapters. Neither Smith nor her students, however, have done the kind of empirical study of the labor process which is needed to understand the women's professions fully.

In addition to filling a gap in the sociology of work and labor process literature, and to contributing to the body

of empirical work which can contribute to the development of a Marxist feminist theory of the labor process, this study explores the relations between the structure, experience, and expression of the relations of domination and subordination.

There is a regrettable tendency in much sociological literature to emphasize structure at the expense of interaction. Many sociologists, particularly those who have studied the professions from outside them, give undue weight to the statutes, regulations, and formal rules, but ignore the way those rules are expressed and experienced in everyday life. In order to counteract this tendency, this study has taken the position often associated with symbolic interactionists. That is, the workers themselves are assumed to have some freedom to operate within the rules; they may obey, defy, or ignore them at times, and use them to their advantage at other times. Workers are assumed to be active, not passive robots confined by the rules. The study assumes that workers make decisions with the intention of achieving their goals. In doing so, this study assumes, they give rise to customs and practises which themselves take on the appearance of structure.

The present study, therefore, uses the Marxist, feminist, and sociology of work and the professions literatures combined with a phenomenological approach to enquire into the interaction of gender and class in an

occupation that-thinks of itself as a profession. We will investigate the experience and expression of structure in a case study of physical therapy.

Methods to suit the purpose

The expectation that the research would provide information about physical therapy, that it would explore the relationship between class and gender at work, and the expectation that the study would explore the relationship among structure and the experience and expression of that structure, suggested the methodologies that were used.

Historical data were used to explore the class and gender origins of physical therapy. The historical method provided data about the relationship between the professions of medicine and physical therapy, and about medical professional dominance. The historical data also showed the involvement of the state in the development and maintainance of physical therapy as a profession..

Participant observation was used to document and to explore the relationships among physical therapists and others, particularly patients, doctors, and managers, in their working environments. The investigator's own identity as a physical therapist facilitated access to the research settings and to data which otherwise would have been

unavailable. The researcher's experience allowed her to fill in the gaps when parts of conversations could not be heard; it allowed her to understand the jargon used by physical therapists, and it provided at least one possible explanation for many of the events and sights that might otherwise have been incomprehensible.

The early labor process studies, for example Burawoy's (1979) study of the labor process in a machine shop, provided a precedent for use of participant observation in studies of the labor process. Burawoy, like others such as Chinoy (1979) went to the the shop floor as a worker to gather data; these data were used to draw conclusions which took note of workers' actions and reactions to the labor process. Even Braverman's (1974) path breaking work which brought Marx's (1867/1967) analysis of the labor process to bear on the degradation of work in the twentieth century, used experience and concrete examples from Braverman's previous career as a tinsmith to support and elucidate the theoretical arguments. It may have been the practical examples which made Braverman's deskilling thesis so compelling; certainly Braverman triggered a long line of further investigation and debate (see, for example, Wood 1982, Littler 1982).

Later studies of the labor process (e.g. Edwards 1979, Clement 1981 Pollert 1981) were accomplished by sociologists who had not experienced life as workers in the industries

they studied. These studies' perspective could be characterized as "outside" and "above". The "outsider" perspective permits a wider view of the industry but provides thinner data. It risks losing the perspective of the workers; it cannot discover subtle resistance or hitherto undocumented forms of resistance; it seldom captures or attempts to account for the conflicting feelings and divided loyalties engendered by the particular expression and experience of structural control in the workers.

A return to participant observation of the labor process is necessary. In this study of an occupation which has not been studied before, a study which intends to gather new data about the relationship, expression, and experience of class and gender in the work place, participant observation is an essential component of the methodology.

The term, "participant observation" may be used for any method, from covert observation and recording by a researcher who passes as a member of the group being studied, to an observer who participates minimally in the life of the group being studied. In the present study, the investigator, who did have some previous knowledge of physical therapy, began the research as a stranger to the settings, observing and recording with minimal participation, but gradually increasing her interaction with the people being studied,

talking first with patients, then with staff. By the end of the research, when the report was taking shape and some conclusions had been reached, the investigator was sharing findings and discussing conclusions freely with the "subjects", who were thus actively involved in and to some extent shaping the path of the investigation.

Participant observation by itself, however, raises more questions than it answers. The investigator must have access to information about the structures which govern the occupation. Information about the labor market for the workers, the constraints on them, and the history of their relations with the state and with other professions and clients is necessary. Thus, the participant observation phase of the study was followed by a phase of investigation of archival sources, records of the professional association and legislative action; journals of the professional association and the medical profession, government publications about the profession and about health labor in general, and interviews with informants who could recall and recount events and experiences from earlier days of the profession. The historical data were used to explain and support the observations and interactions from the field work. Some of the material from government sources and other literature about the occupation of physical therapy appears in the chapters that deal with the contemporary labor

process; most of it appears in chapters four and five, where it helps to explain the present day labor process, customs, and habits of physical therapists.

Both participant observation and historical methods present investigators with masses of information from which relevant parts must be selected and interpreted. The selection and interpretation requires active effort to make sense of the data. Making sense requires researchers to test the data both against their own knowledge and against the chosen theoretical orientation. Thus, it is important to specify at the outset the theoretical frameworks being used. It is also necessary to report as far as possible the steps that were taken to make sense of the data. Because this research explicitly recognized that there is no single account or interpretation of reality which is more valid or more correct than any other, because it was reflexive in that it required the data to fit with the theory and the theory to fit with the data, and because it acknowledged the interaction and effect between observer and the observed, it differs from conventional observational approaches such as those explicated by Glaser and Strauss (1967).

In conventional observational approaches (Glaser and Strauss 1967, Rosenthal et. al. 1980) the observer is instructed to approach the subject as if she or he had no preconceived notions of what was relevant and what should be

recorded. The observer is further enjoined to record everything. Tentative hypotheses are supposed to "emerge from the data" (apparently by themselves without further effort from the researcher). Further investigation is supposed to provide additional information to confirm or reject the hypotheses; the result is supposed to be a true picture of the world as it is.

The method used in this investigation used similar procedures for gaining access to research settings and for recording data, but it took account of the fact that all knowledge is theory laden. This research takes the point of view that all observations and measurements are based on previous experience; observation is therefore not possible without theory, whether the theory is acknowledged or not. The investigator adopted the philosophical position suggested by Smith (1981: 314) who observed,

Social phenomena arise for the sociological observer only in an interpretive act. What is there for her is constituted by her observational work. There is no such thing as non participant observation. . . . The sociologist uses background understandings, expectancies and knowledge to make sense of 'appearances'. . . the reader herself fills out the text by reading in background knowledge to accomplish its meaningful character.

The sociologist, like any interpreter, is trapped in the hermeneutic circle (Ricoeur 1981) and must recognize that as inevitable. One's own stock of knowledge (Shutz

1972) determines what one can apprehend and understand from an event or text. As Smith explains, "the problem cannot be solved by adding more detail. Every description necessitates interpretation, so added detail merely compounds the problem."

Sociological description, as Smith (1981: 314) continues, is

not just any old description, but a description which is relevant sociologically (whatever that may be) and one which can be relied upon for use by others.

In other words, for this study the investigator did not go into the field with a "tabula rasa" although she attempted to record everything in the hope that its significance would eventually become evident. Observations were guided by the purposes of the research; the observer was interested in control of work in physical therapy; in what makes physical therapists work and attempt to cope despite a sense of ever increasing work loads, in what it means to be a worker in a women's professional occupation, and in observing events and evidence which would support or reject existing labor process theory.

The observer had to work to make sense of the events observed and texts read, and she used sociological knowledge to understand what was happening. In some cases, several explanations were possible. Common sense, physical therapy,

and one or several sociological explanations were usually possible. Data which could be clearly related to the purposes of this report are included here, but for many incidents, the competing interpretations are presented, together with the logic that supports the interpretation finally adopted. It is not expected or hoped that all readers would arrive at the same interpretation as the investigator. Different theoretical orientations and different life experiences provide each reader with his or her own stock of knowledge from which to make sense of the data. In addition, subsequent events may lend support to some interpretations, and the interpretations presented in this report and presented to the therapists as the investigation proceeded may influence them to change their actions, thus altering the pattern that may be observed. Long quotes from historical sources and lengthy segments from the field notes are included in the body of this report, in order that readers may speculate about their meaning and provide their own interpretations.

Theoretical model used in the study

This study of the labor process in physical therapy is Marxist and feminist insofar as it recognizes inequalities based on class and gender in society and questions the legitimacy of such inequalities. Class and gender are not

simply used as explanatory variables. The class structure of the context society, capitalism, and the gender structure of the context society, patriarchy, are acknowledged.

This research focuses on the way capitalism and patriarchy are expressed and experienced in everyday life. In physical therapy, both the class and the gender structure of society often appear to work through the ideology of professionalism. Class and gender, therefore, are understood as organizing principles which shape much of what can be observed about present society. Profession is treated as a phenomenon which is used by people organized into a clearly defined occupational category, in order to maximize their advantage within existing class and gender structures in society.

In trying to understand the profession of physical therapy it is important to recognize that education and professional socialization produce shared perspectives and a tendency to agree that "this is the only right way to look at this." Here, however, the focus is on the labor process of physical therapists, not their education and professional socialization. The values, habits and attitudes acquired during their training as physical therapists may influence how they behave, but class and gender, influences which connect the labor process with the social arrangements in the

entire society, are given priority in this analysis. It should also be noted that since the majority of the physical therapists studied are women, many with family responsibilities, the intersection of their family lives and their working lives is very important. Other research has investigated, and continues to investigate, this critical area more fully than was possible in this research (see, for example, Ganange 1986).

Class and gender are not treated in this study as fixed categories, but as relationships. They change their appearance with changing historical situations, settings, and individual choices and strategies. Certain tendencies are constant, however, and should be found in any set of data. Giddens' (1979) position that structures such as class and gender constrain the actions of individuals has been adopted in this analysis. According to Giddens, and to the theory used in this study, people are not merely passive victims of their class or gender, but tend to act in ways that produce and reproduce those structures. The next section sketches a model of those tendencies.

The model was derived by thinking systematically about relationships among more than one organizing principle. It predicts the directions and forms of dominance in a women's semi-autonomous profession. The thesis focused on the way these relationships are experienced and reproduced. This

theoretical model is introduced for its heuristic value. It helped to make sense of the wealth of data available. It is one way to approach the contradictions and uncertainties the data present. The major concern of this study is with control and dominance. Control and dominance, which less threateningly can be called inequalities in the work place, are taken to reflect and perpetuate inequalities within society.

Like all women workers, physical therapists' engagement with society as a whole, and particularly with their families, affects their participation in the labor force, their occupational choices, and the strategies they use to interact during the course of their work. This inquiry, however, focused on the work setting. There, the major influences to consider are class and gender. Profession and professionalism can be considered second. Professional relationships are linked with both class and gender in ways to be described.

Class and gender are treated in this analysis as primary; one is not regarded as more important than the other though one may operate more strongly under certain circumstances. For clarity, class is considered first, then gender, then a combination, before some of the complexities introduced by profession are discussed.

Class

The relationship between classes dominates social life. In modern industrialized and bureaucratic societies, however, open confrontation between the owners of capital and the workers they employ is seldom apparent. Owners are almost always represented by managers, and the working class is internally stratified. The basic class conflict of interest is concealed within intra - class struggles. Physical therapists fall into contradictory class locations described by Wright (1976) either as semi - autonomous professionals or as managers and supervisors. A very few private practitioners who own their own businesses can justly be considered petty bourgeoisie, because they own their own means of production and also provide the labor. Physical therapists' work relationship is more complex (contradictory) than a simple worker - management relationship, a point to which we return throughout the analysis. However, the first salient relationship flows from their position as employed professionals.

Identifying the class location allows students of the labor process to predict the character of the relationship, while recognizing that each historically specific situation has a different appearance. Class, within Marxist discourse, conveys a set of meanings about appropriation, inequality,

conflict, and domination. The class relationship in the work place is expected to take the form of management - worker conflict. We expect to find this class struggle expressed in management attempts to increase control of the pace, content, and product of work, while the workers openly resist. Diagrammatically expressed, the simple class relationship in the work place would be:

Gender

If the other principal relation, gender, is used to analyze the labor process, other patterns are predictable. Patriarchy, as the term is used in much feminist discourse, is a system of gender hierarchy which has crossed modes of production. When we talk about patriarchy in connection with modern industrial society, we assume a system of economic, social, and ideological dominance of one sex, women, by the other sex, men.

Gender inequality is institutionalized in the state, the family, custom, and social roles. Day to day interactions

reproduce the structures which allow the dominance relationship to continue. "Women are part of the institutions, participating in the ways in which they have been rendered powerless" (Smith 1985:3).

The relation of dominance in patriarchy could be represented by the following diagram:

Combining class and gender

Putting the two relations, class and gender, together into a simple model we can predict not only the direction of domination, but also the form the relationship will take. Managers dominate workers. Men dominate women. Four possible class - sex combinations could be considered here:

1. male manager - male worker
2. male manager - female worker
3. female manager - female worker
4. female manager - male worker

The first two cases are clear and simple. They represent

usual arrangements, and we have lots of information about the interactions in such pairings. Most work place studies involve male workers and male managers. Class is the operating principle that applies. Conflict is inherent in the relationship, and the struggle is open.

The female worker - male manager is also a familiar combination, because many men occupy management positions with staffs of women workers. The dominance produced by the gender relationship reinforces the dominance produced by the class relationship. But because women have been in charge of reproduction of social relationships, including the relationships that oppress them, we expect less overt conflict in a work place with a female work force and male management. "Most studies of women workers, whether in the office or the factory, have noted a greater passivity and compliance with the conditions of work" (Thompson 1983: 175). Studies of the labor process have not resolved whether this passivity comes from the conditions of work. That is because they have considered class only, not gender, as a primary variable. They have not exposed the way workers translate and use their experience of gender in the class struggle. By paying attention to class and gender, and the social construction of those relationships, this study shows how women physical therapists acquiesce to management control, and how, in a different way from male industrial workers,

they resist.

The female worker - female manager combination, one which is often found in physical therapy, is not as familiar to sociologists as the first two cases, but it does not seriously challenge social stereotypes. The class relationship predicts management - worker conflict; the sex role stereotypes suggest that conflict will appear in more subtle form.

Only the last arrangement, male worker - female boss, seriously violates social stereotypes. It is impossible to predict what form the domination will take, because without knowledge of the particular circumstances, we cannot predict whether gender or class is the most powerful relationship. We do not need to speculate here. Examples of such a situation are too few to analyze. Furthermore, we assume that gender and class are equally important principal organizing relationships for the purposes of this inquiry.

The heuristic model presented here and the classification devised by Hughes (1958:107) to discuss the so-called "natural" combinations of stereotypes associated with social groups and the status accorded to certain high status occupations appear similar. The similarity comes from thinking systematically about status and the results that occur when a low status group (women) enter a high status

occupation (management).

In the two settings studied most intensively during this research, the physical therapy staffs, supervisors, and department heads (Directors of Physical Therapy) were all women, but doctors and higher level managers were men. Thus, at the daily interaction or shop floor level, the case is an example of the third situation: woman worker - woman boss. However, it is not quite that simple.

Adding doctors to the model

Traditionally, physical therapy was provided under the nominal supervision of a doctor. That supervisory relationship no longer exists, but physical therapists are dependent upon doctors to provide a flow of new referrals and thus a flow of work. Doctors, through their medical staff organizations, influence the management boards of health care organizations. Clients, who become "patients" of the physical therapist while undergoing treatment, nevertheless remain "Dr. White's patient." Cordial relations with all the doctors must be maintained. Thus, although there is no direct relation of supervision, physical therapists are in effect subordinate to doctors, and clients are subordinate to both.

Physical therapy is also in a subordinate gender relationship to medicine. While there are some male physical

therapists and female doctors, the customs that govern the relationships between the profession grew up in a time when doctors were men and physical therapists were women. The gender relationship, like the class relationship, tends to put the doctor in the dominant position. A diagram to represent the relationships currently seen in physical therapy would have the doctor on or near the level of management, because of the heavy input from doctors as a group into hospital management, but the lines of authority would be dotted, indicating a consultative, rather than a supervisory, relationship.

Since doctors, like supervisors, come in both sexes, we might expect to find qualitative differences in the relationship depending on the sexes of doctors and therapists. Similarly with patients. However, medicine is still part of the patriarchal and class dominance system in society; doctors who happen to be women and physical therapists who happen to be male approximate the behavior patterns of their profession and class, rather than of their

sex, for reasons that are about to be explained.

Theorizing the effects of profession

Professions have been treated as part of the oppressive apparatus of the dominant class; this approach to medicine in particular surfaces in the work of Navarro (1976) and Waitzkin (1983). Feminists have condemned medicine for its misogynist views and reinforcement of patriarchal structures (see, for instance, Ehrenreich and English 1979 as one of the many examples). However, whether or not these simplified views of the profession of medicine are sound, the important issue for this study is the influence of the condition of "profession" on the relationships of physical therapists, not doctors.

Wright (1982) treats professionals as occupants of a contradictory class location. That implies that their interests are sometimes with the working class and sometimes with the bourgeoisie. A helpful beginning; we can expect to find physical therapists acting sometimes to benefit the class interests of the dominant class (and identifying with them) while sometimes siding with the working class and acting in their own interests as workers.

Much sociological literature about professions, while not explicitly concerned with the class relationships of the

professions, views "a profession" as a collective upward mobility project for its members. As such, a profession acts to benefit its members, striving to raise their status, and thus their economic position, by various means. A profession defines an area of competence for its members, asserts its members' exclusive competence in this area (often by specifying educational qualifications and standards of practice), restricts entry to its ranks, and disciplines non-conformers by excluding them.

In any profession, the professional body strives for the collective benefit of its members, raising the status of that profession by whatever means seem appropriate at the time. In turn, it demands conformity to the standards it sets. Thus, in terms of the relations of dominance, the profession both strengthens the position of its members, the workers, and enforces discipline on them, relieving management of some of that responsibility.

Profession, therefore, at times can be used by women workers to resist management or masculine dominance. At other times the prevailing dominance relationships are reinforced by profession. The theoretical model being built here does not specify the dominance relationship imposed or supported by profession; rather the model holds profession as one of the variable factors that can be used by either side in the struggle for dominance.

Gender and class structure action

The model proposed uses the notion of class and gender as the principal relationships which structure action. Both class and gender dominance tend to subordinate physical therapists. The structure of dominance relationships is treated as influencing both the direction and the form of the working relationships experienced by physiotherapists. There is some scope for individual action, especially when more than one dominance relationship is involved. At times, women professionals may use and reproduce one form of dominance in resisting the other. Profession complicates the relationships, as we shall be seeing when we come to examine the data from both the observational and historical components of this study, but it does not fundamentally alter their basic character; thus profession is treated as a secondary principle.

Other concepts used in the analysis

Two terms, "ideology" and "the state" which have multiple definitions in the literature and which are used frequently during the dissertation should be explained; so that readers may understand how they are being used in this analysis.

The ideology of professionalism which surrounds the

labor process in physical therapy mediates between class and gender structures and everyday lived experience. In this work, the term "ideology" is used to denote a set of ideas about how things "really are" that limits and shapes how the participants can act. Ideologies are views of the world. They are not necessarily incorrect but from some perspectives they can certainly appear to be mistaken. Ideologies are not necessarily correct either; there always are alternative ways to understand the world.

Social groups share ideologies; there may be conflict between groups over which ideology will prevail. In cases of conflict, the ideology of the more powerful group becomes the prevailing ideology. Thus this thesis generally accepts the maxim that the prevailing ideologies of any time are those that suit the interests of the dominant group. Other groups have to accept the dominant ideology or act as if they do. The dominant ideology establishes the legal structures (such as statutes that govern professional practise) of a time. The existence of formal structures (such as laws and policies) in turn shapes practise and ideology.

In this dissertation, the state is defined as the governing institutions such as the legislature, the executive, and the courts; laws and policies; and the² military, police and civil structures which implement them.

Liberal theories tend to treat the state as an impartial arbiter of the various interests in society, acting to equalize inequities. Marxists, on the other hand, have treated the state as supportive of the interests of the dominant, capitalist class.

While liberal theories treat the state involvement in health care as inspired by the good intention to provide equal health for everyone, Marxists analyze the state involvement in health care in terms of its usefulness for maintaining the capitalist system. The state is seen as providing services to ameliorate the worst consequences of inequality. The amount of these services, this argument goes, must be sufficient to prevent revolt, but not so high as to increase the tax burden so greatly there is no profit. Some Marxists (e.g. Swartz 1977) argue that socialized health care contributes to individual capitalist profit by spreading the cost of maintaining healthy workers over society. If the state did not support health (and rehabilitation) care, these theorists argue, the cost would have to be borne in higher wages paid to labor by individual capitalists.

In the liberal view of the state, exemplified by Freidson (1984) and Gritzer and Arluke (1985), developments in health care funding and legislation come about as the result of the state's impartial arbitration among pressure groups. In this power perspective, the more powerful groups

are able to influence state policy, laws, and the like in their interest. Freidson's understanding of the professions (particularly medicine) and their relationship to the state underlies much sociology of the professions work.

Marxists, on the other hand, relate developments in health care policy and legislation to benefit for the state, which they see as ultimately serving the interests of the capitalist class by keeping a healthy work force available to labor productively in capitalist endeavors and by securing the legitimacy of the capitalist social system by ameliorating the worst effects of inequality and subordination.

Freidson's power analysis can be integrated with a Marxist analysis of the state by looking at which "interest groups" consistently have the power or manage to influence the state to enact legislation and policies which suit their interests. Some of the data from the present study might be used to support either a Marxist or a liberal view of the state, but for the purpose of this study there is no need to choose. Either has some use for understanding an employed women's profession.

Whatever function state involvement in health care is presumed to serve, it is reasonable to assume the state's

budget is limited by the amount of money that can be raised by taxes and the competition for support for other state functions and services. The state cannot provide all the services that might be requested or demanded. The demand for health services might expand endlessly, but the amount that can be paid for them is limited by constraints on the state budget. Unlimited expansion of the services provided would soon cause intolerable increases in the tax burden or cuts in other areas thought to be essential. Therefore the state limits expenditures on health care costs. Demands for increased funding to pay for new services are resisted, existing services which can be cut without increasing public discontent are cut, and methods of cost accounting and efficient exploitation of labor power, similar to those developed in profit making industries, are used to control health care expenditures including expenditures for physical therapy.

The state's need to maximize services for minimal outlay of funds creates an environment in which capitalist management methods are adopted; this is why it is appropriate to use labor process theory and methodology to study an employed women's health care profession such as physical therapy.

This study, then, uses theory to explore and interpret data gathered by participant observations, perusal of

historical sources, and reflection. After examining the literature that relates most closely to the topic being studied, we look at the development of physical therapy as a recognized occupational group in Canada. Chapters six and seven are descriptive. They introduce the contemporary work of physical therapists to readers who are not familiar with it. Gender and class control of the labor process are analyzed in turn in the next five chapters, which are followed by a conclusion and an appendix which describes the research sites and the observational techniques used to collect data.

CHAPTER TWO

Literature about the Labor Process

The research problem was outlined in the preface and first chapter. In this chapter, we investigate the sociological literature about the labor process for clues about how to approach an understanding of physical therapy as an employed women's profession. The physical therapy profession and its work are described and many terms commonly used in the health care system are explained in chapters six and seven. Readers who would like an orientation to the field before embarking on a critique of the literature should refer to that section first.

The labor process literature is very useful for understanding the day to day work in physical therapy; it makes clear the relationship between forms of supervision, control, and resistance to control of work. It has severe limitations when it comes to analysis of women's professions, however. This study showed many of the limitations of conventional labor process literature with respect to physical therapy in particular. With some exceptions, the labor process literature so far produced is excessively masculine; it ignores characteristics workers bring to the labor process from outside work, and it treats sequences of events observed in a few case studies as indicative of

overall trends. It does, however, approach closer to the possibility of understanding what is happening at work than other literatures. It merits review below.

The research began with a desire to understand why physical therapists work hard, what makes them take on extra work "for the good of the profession." The extra work includes working overtime without pay, taking courses at their own expense to improve their performance of their work, and co-operating with, even helping develop, management schemes to increase productivity.

The question, why do physical therapists work so hard, can be asked in sociological terms: why do workers participate in their own exploitation? Exploitation is a term used by Marx (1867/1967). Value, Marx said, is produced when raw material is transformed into a useful product by labor. Only labor power can produce value. If the object transformed by labor power is consumed by the worker, the worker's labor has produced a use value. If, however, the object is sold for more than the cost of the labor necessary to produce it, the result is surplus value. In ordinary industry, which Marx examined closely, the owner of the shop and the tools, and the employer of the labor is called the capitalist. The capitalist appropriates the surplus value, which is then called profit. Exploitation denotes the process by which the capitalist appropriates the surplus

value derived from the labor of the workers.

Capitalism, Marx said, depends on increasingly efficient exploitation of the workers' labor power. Labor power supplied by workers produces the commodities the capitalist sells. The price must be such that the capitalist can pay the wages of the worker, pay for capital equipment to make the operation more efficient, and it must provide profit for the capitalist. The capitalist system requires that the capitalist maximize the output of the labor hired, that is, exploit the labor efficiently, by getting the workers to work efficiently and by developing ways to multiply each worker's output.

Marx's theory was developed at the time when British industry was mechanizing, after work had passed from home to the workshop and factory, and when the workers had become, or appeared about to become, machine tenders. Machines allowed capitalists to produce more product with the same labor power; the machines were paid for from the value of the commodities produced by the workers and sold. Although Marx did not foresee and analyze the extensive development of unproductive and service sectors of the wage labor economy we have to deal with today, his concepts of value and exploitation remain valid.

Exploitation refers to appropriation by the capitalist

of surplus value, that is value in excess of the cost of reproducing the labor power. Exploitation, Marx said, can be increased directly, by getting the workers to work harder or longer. This, he called increasing the production of absolute surplus value. By reorganizing the labor process, Marx said, the same amount of labor power can be made to transform more raw material into useful objects, thus increasing the production of relative surplus value. In answering the question, why do physical therapists work so hard, it is necessary to show how both direct and indirect exploitation occur.

Before starting to discuss the labor process, and the literature about it which may help answer the question, it is necessary to explain why labor process theory, developed to explain work in which things were produced for profit, can be applied to health care work, in which services are produced for payment by the state. Health care work is generally not for profit, at least in Canada.

There are two threads to this argument. One depends on the concept of a dominant ideology, which, briefly expressed, says that the ideas of any given time are the ideas which support the interests of the dominant class. Under the present economic system, the owners of capital, that is, the capitalist class, are dominant. Managers perform the global

function of capital. They arrange work so that production produces maximum profit for capital. Capitalism depends on the acceptance of management's right to manage; because the ideology of capitalism is the dominant ideology it appears that the way things are arranged at present is "natural," the only possible way. Management theory and practice have been well developed in the interests of organizing production and controlling the workers to maximize profit, in business and industry. Management theory and practice make business and industry "efficient," that is, they get maximum output from the labor power they pay for. Management practices are adopted by hospital hierarchies because they appear to be the most efficient way to organize work.

The second argument which makes labor process theory relevant for analysis of non-profit, state funded work says that the constraints on health care organizations are the same as those on capitalist firms. This line of argument was developed most fully by Gough (1979). Describing the rationalization of the welfare state in Britain, he describes in abstract terms a situation similar to the one experienced by employed health professionals such as therapists in Canada.

Larger authorities were created and corporate management systems introduced. Within these new large-scale "service industries" work study and work measurement are increasingly used, especially among the manual and ancillary grades, in order to increase the tempo and intensity of labour and thus to raise productivity. Lastly, the wholesale application of the "computer revolution" may soon be envisaged within many of the welfare services. All these developments may help redirect expenditure away from labour and towards "machinery" produced in the capitalist sector. Much of this may run counter to the interests not only of the workers in these services but also of their consumers. In the health service, for example, resentment is increasingly voiced against the impersonal and mechanical treatment of patients inside modern hospitals. If the essence of human service is interaction between provider and consumer, increased rationalization of these services may more and more conflict with the quality of the "output" provided. The needs of capital for a cost effective system comes into conflict with the needs of patients and other consumers.

(Gough 1979:248)

Health care is an essential service. It must be provided to ensure reproduction of a healthy population -- and a healthy work force. Since health is thought of as an essential right, and in Canada the state is seen to be responsible for providing health care, it must provide it to avoid discontent or revolt. Health care, like other state funded services, must be delivered as cheaply as possible in order to avoid tax rates which cut into profit. Therefore, health care organizations must deliver their commodity, health care services, as cheaply as possible. In order to achieve this end they have adopted capitalist management methods.

Capitalism has become more complex since Marx's day, and many ways have developed to exploit the labor power of workers efficiently. Familiar management methods such as bureaucratic systems of control, assembly line and continuous process technology, and scientific management can all be analyzed as developments which serve the requirements of capital to maximize profit by keeping down the amount it pays for labor in comparison with the amount of commodity produced. The capitalist system is so predominant that systems of management which were developed to suit the needs of capital appear to be the only way large organizations can be managed. Hospitals import management techniques from business. Physical therapists, whether they work in the "private" or the "public" sectors, face continual pressure to increase output and reduce expenditures.

The labor process literature, in general, is written as if the men's work it studies were the only work in society. Labor process literature has usually dealt with industrial work, probably because it is the most clear-cut case of direct production of surplus value in present society. The labor process literature has ignored professional work. However, labor process theory has informed some studies of the unproductive sector, for example, clerical work (Lowe 1982). Women's work in the service sector has also been

discussed by writers using a Marxist, if not specifically labor process, perspective (Armstrong and Armstrong, Ganange 1986). This perspective applies to work in the health sector as well as to any other work.

Labor process theory is the main body of literature which attempts to explain the connection between work and the capitalist society which forms its context. The type of work, and the observed forms of control of the work force and of resistance to that control by the workers, vary. Industries, and in fact all work, have changed since Marx's day but theories based on Marx's contribution still have explanatory power. Therefore, any study of work can benefit from beginning with labor process theory and substantive observations. Labor process theory by itself, however, is inadequate because it does not account for the kind of control seen in women's professions.

Deskilling

Braverman (1974) rekindled an interest in Marx's analysis of the labor process with his analysis of scientific management. Drawing on his own experience as a tinsmith, Braverman showed how scientific management increased its control over the labor process. In work organized on a craft basis, Braverman said, each worker was responsible for a complete project. The craft worker planned the project,

owned the tools, obtained the materials, executed the work and sold the finished product. Even when a number of craftsmen were gathered in one workshop, craft organization of work meant the worker had a satisfying relationship to the work. Braverman noted, however, that under the workshop system, opportunities to increase efficiency and profit were limited by the individual work rate of each worker.

A necessary step in the development of capitalism, Braverman argued, was the reorganization of work so that the skills of the workers were split up. This form of reorganization, called Taylorization after its foremost proponent, Frederick Taylor, developed into a movement called scientific management. It emphasized "the attempt to separate mental and manual labour, subjecting both to exact measurement." (Thompson 1983: xiii). The capitalist, usually through managers, took over the planning, coordination and evaluation functions, paid for (capitalized) the tools and disposed of the product. The remainder of the job: fetching material, executing the work, and cleaning up, could then be divided into routine, repetitive tasks which required little training to master, and which could be accomplished by machines or less skilled and easily replaced workers. With an unskilled work force, many multiples of the same product could be produced, with or without the use of machines. Braverman's analysis is attractive, even though

Taylorization was not adopted universally. In many occupations, of which physical therapy is an example, some aspects of what Braverman called craft organization of work survive, and management has adopted many planning, coordination, and evaluative functions.

Braverman thought Taylorization produced deskilling, and argued it was an inevitable result of the requirement of capital. Deskilling, Braverman implied, was a trend that would affect all work. Because the deskilled workers did not have control of the entire project, from idea to sale, their labor would be increasingly alienated.

Although the basic concepts of capitalist control and reorganization of the labor process stood the test of time, Braverman's work has been subjected to strong criticism. The criticisms most relevant to the present endeavor will be taken up here. First, deskilling is not the only way management can increase exploitation. The labor process has changed differently in different industries. In any industry, not all the labor force is equally deskilled, and in some cases, management control of the work force has increased, but not through deskilling.

Deskilling assumes some uniform skill ideal that existed in the past. Braverman, who did not consider women workers outside the home, thought a craftsman was responsible for the whole job, ignoring the division of labor between journeyman

and apprentice; between craftsman and his family labor, which pre-dated capitalist organization of production (Littler 1982; Beechy 1982). The idea of the skilled craft worker, however, has a romantic appeal, even to physical therapists, who would not consider themselves tradesmen but know they possess a specialized skill acquired through years of study and practice. We find for example in physical therapy that physical therapists sometimes use machines. These machines are applied to the patient to give part of the treatment, while the therapist treats other patients or writes in patient charts. Some machines used in physical therapy do extend the therapist labor, allowing them to have more than one patient "on the go" at once. Machines, the advertising in physical therapy journals implies, make therapists more productive. In other words, using machines is supposed to increase the amount of the commodity (physical therapy care) that can be exploited from therapist labor power.

Therapists have not been reduced to machine tenders, however, like the factory operatives in Marx's time. They may do more work, but there are now more things to do. Refinements and elaborations in physical therapy treatment mean the therapist has more to do for each patient; he or she also has a growing list of other responsibilities such as committee work to do as well as treating patients. Therapists have not been replaced by cheaper labor or

machines. The predictions of Marx and Braverman regarding deskilling do not appear to have materialized yet in the physical therapy world.

Braverman wanted to show that scientific management, which he thought of as a divide and conquer strategy, was subdividing and fragmenting all work and alienating it. He thought work would become less meaningful and satisfying to the workers. Certainly, physical therapy work is monitored more closely by management than it was twenty years ago, but it also seems to be more complex. Physical therapy craft skill which originally consisted of massage, with the later addition of remedial gymnastics and still later, medical electricity, has been subdivided into a number of physical therapy specialties. The specialties do not yet reflect a division of the craft skills, although they may in the long run reduce the scope of practice of which each therapist is capable and thus fragment the field. The specialties are not divided along types of skill, but along types of patient problem. A physical therapist in any of the specialty areas: neurology, musculo-skeletal, cardio-respiratory, gerontology, pediatrics, or obstetrics, may expect to use massage, remedial exercise, and most other physical therapy techniques. The underlying knowledge demanded for each specialty is more detailed than it was, and

the qualifications more rigorous. In part this reflects the general increase in scientific and medical knowledge, and in part it reflects an elaboration of physical therapy skills and techniques. The picture is not the simple deskilling Braverman portrayed.

The idea of deskilling presumes that skill is an objective, fixed "thing" which is "taken away" by managers fulfilling the global function of capital, that is, managing the work to maximize efficiency. Ample evidence has accumulated since Braverman, however, to show that skill is attributed to people according to how powerfully they can defend their claim to skill. An occupational group may, if it can gain enough power, have the work it does defined as skilled. Having their work defined as "skilled" helps a group bargain for increased pay and job status.

The Braverman concept of skill and the deskilling debate which followed it (Wood 1982) do have implications and pertinence for physical therapists, but it is not because they are being deskilled, whatever that may mean. Physical therapists routinely do proficiently what members of the public, and even other hospital employees, regard as skilled. Physical therapists can palpate (touch skin with their hands and visualize the tissues beneath it), detecting abnormalities and disorders of movement and correct them. In a more obvious example, physical therapists routinely

approach paralyzed patients whose disabilities appear so great to the untrained observer that the patients are consigned to life in a bed or wheelchair, and by means of exercise, encouragement, facilitation of muscles and movements, and judicious use of strength and leverage, therapists get those patients to their feet. The work is skilled.

Physical therapists have almost maintained their position in the salary and status structure of hospitals, keeping their pay rates near those of registered nurses. The fact that they have suffered some setbacks in the nineteen eighties likely has more to do with the bargaining power of other groups and the way high technology equipment and dramatic life saving procedures attract better funding than caring work than it has to do with deskilling. The proportion of low paid routine or deskilled workers¹ in physical therapy (physical therapy aides) has not increased except, as a recent Ontario Ministry of Health survey of Rehabilitation staff shows, in private physical therapy clinics.

The growth of private physical therapy clinics may be changing the overall picture of physical therapy labor. In private practice clinics, the cost factor is much more obvious than in hospitals; that is, clinic owners can say

"you have to produce more or we can't make money," whereas in hospitals and other public institutions the cost consideration is usually concealed under an emphasis on efficiency and an ideology of service. Because of cost, private clinics do use more aides and helpers than physical therapists; they also tend to specialize in the treatment of a relatively small range of patient problems. The present study is concerned mainly with hospitals, where the majority of physical therapists work. It concentrates on the way more efficient use of labor power is secured within large institutional settings. With the growth of private practice, we may expect some changes in the way physical therapy is practised and controlled. The use of aides to do routine work and emphasis on standardized treatment are reminiscent of the Braverman predictions of deskilling. Physical therapists, however, all go through a training process which emphasizes the factors discussed in the rest of this dissertation, and even if they are in private practice, may retain many of the habits and attitudes of institutional, employee physical therapists. Therefore, ascertaining trends in private practice is an empirical question which must await further research. As the example of physical therapy shows, the picture is not the simple, universal deskilling of the labor force that Braverman predicted.

Braverman not only proved to be wrong with his prediction that the entire labor force would be deskilled, he

also neglected agency on the part of the workers. Treating workers as passive victims of trends in management, Braverman did not appear to account for worker resistance to change, but assumed change was introduced by management and proceeded unhampered. Edwards (1979) took up the problem of worker resistance, and showed how the tension between capital's need for enhanced exploitation on one side, and worker resistance on the other accounted for the pattern of change in the labor process.

Contested terrain

Edwards (1979) saw that changes in the labor process were the result of the interaction between work place conflict and economic constraints on the firm. Management has two functions: first, coordination, which is necessary to avoid waste, and second, exercise of authority over the labor of others. In the past period of competitive capitalism, Edwards said, simple, personal control of labor predominated. That is, the owner, who was also the manager, directed employees personally, coordinating the labor process and trying directly to make them work harder and faster.

As competitive pressure grew and firms increased in size, there was a shift, Edwards argued, toward structural control. That is, control embedded either in the physical structure of the work place or in the systematic hierarchical

administrative structure of large firms. Control embedded in the physical structure of the work place, technical control, ~~was~~ possible in assembly line work, in which the employer set the pace of the line and the workers must comply. Assembly lines subjected all workers to the same pace and pattern of work. Workers were aware of their common oppression, and union organization became easy. With unions, workers could better resist control. Technical control increased worker resistance, Edwards argued, and thus would eventually be replaced by bureaucratic control, the next management move in the continuing struggle.

In bureaucratic control, companies employ a divide and conquer strategy. Each job has a description detailing its rules and duties. Bureaucratic control transforms the nature of supervision, because evaluations, formerly personal and idiosyncratic, are given an appearance of objectivity by the job descriptions and evaluation forms. Ranks and grades exist within the company hierarchy. Thus, Edwards argued, workers have less in common with each other and are more likely to identify with company goals. As others have noted, the graded hierarchy of bureaucratic control "is said to allow for mobility within the firm, more rights, and job security and rewards for positive behaviour by workers." (Thompson 1983:148).

Edwards' stages are still useful for describing types of

control. For example, the Director of Physiotherapy, who is both a physical therapist and a member of the hospital's middle management, announces that it is important to promote the profession and that she is planning to attend a meeting outside working hours. That makes staff therapists feel they, too, should attend. This is an example of personal control. Facilities that are very busy, with fixed routines, such as "a patient every fifteen minutes" have been described as "assembly line-like." Aspects of bureaucratic control are obvious in the organizations where physical therapists work. Most departments have job descriptions; employee evaluation forms are standard. Quality assurance programs, which purport to improve quality of patient care by setting standards and guidelines for treatment, also provide supervisors with an apparently objective standard for assessing employee output. The requirement for charting all assessments and treatments, "if it's not charted, it didn't happen," facilitates bureaucratic control.

Edwards' contention that the three types of control represented stages through which all society passed has not proven to be the case. Many organizations combine forms of control. In hospitals, both bureaucratic and personal control are obvious. While a hospital is certainly a hierarchical bureaucratic organization with well defined chains of command, written rules and policies, even uniform

standards of performance appraisal for employees, the hospital lacks an internal labor market, especially among the professional and technical staff.

Edwards argued that there is an internal labor market in bureaucratic firms. This market, which provides a scale of jobs with increasing rates of status and pay within the company, allows employees to move up the hierarchy if they perform well. Other writers have stressed the importance of internal labor markets in securing control of the labor force. Even though they had no hope of becoming managers themselves, foremen in Nichols and Beynon's (1977) study, for example, knew they had to act as if they did. It certainly seems as if the existence of an internal labor market would be associated with increased employee compliance.

It is doubtful, however, how well the concept of the internal labor market applies to physical therapy. While it is true that basic grade physical therapists may move up to senior and department head positions on the basis of what are informally called "brownie points" or the "old girl network," physical therapists have a notably short and mobile career. Job changes every two years for the first part of a career are encouraged "to get experience." People can become senior therapists and even department heads, depending on the locality, in their thirties. To raise their status and pay from there, they require more qualifications, and usually

change employment to another organization, or go into private practice. Hospital and rehabilitation institution staffs consist of support staff, unskilled workers who need no special training and can go from job to job at their level but not rise, and the professional and technically specialized staff such as maintenance personnel; nurses; lab, X-ray and respiratory technologists; physical, occupational, and speech therapists; administrators and accountants, and the like. Each of these occupations requires considerable advance preparation and experience. The specialized training is not transferrable. A laboratory technologist could not be "promoted" to speech therapist, nor a physical therapist to director of nursing. Indeed, the lack of a career structure and the lack of opportunity for advancement is one of the most frequently voiced complaints from physical therapists, as it is in other women's professions. There is no internal labor market in hospitals. Physical therapists are subject to control of their labor process, and they work in a bureaucratic organization, but what controls physical therapists is not the expectation of promotion; it is not the internal labor market.

Edwards' concept that opposing forces, management and workers, struggle against each others' efforts to control and resist, and thus produce new forms of control, that is, the notion that the work place is contested terrain, has fared

better than his notion of ~~stages~~ of control. "Contested terrain" proved valuable in the present study. It suggests we look at the opposition between the interests of physical therapy department directors and their staffs. It helps us see clearly something that is not widely discussed or acknowledged in physical therapy. It allows us to organize information about the huge variety of methods for dealing with the work load in physical therapy. If we think about the labor process in physical therapy as a contested terrain, if we think about the struggle for control by management resisted by other strategies on the part of workers, we can understand the development of new forms of assigning work, new ways to get the work done, as outcomes of the struggle for control of work.

In the literature reviewed so far, the methods of control of labor are methods imposed from above; developed and imposed by management. Braverman saw deskilling as a management policy unresisted by acting workers; Edwards noted the existence of employee resistance, but saw the structure as the outcome of management effort to control recalcitrant workers. Burawoy (1979) introduced a new focus, by showing consent arises at the shop floor level. In the process, Burawoy approached closer to a method which can apprehend what is going on in the labor process.

Manufacturing consent

Burawoy's question when he started participant observation as a machinist at "Allied" was, why do these workers co-operate with the company and participate in their own exploitation? Their basic salary provided an adequate living, why did they work extra hard, even at machines which had difficult piecework rates, to "make out?"²

Burawoy discovered a variety of games and practices which were ostensibly violations of the rules but were allowed by foremen and managers. As he became caught up in the shop floor culture, he found himself trying just as hard as his fellow workers to make the rate. The games and practices at "Allied" were strikingly masculine, and revolved around the piecework system of payment. They involved strong rivalry and competitiveness among the workers. It is not clear whether women workers engage in similar games. What evidence there is seems to emphasize co-operation, which also suits the employer's overall purpose. For example, in a study of secretarial work,

An elaborate ritual of skiving and sharing builds up in the pool; friendships are intense and solacing. Gossip and daydreams are shared. Anniversaries of joining, birthdays, leavings, engagements are ardently celebrated, with noisy all-girl parties at flashy but inexpensive restaurants.

(Benet 1972:52)

Shop floor games, Burawoy said, regulate output so that it is consistent, which is in management's interest. Union activity, which defines and regularizes resistance, also serves management purposes, and "when you are playing a game you don't question the rules" (Burawoy 1981:85).

Burawoy's contribution is important to understanding why physical therapists work hard, because it acknowledges that conflict between labor and management is often concealed. Workers do, as Burawoy showed, often seem to cooperate with their own exploitation. The conflict of interest between the machinists on the shop floor and the owners of "Allied" was hidden by conversation, effort, joking, and shared preoccupation with the game of "making out." The conflict of interest between physical therapists and hospital or facility management is also hidden, in part by the politics of coping with the work.

CHAPTER THREE

Profession, Professionalism, and Care

Members of a profession often argue that professional workers are different from ordinary workers, that they have higher, or different, motivation to work. Many therapists believe that as professionals, they work hard because they want to, or that to be worthy of the designation professional they must sacrifice themselves. For example, Brockett (1985), in an article which purports to analyze a strike by workers against a long term care institution, argues that therapists should cross picket lines. Brockett occupies a position of influence in the occupational therapy profession in Canada, and received a standing ovation when she presented her views at a national association meeting. Many physical therapists share her convictions.

In view of this strongly held conviction, it is important to examine what the sociology of professions literature has to say about worker consent to management control. The literature on the professions, particularly the interactionist literature, is extensive and exhausting on the subject of professional socialization. These authors emphasized how education and apprenticeship training as well as experience as students and interns prepares professionals

to define their areas of expertise, "assume a cloak of confidence" (Haas and Shaffir 1981) and move into a professional role in society.

While most writing on professional socialization has been concerned with training doctors, some sociologists have applied the same concepts to other occupational groups. Kelner (1984) for example, explored the border between school and practice in the training of students at the Canadian Memorial College of Chiropractic. She showed how the required clinic hours and the clinic cases the fourth year chiropractic students must see under supervision prepare the "neophytes" for office practice after graduation. The professional socialization literature emphasizes how professional training imparts knowledge, skills, attitudes and demeanor suitable to the profession in its relationship with clients. Professional socialization is important in the training of physical therapists, just as it is with all the others. Professional socialization gives rise to attitudes and ideas. There are also, however, material reasons why physical therapists work so hard. The professions literature, by itself, does not provide a guide to those reasons; we must combine insights gleaned from professions and labor process literature with our own observations and analysis to understand and employed women's profession such as physical therapy.

Both medicine and chiropractic are "free standing," that is, the professionals provide service directly to the public and manage their own offices, whereas the majority of physical therapists are employed, but the acquisition of client related skills is much the same for all human oriented professions. The professional socialization literature alerts us to the fact that when newly graduated physical therapists arrive in their first jobs, they already have acquired a set of ideas and skills to make them able to deal with patients, to define their physical problems, to analyze them and to implement treatment. Graduate physical therapists, because of the internship (apprenticeship) component of their training, have also already acquired the social skills necessary to deal with their patients. The literature about professional training, however, ignores gender socialization experience; it ignores the possibility that some professionals may bring to their student lives a training which has taught them to act subordinate, which values a "service orientation" or which disposes them to accept control easily.

Gendered attitudes and control

Cockburn (1985) studied male dominance and technological change in Britain. Her perspective was feminist, although she used Marxist concepts in her analysis. She did not refer

to profession at all, but did show how ideas about men's and women's so called natural abilities and inclinations allowed men to maintain control of technology, which in turn gave them an superior position in the labor process. Cockburn showed that technological change made work lighter while at the same time making it more routine and tedious and removing control of the work from women.

Cockburn chose to study the X-ray department because it was a technologically oriented field in which women already had an established place. Her description of radiography work, however, made it clear that their contact with patients was limited to instructing and positioning them for examinations or treatments. Patient contact was confined to the time the patient was in the X-ray department or was having X-rays taken, and was minimal in comparison with the work of professions more commonly thought of as caring professions.

Even in medical X-ray, however, Cockburn showed that men maintained not only the highest paid jobs, but the most control of their labor process and that of others. They also maintained an ideology that women were excellent care givers but that went along with an ideology of female weakness, incompetence with technology, and low commitment to work other than caring. These attitudes persisted, Cockburn said, in spite of the fact that the men worked with competent women

medical physicists, and with female radiographers who relished the technical, calculation, and physical aspects of their jobs.

Cockburn's work is a useful empirical documentation of masculine dominance in relation to work, but although it used Marxist terminology and was informed by Marxist categories, it neglected class relationships in its analysis. Concentrating on masculine dominance in a profession with many women, it neglected class dominance in that profession. It is necessary to combine both class and gender analysis to produce a satisfactory study of the women's professions. Cockburn's study concentrated on documenting inequality, showing that inequalities persisted in spite of equal pay legislation, but did not show how they were maintained in daily working life.

Later in the dissertation, we will be exploring the general expectation in our society that women will take care of people who are unable to care for themselves. We will see how that expectation is an important factor in the labor process in physical therapy (chapter eight). The expectation that women care, as we shall see, helps elicit physical therapists' and other women professionals' consent to exploitation of their own labor power. Before we can examine gender in the labor process in detail, however, we should

briefly see what sociologists have said about the relationship of professionalism with class relationships and about professionalism's ability to shape consent.

Imported ideologies

The writing about how professionals learn to deal with the objects or clients on which they work neglects an equally important issue, how their training prepares professional employees to fit into the firm or organization. Prandy (1965), working in a Weberian tradition and studying professional engineers, stated that people generally hold to the ideology of their parents. Children of professional parents, or of parents with positions of high prestige, usually start with an ideology that explains or legitimizes their power. Their way of thinking about unequal power and status, he states, is usually that the positions of high power were obtained by people who worked harder, or had higher intelligence, or perhaps who took higher risks. Prandy called this way of thinking a status ideology, and contrasted it with what he called class ideology. Children of working class parents, he said, are usually invested with an ideology that social rewards are based on economic power. In Prandy's use of the term, class ideology does not accept that those with power deserve to have power, but says that they likely had better access to education, jobs, kinship ties, and the like which allowed them to achieve positions of

power. Children of middle class or professional families, Prandy says, are likely to accept the right of managers to control others' labor power, whereas working class children are not. It should be noted that Prandy's use of the term "ideology" differs slightly from the way it was defined in chapter one and is used elsewhere in the dissertation.

Prandy's concept of imported ideology is useful as far as it goes. If we asked the questions the right way, we likely would find that some physical therapists have a status ideology. The ideology of one's parents, however, should not be used on its own to explain current attitudes and behavior in something so vital as one's occupation. As McColl and Miles-Tapping (1985) argued, ideologies can be either perpetuated or altered by experience of power. The experience of a job without control over one's own labor, that is, an alienated job, can lead one to question status ideology and increase one's acceptance of class ideology. Thus, the ideologies workers bring to the labor process may provide an orientation toward compliance or resistance to management control, but the work experience, the actual labor process, can modify it. Physical therapists may bring a status ideology, which accepts the right of managers to manage, to the labor process, but that by itself is not sufficient to explain why they continue to co-operate with management schemes which are or may be against their

interests.

When looking at why workers accept control by management, we must look not only at the characteristics they bring into their jobs, but their day-to-day experience in them. Therefore this study focussed, not on the education of physical therapists, but on daily observation of many physical therapists at work. The objective was to gain a "shop floor" level understanding of their working experience. The results showed that the labor process does "manufacture consent" in physical therapy. The games played, the shape of the labor process, even the ways by which control is exerted, however, are very different from the games played by the machinists Burawoy described at "Allied."

It is tempting to attribute the very different character of shop floor games to the fact that therapists work on people while machinists work on objects, and to some extent this may be valid. Objects cannot complain about being rushed through a process, but patients can. Much of what therapists do is concerned with securing patient cooperation. By dismissing differences between male machinists and female physical therapists as simply attributable to the fact that the men's product is auto parts while the women work with people, we risk falling into the trap of confounding aspects of the labor process which are structured by the expectations

we have of therapists because of their gender with aspects of the labor process which are structured by other techniques of control and features of that labor process. Some of the differences are attributable to the gender of the workers. Many of the observed differences between Burawoy's machinists and the therapists observed in this study, however, might be traced to the therapists' position as professionals within the overall social structure.

Most sociologists of the professions have emphasized the value of the professional training to the individual, or to the profession itself. Professional training does not, by itself, explain why workers comply with control of their labor process and allow themselves to be exploited. The connection of profession with the social structure has been investigated by Larson (1977) and by Johnson (1980). These authors produced concepts which help analyze professionals' compliance to work regimes.

Professional status ladders

Larson (1977) followed her historical analysis of the rise of modern professions with a structural analysis of the current situation of professions in the United States. Socialized education, Larson said, produced a person who embodied standard skills and competencies. This person could then be employed by capital (as are many engineers) or could

work directly to provide service to anyone (as in private practice medicine). Private practice physical therapy would fit in the latter category. Recalling arguments that the state must provide health services to serve the interests of capital, it could be argued that employed physical therapists work for capital. The monopoly of instruction and "credentialling," Larson argued, appears "as a structural condition for the creation of 'professional exchange value'" (:211). If the professionals provide service directly to the public, Larson theorized, they escape direct involvement in capitalist relations of production and exploitation. However, she maintained, when professionals are employed, they are engaged in the labor process and are simply high status laborers.

If the self employed professionals were involved in a direct market relationship with the public, as Larson appears to have assumed, her argument that self employed professionals escape involvement in capitalist relations of production and exploitation would be valid. In Canada, however, with universal health insurance and insurance coverage for most forms of health related care, the role of the state as funder, if not as employer, must be considered. Such arguments, however, are outside the scope of this study, which deals primarily with the condition of employed women professionals.

Professional training, Larson went on to explain, conceals the features of wage labor "by covering it with all the structural and ideological advantages derived from status stratification and the particular ideology of professionalism" (:211). Professionals identify strongly with their profession, and acquiesce to control by their profession rather than by their employer. They insist upon and get the right to make independent decisions at the level of execution, and they work their way up professional ladders.

The professional ladders are hierarchies of status and prestige (usually based on attributions of competence) within the professional organization. The elite of the profession, Larson argued, have especially close connections with the members of society who hold real power, such as the upper echelons of the state and capitalist enterprises. The fortunes of the elite are closely tied to the position and prestige of the profession as a whole. Subordinate members of the profession depend on the elite for recognition and advancement; the profession supplies their needs and wants. Thus, ideological allegiance to a profession, begun at the recruiting and training phase with the idea of profession as a calling, continues as professionals find their access to status, prestige, and relative occupational freedom is bolstered by their profession. We can think of the professional ladder as an alternate to the internal labor

merely implement policies and systems designed elsewhere; if they have no control over the allocation of health care resources, they must be analyzed as workers. Probably the functions are mixed; most physical therapy department heads, and especially physical therapy supervisors, mostly facilitate the flow of work and the efficient deployment of staff effort. Both physical therapy department heads in the hospitals studied in the field work, however, were active contributors to the design of quality assurance and control methods; the work they did which was seen as "innovative" was probably fulfilling the global function of capital.

Johnson mentioned an elite of each profession, and indicated that accountants who decide upon the movements of capital have closer connections with capitalists than the majority of professional accountants, but he did not explore the implications of stratification within the profession as thoroughly as did Larson. When we put the ideas of Larson and Johnson together, we can approach understanding of professional consent to exploitation by constructing the following model.

Elite professionals, ones with close identification and connections with management and the capitalist class, exist in every profession. They identify with and depend on the status of the profession as a whole. These people work for increased status and prestige for the profession. The

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market in Edwards' analysis. Intent on climbing the professional status ladder, physical therapists comply to the requirements of their jobs, which includes control over the product of their labor.

The ideology of profession, Larson maintained, conceals the fact that professional ladders do not lead to real power in decision making.

management manipulates both the real and the symbolic dimensions of freedom at work and social prestige, in order to conceal the fact that 'professional ladders' do not lead to increasing control in decision making. Because it shapes the expectations of professionals, the ideology of profession contributes to the success of these strategies; it confuses, that is, discretion at the level of execution with real power and freedom of choice.

(Larson 1977:236)

Larson stresses that notions of prestige and respect, and some degree of occupational discretion and freedom from supervision, conceal the real lack of power that professionals have. Furthermore, Larson contends, protected within their niches of expertise, professionals subscribe to the individualist ethic which dissociates their actions, and their clients' problems, from wider social reality.

Larson's account of the way professional ideology conceals the real relations of production alerts us to look for distinctions between true freedom of choice about

important matters and illusory participation in decision making. Her notion of professional status ladders is also useful, because it helps us account for physical therapists' concern with developing expertise and gaining respect in the profession, even if it requires going to courses on their own time, paying to attend lectures and seminars, and the like.

Larson appears, however, to have thought professionals have more day to day discretion in their jobs than the field study found with physical therapists. Therapists do have a fair amount of discretion, especially about "professional" matters such as decisions on how much to treat a patient, but, as we shall see in succeeding chapters, their discretion is limited in important ways.

Global functions of capital and of workers

Johnson (1980) took up the problem of professions' relation to the means of production, and therefore their insertion into the labor process, in a more explicitly Marxist analysis. Drawing on Carchedi's (1975) economic identification of social class, Johnson distinguished between professionals whose work is part of the global functions of capital and of labor. Johnson used accountancy and engineering as his primary examples. Both professions have some members whose jobs place them in the capitalist classes, but other members whose jobs are part of the global function

of labor. Accountants who control the flow of capital, who make investment decisions and decide upon the movement of capital, are fulfilling the global function of capital, Johnson argued, and are like owners. Engineers and industrial psychologists, or managers who design quality control and monitoring systems, which increase capital accumulation, are performing the global function of capital and thus should be regarded as members of the capitalist class. On the other hand, Johnson went on to say, those who are engaged in a labor process should be classified as workers. Therefore, he said, bookkeepers and accountants who merely record the movements of capital and commodities are workers, as are engineers, supervisors, and other so called managers who coordinate production or merely implement control or surveillance processes.

When we speculate about how physical therapists would fit into Johnson's analysis of the labor process, it is obvious that staff therapists are workers, but we must decide whether physical therapy managers actually design quality control and monitoring systems or other new management systems intended to increase production, which in the case of physical therapy means processing more patients with the same amount of paid labor. If they do, physical therapy managers should be classified as agents of the capitalist class, whose interests are opposed to workers. If, however, the managers

merely implement policies and systems designed elsewhere; if they have no control over the allocation of health care resources, they must be analyzed as workers. Probably the functions are mixed; most physical therapy department heads, and especially physical therapy supervisors, mostly facilitate the flow of work and the efficient deployment of staff effort. Both physical therapy department heads in the hospitals studied in the field work, however, were active contributors to the design of quality assurance and control methods; the work they did which was seen as "innovative" was probably fulfilling the global function of capital.

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profession provides status, prestige, control of working conditions, and rewards which are superior to the ones available to ordinary workers. Because they, like their superiors, are invested with the ideology of the profession and professionalism, and because they depend on the approval of the professional elites for advancement, themselves, subordinate members of the profession adopt the advice and many of the attitudes of their professional elites. Thus, because of the interconnections at the elite level, the professionals at all levels on the professional status ladder show attitudes and behavior which benefits the capitalist class.

This model, although it depends rather heavily on ideology and neglects the material circumstances which might convince a therapist to consent to exploitation, makes progress toward explaining the puzzle posed by the case study of the physical therapy profession. Directors of Physical Therapy and department supervisors are elite members of the profession. They are convinced of the importance of containing costs, and also of the importance of having physical therapy provide the service so that potential clients will not be lost to competitors. Staff therapists who are lower on the professional status ladder but climbing it, adopt the ideas presented by the elite physical therapists, agreeing that it is necessary to contain costs and to get the

patients treated by physical therapists.

The elite of the physical therapy profession, like the elites of other professions, have relatively close connections with powerful societal elites, especially with medical elites. Some of the connections become clear when we examine the development of the physical therapy profession. Physical therapy serves, or at least can be said to serve, the interests of the state by avoiding excessive claims on welfare by injured and disabled persons. Providing physical therapy at minimum cost to the state thus can be said to serve the interests of the state. The aims and goals of elite physical therapists, and if the notion of status ladders is correct, of all physical therapists, coincide at least partly with the aims and goals of the capitalist class.

We can see that the literature points to considerable tension around the aims and goals of physical therapy. Physical therapy is expected to be of service, and that implies taking care of patients -- any patients who present themselves. On the other hand, physical therapy, by reproducing a labor force able to work, and by keeping injured workers and disabled people off the welfare rolls, serves the interest of the state by reducing the state's need for social expenditure. As professionals, physical therapists are in a position to demand, and to get,

considerable autonomy over the work they do. On the other hand, the state, as provider of the funds which pay them, must endeavor to ensure that its goals are met at minimum cost. Physical therapists are in an ambiguous relation with the state, which both awards them legitimacy and pays them, while at the same time controlling them.

The ambiguity of physical therapists' position with respect to their employers is further compounded by the fact that the department directors and physical therapy supervisors, an elite within the profession, are also physical therapists and have a common interest with physical therapy workers in maintaining the status and promoting the interests of the profession. At the level of shop floor experience, this ambiguity is likely to be felt as conflicting pulls. We will be examining how this tension is resolved by therapists on a day to day basis.

Before we go on to consider the data about physical therapy, however, we must consider yet another complexity introduced by the fact that we are studying a women's caring profession. We must examine the literature about care.

The meaning of "care"

Care as used in the literature has two separate, but associated, meanings. In one sense it means "caring about",

while in another "it describes the direct work which is performed in looking after those who, temporarily or permanently, cannot do so for themselves" (Parker 1980). A standard Canadian dictionary provides the same definitions, but not as succinctly (Avis 1980:206). The labor of caring includes helping, nurturing, educating, and supporting. Caring tends to be associated not only with women, but with the home and family. As Dymond (1984: 556) states, "'Caring' refers to the labor of tending to an infirm person, usually a child, parent, or spouse, within a household as part of unpaid work." Ungerson (1983) asked the question "why do women care?" She concluded that there are strong ideological and material reasons why women are the people who do the work.

Most literature about caring, with the exceptions discussed below, has been concerned with women caring for others at home. There are, however, a few exceptions to the expectation that women care in the home. These are "occupations where 'the woman's touch' has been incorporated into the job specification" (Graham 1983: 16). Nursing is one such occupation, of course; so is physical therapy.

Discussion of gender/care in the sociology of health literature

Care, except in connection with nursing or feminist literature, has not been discussed by sociologists. Thus, an

attempt to cull information on care from sociology leads us into various areas which touch tangentially on the topic of care. Some of them are surveyed below.

Historical

The sociology of health literature offers limited support for the hypotheses that gender expectations, as much as quality of care, affect the patients' satisfaction with health care, and that women health professionals are expected to care as part of their work. Historically, much of Canada's early institutional health care was provided by French nursing sisters, and the caring and service expectation associated with religious orders was clear:

The provision of health care and shelter for the aged was recognized as a public responsibility from the earliest stage of community development in Canada. In the early days an integrated approach was generally taken through the provision of public residential care with access to health services since most homes for the elderly were built under the auspices of a municipality, a religious order, or a lay voluntary organization.

(Walker 1982:107)

Institutional (as opposed to family) health care and care of the aged and infirm in institutions was a charitable, feminine activity in Canada.

Medical sociology and sociology of medicine

Medical sociologists such as Mechanic (1978) discussed the effectiveness of placebo, which embodied some element of

care in that it signified the medical practitioner was attempting to do something to heal the patient's symptoms. Deliberate use of the placebo effect was regarded as quackery, if practised by non-medical practitioners, or as conservative treatment of psychosomatic ailments, if practised by doctors (Starr 1982, Ehrenreich and English 1978). Little was said about care although acquiring a doctor's bedside manner was of some concern (Haas et. al. 1981). Predictably, since care is attributed to and expected of women in our culture, care was not mentioned in connection with the profession of medicine, which until recently was predominantly male.

Nursing and related occupations

Early sociological literature about nursing is consistent with the widespread tendency to associate women with caring. Later writers, however, examined the supposed natural functional role of women in caring more closely, and some even reversed their opinions. For example, Schulman claimed in 1958 that nursing combined a mother surrogate role with a healer role, but in 1972 he stated that "there is no longer any doubt that professional nursing has left the patient's bedside and that a majority of professional nurses have resolved the mother surrogate-healer role conflict by abandoning, circumventing or sublimating the mothering

functions of the nurse's role." Hospital economics, Shulman explained, dictated that professional nurses must fulfill an administrative role, leaving bedside nursing, or care-giving, to aides.

According to Hall's (1964:658) speech to the Canadian Nurses' Association, which presented a rather rosy picture of the old fashioned nurse, the traditional nurse was a private duty nurse. She was assigned responsibility for a number of patients (in contrast to what he saw as "the employee nurse" who would "see herself responsible for keeping a ward going -- in which case specific patients are secondary") the nurse's time and thoughts were measured in terms of patient needs. Time points for the old fashioned nurse, Hall suggested, were in the patient's time; the admission of the patient to the nurse's care, stages toward recuperation, crises of illness, and the "dramatic finale of discharge of the patient."

In the same article, Hall wrote about the changes in care which take place as hospitals become progressively larger and nurses became employed by them:

This shift seems to go on relentlessly as hospitals grow larger and thereby require larger nursing staffs. Such staffs tend to become depersonalized. Moreover, they are allocated to their tasks in terms of the requirements of the institution and the economical provision of services, rather than in terms of a personalized relation between a nurse and a set of patients whom she knows, who come to expect her and look forward to her services. In this situation it becomes progressively difficult for the nurse to provide traditional bedside nursing. Instead, she provides what care she can for patients who are essentially strangers to her. In such circumstances she is prone to feel some guilt for not living up to the standards of care she was taught to idealize in school. However, a vivid sense of guilt cannot change the impersonal rebatements back to the standards she was taught to idealize in nursing school.

(Hall 1964:658)

Hall went on to "describe an "employee attitude" which he characterized as clock-watching and grudging of the time it takes to care. He maintained it was different from and could not exist along with a professional attitude of caring for patients. His assessment of the move to employee status and some of its consequences proved be uncomfortably accurate, but he did not foresee that professional employees would maintain their desire to care (as well as the sense of guilt when they could not) and that that desire to care could be used to make them work harder.

Women employee professionals are expected to care, not only because they are professionals, but because they are women. Doctors, on the other hand, who are certainly considered professionals and are usually thought of as male (and

in the past, were mainly male) are expected to show their "care" and to perform their duties differently. What is expected of other male health care workers? Male hospital workers not only are expected to have a more instrumental approach to their work, they also show less interest in the care-giving aspect of their jobs. In a 1975 study of hospital work, Torrance (1984) found that only 11 per cent of the male workers in the laundry and kitchens of the hospital expressed intrinsic or service-oriented commitment to their jobs, while over 80 per cent of the women nurses in hospital work saw the service oriented aspect as a special feature of their work. Torrance acknowledged that he was comparing non-parallel occupations. — Still, the clustering of men into the support staff functions in hospital, with the women clustered in helping and service occupations reflects the gender difference in societal distribution of occupations. As we saw in the Cockburn (1985) study referred to above, even in health occupations which have patient contact and require considerable technical expertise, different expectations and different opportunities are available for women and men.

Until now, sociologists have not studied physical therapy although Gritzer and Arluke (1985) mentioned them briefly in their historical study of medical rehabilitation in the United States. There is no recent published discussion about men in physical therapy. In 1954, however, when the Univer-

sity of Toronto was about to admit male students to its physical therapy program, the opinions of male members of the Canadian Physiotherapy Association were sought. One responded:

If physiotherapy is to expand to become a universally accepted means of therapy on a plane comparable to Drug Therapy we must have more therapists who will make the profession a lifetime career.

Girls become good therapists but are better homemakers, hence the majority practise physiotherapy just long enough to acquire the experience necessary to become a good physiotherapist and thus leaving the profession with too many inexperienced and too few skilled therapists.

(Perkin 1954: 9)

Another wrote:

Frequently situations arise in treatment and procedure which are much easier for a man to handle than for the girls. . . . There are many points of administration to know . . . and it takes several years to really become familiar with treatment classification. It is more natural for a man to learn these because he is thrown into contact with the male staff. . . . It is the policy in D.V.A. to have a Director of Physical Medicine in charge of the departments. With all due respect to these doctors, I do find there is a slight tendency to over direct the technique of the therapist. . . . Here a male therapist is more likely to have longer experience and create better understanding between technician and director.

(Hopkins 1954: 10-11)

Times have changed in the years that have elapsed since those words were written. Women still marry, but they usually continue to work as therapists after marriage. Still,

many of the attitudes that Perkin and Hopkins mentioned above still persist, and the opportunities and expectations for women therapists are different from those for men.

The definition of care as nurturing, supporting, teaching, and helping those who are unable to care for themselves, is present in the minds of physical therapists. The expectation that women care because they are women, not because they are paid for it or trained for it, also pervades the physical therapy labor process, with the result that it is possible to get therapists to work hard by means of gender control. We shall be examining this issue with respect both to the history and development of physical therapy, and the present day labor process in physical therapy.

Useful directions and unanswered questions

In these two chapters, we have examined important contributions the literature makes to our understanding of the labor process of employed professionals. To do that, we have examined sociology of work and the professions, feminist, historical, and labor process literature.

By comparing what writers about the labor process said with what we know about physical therapy, we discovered that the Braverman concept of deskilling, while a good starting point, was inadequate to explain what is going on with employed professionals. From Edwards we took the idea of

evolution of forms of control through struggle. Although we found that his "stages of control" were too simplistic to describe what we can see in health care institutions now, the notion of contested terrain of struggle for control between management and workers is very useful.

Burawoy's "manufacturing consent" alerted us to look for ways the day to day process of getting the work done facilitates consent. It indicated the importance of studying the labor process on the shop (or physical therapy department) floor; it also justified the adoption of a phenomenological approach to find out what was going on.

When we shifted attention to the writers about the professions we were presented with several explanations of professional ideology, some of which explained how the professional ideology suits both the interests of the professionals and the interests of the capitalist class.

We considered caring and the ideology of caring separately from the ideology of professionalism, in part because information about caring comes from so many disparate sources. Caring, the literature warns us, is something women are expected to do because they are women. This insight proved very useful in analyzing the complex relationships among physical therapists, their supervisors, doctors, and their employer (which ultimately is the state). The

variety of theoretical approaches we have encountered should make us suspect that the situation is very complex -- which it is. Not only are physical therapists officially responsible to two authorities, their employer and the doctor, but also physical therapists are enmeshed in ideologies which themselves contain conflict (between service and status, for example). It is the purpose of this dissertation to examine not only the structural situation of this employed women's profession, but to explore how that situation is experienced and expressed. In the next section, we examine the historical development of physical therapy as a profession in Canada; later chapters examine the current structural situation and labor process.

PART II

THE DEVELOPMENT OF A GENDERED PROFESSION

CHAPTER FOUR

An Honorable Profession: Its Beginning

The first part of this dissertation introduced the study and discussed theory and methodology. We have examined the salient literature about the labor process and about professions. Efficiency is a major requirement in the provision of physical therapy services because health care is funded by governments, which must provide services to meet the demand while at the same time keeping the tax burden low. Management is required to provide as much of the product, health care, for as little money as possible. The drive for efficiency in health care underlies the various control measures that constrain the practice of employed physical therapy professionals. Physical therapists are induced to co-operate with schemes that intensify exploitation of their labor power. Often, physical therapists are induced to co-operate not only because of the idea of service to patients, but also because the new schemes appear to be "good for the profession." Now, it is time to look more closely at the profession, and the history of its development in order to make sense of the customs and attitudes that help shape consent in the physical therapy labor process. Some

knowledge of the history of the profession is necessary to understand what it means to be a professional, and especially to be an employee professional in a women's service profession.

Physical therapy work is varied and often interesting; the pay and working conditions are better than in many women's occupations (although not better than other professions), and the job market favors the workers, who have many vacancies from which to choose. Still, however, therapists are subordinate to and controlled by management and in a different way to physicians. In order to understand how this control is possible, we must know something about the occupation's history.

Systems of class and gender dominance act through seemingly trivial, everyday customs of speech, habit, and action as well as through laws and formal structures. Physical therapy is an occupation with its own culture, derived from its own history, and with its own stock of habits and customs which both shape and reproduce its relations with other groups. This chapter describes the development of physical therapy as a professional occupation, from the Society of Trained Masseuses founded in Britain in 1895, through the Canadian Association of Massage and Remedial Gymnastics to the present. This chapter is a brief

social history of the profession in English-speaking Canada. Incidents were culled from journals, other documentary sources, interviews and conversations with physical therapists who remembered how things were in the past. They were selected with a view to explaining the current situation of physical therapy: its relationship with medicine, its relationship with the state, and its position in a social hierarchy. This chapter and the next are included not as a definitive history of the profession, but to show how the current class and gender structured occupation developed.

Beginnings

In 1923, the journal editorial of the new Canadian Association of Massage and Remedial Gymnastics, a group struggling for recognition as a profession, said the following:

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. There are, of course, still some qualified masseuses in Canada, who are not members, but we hope they will join us when they realize, as they will one day, the prestige gained by membership in our Association.

(Cartwright 1923: 5-6)

By 1923, when that editorial was written, the C.A.M.R.G.

had established qualifications and incorporated most masseuses, masseurs, and remedial gymnasts who met those qualifications. Not only did they have to persuade powerful groups to employ only people who met their qualifications, they had to exclude "unskilled rubbers" whose activity might tarnish the image the new profession was trying to build. Profession and professionalism are essential components of the physical therapy work experience, and have been throughout its history. Fifty three years later, the sense of superiority to "unskilled rubbers" was still present. As a physical therapist, I wrote about the experience of working at the Olympics with people (in this case athletic trainers) who were not qualified physical therapists:

Well, opening day came and went. You probably saw a lot more of it than I did. All the therapy staff were required to congregate for a meeting at 2 p.m. The meeting consisted of the director telling us not to steal each other's uniforms and not to smoke, drink or take pictures while on duty, and other similar injunctions. I guess the homily was necessary -- there were all sorts of people working in our group. Some are professionals, like physiotherapists, and some are trainers whose knowledge and skills related to athletes are unquestioned but whose contact with professional organizations and codes of conduct has been limited. Still, it surprises and dismays me that these basic rules have to be repeated.

(Tapping 1976)

The profession was shaped by and reflects the class and gender structures of the large society which formed it. Gender structures appear in the way writers in physical

therapy journals unselfconsciously talk about "our physio girls" and "medical men". Class structures appear in the physical therapists' sense of superiority to other occupations. The class structure of Canadian society, which formed a frame within which the profession of physical therapy developed, also appears. Gender and class appear together in the kinship ties among the elite of physical therapy, medicine, and law.

Although interest in physical remedies dates back to ancient times, the modern profession of physical therapy began at the turn of the century. The Canadian Physiotherapy Association, an organization which now represents the professional interests of physical therapists in Canada, was known first as the Dominion Association of Masseurs and Masseuses. Its members were massage practitioners who had obtained their certification from the Society of Trained Masseuses in England. Even today, although the Canadian Physiotherapy Association is officially bilingual and has French speaking members, it represents primarily English speaking physical therapists. In Quebec the organization of health care services is sufficiently different from the rest of Canada to require a separate study. Thus, this short history primarily refers to the English speaking sector.

Physical therapy, being a health discipline, is under provincial jurisdiction even though the federal government

shares the cost of health services and over the years has introduced legislation, such the Hospital and Diagnostic Services Act of 1957 which provided for universal insured hospital services for all Canadians, and Bill C-227 in 1968, which provides universal coverage for medical care by doctors. The legislation which controls the practice of physical therapy is a provincial matter. Of necessity, one province was chosen for closest scrutiny. Ontario was convenient and judging by the 1983 membership figures of the Canadian Physiotherapy Association, it has more than twice as many physical therapists as any other province. Much of this chapter, therefore, concerns legislation which affected physical therapists in Ontario.

Roots

By the middle of the nineteenth century, allopathic medicine in North America was well advanced and had achieved public and state recognition of its form of healing. Medicine had achieved dominance by excluding occupations which competed with it. Women healers and midwives were labelled "old wives" (Ehrenreich and English 1972); men who healed by osteopathy and naturopathy were labeled "quacks" (Starr 1982). The profession of medicine was virtually closed to women because universities would not admit women to medical courses. Canada still took many of its customs,

particularly with regard to professions, from England, although in French Canada the tradition of care of the sick and indigent by religious orders was strong. In contrast with the French nursing sisterhoods, whose members came from the upper classes and who exhibited great pride in and religious devotion to their work, the English nurse was a domestic servant who often worked in unpleasant, degraded circumstances (J. Coburn 1974).

Victorian English middle class women, tired perhaps of being closeted in their families, sought useful work, and eagerly entered the profession of nursing which Nightingale founded in the 1860s. Nightingale herself was a gentlewoman who achieved her goals through relentless exploitation of her family ties and influence with medical men and law makers, but she sought to create a useful profession for women of both upper and middle classes. Nightingale established a profession in which ladies, or women trained to ladylike behavior, nursed people of every class, but under the supervision of doctors. Nurses under Nightingale took charge of all the caring tasks, from nutrition to bed making, that were needed to ensure the "curing" activities of the doctors resulted in healing. The Nightingale nurses were trained in hospitals and stratified on a class basis, with lady superintendents drawn from the upper class and registered nurses drawn from less wealthy social strata but trained in obed-

ience, self sacrifice, cleanliness, hygiene, sobriety, chastity, and other Victorian feminine virtues which also made them good employees (Cook 1942, Cope 1958, Woodham-Smith 1951).

Trained nurses' clubs, forerunners of professional associations, formed to promote the professional interests of their members. Some trained nurses of the time were midwives, others were masseuses, and some combined all three skills as nurses, midwives, and masseuses. All Nightingale nurses of the period were women, and all worked under doctors' orders. They were able to gain prestige and recognition as a profession not only because of Nightingale's strenuous efforts to persuade members of the ruling class to support "her girls" and the upper class origins of many nurses themselves, but also because some of the prestige doctors had obtained would be reflected on them.

Thirty years after the establishment of the first Nightingale school, nursing was well established as a women's profession in Britain. Massage scandals were widely reported in the English popular press of the eighteen nineties. Colorfully written articles about houses of ill repute alleged that the so-called nursing homes which promised to give massage to patients were merely a front for prostitution and extortion. Four nurse masseuses, members of a London trained nurses' club,¹ became concerned that the massage

scandals reflected ill upon their chosen profession. That might lead to a reluctance on the part of medical men to prescribe massage. They set out to reform the reputation of massage (Chartered Society of Physiotherapy 1985: 3-4).

The trained nurse masseuses founded a club, which they called the Society of Trained Masseuses (S.T.M.). The fledgling group was allotted a small room in the trained nurses' club, and it went to work improving the image of massage. Four founding members of the S.T.M. announced their existence in "Nursing Notes" and held their first official examination in 1895. Seven candidates were awarded the Society's certificate. A circular was sent to hospitals, nursing homes, and members of the medical profession. The circular announced the formation of the Society and published its Rules of Conduct. (Chartered Society of Physiotherapy 1985). The rules specified, among other things, that massage was to be done only under the supervision of a doctor and for therapeutic reasons; and that no general massage was to be given to men. A fee schedule was set. The rules required compliance with the Victorian notion of proper ladylike behavior, and they stressed the difference between trained, reputable, respectable masseuses and the persons involved in the massage scandals.

In 1896, the Society of Trained Masseuses invited "a select number of the medical profession" to become patrons.

With this move, they formally acknowledged the medical patronage that had allowed them, like nursing, to become an established, though subordinate, professional occupational group. In 1900, when its membership had reached 250, the S.T.M. became the Incorporated Society of Trained Masseuses (I.S.T.M.). During the first decade of the twentieth century, the I.S.T.M. admitted Swedish masseuses who combined remedial gymnastics rather than nursing skills with massage, but no men were admitted.

Prospective massage practitioners were trained in several privately-run schools. One of the most prominent, Paget's, was run by one of the founders of the I.S.T.M. Men were ineligible for membership in the society, but men blinded in action during the First World War were trained in massage at St. Dunstan's. The I.S.T.M., an offspring of the all woman Trained Nurses Association, and still lodged in premises in the Nurses' club headquarters, could not admit men. The rules of conduct specified that no member could give a general massage to a member of the opposite sex. The I.S.T.M.'s certification examination required not only a written paper, but a practical demonstration of skill, which involved having the candidate give a member of the examining committee a full massage. Therefore, examination of men by the all woman I.S.T.M. was impossible. The ladylike profession was in a quandary because the founders recognized

that men, like women, had problems which could benefit from massage, and they agreed that the military request to train men in massage was reasonable.

In 1905 the War Office approached the I.S.T.M. to examine male nursing orderlies in massage. The Society agreed with the provision that "only men of good character be allowed to train." They dealt with the ethical problem of administering massage to the opposite sex by arranging for the son of one of the founders, himself skilled in massage, to conduct the examinations (Chartered Society of Physiotherapy 1985).

Early days

In Canada, groups of masseurs and masseuses, people certified by the British I.S.T.M., began to organize in Toronto and Montreal around 1915. These groups considered applying for provincial charters, but eventually pooled their resources and obtained a Dominion Charter in 1920 as the Canadian Association of Massage and Remedial Gymnastics (C.A.M.R.G.). One of the ten founding members was a military man. Where before massage was considered a luxury, mostly useful for dealing with women's complaints, with the war the benefits of massage for men became more evident. The Canadian masseurs and masseuses found themselves deluged by demands for personnel to treat the mass of returning World

War I wounded. They organized an association to ensure that their standards would be maintained.

Government officials and medical men were beginning to recognize the need for services that would restore injured workers and soldiers to useful activity. A report by Mr. Justice Hodgins, commissioner, to the Legislative Assembly of Ontario regarding medical education in Ontario clearly stated,

The war has brought forcibly and immediately before the minds of all the pressing necessity for proper and scientific after-treatment of the wounded soldier. If it had not done so, it is probable that the question would have sooner or later been forced to the front by its own importance, emphasized by the operation of The Workmen's Compensation Act.

(Hodgins 1917: 74)

The Hodgins report was rich in detail and lengthy quotes from prestigious doctors. It made a strong case for various rehabilitative services, including massage and remedial gymnastics. Dr. Tait McKenzie (Hodgins 1917: 75) described the problems of the thousands of injured soldiers "useless from a military standpoint" who crowded holding areas called command depots.

a strange assemblage of cases: (shell shock); overstrained hearts; . . . rheumatism, real and unreal, in all its forms; . . . bronchitis of gas poisoning, asthma and even tuberculosis; profound debilities following typhoid, dysentery and malaria, requiring months of good food, light duty and progressive exercise to build them up. Then the wounded -- an endless stream -- feet and legs pierced by bullets, or pitted by shrapnel, arms and hands with torn nerves and jagged, tender scars, chests still containing bullets or pieces of shell; in fact, no part of the body escapes the awful and sometimes fantastic effects of the ordeal through which it has passed.

Dr. McKenzie, quoted by Justice Hodgins, suggested the solution to this carnage. The solution was physical therapy, performed by trained "operators" and directed by medical men.

For almost all these cases the treatment comes under what might be called 'physical therapy' -- electricity, hydrotherapy, massage, mechanotherapy, corrective exercises, physical training and marching. The Almeric-Paget Massage Corps has supplied trained masseuses, one operator being able to treat twenty cases a day. . . . The histories of cases neglected for months, or maltreated by unskilled amateurs, show the imperative necessity for careful training in this most important work. Many cases come in with limbs which have become wasted and joints stiffened by long immobility in splints, cases which must be slowly coaxed back to strength and usefulness by skilled massage and manipulation, and other apprehensive patients appear on inspection whose joints have been rendered painful, and in whom freshly formed scar tissue has been torn and inflamed by manipulation which a well trained masseuse would never have undertaken.

(McKenzie, quoted by Hodgins 1917: 75)

The medical men wanted trained "operators". Trained masseurs and masseuses viewed themselves as professionals. However,

I.S.T.M. members were governed by a code of conduct which specified that treatment would be under the direction of a physician, and they used the demand to their advantage. In spite of some reservations by organized medicine, which saw masseurs as another competitor like osteopaths and other "irregulars," Justice Hodgins' report to the Ontario legislature was accepted.

An intensive six month training course was begun, first in Whitby, then in the newly constructed University of Toronto Hart House in 1917. Enthusiastic, well born young women were trained in four sections; massage, muscle function training, occupational therapy and gymnastics (Maxwell and Maxwell 1979, J.C.P.A 1923, J.C.P.A. 1970). Courses in what later became known as physical therapy were also offered at McGill University in Montreal from 1914 to 1920.

When the pressing need for newly trained people to deal with the war wounded abated, the Hart House courses were disbanded in 1919. The University of Toronto did not reinstitute a physical therapy training program until 1929. The C.A.M.R.G. offered postgraduate courses so the Hart House graduates could upgrade their skills and pass the C.A.M.R.G. examinations. McGill offered a program in Physical Education for Women in the 1920's. This program was advertised in the Journal of the C.A.M.R.G., and it was directed by E.M. Cartwright, an early contributor to the Journal, but it seems

not to have been a physical therapy course. Until 1950, when for the first time 150 Canadian and only 105 British Chartered Society members were added to the Canadian Physiotherapy Association, the majority of new members to the physical therapy profession were immigrants from England.

The Canadian Association of Massage and Remedial Gymnastics (C.A.M.R.G.) published the first edition of its professional journal in 1923. At the time, it had 95 members (listed in the back of the journal) who were scattered from Victoria, B.C. to Halifax. Its activities were listed in an editorial in that first journal:

The outstanding work accomplished by the Association, apart from the steady gain of professional standing is as follows:

1. A Diploma, Seal, and Badge have been adopted.
2. An attempt to standardize the teaching of massage to Nurses in training has been made, and a Committee is still at work on this important matter.
3. An Advisory Board consisting of prominent Medical Men and Educationalists representing each Province has been elected.
4. An Advertising Committee is devoting itself to the Interests of the Association by trying to bring its aims before the public.
5. Series of lectures and demonstrations have been organized at the local branches.
6. This Magazine is the work of the present Officers and reflects great credit on their energy and enterprise.

(J.C.A.M.R.G. 1923: 3)

In the early years, the C.A.M.R.G. endeavored to make trained massage and remedial gymnastics a respectable healing occupation. To do this, the executive of the young association had not only to promote a positive public image, but also to police the activities of its members so that the public image it presented could and would be favorable. Editorials and letters to the editors show it took considerable persuasion to get masseuses to give up their old habits of treating everyone and to treat people only under the supervision of a doctor.

A signed promise has been given by every member to work under Medical Supervision and yet this promise, which like all promises should be sacred has been broken by more than one member and no resignations sent in. The sentiment, that no mercy could possibly be shown to those protecting themselves under the name of the Association whilst breaking its laws, was most strongly voiced at the Annual Meeting. To cut such members off from our Association is gain only since it leaves the remainder a true strong body.

(Editorial, J.C.A.M.R.G., March 1924)

Slow growth in the twenties and thirties

As clients, members of the C.A.M.R.G. had the permanently disabled war veterans, disabled workers, and private patients (referred by doctors, of course) who could pay for the services of a masseuse or masseur. The potential of physical therapy to contribute to the rehabilitation of the injured worker had been extolled by Hodgins in 1917; in

1915 the first of the provincial worker's compensation acts was passed in Ontario. The Canadian Medical Association, unconvinced as yet of the usefulness of physical therapy in patient treatment and not yet using the existence of physical therapy in its own fight to continue to control osteopaths and chiropractors, published an editorial expressing its skepticism:

At first reading it appeared as if he were trying to appease the righteous wrath of the osteopath by advocating for greater attention to physical therapy than has been given in the past, but a careful reading of the report makes it clear that he has the treatment of the returned soldier in mind. To a certain extent his contention is correct, although he probably overestimates the benefits likely to result from extensive training along these lines.

(Wilson 1918: 557)

The C.A.M.R.G. continued its efforts to maintain high standards and to exclude non-members from practising. This effort remained constant through the history of the professional association.* At first, the problem was to get qualified practitioners to join them. Then powerful groups within society had to be convinced of the worth of physical therapy. Family and personal ties between prominent members of the association and professional and social elites helped.

A prominent physician, Dr. F.W. Harvey of Montreal was made honorary president. As the president and a founding member of the Canadian Association of Massage and Remedial

Gymnastics, later the Canadian Physiotherapy Association, wrote, "Dr. Harvey's knowledge and co-operation helped us enormously, and his kindness in our problems has never faltered" (Graham 1939: 11). Dr. Harvey may have been an enormous help to the physical therapists, but he also served the interests of organized medicine when he wrote to the Canadian Medical Association Journal denouncing chiropractors and osteopaths and advocating the skill and knowledge of the C.A.M.R.G. members (Harvey 1922: 258). He stressed that the group's work "is only carried out under medical direction."

Mrs. Graham, who had been so grateful to Dr. Harvey, continued to document the personal and family connections which had helped the C.A.M.R.G. She wrote, "Mr. Charles M. Holt, K.C., L.L.D., too, our Honorary Solicitor, and the father of one of our McGill members, has been and still is, a faithful friend of the Association. His son, Mr. Mathew Holt, has taken up his father's work for us" (Graham 1939: 11).

In addition to appointing "medical men" as patrons, the C.A.M.R.G. was pleased to have them as instructors and to be allowed to attend medical lectures. Many articles in the Journal of the C.A.M.R.G. and in its successor, the Journal of the Canadian Physiotherapy Association, were authored by medical doctors. As an editorial in the C.A.M.R.G. journal

(J.C.A.M.R.G. 1923: 5) proudly reported:

The Canadian Medical Association which held its annual meeting in Montreal in June, 1923, opened its doors to the Association and allowed members the privilege of attending lectures by Sir Robert Jones and Dr. Mayo.

Medical dominance in the Canadian Physiotherapy Journal continued into the nineteen sixties. Doctors also continued to head physical therapy schools and to lecture in the physical therapy programs. The dominance began to lessen in the nineteen seventies as physical therapists themselves began to obtain advanced degrees in anatomy, engineering, epidemiology, physiology, kinesiology and psychology, which enabled them to publish in scholarly journals and to hold academic posts in the university programs which taught physical therapy.

This early dependence on medical men, the apparent eagerness of physical therapy to subordinate itself to another profession, sometimes puzzles young therapists today. They do not understand that the young physical therapy profession needed the protection and status afforded by medicine. Unlike chiropractors, who were businessmen and could operate independently, masseuses were primarily women who faced allegations of prostitution, charges of witchcraft, or charges of practising medicine without a license if they worked independently. Moving under the protective wing of

medicine was the best possible choice in the circumstances.

Like nurses, qualified massage practitioners worked for low pay. Some, like the founders and the people who ran the Association's affairs through the thirties and forties, had incomes which were independent of their work. Often they maintained their own offices to which patients came for treatment, but others worked like private duty nurses in middle class homes where they were given room and board. Masseurs and masseuses regarded their work as a profession, however, and depended on referrals from doctors for a steady stream of work. Remedial gymnastics, electrical treatments, and other forms of exercise were used primarily by practitioners who worked in institutions, also on patients referred by doctors. Between the two world wars, growth in the institutional employment sector was slow, but positions for therapists increased slightly.

During the period between the two world wars, the importance of governments in providing health services to the population had grown. The 1927-28 Canada Year Book (Dominion Bureau of Statistics 1928: 954-5) reported:

Greatly increased attention has been devoted in Canada during recent years to public health and its related subjects, the work embracing, in addition to the supervision of the general health of the community, the maintenance of hospitals and institutions for the care of needy and indigent persons.

The Year Book went on to describe general hospitals:

Such hospitals are generally erected and supported by the municipality, their actual administration being in the hands of a board of trustees; their revenue, in addition to that provided by the municipality, is derived in the main from grants from the Provincial Governments, from donations of individuals and societies, and from patients' fees. Admission and treatment are free to all deserving persons who apply for it and whose resources are so limited as to prevent their otherwise receiving proper medical attention The inability of private effort to cope with a problem of such rapidly increasing dimensions has led to the present Government control of the majority of benevolent institutions.

(D.B.S. 1928: 955)

Too few physical therapists worked for pay in hospitals in 1928 for them to appear in the hospital statistics, which included only doctors and nurses. Entrenched within the general scope of "medical care" by their policy of treating patients only with a medical referral, physiotherapists (as they were beginning to call themselves) worked their way slowly, and with great effort from individual leaders of their profession, into paid posts in public funded institutions.

During the nineteen thirties, the Canadian Association of Massage and Remedial Gymnastics published its journal in combination with the Canadian Association of Occupational Therapy as a cost saving measure. That journal was called The Canadian Journal of Occupational Therapy and Physiotherapy (C.J.O.T.P.). Publication was abandoned altogether for a period in the nineteen thirties because of a shortage

of funds, but during the Great Depression, the work of convincing hospital superintendents of the value of physical therapy continued. Miss Kathleen McMurrich, daughter of the Dr. McMurrich after whom a University of Toronto medical building is named, traveled around the country at her own expense, talking to medical men and hospital superintendents and securing hospital posts for members of the Association. A number of members who were superintendents of physical therapy services created more work in their hospitals, which then took on more physical therapists.

As a personal history of the the association by one of its founders and active executive members noted,

Others, like Miss Margaret Finley and Mrs. H.A. McKean of Montreal, have given months or years of voluntary work in new hospitals, finally convincing the authorities that physiotherapy was necessary in their institutions. Thus new posts were created for younger members.

(Graham 1939)

Thus, also, the tradition of sacrifice and gentle womanly devotion which had come from physical therapy's early association with nursing and remain in the occupation today, was maintained and reinforced in the growing physical therapy profession. The ideals of womanly devotion and sacrifice ensured that this type of care would be provided at a very low cost to the funding bodies, both charitable institutions and the state.

Wartime expansion

The Canadian Association of Massage and Remedial Gymnastics was successful both in attracting members and in selling their services. Publication of a journal did not resume until the economic upswing which accompanied the World War II. By then the unwieldy C.A.M.A.R.G. had been renamed the Canadian Physiotherapy Association (C.P.A.), a name it still has in 1987.

The war, like World War I, increased demand for qualified physical therapists, and physical therapists were eager to serve. Eventually, more than a third of C.P.A. members enlisted. The association was bombarded with requests for information from qualified physical therapists about where and how they should enlist. Enid Graham, who in accordance with the polite custom of the time was always called Mrs. Duncan Graham by physical therapists, headed the military affairs committee of the association. These are her recollections of the negotiations.

When the Committee first offered the services of our members to the Royal Canadian Army Medical Corps, suggestion was made by a Medical Officer sent to interview us in 1939, that our physiotherapists should enlist as "Warrant Officers". This we were unwilling to accept. We felt that the length of our University training, our social background, and our position in civilian hospitals warranted our receiving officer rank in the R.C.A.M.C. In our request for officer rank -- and other corresponding conditions of service, -- we had the generous support of the Canadian Nurses' Association . . . and of the Canadian Medical Association through the Secretary, Dr. Clarence Routley and the President-Elect, Dr. Duncan Graham. (Graham 1956: 16)

The personal ties between the elite of the Canadian Physiotherapy Association and influential elite of the C.M.A. are again evident. The physical therapists, with the help of Mrs. Graham's husband (among others) successfully negotiated that physical therapists would enter the army at the rank of 2nd. Lieut., with a promotion after six months to 1st. Lieut.

Growth of public funding in health care.

The physical therapy profession benefitted from the growth of public funding in health care. By 1943, concern with the economic need for a healthy population had reached the level of public debate at which it was discussed in the House of Commons and by the Special Committee on Social Security, which professed a "desire to relieve the people of the crushing burden of sickness in the home" (House of Commons 1943). This committee's report, which was commonly

known as the Marsh report, recommended that health insurance be provided on a Nation-wide basis, but under provincial administration. The working class recruits to the armed services in the war were not healthy; many were rejected as unfit for active service. Calls went up for welfare and health schemes to improve the health of the working class. The Royal Commission on Health Services noted "the production lost as a result of illness and the welfare expenditures which were a consequence of sickness" (1964: 5-6). As Walters (1982: 167) argued, money spent by the national government on health and welfare was seen not only as a drain on resources, but as an investment which would produce a healthier work force. Walters also noted that private health insurance plans were part of many labor contracts, therefore the working class may not have been as concerned to have universal health insurance as was the capitalist class. When government assumed the burden of paying for health care, the costs of paying for hospital and medical care for the labor force were spread over the entire tax base rather than an individual cost to each capitalist employer.

After World War II, the Canadian government again accepted responsibility for the care and rehabilitation of war wounded. It provided military and Department of Veteran's Affairs (D.V.A.) hospitals. Many demobilized army physical therapists found posts after the war in the well equipped and

staffed D.V.A. hospitals. Other places of employment for physical therapists were also developing. To express the health needs of special groups, and to support programs of research, public education and medical rehabilitation, a number of private, non profit societies formed.

- 1945 - Canadian Paraplegic Association
- 1948 - Canadian Arthritis and Rheumatism Society
- 1948 - Canadian Foundation for Polio-myelitis
- 1948 - Multiple Sclerosis Society
- 1953 - Canadian Diabetic Association
- 1954 - Muscular Dystrophy Association
- 1956 - Canadian Heart Foundation

Physical rehabilitation centers, special hospitals for handicapped children, and hospital departments of physical medicine were all established under the auspices of these organizations, which obtained public funding (discussed below) to build and staff them.

In 1951, concern with the results of the first Canada Sickness Survey (Dominion Bureau of Statistics and Department of National Health and Welfare 1956) prompted the federal government to convene a National Conference to discuss the rehabilitation of the physically handicapped. According to the sickness survey, (reported by Campbell 1956: 185) there were 957,000 people with substantial disability. Of these 423,000 were totally disabled and although half of these were in the working age group only 50,000 were gainfully employed.

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Campbell (1956: 185 - 186) reported that the federal government offered assistance to the provinces in the areas of vocational training, salaries "for a rehabilitation coordinator and his staff." These people were doctors specialized in rehabilitation. Most importantly, the conference established "a Medical Rehabilitation Grant of \$1,000,000 per year." The Medical Rehabilitation Grant could be used to pay the full cost of equipment for hospitals and rehabilitation centers, and the full cost of training doctors for rehabilitation. Where the funds were used to hire other staff (such as physical therapists) for hospitals and rehabilitation centers, the federal government would pay half the cost. As Campbell 1956: 186) also noted, "one of the great difficulties in advancing a rehabilitation program is the lack of properly trained staff and facilities to train that staff." Medical Rehabilitation Grant funds were used to help establish university programs to train physical therapists in Alberta, McGill University, the University of Montreal, and other programs which were established later.

The close connection between rehabilitation services and the political goals of the state are perhaps best illustrated by quotes from addresses given by rehabilitation doctors to national conventions of physical therapists in the nineteen fifties. In an address entitled "The relationship of medicine to democracy or the doctrine of the even chance",

delivered to a 1951 convention of the Canadian Physiotherapy Association, and printed in a subsequent journal issue, Gardner (1951-52: 34) said:

It must be obvious, in our present world, that no one with an unhealthy or crippled mind or body can have an even chance. Therefore, we can perhaps consider ourselves front-line soldiers in this battle because it is usually we who first come in contact with wounded bodies and spirits, we who are trained to heal them, and we who are best qualified to educate our fellowmen to understand and accept the responsibility the owe to the sick and disabled.

Surely, as democrats, as Christians and as members of the medical profession, in its broadest sense, we are pledged not to rest until there is adequate medical care available to all who need it.

After this remarkable statement, which managed not only to link rehabilitation with the advance of "democracy and freedom," but also to spread some of the mystique of the medical profession on physical therapists and appeal to their ideals of service, Gardner went on to declare:

Whether this (rehabilitation) project can better be handled by the state or by private enterprise is a technical and financial matter, and we may be wasting our time and strength by engaging in this controversy. What we, in medicine, must constantly insist on is the necessity for the provision of this care and express our willingness to play our part in any reasonable plan.

Gardner (1951: 35) made the economic argument for rehabilitation, drawing on the wartime experience and the example of England.

At the beginning of the War . . . it was soon realized that trained men were far more precious and difficult to replace than machines . . . and hospitals were established where the aim was not only to save life but to return pilots to combat duty. . . . The system finally reached such a point that almost 80% of all pilots injured were returned to full duty -- an amazing achievement!

The rehabilitation doctors had close links with their colleagues in the United States, where rehabilitation doctors also were addressing physical therapists. Rusk (1956: 128), like Gardner, Campbell, and all the other rehabilitation doctors who were championing the development of rehabilitation programs where physical therapists would work, concentrated on the rehabilitation of men as defenders of the American way of life, as producers and especially as consumers. Rusk asked:

How can the man who is doubled up by pain and disability stand up and fight militantly for the principles of democracy and freedom? Unless he can produce how can he enjoy the fruits of his labor and become a customer for the goods which all the world wants to sell him?

Equating an interest in rehabilitation with political maturity, Rusk said that nations,

particularly of the Asia-Africa area, have, after years of colonization, recently achieved the long-sought dream of political independence. Now they are desperately looking for ways of proving to the world, and more importantly to themselves, that they have the political and social maturity to justify their political independence.

Rusk (1956: 132) ended his address to the physical therapists with an anecdote about a congenital amputee from Bolivia who had received artificial legs and training in how to use them in a United States rehabilitation center and who had returned to his home. The story about the young man was run in a national magazine Rusk did not identify, but he quoted from a letter to its editor:

We found your article on Juanito gained us more friends (and respect) than all the millions our government is pouring into these countries. We noted no sudden pro U.S.A. feeling in Brazil as a result of the 75 million dollar donation given Brazil by the United States but we were pleasantly surprised with the many compliments for what the U.S.A. has done for Juanito. I . . . can tell you the peons in the backwoods knew all about Juanito within 24 hours after the issue was on the streets.

The physical medicine doctors (physiatrists) were active and valued sponsors of the profession of physical therapy. They campaigned for allocation of funds to rehabilitation. If the physical therapists noticed that full funding was secured for medical rehabilitation training and medical positions including a "rehabilitation co-ordinator and his staff" (my emphasis), there was no comment in their journals. Rehabilitation specialists loaded their speeches with all the popular cliches of the cold war and of society in the nineteen fifties. Rehabilitation promised to keep cripples off the welfare roles, and promised men a life of independent function as producers and consumers. Because rehabilitation's major argument for funds at that time was economic,

and in keeping with the social climate of the time, they stressed getting wage earners (a category in which they included only men) back to work. "Getting people on their feet," one of physical therapy's major services even today, was acknowledged, but given less value:

Sometimes, of course, the aim must fall somewhat short of this (the author meant return to work). The housewife who returns to her tasks in the home, or the crippled person who is restored to self-care, is just as successfully rehabilitated as those who find their goal through employment.
(Campbell 1956: 184)

At the time, housework was not regarded as work, women were not supposed to be wage earners if they were taking jobs away from men, especially veterans. There seems to have been no sense of the incongruity of having a man with such condescending attitudes to women and to women's work addressing a profession of employed women. Probably, the ideals of service and self sacrifice, and gratitude for having a prominent person interest himself in their profession, overcame any discomfort the physical therapists felt.

Today, physical therapists are just beginning to question the economic argument for rehabilitation, to ask whether return to full independence and getting a job is appropriate for the patient, or is what he or she wants. Few physical therapists are aware of their profession's history; the emphasis in the profession is so heavily on new scientific

research and new techniques that five year old journals are considered outdated, and are discarded to make room for new information. The aging of the general population, as well as a growing awareness that most of the clients of physical therapy are people with degenerative disorders, and that most are older and many are retired, will require physical therapy to rethink the justification for its existence. When that happens, habits of thought and images of appropriate professional behavior which came from the past may have to be discarded.

We have seen in this chapter how the profession of physical therapy got its start, first in England, then in Canada. The founders of the profession were women of means; the rank and file of the profession were not necessarily from comparable family backgrounds, but they by entering a women's profession, they entered a social world where they had to act like "ladies." In Canada, there have been some men among the leaders of the profession from its beginning, but much of the early work to get the profession established was accomplished with voluntary work by women of means. These women exploited social position, and family ties, and gender relationships to accomplish their goals.

We have also seen that physical therapy as a gendered women's profession had some utility for the medical

profession -- once it was clearly established in its place as subordinate, it could help in the fight against competitors. Similarly, the profession which could help rehabilitate injured soldiers and workers had considerable utility for the state, and once it was established as a women's service profession, sponsored and officially controlled by medicine, it was acceptable.

As we shall see in the next chapter, the apparent utility of physical therapy for the state continued to increase during its middle years. The new profession had to battle to avoid dominance from chiropractors and osteopaths, male gendered professions which were initially given authority over them. Only with the help of their physician sponsors were they able to separate themselves from what, in accordance with the dominant medical view, they were calling "quacks." Acceptance of domination by medicine, without which they probably would not have succeeded as a state-recognized occupational group, made physical therapists strong members of a subordinate occupation.

CHAPTER FIVE

Establishing an Independent Profession: Recent History

As early as the nineteen forties, the Canadian Physiotherapy Association had convinced some influential medical men of the need for physical therapy. As long as the physical therapists kept their place, properly respectful of the "real" profession of medicine and willing to treat patients only on referral from doctors, medicine was willing to offer physical therapy its protection and sponsorship.

Physical therapists saw the need to protect the standards they had established against dilution by people trained in short courses to answer the immediate demand produced by the war and by polio epidemics of 1942 and 1943. A report from that Military Affairs Committee (J.C.P.A. 1940: 16) warned:

Some of our members have been asked to give short courses in massage and electrotherapy to enlisted men in the R.C.A.M.C. and in the R.C.A.F. and to organize groups of women's volunteer associations. Members must realize that they are not permitted to do this under By-Law IV. Rule 4 of the revised C.P.A. constitution, unless permission has been granted by the executive.

They succeeded in their effort to prevent impingement by briefly-trained people, because the C.P.A. accepted the principle that no teaching of physiotherapy should be done by

its members except a short standardized course for nurses in training. This principle was embodied the C.P.A.'s rules of conduct. Those rules have been maintained until the present. Most importantly, the professional association managed to convince the military to accept their decision. Physical therapists did not "delegate the dirty work downward," (Hughes 1958: 135) as other professions, for example nursing, have done. The Canadian Physiotherapy Association consistently has opposed the development of training courses for rehabilitation aides, physical therapy assistants, or other people who could be given a shorter training and emerge with some qualifications that allowed them to do physical therapy work.

Training of other health care workers in physical therapy skills still provokes fear that other workers, for example respiratory technologists, will encroach on physical therapy practice. In 1986, the Ontario Physiotherapy Association, a branch of the C.P.A., circulated a position paper on cardiopulmonary physical therapy which maintained that

physiotherapists are the only appropriate practitioners of Cardiopulmonary Physiotherapy ... it is the Physiotherapist's education and training that enables him/her to recognize both the indications and contraindications of the various forms of physiotherapeutic intervention and that ability cannot be taught in a few hours of inservicing.

(O.P.A. 1986)

Pay

During the Second World War, the Association developed various additional committees to look after the affairs of its members. A salaries committee distributed a suggested salary scale to hospitals, with a minimum set for new graduates of "\$90.00 with lunch and laundry, and \$100.00 for those with six months' experience" (Graham 1956). Army salaries were advanced to \$4.25 a day, with 1st. Lieut. at \$5.00 a day equaling the Nursing Sisters of the same rank. That rough parity with nurses, established during the war, has persisted since. When parity was established nursing salaries were low, about the level for unskilled manual workers. After nurses formed collective bargaining units in the nineteen seventies, their salaries rose to the level paid skilled male manual workers (Gelmon and Williams 1982). Physical therapy salaries rose as well, nearly keeping pace with them. Only in the nineteen eighties have physical therapists looked outside the women's professions for a comparison group. Recently, recognizing that all women's salaries were depressed in comparison with men's, they selected pharmacists as a health care group with similar educational level and professional responsibility to which their salaries should be compared.

Educational standards

In 1942, an education committee and examining board set standards of fundamental training to govern eligibility to sit for examinations. The two years academic training which was available at the University of Toronto, followed by six months' internship arranged by the Association, were recognized as the standard for membership in the Canadian Physiotherapy Association, and recognized in legislation (discussed below). Since then, the standard of education has been upgraded several times. In the nineteen fifties, the accepted syllabus required three years university training, interspersed with and followed by practical experience and internship. In 1982, the basic requirement for membership in C.P.A. was upgraded again. Now, a four year University degree in physical therapy is the standard. Supervised residencies and comprehensive written examinations are required for foreign trained physical therapy graduates who wish to become C.P.A. members.

Protective legislation

In an address to the members of the C.P.A. in 1945, Captain Matron E.J. Ely stressed that they as an association were "organized for a very definite reason; first, to maintain the standards of training and professional practice; and second to maintain a register of members in good standing"

(1945: 11). This emphasis on standards and exclusive membership continued as the association grew more complex, and as physical therapists obtained greater professional autonomy. However, some of the work of maintaining lists of qualified members and of policing the lists to ensure adequate standards of care to the public was assumed by provincial licensing boards set up to protect members of the public from dangerous practices.

The professional association had to be sure that the provincial licensing boards enacted and enforced regulations which guarded the standards physical therapists had set for themselves, and protected physical therapists against competition from other skilled and unskilled providers of health care. Legislation Committees became an important part of the executive of the C.P.A., and reports on the progress of legislation in the various provinces became an important feature of the Annual Reports of the Association. These legislative struggles became prominent after the Second World War, but always they were a feature of the Association and the struggles continue now.

In 1923, Mr. D.J. McDougal, C.A.M.R.G., reported to the Association concerning legislation that would affect them. At that time, medical doctors, through their Canadian Medical Association and its branch the Ontario Medical Association,

were struggling to regulate and limit all non-medical forms of healing. The contradictory opinions within the medical profession about the status and usefulness of physical therapists have already been documented. The doctors proposed an amendment to the Ontario Medical Act requiring all persons "engaged in the practice of osteopathy, chiropractic, and drugless healing on January 21st 1923 . . . to file with the Provincial Secretary, within sixty days after July 1st." Mr. McDougal (1924: 17) went on to say:

Although the Toronto members of the Association (C.A.M.R.G.) were assured that it was not the intention of the Legislative Council of the Ontario Medical Association that they should be included among those persons upon whom the restriction was thus placed, the Provincial Secretary interpreted the amendment as including all persons engaged in the practice of massage.

Mr. McDougal and the C.A.M.R.G. won exception from that restrictive medical act for the masseurs and remedial gymnasts who worked in hospitals "under medical direction." However, masseurs and remedial gymnasts were included -- along with chiropractors, chiropodists, drugless therapists, and osteopaths, defined by regulations under the act (Ontario Reg. 2114/44). Osteopaths alone were required to pass an examination held by the Board of Directors. The Drugless Practitioners Act of Ontario (S.O. 1925) was the first legislation which directly included the new profession. It made no distinction between ordinary masseurs and members of the

C.A.M.R.G.

In 1944, the regulations under the Drugless Practitioners Act were revised. The 1944 regulations were amended to include a separate classification for physiotherapists. At the same time, provision was made for major and minor classifications. Chiropractors, osteopaths, and drugless therapists, the "irregulars" who were especially feared by the medical profession, were included under the 1944 regulations as "major classifications." Physical therapists and masseuses were in the "minor classifications." Members of a minor classification were not allowed to diagnose or prescribe; they were required to secure a referral from a medical doctor, dentist, or one of the major classifications under their own Act before they were allowed to treat patients (O. Reg 214/44, McNab 1970).

During this study, the information about the Ontario regulations was checked by reviewing the regulations in the provincial archives. The regulations (O.Reg. 214/44) define "chiropractor", "drugless therapist", "osteopath", "masseur", and "physio-therapist":

- (e) "physio-therapist" shall mean any person who practices therapy by means of manipulation, mechanistic, hydro, thermo, helio, or electrical methods, for the treatment of any ailment, disease, defect or disability of the human body, but who does not diagnose or prescribe.

and:

- 3.--(1) The major classifications shall be chiropractor, drugless therapist and osteopath.
(2) The minor classifications shall be masseur and physio-therapist.

It is not clear from the regulations just who was meant to prescribe what for whom; just that the minor classifications were not to prescribe. McNab (1970: 142), surmised:

Those engaged in the minor classifications were not to undertake any treatment except upon the prescription of a medical doctor, osteopath, chiropractor or drugless therapist. These prescriptions were to be kept on file, except where the masseur or physio-therapist was working in the employ of one of the above. Finally, these two groups were specifically prevented from attempting to make any adjustment of the bony structures of the human body.

Physical therapists persisted in acting independently from chiropractors and osteopaths. Physical therapists learned that the Drugless Practitioners' Act bound them to treating patients on referral from a doctor or dentist. Chiropractors in casual conversation with the investigator, however, more than once informed me that "chiropractors can refer to physios." The Board of Directors of Physiotherapy, in one of its annual reports, just says "the physiotherapists thought the old board was overly dominated by chiropractors and osteopaths." One physical therapist, a former president of the C.P.A. and chair of a program in physical therapy education was questioned about the effect of the Act, and the discrepancy between McNab's interpretation and the one that is commonly accepted by therapists. She stated firmly,

"McNab was very inaccurate. We didn't like her book at all."

The C.A.M.R.G., and its successor the Canadian Physiotherapy Association (C.P.A.) continued to fight for the exclusion of its members from the Drugless Practitioners Act. In 1940, they won a recognition, which they called a gentleman's agreement, that those physical therapists working in hospitals would not have to register with the Drugless Practitioners Act; only those who had private patients would be deemed to be "practising" under the terms of the Act. As an editorial in a 1940 issue of the Journal of the Canadian Physiotherapy Association (Graham 1940: 2) said in reference to that achievement,

This last step will mean a saving to future members of a thirty five dollar entrance and examination fee and to the seventy five active Ontario members an annual fee of five dollars. Most important, it clearly separates us from that group who do not work under medical direction.

The same journal (n.a. J.C.P.A. May 1940: 15) expanded upon the importance of C.P.A. in protecting its members:

For fifteen years, our Ontario members have deplored their inclusion under the Drugless Practitioners' Act, an act designed primarily to control osteopaths, chiropractors, chiropodists, and other drugless therapists. The Executive felt so strongly about it, that when British Columbia was faced with the same situation under the Naturopathic Act two years ago, they rallied all their forces, influential and financial, to exclude our British Columbia members from a like fate, and were successful in their fight.

By 1955, a Board of Directors of Physiotherapy had been established under the Drugless Practitioners Act of Ontario. This board provided for a governing body of physical therapists to administer the registration of people in their own discipline. The C.P.A. was happier with this arrangement, but physical therapists were or had been embroiled in legislative battles in Alberta, Saskatchewan, British Columbia, and Manitoba. As Kathleen Macpherson, (1955: 28) chair of the Legislation committee reported to the Ninth Annual C.P.A. Congress:

Manitoba has no legislation at the present time, but the C.P.A. Branch there has formed a Legislative Committee in order to be prepared for any move towards legislation. The Maritimes are still dormant--legislatively speaking--with very few C.P.A. members working there. Some doctors still think a few night courses will make an efficient physiotherapist. Quebec has not been heard from, but it is to be hoped that all members here will be on the look out for any move towards legislation.

Health insurance

By 1958, the federal Hospitals and Diagnostic Services Act had proposed a universal plan to cover hospitalization for all persons living in Canada, and all the provinces had adopted it. In-patient physical therapy was included automatically under the federal Hospital and Diagnostic Services Act of 1957. This gave all strata of patients access to

physical therapy while they were in hospital. Out-patient physical therapy was not covered. Physical therapy associations, with the help of their physician sponsors and spokesmen, endeavored to be included in provincial legislation which developed to cover services ancillary to medicare. In most provinces, they succeeded in arranging to have physical therapy office visits covered, at least in part.

It is ironic that in Ontario, the province which has the head offices of the Canadian Physiotherapy Association and more than twice as many of its members as any other province, the coverage for outpatient physical therapy services is the most restrictive. Therapists who were in private practice in 1962, and physicians who operated physical therapy clinics, obtained the right to bill the Ontario Health Insurance Plan (O.H.I.P.) at 70 per cent of the fee that was current in 1962, with no extra billing permitted. At that time, most physical therapists were employed in institutions and the issue did not affect them. No physical therapy clinics have been added to the list of those who may bill O.H.I.P. since 1962, however, and many clinic owners who have retired were not replaced. Since 1962, physical therapists who want to set up private practices in Ontario must either buy a clinic with an existing O.H.I.P. number or bill patients directly, hoping the patients either have the funds to pay their bills, worker's compensation, or private insurance

plans which pay for physical therapy. Physicians are not under such restrictions. They may open clinics which may or may not hire physical therapists, and which can bill O.H.I.P. for physical therapy services. Most physical therapy services in Ontario, as a result, are attached to hospitals and most physical therapists must work as employees.

In contrast, Ontario's almost 4000 chiropractors successfully obtained billing privilege with O.H.I.P. in 1969. Boase (1982: 337) estimated that in fiscal year 1980/81, 2.4 per cent of O.H.I.P. funds were paid for chiropractic. Chiropractors "balance bill" their patients approximately 50 per cent of the amount they bill O.H.I.P. Chiropractors see patients who walk in off the street, and treat many problems similar to those treated by physical therapy. They are all in private practice. A Medical Post article (Marmer 1974: March 5) concluded that chiropractic incomes exceed those of general practitioners and psychiatrists.

Organized medicine no longer seems to be interested in using physical therapists as a weapon with which to fight chiropractors and other practitioners they call "quacks." Elements of medicine again see physical therapists as a threat (Damude 1978, Gordon 1978). Therapists, pressing for independent practice and with their official stance opposing employment of physical therapists in medically controlled clinics, can be regarded as a profession similar to the

chiropractors, osteopaths, and other irregulars whom doctors fought to regulate in the recent past, -- or to the witches, midwives and housewives who delivered health care in competition with nineteenth century doctors. The maturing of physical therapy has again made it a threat to complete medical dominance among the professions. Physical therapists are now fighting for professional status and privileges on their own, as a competitive, not a sponsored, profession. The matter of billing privilege with O.H.I.P. is now of great concern to the 3000 Ontario physical therapists. Private practitioners say there is a large demand for their services, there are not enough of them to keep up, and potential physical therapy patients are lost to chiropractors (Steen April 9, 1985). Private practitioners in clinics without O.H.I.P. billing numbers must restrict their practice to patients who have extended health care insurance, worker's compensation, or other private funds to pay for services. Physical therapists employed in institutions (the majority of the profession) are convinced that the lack of "a free enterprise alternative" to hospital employment keeps wages for physical therapists down (Fryday Field 1985).

The C.P.A.'s Ontario branch (O.P.A.) claims it is an injustice and a risk to patients for the O.H.I.P. remuneration scheme to allow doctors to bill it for physical therapy services, whether or not qualified physical therapists per-

form the treatment. It also complains that chiropractors, performing many of the same treatments as some physiotherapists, are allowed to set up private practices; to bill O.H.I.P., and to charge patients above what the O.H.I.P. fee schedule permits, while physical therapists are restricted to institutional employment. O.P.A. spends a large proportion of its resources on negotiations to change the situation with O.H.I.P.

In Ontario now, several briefs have been submitted to the Health Disciplines Review Committee by all the occupations which are being considered for inclusion under the proposed Health Disciplines Act. It appears that physical therapy will be given certification status, with protection of title, but will not be able to prevent other disciplines from treating patients with physical measures. Chiropractors will be registered under the Act as well, with similar privileges to physical therapists. Massage therapists, a group that claims an area of expertise similar to the original Society of Trained Massage (England) (which was the parent of the Canadian Physiotherapy Association) will be registered under the new Health Disciplines Act for the first time. Massage therapists practice without medical supervision, although many of them have cordial relations with doctors who refer patients to them for treatment of pain and stress related ailments. No immediate changes to the funding system

which prevents physical therapists from entering private practice seem likely.

Now, in the 1980's, the Canadian Physiotherapy Association has passed the responsibility for attempting to improve legislation to its provincial branches. The Branches monitor developments in legislation and attempt to influence them favorably for physical therapy. The struggle to maintain the autonomy of physical therapy, to promote it as a separate profession, and to supersede their competitors such as chiropractic, only intensifies.

"Increasing awareness within government, amongst the profession and the public at large of the Association's standards and scope of practice" now appears as the fifth priority in a list of C.P.A.'s goals which includes, first, "The development of an academic body of knowledge which is the science and art of physiotherapy through research" and goes on to list goals related to "development of standards in physiotherapy practice and education, the attainment and maintenance of the Association's standards by physiotherapists, and the development of leaders within the profession and the association" (Canadian Physiotherapy Association 1983).

Sponsored profession to competitive profession

As the data from the early days of physical therapy show, the physical therapy profession developed with support and assistance from prominent physicians. Maxwell and Maxwell (1984) extended the terms developed by Hall (1948) to apply not only to mobility within a profession, but also to mobility of professions among society using the terms "sponsored mobility" and "contest mobility" to describe the activities of professions which are trying to gain public recognition, legislative recognition, and status. The Maxwells described the progress of occupational therapy in Canada. Although the professions are different and have developed differently, the concept applies equally well to the progress of physical therapy.

Physical therapy first gained legislative recognition, acceptance from powerful bodies in the community and hospital, and public acceptance with the help of physician sponsors. As the profession matured, it moved away from the protection of its physician sponsors and recently has engaged in political action, public relations, and internal reorganization appropriate to a profession fighting for recognition and status in open contest with other occupational groups. The shift from thinking about physicians as sponsors and role models to competitors has not happened all at once. Physical

therapists in many jurisdictions, are still nominally controlled by medicine. Just as importantly, the habits of deference, and the habit of thinking about doctors as the authorities on all professional issues, have not just disappeared. Rethinking their relationship with medicine and acting upon the new relationship is one of the major stresses of day to day work in physical therapy.

Working in the beginning as "trained operators" "under the supervision of medical doctors," physical therapists developed their skills and diversified their activities. By the Second World War, physical therapists held posts in general hospitals, entered the military as officers, and ran physical therapy clinics to treat wounded soldiers. In the nineteen fifties, they went to work in rehabilitation centers; they flew to northern outposts to treat patients stricken with polio; and they traveled to third world countries to establish rehabilitation services to deal with the effects of polio, leprosy, trauma, and the like. Physical therapy developed with the sponsorship of the medical profession; it gained some support from the state because it promised to rehabilitate (and thus remove from the welfare rolls) the injured and ailing. This support, however, was limited to employed physical therapists; private physiotherapy practice was and still is quite limited by government policy, especially in Ontario.

Although nominally physical therapists were working under medical supervision, and some facilities had medical department heads, the day to day physical therapy work was autonomous. Therapists made their own decisions about how to proceed with treatment, dealing with problems as they arose, and informing the referring doctor what they had found and what they had done. The actual autonomy of the physical therapist far exceeded the official autonomy granted by the legislation concerning the professions. The autonomy was "given" to physical therapists by doctors who "referred them patients" and "supervised" them very lightly or not at all. Being "heads" of physical therapy departments and sponsoring a subordinate profession enhanced the doctors' status -- and incomes. It also provided them with a handy weapon in the fight to control irregular practitioners such as chiropractors; physicians could argue that with physical therapy already provided within regular medicine, there was no need for alternative healers to be licensed.

By the nineteen seventies, physical therapy associations had begun to push for recognition of their independent professional status. The movement coincided with, and gained impetus from, the women's liberation movement and similar trends in other women's professions such as nursing. Physical therapists were no longer willing to accept the "doctor's handmaiden" role, but demanded recognition as con-

sulting professionals in their own right. This struggle for increasing independence came at a time when physical therapy budgets were increasingly constrained by concern about the high cost of health care. As we shall see when we examine the labor process of physical therapists now, constraints to health budgets led to increasing management control of physical therapy by workload measurement, quality assurance auditing, and increased standardization.

Physical therapists are asserting, and gaining, the right to practice independently; they are gradually removing the nominal "supervision" by doctors, only to have it replaced with more stringent controls instigated by the state and implemented by hospital and physical therapy facility managers.

In this section, we have traced the development of the physical therapy profession from a small group of trained nurse masseuses concerned about improving the reputation of massage to the present seven thousand member strong, diversified, competitive profession. Family ties and social connections, always important in the development of women's professions, served physical therapists well at first. In the case of physical therapists, the "family ties" included several husband-wife and father-daughter doctor-therapist connections, in which the respective demeanors of the

incumbents reflected the overall customs of polite society of their time. The "place" allotted to past physical therapists: resourceful, practical, adventurous, devoted to service, -- but subservient to doctors -- seems remarkably similar to "women's place" in the same times.

In these two chapters, we have seen how the physical therapy profession developed as a subordinate women's profession. For most of the physical therapy profession's history, it was subordinate to the medical profession, as the (mainly female) physical therapists were subordinate to the (mainly male) doctors. That subordination gave the growing physical therapy profession protection against persecution as competitors of the powerful medical profession, and allowed it to establish itself relatively quickly as a recognized occupational group with at least some of the characteristics commonly attributed to professionals. The utility of physical therapy and rehabilitation to the state, its ability to keep cripples off the welfare rolls and to turn them in to producing and consuming members of society, has played a large role in justifying the new profession, and has no doubt contributed to its success. Ideals of service and self sacrifice, so common in women's professions, made physical therapy both an attractive and a relatively cheap form of labor power to accomplish its goal of providing health and social services to meet the demand.

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PART III

THE LABOR PROCESS IN A GENDERED PROFESSION

CHAPTER SIX

An Employed Women's Profession -- With Exceptions

This chapter and the following one are included to give readers who are not physical therapists an overview of the profession and its work. It combines observations from the field work with data from government and professional documentary sources. Like all summaries, it glosses over many of the variations within the profession. Physical therapists, who do not need to be told about their own profession, would be wise to skip chapter six and seven, because knowing the field so well, they will be tempted to say "yes but what about . . ." at every sentence. It must be emphasized that this is a summary.

Official definitions of physical therapy

The Canadian Physiotherapy Association, the professional association for physical therapists in Canada, in a "Scope of Practice" document, defines physical therapy thus:

Physiotherapy is a professional health discipline primarily directed toward the prevention or alleviation of movement dysfunction in people. . .

A movement dysfunction may be defined as any alteration in normal body kinetics which limits effective or efficient body performance.

The more common movement dysfunctions with which physiotherapy is concerned are those resulting from pain; congenital abnormalities, disease processes, problems secondary to aging; from accident or injury, enforced inactivity, indolence or ignorance; and from psychological or social stress. They may be manifested in impairment, actual or potential, related to the neuromuscular, musculoskeletal, respiratory or cardiovascular systems.

The document goes on to list "the primary objectives of physiotherapy"

1. the determination of a person's potentialities for effective body movement;
2. the prevention of potential movement problems;
3. the correction or alleviation of movement disorders which cause pain or reduce movement effectiveness;
4. the maintenance of improved levels of movement;
5. the prevention of unnecessary deterioration of movement and function.

(Canadian Physiotherapy Association 1980)

It can be seen from this official statement about physical therapy that the discipline is concerned with physical treatment of bodily disorders. Mental, emotional or social problems become part of its official concern only when

they cause disorders of physical function. The official definition adopted by a corporate group, in this case the professional association which represents physical therapists in Canada, is interesting not only for what it tells us about what the group does, but because it tells us something about how they think about what the group does. This definition tells us, among other things, that the official business of the physical therapist is "body movement". It does not tell us what skills are involved in the practice of the profession; what rules and customs constrain it, or what the work is really like, either for the worker or for the person with the "movement disorder."

The Ontario Physiotherapy Association, a branch of the Canadian Physiotherapy Association, gives a definition of the practitioner, which again emphasizes the profession's preoccupation with the physical:

After graduation from a recognized School of Physiotherapy, a physiotherapist is one who is qualified to establish a physical diagnosis and determine the movement potentialities of a person; to plan and implement physiotherapy programmes using selected knowledge and skills for preventing or treating movement dysfunctions; and to participate in professional activities such as research, teaching, administration and consultation.

(O.P.A. 1980:25)

This definition tells us qualifications are required to

be a physical therapist. It also tells us that this group considers physical therapists are qualified to establish physical diagnoses and to plan and implement programs.

The definitions quoted above are the official professional definitions. During the field research, members of the public's responses to the term "physical therapist" ranged from "what is it?" to "I went to physical therapy when I tore my knee ligaments skiing." Perceptions of their role in the health care system range from "they have their own clinics but you have to be referred by a doctor" to "they're the people who come to get you out of bed when the doctor tells them to." Few members of the public in Ontario, where the present research took place, recognize that physical therapists can be independent practitioners, or that in certain provinces only some physical therapists can have their own clinics. People interviewed in physical therapy departments during the field work had a more realistic view of what physical therapists do than members of the general public, but none knew the legal or professional status of the therapists who were treating them.

Official government documents provide another source of information about physical therapists. The current Canadian Classification Dictionary of Occupations (C.C.D.O.) lists physical therapists in a unit group with "occupations concerned with giving therapeutic treatment to physically

handicapped, impaired or disabled persons to rehabilitate them, using physical, psychological and mechanical means. Includes treatment, using heat, water, light, sound, exercise, massage and other means;" (Employment and Immigration Canada 1986:56). The C.C.D.O. title "physiotherapist" has the term "medical" in brackets after it. Certainly the C.C.D.O. raters see the physical therapist as part of a medical care system. This is consistent with the physical therapists' view of themselves. Unfortunately, the whole definition of physical therapy appears to have been given to the C.C.D.O. by doctors about twenty years ago and repeated without revision since then. Reference to diagnosis is notably absent from the C.C.D.O. definition:

Plans and carries out programs of physical treatment, in consultation with physician and other health care workers, to rehabilitate injured or disabled patients:

Administers muscle, nerve, joint and functional ability tests to identify physical problems of patient. Assesses patient's symptoms and capabilities. Directs and aids patients individually or in groups, in exercises designed to assist in muscle restoration and joint mobility. Guides patient in remedial activities involving use of parallel bars, weights, traction and other equipment. Gives whirlpool and contrast baths and applies moist packs. Administers treatments, using diathermy, ultrasonic and microwave machines, infra-red and ultraviolet lamps, low voltage generators and other electro-therapeutic equipment. Instructs patients and their families in procedures to be continued at home. Records treatments given and patients' responses and progress.

This definition, although it appears in a 1986 document,

contains a list of the treatments and equipment used which might have been correct in the early nineteen sixties. Microwave is no longer used for physical therapy; low voltage generators have been augmented by interferential, transcutaneous electrical nerve stimulation, and other electrical treatments. Although physical therapists still use traction, weights, moist packs and hydrotherapy pools, these methods and machines are often supplemented by sophisticated (sometimes computerized) resistance exercise equipment. In the hospitals and clinics where most of the field work was carried out, most therapist treatment time was spent mobilizing, manipulating, and using other manual therapy techniques to treat problems with the joints of the spine and extremities, with massage and breathing exercises, and with exercise and patient education.

The location of practice implied from the C.C.D.O. dictionary is a hospital or rehabilitation facility. That is consistent with the findings reported by other sources. The majority of practising physical therapists in Ontario in 1983 (when the field work for the present study was begun) were employed in hospitals and in private practice physical therapy clinics; substantial numbers worked in home care and other settings (table 1).

The C.C.D.O. describes physical therapy work as light, with weights lifted less than twenty pounds. The C.C.D.O. assessors may have assumed the work was light because of the predominance of women in the profession. Less than nine per cent of physical therapists are men (table 1). Men are not evenly distributed; most of the men are in private practice and university positions, where the work is likely to be light. The proportion of women is nearly twice as high as the proportion of men in chronic care, where the work is likely to be very heavy. Proportions of women are higher in the areas of work which fit feminine gender stereotypes, such as pediatrics and home care. In home care, where the discrepancy between the proportion of women and men is most obvious, there is considerable part time work. Thus, although no figures on the comparative incomes of women and men in the field could be found, we may surmise from the ~~of~~ distribution that the small proportion of men in the field cluster into the high status higher paid jobs (table 1).

In addition to ignoring the uneven distribution of women and men in the profession, the official documents apparently ignore the physical effort involved in lifting and moving a patient's paralytic limb, helping a hemiplegic patient to stand, lifting a paraplegic from a floor exercise mat to a wheelchair, and the like. The admission requirements for physical therapy training programs make no such mistake.

They specify that applicants must be physically capable of performing the work of a therapist, and be physically fit (Gartland 1977).

The Drugless Practitioners Act of Ontario (R.S.O. 1970), a legislative act which controls the practise of physical therapy in Ontario, has counterparts in the provincial legislation of all the other provinces. Although it is outdated and will be replaced by a new Health Disciplines Act which is under review in 1987, the Drugless Practitioners Act provides us with information which is not specified by the other sources.

The Drugless Practitioners Act defines a physiotherapist as a person who is registered under the act. The registrar is directed to register as a physiotherapist anyone who is of good character and who is the holder of a degree or diploma in physiotherapy from any university in Canada having a course that meets the requirements specified. The specifications include a course of not less than 2600 hours of theoretical and clinical instruction which includes at least 250 hours instruction in anatomy including dissection "performed or caused to be performed by the instructor and the use of cadavers or parts thereof prepared by the instructor" (Board of Directors of Physiotherapy 1978:11). The act specifies that the course of instruction includes anatomy, chemistry, electrotherapy and physics, first aid,

gymnastics and recreation, hydrotherapy, massage and hospital techniques, medical and surgical conditions, physiology, psychology and psychiatry, and remedial exercises and methods of rehabilitation. It further specifies that clinical experience should consist of training of "not less than 1000 hours under the supervision of a physiotherapist in a public hospital approved under The Public Hospitals Act" (Board of Directors of Physiotherapy 1978 :11).

The current physical therapy syllabus of the University of Toronto (University of Toronto 1986) provides additional information about the knowledge and skills of the physical therapist. The University of Toronto graduates over sixty physical therapists per year, one of the largest classes of any institution in Canada. The University of Toronto program, like the other programs in Ontario, is more extensive than the basic requirements dictated by the Drugless Practitioners Act. It specifies bodies of knowledge and competencies which reflect the knowledge and skills now thought to be necessary for basic level graduating physical therapists. Emphasis is on anatomy, physiology, and kinesiology as basic bodies of knowledge upon which physical therapy techniques and skills are based and with which they can be evaluated. The program is divided into four blocks of courses, called basic sciences, clinical sciences, applied therapeutics (physical therapy) and electives. The clinical

practice component of the course now consists of 1160 hours of "placements" in physical therapy departments of hospitals and other treatment facilities accredited by the Canadian Physiotherapy Association. Completion of each internship period is required before the student may be promoted to the next academic year. Students in placements (internships) both observe physical therapists at work and apply their developing skills at assessment, evaluation and treatment.

Like all thirteen physical therapy education programs which now exist in Canada, the University of Toronto has a four year program leading to a professional baccalaureate degree. In 1976, the Canadian Physiotherapy Association (C.P.A.) passed a resolution which would amend the regulations of the association to require a university degree for registration as a physiotherapist. There was a grandfather clause which allowed physical therapists currently practising to register before 1980 whether they possessed a degree or not. Universities have offered degree completion programs to allow physical therapists who had only a diploma to complete their degrees. Now, all new registrants with C.P.A. either must have graduated from a Canadian university program in physical therapy, and thus have a degree, or must have passed the Canadian Physiotherapy Association examinations.

The professional association definitions of physical therapy are so general and inclusive they do not provide much information for people not familiar with the field. Government definitions provide more specific information, but much of it is outdated or incorrect. The field notes accumulated during the observational field work for this project describe many frequently seen acts and interactions in physical therapy. Very few of these are described in the available documentary sources. Physical therapists were seen helping patients to stand, to cough, to exercise, and to correct their posture and work habits. They were heard giving patients advice on job simplification, footwear selection, work scheduling, physical conditioning and activity selection. They were seen assessing and arriving at physical diagnoses; planning and recording treatments; communicating and negotiating with nurses, doctors, and other paramedical personnel as well as with patients and families. They were observed maintaining treatment records, writing protocols and communiques, teaching and evaluating students, and maintaining equipment used in physical therapy treatment. Many of these interactions were recorded with verbatim dialogue and gesture. Some of them appear as segments from the field notes throughout the dissertation. Before examining examples of physical therapy drawn from the field observations, we will look more closely at the education of therapists and the job market for them. Such information is

necessary "background" for understanding the labor process in physical therapy.

Physical therapy education

Physical therapists in Canada are educated at Universities, with the exception of one program at Mohawk College, in which the students pursue a three year program with similar content to the universities, then complete their degree with one year at McMaster University. In the past, the C.P.A. accepted for registration without examination physiotherapists who were certified by the Chartered Society of Physiotherapists (England). The Chartered Society of Physiotherapists also accepted physical therapists trained in Canada. This reciprocity, however, ended in 1980 with the introduction of a minimum requirement of a degree for Canadian physical therapists. Eligibility for registration with the Canadian Physiotherapy Association remains a basic requirement for license to practice as a physical therapist in most parts of Canada.

Students apply to the basic physical therapy programs after one or two years of university or college. There are thirteen physical therapy education programs running now in Canada (table 2). Applicants are expected, the admission requirements say, "to have a solid B average, in addition to being of good character and physically fit" (Gartland 1977).

Some programs require a personal interview, others require a biographical letter in the student's own handwriting, and others administer aptitude tests before admission (Balogun 1987: 39). Williams and Gelmon (1982: 259) reported,

it is estimated there were approximately 4000 applications for 500 positions in 1981-82 (the number of duplicate applications is unknown.) The program directors estimate that there are four or five "qualified" applicants for every position.

These authors go on to state skeptically that "such ratios impress academic administrators" (1982: 259). Because of the limited number of approved hospital placements available in any city, and because students must have supervised clinical experience intermixed with their academic work, it is usual, when more places are required for physical therapy students, to start a new program in a new city, rather than expand current ones. Five hundred bright, energetic and ambitious women and some men enter physical therapy programs each year. Few fail or drop out. When they graduate, they find employment in a job market which is continually expanding.

The supply of physical therapists

The number of active physical therapists in Canada is difficult to estimate, because most national figures are based on the membership figures from the Canadian Physiotherapy Association (C.P.A.), which is a voluntary organization. It was estimated in 1982 that about 70% of

registered therapists, that is, those registered with provincial licensing boards and therefore legally permitted to practice, belong to C.P.A. Membership ranged from 100% in Prince Edward Island and Alberta, where until recently the C.P.A. roster was used to determine eligibility to practice, to 33% in Quebec (Williams and Gelmon 1982, confirmed by J. Pape of the C.P.A. in telephone interview May, 1984).

A national health manpower study (Health and Welfare Canada 1981) which based most of its figures on information from national professional associations and current census figures, reported the number of physical therapists in Canada in 1980 as 4,673. This figure can be compared with the health manpower study's estimate of 232,820 registered nurses in Canada at the same date, 18,853 active civilian general practitioners, and 1,988 chiropractors. Extreme caution should be used in making such comparisons, however, because even though they appear in the same agency publication, the sources of data are mixed. The data for chiropractors in the Health Manpower Inventory, for example, came from chiropractic associations in most of the provinces, but from the Board of Directors of Chiropractic in Ontario. Thus, the Health Manpower Inventory used voluntary associations, which likely would underestimate the number of chiropractors, for all provinces except Ontario, and used a mandatory licensing body for its Ontario data. For nurses, the Health Manpower

Inventory used data from the Canadian Nurses Association, a voluntary national association like the Canadian Physiotherapy Association. Therefore, the underestimation is probably of the same order of magnitude as the underestimation for physical therapists.

The Health Manpower Inventory (Health and Welfare Canada 1981) gives data on population per practitioner ratios in the various health disciplines for the years 1970 to 1980. There was a large population per registered therapist in 1970. The ratio dropped as the number of trained and active practitioners increased. There was a marked variation from province to province (table 3). This reflects in part the variation in the proportion of practising therapists who are registered with the Canadian Physiotherapy Association, and in part the tendency for therapists to be employed in the urban areas. In the Health Manpower figures, Quebec appears to have a very high population per therapist. This is a reflection of the tendency for few French speaking therapists to join the Canadian Physiotherapy Association (they have their own professional corporation). Canadian Physiotherapy Association officials estimate that about one third of Quebec physical therapists belong to C.P.A.

Despite a steady increase in the number of therapists being trained, physical therapy is a small profession in

comparison with other health professions. The population per physical therapist ratio can be compared with the proportions for other health professionals (figure 1). Respiratory technology, the occupation concerned most directly with the growth of high technology life saving procedures, has had a growth rate which is strikingly higher than the other health occupations.

The job market

Physical therapists work in a variety of settings, but the majority work in hospitals (table 1). In a survey of Canadian Physiotherapy Association members, Gelmon and Williams (1983) found that 53.2% of the 804 people who responded to the survey held staff therapist positions. Supervisory positions, from senior therapist to director/administrator, accounted for a further 35%. These authors surveyed a sample which consisted of 100 per cent of the physical therapists in those provinces having fewer than one hundred C.P.A. members, and all C.P.A. therapists who were pursuing graduate studies in 1981. The Board of Directors of Physiotherapy, the mandatory licensing body, supplied a breakdown of their registrants by position of employment for 1983. Of 2485 physical therapists, 1707 (68.7%) were staff therapists; 480 (19.3%) were senior, sole charge, and directors of physical therapy¹. It is not surprising that Gelmon and Williams found a higher proportion

of both charge therapists and professors (3.4%) than the Board of Directors. Gelmon and Williams found 13.6% working in rehabilitation centers, in contrast with the 7.6% working in rehabilitation facilities reported by the licensing body. While this discrepancy could have come from the various definitions used, it is not clear from the information given which of the categories given in table 1 would be included in the Gelmon and Williams figures and the large difference in the results from the two studies can not satisfactorily be explained.

A recent survey of rehabilitation professionals conducted by the Ontario Ministry of Health (table 4)² showed that "full time equivalent (F.T.E.) budgeted positions increased significantly between 1984/85 and 1985/86 in all four rehabilitation professions; 7.7% in physiotherapy; 9.1% in occupational therapy; 11% in speech pathology; and, 5.5% in audiology. The highest percentage increases in F.T.E.'s occurred in boards of health and home care programs." Using figures from the licensing board for physical therapists in Ontario, the same report found that 61% of the 3,136 physical therapists occupying the 2226.4 F.T.E. positions were working full time; 26.3% were working part time; 6.5% were working casually. Less than 1% were working in other areas, 2.2% were seeking employment, and 3.4% were not working and not seeking employment.

An F.T.E. is not necessarily the same as one person employed (table 4). Funds received by the physical therapy department are sufficient to employ one full time therapist for each F.T.E. Thus the actual number of therapists employed, full and part time, can be much higher than the F.T.E. figure indicates. This has implications for interpretation of statistics on employment, and is the reason the Ontario Ministry of Health survey of rehabilitation professionals used Board of Directors data to discuss the supply of therapists available, but used F.T.E.'s obtained from facility administrators to estimate the supply of jobs.

Although the difference between full time and part time work was not a focus of the field work, it can be surmised from the number of part time therapists at one of the field work hospitals (appendix C), from the figures given by the Ontario Ministry of Health study, and from comments by therapists themselves that job sharing and part time work are common in physical therapy. The Director of Physical Therapy in one of the field work settings said:

Our part timers and job sharers prefer part time work. Some of them say they come out ahead financially, because they don't have child care expenses and they can be home with their families more. Besides, they keep up to date and don't have to worry about a lapse in their license while they raise their families.

In one of the hospital observation sites for this study, there were no part time staff therapist positions during the field work period. Part time physical therapists in the other field work hospital cover the weekend rotation, treating acutely ill patients who are expected to deteriorate if they do not receive physical therapy for two days. Part time workers staff the evening outpatient clinic, and part time and job sharers work a variety of partial day shifts, mainly in outpatient areas where patient appointments can be scheduled conveniently into the times the therapist is present. Except for the weekend shift, all part time and full time therapists retain their own patients. Thus, physical therapists say, part time physical therapy work appears to have no deleterious effect for the patients. Further study would be needed to ascertain the precise effects of part time physical therapy work for workers and their employers.

Gelmon and Williams found 11.8% of their national sample were pursuing other (non physical therapy) work. Gelmon and Williams (1983) survey questioned physical therapists about reasons for career breaks, and found most (52.7%) had stopped work to raise a family, but 36.2% were travelling and 27.1% were pursuing further education. Most of these respondents regarded the break in their career as temporary, and intended to return to physical therapy as part time or full time

workers. This finding was confirmed by observational data from the field work. Between 1984 and 1987, there had been four maternity leaves at one hospital and six at the other; one therapist had gone to part time work in order to pursue her career selling orthopedic equipment, and one therapist had left to travel. One of the therapists at the downtown hospital left her job after her second baby was born, in order to take a part time job at a suburban hospital closer to home, and one therapist who had been on educational leave from one hospital returned to her job.

Gelmon and Williams' sampling strategy captured a sample which may have been representative for their purposes, primarily to examine job satisfaction and reasons for attrition in physical therapy. They state,

The sampling fractions were adjusted by taking the square root of the size of the membership in each province and multiplying by a constant, rather than using a constant fraction of 25% for each province. This adjustment permitted a reasonable representation from all provinces.

(Gelmon and Williams 1983; 22)

Their survey is the only published source to answer many questions about the labor force and working conditions in physical therapy. However, their sample and the information they provided does not suit the present inquiry. Their sample consisted of physical therapists who were members of C.P.A., but it sampled different proportions of groups within

C.P.A. Gelmon and Williams included all therapists who were currently engaged in or who had completed graduate studies but were still members of C.P.A. In order to be sure to have data from the less populous provinces, they also deliberately over sampled the physical therapy populations of provinces with fewer than 100 members of C.P.A. One of these provinces was Prince Edward Island, in which all physical therapists were members of C.P.A. Because of the tendency for the less populous provinces to have most of their physical therapy facilities staffed with only one or two therapists, sole charge physiotherapists and directors of small departments are likely to be over represented in the Gelmon and Williams sample. It is difficult to ascertain distribution of therapists in jobs from Gelmon and Williams' published figures because of their sampling and data handling technique. Furthermore, because C.P.A. is a voluntary professional association, it is reasonable to expect that a sample of C.P.A. members might be more committed to the profession than a random sample of all physical therapists.

The Board of Directors' figures shown in table 1 and used for comparison throughout this chapter include all physical therapists who maintain their license in order to practice in Ontario. Registration with the Board of Directors is mandatory for physical therapists who wish to practice in Ontario; on the other hand, therapists who are still interested in the profession may let their registration

lapse if they are not actively practicing physical therapy. Thus, that "sample," which is really a population of practicing physical therapists in Ontario but could be regarded as a sample of Canadian physical therapists, underrepresents physical therapists taking career breaks for motherhood, education, travel, and other employment.

Since Gelmon and Williams' survey included all C.P.A. members who were graduate students and therapists with graduate degrees, the fact that they found a higher proportion of physical therapists who have left the field for other work or for further education is not surprising. The Ontario Physiotherapy Association, a branch of the Canadian Physiotherapy Association, conducted a survey of its members in 1979 (O.P.A. 1980). The O.P.A. results should be most comparable to Gelmon and Williams' because both surveyed members of the voluntary professional organization. The O.P.A. found that of the 1,401 therapists who responded to their questionnaires, 92.4% were actively practising physical therapy, with the remainder retired or unemployed. There is no mention of therapists pursuing other work.

Of the respondents to the O.P.A. survey, "57% were hospital employees, 16% were involved in private practice and the remainder were spread out amongst rehabilitation center employees, university teachers, government consultants, home

care plan, and industry. . . 68% being employed on a full time basis and 30% being employed on a part time basis" (O.P.A. 1980:71). The figures for full and part time work are close to the 71% full time and 29% part time which can be calculated from the Ontario Ministry of Health survey.

To summarize this information (table 5): The national health manpower survey (Health and Welfare Canada) and Gelmon and Williams' survey provide the only available national data. The manpower survey tells us that physical therapists have increased in proportion to the population; that there are fewer of them than of other health disciplines, and that their rate of growth is slower than that of respiratory technologists and chiropractors but faster than the established professions of dentistry, pharmacy, and medicine. Williams and Gelmon's data provide answers to questions about career patterns for physical therapists and about their satisfactions and dissatisfactions but because of their sampling strategy, it is questionable whether their results describe well the large population of employed therapists who were the focus of our study.

We have several sources of data about physical therapists in Ontario. One source, the O.P.A. survey, was based on a sampling frame of Canadian Physiotherapy Association members. It is subject to the distortions caused by sampling members of a voluntary association. The Ontario

Ministry of Health survey of rehabilitation professionals obtained more complete data regarding positions available by surveying employers. Its information about the employment status of physical therapists, as well as its estimate of the number of available physical therapists, came from the Board of Directors' figures. The Ontario Ministry of Health obtained the most complete data by surveying the employers of physical therapists and by using the registration data for all physical therapists practicing in Ontario. Surveying employers, however, is likely to miss some physical therapists in private practice, as well as many who are not working. The registration data from the Board of Directors misses therapists who have not maintained their license because it is not required in their current line of work. Thus, most homemakers and graduate students as well as many physical therapy faculty are missing from the Board of Directors of Physiotherapy lists. The lists are limited to practicing therapists.

An employed women's profession

From the available data, after considering the probable biases of the various samples, we can estimate that there are about seven thousand physical therapists in Canada, with the majority located in urban centers and in Ontario and Quebec. Over ninety per cent are women. We have no information

about their social class background, but they must have had good grades and suitable attitudes to gain admission to their university training.

Applying the proportion of private practice owners for Ontario to the rest of Canada, which may underestimate the number of private practitioners because of Ontario Ministry of Health Policies which restrict practice, we can estimate that about five per cent, or 350, are private practice owners. The rest are employed by health care and educational institutions or by private practice clinics. Of employees, twenty to thirty per cent hold senior or supervisory positions, and fifty five to seventy per cent are staff therapists. Sixty to seventy per cent of physical therapists work full time, with about thirty per cent employed part time. Thus, we can conclude from the available evidence that with few exceptions, physical therapy is an employed women's profession in Canada.

In this chapter we have examined the formal definitions of physical therapy; the training of physical therapists; and the job market for physical therapists. In succeeding chapters, we will examine the type of work physical therapists do. As in this chapter, the information in the next is presented primarily as an orientation to the field for readers who are not physical therapists.

CHAPTER SEVEN

The Daily Work

By this time, a picture of physical therapy as an employed women's profession has emerged. We know how the profession emerged, and we know about the rules and definitions that define it now. But what is physical therapy? What does the daily work look like? This chapter examines the practice of physical therapy, drawing mainly on the field notes and the few documentary sources that give us clues about the labor process in it. Some commonly used terms in physical therapy are explained.

Working conditions, pay and satisfaction

Since this thesis focuses on employed women physical therapists, working conditions for them will be discussed here. Working conditions vary from setting to setting, and for staff therapists, department directors, private practitioners, and home care therapists, but since the study did not focus on them, they are omitted from this brief overview. Full time physical therapists work seven and one half to eight hour days in hospitals and rehabilitation centers. Most work is Monday to Friday, but some settings require occasional weekend and evening work. Staff

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therapists may take turns, or "rotate" onto evening and weekend work, or those shifts may be filled by part time staff therapists. In a very few settings, physical therapists are on call for night duty. Starting and quitting times vary from facility to facility and within the facility. Often, the physical therapist can negotiate variations in starting times, giving the appearance of "flex time." Institutional routines such as meals and meetings and other elements constrain therapist schedules, however, and in practice the choice of working hours is limited by the demands of the job.

Williams and Gelmon (1982), in the national survey of Canadian Physiotherapy Association members discussed in chapter two, reported the socioeconomic status of physical therapists using the Blishen index (Blishen and McRoberts 1976, Blishen and Carrol 1978). The Blishen scale indicates the relative prestige or social standing of occupations. It is calculated from a procedure which, according to Blishen (1971: 496):

consists simply in constructing a regression equation which has as the dependent variable the Pineo-Porter scores for the 88 occupations that overlap the census list, and has as the independent variables the corresponding income level and educational level indices. The regression weights so determined are then applied to all census occupations.

The possible scores range from a low of 14.4 for men who

are hunters and trappers to a high of 80.8 for women who are physicians. The socioeconomic index score for women who were therapists in 1971 was 65.4, and for men the score was 53.2. Women therapists ranked 53rd among 500 occupations, and men ranked 137 among 500 occupations, possibly reflecting the larger number of high status occupations available to men in 1971 (figure 2).

Williams and Gelmon (1983: 281) also compared rates of pay for physical therapists with the wages of industrial workers and other professional occupations. They said:

Before the adjustments in salaries of health professionals were made, following the large wage increments given to nurses in 1974, the average physiotherapist in Ontario could expect to earn the average wage of an industrial worker. By 1981 . . . the average physiotherapist could expect to earn 1.25 times the average industrial wage. It should be recognized that successful bargaining by militant nurses in unions has produced benefits for all the health professionals.

These authors went on to say:

In the meantime, physicians in Ontario have won large increases, so that by 1987 their earnings could be between 5.4 and 6.0 times the average industrial wage. Nurses will push for large settlements as will other health professionals. There are attempts underway to peg the salary of physiotherapists to that of a more senior professional, such as a pharmacist, in which case increases will be greater still.

Pay rates are negotiated individually by the department director with the hospital administration. It is difficult

to get up to date comparative information. In one of the field work hospitals, the Director of Physiotherapy reported that she had negotiated substantial raises for the physical therapy department in 1986, and that they were now within 2% of the rates for the hospital pharmacist. This does not yet appear to be a general pattern. An article in a newsletter of the Ontario Physiotherapy Association in 1986 reported:

Physiotherapists from many hospitals across the province are expressing sentiments from amazement to anger, frustration and helplessness when they discover that they are being paid salaries comparable to those paid to other allied health professional (sic) who have less education and independence for decision making. A 'mini survey' of 1985 salaries paid at 7 smaller hospitals in southwest Ontario showed a mean starting salary of \$2375 month. The same facilities paid technicians (lab and x-ray) just 3% less (\$2305). Another 'mini survey' of 13 larger hospitals, again reporting 1985 rates, revealed a mean starting salary for physiotherapists of \$2261. Registered Nurses at some of these same facilities are compensated at approximately this same rate. Technologists under the bargaining units of CUPE are also paid similarly, with additional bonuses for courses specifically completed and generous overtime compensation.

(Crowe 1986:5)

Crowe went on to say that administrators argued that they had to meet large settlements awarded unionized staff and groups with strong provincial representation, and physiotherapists were awarded the leftovers. Despite the inflammatory tone of the article, which then went on to suggest that physical therapists approach their hospital administrators with "a brief outlining the educational background required for the

practice of our profession, the use of physiotherapists as consultants in the diagnosis and management of the patients" the information given is clear. Physical therapy salaries have increased, but physical therapists have not held their position with respect to other, more heavily unionized, health personnel.

Outpatients and inpatients

In all but the smallest hospitals, physical therapy work is divided into "inpatients" and "outpatients." A therapist assigned to treat "inpatients" goes to the hospital wards, and often to the patients' bedsides, to treat them. "Inpatient therapists" are usually assigned to particular wards, and they treat all patients referred from those wards. In most hospital physical therapy services, a policy exists that therapists will assess (explained further below) patients referred by doctors, nurses, and other health care personnel, but a doctor's order must be written on the patient's chart (hospital record) before active treatment begins. This policy allows physical therapists to assess all referred patients, and to recommend treatment or to say physical therapy can do nothing for the patient, while eliminating the necessity to treat all suggested patients. The requirement for a doctor's order thus controls the flow of patients. "Doctors' orders" are seldom more specific than

"physio please" or "assess and treat for back pain" (O.P.A. 1980, Miles-Tapping 1985).

Instead of being assigned to a "ward" (section of the hospital) which could be medical, surgical, gynecological, pediatric, etc., therapists in some large treatment centers are assigned to a particular service. This allows therapists to specialize. In the Health Sciences Centre in Winnipeg, for example, therapists are organized into Neurosciences, Musculoskeletal, Respiratory, and General Medical-Surgical services, and treat both inpatients and outpatients who require the type of treatment in which the service specializes. Inpatient therapists have flexible schedules, into which they fit their assigned caseloads, other duties, and interruptions as well as they can. In contrast, outpatient therapists have patients arriving for regularly scheduled appointments, and they must keep as close as possible to the schedule. On some services, and in small hospitals, physical therapists treat inpatients for part of the day and outpatients for part of the day.

Physical therapists assigned to outpatients see and treat patients referred to the physical therapy department from doctors in the community. The requirement for a doctor's referral is fairly consistent policy in hospital physical therapy departments; it serves to control the flow of patients. The Director of Physical Therapy in one of the

field work hospitals reported that she had launched a concerted search to find the written hospital policy which required a medical referral since, she said, no law requires a medical referral. The Director of Physical Therapy suspects the policy is mere custom, and was never written. The hospital administrator thinks "it must be there somewhere." There are no plans afoot at present to alter the custom of requiring medical referrals in that department.

Outpatients must be ambulatory or otherwise able to get to the physical therapy department for treatment; therefore in general they are less sick than inpatients. Like inpatients, they may have respiratory, musculoskeletal, general or neurological problems or a combination of disorders, and they may be children, elderly, or adults of any age and social class.

Physical therapy work varies from hospital to hospital. It varies more between hospitals and specialized settings such as rehabilitation centers, workmen's compensation hospitals, and private practices, which may be general or specialized, e.g., to sports physical therapy, back problems, industrial injuries, etc. Schedules, charting, and other aspects of control of the physical therapy labor process are described in more detail in the appropriate chapters later in the dissertation. None of the features of work organization

in physical therapy is constant, although some patterns, such as the division between outpatients and inpatients, appear consistent because of federal government policies for payment and record keeping. It should be noted, however, that schedules, charting, and all the forms of control of the labor process discussed in this study cut across and affect nearly all types of physical therapy work.

Assessment and treatment

Typically, a physical therapist receives notice of a new patient referral by means of a form delivered to the physical therapy department by the hospital's internal mail system. Some doctors' offices telephone outpatient referrals to the physical therapy receptionist and send a referral form with the patient. New inpatients are seen right away, within a day or at most two. Outpatients may be assessed right away or put on a "waiting list" and given an appointment when one becomes available. Waiting lists may be a few days to a few months long, depending on facility policies and volume of patients referred. On the first visit, either to an inpatient in a hospital ward or by an outpatient to a physical therapy department, the therapist assesses the patient. The assessment process consists of asking a lot of questions about the presenting complaint, any associated problems, general health and activity levels, and lifestyle requirements such as job demands and leisure activities. A

physical examination is conducted. The patient is usually required to undress so the therapist can examine the affected part, and is asked to bend and move the affected part, to submit to having it passively moved, prodded, and examined by the therapist's hands, and to demonstrate its use in functional activities. Measurements such as range of motion of joints, muscle girth, muscle strength, coordination, and the like may be taken. The history taking and examination is usually detailed and takes 30 to sixty minutes to complete, but the therapist adapts it depending on the condition of the patient and the time available. It was not possible to record a complete assessment in the field notes, both because of the time taken and because of the requirement to protect patient privacy. The field notes do contain several accounts of reassessments; shortened assessments conducted by a therapist who has not seen the patient for some time, or who has taken over the patient from another therapist. The following field note account of an assessment of a patient referred for shoulder pain is just one example of an assessment and treatment. This experienced therapist, guided by information already in the previous therapist's notes, sounds much more directive than therapists like to sound in initial assessments. This segment from the field notes not only illustrates a "reassessment, it shows the way the therapist must negotiate with the patient about the kind of

treatment she wants, and the times she is willing to come to physical therapy for treatment. In the note below, the abbreviation "Th" refers to the words of the physical therapist, and "Pt" refers to those of the patient. Exact quotes are surrounded by double quotation marks and approximate quotes are surrounded by single quotation marks. Names have been changed to protect confidentiality.

09/20/84

3:15 p.m.

Th: "Mrs. Grodo?"

Pt: "Yes?"

Th: "I'm Mildred Jones. I'll just take a little time to read about you."

She pauses less than one minute, reading the patient's chart.

Th: "Now, you have pain in your neck?"

Pt: 'Yes. Still about the same.'

The patient has a European accent and speaks softly, which makes some of her replies difficult for the observer to understand. The therapist appears to have no difficulty, perhaps because she is closer to the patient.

Th: "And you had traction?"

Pt: "But not anymore."

Th: "Yes. Discontinued last week."

She pauses again, reading and flipping pages in the chart.

Th: "And you had neodynator?"

Pt: 'Mmm?'

Th: "Neodynator? That machine with the suction cups?"
(pointing)

Pt: "Oh, yes"

Th: "And did it help you?"

Pt: "Well"

Th: "But you think it might be helping?"

Pt: "Well, yes, I guess you've got to"

Th: "O.K., We'll put you on that first. Do you like it?"

Pt: "No, but I guess you got to take it if it'll help."

They walk away together towards the gym side of the department and the conversation becomes inaudible.

4:00 p.m.

The same therapist and patient have returned within earshot of the observer.

Th: "O.K., lie down. I'm just going to put my papers down over here."

Pt: "That's O.K."

Th: "Just now, I'm just going to move this a bit."

The patient is supine on a plinth (padded treatment table) with a pillow under her head. The therapist is by her right side. She slides her right arm under the patient's back between the shoulder blades and supports the patient's right arm with her left, guiding it through shoulder flexion with the patient's elbow bent. The patient grimaces.

Th: 'Now where's the pain?' (The patient responds, but the words are inaudible to the observer two meters away.) "Yes, you know I think some of that pain is coming from your neck. Let me try the other."

She goes to the other side of the plinth, repeating the examination of the shoulder movement.

Th: "Oh, that's a lot better, isn't it? Let me write that down, I can't remember anything if I don't write it

down."

She moves back around to the patient's right side. She has been holding the patient's right arm in her hands, one palpating (feeling the tissues) near the shoulder joint, and the other performing small amplitude passive movements of the shoulder joint.

Th: "Does that hurt?"

"How about that? Better now?"

"Do you sleep on this shoulder?"

Pt: "Yes."

Th: "Does it wake you up when you sleep on this shoulder?"

The patient's reply is inaudible to the observer.

Th: "Do you sleep well?"

Another inaudible reply.

"No, eh? Have you had X-rays of your neck?"

Seven minutes later, the therapist is still with the same patient, but is now treating the shoulder with mobilizations (to relieve pain and improve range of motion).

Th: "I'm just going to go easy at first, to get the feel of the shoulder. What day do you come in?"

Pt: "Thursday."

Th: "Do you come in twice a week?"

Pt: "Yes."

Th: "Would it be O.K. if I put you on two different days, Monday and Wednesday, because I've got a different person in that slot?"

Pt: "O.K. sure. Do you want me to come tomorrow?"

Th: "Oh, Wednesday. No. Tuesday and Thursday for this week, then switch over. Here, I'll write it down."

Pt: "O.K."

The therapist leaves, and the patient is now standing.

She gets dressed in a plain T-shirt. She had kept her bra and black slacks on with a blue halter (provided by the physical therapy department) over the bra. When she left she was wearing the T-shirt and slacks, carrying a handbag and a black jacket and the blue top. She looked about 45 years old.

After examining the patient and noting all abnormalities and problems found, the therapist typically records an assessment, diagnosing the physical problem and making plans for treatment. Treatment often consists of advice, exercises taught, active and passive movement, mobilization and manipulation, of the joints, thermal modalities such as hot packs or pool, and electrical treatment such as faradism or ultrasound (a treatment thought to promote circulation and healing) and transcutaneous electrical nerve stimulation (TENS), a treatment for relief of pain. The treatment varies widely, depending on the problem, the condition of the patient, the training and experience of the therapist and the customs and facilities available at the site of the treatment. It can be directed to any of the types of patient problem listed in the scope of practice and it may include any of the treatment methods, often called modalities in physical therapy parlance, included in the scope of practice.

Physical therapy work is varied, has a great deal of patient contact, and is described as interesting by its practitioners. There are problems and pressures, however. As Gelmon and Williams (1983:28) reported, "the outstanding finding of this study was the high level of satisfaction

reported by a large majority of the participants -- all C.P.A. members -- in our study. These therapists were satisfied, with the profession as a whole, as well as with their opportunities to pursue professional interests, their responsibilities in patient care, the supervision and administration of their work, and their basic working conditions." This finding was echoed by a study done by the Ontario Physiotherapy Association (O.P.A. 1980:52),

Ninety one percent of the respondents are happy with their choice of physiotherapy as a career and 93% of them intend to continue in it as such. Eighty-one percent are satisfied with their present employment and 91% are practicing in their preferred location. Ninety-five percent are proud to be physiotherapists. Eighty-five percent are satisfied with the degree of independence they have in their work situation. Ninety percent describe their working relationships with other professionals as satisfactory.

Both these studies were questionnaire surveys of members of the Canadian Physiotherapy Association. It is reasonable to expect that professional workers who belong to a voluntary professional association will express satisfaction with that profession in addition to the "satisfaction bias" commonly found in questionnaire surveys. In addition, Gelmon and Williams surveyed a high proportion of people in influential posts, such as directors of departments and physical therapy educators. There is no indication of the breakdown by job status of the respondents to the O.P.A. survey. The O.P.A. survey asked physical therapists to rank order job

satisfactions but not dissatisfactions. We can presume that therapists are relatively dissatisfied with an item if it ranks near the end in a forced choice situation where therapists are required to rank order "satisfactions."

The order in which the respondents listed their "satisfactions" tends to confirm the suspicion that all is not well in physical therapy and that the most dissatisfaction is expressed in relation to those parts of the labor process that are most closely controlled. The most satisfying part of their job, said the O.P.A. respondents, was "amount of independence" followed by "usefulness of learned skills" and "amount of decision-making/responsibility for choice of treatment." Physical therapists are responsible for choice of treatment, and they have the opportunity to use their skills to the benefit of their patients. Patients often experience relief from pain, improved function, and the like, and they express their thanks with cards, notes, flowers, and candies.

Physical therapists do not have as much control over the pace of work or its quality as they should have considering their responsibility for treatment. The field observation that physical therapists feel frustrated by pressure to speed up was confirmed by the fact that "Control over pace and quality of work" ranked tenth in the O.P.A. survey, with

"amount of appreciation of role and function by other health disciplines", "amount of pay," "opportunity to learn more skills/techniques/theory," following in eleventh, twelfth and thirteenth place respectively.

"Opportunity for advancement" was ranked last in the O.P.A. survey list of satisfactions. Physical therapists have little opportunity for advancement as physical therapists within their employment situations. The truncated career structure for physical therapists is often attributed to the fact that physical therapy is a women's profession, with assertions that women retire to have children and leave the world of paid work. The fact that therapists placed "opportunity for advancement" so low on a list must indicate that this myth does not reflect the reality or the ambitions of physical therapists now.

Gelmon and Williams' survey (1983:28) found low satisfaction levels, particularly with professional interests and patient care, "were most likely to be expressed by physiotherapists in traditional settings who had indicated discontent with their work." These authors concluded that "it would also appear that it is the front-line staff therapists in traditional settings (hospitals and rehabilitation centers) who are mostly likely to indicate discontent with their profession." This dissertation is about the labor process in physical therapy, particularly the

labor process of front-line staff physical therapists in traditional settings. Although discontent is certainly present, willingness to work harder, for the good of the patients and for the good of the profession, was also found. The following chapters seek to understand that contradiction.

Gelmon and Williams appear to have found a higher level of satisfaction than they expected. Possibly they expected to find less satisfaction because one of the authors (Gelmon) was a physical therapist who had left the field for further study and an alternate career. Gelmon was familiar with the day to day problems faced by physical therapists.

Many comments recorded in the field notes indicate that the physical therapists observed during the field work would likely have expressed themselves as content with their work if questioned directly in the questionnaire style adopted by the surveys, especially if faced with questions which only gave them a chance to respond positively, as the O.P.A. survey did. Participant observation, however, allowed the gripes and dissatisfactions as well as the pleasures and rewards to become visible and to be recorded. The method used by this study, therefore, has a better chance of giving a fair picture than the so called "objective" questionnaire methods.

More examples of physical therapy work

Physical therapists treat people of all ages and from every social class. Patients range in condition from slightly injured athletes to the severely disabled and people near death. Although occasionally treatments are completely passive, usually the therapist attempts by voice, gesture and touch to get the patient to move actively and thus participate in the healing process. The field notes contain observations from two hospitals and one private practice. Observations from the private practice are included in this chapter because they happen to be the most complete description of a manual therapy treatment in the field notes. Manual therapy is commonly used by therapists in outpatient settings both in private practice and in hospitals, to treat a variety of problems, especially back problems; therefore it is important to describe it.

The incidents related here do not represent the entire range of physical therapy practice. That would be impossible. The treatments recounted below, however, often can be observed in physical therapy facilities. In every example in the field notes, the therapist is doing something technical with or for the patient; teaching crutch walking, giving back traction, helping the patient expectorate troublesome mucus, teaching exercises, or assessing range of

motion and strength. In almost all the examples, the therapist is physically handling the patient. But physical therapy is not just the technical application of treatments, despite the impression given by some of the official descriptions in the preceding chapter. Physical therapy is a social interaction; the treatment and healing, when it occurs, could not take place without the social interaction. Some of the interaction is described in these examples.

Support

Physical therapists in all specialties are called upon to teach patients to walk with crutches, canes, and other aids. The techniques used depend on the age and condition of the patient. In the following item from the field notes, a therapist had interrupted her usual work to teach "crutch walking" to a boy with a broken leg who had just arrived from the hospital plaster room. The words in brackets in the field note are observer comments.

09/20/84

Jane A., a therapist, is with an eight year old patient. She is teaching him to walk with crutches. The patient has a very large, very white, new cast on one leg, and is whimpering (with fear and pain?) as she helps him stand up. She maneuvers the wheelchair on which he is sitting to the end of the parallel bars, then goes to stand between them herself, facing him. She puts one foot near his good leg, and one hand under each of the child's arms. Leaning back, she lifts him to a standing position, telling him to hold the bars with his hands and push down with his strong foot. Then, when he is

balanced, she encourages him to hop the length of the bars, bearing weight on his hands. She hovers with her hands near, but not touching him, ready to catch his weight should he falter.

Protect

The following example from the field notes describes the routine set of commands and gestures physical therapists use protect patients and to give them confidence to move by themselves. In this note, the physical therapist has had a back pain patient on lumbar traction, which requires the patient to lie supine on a table with a harness around ribs and another around the pelvis. The pelvic harness is attached by a rope to a motor which alternately pulls and releases. The treatment is not painful but does require the patient to lie in one position for twenty minutes. To avoid fainting, the patient must get up slowly. Like all patients with back problems, she must be careful not to put excessive strain on the back, and has been taught the most efficient way to get from lying to sitting by the therapist.

10/1/84

I arrived and sat at "my" place near the pillar, just in time for a patient's lumbar traction treatment to end. As soon as the bell on the machine rang, the patient reached for her bell to call the therapist. From the other side of the department came a call, "Coming." and Mary appeared. She unhooked the traction belt and tried to push the foot half of the sliding bed towards the top, saying,

"I'll try to close up the bed. It doesn't always work. No, I guess it's not today. Just try

to sit up."

The patient smiled up at Mary and turned towards her on her left side, where Mary was standing. Mary was telling her, "That's good, she's learning. Now careful, try not to fall down the gap."

Mary assisted the patient to sit by guiding her knees over the side of the bed with her left hand, and, by placing her right hand under the patient's neck and lifting gently. Mary kept a hand on the patient's left arm between shoulder and elbow and held her own left arm in front of the patient, curved in a protective, ready gesture but not touching her, while the patient slid to the edge of the plinth and stepped down. When that was finished, both smiled, and the therapist said "Whew!"

The supportive posture, ready to give assistance but not actually touching the patient, is commonly seen when physical therapists are treating patients. Physical therapy students take courses in body mechanics in their first year of training. They learn how to lift, teach crutch walking, cane walking, and transfers to patients. They are marked on safety and security of the patient and on safety and efficiency for themselves. Third year students observed in the field work settings used supportive gestures exactly like those employed by the therapists.

Encourage

The next note concerns a therapist who is treating an elderly man dying of respiratory problems. The patient is barely conscious, and the techniques used are quite different from the two treatments already described.

12/02/85

Anna Watts is doing chest physical therapy with an emaciated, elderly man who has suffered a stroke and chronic bronchitis. The man is lying on his side in his hospital room bed, facing his wife, who is sitting in a chair pulled up beside the bed. Anna stands behind the patient, with her hands on his rib cage and one knee on the bed. I sit at the foot of the bed, observing and recording. The patient is groggy and not very responsive. Anna massages his chest wall for a minute, then asks him to,

"Take a deep breath in."

She leans forward, lifting his rib cage slightly. The wife leans backward, away from the bed. Then Anna says,

"Now out."

She leans back, pressing on his rib cage as if to press out the air. The wife leans forward. The cycle is repeated three or four times.

"In,"

"And out"

Then Anna speaks, a little more sharply,

"Now cough!"

The patient, his wife, and the observer, who have all been following Anna's gentle commands, leaning in tune with her body leaning, and breathing on her command, all cough obediently. When the patient's cough produces some sputum, Anna helps him expectorate it into a tissue and disposes of the tissue.

Anna has been "deep breathing and coughing a patient."

This limited form of chest physiotherapy is used by therapists in all specialty areas who need to help patients expectorate sputum. It is often called "routine chest physio." The exact techniques used vary with the condition of the patient. Therefore, the therapist must assess the

patient each time before even such "routine chest physio." The amount of time take to perform such a treatment depends on the time it takes for the patient to improve his or her respiratory volume and rate, and to cough effectively.

Sympathize

Sometimes, physical therapy treatment is not primarily handling the patient, but educating him or her; as we see from the following episodes recorded in outpatient physical therapy areas.

The patient with the sore shoulder has gone to get dressed, saying,

"Oof!"

His therapist asks, "Sore now."

"Yes," comes the reply.

She says, going on with what she is doing, "Just bend over and let it hang and swing for a bit. That will ease it off."

"O, yes," says the patient, as if he has just now remembered the exercise, and leaning forward, begins to swing his arm like a pendulum.

Teach

In the next example, the therapist was assessing a patient at the beginning of a treatment, and doing what she would call patient education at the same time. The note of exasperation was audible in her voice; it was apparent that

she had been working with this patient over the course of several appointments. The patient had suffered "whiplash" and had become dependent on a cervical collar, a device which supports and protects the neck. Collars, when worn for a long time, cause the neck muscles to waste away, therefore the neck muscles must be retrained so they can resume their function of protecting the neck joints from excessive movement. The process is called "weaning" and the therapist was trying to wean the patient from his collar.

Th: "How is the pain below your shoulder blade? Is it still there?"

Pt: "Yes, below the shoulder."

Th: "Do you notice any pattern?"

Th: "Yes, when I'm sitting in a draft, or when I go out to drive in the morning."

Th: "Yes, when you're cold. Now when you're cold your muscles tighten up and that gives you some pain. Your posture too. You hunch up when you're cold and that presses on the nerves."

Pt: "Yes, I see. It is sore right here, it was when I came in."

Pt: "Yes, if I were standing the way you were when you came in I'd have a pain too."
(The patient laughs quietly.)

Th: "And your collar, how long have you had it?"

The reply is inaudible.

Th: "It's too bad that you had it for so long, that you got dependent on it, but now you are going to have to learn to get along without it, now will you try to get along without it."

The conversation goes on in the same vein for five

minutes, with the therapist repeating information about the interplay of muscles, posture, and pain, and the patient complaining of pain, and the therapist asking questions to evaluate the current state of the problem. Then the therapist applies a hot pack to the neck, meanwhile continuing to try to educate the patient.

Tease

Teasing is another technique therapists use deliberately to help patients accept treatment. The therapist in the next note is one of the men who work in the profession. This man is a private practice clinic owner, and thus he both owns the equipment and supplies his own labor power. Thus, he controls the pace of his work, although he works as hard as or harder than his employees in order to make money in his clinic, which is funded on a per treatment basis by the Ontario Health Insurance Plan (O.H.I.P.). Although this therapist's situation is analytically different from that of employed physical therapists, the manual therapy techniques he uses, are the same as those used wherever a physical therapist skilled in manual therapy techniques treats patients with acute back problems. The therapist uses mobilizations, called "mobs." Mobs are low velocity, low range specific movements of bone upon bone. Higher velocity, higher amplitude movements of the same bones would be called manipulations, or "manips."

21/05/85

Mary, a patient who works in an active job but who is now off work with an acute disc problem in her back, is having a manual therapy treatment from Dave, a clinic owner and specialist in orthopedic and sports physical therapy.

When she arrived at the clinic he asked how she was, what the doctor had said, how far she had walked today and how she felt afterwards. After testing her ability to tolerate straight leg raising on each side (which told him how irritable the affected nerve was) and after testing strength by asking her to lift her leg against his holding hand, Dave declared that those tests were "Much better than last week. Don't you agree? Much better."

Dave put Mary on lumbar traction for twenty minutes, with heat applied at the same time. The lumbar traction, Dave explained to the observer, separates the lumbar vertebrae, reducing pressure in the intervertebral foramen, the gap through which the nerves run, and thus alleviating symptoms of pain, numbness and weakness in the areas of the legs the nerves supply. The heat is intended to relax the muscles and calm the nerves, making the patient easier to treat.

After the traction-heat treatment was over, Mary reached over and switched off the machine, and began undoing her pelvic and rib harnesses. Dave went to the table and helped her up, placing a hand lightly under her shoulder, saying jovially,

"Right, you little cripple, come with us".

She walked over to a mobs table with him hovering protectively behind her, and lay down on it. The table adjusts in height so it can be placed at a good working height for each physiotherapist. Segments of its surface can be adjusted in height and angle to keep the patient fully supported while a specific mobilization is carried out.

Dave started with what he called "muscle energy techniques, in which he had Mary, who was on her back on the mobs table with one leg flexed at the

hip and knee and supported on and resisted by Dave's arm, alternately contract and relax the muscles which internally rotate her hip. This procedure was repeated five times with each leg. The command was,

"Push your leg in, and rela-a-a-ax."

Mary had to make an effort with each contraction, but Dave's resisting arm allowed no movement. (Later Dave explained "I always use some muscle energy or contract-relax first, to relax the antagonists before I mobilize.")

Then Dave said,

"Lie on your right side" and she turned on the table towards him, lying on her side but with her chest and face almost prone on the table so her spine was twisted, as Dave explained, "to gap the foramen".

Mary was wearing a sweat suit and turtleneck; before the traction she had taken off her track shoes and socks. Dave was wearing dark suit pants and a short sleeved dress shirt with a tie. Dave supported Mary's uppermost leg on his arm, and he leaned over her, applying pressure with his chest to her hip to twist the spine a little more and mobilize the joint. His other hand rested on the surface of her lumbar spine, where her sweat top and pants had separated, and he palpated (felt with his fingertips) for evidence that the desired movement had taken place.

"Any pain there?" he asked.

"No."

"There?"

"No." she replied.

"Any pain in your leg at all?" he persisted.

"No." she maintained.

"Good. I've gone past where we were before."

Dave stood up and Mary rolled back onto her back.

"He (the doctor) was amazed when I told him how much treatment I was getting." she said.

"Push your leg in, and relax." he instructed.

"He wasn't too impressed, he was more concerned

with the length of time I was up every day."

Dave had Mary turn onto her side again, facing him, this time with both knees curled up. He reached under the table and released a latch which freed the foot end of the mobs table, then leaned over Mary, placing both hands on her spine, fingers on either side of the joint he was mobilizing. The lower half of the table glided slowly back and forth as Dave applied gentle rhythmical pressure to glide the bones in the desired direction. The therapist's movements were quick and sure. Mary appeared completely relaxed and confident in the therapist. Both patient and therapist treated their convoluted poses as normal and comfortable. Finally, the treatment over, and Mary got to her feet and put her shoes on, bidding goodbye to the therapist saying, "See you tomorrow."

Negotiate

In the next section from the field notes, the therapist was going to do what she called "a pre-op." She was assessing the level of function, range of motion, and strength in a patient who would be having knee surgery on the following day. Before she went in, she told me it would be "a quickie." It took much longer than she expected, partly because a nurse was with him when she arrived, and partly because the patient had a lot to ask. It can be seen from this field note how teaching is incorporated by therapists into seemingly casual conversation, and how therapists often interpret hospital procedures and doctor's actions for patients.

11/28/84

2:10 p.m.

Kirsten went to orient her pre-op patient, but he was out of his room. She found him in the hall, talking to a nurse.

"Are you just about finished?" she asked.

"No, I've just started."

"It makes me feel really great to have all these girls chasing after me" said the patient, a white haired, healthy looking man. All smiled briefly.

"Well, about how long will it be?" Kirsten asked.

"About ten minutes more."

"O.K., I'll get you later."

Walking away, she said to me, "Now, I have to decide what to do for fifteen minutes. The other one I have to do is an A.C.L. and it will take longer than fifteen minutes." She paused, and looks at her list. "I think I'll do a note." She settled down to write in a patient's chart. Someone came into the nursing station to make arrangements for the patient to go to X-ray. Kirsten asked, "Sandy, can I see him before he goes?" The reply, if any, was inaudible.

2:20 p.m.

Kirsten went back to the same patient's room, and said, "Laura, are you just about finished?"

"Yes, well, I just have to finish" the nurse replied.

"Can I listen?" Kirsten asked.

"Sure."

After Kirsten got to the patient, she began her pre-op assessment, going through a standard routine, asking him what problems led to the surgery, what his usual activities were, and the like. She stood by the patient's bedside table, writing on a form she had placed on it. The patient, who was dressed in a golf shirt, sweater, flannel slacks, black socks and loafers, sat on the

side of the bed.

"Now I have to do a few quick measurements. Could you just take off your shoes and socks and roll your pants up over your knees and hop up on the bed."

When she asked, "Have you ever had orthopedic surgery before?" he replied,

"Just my hand, when an aircraft propeller almost chopped off my hand." He held up his left hand, which had most of the fingers missing.

Kirsten asked him how he played golf, one of the activities he had mentioned earlier in the assessment. He told her, then she asked, "Where do you play golf?" When he told her, she said her father played in the same place. They began to compare families, and found his daughters had gone to the same high school as she had, but ten years earlier. (The conversation proceeded in a way which is typical in physical therapy, with social comments interspersed with technical questions and instruction.)

"Are you tender there?" she asked, stabilizing his knee with her left hand and pushing along the joint line with her right.

"Well, that's where Doctor Smith found tenderness, but you don't push as hard."

"No, I don't push as hard."

The man plied her with questions about what, exactly, was wrong and why it happened to him.

"You see, usually when we see a person in your age category, the cartilage is just sort of worn out. I'm sure he explained it to you."

"Oh, yes."

"And its just like a washer that's, well, worn out."

"Yes."

"So when he goes in and pushes on your joint line, it will be a little inflamed. But you don't

have any swelling."

"No, no swelling."

"So it won't be as acute."

After she finished the leg, she listened to his chest with her stethoscope, and explained that the anesthetist would be in, and would discuss with him whether a local or a general anesthetic would be used. The patient declared,

"I'd rather not have a general."

"Yes. Well, you'll have to discuss that with your anesthetist. I'm sure they'll try not to give you a general if they can help." Then she went on to explain his home exercises. He asked,

"What are we trying to do with these exercises? What is their purpose?"

Kirsten answered that question, and many more. At 2:47, she said,

"Well, I guess that's it. Do you have any more questions?"

"No."

"Fine, see you tomorrow" she said, and walked to the nursing station to write in his chart. She spoke to several nurses, and briefly visited several other patient rooms. Then she asked the observer,

"Are you planning to come in the morning?" I replied,

"Yes, I'd like to, why?"

"Well, in the morning is when we do most of the treatments because now we've got so many admissions we just leave ourselves free for them in the afternoon."

"Oh, yes, I see. So the patient you saw, not the pre-op, you had also seen in the morning?"

"Oh, yes. Also the other lady in the next bed. She's really old, over ninety."

"And really asleep."

"Yes, so I thought I'd just leave her for now. She's great, really neat, a great sense of fun, but it takes her a long time to wake up."

The field notes from the day I followed Kirsten not only illustrate the variability and the negotiated nature of the therapist patient interaction, but they also show how many times a therapist must shift her schedule, alter her plans, and accommodate the other health professionals trying to get their work done with the patient. The relationship between the nurses and the therapist on this ward is friendly and cooperative, as it usually is on wards where the therapist is experienced and well known to the nurses. This atmosphere is carefully nurtured by physical therapists, because they must have the cooperation of other professionals and the patients to get the work done.

The forgoing segments from the field notes described an important aspect of physical therapy work, patient treatment. They showed how varied the work can be. Even though similar techniques, for example lumbar traction, may be used with patients with broadly similar problems, the details vary according to the problems the patient presents. Therapists therefore assess each patient individually, and briefly reassess them before each treatment. Therapists vary their manner from patient to patient, deciding as they go along how

formal they should be, and how much detail to include in their explanations. As we saw in Kirsten's assessment of the patient who was going for knee surgery, therapists often experience delays in their projected schedules because other hospital staff want to treat the patient, and a certain amount of negotiation is required to get through the day's work.

Patient treatment is regarded by most staff physical therapists as the most satisfying part of their work. In a survey conducted 1980, (O.P.A. 1980) physical therapists were asked to rank order how time is spent and how it should be spent. Patient treatment ranked first in time spent and in how it should be spent; patient evaluation and assessment ranked second, and administration ranked third. The results of a small survey done by the educational services department for the physical therapy department of one of the field work hospitals was made available to the field worker December 10, 1984. Fifteen of thirty seven therapists who replied to the survey said that interaction with different patients provided the most satisfaction, and six more reported they received most satisfaction as treatment caused improvement.

Physical therapists enjoy patient treatment. They regard it as the most important aspect of their work. They also enjoy the flexibility of their job, planning their own schedule and work day, despite the frustrations it sometimes

presents. Planning the work day and flexibility to decide about patient treatments are important parts of the labor process, ones that merit further consideration, and ones that are under attack, as the labor process increasingly is being controlled in the interest of "efficiency."

In the next chapter we proceed to more detailed examination of schedules. We look at how the organization of schedules induces physical therapists to work hard and to cooperate with efficient exploitation of their own labor power, both by working harder (in Marxist terminology, absolute exploitation) and by working smarter (relative exploitation.)

CHAPTER EIGHT

A Gendered Profession: "We expect to care."

The history of physical therapy showed that the profession developed to help people get better. Its founders were imbued with a service ideal, and the developing profession gained its main support from doctors who wanted trained operators who took orders, and from a state which needed trained qualified people to deal with the injured and disabled. The last chapter introduced our study of present day working conditions for employed physical therapists, and we saw that those therapists like treating patients, that they consider patient care the most important part of their job. We have noted that routines of the hospital or clinic and the schedules of other staff affect the way therapists do their work, and we have seen a wide variety of technical skills as well as social skills are required for them to get patient care accomplished. Although therapists generally express themselves as content with their work when questioned by questionnaire, there are indications that they are most discontented with aspects having to do with control of their work and relations with other professionals.

This section of the dissertation deals with consent as it is shaped by one of the main relations of dominance within our society, the relation of gender. That is, we explore the

dominance of men as a group over women as a group. Dominance of men as a group over women as a group (also called patriarchy) has taken many forms in many cultures over the years. It is our purpose to examine one such form as exemplified in one present day occupation, the profession of physical therapy.

Before we begin, a few cautions are appropriate. First, gender dominance is connected with class dominance in society so closely that separation of the two is difficult. In physical therapy as well, it is difficult to decide, even for the purposes of analysis, where one form of dominance begins and another ends. In physical therapy, a women's profession which developed in explicit relationship to medicine, the relationships which are shaped by gender are often hard to separate from the relations shaped by professional dominance. (For a review of the literature on professional dominance as it pertains to physical therapy see Miles-Tapping 1985).

Second, relations of dominance are never static, nor are they complete. They change constantly, but are reproduced in accordance with predictable patterns (which we call dominance) by the everyday actions of the people involved. Incidents quoted in these chapters may never be repeated in exactly the same form. That is not important. What is important is that the pattern of the relations remains and persists through many of the "shop floor" interactions, the

customs, rules, and laws surrounding the practice of physical therapy. The issue focused on by this chapter is the observation that gender expectations for women in society help induce physical therapists to work as hard as they do. That is because "caring" is expected of women because of their sex, not their job description.

Physical therapy, like all professions, is essentially gendered. It is a "women's profession." The labor process of physical therapists reflects the gender dominance by men as a group over women as a group in society. This chapter explores the gender relationship which is vital to understanding the physical therapists' labor process. Because there were no male therapists employed in the hospitals where most of the field work was done, scant observational data is available about the differences in male and female labor process. The investigator's personal impression, gained from years of working with men in sports physical therapy clinics and supervising men in hospitals, is that however egalitarian the men are, male physical therapists are treated differently, and the expectations for them are different. The disproportionate representation of men in private practice and management jobs suggests an inequality of opportunity. While it might be interesting to investigate the actual differences in organization of work for men and women, such an inquiry is nearly impossible

because of the tendency for the few men in the physical therapy profession to cluster in certain areas (table 1).

Physical therapy students quoted in this chapter, physical therapy managers, and staff physical therapists all suggest that men are treated differently. The Director of Physiotherapy at one of the field work hospitals hired a male therapist after the observational component of the research was completed. She reported:

He was very frank. He came here as a junior staff member, because he wants to learn from us and then start his own private practice. We have a clear understanding, _____, _____, and _____ are the seniors, not him.

I met the therapist in question, and he was quiet and unassuming. Women therapists, however, even a senior therapist who had been at the hospital for many years, introduced him as "Fred Jones, who is going to teach us all about pain control." There was no chance to observe them all at work.

In this research, the observations of male therapists at work were necessarily drawn from the private practise where limited observation was conducted. That clinic is funded by the Ontario Health Insurance Plan (O.H.I.P.), which means that any patients who could attend a hospital-based physical therapy clinic could attend it. The work is different,

however, because the owners work in the clinic, and they are more conscious of cost and efficiency than most hospital based physical therapists need to be. Inevitably, the issue of hospital/private practice is mixed with the issue of gender. Where this may occur, I have made a note of it, and suggested the reasons why the gender explanation, rather than the hospital vs. clinic explanation, should be favored.

The situation in physical therapy today

It will be recalled that ninety per cent of physical therapists are women. The men in the profession occupy positions of power as managers, owners of physical therapy clinics, and professors in numbers much greater than their proportion in the profession (Gelmon and Williams 1983). Twice as high a proportion of men as of women work in private practice in Ontario, and over three times as high a proportion of men are employed as educators (table 1). Women, on the other hand, are over represented in pediatric facilities and home care -- two areas which are more consistent with their presumed "domestic role" and consistent with the ideology of femininity. Women outnumber men in hospital and rehabilitation centre positions as well. This thesis focuses on employed physical therapists, therefore it focuses on women physical therapists.

Some physical therapists, physical therapy educators,

and hospital administrators strongly object to the notion that physical therapy is a gendered occupation, and that physical therapists care because of their sex as well as their training. They use two arguments to reject the idea that gender is associated with the physical therapy labor process. They point first to the men in the profession, and second to the training all physical therapists receive. These objections must be dealt with before we can proceed to use gender as a way to examine the labor process in physical therapy.

Men in physical therapy

Male physical therapists are usually found in managerial, not staff positions (Gelmon and Williams 1983). Even the few male employee physical therapists are subjected to noticeably different expectations and constraints from the women with whom they work. Of course, some men care. The contention is not that no men care, nor is it that women do care because of their biology. The point is that women are expected to care as part of the social role assigned to them because of their sex, and that this expectation shapes their work, and also what is recognized and accounted for as work.

Physical therapy in the health care system

Physical therapists work in the health care system, critics say. Their circular argument claims that since the

system is a health care system, therefore health care must be what they do, and caring is what they are taught. Health care may be what physical therapists do. It is not what brings them status and material rewards.

Physical therapy education curricula and the literature about physical therapy show that physical therapy students are taught knowledge and techniques, not care. Care does not appear as a subject for discussion or teaching. Care is part of the gender appropriate training that women and girls receive in the home in our culture. There is no need to teach it in formal education programs.

Powerful economic reasons support the concentration on physical therapy techniques exclusively. It seems hard to describe and define caring acts such as support, protection, and nurture because we are not used to putting a value on them. We do not put a value on "women's work" because powerful groups in society benefit from the fact that it is unpaid labor. If an ideology can be developed (as it has) that supports women caring "because it is in their nature to care" the question of paying for this work does not arise. If physical therapists' actual caring labor, like the care women give in the home, was acknowledged and accounted for, it would also have to be paid for. That could make physical therapy, and indeed other women's professions such as nursing

and teaching, far more expensive than they are now; it certainly would alter the emphasis of work load measurement and accounting systems that deal with these activities.

Cost of care

In present capitalist society, care cannot be paid for at the same rate as technical work. The state must keep the cost down for the services it provides, in order to keep taxes down while providing services needed to support the prevailing social system, capitalism. The state funds health care. If it were to assume the cost of paying for care, instead of having care performed as an unpaid service by women both in the family and in institutions such as hospitals and rehabilitation centers, the burden would be insupportable. As it is, however, women do most of the caring labor in the family, without pay. In hospitals and other health care institutions, workers are paid only for the technical work they perform. The commodities thought to be delivered in physical therapy are heat, exercises, instruction, and the like, not the social and so-called "soft" (meaning both feminine and not amenable to measurement) components of care. There is no provision in physical therapy budgets for time to care. The expectation that women care, and that women professionals care and provide the services involved in care because of that, makes available an army of skilled, experienced, workers who do

skilled, undervalued work.

Physical therapy and gender obligations

Gender and the obligation to care pervade the physical therapy labor process. Not only do physical therapists have to balance family and wage earner roles, and to deal with medical dominance which often takes the form of sexual politics at work, they also work in a career and in a work setting structured by gender based expectations that they will care.

Family considerations enter into the physical therapy labor process. When therapists decide where to seek employment, for example, or decide whether to work full or part time, and whether to stay late for extra work or associated activities such as professional meetings, they often must consider their other job at home. Therapists who work part time say that "you can kill yourself for four hours because you go home after that." The therapists use this rationalization glibly, not stopping to think about the other work they have to do. They seem to have accepted the definition that counts technical physical therapy as work but classifies caring and other women's work as not work. One experienced therapist from one of the study hospitals accepted work at a hospital where she knew she would have to work harder and where she had some doubts about the effect

the hospital's organization of work would have on patients. She accepted the part time job to be closer to her work and to have more time to spend with her growing family.

Family responsibilities make some physical therapists accept jobs they would not otherwise tolerate. On the other hand, family expectations and responsibilities also affect how willingly physical therapists comply with management control. Therapists with families object more strongly to being asked to stay late, on the grounds that they have children to pick up from the babysitters and other work to do. Domestic caring responsibilities make therapists both more and less tractable as a work force.

Although data were collected on the relationship between family obligations, control and resistance, the topic is more ~~extensively~~ addressed in other studies. (See, for example, Ganange 1986.) This chapter focuses on the gender structured aspects of the labor process itself. It explores caring and the gender expectation to care as it affects physical therapy.

The literature on care predicts that in a health care occupation such as physical therapy, we would expect to find care in the sense of the direct work of looking after dependent people. We do find that. Since women work at physical therapy, and women are expected to care, the

emotional side "caring about" is also expected. We find both "caring for" and "caring about" in physical therapy, but as unofficial, rather than officially sanctioned parts of the labor process.

Both caring for and caring about are required in physical therapy, but are not measurable by the bureaucratic system of cost accounting which, as Hall (1964) noted, is administered by a management which comes from a business, rather than a health care, background. The time and energy taken to care often comes out of the physical therapists' personal time and resources. Therapists are required to stay late or to work through breaks to get the work done. The image or ideology of physical therapy as a service and / or caring profession creates the expectation that therapists will care because they are women professionals, not because they get paid to do so. The expectation that women care is a powerful social influence which tends to make physical therapists work hard and consent to ever increasing exploitation.

"We expect to take care of people."

One experienced physical therapist summed up the tension between caring and getting the work done as follows:

I think that I was like everyone else. When I went into physical therapy I expected to be helping people, taking care of people. After all, physiotherapy is a helping profession. But after I had been working for a while, and especially lately, it seems the only thing that gets you credit is something that produces numbers. Something you can point to when administration asks what you've done lately.

Care, this therapist was saying while others nodded agreement, is something you do because you want to, or because you think you should, but you don't get credit for it. How is it possible to ignore caring activities in a health care institution and in a health care profession? The answers lie in the gendered nature of caring, and in the organization of work to maximize the output from the labor that is paid for while minimizing resistance to control.

Care is a term used for "what women are 'meant' to do for others -- for anyone but themselves." (Osmar 1985: 27). Physical therapists, if asked, will say they work for a health care organization. If pressed, they acknowledge that care seems to be a trait demanded of women, and that "of course" they "care about patients." Apart from quality of care programs in which procedures and treatments, not care itself, are defined, care does not appear in the professional literature except as part of the workload measurement system. Quality of care and work load measurement are themselves important aspects of control of the physical therapy labor

process. They are discussed later. Even in the work load measurement system, the titles assigned to tasks are misleading. Indirect patient care and direct patient care are defined by the workload measurement system but only as units of time during which the therapist does one of an extensive list of concrete procedures. Treatment which consists of technical procedures can be measured by the workload measurement system. It can become a commodity, and can be charged for as such.

Therapists do much more, however, than administer technical procedures. Listening to a patient's worries; helping a feeble person to the bathroom before starting physical therapy; coming back later because the patient is too tired; comforting a fearful patient; chatting to distract a patient whose exercises are causing pain; all these are common everyday occurrences for physical therapists.

Treatment cannot proceed until the patient is calm and reasonably comfortable. The work of caring has to be done, even if it is not a recognized treatment. Care must be done before other treatments are effective. Patients who have not formed an attachment for their physical therapist, who do not have the trust that caring (and fulfilling the patients' expectations of care) generates, do not co-operate with the advice, exercises, and life style changes that therapists recommend; they are unlikely to receive benefit from therapy.

The dire predictions Hall made about the effect of employee status on the care-giver's attitude to care have not come true. Care is still given. Caring takes variable amounts of time, however, and does not lend itself to standardization or bureaucratic manipulation. Therefore, in the rational system of cost accounting used by modern health care management, care "disappears." It cannot be counted.

Commonplace, everyday caring activities, part of the physical therapists' work, do not "count". When therapists take time to listen to patients, to chat with them, to reassure them and to care, those therapists feel guilty for wasting time. In the previous chapter, the anecdote about Kirsten's "quickie pre-op" illustrates that. Kirsten was concerned that the observer would accompany her in the morning, so she could see some "real treatment." Therapists know the system does not recognize the social aspect of care, so they try to cut down on them, and feel personally responsible and inadequate when they cannot.

In the seminar to publicize the new trend in physical therapy work organization, the "waiting list management" system which requires therapists to assess, treat, teach, and chart on their patients all within a single one-hour appointment a physical therapist said after the change,

The scheduling was tighter. There was less chit chat perhaps. You didn't ask how Aunt Nellie's dog was. I think some of it's important, you do have to get to know the patient but we have to cut down on some of the extraneous chit chat.

Like that therapist, we must acknowledge that some chit chat is important, even necessary for care. All of it may be, and it may be harmful to eliminate any of it. Certainly, therapists who do not have time to chat with their patients feel rushed and frustrated with their work. For now, it is important to note that social activities, those which involve getting to know the patient, are not seen as important techniques used in physical therapy. Ignoring care, as the newer methods of organizing physical therapy work do, cuts down on the social interaction which helps patients feel better.

Gender and the type of care expected

Patients value the time physical therapists take with them. The field notes suggest that the level of care expected from women physical therapists, and probably from all women health care professionals, is different from the level of care expected from men. Repeatedly, patients interviewed during the field work praised the concern and care taken by physical therapists. Some of them are quoted here. A woman out-patient at one of the field work hospitals said:

The therapists here seem so organized. They seem so knowledgeable. They take the time with you, to make you feel comfortable and answer your questions.

You really get a lot of support here, a lot of moral support from therapists and patients, yeah, patients talk to each other and cheer each other on. These girls are great. The therapists are so great. They help a lot, they're so open. They talk about their families, chit chat away while they're killing you. You need it, to get through. They really help you.

One patient, however, provided a conflicting report. She was reporting on a series of outpatient treatments for which she had gone to a private physical physical therapy practice in Toronto. That should have made little difference; other private practice patients expressed complete satisfaction with their therapists and therapy. Crowding and rushing are inevitable, however, in the private practice system where setting up a clinic costs fifty to sixty thousand dollars, and buying an Ontario Health Insurance Plan (O.H.I.P.) license (permission to bill O.H.I.P. for physical therapy visits) costs one to two hundred thousand dollars. Extra billing is not allowed in O.H.I.P. funded physiotherapy clinics. If all the clinic revenue must come from O.H.I.P. fees of \$9.00 per treatment, the result is great pressure to see large numbers of patients.

Hospitals in the past were more relaxed places for

physical therapists to work, because therapists were salaried, and patients who could not be fitted into their lists were placed on a waiting list. More frequently now, the hospital administration will not tolerate the waiting list, and physical therapists are told "it's somehow our fault if we have a waiting list, we're not coping." Limits to hospital capital budgets restrict the opportunity for physical therapy facilities to expand their space with their expanding caseloads. New management methods, adopted from business and similar to those already in use in private practice physical therapy, intensify labor in hospitals and we can expect to see the conditions in hospital outpatient physical therapy departments increasingly to resemble those found in private practices.

Ms. Adams reported:

It was a, not very satisfactory experience. . . . So I was waiting and someone came and said your three o'clock is here, yes, Adams is here, so I went in. She didn't introduce herself or anything, just asked me a lot of, well, sympathetic questions about the pain, when it came on, what relieved it and so forth, then she looked at my back, had me bend this way and that and so forth. Then without any explanation she spread some, Crisco or something on my back and applied . . . (ultrasound). I don't know. She never said. I had to keep asking for information. Is this? Is that? Eventually you get a bit tired of it. . . . I don't think I'll go back many more times because it was a bit of a pain really. They seemed technically proficient, but it was as if we were so many slabs of meat.

This patient's comments stand out from the majority of field work notes, because most patients praised physical therapists even when those therapists seemed busy or rushed. A number of factors combined to allow this person to express negative feeling about the physical therapy she received. First, the clinic may have been giving inferior care. That clinic, however, is a private practice in a large urban centre. It has a good reputation among physical therapists for giving excellent treatment, especially manual therapy. Second, the patient said she was treated by four different therapists in five days. She had very little chance to develop trust in any one therapist, to get to know that therapist. There would have been very little time for chit chat, or for the patient to develop a sense that the therapist cared about her. Being treated by a succession of therapists is unusual. In even the most rushed public or private settings, patients are assigned to a therapist and, except in the most unusual circumstances, are treated by that therapist until they are finished with physical therapy.

The dissatisfied patient reported that she was lying on a treatment table in a curtained cubicle and the curtains were closed so she had visual privacy, but she felt as if she could reach out and touch the next patient's elbow. Crowding is common and treatment in the open or in cubicles which are merely divided from others by curtains is customary.

Complaints about crowding are not common. Therapists usually put their patients at ease, make tactful jokes about the company, and otherwise arrange to dispel patients' unease at the setting. It seems no such care was taken in Adams' case.

The patient Adams' dissatisfaction, which probably is shared by other patients who did not express theirs, cannot be attributed merely to crowding and rushing. That takes place everywhere, but therapists are not usually criticized for it. Nor can it be attributed to the fact that Adams received therapy in a private practice and not a public hospital facility. As we have already seen, the treatments given and the organization of work are quite similar in most private practices and hospital clinics.

It could well be argued that the most important difference is gender. The gender of the therapist is the difference between the rushed private practice clinic which the informant criticized and others where patients speak about the therapists in glowing terms.

In a private clinic owned by male therapists and visited during the field work, a patient described one of the physical therapy partners:

He sure goes, that one. I just saw him going around the corner. I had treatment here before for my shoulder. He's such a fast mover. I've seen him get up from treating a patient, fling that stool away across the room, and be across the hall before it stopped!

The clinic owner explained how he gave patients a feeling that they were being cared for:

You use everything you've got that will help. If you flirt with them, if that works, helps them get better sooner, O.K. You've heard me say I have different explanations for different types of patients. Also . . . We use the machines. They go in the whirlpool to do their exercises, or they have short wave and traction for half an hour. Then you do a manipulation and start them on exercises. While you're working with one patient you call out encouragement to the others. That way, they're in your clinic for two, two and a half hours but you only have to spend a few minutes with them. But they leave thinking they've had you for the whole time.

That clinic owner, and the therapists who worked in his clinic, were paid on a per capita basis, and they used machines to extend their labor power. Therapists in hospital clinics also use machines to extend their labor power, although they are seldom so conscious of that reason for using machines. The important point for the present discussion is the apparent pace of the work and the way care was given or perceived.

In the clinic which made "Ms. Adams" feel like a slab of meat, the treatments were brief. She said:

The waiting room was small and full of patients, and they turned the whole lot over every ten or fifteen minutes.

With that rushed schedule, without using the machines and all the personality wiles the other clinic owner consciously used, and without further reorganization of their labor process, therapists were unable to offer the reassurance, explanation, and teaching that characterize physical therapy as it is usually practiced. Given no clues about what to expect, the patient felt frustrated and angry.

The contrast in comments between the unsatisfactory facility and others likely is not based exclusively on the technical quality of the physical therapy or the care, reassurance, chit chat and nurturing received, but on the expectations patients had for the care received. Both clinics were rushed. Both clinics have reputations for technically proficient care. In one clinic, the workers were all women. In the other, both the owners and some of the staff were men.

Patients expect different care from women and men. In the gendered society we live in, they can usually demand, and get, better "care" (in the sense of support and time taken with them) from women than from men. The gender expectation for women who work in the helping professions is colored the patients' experience. The patient judged the unsatisfactory

clinic technically proficient; this judgment is corroborated by the clinic's reputation among physical therapists. However, that clinic did not take care of the patient; it did not explain the treatment, show concern, or deal with the emotions of its patients. The women employed there fell short of the patient's expectation.

Women are expected to take care, not to be just technically proficient. The patient who found the male clinic owner's rushed style charming and who would have expected the same style from a male doctor, might have condemned it in a woman therapist or doctor. The patient Adams, who found the physical therapy experience unsatisfactory, was a social work educator. As an educator, she had well formed ideas about what should be expected from a service profession. Further questions revealed that she expected more care than she received; she thought the physical therapists should have shown more warmth and humanity; she did not like being treated as a technical problem. The patients in the male therapists' clinic voiced no such complaints. They compared the male physical therapists with doctors' manners and work organization, not with what they expected of women. Finding themselves in a busy clinic, they were delighted to "have physio" for two and a half hours, even if the therapist divided his time among many patients.

Other aspects of gender and control

We have seen in chapter two that a disproportionate number of powerful positions are occupied by male physical therapists. Therapists note that male therapists usually call doctors by their first names, but women therapists usually address their medical associates as "Doctor Jones." Many patients mistakenly call male therapists and even male physical therapy students "Doctor." Notes and quotes from a conversation with a group of fourth year physical therapy students reflected both the ideology and the experience of gender in physical therapy were already established during training.

Student 1: "Men and women are equal in physiotherapy."

Student 2: 'It is an "equal opportunity profession." But . . .'

Student 3: "The guys get treated better. They wear white coats and patients call them doctor."

Student 4: "They're more serious. They expect to work at this all their lives."

Student 1: "They're lazy." (this was from a male student) 'Well, there are some good ones, but many at the top are so bad'

Student 3: "You wonder how they got there."

We saw from the reports from male therapists in the early days of the profession that men expect to be better at some parts of the management work, and to develop better

collegial relations with doctors and other department heads than women. Women therapists have also occupied many powerful positions and still do, but somehow the expectations for men are different from the expectations for women. Later, we examine more closely the relationships between female physical therapists (and department heads) and doctors, and find that the ideology of gender has persisted into the present, causing considerable tension and conflict for therapists.

In this chapter, we have seen that care is something physical therapists expect to do, and that it is something they must do to get their work done every day. Care is not measured, however, even though it is necessary. The system of cost accounting makes it seem less important to hospital administrations and to the physical therapy professional organization than it is to patients and therapists. The system of cost accounting impinges on the labor process of physical therapists in many ways; we will return to discuss the system of cost accounting and the tension between administrative goals for efficiency and patient and therapist desires for human interaction as we progress through the analysis of this women's caring profession.

We see from this discussion that although patients value care, they may expect different care from men and from women.

An ideology of femininity which includes care and service not only benefits men as a group, but in the specific case of women's caring occupations, benefits the health care system, and ultimately Canadian society, by reducing the cost for health services. Gender expectations of care facilitate management effort to get physical therapists to work efficiently by hiding work that is necessary, and that must be done, in the health care system.

In the next section, we closely examine one of the strategies physical therapists use to get through the work. Physical therapists are not always passive victims of their gender or class position. Sometimes they consciously exploit it to get the work done.

Physical therapists are under pressure to get treatments done expeditiously, to produce the maximum number of "patients treated" or "treatments done" per day. The presence of a waiting list provides an endless supply of patients. To keep the time taken between the patient's first contact with the physical therapy facility and the actual treatment to a minimum, therapists rush through the work, trying to minimize the number of treatments per case, so they can discharge old patients and admit new patients. The sense of rush produced by this effort is felt as "pressure to produce the numbers."

Some patients, however, take longer to treat than others. They have more questions, they don't understand the instructions, they do not do their exercises, they have multiple complaints. Therapists become adept at "managing" difficult patients. As the clinic owner quoted earlier said, "you use anything you can." That therapist said he used a different explanation for different types of patient. He was referring to the therapist's highly developed ability to "size up" patients quickly and to decide how best to present the explanation.

"Chit chat" has also been mentioned. "Chit chat" is the way therapists talk with patients, often talking about the weather, children, pets, or some other topic of mutual interest while they proceed with the treatment. These techniques are similar to "taking the measure" of a patient or "softening them up for a sale" as a salesperson might do with a client. The techniques are an integral part of treating patients, helping them relax and gaining their trust. The techniques are learned during internship and supervised practice and perfected on the job by watching and listening to other therapists. In the following episode from the field notes, the senior therapist happened to have an especially long time to treat a patient, because the city had experienced a snowstorm and the patients who were scheduled to arrive next did not. She used the time to demonstrate an

advanced, expert manual therapy technique (and, less consciously, an equally skilled patient management technique) to a student physical therapist.

The notes were made while observations were being openly conducted and recorded in the physical therapy department. Other therapists were present, with their patients, but because of the storm, fewer patients than usual were about.

November 11, 1983

2:10 p.m

The patient on the manip table (a specially designed treatment table) is about twenty five, handsome, and well muscled. He's wearing shorts and a tan. Two physical therapists have the back of his shorts pulled down so the untanned upper part of his buttocks shows. For fifteen minutes, they have taken turns kneeling on the table and placing their hands, fingers and thumbs spread, over his low back area. They concentrate carefully and press down with their thumbs. Their voices are only partly audible to an observer three meters away, but they are talking about right posterior, left anterior, "now let me show you right anterior."

At the same time, something which looks like flirting is going on between the instructing therapist and the patient. Following the therapists' instructions, the patient gets to his hands and knees on the treatment table, while they manipulate his low back and test his muscular strength. He smilingly says something, and the therapist blushes, grins, and in a gesture that appears affectionate, pushes him down toward the table. Minutes later, the instructing therapist, with her hands still on the patient, appears to be massaging his buttocks through his shorts. This lasts for several minutes, then both therapists crouch beside a neighboring treatment table which has the patient's chart on it, and engage in earnest discussion while the patient looks on with a worried expression.

The physical therapy department is large, well lit, brightly painted, and contains four manip tables, two traction apparatuses, ultrasound machines, other electrical apparatus, and a steel whirlpool. Although curtains are available to partition cubicles, including the ones which contain the manip tables, all the curtains are pulled back against the walls on this fairly quiet afternoon.

The other patients and therapists in the department ignore the scene at the manip table, and ignore the observer watching and writing at a small table across the room. Another young man has a therapist with him, she is talking to him, getting him to do exercises for his leg. A middle aged woman patient is lying face down on another plinth. She has hot packs on her back and a timer beside her; when the bell rings, the student therapist goes to her, helps her up, speak with her for a moment, and leaves while the woman draws the cubicle curtains closed, and goes back to the patient and instructor at the manip table. The woman emerges from the cubicle in her street clothes, tidies the cubicle, pulls the curtains back to the wall, and goes out.

Several possible interpretations of this incident, which one of the thesis supervisors jokingly called "pornography" and which the investigator came to think of as "the sexy incident" are possible. The first two hypotheses about the meaning of this hands-on incident emerged from the data, or rather from the observer's ruminations about it, almost at once. These were:

1. The interaction in the corner of the physical therapy department is an assessment, directed at ascertaining the physical-mechanical cause of the patient's presenting complaint.
2. The interaction is a seduction, in which the teaching therapist is:

- a. flirting with the patient because she is interested in him sexually
- b. already engaged in an intimate relationship with the patient and is showing off to the other therapist,
- c. any other possible explanation for the "seduction" interpretation.

When assessing the validity of these hypotheses, it is essential to consider the meaning usually assigned to interactions which take place in a physical therapy department. The incident takes place in a physical therapy department, not a massage parlor or a beach. When the patient arrived for his appointment, a clerk took his name and recorded his hospital insurance number, doctor's name, and doctor's diagnosis on several forms. Then the patient sat in a waiting room until the therapist arrived, introduced herself as a physical therapist, and instructed him to come to the treatment area, where she asked him questions about his health, his occupation, his back pain, its nature, extent, and what aggravated and relieved it. Then she gave him a pair of hospital issue blue shorts, asking him to change into them so she could examine his back. The setting and the rituals provided all the participants with clues about the nature and purpose of the interaction, and even if the man had never been a physical therapy patient before, he would have recognized some of the clues as pertaining to a medical setting.

The therapist who did most of the talking has worked at the hospital for several years and is regarded by her peers as an expert in manual therapy. According to physical therapists, the instructor was doing a "muscle energy" treatment and showing the other therapist some "mobs" (mobilizations). The senior tutor who teaches mobilizations, muscle energy, and other manual therapy techniques in a physical therapy education program listened to the description recorded above and agreed that the therapist was doing a manual therapy assessment and treatment. However, when questioned about the sexual overtones of the incident, particularly the young man's obvious interpretation of the incident as flirting, he agreed that the patient could have interpreted the contact as flirting, but that too was routine.

"You use it," he said. "You use everything you've got to make the patient believe in you, to help the patient get well."

"But don't they sometimes get the wrong idea?" I asked.

"Well, they soon see I'm the same with everybody, everybody gets the same treatment."

For the patient, the interaction with the two therapists was not "just an assessment and treatment." He was not passive. Although he did follow instructions obediently, he communicated with the therapists by gesture and facial expression, and at least once said something which made the

teaching therapist grin and blush. He swaggered when he left the department after his treatment was over, his blue work shirt unbuttoned over his chest. He looked over at the observer busily making notes, with a wide smile and a warm "Hi." The next day when he arrived for treatment, he greeted the therapists with a purr in his voice. The field notes reveal some further efforts to clarify the interpretation.

November 12 (recorded at my university office in the morning)

From my own experience as a physical therapist, I found it hard to believe the therapist was flirting or seducing the patient, but I did check with some other people, concealing names.

A male friend supported the interpretation that the handson incident was at least flirting, possibly a seduction.

"Flirting goes on everywhere," he said. "It doesn't matter what the setting is, its always there, you shouldn't be surprised."

A male faculty member, one who is not a physical therapist but who teaches physical therapy students, agreed that the patient probably thought that the physical therapist was "coming on to him." but added, "She probably thought nothing of it."

"It's their training," he explained. "As soon as they (student physical therapists) hit fourth floor (where they have applied anatomy and physical therapy classes) they strip to their bra and pants. Nudity is so normal for them," he continued, "they don't even realize what an effect it can have on outsiders. Sometimes I have teaching and research assistants in here who are engineers or phys. ed. students. It really shocks them."

The day after the above incident was recorded, another treatment, featuring the same therapist and the same young

male patient, but without the student, took place.

November 12

2:00 p.m.

The young man from the sexy incident is back. He came in the back door, and greeted the therapist with a purr in his voice. She is busy with another patient, a young woman, mobilizing her spine and talking about the magazine she is reading. I can't see the title.

She interrupted that discussion to direct the male patient to his manip table, then went back and forth from the young woman to the man, giving each some hands on treatment and instruction, while continuing the conversation with the woman. Her interaction with the male patient appears cool, though she cradles his arm in hers while mobilizing his shoulder joint. He complains of pain. She replies,

"Well, that's what you get. No pain, no gain. Can't have all sunshine, you know." "When I go upstairs, I'll put you on Jane's list, she knows muscle energy too."

The therapist ostentatiously continues to treat him impersonally while being very warm and friendly with the other patient. His voice now sounds querulous. He complains of pain more frequently.

The patient interpreted the therapist's demeanor the day before as "a come-on." The therapist had no such intention, and when she realized what had happened, she deliberately acted to show him that her manner was the same for everyone, that he should not take the flirting seriously.

Other people who have had physical therapy have commented to the investigator that while they were in physical therapy they were treated like equals by their

therapists, who shared interests and ideas with their patients. Perhaps because this was such a contrast with the social distance maintained by most doctors, with whose demeanor all the former patients were familiar, the patients interpreted the therapists' friendliness as personal interest in them. Like the young man who received different non-verbal messages on the two successive days, they were disappointed to discover that it was routine for the therapist.

As Smith (1981: 314) explained, observation and interpretation require active effort to make sense of what is observed. As Smith explains, "The sociologist uses background understandings, expectancies and knowledge to make sense of 'appearances'. . . the reader herself fills out the text by reading in background knowledge to accomplish its meaningful character." The problem cannot be solved by adding more detail. Every description necessitates interpretation, so added detail merely compounds the problem. Each of the participants and informants in the "sexy incident" brought a different set of background expectancies and experiences to it; each interpreted it differently.

While the "hands on" incident recounted above has many possible interpretations, it makes sense, in this investigation of the labor process of physical therapists,

only if it is regarded as an example of a technique therapists may use to get the job done.

Physical therapists use manual techniques to move their patients' bones and joints, muscles and tissues. They use touch to palpate the tissues to discover the problem and to assess the effect of the treatments they use. They also teach patients, explaining the effect of the treatments, showing them how to do exercises and how to apply their own heat, ice, and the like. They learn these techniques by listening and observing, and by practising under the supervision of experienced therapists, as did the student in the foregoing episode.

One technique which all therapists appear to use but of which they seem not to be aware is the use of their own personality and vivacity in the social management of patients. Not all therapists flirt. It depends on the patient and the therapist. They are all experts, however, at developing and maintaining warm social relationships with their patients; they are also skilled at managing the relationships so that if patients should happen to "get the wrong idea" as the young man on the manip table did, they are quickly "set straight".

Physical therapists manage their patients by getting the patients to like them and to trust them, and in this way the

patients are persuaded to do what the therapist recommends to get better. Experienced physical therapists seem to have a ready line of "chatter" for almost any patient. It helps smooth the way and helps them to get through the work without wasting time. Medical literature discusses compliance, the probability that the patient will follow the doctor's orders and comply with the prescribed treatment. Physical therapists use their personal relationships to maximize compliance.

This incident is only one of many that could have been used to illustrate the use of the physical therapist's person along with her or his knowledge and skill to treat both the problem in the body and the social or emotional problem presented by the patient at the same time. The field notes contain many such accounts:

One therapist chatted casually about her holiday in the Bahamas while bandaging electrodes (from a machine that stimulates muscle contraction) to an older patient's thigh. Another was heard deep in conversation about the difficulty of finding good play schools with a woman patient her own age, while she gave manual resistance to the patient's efforts first to "straighten", then "bend" her stiff painful knee. That patient later reported, "They chat away while they're killing you. You couldn't do it without them. You'd never progress." One therapist was observed while she

reassessed a patient's tenosynovitis (inflammation in the sheath around the tendon) of the wrist. The patient told the therapist it was "getting better." "It only bothers me now when I have been knitting for an hour or so." The therapist discovered, by several questions, that knitting is the patient's main hobby. As she applied ultrasound⁴ to the patient's wrist, she talked about "overuse" syndromes, explaining that the tendon sheath became inflamed from repeated movement carried on beyond the point of fatigue, and explaining the necessity to vary her grip and to alternate activities to give the tendon a rest. She told an amusing story about her efforts to learn to knit as a young girl. The patient responded with a story of her own, and by the time the ultrasound treatment was over they were laughing and chatting together like old friends -- but the teaching had been done, rapport had been built, and a "therapeutic modality" (ultrasound) had been applied.

Physical therapy is a "hands on" profession, perhaps to a greater extent than almost any other. As one contributor to a physical therapy journal wrote:

In this profession we use our hands, for palpation, to explore tissue condition, for alignment, to feel pressure, to feel tension. We have another way too of using our hands; we use them in a therapeutic healing way, we touch people, we stroke people, we have a healing sensory touch that expresses care and human contact. We do not say this aloud very often, but all physiotherapists know that it is

part of what we do, and with virtually every patient we meet. Other professions do not do it, and the difference is quite marked.

(Williams 1986: 67)

In this section, social and physical handling skills and techniques used by physical therapists have been stressed. Chatting, even flirting, which may embarrass physical therapists when it is noticed or commented on, should be understood as ways of getting the work done. They are necessary. Therapists have choices about how to employ their personalities; how to develop rapport with the patient; and which techniques and modalities to use. They have no choice about the necessity for using all of them. Therapists manipulate patients, in a figurative and in a literal sense. It is important to grasp this point because all succeeding discussion of the labor process, control of the labor process, and consent to exploitation of labor power in physical therapy is based on an understanding of physical therapy as an occupation which interacts, often in very intimate ways, with patients.

This chapter began with an anecdote about an interaction between a therapist and patient. The interaction had sexual overtones. The therapist used touch and attraction to flatter the patient into cooperating with treatment. The physical therapist was in control of that interaction; she was using it both "for the good of the patient" in her

opinion, and "to get through the work."

The therapist in this incident, as therapists frequently do in day to day work situations, exploited common gender stereotypes and ways of dealing with men as a way to get through her work quickly and efficiently. Other therapists were observed using other techniques, such as "chit chat" and "woman talk" in appropriate situations for similar purposes. Thus, we see that gender not only creates an expectation that physical therapists will work in certain ways (they will care because they are women), but gender can be used by physical therapists to suit their own purposes. In the next chapter, we examine a relationship which is consistent with usual relations between men and women in our society, but in which physical therapists have less control.

CHAPTER NINE

Dealing with Doctors

In the last chapter we discussed the way gender control shapes the labor process by influencing the way therapists participate in the labor force, what jobs they select, how they are expected to do their jobs and how they get through the work. In earlier chapters we saw how the physical therapy profession was shaped by class and gender influences, and how it grew up in a specific, ancillary relationship with medicine. In this chapter, we examine current relations between physical therapists and doctors. These relations have a history (of medical dominance) and a gendered character.

Interaction between doctors and physical therapists in clinics, rounds (meetings to discuss patient problems and treatment), telephone conversations and the like, always reflect the power difference between doctors and therapists. Sometimes they contain sexual banter initiated by the doctor. These interactions reproduce a dominance relationship, with the physician displaying dominance, and the therapist, willingly or not, acquiescing.

Dominance

The official relationship between doctors and therapists today is one of colleagues. That is, the doctor refers the patient to physical therapy; he or she does not prescribe physical therapy. The therapist can be self employed or, more usually, employed in a hospital or rehabilitation institution. Doctors, except in very unusual circumstances, are not in a direct supervisory relationship with therapists. Employed therapists are managed by hospital administrative hierarchies; doctors' only input into supervision of therapists is indirect, through either membership on the hospital board of directors or through informal control. The latter, as we shall see, is very important, and doctors are a great influence on the work of physical therapists.

The relationship between doctors and physical therapists involves us in an examination not only of dominance, but of sexual politics in the physical therapy work place. This issue is complicated. Most, but not all, of the obvious sexual politics we see in physical therapy occurs between male doctors and female physical therapists. It is colored and shaped by professional dominance and professional rivalry, and it also reflects wider social patterns of dominance of women by men.

Sexual politics in a professional occupation such as

physical therapy or nursing is not as straightforward as it is reported to be in working class women's occupations. Pollert (1981) for example described sexual teasing, flirting, and harassment as merely another form of personal control to keep the workers in line. Sexual politics between doctors and physical therapists seldom reaches the point of overt harassment, but it does cause therapists considerable discomfort and often alters their ability to get the job done. Politics sometimes wins better treatment for favored doctors' patients; sometimes it meets the purposes of the therapists as well, and sometimes it merely takes time away from other activities. We might well question whether the sexual comments and dominance gestures observed during the field work were supposed to keep the workers under control, to keep physical therapists under control, or to keep women under control. Since the therapists studied were employed women professionals, we might assume that all three purposes were served.

Changing medical dominance

The physical therapy profession began by establishing a place in the medical hierarchy. It remains there today, but its relationship with medicine has changed as it developed as a profession. Therapists believe they are independent practitioners, intent on developing a true collegial relationship with doctors, but they acknowledge differences

in status and income between the medical profession and the physical therapy profession. This research addressed the following questions: What is the state of "shop floor" relations between doctors and physical therapists, and how do doctors affect the labor process in physical therapy?

Many different relationships between doctors and physical therapists exist. This chapter focuses on several that are common enough to be considered typical and that illustrate the theoretical contention that medical, class, and gender dominance are interconnected, and that they are reproduced daily in the interactions of physical therapists and doctors.

In most situations, physical therapists are employed by a hospital or other health care facility, and doctors are not. Doctors have "medical staff privileges" at the hospital, which means their qualifications and conduct have been found acceptable by a medical advisory committee to the hospital, and the doctors are allowed to admit patients there. Physical therapists, therefore, are not supervised by doctors. Doctors do not have the direct authority over therapists that facility managers have. In the few cases where doctors own physical therapy facilities, or direct them, they can be treated analytically as managers. In the majority of situations, as it was in the two field work settings, the doctor "requests" specific actions from the therapist.

Scant information is available about the working relationship between the doctors and masseuses of the early days of physical therapy. We have indirect evidence from physical therapy journals which exhorted members to work "under Medical Supervision" or send in their resignations. (Journal of the Canadian Physiotherapy Association 1970: 65). The journals also comment on the honor that physical therapists had been shown in being allowed to attend the scientific meetings of the Canadian Medical Association.

Likely, "under Medical Supervision" meant much as it does today: the therapist received referrals from a doctor, assessed the patient, decided on the appropriate physical therapy treatment, and carried it out, consulting the doctor for discussion if any major change in treatment was required or if problems arose. Except in large rehabilitation departments in urban hospitals, it has not been common for doctors of physical medicine (physiatrists) to control access to physical therapy departments. The communication (and what supervision there was) passed between the therapist and the patient's general practitioner and or orthopedic, neurological, or medical specialist. In the past, however, therapists were subordinate to medicine by law and custom. They were required to treat patients only with a doctor's referral. The requirement that they treat patients under medical supervision shielded them from the intense scrutiny

by the state and management which they face now that they are becoming independent.

In some settings, until the nineteen fifties, the relationships between doctors and therapists were very formal. Like nurses, physical therapy students were trained to stand when a doctor entered the room. In many settings, however, such formality was abandoned in the working world.

A physical therapist who is now retired, reminiscing about the influence of one of the first teachers at the University of Toronto physiotherapy teacher training program, said in an interview,

I had worked in Montreal, and I had had a very close working relationship with the doctors there. We were on a first name basis. But Miss Pollard was very definite, and she trained all the teachers. There were certain ways to behave, and they were quite formal. I got myself into a lot of trouble when I came here to train (as a teacher). I had worked in Montreal, yes, and down South, and I knew Gus, Gus Gingras, you know, quite well. It was silly, it didn't make any sense to me to call him Dr. Gingras. All of those guys, Bob Salter, Bud Godfrey, you've known for 40 years and suddenly you're going to be all formal?

Even in the nineteen fifties, there was individual variation in the way therapists and doctors related to each other. In that period, this therapist and many others were working in far corners of the world, developing rehabilitation programs and using physical therapy to alleviate the problems caused by polio and other contagious

disease epidemics. At the same time the Canadian Physiotherapy Association was advancing and defending the status of the profession with the help of their physician sponsors. The leaders of the profession at the time, members of the executive of the C.P.A. and teachers such as Miss Pollard, were active, capable women but they believed in maintaining a ladylike, deferential approach to doctors. How did the transition to the present, ambiguous and tension filled situation occur? The investigator's own experience, typical of therapists trained twenty years ago, helps supply some answers.

By the nineteen sixties, when I was training to be a physical therapist, the contrast had become entrenched in a "training program vs. the real world" conflict. The School of Rehabilitation Medicine where I trained had a medical director. Now it has a therapist with Ph.D. qualifications at its head, as do most other physical therapy training programs in Canada. As students, we were taught that we were independent practitioners; that we were to work out problems by ourselves and that we did not need a doctor's prescription to work. However, textbooks of physical medicine insisted, as they do today, that doctors should prescribe exact dosages of physical treatment as they do doses of medication (see for example Krusen et. al. 1971: 5).

I found when I interned and later became a therapist that neither the physical medicine textbooks nor the way we were taught to think of ourselves at the school were exactly right. Few doctors prescribed any treatment more specific than "heat" or "ice" and that was only what they had been coached to write by the therapists. Doctors in general did not wish to do anything more than refer patients to physical therapists, who would take care of the problems. However, the interaction between doctors and therapists was formal, and wise therapists deferred to doctors, treating them respectfully. We learned as physical

therapy interns how to handle doctors, and we passed it on, in turn, to younger therapists and students.

Vestiges of that professional socialization and its results remain today. During the field work, a therapist who had graduated in 1982 and was working in long term care talked about her working schedule:

"The doctors make rounds really early here, so I like to be here even before eight if I can. Today I caught two."

She later explained, "You can only see these patients between ten and three. They don't finish eating and everything until ten and after three they're too tired."

The therapist started her working day almost two hours before she could really see patients, just to catch the doctors on their rounds. She spent the rest of the time between eight and ten doing charts, working on committee work, and going for coffee. Therapists must "catch the doctors" in order to have medications changed, to have them order prosthetic aids, to suggest transfer home or to a nursing home, and to alert them to signs of trouble. The following telephone exchange is typical of many between therapist and doctor. Only the therapist's side was recorded, but the other parties' words may be easily surmised.

October 23/84

14:18

"Hello, its Bonnie Taylor calling. Is Dr. Williams in his office this afternoon?"

"Is he with a patient?"

"Would he be able to call me back? I'm calling about a patient of his, Mr. Ed Worthy."

"Yes. T.A.Y.L.O.R. My number is 456-7890 and I'll be here until about three thirty this afternoon."

"Thank you. Goodbye."

Two minutes later, after the therapist had started another activity, the telephone interrupted her.

14:20

"Hello, Doctor Williams. I'm calling about Mr. Worthy. I've got two concerns, one's mine and one's his. His knee is really swollen, and he has pain on extension. He describes it like a blade running through it."

"Is that normal? Are you concerned?"

"Yes. He's coming to see you a week from tomorrow."

"Yes, O.K. I'll have him see you next week."

"Oh, no, flexion's not a problem. He got eighty degrees easily yesterday. It just sort of came along on its own. The problem's with the swelling and --"

"Yes, well, I have been treating him just once a week because its a hassle for him to get in here and the treatments he has, ice and exercises, he can do at home."

"Yes, fine. Now the other concern is his. He's been on Percoset (a compound synthetic narcotic analgesic with properties like morphine) for pain, and he's only taking one a day now but he's getting very low. When his wife went for a refill the pharmacy told her they couldn't give him any more without a prescription. He was wondering if you could phone in an order for something else?"

"No, I don't think he needs Percoset but he could do with something a little less strong."

"Fine, I'll tell him that. Thank you very much."

Catching doctors on their rounds is often more efficient and less time consuming for therapists than phoning them at their offices, because when the therapist telephones the doctor's office she or he must usually leave a message with the receptionist because the doctor is "with a patient." Then, when the doctor returns the call, the therapist must interrupt her own time with a patient to go to the phone. Therapists consider the doctors' schedules, and arrange their own working days to suit the doctors, in order to get through their own work.

The hierarchical relationship between medicine and physical therapy affects not only the scheduling, but the content of physical therapy work, as the following series of field notes shows.

Sept. 20/84 Physical therapy staff meeting.

The physical therapy supervisor has reported to the staff on the results of a chart survey she has done regarding C.P.M. (continuous passive motion, a relatively new method of treatment for stiff joints) which has been introduced by the orthopedic surgeons. She has asked for staff input and prepared a presentation for the orthopedic surgeons. The physical therapy department head sums up and ends the discussion with the comment,

"It is really important for us to be there, to increase our visibility with the docs. We have definitely been invited to this rounds where before

we were definitely uninvited. For the good of the profession and the department we should be there in large numbers, and I for one am going to get my fanny in there. I hope you will too."

September 24, 1984

I arrived at 07:45 to join the physical therapists who arrived, half an hour to an hour before their usual starting times to go to surgical rounds where C.P.M. might be discussed. The rounds were held in a lecture theater with four rows of seats. Five surgeons sat in the first row. The resident sat at the right end of the second row, then there were four empty seats and a row of therapists which included the department head, the supervisor, and the observer. Four more therapists sat in the row behind us. The chief of surgery opened the meeting:

"The girls spoke to me about C.P.M., about our rationale and about what they can do in addition to C.P.M. I invited them to come. I know I haven't told you, but we'll go over this and give them some guidelines and set down a protocol then go on to business. Who's going to be spokesman? Jane, good. I'd like to introduce Jane from physiotherapy."

"Thank you very much, Dr. Williams," the supervisor replied. "We would like to know what your criteria for C.P.M. are because it gives us a bit of a head start. We see them in the P.O.P. (patient orientation program) and prepare them, and it all helps with compliance postoperatively."

"Well, I've done them on total shoulders, true adhesive capsulitis about the elbows, no shoulders, does anyone use them for anything else on shoulders?"

He continued for a while. The physical therapy department head interrupted. "Do you know when you see them in the office they're for C.P.M.?"

"Yes, and they're on the admission bookings, the O.R. (operating room) list, . . . He went on in a rapid manner as if (the observer notes say) he feels defensive, then said "I take your point, you should know ahead of time." Later he said, "The

who, would the physios be willing to be the who?"

"Yes" the department head replied.

"The trouble is, we're not getting there soon enough," another therapist interjected. "We don't know they're coming up and then they have to call us, they want X-rays first in the P.A.R. (post anesthesia recovery room) and when they finally get around to calling us the patient's awake."

The supervisor continued, "The best results seem to have been on those patients who have happened to have the C.P.M. applied in the O.R. before they wake up."

The chief of orthopedics was the main speaker for the doctors; occasionally another doctor interrupted him, disagreeing with him. The supervisor proceeded through a list of questions which she had prepared on transparencies for the overhead projector. She prefaced each question with a short explanation of why the therapists wanted to know that, and wrote notes of the replies onto the overheads as she proceeded. The surgeons disposed of all the questions in ten minutes with a promise of a protocol. The supervisor concluded with, "the next step is for me to write this all up into a protocol and circulate a copy to each of you, for you to scribble on and return. O.K.?"

There were nods and assents. "O.K." "Yes" "Fine" "Mmm." Then they went on to the "business." The resident presented the X-rays of a patient, then another, then another. The surgeons became much more animated during this part of the meeting, interrupting each other, arguing, and leaping up, sometimes two at a time, to peer at the X-rays closely. The resident seemed to control the pace of the meeting by putting up and removing the X-rays for each case. Each case lasted about ten minutes, and the physical therapists were silent until the case of a woman who had has a hip ball prosthesis and some surgical difficulty which required a bone graft. Dr. Kidner asked,

"How active is she?"

A physical therapist replied, "She's very active. She's worn out two pairs of crutches in the past year."

"Oh, she's on crutches. What's her goal now?"

"I think to get rid of her pain."

The therapists were silent while the doctors continued to discuss the patient jocularly. The therapists did not contribute anything more to rounds.

The physical therapy supervisor had prepared for this interaction with the medical staff. She had reviewed the literature on C.P.M., reviewed the charts of patients who had undergone the treatment, consulted with the other therapists, and prepared an outline of what she wanted to say. Her manner was poised and confident, and she was well groomed and smartly dressed. The physical therapy staff were also well informed and had attended rounds on their own time to increase their visibility as the department head had suggested. The doctors, on the other hand, were unprepared, treated the therapists casually, and regarded their questions as an interruption, even though the therapists were seeking information to help them treat the doctors' surgical patients better.

There is little excessive deference in the physical therapists' demeanor in rounds now, but therapists know the boundaries and are careful to be formal and direct, as befits an aspiring profession. The doctors' overly casual treatment of them is noted, and resented. "You wouldn't believe the amount of bum patting that goes on around here," one therapist said. Therapists preserve the formal relationship,

avoiding open rebellion, in order to avoid unpleasant repercussions. They search continually for new, more collegial ways of relating to doctors, and of making a recognizable independent contribution to patient care.

It is interesting to note that the above anecdote illustrates the contrast between the therapists' idea of "professional" behavior and the mode presented by the "senior profession." The doctors were in various states of casual and formal dress, including the scrub suits which are appropriate for wear in an operating room. They were casual in their conduct of the meeting, they interrupted and disagreed with each other, and they engaged in ribald humor. The therapists, who might do all the same things among themselves, present a much more formal, restrained, polite image to the rest of the world; and they are now demanding similar treatment from others groups including doctors. The therapists say:

"We want to be respected for what we know and what we contribute, not treated as some doctor's go-fer or handmaiden. We don't show him our difficulties and take out the tensions we have in our jobs on him, why should he yell at me because his divorce is going badly?"

Therapists now object to the tension reliever role the doctor has assigned to them. The objection seems not to be that they deny they are good at it, but that they have no choice in the matter. Therapists acknowledge that they are

skilled in tension relief and use the skill deliberately to get through the work, but they are struggling for control of the situation in the face of what they see as "sexism."

Working toward collegiality

In one of the field work hospitals, a physical therapist attends doctors' "clinics" several times a week. Only experienced therapists with considerable confidence are permitted to go on "the clinic rotation," the Director of Physiotherapy explained, because the therapist must assess and treat rapidly and under pressure, and must be able to stand up to the demands the doctors make.

Clinics are held in the hospital outpatient department, and staffed by a surgeon, a nurse, a physical therapist, and sometimes an occupational therapist. Patients who have been referred to the doctor are seen and assessed by the team. Waiting patients sit on chairs outside the clinic room. Patients are seen while they are lying on one of two stretchers (around which curtains can be pulled for visual privacy) or on one of the two chairs in the clinic room. The nurse co-ordinates the flow of patients.

The nurse or the physical therapist, whoever gets to the patient first, takes the history and records it on a pre-printed form. The physical therapist or the doctor, whoever gets to the patient first, does the physical examination. In

the clinics observed, the therapist did most of the physical examinations that were recorded on the pre-printed form, then the surgeon came and repeated the manoeuver that produced symptoms. He then spoke to the patient and to the others present. Often, after the doctor had gone on to the next patient, the therapist explained his instructions to the patient saying "What he just said was" Then she added some instruction of her own.

The clinic therapist told me she liked to attend clinic, because "If I can see the patients in clinic, and do a little postural correction with them and teach them some exercises, that saves them another visit, so it is worthwhile for me to attend." She did not like being used as a physician's assistant, just to do the physical examinations. She tried to discourage that. "Dr. Jordan likes me to do all the physicals, then just come in and confirm the assessment and prescribe surgery. Most of his patients go under the knife and there is really very little for me to do, so I'm thinking I might stop going to his clinic. It's not a good use of our time." The physical therapist would have the backing of her department head if she decided to stop attending clinics, using the justification of efficient use of physical therapy labor power. In this case, a physical therapist would enlist the support of the hospital hierarchy in resisting medical dominance.

Asserting physical therapy demands as professionals, not just as doctors' eyes, ears, and hands, is not without hazard, and has caused friction between doctors and therapists. Hostile exchanges are uncommon, but hostile feelings are not. As the department head told the observer, "Dr. Hunter, for one, tried to take over our research project and he found that physios weren't as pushable as he'd like."

The investigator accompanied the clinic therapist to several doctors' clinics. An experience in one of them illustrates the suspicion and uneasy relations which now characterize the relations between medicine and physical therapy. The single quotes denote approximate dialogue. It is as accurate as possible considering it was recalled later, not recorded at the time.

11/21/84 (recorded that evening)

My presence as an observer in one physician's clinic made him so nervous he demanded to see my notes. The notes contain verbatim accounts of the interaction that had occurred so far, and the physical therapist's confidential explanations to me about the way that doctor practiced. I refused to let him see the notes, saying,

'They're confidential. No-one sees my notes.'

'Aw, come on, let me see them,' he said.

'No, I'm sorry, they're confidential.' I replied, backing away and holding my clipboard against my chest.

'I'm not sure I like being observed so closely. You should let me see what you are writing about me.'

'I'm writing about the clinic in general. My study is about physical therapists, and I'm observing how they do their work.' The debate continued for a minute, then the doctor asked me to leave, which I did.

When I got back to the physical therapy department to report my misdeed, and to say that it was probably an error in judgment to record openly, the department head reassured me,

'Oh, don't worry, it's just Doctor _____. He's so juvenile.' Then she went on to tell me several anecdotes about the man's behavior towards other staff, concluding with 'Even his wife left him. She just said, 'I don't have to take this' and walked out.'

Before the department head was finished, the clinic therapist was standing in the door of the office, offering me reassurance. As word got around the physical therapy department, other therapists dropped by to reassure me and to offer advice on how to handle doctors. Next week when, after several discussions with the therapists and department head, I decided to attend another doctor's clinic but not take notes openly, the department head warned: "Just make sure you don't get pinched." (I learned later that the "pincher" and the "good doc" were different people.)

"Pinched?" I enquired.

'Yes, pinched. He's famous for it. . . . we tolerate it because he's really quite a good doc.'

"A good doctor. I've heard that term many times from therapists. What do you mean, a good doctor?" I asked.

'Oh, you know, Carole, one who listens to us and respects us, who answers our calls, who takes time with his patients. . . .'

Keeping peace with doctors

Physical therapists tolerate condescension and sexist remarks from some doctors, if the doctors in general respect their opinions, answer their calls, and make the work easier for them. If a doctor speaks warmly of physical therapists to a patient, the patient is more likely to trust the therapist easily and to cooperate with treatment. Thus, the doctors' attitude can facilitate the therapist's work. Doctors who respect physical therapy competence are likely to comply with the occasional request to "sign a referral" the therapist has written after assessing the patient and initiating treatment. If the doctor trusts the therapist, problems such as the inflammation in the patient's knee, which was the subject of the telephone call reported above, are less likely to be blamed on the therapy. Cooperative doctors are assets in getting the work done, and physical therapists tolerate sexist remarks and behavior to keep peace with medicine.

In the past, it was customary for therapists to enlist the doctors' support for their demands for more staff to cope with increased work loads. In the battle to resist exploitation of the physical therapists' labor power, doctors possibly could be used as allies. During the field work I saw no evidence of that, but instead saw managers supporting staff in resisting the demands of doctors.

Remarks and behavior which therapists call "sexist" and "inappropriate" may be tolerated, but they do not go unnoticed. Ritual forms of resistance, such as gossip to insiders, provide a way to ventilate the resentment without disturbing the convenient co-operative relationship with the doctors. In the course of the field work, the observer was told many stories about doctors on the hospital staff. The stories would come under a general heading of "gossip." Many were prefaced with a remark such as, "If you write that down, I'll kill you!"

There is a discernible shift in the doctors' dominance of physieal therapy and in the form resistance to it takes. It appeared particularly clearly in the discussions surrounding the physical therapy department's planned contribution to the Christmas party in one of the field work hospitals.

Each year in the past, the physical therapy department had written and performed a skit for the Christmas party which was attended by all the hospital staff and doctors. In 1983, they hesitated. They explained why:

"We used to poke fun at the doctors, but lately we've been taking shots at administration. It seems now we're all in competition with the other professions, other departments, and you don't really want to go out on a limb, to expose yourself, for them because you can't count on their support."

The physical therapists were reluctant to stay after work to create a skit which would entertain other departments and the medical staff, when they no longer felt that the effort would be reciprocated with loyalty or support. Medical sponsorship for physical therapy could no longer be counted on; with the loss of medical protection, the relation of physical therapy with other professions was changing as well.

Some therapists also objected to the material. Therapists who did not feel personally offended by the material nevertheless felt the sensitivities of the more conservative therapists should be respected and that gags with double meanings did not reflect well on their profession. One explained,

"Before, some of the things we came up with were pretty, well, ripe. We'd write the skit, and have a good laugh, blow off steam then we'd have to clean it up a bit, clean it up a lot, for public presentation. You hate to risk offending people you've got to work with."

Another therapists gave an example of how presenting a previous skit made the work of at least one therapist more difficult.

"One year, Dr. Carstairs got mad at Laura, and went almost a year without speaking to her. Imagine, working every day with a person who wouldn't even speak to you!"

Finally, a vote was taken in the staff meeting.

Although nine therapists voted in favor of presenting the skit, eight were opposed, and it was decided to respect the feelings of those that were opposed and bow out of the skit for the Christmas party.

Like the field note segments which dealt with "rounds" and "clinic", the Christmas skit illustrates the complex relations in which physical therapy is enmeshed. In the past, doctors protected and sponsored physical therapy departments; in return they exacted deference, expected therapists to obey orders, and "humored" therapists. Therapists responded by outwardly complying with the doctors' expectations of them, but they resisted with gossip and satirical skits presented to other insiders, the rest of the hospital staff. Now, relations between therapy and medicine, and between therapy and other departments, have changed. The hospital administration, not the medical staff, is seen as the major oppressor (with some justification, it could be argued, as we shall see in the next two chapters). Skits and gossip are directed at management as well as at doctors. Other hospital staff are competitors, not insiders, and physical therapists are reluctant to expose their "inside" gossip and informal behavior to them.

Day to day interactions between therapists and doctors are polite, and range in tone from formal and deferent to casual and joking, but tension lies just beneath the surface.

Physical therapists often question the doctors' judgment in handling cases, although they do not always openly disagree with doctors, especially in the presence of patients. (O.P.A. 1980:58, Miles-Tapping 1985:290). Physical therapists see the results of clumsy surgical technique or poor judgment. Several times during the field work physical therapists in both settings were overheard discussing a poor result from surgery; trying to avoid being blamed for the patient's slow rehabilitation without directly accusing the doctor of clumsy surgery.

Even though they are progressing toward establishing themselves as an independent profession, and have accepted that they will have to compete openly with other professions, including doctors, for public recognition of their skill, physical therapists still cater to the doctors; adjust their schedules to catch doctors when they make rounds; attend clinics where they are used as physicians' assistants; resolutely ignore insulting and condescending remarks. Why do physical therapists work so hard to keep the peace?

Medical dominance today

Despite strides made in the area of independent work, research based arguments supporting physical therapy procedures, and the replacement of doctors by physical therapists in educational programs and professional organizations, physical therapy is still a profession

dominated by medicine. The reasons for continuing medical dominance include a residue of habits and customs from the time when physical therapy was an aspiring profession sponsored by medicine; the continuing custom of medical referral which controls the flow of patients to physical therapy; the presence of doctors on the boards of hospitals, on research committees, and on other bodies with funding authority over physical therapy programs; and the prevailing relations between men and women within society. The next section deals with these factors in turn.

Residual habits and customs

Much of physical therapists' everyday behavior is learned from contact with other physical therapists. The internship period which all therapists are required to complete before qualification is the beginning of an apprenticeship which continues as new graduates work in the company of more experienced therapists. This professional socialization, which goes on in any occupation, is often described as "learning the ropes" (Geer et. al 1968: 209). As McFarlane (n.d.: 8) quoting from Merton et. al. (1957: 128) said:

The recruit 'develops his professional self, with its characteristic values, attitudes, knowledge and skills, fusing these into a more or less consistent set of dispositions which govern his behaviour in a wide variety of professional (and extra-professional) situations'. The recruits in the educational and training environment 'learn more than . . . facts, techniques, and concepts: they come to have particular ways of thinking about themselves . . . and their profession.'

Apprentice physical therapists not only learn how to handle patients; they also learn how to handle doctors, difficult colleagues, managers, and other professional staff. The working environment in most physical therapy departments facilitates ongoing professional socialization. The physical therapy facilities observed during the field work were similar to many others. They consisted of large rooms, most of which were divided by curtains, not walls, into treatment cubicles. Parts of the rooms were left open and undivided. In many facilities this part is called "the gym" and it contains exercise equipment and "mats" on which patients sit, kneel, or lie for active exercise and treatment. In "the gym", physical therapists treat their patients out in the open. They watch each others' techniques and learn by observation. In some physical therapy facilities, cubicle curtains are also left open (except for when the patient is changing or undressing) so that learning by observation can go on all the time. Offices, too, are collective. Office areas consist of rooms lined with a counter or shelf, at which several therapists sit to do their paperwork. They

have drawers for charts and notes, but policy manuals, notices to staff, schedules and message boards are communal property. Colleagues are nearby, to consult about problems with patients, staff, or doctors. Advice and support is shared, and techniques that seem to work are easy to learn by imitation.

Students and new therapists learning the ropes quickly learn which demeanor is the accepted custom with which doctor. They experience pressure to conform: if they don't, the doctor may call them "difficult to deal with" or "prickly" and their colleagues will not support them. Refusing to act in the customary therapist pattern is risky, and carries with it a sense of inadequacy.

Professional socialization does not mean that change is impossible, it just means that it is slow. Physician sponsorship of physical therapy ended in the nineteen sixties and seventies but some of the patterns of deference still persist. The women's liberation movement, however, has alerted all women to the deleterious effect of sexist remarks and attitudes. Physical therapists who want to change can recruit support from the women's movement and from other women's professions, such as nursing, which are undergoing similar struggle.

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Medical referral

Physical therapists depend on doctors for referrals. Even in places where a medical referral is not required before treatment begins, such as in private practice in Australia, Manitoba, or Alberta, physical therapists depend on doctors to supply information about medical problems the patient may have in addition to, or as the cause of, physical problems. Even though medical referral has not been required by the code of ethics of the Canadian Physiotherapy Association since 1978, physical therapists are required by their code of conduct, and by prudence, to ensure that they have adequate medical information before beginning treatment.

Removing the requirement for medical referral has placed physical therapists in a stronger position with respect to medicine, because it put them in a position to refer as well as to receive referrals from doctors. However, it has not negated the obligation to maintain cordial relations with doctors. Independent referral or even the prospect of achieving it has increased the importance of other external control of the physical therapy labor process. Legislation will have to be strengthened to permit adequate supervision and control of physical therapists providing service directly to the public. The Board of Directors of Physiotherapy, the licensing body in Ontario, has added a lay representative to the physical therapists on it. The Canadian Physiotherapy

Association has added a lay representative to its board of directors. Although it is doubtful that these changes, by themselves, will have great effect, they indicate awareness of the need to be seen to be accountable to the public. The shift from medical to managerial control has been bolstered by government requirements for quality assurance in all hospitals and health care settings. Quality assurance has a profound effect on the physical therapy labor process. It is taken up next.

Doctors in powerful positions

Doctors, as sociologists from Freidson (1972) to Navarro (1976) and Illich (1975) have shown, hold powerful positions in society. They are members of the dominant class. They have powerful lobbies with legislative bodies; their professional associations and research activities are the beneficiaries of grants and support from economic forces such as the Kellogg Foundation, and they sit on committees and boards which manage most of the institutions where physical therapists work. Hospital boards consist of economically powerful and socially prominent members of the community. Doctors, through their medical staff organization, are the only health care profession which customarily has direct representation on hospital boards. Doctors control ethics and research committees within hospitals. In order even to gain access to one of the field work hospitals, the research

proposal had to clear the hospital ethics committee, and doctors had to be convinced that the purpose was studying physical therapists, not "raking up muck" about doctors.

Physical therapists must convince doctors as well as health care administrators that physical therapy treatment is effective, and is being performed efficiently. Mistakes which even potentially could result in harm to the patient must be reported on an "incident report" which must be signed by the physical therapy supervisor and the patient's attending doctor before it goes to the hospital administration.

Doctors not only assume responsibility "for the good of the patient" but become "cost conscious" when it suits them. In one of the clinics attended during the field work, for example, a doctor chaffed a physical therapist about "over-treating" patients. He mentioned a patient who had had twelve ultrasound treatments. "Good for business?" he asked.

If physical therapists do not succeed in persuading doctors that their treatment is useful, their resources will be cut. Budget restraint imposed by the Ministry of Health in 1982-83 had made this a real threat to physical therapy departments. Unless they produced the figures to prove they were working efficiently, and recruited support from dominant groups in the hospital hierarchy, including doctors, they faced budget and staff cutbacks.

Gender structured relations

Physical therapy, like nursing, arose in a specific ancillary relationship with medicine. The qualities thought necessary to the profession were qualities also thought necessary in good middle class women. In this chapter we have seen the condescension and sexist comments in present day relations between physical therapists and doctors. We know medicine, despite a recent influx of women into its junior ranks, remains a field in which masculine culture predominates. We know physical therapy, with an almost constant ratio of nine women to one man, is a gendered profession, and remains a women's profession, especially at the worker level.

We cannot say, even with all this circumstantial evidence, how much medical dominance is because of the sex of the physical therapists vis a vis the doctors, and how much is because of professional dominance. The effect of gender and the effect of profession are mixed. It seems likely that since dominance of women by men is a social phenomenon which can take different forms in different circumstances, medical dominance is, in part at least, gender dominance. In their relationship with doctors, physical therapists are constrained both by a history of medical dominance, and by the prevailing gender relations in their society.

CHAPTER TEN

Schedules and Rules

Attempting to explain why physical therapists work so hard, and exploring what it means to be a woman professional, from the view point of work control, we have so far focussed mainly on historical professional dominance and gender dominance. Now we turn our attention to management control in physical therapy.

Patient care activities constitute the main work of physical therapists. Patient care may involve assessment, evaluation, education, heat, electrical treatment, support, manual mobilization or manipulation, instruction, and exercise. Patient care also involves recording information about the assessment, treatment, and results; communicating the findings to doctors and other health professionals, the patient, and the family; and preparation for treatment. To a large extent, patient care is at the discretion of the physical therapist. That is to say, therapists are given minimal information about the problems the patient has, and they have available to them general information about the patient's health. They are responsible for identifying the physical problem and for planning, executing, and evaluating the physical treatment. They decide what to do for each patient. This responsibility makes physical therapy as an occupation appear rewarding, flexible and autonomous.

There are, however, flaws in this picture of physical therapy work. Physical therapy, like many other occupations, is characterized both by considerable flexibility and by many constraining factors which limit workers' choice.

The majority of physical therapists work for health care institutions. As such, they are constrained by the requirement to operate efficiently. Health care organizations are hierarchical, with a central "administration" and accounting department, a nursing department, service departments (laundry, housekeeping, and the like) and many parallel departments which consist of technical and professional staff and provide various diagnostic and treatment services (laboratory, X-ray, rehabilitation services, etc.). Physical therapists form one such department; often they are combined with occupational therapy and other rehabilitation staff and may share clerical staff, offices, department directors, and aides.

Physical therapy department heads, themselves physical therapists who have acquired management expertise, are responsible for ensuring that the health care dollars allotted to their budgets produce the maximum amount of the "product," physical therapy treatment. As such, especially if they devise methods to increase control in the interests of efficiency, the managers perform part of the global

function of capital.

Employee physical therapists and supervisors produce and coordinate the service. They can be thought of as performing the global function of workers. They are subject to management control and to professional and gender control because of the specific set of circumstances which organize health care today. When we examined control of the labor process that related to gender, it was not always clear whether physical therapists were being controlled as workers, as women, or as a profession. The situation is clearer in the next two chapters. In the situations we look at here, physical therapists are being controlled as workers. The way they are controlled, however, is not always as it has been described in the labor process literature reviewed in chapter two (pp. 55-76). In physical therapy, the control mechanisms appeal to the workers' sense of professionalism to get them to comply with schemes that increase the exploitation of their labor power.

Four distinct but related mechanisms of control stand out. In this dissertation they are called schedules, charting, quality assurance and work load measurement. These mechanisms combine a mixture of formal control, that is, rules and policies; and informal control such as peer pressure and unwritten rules. Schedules control the working day. No treatment is considered complete

until it is charted. Quality assurance controls the content of the charts. The work load measurement system (which is described and discussed in the next chapter) records treatment units (time units) and allows management to divide the work load and to monitor the workers. Every day, physical therapists confront these mechanisms of control. They are constant features of their working life.

All the control mechanisms help managers plan, organize, supervise and control the work of all employed physical therapists. Self employed physical therapists in private practice keep charts and schedules, but may not keep time units or have formal quality assurance programs. Schedules, time units and charting allow management to control the physical therapy work process to achieve uniform, constant output of measurable physical therapy services. Efficient output is required because the physical therapy department, as one of the services provided to the public and funded by the state, must operate efficiently and not cost too much. Managers are responsible to ensure that the resources allocated to the physical therapy department are spent according to an overall ideal of efficiency. Schedules, charts, and work load measurement are the peculiar physical therapy expressions of the class structure which help managers achieve this goal. They are the structures within which physical therapists work.

Physical therapists universally complain about the amount of paper work associated with their jobs. They grumble about "filling in time units" required by the work load measurement system. They complain that they never have enough time to do their charts, or that they have to spend too much time charting, but they chart what they did for every patient, at times working overtime or taking charts home to get the work done. Physical therapists constantly reshuffle their schedules in the attempt to "fit everything in." There is never enough time.

The illusion of autonomy

Schedules are usually arranged by individual physical therapists, who therefore seem to be in control of their own work routines. However, on close inspection, we find many factors constrain physical therapists when they set their schedules.

Physical therapists devote thought and effort to schedules and timetables. They attempt to organize them efficiently. Many are aware that they seem to be working harder than physical therapists used to, although most are cautious about romanticizing the "good old days." Early in the field work, one staff therapist said:

We're working a lot harder than we used to. Fifteen years ago, you had time to do charts while a patient was on short wave. Some people even did their knitting. Now we're always on the go, you scarcely have time to catch your breath.

Her department head disputed this, telling me about the discrepancy between what the therapist thought and what the work load measurement system showed. The time units she was talking about are the units of patient care time; patient attendances means the number of patients the physical therapy department sees each day, that is, the number of outpatients who come in to the facility for treatment and the number of hospital patients (inpatients) who are treated by the physical therapy staff.

Their time units show they are actually seeing fewer patients than before. They probably feel they are working harder. Their charts are better, and committee work and quality assurance takes more time. I try to give all the therapists a voice in the running of the department, and of course that takes time. But our time units are about the same, and patient attendances have gone down.

In another setting, the department head recalled the days when she had been a staff therapist.

We always stayed after work to catch up on charts. They still do, but now they grumble about it. I used to wonder if it was because we were so interested in patient care that we put that first. Only after the department was closed or patients were at dinner we would settle down to chart, and of course that meant we stayed late.

The formal control mechanisms used in physical therapy

all reflect management requirements for regular, predictable and efficient output from the labor force. However, patients are anything but predictable, and the therapist must adjust treatment to suit the needs of each patient. Management need for a predictable work output conflicts with workers' need to spend time with patients as they see fit. Both needs are "for the good of the patient" and because the strategies such as organizing schedules, auditing charts, and measuring work load have the support and endorsement of the professional association, they place workers in a bind.

Physical therapists can not reasonably object to the control to which they are subjected, because it takes the form it does. Schedules, charting, quality assurance and work load measurement are all arguably "for the good of the patient." If a therapist objects to working harder, management has the work load measurement system to "prove" that is not so. If a therapist lets her charting slide, she is judged unprofessional, an inadequate therapist. Ideas about service and professionalism disguise the conflict between the need for flexibility and the need for predictable output. As Larson (pp. 87-90) observed, the ideology of professionalism conceals the powerlessness of the professional worker. Therapists are aware they have to work hard and that they always feel pressed, but the only acceptable explanations hinge on personal inadequacy rather than on organizational conflict.

The following chapters apply a sociological perspective to familiar features of physical therapy working life. This perspective is not presented as the only truth, but as a useful way to ask "what is going on here," and to see "why physical therapists work so hard." During this and the next chapter, the term "ideology" appears frequently. In this dissertation, it means a system of ideas about the world which generally support the current system. Thus an individual, competitive ideology held by physical therapists encourages them to focus on personal inadequacy and to feel guilty about not getting work done on schedule. If they had a more collective ideology, they might see their predicament as a result of group conflict produced by divergent interests.

Types of schedule and constraints to therapist choice

An observer walking into a physical therapy department is impressed with the bustle. Therapists arrive and depart from their office, looking at watches and lists. They sit briefly to make phone calls or to write in charts, but dash away again within minutes. Each therapist works and rests according to a different schedule, and each day's work is different. Therapists walk a great deal in a working day; usually several things are attempted with each trip.

Therapists say they like to be "busy" but not "rushed." They like to have "enough (patients) that you have to move quickly and be well organized to get through the day." Being rushed means there is not enough time to treat each patient properly, so some duties or treatments must be skipped. Being busy but not rushed is achieved by having a suitable work load. Administrative needs for efficiency and regular output must be balanced with patient demands for more therapist time. The pace of work seems similar within each setting because therapists and first line supervisors informally come to an understanding about how hard one should work (an effort bargain). Actual therapist schedules, however, vary from setting to setting and even within one setting. Rather than describe schedules, it is more useful to describe the factors which influence therapist choice of schedules.

Department standards for case loads

Physical therapy departments have standards for the size of work load each therapist is expected to manage. Although some have written policies, most settings communicate the standards informally. A manager or supervisor will tell new therapists: "We try to see ten new patients a week in outpatients" or "our departmental average is ..." Within that guideline, the therapist is expected to arrange his or her work load and schedule.

Therapists import ideas about what constitutes a suitable effort level from previous work settings and from settings where they were students. Professional and regulatory bodies survey current practice and establish guidelines for work loads (Leslie and O'Neill 1971, O'Neill 1976, Calder and Jarvis 1986, Wolpert et. al. 1986). Guidelines meant to apply to the whole profession provide a large acceptable range. Each facility's acceptable work load standards are narrower. Local custom establishes the work load therapists are expected to manage.

Other duties in the work load

A case load is only part of the work load. Other duties include meetings, rounds and clinics, committee work, departmental maintenance, and statistical record keeping. All these must be done in addition to "seeing patients." A case load is the number of patients a therapist "has on her list," that is, the patients she or he is responsible for at any one time. The therapist must know the condition of the patients on his or her list, know what treatment is needed, give the treatment, and chart the assessment, treatment, and results. The size of case load varies. Certain patient problems are acknowledged to take more time to treat, and a therapist who sees mainly that type of patient handles a smaller case load than a therapist who sees patients which can be treated quickly. Within a given case load, the

therapist decides how often each patient must be seen per day or per week. The therapist also decides, within guidelines, the amount of treatment to give each patient. Some physical therapy settings have treatment protocols for some patient problems. Protocols specify what must be done; they may also specify the timing. For example, "All at-risk patients should be assessed for chest problems, encouraged to deep breathe and cough to clear secretions, and to do foot and ankle movements on the first day after their surgery."¹

Admissions and discharges

Patients enter a therapist's case load when a referral comes from the hospital ward, when they are transferred from another therapy service, or, if they have been on a waiting list, when they can be given an appointment by a therapist assigned to outpatients. Patients leave a therapist's case load when they are discharged by the therapist or when, as with inpatients, they leave the hospital. New patients take longer to assess, treat and chart than patients the therapist has seen before. New referrals which must be seen, assessed and treated within the day disrupt the best-organized schedules.

Fixed and variable interruptions

Starting and quitting times, availability of treatment space and equipment, patient meals, and hospital routines are

fixed boundaries within which a therapist must organize her or his own schedule. Patients who come late or at the wrong time for appointments, incoming telephone calls, conflict with other treatments, visits from doctors, and other interruptions also disrupt schedules. In many places, therapists can be asked to see additional patients during the day. Therapists have no control over the variable constraints to their schedules. "Flexibility" is rated high among the virtues of a good therapist.

The role of supervision in scheduling

Supervisors and senior therapists "keep an eye on things" by being present in the physical therapy department when staff therapists are treating patients and by moving around the wards talking with other staff and patients. Supervisors also ask therapists, "How's it going?" at intervals. They monitor therapist work loads by checking appointment schedules, and by comparing time units collected for the work load measurement system. At times they rearrange work loads to distribute the work more evenly, and they ensure that space and equipment are available to facilitate patient treatment.

Therapists are expected to be able to "cope" with heavy and variable case loads by being "well organized." When case loads grow too heavy, therapists typically deal with the

problem by "organizing and prioritizing" (discussed below). Supervisors step into the process as soon as the therapist's own coping methods are seen to be failing. With students, junior staff, and staff who are not seeing as many patients as expected in the setting, the supervisor may "go over the case load with them." The first step is to "prioritize" which means deciding which patients need treatment most. Priority patients are given relatively intensive treatment; the rest are seen less frequently or are discharged.

Organizing and prioritizing

Physical therapists are expected to organize their days so several activities can be accomplished at the same time. They might assemble a "class" which consists of several patients who can exercise with minimal supervision. They might arrange to have several patients receiving heat or ice pack treatment while they give individual attention to one. They may try to catch up on charting while they have patients receiving passive modalities such as heat, ice, or machine traction. Experienced therapists organize and prioritize on their own; they can usually arrange their schedules to provide a little "leeway." They tend to treat more problems in each patient, and may even spend longer with each one. Thus they appear to be busy most of the time. Experienced therapists are usually expected to cope with more patients, and it is a point of pride with them to be able to handle a

big case load and to cope with the unexpected. As one therapist said:

I always like to get through most of my list in the morning, leaving only the second treatments and the pre-ops for the afternoon. That gives me some flexibility because you never know what's coming at you.

Charting, meetings, committee work, rounds with doctors, clinics, and other official activities must be fitted into the schedule along with treating the case load. Some of these activities are directly concerned with patient care and some have other management-sanctioned purposes. Prioritizing a patient load does not reduce the time allocated for other activities. Physical therapists find it difficult to reduce their participation in meetings, clinics, and other official activities, because it implies they "cannot cope." They must seek support from their peers and supervisors in saying their work load is too great or they are not accomplishing physical therapy goals by the activity. It is almost unthinkable to try to reduce official work such as committee work, which is seen as being for the good of the whole department, all its patients, and the profession. In contrast, patient-prioritizing decisions, which reduce service to patients, are considered professional clinical decisions which physical therapists make routinely and independently.

Direct patient care is flexible. Physical therapists allocate time for it at their own discretion. Other official

activities are not as amenable to expansion or contraction. Consequently, patient care may be slighted on busy days, and physical therapists feel, with some justification, that other activities take on more importance than patient care.

Dealing with heavy work loads

When prioritizing and organizing the schedule does not provide enough time to deal with the case load, therapists typically work through their breaks, eliminating coffee breaks, eating lunch at their desks while they chart. Many stay overtime or come in early, for periods ranging from ten minutes to over an hour a day, to "catch up on charts." If it is permitted by hospital or facility policy, therapists take paperwork home. Such overtime is unpaid. It is often justified by saying, "A really organized therapist would get it done within working hours."

All professionals work late at times and take work home with them. That, they are told, is why they are paid a salary and not an hourly rate. Most professionals who take work home, however, expect to have control and flexibility in their schedules. University professors, for example, often mark papers at home but seldom have difficulty finding time during the day to schedule a dental appointment without asking permission from a superior. In many of the service professions which are identified with women, for example

nursing, elementary school teaching, and to a lesser extent, physical therapy, taking breaks during ordinary working hours is impossible. Hospital routine demands that wards be "covered". A staff nurse cannot leave her post until she is relieved. Time off for physical therapists usually necessitates rescheduling of outpatient appointments or finding someone to "cover" one's work if one is assigned to inpatients. In this situation women professionals neither have protection as hourly rate employees who are paid for overtime, nor the freedom and flexibility of other professions. The overtime therapists work to catch up on charts or to complete their other duties, therefore, is time out of their personal, off duty hours.

Schedules enforce cooperation. Therapists are free to arrange their own schedules but they must stay within the limits imposed by sharing facilities and space, by hospital and department routines, interruptions, and other duties. All physical therapists have or aspire to have the virtues of flexibility, organization and ability to set priorities. These virtues are admired at the shop floor level; they also make therapists efficient workers.

Organization, flexibility, and ability to set priorities are necessary qualities for a good therapist under the current system. The same qualities were required of a good nurse in the nineteenth century, of a good masseuse in the

early days of massage in Canada, and of a good staff therapist now. These are not just random virtues. They systematically make therapists into good employees. They assure a work force that is as efficient as possible. Moreover they induce therapists to work efficiently, even without managerial intervention.

Informal arrangements

When changes in work load are prolonged enough to come to the attention of the supervisor, she or he rearranges the case loads to share the load more equally among the staff. However, therapists, like many workers such as the "factory girls" in Pollert's (1981) study and the machinists in Burawoy's (1979) study, also have an informal sharing ethic; a system which helps them cope from day to day. Many therapists try to work especially quickly and to treat most of their patients early in the day. This leaves afternoons relatively free for second treatments, assessing new patients, and catching up on charts. Caseloads fluctuate, and a therapist who has had a patient cancel an appointment may ask if anyone needs help, or be asked for help by an especially busy therapist. One therapist may offer to watch another's patients while the second goes for take-out coffee for both. The departmental image of a fair work load operates here, as do the virtues of flexibility, organization and ability to set priorities. No one who has not shown

herself to be able to cope most of the time will be offered help. Help is offered in the expectation that it will be reciprocated later.

Sanctions for not co-operating with the informal sharing ethic are as informal as the ethic itself. No-one officially recognizes that sharing goes on, although the field notes contain many incidents of therapists arranging to help one another. Sharing and helping out are taken for granted within the physical therapy work culture. The expectation that therapists will share and help each other probably becomes part of the informal socialization and work culture of physical therapists in student days, if not before. Students co-operate to take notes for each other in classes and to study the onerous anatomy, physiology and kinesiology together. They are encouraged by their teachers to work together in "labs," taking turns being "patients" to perfect their handling and manual skills. By the time they reach clinical settings as interns, the sharing ethic is well established. It is reinforced by example from their supervising therapists. Often, supervising therapists and students will sit together and "divide up the case load," the therapist saying something along the lines of,

You see Mr. Green and Mrs. Jones because you've seen them before and then go assess Mrs. McArthur, who has an interesting knee and you need to do a knee assessment. I'll look after the rest. O

Gossip is a powerful tool for social control among physical therapists. A therapist who does not offer to share might be labelled "inexperienced" or "disorganized," and be the subject of gossip. He or she would not be offered help when "rushed." The sharing ethic is so well established among physical therapists, however, that an observer likely would not see sanctions for not sharing. Gossip that was overheard in the field work settings pertained to the shortcomings of other physical therapy departments, other departments within the hospitals, powerful figures within the physical therapy profession but outside the field work hospitals, men in the profession, and doctors. Intense loyalty to fellow staff therapists prevailed in the two settings which were observed closely. Therapists praise particular therapists' abilities, at times even recalling the feats of former staff members, more often than they criticize other therapists.

Informal sharing arrangements organized among staff therapists (at the shop floor level) benefit therapists by giving them some control of their schedules. They benefit patients by smoothing out the day so therapists can give more adequate time to each treatment. They also allow therapists to vary their routine by "going all out" for part of the day and then "sitting back" for a while. They leave room in the schedule for therapists to deal with unexpected new work. They allow therapists to demonstrate, to themselves and to

each other, that they "can cope with whatever comes along." Physical therapy managers know about these informal arrangements and acquiesce to them because they regulate the flow of work, ensuring that all patients are treated and all the paperwork is done.

Intensification of labor

Physical therapy work loads tend to expand. As the Canadian population ages, more people develop musculoskeletal and neurological problems physical therapy can treat. Treatments that seem to be effective and patients who have had good results persuade others of the value of physical therapy and the list of patients seeking treatment grows. When slack appears in a therapist's schedule, there are always more patients to fill it.

When the physical therapy work load grows beyond the size that can be managed by the efforts of the current staff, even with organizing, prioritizing, working overtime and shop floor sharing, several possibilities are available. Workload statistics and waiting lists may justify additional staff. However, budgets limit this strategy. Reducing service is unpopular and visibly contravenes the service ethic on which claims to professionalism are based and on which the hospital bases its claim to government operating funds. Furthermore, neither increasing staff nor reducing service increases

efficiency or increases the exploitation of labor power. A strategy which intensifies or multiplies the labor of the existing physical therapists is most likely to be adopted.

Indirect intensification of physical therapy labor: specialization

One commonly used strategy attempts to reduce the amount of time therapists spend with patients to resolve the patients' symptoms. Treatments which promise quick results are popular, and the proponents of specialized postgraduate courses claim or imply that therapists trained in their methods effectively can treat more patients in shorter times. Therapists who have spent time and money becoming qualified to use a certain form of treatment tend to use it frequently enough to become adept. They also tend to limit their practice. They become known as specialists, treating only the patients who have the specific problems their skill can treat and thus becoming proficient.

Specialized therapists who limit their practice to certain patient problems can engage in what amounts to health care's version of mass production. They use a certain type of treatment for a certain type of client. By limiting their practice to a specialized problem, they acquire great depth of knowledge over a limited range and become renowned for their expertise. Doctors and other therapists hear of their success and refer patients to them. Specialization in the profession of physical therapy is in its infancy, but several specialties such as orthopedic physical therapy and

sports physical therapy have formed divisions of the Canadian Physiotherapy Association and have developed their own courses, examinations, and certification procedures. Specialization, and the formal recognition of therapists who are specialized, is a high priority for the national professional association now. The current proposal on specialization (Magee 1986) clearly states that the intention is not to extinguish the generally qualified physical therapist. It does, however, state that

Clinical areas covered by physiotherapy are so diverse, and the knowledge base acquired by physiotherapists has become so broad, that no one physiotherapist can be expected to be able to practise effectively in all areas.

(Magee 1986:102)

A College of Physiotherapy is proposed. The College would certify therapists according to a comparable set of standards agreed upon by the special interest groups (divisions) of the Canadian Physiotherapy Association.

Private physical therapy practices often are specialized, for example, to back problems, sports injuries, and the like. In Toronto, there is at least one private physical therapy practice which specializes in disorders of the temporomandibular (jaw) joint.

Specialists are recognized with higher status on the professional status ladder. In some places they can command

higher pay. Often, they go into, or hope to establish, private practice. Large hospitals often advertise for senior therapists specialized in cardiorespiratory, pediatric, or neurosciences to direct specific services. It remains to be seen whether specialization, a recent trend within physical therapy, reduces the scope of physical therapy in general, and whether it will be accompanied by a reduction in the types of client who may be offered physical therapy services. Despite statements that specialization is not intended to extinguish general physical therapy practise, such an outcome is possible.

The current job market for physical therapists has many openings in small centers, mainly hospitals, where physical therapists are expected to deal with a wide range of patient problems; physical therapy generalists are needed. To take jobs in such settings, physical therapists must maintain the full range of their skills, thus the scope of practice of the profession remains wide. Judging from the positions advertised in Physiotherapy Canada, the national journal, and from the 1985 survey of rehabilitation staff done by the Ontario Ministry of Health referred to earlier, it is the small hospital generalist positions, away from large urban centers, which are most difficult to fill. In hospitals with limited budgets, if positions remain unfilled for a long time, they are likely to be absorbed into the budgets of other departments with more available staff. This may cause

the number of general physical therapy positions to diminish.

Combined with a trend for private practices and other employers of specialized physical therapists to be more attractive employers (e.g., by paying more or by offering higher status on professional ladders) this will lead more therapists to specialize and to go into specialized jobs. As a result, physical therapy would show a growth in the specialized areas and a diminution in general practice, with consequent fragmentation (Moore 1978) and limitation of the scope of practice.

Whether or not it eventually limits the scope of physical therapy practice specialization allows more intensive exploitation of physical therapy labor but camouflages that exploitation by offering higher status on the professional status ladder.

Mechanization and computerization

A second way to increase the efficiency with which labor power is exploited is to use machines to multiply therapists' labor. "Modalities" such as short wave diathermy, hot packs, ice packs, and mechanical traction have long been used in specific circumstances. According to an investigation by the Board of Directors of Physiotherapy in cooperation with the Ontario Ministry of Health, billing records show that heavy use of these modalities is associated with high case loads

(Wolpert et. al. 1986). Modern, expensive resisted exercise machines advertise that they multiply the number of patients that effectively can be supervised by one therapist. Computerized graded resistance equipment incorporates an electronic "voice" which instructs, encourages and corrects the patient according to how he or she has performed the exercise. At present, these expensive machines are not widespread. They are financially feasible only in high volume specialty clinics, and in research, where many patients undergo similar exercise for similar problems. As the demand for therapy rises, and the relative cost of labor rises, these machines will become financially feasible in more settings.

Most present physical therapy practice requires individual therapist judgment to adjust the treatment to the patient. New methods of indirect intensification of physical therapy labor power will continue to be developed because of the inevitable drive for efficiency which shapes all work in the capitalist state system, but indirect intensification of physical therapy labor by specialization and by replacing staff with capital equipment have limited potential. As long as physical therapy maintains its character as a "handling" and "service" profession the major thrust will be towards developing better methods of direct intensification of physical therapy labor. Coping with increased case loads

requires direct intensification of the labor power of physical therapists. Hence, physical therapy managers constantly devise and adopt new methods of work organization and new strategies to maximize the efficiency of the labor power they hire.

Direct intensification of physical therapy labor

A supply of new patients always is available to fill gaps in a physical therapist's schedule. When the facility work load grows, physical therapists feel they must "cope with it" because refusing treatment to a patient would violate the service ethic, which is a cornerstone of their claim to professionalism. Their first attempts to cope are to "work harder." They try to organize their work load efficiently, they "priorize" treatments and patients, and they try to be even more flexible than usual. They try these things, not only because they believe that "a good therapist would be able to cope" but also because sanctions from supervisors and fellow therapists will follow if they do not "cope." Failing to get through the work is seen as "letting down the profession" because "physios always cope." It is taken as a personal failure. That is why certain patients get short treatments and terse explanations, if they get any at all. That is why therapists miss breaks, eat meals at their desks, and stay overtime without pay. The formal control mechanisms are bolstered by the ideological control

mechanism of the work ethic (also thought of as a professional ethic) to ensure that physical therapists work hard.

In addition to working harder when caseloads become heavy, therapists also try to work "smarter." Although there is seldom enough money in the department's education budget to fund all the therapists who want to take courses, therapists attend weekend courses (on their own time) to learn specialized treatment methods, they attend seminars to learn about new treatment equipment and techniques which promise better results, and they reorganize their schedules in a willing effort to become more efficient because they feel they must meet the patient demand.

From time to time, when all the old methods, even pursued as efficiently as possible, fail to keep up with the load, new methods of practice emerge. Specialization is now spreading throughout the physical therapy world, and with it various forms of private practice, where, in the words of one specialized private practitioner,

They (the therapists) become more efficient. In hospitals, therapists will treat several patient problems at once, and it takes a long time. In private practice, they only get paid for treating the problem the patient came in with, so that's what they treat. The patient has to come back with another referral to get the other problems treated.

Therapists in private practice, this therapist was

saying, become more efficient by ignoring all patient complaints other than those associated with the problem for which the patient was referred. Extra problems which develop during treatment, or which complicate the treatment of the presenting problem, have to be ignored in the interest of efficiency.

Specialization and private practice are two examples or ways to reorganize physiotherapy practice which increase relative exploitation of physical therapy labor. Work can also be reorganized within physical therapy facilities when therapists are persuaded to accept new methods of work organization and control. One such new method is called the new "waiting list management scheme". When patients are referred to a physical therapy facility for treatment, but cannot be given an appointment immediately because there are no spaces available, they are placed on a waiting list. Waiting lists can grow long, with patients waiting four or more weeks for a physical therapy appointment. When the waiting lists grow long, new schemes to process patients faster must be devised. One such scheme was developed and popularized in Ontario. Nothing has yet been published about it, but the new waiting list management scheme has been the subject of several presentations at professional meetings and seminars. The observer was invited to attend one of them:

During the field work, the Director of Physiotherapy at a large suburban hospital telephoned me.

She had reviewed my proposal for a grant from the Physiotherapy Foundation of Canada, she said, and she didn't agree at all with its Marxist hypotheses. She said they had introduced a new, more efficient system of organizing physiotherapy outpatient services at their hospital, and "everyone likes it." Her physical therapists had been cautious at first, she said, but now support the new scheme. They were participating in a workshop to explain their new waiting list management system to other interested departments, and she wanted me to come. The proposal did not receive Physiotherapy Foundation funding, but I did attend the workshop on the new waiting list management scheme.

The new system was developed, the department head explained, because the waiting list for outpatient physical therapy services had grown so long. The hospital administration had told her there were no more dollars for more staff; her department had to cope using existing staff. She expressed the fear that patients would become tired of waiting and go to "other, non-medical, practitioners" such as chiropractors. "The waiting list was no longer our friend," she stressed, "it had become our enemy."

The new waiting list management system involved a change in the way physical therapy is delivered. Where before each therapist had seen four to six patients an hour, assessing them briefly and continuing to assess or reassess them over a series of eight to ten further appointments scheduled two to three times a week, new patients who were referred after the new system was in place were each allotted a one hour appointment. Each therapist was to see at least ten new patients a week; ten hours were set aside for "assessments." During the patient's initial assessment appointment, the therapist was expected to examine the patient and take a history, chart those; assess the problem and chart that; decide on a course of treatment; explain the problem and treatment, chart that; and teach the patient home exercises and treatments to carry on themselves. All the assessment, treatment, and charting were to be accomplished within the hour. No additional paid time was allowed.

In contrast with the more usual treatment pattern in physical therapy, each therapist in the new system has only one patient in the department at a time. In the traditional pattern of work

organization, therapists have several patients "on the go" at one time, giving one individual attention while the others have passive treatments such as heat or mechanical traction, or exercise with minimal supervision. In the new "waiting list management" system, after his or her initial appointment, the patient is sent away for a week or two weeks, at the therapist's discretion, and given a fifteen minute appointment for a recheck. The expectation is that most patients will get better after assessment and advice without any further treatment. Only after the assessment and self treatment at home had been tried, might the therapist have the patient come in for repeated treatments. To do that, the therapist must discharge another patient to make room in her schedule.

At the time the investigator attended the waiting list seminar in 1985, there had been no inquiry into the effect of the new regime on the patient. In 1987, therapists characterized this new system as "moving the patients from a departmental waiting list to a therapist waiting list" and said that many further changes in the method of practice were required for the system to work. In 1985, the additional changes had already taken place; that is, a supervising therapist was reviewing caseloads of the staff therapists once a week, the therapists had shifted their perspective from a "treatment" to a "consultation" mode, and they had focussed their efforts on patients with musculoskeletal problems, particularly back problems.

This new system moved the treatment experienced by patients toward the style of a doctor's office visit. That is, patients were seen by the therapist one at a time, a therapist diagnosed their problem and told them what to do

about it then sent them away. Patients were processed faster, reducing the amount of time they must spend on the department waiting list. The reduction of the waiting list to get into physiotherapy meant they got a first appointment faster, but eliminating return visits meant they did not get the ongoing interchange with the physical therapist that could have allowed them to express their problem clearly. It also did not allow patients to have instructions modified or repeated as necessary. Patients who could not get better with the simple, one-time instruction, had to wait "on the therapist waiting list" until another patient had been discharged and the therapist could fit them in.

We have seen how much teaching, support, and general interaction is required in physical therapy treatment. All this is severely reduced under the new system. Since they are no longer left to exercise or have passive treatments in the company of several patients under the eye of one physical therapist, patients also miss the joking, camaraderie, shared discomfort, and support which characterized physical therapy as it was experienced by patients treated in the old system.

Supervision of therapists is increased under the new system. The physical therapy supervisor, an acknowledged expert in musculoskeletal physical therapy, goes over the caseload of each therapist weekly, recommending changes to treatment and occasionally discharge of patients who are not

progressing. Although the staff therapists accept this intensified supervision because, they said, "we're learning from the supervisor," the intensified supervision reduces their responsibility for patient care decisions.

Physical therapists giving the seminar were questioned after they had about four months' experience with the new waiting list management system. "At first it was hard" they said, "but you get more efficient." "We really are consultants now." They told the investigator how supportive the department head and supervisors were. "At first we had a blitz, to get rid of the waiting list. They brought their own coffee makers, and made coffee so we could grab a sip between patients." "You have to work hard, but you feel good about it." When asked how they managed to do all the work in the time allotted, they replied: "I think it helps that we're all part time." and, "yeah, you can really kill yourself for four or six hours because you know you're going home afterward."

The physical therapists working in the new system moved from "patient treatment" to "consulting" without improvement in pay or job status, and with decreased autonomy and intensified exploitation of their labor power. Under the old system, therapists usually spread the assessment over several appointments, evaluating the results of one type of treatment before adding others or trying new ones. The "assessment time" in the past was usually time spent with the patient; writing it all down consumed ten to thirty minutes of additional time after the patient had gone (the variability depending on the complexity of the problem and the experience of the therapist). Under the new system, if therapists were unable to fit everything into the hour allocated for an

initial appointment, they were required to complete it on their own time.

Therapists found they needed even better knowledge of the problems and conditions they saw than they had formerly, because they had no time to consult reference books or colleagues before deciding on a diagnosis and treating. This meant they spent more unpaid time each week "boning up" on the conditions and treatments. The new system induced the therapists to produce more, that is, it speeded up production by processing more patients through the system. This was only achieved, however, by persuading the therapists to work harder and by reducing the services the patients received.

Skilled, experienced physical therapists, who could have had jobs anywhere at the same pay rates stayed and worked extra hard under the new system. They willingly, even enthusiastically, took part in a system which made them work harder, and required them to work steadily through all their regular working hours, plus unpaid overtime, without any of the breaks and changes of pace provided by full time work. While considerations other than the nature of the work (such as being near home and able to work part time while raising a family) induced some of them to stay in this situation, most therapists stayed because they wanted to. Like all physical therapists, these women were proud of their

ability to "cope." The fear of loss of patients "from physical therapy to chiropractors," and verbal assurances and support from the department head and supervisors bolstered the technique of increased control, camouflaging it with an appearance of "professionalism." Together, formal and informal control in physical therapy apparently persuaded these therapists to accept a system of work whose effectiveness, at anything other than reducing the time patients must wait for a first appointment in physical therapy and increasing the exploitation of labor power, has not been shown.

The "waiting list" episode is just one example of the way physical therapy managers can borrow from industrial methods and invent their own ways to exploit labor power efficiently. Physical therapist schedules are nominally under their own control. They allot time to treat each patient on their case load, dealing with interruptions, new patients, and non-patient care activities as they come along. Management, however, has a stake in physical therapist schedules because physical therapy facilities must use health care funds effectively and efficiently. Supervisors intervene to keep things moving along efficiently and to distribute the work load evenly. When the resources of the facility can not keep up with the demand for physical

therapy, methods are introduced which directly and indirectly intensify physical therapist labor.

In this chapter, we have considered schedules and organization of work as methods of control of the work force, and we have seen that formal control mechanisms are bolstered by informal peer control and the ideology of professionalism. In the next chapter, we continue our examination of formal control mechanisms and their associated ideologies.

CHAPTER ELEVEN

If It's Not Charted, It Didn't Happen

In the last chapter, we examined the organization of physical therapy labor power through the formal and informal arrangement of schedules. Schedules allow management to ensure that the physical therapy labor power is used most efficiently. Schedules control the rate at which care is delivered. In this chapter we first explore how the content of care is supervised and controlled. In the next chapter we look at the work load measurement (time unit) system which allows management to supervise and control the amount of physical therapy service provided. Together, audits of charts and audits of time units provide the basis for technical control of the labor process in physical therapy.

Turning human interaction into concrete documents

By hiring registered physical therapists, a health care organization guarantees that the workers it hires have adequate training and are certified capable of providing competent physical therapy. Not only must management hire competent workers; it must also ensure that they work efficiently to provide adequate care. For the sake of simplicity, this chapter discusses quality of the product, physical therapy treatment, while the next chapter discusses

quantity of the product. Quantity control and quality control in physical therapy are achieved by different procedures, but they have a common underlying process. Ephemeral human interactions are turned into documentary form which can then be handled, reviewed, evaluated and used as evidence. In these chapters, we describe and discuss two ways by which the translation from ephemeral to concrete form is accomplished; charting (and its associated quality assurance procedures) and work load measurement.

The nature of patient care makes it difficult to manage by direct supervision of workers. Physical therapists work all over the hospital, seldom directly under the gaze of supervisors. Consideration for patient modesty and the appearance of privacy make it inadvisable for supervisors to watch therapists treating patients. A less direct surveillance method is required. As Larson (1977) explained, professional training and the ideology of professionalism produce workers who are likely to perform conscientiously even though they work without supervision. The managerial techniques used by modern health care institutions require more direct control of work. The discipline imposed by training and continuing professional socialization is bolstered by formal quality assurance and work load measurement schemes. Close surveillance by auditing charts and monitoring time units can be followed up immediately by corrective measures and discipline if necessary.

Charts as patient care records

Charts are records of patient care. In some ways, they are the hospital bureaucratic equivalent of "the file" on cases in social service or worker's compensation agencies. While they are the most complete bureaucratic record of what happened during the patient's stay in hospital, they are imperfect accounts of the human interaction between patients and staff. Charts are, however, essential elements of the labor process in hospitals, and in physical therapy.

Physical therapists spend part of every working day reading charts and writing in them. Charts consume time, and time spent with the chart cannot be spent with the patient. The importance of charts in the labor process, however, does not end with the time they consume. Charting transforms human encounters into permanent paper records that can be stored, reviewed, and audited. Experiences cannot be recalled for evaluation later. They cannot be stored, reviewed, and audited. Charts can. Performance of complex patient care tasks is judged in the hospital by the evidence on the chart. "If it's not charted, it didn't happen."¹

Charts as sources of information

Physical therapists read hospital patient records. They consult the chart to discover the condition of the patient.

In the chart, they read reports from other professionals to learn what led to hospitalization, and to know what the others plan to do for the patient. "Reading the chart" physical therapists say, "lets you know what to expect, what you're going to find when you get to the patient." In turn, they hope doctors and nurses will read their notes. Presumably, charts are consulted by other professionals, although when the investigator was working as a physical therapist, it was a notable exception when someone said "I read in your notes that" Many therapists resort to personal communication and diagrams taped to the wall above the patient's bed to communicate essential information about the patient's condition, rather than expecting other staff to read their notes on the chart.

Reading the entire chart in search of information is time consuming and frustrating. Some therapists consult another written record such as the Kardex or nursing care plan for a quick summary of the information contained in the chart. Some develop sufficient rapport with nursing staff to get the information they need verbally. These options are not universal, and such short cuts may not provide the information specifically needed for physical therapy. Metal implants, suspicion of cancer, heart conditions, and myriad other problems seriously alter the physical therapy that can be given, and are called "contraindications." No other professional can be expected to know the list of

contraindications for each physical treatment. Therapists may be found liable for injury that results from their treatment, whether or not it was ordered by someone else. Therapists may not rely on orders from other disciplines without checking to see if it is safe to use the planned treatment with a particular patient. Thus, no therapist who treats hospital patients is ever free from the obligation to read charts.

Physical therapists who treat outpatients create a chart for each patient. They take histories, a process by which they systematically enquire about the patient's health and the problem. Physical therapists are required by their ethical code of conduct, and by good sense, to ensure they have sufficient information about the general condition of the patient to treat effectively and avoid causing harm. At times, they must contact the referring doctor or other agency for X-ray reports and other information. This they also record on the chart.

Charts as reminder

Fifteen years ago, few physical therapy charts contained more than a short note which served to remind the therapist about the patient's condition and the treatment given. Sometimes, patient visits were recorded by ticking boxes on a calendar. Charting has changed. All physical therapists are

now required to record their assessment and treatment of the patient. Often using standardized assessment forms, they note the history of the problem, the present complaints, the tests they conduct and the results of those tests. They then record their diagnosis, listing the problems they find and the treatment plan they think will help. The list of problems consists mainly of problems they think physical therapy can address. For each treatment, therapists record what they did and the results, as well as change in the condition of the patient.

This chart, or the physical therapy section of the patient's hospital record, becomes the official record of physical therapy treatment. Its most immediate practical function is to remind therapists what they did last time when next they treat the patient. However, the chart as it is presently used in physical therapy serves as much more than a reminder.

Charts as evidence

Not only is the chart a reminder, it is the official record of treatment. It is consulted by anyone who wishes to evaluate the physical therapy or the physical therapist. Charts routinely are reviewed by supervisors and by quality assurance auditors (described below). Hospital and facility accreditation surveyors review charts to judge care. Charts can be and are used as evidence in malpractice claims.

Litigation concerning physical therapy in Canada is rare, but the few cases of it are vividly reported and remembered. One of the field work hospitals, however, has added one clerical staff position to cope with all the "legal letters" (letters which describe the patient's problem, the treatment given, and the results) the Director of Physiotherapy is required to write. Physical therapists are frequently reminded by their supervisors and their professional associations that they are responsible not only for the treatment they give, but for performing an assessment sufficient to uncover and anticipate potential problems. The chart provides the evidence of the physical therapy that allegedly was given. The prospect of audit and litigation is strong incentive to take time and to be careful with charting.

Charts are the official record of care. They make the interaction between therapist and patient tangible. Because therapists are responsible for charting everything that is relevant, including patient behavior that may make treatment less successful, therapists can be judged by their charts. Thus, if a treatment is less successful than expected, or has to be modified in some non-standard way to suit the individual patient, the therapist already must have recorded the patient's deviation from "normal" to defend him or herself from criticism. Charts allow supervisors and peer review committees (explained below) to watch only an

occasional treatment but to know "everything the therapist found and did for the patient." Patient opinion, gathered by questionnaire or interview, is sometimes used to a limited extent, but it is regarded as "too subjective" and "uninformed" to furnish reliable estimations of therapist performance. Charts, however, are treated as valid, reliable objective records of patient care in hospitals.

Physical therapy assessments and treatments are complex human interactions. Therapists not only measure and assess physical function and problems such as limited range of motion and weakness, they pick up emotional and social cues as well. In addition to noting that the patient complains of pain, for example, the therapist forms an opinion about the patient's propensity to complain -- and consequently the amount the patient should be "pushed" to achieve maximum results. Therapists usually do not record such opinions (which are vital to successful treatment) on charts, however, because they consider them "subjective" and difficult to document.

Physical therapists have a well developed system of terminology for writing about physical conditions and disorders. The terminology is based on the anatomy, kinesiology and physiology they study so intensively during their training. They also have a shorthand of approved abbreviations for noting findings and treatments. Social

cues, however, particularly the therapist's impressions, must be written in longhand. Consequently, when the therapist is rushed (which turns out to be most of the time) "subjective" impressions and social data do not get recorded. Charts are records of the technical procedures administered to patients, but the so called "soft" elements of physical therapy care (as described on pages 187-250) are not recorded. In charting, then, as in cost accounting, care disappears. Charts list only the small proportion of information the therapist recognizes as important and has time to write down, but they are almost universally regarded as the best way to assure quality care. Most physical therapy quality assurance committees review charts.

Quality assurance and quality of care

Quality assurance is an umbrella term for programs meant to assure someone that work meets acceptable standards. In health care institutions, high quality care is the stated goal, and programs are designed to assure management, government funding bodies and the public that good, safe, efficient care is being provided. Quality assurance programs vary from setting to setting, but in Ontario, where this study took place, quality assurance is required by the Canadian Council on Hospital Accreditation and by the Ontario Ministry of Health. Often, quality assurance programs involve a process whereby the workers are appointed to

committees to set standards, to audit the work and to enforce the standards.

As the department head quoted at the beginning of this chapter said, "We like to give the therapists a voice." When the workers are involved in setting the standards it gives them a chance to "have a say" in the standards by which they will then be judged. It forces them to codify their knowledge, to specify what should be done in specific situations. In physical therapy, standard setting by workers is a long and difficult process, because it requires therapists to specify treatments and procedures which they customarily apply but which ordinarily they adapt, to suit the needs of each patient. In order to set standards for care, they must agree on a common procedure, perhaps with a few specified allowable deviations. When therapists participate in standard setting, all the effort involved means they become committed to the standards they have chosen. The standards seem less like impersonal demands of management because the workers themselves have agreed they are good physical therapy practice. This is the essential virtue of "giving therapists a voice." Quality care assurance, and especially giving therapists a say in the standards by which they will judge their care, also gives the therapists' professional knowledge to management, without taking it away from the workers.

Here we see a concrete example of the ideological process which Larson described in the abstract. Professional employees, engrossed in a process which depends on their professional judgment and which appears to give them power, lose sight of the fact that they are losing control of their own professional knowledge and discretion. In setting standards, skilled workers codify their own knowledge. When they have done this, the power they had because of their exclusive control of their skill is lost to them. Their codified knowledge has become a standard by which they are judged. The process resembles the deskilling process Braverman predicted, but with important differences. Braverman observed a process in which management acquired the knowledge from skilled craft workers, then used it to rationalize and subdivide the labor process, deskilling the workers. However, in its modern guise in health care professions such as physical therapy, management does not deskill the workers, but achieves control of the work process by getting the workers to codify their knowledge. Skill in delivery of the service remains in the workers, but they become more amenable to control. The process does not cheapen the labor force, but does enable management to control it better and to standardize the output of the workers.

Quality assurance audits are often delegated from management to a committee of staff therapists, and the

process is called peer review. The physical therapists' concern for the well being of the patient and the profession makes them willing participants in such quality assurance activities.

It might be inferred from a hasty interpretation of some "ideology" arguments that the therapists are being misled with a mistaken idea about the purpose of quality assurance. The process is more subtle and more effective than a campaign of simple misinformation could be. Therapists' ideas that charting and quality assurance are "for the good of the patient" are correct, if "quality" means uniformity, replicability, and standardization. The idea that having a working quality assurance program in their department is good for the profession is also correct, in part. It is necessary for the department to have a working quality assurance program in order to compete for scarce health care resources. Since therapists use a complex medical terminology and employ specialized skills, they argue, like other professionals, that judgment of quality care cannot be left to the opinions of patients. Some form of quality care assurance is needed. These arguments for charting and quality assurance are in part correct. What the ideology ignores or conceals, however, is the process by which the workers' own professional knowledge is used to control them.

Workers use their professional knowledge to set the

standards. The effort required to reach agreement, plus the fact that their peers will be judging by the standards they have agreed upon, makes physical therapists likely to try to conform. In the usual form of peer review, a committee of physical therapists audits a sample of all the physical therapy charts to see they meet the standards. The peer review committee may report cases that do meet the standards to the physical therapy manager or supervisor, who then takes action to "correct" the non conforming therapist. In many settings, the peer review committee itself may take up non-conforming cases with the offending therapist. Either way, the arrangement ensures that all charted treatment eventually conforms to the standard.

Standardized treatment is easier to control than individually variable treatment. When there are agreed-on standards, it is easy to judge what treatments "should" be done and how long treatments "should" take. This enables managers to control the work in the interest of cost efficiency. Physical therapists cannot easily argue that they need to take longer with particular patients because the patients are more difficult. The "objective" standards specify how long the treatment should take. Other patient problems in addition to the main presenting one must be assessed and documented before the therapist can justify spending the extra time to treat them. On busy days, there

is no time to assess and document extra problems. They are ignored rather than treated. Thus, even in hospital physical therapy settings, cost constraints affect the type of physical therapy provided. The process is more direct in the case of private physical therapy clinics where, as the clinic owner said, "they become more efficient. They know they only get paid for one problem, so that is all they treat." In the hospital setting, cost constraints, brought by the necessity to restrict the drain on state funds, dictate that therapy treatments must become standardized, and that physical therapists only treat the problems they have had time to chart.

Once the quality assurance process is set in motion, it works with little management involvement. Because they have been involved as professionals, from the standard setting stage to the discussion of non-conforming cases, therapists are convinced the process will improve the profession and the quality of care provided. There is reason, however, to question this belief. New innovations from the shop floor level are no longer possible, because the agreed upon standards do not permit change. New treatment methods must come from elsewhere, and workers and management must all be convinced of their merit, before they can be tried and the standards can be changed. Most importantly, the standards, which have the appearance of being the workers' own, are taken out of their control and work against them to produce

work that conforms to the need for efficient, uniform care. Creative decisions at a patient care level are stifled.

Charting and quality assurance both contribute to a process which achieves a uniform standard of care among disparate professionals. All professional personnel in health care organizations contribute to the patient care record or chart. Quality assurance programs are facility-wide programs which include such different activities as laboratory assessments and nursing, physical therapy and food services. Quality assurance has been in place only since the late nineteen seventies, charting somewhat longer. Quality assurance, however, created a marked intensification in charting, which therapists interpret, quite rightly, as intensification of their work. Charting and quality care assurance programs have intensified as the medical supervision of physical therapists decreased. As independent practitioners, therapists have become responsible for documenting and assuring the quality of their own care, rather than relying on doctors to defend them. The result is more surveillance by management.

Charting and quality of care, both concerned with the quality, not the quantity of care, legitimate some activities and ignore others. They legitimate those activities that can be standardized and recorded using agreed-upon terminology and abbreviations. They ignore the subtle exchange of

information and balance of power in normal human interaction. The terminology in use calls some activities (the ones that can be recorded) care, and ignores the information it calls "subjective." Activities are rewarded which produce results that can be audited. Other things that are done to enhance care or to get through the work are discouraged. Thus, things like the "chit chat" which builds trust between patient and therapist and helps patients get through the pain and hard work involved in treatment are discouraged. Therapists feel guilty about taking time for caring, because it is "not treatment."

Such a process is the inevitable result of working in an environment -- however professional -- which is subject to management control. Professional, therapeutic interaction with the patient is insufficient. It is not enough that patients are cared for, that patients regain function and have pain alleviated, or that patients are satisfied. In order to get a share of the resources allocated from the government to the health care institution, the physical therapy department must document its activities in a form acceptable to the management hierarchy. It must produce results in a form that are tangible to the bureaucratic management system. Financial considerations and overall management of the institution dictate that the output of disparate occupations and professions must be compared.

Thus, charts, concrete records of care, are required.

So far, we have discussed charting and quality assurance audits; methods by which patient care is turned into concrete form which can be audited by management. We also noted that such control activities, which appear to be for the good of the profession, cause physical therapists to intensify their labor.

Charts and quality assurance are seen as necessities for good patient care. Professional physical therapists chart assiduously. They may grumble about the time it takes and the effort involved, but they willingly act as quality assurance standard setters and auditors. They hope, and are repeatedly told, that such activities will improve quality of care. Indeed, many of them have had a chart or two identified as "deficient" in some way, so they have seen that the system "works." Therapists also "know" that good quality assurance and good charts are important for the image of the profession. Charts and audits are the account by which their work is judged. Well publicized malpractice cases in which charts were used as evidence confirm this knowledge.

Charts, however, have hidden benefits to the management project of providing health care services to meet the demand with the lowest possible expenditure. Quality assurance procedures get therapists to produce efficient, standardized care without requiring expensive management supervision.

Charting and quality assurance provide subtle but effective management control over the labor power of physical therapists. They get therapists to set "their own" standards, then they persuade them to comply with those standards. They enhance the willing co-operation by therapists with efficient exploitation of their own labor power.

Charts and quality assurance are forms of bureaucratic control. They take personal, interactive, and gendered acts of patient care and render them into "objective" impersonal data which are amenable to bureaucratic surveillance. They are not the bureaucratic control of the labor process Edwards (1979, discussed in chapter two pp. 71-76) envisioned. They exist alongside personal and professional forms of control. Thus, if we wished to be generous to Edwards we could say he correctly predicted the development of bureaucratic control, but if we wish to be critical we can say the form of bureaucratic control is much more complex than Edwards envisioned.

We have been discussing aspects of the physical therapy labor process which seem to be primarily for quality of care, and are presented as part of the professional obligation of physical therapists. These measures have the hidden function

of controlling the work and the work force. Next, we discuss the work load measurement system, which is a less well camouflaged way to control the quantity of work produced by physical therapists.

CHAPTER TWELVE

What Have You Done For Us Lately?

The work load measurement system

The following quotes were recorded at a staff meeting in one of the field work settings, but they could have come from any physical therapy department in 1985. The topic was the new version of the work load measurement system which the department had been using experimentally for six months. The new work load measurement system (which informally is called the time unit system) was formally accepted by the profession in 1986 and is now in use across Canada. Time units are a way to measure the amount of time the physical therapist spends actually treating patients.

Supervisor: It's a way of looking more closely into the work patterns of the department. Patterns will emerge from these, we'll start to see the same thing coming up again and again. For example, we've already seen there's more than one therapist worth of weighted units on seven, and Sheila's already come up with some reasons.

Department Head: I want to know what these feedback sheets told you, what you'd like to have included. They didn't tell me much.

Supervisor: We can reassure you, let you know why we are handling it this way and not that. You might suggest another way of looking at it, and we'd say, Oh, we never thought of that.

Department Head: We don't expect everyone to account for every minute of the day. Everybody has some personal time.

The staff therapists did not appear to resist the new system at all, but instead began an energetic exchange of hints about how to improve the accuracy of recording.

Staff therapist: I'm fairly diligent for a couple of weeks and then something slips and soon you're doing your stats for a week.

Staff therapist: What I do is write it down on my daily schedule. It doesn't take two seconds to get to a piece of paper.

Staff therapist: You can go through ~~your~~ list, Did that patient phone, did that patient phone.

After letting this go on until most of the vocal therapists had had a say, the supervisor introduced another chance for them to voice any discord.

Supervisor: How do you feel about comparison with the departmental average?

None of the therapists present at the meeting had anything to say about that.

Work load measurement in Canadian hospitals dates back to 1931 when federal government legislation required hospitals to record and return data about hospital activity. By the late nineteen fifties, an assortment of similar but not uniform time measurement systems were in use in hospitals in Canada. A survey published in the Journal of the Canadian Physio-therapy Association reported the frequency of various conditions treated in general hospital physical therapy departments. Of the seventy-two hospitals which responded to the questionnaire,

Fifteen hospitals in this survey already employ a time-unit system of recording, varying from 15 to 30 minutes per unit, and all these are in favour of its continuation. Forty-six other hospitals considered the system would be advantageous in assessing the departmental work and 47 therapists thought it would simplify the patient charge sheets.

(Gault 1959: 195)

One of the early work load measurement systems was developed to measure physical therapy services at the Manitoba Rehabilitation Hospital. The system was needed to account for the cost of running the department in order to receive funding. In 1965, the chief physiotherapist described the system to readers of the Journal of the Chartered Society of Physiotherapy (England):

Our unit system is detailed sufficiently to be used as a costing mechanism. We work on the basis of a 10-minute period, each modality having been assessed in terms of cost. The most expensive commodity in the department being the therapist, her time is assessed at three units per 10-minute period. For example, for a treatment of massage or individual exercises, three units are accrued for each 10-minute period. If a therapist is supervising electrotherapy treatment such as short-wave, this would count as two units per 10-minute period for each patient, but if giving one individual electrotherapy treatment, her time plus the equipment is assessed at five units per 10-minute period. An example would be a Kromayer treatment or electrical stimulation. Each therapist completes her unit sheet at the end of the afternoon, and when the secretary has checked off each patient in the attendance book, the unit sheets are sent to the I.B.M. department for costing. At the end of the month we receive a detailed account of the number of units of each modality and a total number of units for in-patients and out-patients.

(Edwards 1965: 90)

In the 1960's, the Canadian Physiotherapy Association collaborated with Health and Welfare and Statistics Canada to develop a work load measurement system. The Canadian Schedule of Unit Values for Physical Therapy and Occupational Therapy was introduced in 1971. These unit values, which were set at one time unit for each five minutes of direct, one to one patient care by the physical therapist, were the time units that all physical therapists now record for every patient they treat. The original system recorded only direct patient care, that is, time the therapist actually spent with the patient and direct treatments such as the electrical treatments mentioned by Edwards above.

In 1982, the Canadian Physiotherapy Association established a committee to review the Canadian Schedule of Unit Values. The following information comes from a report published by that committee (Statistics Canada 1985). The committee consisted of representatives from the profession; the federal-provincial subcommittee on productivity improvement, Health and Welfare Canada, and the Management Information System project of the Canadian Hospital Association. Financial support for the project was provided by the Canadian Physiotherapy Association and Health and Welfare Canada. The result of the committee's effort was the revised work load measurement system discussed in the staff meeting referred to in the field notes, and discussed below.

Components of the work load measurement system

The system is designed for recording and collecting quantitative information about direct patient care, indirect patient care, and non-patient care work load components. The Physiotherapy Workload Measurement System (Statistics Canada 1985) officially defines each category.

According to the definitions, direct patient care includes diagnostic, evaluative and therapeutic activities which require the presence of the patient with the physical therapist. Time spent in direct patient care is measured in units. Five minutes of direct patient care is one time unit. Because often several patients are treated at one time, and because passive modalities require less direct supervision than one to one patient teaching or treatment, a weighting system is used. Direct patient care is divided into categories according to the intensity of supervision required. Physical therapists can refer to the Canadian Schedule of Unit Values to see which category applies to the treatment they gave; soon they become adept at assigning time units to categories. Later, time units for each category are totalled, and weighting factors are applied. The direct patient care segment of the work load measurement system is similar to the one described by Edwards (above) and is familiar to all experienced therapists because it has been in

use since 1971.

According to the definitions used by the new work load measurement system, indirect patient care activities are those which support or supplement the diagnosis, evaluation, or treatment of a specific patient, but for which the presence of the patient is not required. Indirect patient care activities are recorded in minutes, not units. There is no weighting system for indirect patient care. Indirect patient care includes: patient related discussions, meetings, conferences, clinics and telephone calls; off site visits to the patient's home or community to assess barriers to personal independence or to educate the family and other care givers, teachers, employers, and the like; recording or reading of patient related records and charts; and designing and fabricating prosthetic and orthotic devices.

Non-patient care activities occur in the physical therapy service or department and are part of the departmental activities but do not involve care of specific patients. Activities which contribute to departmental management include: employee meetings; program management and evaluation such as documentation of the quality of care; maintaining a safe and tidy environment; and keeping statistical records. Service to hospital and community includes board and committee work, public education, public relations, and time spent within paid hours on activities

which support the physical therapy profession. All the work involved in preparing for orientation, instruction, supervision and evaluation of physical therapy students and other department and hospital staff is listed under clinical teaching. "Formally designed and approved clinical investigations for the purpose of improving the quality of Physiotherapy patient care, by means of recognized scientific methodologies and procedures" (Statistics Canada 1985: 27) is called research, and is included in the activities defined as non-patient care. Time for non-patient care is recorded in minutes, and can be broken down by subactivity or aggregated.

The National Productivity Improvement Program Physiotherapy Workload Measurement System pre-publication draft (Statistics Canada 1985) contains all the factual information and definitions. It also contains detailed instructions for assigning activities to categories; what to do when two activities are carried on at the same time, and how to calculate productivity indicators.

Accounting for time

The new work load measurement system accounts for more of each physical therapists' time than the previous one. It leaves little that the physical therapist legitimately can do which is not measured. Although the department head said they do not expect therapists to account for every minute of the day, the system belies that statement. Physical

therapists remain responsible for their own schedules in that they must allocate time to get their assigned work done, but how they allocate time can be completely supervised using the work load measurement system.

Measurement and quantification are very important to the physical therapy profession. To hospital administrators and other people who control resources for physical therapy, statements documented with facts and figures are more persuasive than statements dealing with the quality of human interaction. Since the introduction of the first work load measurement system in 1971, physical therapy department heads have used the work load measurement system to document how hard physical therapists were working. Now, with tight budgets and closer scrutiny of claims for more resources, time units must be used along with quality assurance to make care more efficient and to show that has been done.

Microcomputers in physical therapy departments expedite totalling the time units. Mechanical addition of the time units from each patient care record and from therapists' summaries of non-patient care activities took time and effort. Close surveillance of work loads was difficult for department heads because of the time involved. Surveillance and access to information is more feasible with the use of microcomputer (see Calder 1985, Goldie 1985). In one of the field work settings, a committee consisting of the department

head, a staff therapist, and the staff therapist's husband developed a program to computerize the time unit system.

Other hospital department directors have since reported on development of similar programs. Most of these, like the one at the field work hospital, were developed independently by the physical therapy departments, but some are integrated into total hospital computer data management systems.

Using the program developed at the field work hospital, clerical staff transfer data from therapist summary sheets onto the microcomputer. The department head enters financial data from the hospital's accounting department. She then has access to work load data for the entire department, and to quantitative information about physical therapist work loads including cost per treatment. She can see what patients each therapist has seen, how much time was spent with each patient, and how much time has been spent in non-patient activities. The department head also uses the computerized work load measurement system to answer questions about patients with specific diagnoses, patients referred by specific doctors, and many similar inquiries she calls "frivolous questions." Immediate access to such information is a powerful tool for that manager.

As yet there are no published reports of attempts made to use computers to aid charting and quality care assurance in physical therapy. Word processing, however, is used in

some hospital medical record departments to record medical histories, records of surgery, and the like. It certainly could be applied to physical therapy. The standardized assessments and the standardized treatments being created by quality assurance programs make it possible to record uniformly. If physical therapy assessments and charts are written by computer instead of by hand, little further work would be required to automate quality assurance audits.

Such a step would facilitate management control of the quality, as well as the quantity of patient care. The use of computers alone does not produce increased control of workers by management. Rather, the work has to be standardized before it can be measured and committed to documents subject to analysis by computer. Once sufficient standardization has been reached, the computer appears as a time-saving device, and as such is readily accepted.

Work load measurement and consent

Why do therapists cooperate with such a tight surveillance system? One of the claims about, and reputed advantages of professional work for the workers is its autonomy from close supervision. The new work load measurement system makes all time allocation decisions by physical therapists amenable to surveillance and supervision. It has the potential to reduce the autonomy of physical

therapists by a large amount. Yet, they co-operate with it, competing with each other in a staff meeting with hints on how to improve their accuracy; even helping develop the computer program which empowers the department head with access to information. A number of factors combine to create consent.

First, time units are a fact of life for most therapists. They have been in use as long as most people who are, now staff therapists can remember. The new work load measurement system measures, among other things, the time taken to record time units, and it proved to be less than five minutes a day on average. So one legitimate reason to object to time units, that they took time away from patient care, has been swept away by the work load measurement system itself.

Second, therapists do not question management's right to manage. The introduction to the new work load measurement system book says:

... as costs rise in periods of fiscal restraint, workload measurement becomes important to hospital administrators, department heads and governments alike. It is in this light that impetus was given to the development of systematic workload recording and reporting systems in various specialty areas/departments to provide uniform and reliable workload measurement to assist in staffing, budgeting, planning, quality assurance, etc.

(Statistics Canada 1985: 1)

Few therapists would argue with this justification. Steeped as they are in a hierarchical organization and with a profession that developed within the hierarchical health care system, they do not find it strange to have others monitor and organize their work. Furthermore, the new system bolsters the impression that "department heads and supervisors are in the same boat." Managers and staff alike seem to struggle with statistics, working alongside each other for the good of the patients and profession.

The new work load measurement system measures management functions as well as patient care. Managers, like the physical therapists, have to account for their time. Much of their work is called "non-patient care activity." When management functions such as surveillance of quality care were delegated to staff therapists, the therapists could explain a drop in time units recorded under the old time unit system, which only recorded patient care, by pointing to their administrative duties. The new work load measurement system takes administrative duties into account as indirect and non-patient care.

The justification for the work load measurement system emphasizes accuracy, reliability, and fairness. This echoes the scientific and bureaucratic values in which physical therapists have been trained, and which constantly are being reinforced by ongoing professional socialization. It would

be hard for a working physical therapist to call such a system an adversary. To suggest a different way of organizing or evaluating health care would be to question the fundamental values which organize the profession.

In discussing the physical therapy labor process in this chapter and the one before, we have been dealing with physical therapists as if they were employee professionals responsible solely to managers. We have examined some aspects of class control of the labor process as they appear in physical therapy work. Physical therapists were discussed in relation to their managers and their patients. As we saw in previous chapters, however, physical therapists have to work within a system of gender and professional dominance. As medical dominance of physical therapy lessens, it seems that managerial dominance is strengthening and taking its place. Charts, quality assurance and time units control the labor process of physical therapists and standardize the care of patients. The control is experienced as very different from the control doctors exert or exerted.

At the same time as they control, these techniques induce consent. They are presented as "for the good of the patient" just as medical dominance often was and still is. At times, the managerial control is also represented as "for the good of the profession." Drawing on ideals of individual excellence, rational scientific techniques, and

service, they persuade physical therapists to co-operate with their own exploitation.

It is worth stressing that class dominance and gender dominance were artificially separated during the analysis of the field work. This does not imply that there is no gender element to control of physical therapists by managers; or that control of physical therapists by doctors is strictly gender, not class or professional control. Gender and class control cannot be separated, because the systems of gender and class dominance in society are interconnected as they are in the history of this occupation. Relations between managers and employed physical therapists, however, are embedded in the formal hospital bureaucratic hierarchy, while the relations between doctors and physical therapists are not. The relations between doctors and physical therapists are shaped by the traditional relationship between the medical and the physical therapy profession. The two types of dominance appear together, and while one may predominate at certain periods in the history of an occupation, they should be considered together.

PART IV
KNITTING UP THE ENDS

CHAPTER THIRTEEN

Conclusions

We have confronted a mass of data about the labor process in physical therapy. We have been presented with a picture of an occupation which arose in a subordinate relation to medicine, and which still usually defers to medical dominance, but which struggles for recognition as an independent profession. We have seen practitioners who have skill and confidence with what they do; who know how to "handle" patients and other people in their environment in order to get the work done, but who meekly acquiesce to management pressure to work harder or longer. We have seen therapists who say they entered the profession to be of service to people, but who find that the caring work they do is not recognized by the official standards of quality care or work load measurement. We have seen therapists who say that men have an advantage, that doctors are sexist, and that they hate being used as helpmates, but who also say that physical therapy is an equal opportunity profession.

How can we tie together all these conflicting ideas; how can we make sense of the profession of physical therapy today? When we looked at the history of the profession, we

could see, at least, where these conflicting ideologies came from. When we looked at the present day labor process, we could see how conflicting goals produced tensions that the therapists resolved -- at times by reproducing or reinforcing gender or managerial dominance of their work.

The physical therapy profession as we know it today developed from the example of a few women of the Victorian English middle class who wanted to establish a ladylike profession, and who used kinship ties and independent wealth to allow them access to practice so they could demonstrate the worth of their skill. This group emphasized service and self sacrifice; these qualities became incorporated into the ideology of professionalism which persists today.

In its early days, the physical therapy profession entered into a relationship with the medical profession. The relationship, in which physical therapists agreed to be subordinate to medicine, initially had advantages for all parties. Physicians were able to enhance their status and to fight outside competitors like chiropractors and osteopaths by sponsoring subordinate occupations. Nursing and especially physical therapy, which used similar manual techniques to chiropractors and osteopaths, but who took orders from doctors, allowed medicine to counter (at least partly) the claim that they were denying valuable forms of health care to the public by opposing their competitors.

Physical therapy gained medical sponsorship, which helped establish public acceptance and protective legislation. It gained recognition by important groups such as the military with the help of medical sponsors, who also helped by establishing rehabilitation institutions where physical therapists would work, and rehabilitation training programs where more physical therapists would be educated, with the help of the medical sponsors.

Recently, however, the balance of benefit has changed. Sponsorship has diminished, and physical therapists find themselves on their own, competing openly with other groups such as chiropractors for legislative advantage, public recognition, and patients.

We can surmise that physical therapy initially gained recognition from the state fairly easily. That was probably not only because they had the sponsorship of a powerful social group, the profession of medicine, but also because they provided a service which was needed at the time, for rather minimal cost. Physical therapy and the other rehabilitation disciplines offered to rehabilitate injured soldiers and crippled civilians, keeping them off the welfare rolls and turning them into productive, and consuming, members of society. The rehabilitation occupations offered a unique service here, one that was not offered in such a comprehensive style by other occupations. Such service had

to be state funded if it was to exist at all, because disabled people could not work, nor could they pay for health care. Physical therapists were not in competition with chiropractors for this kind of work, just as today they are not in competition with chiropractors for work with hemiplegics, multiple sclerosis patients, and other severely disabled people. Physical therapists won the right to care for these people, partly because they could provide it at relatively low cost; they did that partly because they were women, imbued with ideals of service and self sacrifice. Like the other women's professions, they worked for low pay.

Recently, pay expectations have changed, although expectations and requirements for adequate wages conflict at times with the service ideology. Physical therapists, like nurses, teachers, and other women professionals, often support families. They demand more pay and status for their work. As the number of them expands, and the salaries they can obtain grow larger, the budgets for rehabilitation personnel and other women professionals grow into a more significant proportion of national expenditure. The growth in the cost of employing women professionals has been accompanied by increasing cost constraints, which are translated into more strict surveillance and control of the day to day work of these professionals, in the interests of efficiency. Thus physical therapists, again like other women professionals, have shifted from nominal subordination to and

supervision by doctors, to real subordination to and supervision by the state.

Subordination to medicine is experienced and expressed in day to day working life for physical therapists now as the requirement to be deferent, to laugh or at least not complain at sexist remarks and jokes, to organize their schedules to fit the doctors' schedules, and to refrain from open criticism of medical acts. Resistance to medical subordination takes the form of gossip, satire, and slander within groups of therapists, but also of vigorous endeavor to build a scientific rationale with which they can defend their work against denigrating comments. Resistance, as we have seen, takes the form of well informed discussions to organize and pin down demands on their time and work into protocols, to which both doctors and therapists agree to adhere. Professional association resistance to medical dominance includes vigorous efforts to obtain adequate legislation which defines and protects physical therapy as an independent profession.

Subordination to management is expressed today in diligent charting and recording, in compliance with new schemes to make physical therapy more efficient, in the development and implementation of standards of care and protocols for treatment, and in acquiescence to the work load measurement system. Resistance to management control takes

the form of grumbling and casual, even inaccurate use of the work load measurement system; of informal sharing of work and leisure; of gossip and slander.

Subordination to management, and ultimately to state dominance overlaps with subordination to medical dominance. Resistance to the two forms of dominance is similar. In some cases, for example with treatment protocols, resistance to one form of dominance (medical) leads therapists directly into another form, managerial. Therapists do not escape from dominance relationships by using one against the other. They do, however, make temporary (and sometimes illusory) gains in control of their immediate working conditions.

Both medical and managerial control of physical therapy contain elements of professional control. The ideology of professionalism, which includes ideas about service, efficiency, and correct behavior, supports and buttresses the techniques of control, and appears to explain part of physical therapists' compliance with control of their labor process.

The data from this study were organized for presentation according to a plan which attempted to take up questions of gender, class, and profession separately. Such distinctions are impossible to maintain, however, even for heuristic purposes. The distinctions are not clear enough. Multiple

processes work together to produce what we see. We can attribute a particular incident observed during field work or found in the historical material to gender dominance, to managerial dominance, to professional dominance or to something else entirely. It depends on the frame of analysis we chose.

Ideas about the virtues of service and self sacrifice which were considered the hallmarks of a professional health occupation, also helped persuade physical therapists to comply with medical dominance in the past. The same professional service ideas also infected the labor force which staffed developing rehabilitation programs and facilities. The ideology of professionalism, particularly as it was applied to women's service professions, made it possible for the government to establish rehabilitation programs and services at relatively low cost. The women who worked in physical therapy, or at least their leaders, thought of themselves as working for the benefit of humanity, not as working merely for pay. They were expected, perhaps even compelled, therefore, to accept low pay. The ideology of professionalism, especially as it applied to women's professions, made a cheap source of labor available, first to private philanthropic institutions, then to the state. Service, self sacrifice, and tractability still have a place in ideas about professionalism and proper practice among physical therapists today. Such ideas still help physical

therapists accept pay and working conditions they might not otherwise accept. The present gender and class control of the labor process by doctors, and by management techniques such as quality assurance, chart audits and work load measurement can be introduced, maintained, and reproduced because they are consistent with ideologies of professionalism and of femininity.

Ability to organize one's time and to cope with whatever comes along seems to have arisen within the labor process, from the necessity to get the work done. Physical therapists today continue to place a very high value on these personal assets. Failure to cope with the workload is treated within physical therapy circles as the personal shortcoming of an individual therapist; -- not as a symptom of the pressure to increase efficiency and control costs. A great deal of the control of the labor process in physical therapy is achieved by informal social means; gossip, expectations, ideology.

Control of physical therapists, either by doctors or by managers, is not achieved merely by ideas. As the data presented in this study show, there are very good material reasons why physical therapists act as they do. They make decisions and act in what appears at the time to be their own best interest. Thus, they accepted medical sponsorship in the past. They would have been unable to establish themselves as well as they have without it. Now, they accept

managerial surveillance, because jobs in hospitals and as employees in private practices are the only ones available to most of them. Physical therapists used kinship with powerful social and professional elites to promote the interests of their occupational groups in the past; they continue to do so now. Therapists use personal charm as well as manual skill and the powerful effect of touch to elicit cooperation from patients. They use gender stereotypes to get along with other people such as doctors in their working environments. From what evidence we have about the labor process in the past and present for physical therapy, this has not changed.

The majority of physical therapists are employed women. There are many jobs to choose from because the demand for physical therapy has always outstripped the supply of physical therapists. Physical therapists, however, may choose to accept lower pay or poorer working conditions in positions that are more compatible with their duties as wives and mothers. Gender entered into the construction of the occupation as an employed women's profession. Gender also structures physical therapists' engagement in the labor market.

The dissertation has shown various forms that medical and managerial dominance have taken. The quotations from past professional journals and documents showed that language and customs used by physical therapists and doctors reflected

prevailing social ideologies of the same periods. Gender ideology and the ideology of professionalism have supported the subordination of physical therapists both to medical and to managerial dominance. These ideologies have been perpetuated by accommodation to the material conditions of medical and managerial dominance.

All field observations, as well as all the material from historical sources, must be interpreted. In this dissertation, the explanatory frameworks used were Marxist theories of the labor process, Marxist theories about the state, and sociological and Marxist theories about the professions. Feminist sensitivity to oppression of women and questions about the right of males to the dominant positions they so often hold also influenced the interpretive process. Despite eclectic use of explanatory frameworks, however, the philosophical stance of this investigation has remained consistently phenomenological. Not only did the investigator listen to and give importance to what people said and thought, the interpretation considered various points of view and explanatory frameworks without insisting that any one was the only correct interpretation. Rejecting the illusions of objective truth and interpretive privilege, the investigation and dissertation concentrated on establishing logical arguments for the acceptance of the interpretations presented.

The logic of the arguments, and the validity of the conclusions, have been tested against the investigator's own experience and that of her physical therapist colleagues. In thinking about and discussing the data and arguments, as well as theories and possible interpretations, these therapists' views of the world and analyses of events have changed. The value of the particular phenomenological approach taken in this study is that such reflexivity is possible.

No claim has been made that the interpretations presented are the only valid way to view the problem. Original material, both historical and field observation notes, has been presented. It is expected that alternate interpretations will arise; the debate they spark should generate further interpretations. In addition, as the findings of this study are made known in the physical therapy community, some of the interpretations and insights offered here will be adopted by therapists. In this reflexive form of sociological enterprise, the picture will always be changing; we can therefore never hope to have a totally "unbiased" or "correct" point of view. What we can offer is several plausible interpretations of "what is going on here."

Viewed from the perspectives used in this study, the data leave no doubt about three things. First, physical therapy as an occupation is subordinate both to the profession of medicine and to management hierarchies.

Second, the form the subordination has taken has varied through time. Third, and most significantly for physical therapists today, the patterns of subordination are shifting away from medical dominance toward managerial dominance.

Possible explanations for the subordination of physical therapists include at least three major themes, all of which were considered and used during the investigation and all of which remain believable. These explanations are listed below. Each explanation also implies a course of action which could be taken to maintain or improve the situation of the occupation and its practitioners; these will be suggested, after the explanations have been identified and discussed.

The future of physical therapy: theory-based speculation

First, physical therapy subordination can be "explained" in terms of its congruence with the general social relations and patterns of dominance in society. Dominance of women as a group by men as a group, for example, can be considered to be a structure which determined the relationships of physical therapists, first with medicine, then with management. Similarly, the class structure of the context society, with the dominant classes controlling the labor of the subordinate classes, can be seen to have prevailed in the relationships between doctors and the "operators" who assisted in the rehabilitation of war wounded; the doctors and the

physiotherapists who assisted in the rehabilitation of cripples, and the managers and the employee physical therapists in modern health care and rehabilitation facilities.

If we consider class and gender structures of society as structures which determine how people can act, we can accept the "class structure" and "patriarchal structure" explanations of physical therapists' subordination. Accepting such an explanation, however, leaves physical therapists with no alternative but to wait for those structures of domination to change; something that is unlikely to happen soon. We might also object that such a view of physical therapists and their work is unnecessarily mechanical, that nothing is that rigid, that there is always individual variability. Physical therapists will always be able to point to some concrete examples from their labor process which "show" the structural explanation to be "wrong."

In contrast with the first, structural explanation, a second, functional explanation of the relations between physical therapists and doctors, and between physical therapists and managers is often used. The relationships can be seen to be functional or useful to both groups in their respective projects. In the functionalist method of explanation, things are interpreted in terms of their

usefulness for maintaining the status quo, for maintaining the order of society. A functionalist explanation notes for example that physical therapists' ideologies of service and professionalism were functional for the state because they persuaded therapists to accept low pay for work which kept returning war wounded off the streets and off the welfare rolls. Physical therapy was sponsored in its efforts to become a respectable profession, a functionalist explanation reasons, because the medical profession could use them to fight against quacks and irregular healers.

Functional explanations help us look for both the intended and unintended consequences of actions and strategies. They are common and familiar. While functional explanations might partly explain why a certain social relationship, law or custom continues, they cannot explain how it arose, or how it might change. Therefore, if we depend on functional explanations to predict what might happen in future to medical dominance of physical therapy, for example, we are bound to say that medical dominance will disappear only when it has no remaining advantages for either group. Medical dominance, therefore, is likely to continue a very long time. By adding in the element of the structural perspective which assumes discrepancies in power, we can see that relations of dominance will continue as long as dominance is functional for the more powerful group. This lets us see that if dominance of physical therapy by medicine

no longer serves the function of fighting non-medical health competition, and if there are no other ways in which medical dominance of physical therapy helps the more powerful doctors, medical dominance might disappear. Alternatively, if physical therapists were able to increase their power relative to doctors, and if medical dominance was not functional for them, medical dominance of the physical therapy profession would be reduced or disappear.

The straight structural, and to some extent, the functional, explanations leave physical therapists with no alternative but to wait passively for a revolution, or at least for major change in the current situation of class and gender dominance. A third possible explanation, however, one which is sometimes called the "action" framework, acknowledges that individuals and groups act intentionally; that they are not mere robots acting out given structures, but that they act to confirm and reproduce structures and that they have some scope for choice in how they will act.

The action frame of reference assumes that structures achieve their appearance of reality because habits and patterns of behavior tend to be repeated. Because people act "the way we've always done it," the same structures, for example, medical dominance or managerial dominance, are preserved and perpetuated.

The apprenticeship portion of physical therapy education, not only allows physical therapy students to learn the techniques practiced by their tutors, it also teaches them the habits of thought and modes of address, action and writing that preserve harmonious relationships and let them get the work done. Deferential habits, when used continually, come to be thought of as the only way things could possibly be. They produce an appearance of reality that is so strong, it seems to be impossible to change. Failure to comply with the perceived structures, to act in accordance with and to perpetuate them, is punished by unpleasant results. Thus, interactions structure and are structured by the prevailing dominance patterns in society.

The action perspective, applied glibly, might be thought to assert that physical therapists merely need to change the way they think and act about things to improve their lot in life. Such a conclusion is obviously absurd. In the first place, not only must physical therapists change their actions, they must persuade others: colleagues, patients, managers and doctors, to change their way of acting as well. Secondly, physical therapists are constrained by law as well as custom, and if they defy both custom and law they are vulnerable to concrete discipline and action to keep them in their place. Changing structures in society other than by revolution takes time; it is necessary to change the customs as well as to change the laws. Physical therapists, by

allying their interests with powerful interests in society, by changing their actions and interactions with colleagues, doctors, managers, and patients, and by persisting might bring about change, but it would occur slowly.

We have seen that specialization, technology, and private practice are fragmenting the profession, enhancing the distinctions between owners and employee therapists, between generalists and specialists. We have seen that other groups, such as massage practitioners, respiratory technologists, and doctors who offer physical therapy treatments by employing untrained assistants in their offices, threaten to encroach on the present scope of practice by physical therapists. We have seen that physical therapists have successfully fought against encroachment on their scope of practice in the past; we should expect them to continue in the future.

Physical therapy could continue with its old strategies, therapists are increasingly reluctant, and unable, to depend on outside sponsorship from doctors. They could, however, continue to resist subordination by restating what they know. They could use the management tools and statistics generated by cost accounting systems to defend their point of view. They could be alert to new forms of control and endeavor to submit to them only when they know it will improve their relative position in the long run.

Physical therapists have an untapped area of potential support in their clients. In the past, they were able to obtain jobs for physical therapists in hospitals and rehabilitation centers because of the state's need to care for the disabled and returning war wounded. Disability has not decreased; the aged population is growing, and with it a demand for services that keep people active as long as possible. If physical therapists can enlist the support of their main client groups, the elderly and disabled (who themselves are becoming a more powerful pressure group), in the physical therapy professional project, they may survive the current pressures and emerge as a more powerful, independent profession.

Not all desired change is possible, however. Physical therapists, like any interest group within society, must recognize the structures of the society in which they live. They must recognize where the power is, and enlist the support of powerful groups by persuading them that the physical therapy aims are also functional for them. Physical therapists might enlist the support and assistance of consumers of their product, the growing elderly population in particular, to gain independent practice so they could provide physical therapy directly to the consumers without the expensive overhead of institutions or the intermediary, expensive and time consuming, preliminary visit to the doctor

to determine that there is a need.

Physical therapists might ally themselves with other employed women professionals, or with women workers in general, to become a large enough pressure group to act collectively to achieve recognition that the caring labor they do is necessary for society and must be rewarded.

In the future, as the profession develops more professional independence (from medicine) but continues to work for the state within a capitalist context, increasingly close surveillance and control of work must be expected. Cost constraints to physical therapy practice are unlikely to diminish; particularly in private practice but also in institutional employment. They will become more obvious. New ways will continue to be developed to reorganize the work, to divide it into specialty areas, and to make it more cost efficient. This process will leave less time and latitude for therapists to negotiate treatment with patients; their sense that they have time to care will increasingly be threatened. Physical therapists will develop ways to resist control of their labor process; some will "escape" to other fields of endeavor and leave the profession, some will practice it different ways, and some will enter private practice, where they will still be subject to cost constraints and quality control from funding bodies, licensing and regulatory agencies. As a result, in the

future we can expect to see a more diversified profession, one which encompasses various modes of practice, various specializations, and various labor processes.

This dissertation has used physical therapy as an example of an employed women's profession. It has explored the contribution made by the labor process, feminist, and sociology of work and the professions' traditions to understanding the organization of work for women in professions. Using participant observation and historical data, it showed that each of the existing frameworks, when used alone, is insufficient. It is necessary to combine analytical frameworks, and to reflect on the various possible interpretations of the data, in order to understand what is happening to women's professional work.

Directions for further research

In much women's work, the expectations associated with gender as well as with class impinge particularly on part time workers. The data collected for this study suggested that part time therapists experience work differently and act differently from full time physical therapists, but not enough information was available to thoroughly explore this topic. Part time work seems to be important in the shift from medical to managerial control of physical therapy; it may also alter the relationships among men and women

therapists. Part time work, and the conjunction of employed work and family work, should be explored further to provide more information about the experience and expression of class and gender in the labor process.

The labor process, its expression, and its experience for males in physical therapy were touched on in this study, but there were insufficient data for analysis. It seems likely that the observations and theoretical orientation of traditional labor process studies are as inadequate for the analysis of men employed in a "service profession" as they proved to be for the women studied. We do not know whether when males are in subordinated positions because of their employed status, but the managers who supervise them are females, if the predominant relation of dominance is that of class or of gender. In the present study, there were indications that men have different opportunity structures because of their gender, and that they are treated differently by colleagues and clients. Deciding whether these differences are significant awaits future research. The topic of men in women's professions, and conversely of women in men's professions, might provide data with which to further develop theory about the links between class and gender.

The future of class and gender: data based speculation

This study used sociological theory, particularly phenomenological and labor process theory, to analyze the case of a particular occupational group and example of employed women's professions. From the analysis came observations and insights which are reflected back to the profession and its practitioners, suggesting alternate ways to think about their situation and, possibly, to act.

It is important also to reflect on theory. This is a single case study. By itself, it cannot prove a theory wrong, or create a new theory. Because of its pheomenological approach, it does not and would not presume to "prove" a theory, or to disprove it. The relationship between theory and data in a phenomenological approach is reflexive; one is used to make sense of or give substance to the other. This study, however, adds to the mass of data which is accumulating about women's work. It shows how gender and class are experienced in particular, historically determined, ways in one occupation. It provides information about the way class and gender are experienced from a particular location within the prevailing class and gender structures in society.

We saw that physical therapists are women workers, but their experience and expression of being women and of being workers is different from that of the "factory girls" Pollert

(1981) studied, and from the clerical workers Lowe (1982) studied. Because they are engaged in a paid labor process, their experience is different also from that of housewives. The similarities are most pronounced among therapists and other employed women's professional workers such as nurses and teachers. Even so, the work is different, the histories of the professions are different, and the experiences are different. By listening to physical therapists and giving them a voice, this study has added to the mass of data about the variety of women's experience and expression of work.

While it was useful to look to studies of the labor process in men's work as a guide, it was found that none of the studies, and none of the theory, adequately described these women's experience of the labor process. Clearly, occupations are gendered; when we analyze them, we must account for gender as well as for class structures and relationships. The problem with previous labor process work, as well as with sociology of occupations' work, is not that it was wrong, but that it lost sight of the idea that the cases it studied were historically situated, and situated within a structure of gender dominance.

In the heuristic model specified at the outset, it was stated that gender and class dominance were to be treated as primary, and that professional dominance arises specifically

in the context of them. It proved difficult, however, to separate the present experience and expression of medical dominance, gender dominance, and class dominance in the labor process of physical therapy. All the dominance exists together, all the systems have historical impact on the position of physical therapy, and all need to be considered together. There is no reason, however, to discard the heuristic model. We saw that class and gender were very important in the historical development of physical therapy. They were incorporated into the structure of the profession and its practices. Class and gender are implicated in the system of professional subordination experienced by physical therapists now. We should not have expected to be able to separate them cleanly. The theoretical model helped us find our way through the data, but it is only a map or guidebook; it represents reality but does not replace it.

One of the most interesting, although contentious issues raised by the conjunction of phenomenological methodology with Marxist and feminist theory is the validity of the categories themselves. The tension raised by using a phenomenological method to study a discipline developed within a dominant positivist framework has pervaded the study. Despite our training in theory, there is a tendency for sociologists, like the people they study, to treat the status categories "manager," "employee," "male" and "female" as if they had reality on their own. We have proceeded on

the assumption that the status categories could define the attributes of the data we fitted into them. Positivist methods give these categories the status of "facts." When we think about the status categories as facts, we are puzzled because we cannot always fit the observed data into the categories; we cannot decide whether we are observing gender dominance, for example, or class dominance, or professional dominance. We are puzzled when we cannot use the data to prove the theory.

A phenomenological approach suggests, however, that categories are merely ways of thinking about the world. They are not necessarily universal, nor do they contain more truth than other ways of thinking about the world. Sociological categories may be more systematic than common sense views of the world; they can be used, as Smith (pp. 35-36) suggests, to make sense of the data. They have proven very useful in interpreting the data in this study. They remain, however, arbitrary ways of thinking about the world. What validity they have is achieved internally, though logic. Constructing theory is an intellectual endeavor; while theory must take account of what can be observed, it can not be proved or disproved by the data it helped organize.

The data on class and gender dominance collected during this study are valuable; they give a voice to the women workers studied and add to sociology's knowledge about the

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specific historically situated labor process of one group. When this study is compared with others, we may well find resonances. Subordination of physical therapy workers to managers was compared with that described in several well known labor process studies; some consistencies were found. When the labor process of physical therapists is compared with other women's labor processes, we may again find similarities. It would be presumptuous, however, to claim that this study, by itself, defines the labor process, or even women's labor process. It does, however, describe the labor process at one point in time, in one employed women's profession.

NOTES

CHAPTER ONE

1. The term "physiotherapy" is the term preferred in Britain. The term "physical therapy" is preferred in the United States. In Canada, the terms are interchangeable.

"Physical therapy" and "physical therapist" are preferred terms in this report because they seem to be gaining in popularity in Canada and because they are acceptable to available spell checking programs. In this report, the term physical therapy is used wherever either would be acceptable, but physiotherapy is used wherever it appears in an official name or document, or when it refers to British physiotherapists.

2. Here the accepted definition of the state quoted by Walters (1982: 169) is used. "The state is defined as a complex of public institutions including federal, provincial, and municipal government, legislatures and executive bodies, the bureaucracy, the military and the judiciary."

CHAPTER TWO

1. Highlights of the survey were obtained through the Toronto unit, Directors of Physiotherapy Services, Canadian Physiotherapy Association. The full report of the study was obtained from the Ontario Ministry of Health.
2. "Making out" was the parlance used at Allied to describe producing, and therefore earning a premium on, forty per cent more than the standard for the job. Buraway described an informal shop floor agreement which limited making out to 140%. More would presumably attract the attention of the time and motion people and result in having the standard for that job increased. If that happened, the machinists would have to work harder to make the earnings they were used to, so they voluntarily limited their production to the "making out" level of 140%.

CHAPTER FOUR

1. This information came from a book produced by a member of the Chartered Society of Physiotherapy (C.S.P.) in 1940, and no longer available. I was able to borrow a copy from the Professional Consultant of the C.S.P. in London, England, but had to return it and do not have the complete reference. The book gave colorful portraits of each of the founders. Clearly, most were women of independent means, although one of the founders "was forced by her circumstances to earn her living from her massage teaching and practice."

CHAPTER SIX

1. Breakdown of location of employment for practising physiotherapists registered with the Board of Directors of Physiotherapy on December 31, 1982 provided by the Registrar.
2. Highlights of the study were obtained from the Toronto Unit, Directors of Physiotherapy. The full report was obtained from the Ontario Ministry of Health.

CHAPTER TEN

1. Belleville General Hospital routine chest physiotherapy protocol, 1979.

CHAPTER ELEVEN

1. I am indebted to Marie Campbell, now of the School of Social Work, Carleton University, for clarification of the concept that human interaction must be turned into documentary reality to be accounted for in health care institutions. Campbell was writing her dissertation at the time the field work for this study was being conducted, and our many conversations helped clarify the issues. Tim Dymond, of the Program on Women, Northwestern University, has also quoted the phrase "if it's not charted, it didn't happen" in a book prospectus entitled Making Grey Gold: The Everyday Production of Nursing Home Life. The same phrase appeared in a recent Directors of Physiotherapy newsletter.

REFERENCES

- Avis, W.S. (ed.)
1980 Funk and Wagnalls Standard College Dictionary.
Canadian edition. Toronto: Fitzhenry and Whiteside.
- Beechy, Veronica
1982 The sexual division of labour and the labour
process: a critical assessment of Braverman. Pp. 54-
73 in Stephen Wood (ed.) The Degradation of Work?
London: Hutchinson.
- Benet, M.K.
1972. Secretary. London: Sidgwick and Jackson.
- Blackburn, R.M.; Prandy, K.
1983 A theoretical approach (1965) Pp. 218-226 in R. Hyman
and R. Price, (eds.), The New Working Class? White
Collar Workers and their Organizations. London and
Basingstoke: Macmillan.
- Blishen, B.
1971 "A socioeconomic index for occupations in Canada."
Pp. 495-507 in Bernard Blishen et. al. (eds.),
Canadian Society. Toronto: Macmillan.
- Blishen, B.R., Carroll, W.H.
1978 "Sex differences in a socioeconomic index for
occupations in Canada." Canadian Review of Sociology
and Anthropology 15: 352-371.
- Blishen, B.R., McRoberts, H.
1976 "A revised socioeconomic index for occupations in
Canada." Canadian Review of Sociology and
Anthropology 13: 71-79.
- Board of Directors of Physiotherapy
1978 Report and Communique 1977-1978. Toronto: Board of
Directors of Physiotherapy.
- Boase, Joan
1982 "Regulation and the paramedical professions: an
interest group study." Canadian Public
Administration 25: 332-353.

Braverman, H.

1974 Labor and Monopoly Capital. New York: Monthly Review Press.

Brockett, M.

1985 Professionalism or unionism: the therapists' dilemma. Canadian Journal of Occupational Therapy 52: 10-14.

Burawoy, M.

1979 Manufacturing Consent: Changes in the Labour Process under Monopoly Capitalism. Chicago: University of Chicago Press.

Burawoy, M.

1985 The Politics of Production. London: Verso.

Burstyn, Varda and Dorothy E. Smith

1985 Women, Class and the Family. Toronto: Garamond Press.

Calder, Doug

1985 "Development of an information system for a physiotherapy department." Physiotherapy Canada 37: 25-29.

Calder, D. and S.H. Jarvis

1986 "Physiotherapy caseload guidelines: summary of a report prepared by the Canadian Physiotherapy Association." Physiotherapy Canada 38: 43-67.

Campbell, Ian

1956 "Rehabilitation in Canada." Journal of the Canadian Physiotherapy Association 8: 183-187.

Campbell, Marie C.

1985. Information Systems and Management of Hospital Nursing. Ph.D. thesis, Sociology of Education, O.I.S.E.

Canadian Physiotherapy Association

1980 Scope of Practice. Toronto: C.P.A.

C.A.M.R.G. 1923

1923 Editorial. Journal of the Canadian Association of Massage and Remedial Gymnastics 1: 3.

Canadian Physiotherapy Association

1983 Activities for the 80's relating to the association's long term goals. Canadian Physiotherapy Association executive committee meeting September 15, 16 1983. Toronto: Canadian Physiotherapy Association.

- Carchedi, G.
1975 "On the economic identification of the new middle class." *Economy and Society* 4(1): 1-86.
- Cartwright, E.
1923 "Editorial." *Journal of the Canadian Association of Massage and Remedial Gymnastics* 1: 5-6.
- Chartered Society of Physiotherapy
1985 *Chartered Physiotherapists Source Book 1985*.
Norwich: Parke Sutton in association with the
Chartered Society of Physiotherapy.
- Chinoy, Eli
1982 "Control and resistance on the assembly line." Pp. 87-100 in A. Giddens and Gavin Mackenzie (eds.), *Social Class and the Division of Labour*. Cambridge: Cambridge University Press.
- Clement, Wallace
1981 *Hardrock Mining: Industrial Relations and Technological Change at Inco*. Toronto: McClelland and Stewart.
- Coburn, J.
1974 "'I see and am silent': a short history of nursing in Ontario." Pp. 127-163 in Acton, Janice D. et. al. (eds.), *Women at Work in Ontario 1850-1930*. Toronto: Women's Educational Press.
- Cockburn, C.
1985 *Machinery of Dominance: Women, Men and Technical Know-How*. London: Pluto Press.
- Cook, E.T.
1942 *The Life of Florence Nightingale 1820-1861*. Toronto: Macmillan.
- Cope, Zachary
1958 *Florence Nightingale and the Doctors*. London: Macmillan.
- Crowe Jean
1986 "Salaries." *Taking Care of O.P.A. Business*. Ontario Physiotherapy Association Newsletter July, 1986.
- Damude, Earl
1978 "Paramedicals pushing in." *Medical Post* Sept. 26.
- Dominion Bureau of Statistics
1928 *Canada Year Book 1927-28*. Ottawa: Kings Printer.

Dominion Bureau of Statistics and Department of National Health
and Welfare

- 1956 "Volume of Health Care for Selected Income Groups."
Canadian Sickness Survey 1950-51 #9. Ottawa: Queen's
Printer.

Edwards, J.

- 1965 "Starting a physiotherapy department in the new
Manitoba Rehabilitation Hospital, Winnipeg."
Physiotherapy (England) March : 88-93.

Edwards, R.

- 1979 Contested Terrain: The transformation of the
workplace in the twentieth century. New York: Basic
Books.

Ehrenreich, B. and Deirdre English

- 1978 For Her Own Good: 150 Years of the Experts' Advice to
Women. New York: Anchor Press.

Ely, Captain Matron E.J.

- 1945 "Address." Journal of the Canadian Physiotherapy
Association 1 (12): 11-17.

Etzioni, Amitai

- 1969 The Semi-Professions. New York: Free Press.

Employment and Immigration Canada

- 1986 The Canadian Classification Dictionary of
Occupations. Ottawa: Government of Canada.

Fox, B. (ed.)

- 1980 Hidden in the Household. Toronto: Women's Press.

Friedson, Eliot

- 1972 Profession of Medicine. New York: Dodd Mead.

Friedson, Eliot

- 1984 "The changing nature of professional control."
Annual Review of Sociology 10:1-20.

Fryday-Field, Karen

- 1985 "Private practice -- an essential element." Taking
Care of O.P.A. Business June, 1985; 3.

Ganange, Charlene

- 1986 Double Day Double Bind. Toronto: Women's Press.

- Gardner, C.M.
1951-52 "The relationship of medicine to democracy or the doctrine of the even chance." Journal of the Canadian Physiotherapy Association n.v. 1951-52: 32-37.
- Gault, Helen
1959 "Physiotherapy in Canada." Journal of the Canadian Physio-therapy Association 11: 193-201.
- Gartland, G.J.
1977 "Synopsis of a study of admissions criteria for physical therapy programs." Physiotherapy Canada 29: 6-10.
- Geer, Blanche et. al.
1968 "Learning the ropes." Pp. 209-233 in I. Deutscher and E.J. Thompson (eds'), Among the People. New York: Basic Books.
- Gelmon, S., Williams, J.I.
1983 "Perspectives on the physiotherapy profession: a survey of Canadian Physiotherapy Association members." Physiotherapy Canada 35: 21-29.
- Giddens, Anthony
1979 Central Problems in Social Theory. Berkeley and Los Angeles: University of California Press.
- Gordon, Lynne
1978 "Life-savers: chose one carefully." Toronto Sun December 27, 1978.
- Gough, Ian
1979 The Political Economy of the Welfare State. New York: Macmillan.
- Graham, Christine
1940 "Editorial." Journal of the Canadian Physiotherapy Association 1: 1-2.
- Graham, Mrs. Duncan
1939 "The Canadian Physiotherapy Association, an historical sketch 1920-1939." Canadian Physiotherapy Association Journal 1: 9-13.
- Goldie, Douglas
1985 "Challenges for the '80s: a middle management perspective." Physiotherapy Canada 37: 40-41.

- Graham, E. (Mrs. Duncan)
1956 The Canadian Physiotherapy Association 1939-1949.
Canadian Physiotherapy Association Journal 8: 15-22,
36-39.
- Gritzer, Glenn, and Arnold Arluke
1985 The Making of Rehabilitation: a Political Economy of
Medical Specialization, 1890-1980. Berkeley:
University of California Press.
- Haas, J. et. al.
1981 "Initiation into medicine: neophyte uncertainty and
the ritual ordeal of professionalism." Pp. 109-123
in K. Lundy and P. Warne, (eds.), Work in the
Canadian Context. Toronto: Butterworths.
- Hall, Oswald
1948 "The stages of a medical career." American Journal
of Sociology 53: 327-336.
- Harvey, F.W.
1922 "On the claims of chiropractic." Canadian Medical
Association Journal 12: 258.
- Health and Welfare Canada
1981 Canada Health Manpower Inventory. Health Information
Division, Information Systems Directorate, Policy
Planning and Information Branch. Ottawa: Minister of
National Health and Welfare.
- Hodgins, (The Honourable Mr. Justice T., Commissioner)
1917 Report and Supporting Statements on Medical Education
in Ontario. Ontario: The Legislative Assembly.
- House of Commons Special Committee on Social Security
1943 Proceedings. Ottawa: King's Printer (Marsh Report).
- Hughes, E.C.
1958 Men and Their Work. Glencoe, Ill.: Free Press.
- Hughes, E.C.
1971 The Sociological Eye: Selected Papers on Institution
and Race. Chicago: University of Chicago Press.
- Illich, I.
1975 Medical Nemesis. New York: Pantheon Books.
- Johnson, T.J.
1980 "Work and power." Pp. 335-371 in G. Esland and G.
Salaman (eds.), The Politics of Work and Occupations.
Toronto and Buffalo: University of Toronto Press.

J.C.M.A.R.G.

- 1923 Journal of the Canadian Association of Massage and Remedial Gymnastics 1923: 1.
- Journal of the Canadian Physiotherapy Association
1970 22, 2: 65, unsigned editorial reprinted from the 1924 issue of the Journal of the Canadian Association of Massage and Remedial Gymnastics.
- Kelner, M.J. et. al.
1980 Chiropractors, Do They Help? Toronto: Fitzhenry and Whiteside.
- Kelner, M.J. et, al.
1981 "Chiropractors and their competitors." Pp. 125-133 in K. Lundy and P. Warne (eds.), Work in the Canadian Context. Toronto: Butterworths.
- Kelner, M.J.
1984 "The transition from student to practitioner: the making of a Chiropractor." in A. Wipper (ed.), The Sociology of Work: Papers in Honour of Oswald Hall. Ottawa: Carleton University Press.
- Krusen, Frank H. et. al. (eds.),
1971 Handbook of Physical Medicine and Rehabilitation, 2nd. edition. Toronto: W.B. Saunders.
- Kuhn, A., and A. Wolpe (eds.)
1978 Feminism and Materialism. London: Routledge and Kegan Paul.
- Larson, M.S.
1977 The Rise of Modern Professionalism. Berkeley and Los Angeles: University of California Press.
- Leslie, M.J., O'Neill, M.
1971 "The Canadian schedule of unit values for physiotherapy statistics." Physiotherapy Canada 23: 227-231.
- Littler, C.R.
1982 The Development of the Labour Process in Capitalist Societies. London: Heinemann.
- Lowe, Graham S.
1982 "Class, job and gender in the Canadian office." Labour/La Travailleur 10: 11-37.
- Luxton, Meg
1980 More than a Labour of Love. Toronto: Women's Educational Press.

- McColl, M., and Carole Miles-Tapping
1986 "Professional representation and conflict in the work place." Canadian Journal of Occupational Therapy 53: 135-139.
- McDougal, D.J.
1924 Legislation covering the practice of massage in Ontario. Journal of the Canadian Association of Massage and Remedial Gymnastics 1: 16-18.
- McFarlane, B.A.
n.d. Keynote address to a colloquium of museum occupations.
- McNab, E.
1970 A Legal History of the Health Professions in Ontario. Toronto: Queens Printer.
- McPherson, K.
1955 "Report of the legislation committee to the Canadian Physiotherapy Association Congress." Journal of the Canadian Physiotherapy Association 7: 28-29.
- Malos, E.
1980 The Politics of Housework. London and New York: Allison and Brisby.
- Magee, David J.
1986 "Physiotherapy specialization in Canada: an update." Physiotherapy Canada 38: 102-105.
- Marmer, J.
1974 "Medicine just can't measure up to chiropractic." Medical Post March 5.
- Maxwell, J.D. and Mary Percival Maxwell
1979 Occupational Therapy: The Diffident Profession -- The Final Report of the Queens University Study of Occupational Therapy. Kingston: Queens Campus Bookstore.
- Maxwell, J.D. and Mary Percival Maxwell
1984 "Inner fraternity and outer sorority: social structure and the professionalization of occupational therapy." Pp. 330-358 in Wipper, A. (ed.), The Sociology of Work. Ottawa: Carleton University Press.
- Marx, Karl
1887/1967 Capital vol. 1. Samuel Moore and Edward Aveling (transl.), New York: International Publishers.

- Méchanic, David
1978 Medical Sociology, 2nd. edition. New York: Free Press.
- Merton, R.K. et. al. (eds.)
1957 The Student Physician. Cambridge: Harvard University Press.
- Merton, R.K.
1957 "The role-set: problems in sociological theory." British Journal of Sociology 8: 106-120.
- Miles-Tapping, C.
1985 "Physiotherapy and medicine: dominance and control?" Physiotherapy Canada 37: 289-293.
- Military Affairs Committee
1940 "Report." Journal of the Canadian Physiotherapy Association 1: 14.
- Navarro, V.
1976 Medicine Under Capitalism. New York: Prodist.
- Nichols, T., and Huw Beynon
1977 Living With Capitalism. London: Routledge and Kegan Paul.
- O'Neill, M.T.
1976 "Physiotherapist caseload standards." Physiotherapy Canada 28: 95-98.
- O.P.A.
1980 Physiotherapy Ontario. Toronto: Ontario Physiotherapy Association.
- O.P.A.
1986 Position paper on Cardiopulmonary Physiotherapy. Toronto: Ontario Physiotherapy Association.
- O. Reg. 214/44
1944 Ontario Gazette 77: July-Dec. 1944: 335.
- Osborne, P.H.
1983 "Malpractice: a perspective for physiotherapists." Physiotherapy Canada 35: 258-260.
- Osmar, S.
1985 "Care." in Paula A. Treichler and C. Kramarae (eds.), A Feminist Dictionary. Boston: Pandora Press.
- Parker, R.
1980 "Care." in Paula A. Treichler and C. Kramarae (eds.), A Feminist Dictionary. Boston: Pandora Press.

- Pollert, Anna
1981 Girls, Wives, Factory Lives. London: Macmillan.
- Prandy, K.
1965 Professional Employees: A Study of Scientists and Engineers. London: Faber and Faber.
- Rosenthal, Carolyn et. al.
1980 Nurses, Patients and Families: Care and Control in the Hospital. New York: Springer.
- Royal Commission on Health Services
1964 Report volume 1. Ottawa: Queen's Printer.
- R.S.O.
1925 "The Drugless Practitioners Act." Revised Statutes of Ontario 1925. Toronto: King's Printer.
- R.S.O.
1970 "The Drugless Practitioners Act." Revised Statutes of Ontario 1970. Toronto: Queen's Printer.
- Rusk, H.A.
1956 Health, a strong force for world understanding: the role of the physical therapist. Journal of the American Physical Therapy Association 1956 n.v.: 127-132.
- Saks, Mike
1983 "Removing the blinkers? A critique of recent contributions to the sociology of the professions." The Sociological Review 31 (1): 1-21.
- Schulman, Sam
1958 "Basic functional roles in nursing: mother surrogate and healer." in E.G. Jaco (ed.), Patients, Physicians, and Illness. New York: Free Press.
- Schulman, Sam
1972 "Mother surrogate -- after a decade." in in E.G. Jaco (ed.), Patients, Physicians, and Illness, 2nd edition. New York: Free Press.
- Shutz A.
1972. The Phenomenology of the Social World. transl. G. Walsh, F. Lehnert. London: Heinemann.
- Smith, Dorothy E.
1981. "On sociological description: a method from Marx." Human Studies 4:313-337.

Starr, Paul
1982 The Social Transformation of American Medicine. New York: Basic Books.

Statistics Canada

1985 National Hospital Productivity Improvement Program
Physiotherapy workload measurement system pre-
publication draft October 1985. Ottawa: Health and
Welfare and Statistics Canada.

Steen, D.
1985 "3-month lineups blamed on physiotherapy freeze."
Toronto Star April 9, 1985.

Swartz, Donald
1977 "The politics of reform: conflict and accommodation
in Canadian health policy." Pp. 311-343 in Leo
Panitch (ed.), The Canadian State. Toronto:
University of Toronto Press.

Tapping, Carole
1976 "Inside the Olympic scene" North Renfrew Times July
28, 1976.

Thompson, Paul
1983 The Nature of Work. Basingstoke and London:
Macmillan.

Thornton, S., et. al.
1986 "Development of a computerized workload measurement
system on the I.B.M. P.C." Directions, C.P.A. 1986:
8.

Torrance, George M.
1984 "The underside of the hospital: recruitment and the
meaning of work among non-professional hospital
workers." Pp. 211-232 in Audrey Wipper (ed.), The
Sociology of Work. Ottawa: Carleton University
Press.

University of Toronto

1986 Calendar. Faculty of Medicine, Department of
Rehabilitation Medicine 1986-1987. Toronto:
University of Toronto.

Waitzkin, H.

1983 The Second Sickness: Contradictions of Capitalist
Health Care. New York: Free Press.

- Walker, Charles B.
1982 "Social security past and present," in G. Guttman (ed.), Canada's Changing Age Structure: Implications for the Future. Burnaby: Simon Fraser University Publications.
- Walker, G.
1986 "Doing it the United Way: A preliminary look at the dilemma of women and professionalism in action." Private communication.
- Walker, G.
1986 "The standpoint of women and the dilemma of professionalism in action." Resources for Feminist Research 15: 18-20.
- Walters, V.
1982 "State, capital and labour: the introduction of federal-provincial insurance for physician care in Canada." The Canadian Review of Sociology and Anthropology 19: 157-172.
- Williams, J.I., Gelmon, S.
1982 "Judging the worth of one's work: physiotherapy as a profession in Canada." Physiotherapy Canada 34: 257-265.
- Williams, Joyce I.
1986 "Physiotherapy is handling." Founders lecture. Physiotherapy (London) 72: 66-70.
- Wilson, R.
1918 "On the role of physiotherapy in the treatment of the returned invalided soldier." Canadian Medical Association Journal 8: 700-702.
- Wolpert, R. et. al.
1986 "Outpatient caseload guidelines." Physiotherapy Canada 38: 361.
- Wood, S. (ed.)
1982 The Degradation of Work? Skill, deskilling and the labour process. London: Hutchinson.
- Wright, E.O. et. al.
1982 "The American class structure." American Sociological Review 47: 709-726.

APPENDIX A: TABLES

Table 1

Location of Employment for Practising Physical Therapists in Ontario by Sex for 1983. Information supplied by the Board of Directors of Physiotherapy in Ontario.

Location	Women		Men	
	No.	%	No.	%
Total of each sex practising	2229		256	
General Hospital	1028	46.1	129	50.4
Pediatric Facility	103	4.6	1	0.4
Rehabilitation Facility	175	7.8	15	5.5
Chronic Care Facility	92	4.1	7	2.5
Facility for the Retarded	19	0.8	5	2.1
Psychiatric Hospital	8	0.3	1	0.4
W.C.B. Hospital	25	1.0	3	1.2
Nursing home/Home for the Aged	10	0.4	-	-
Community Health Centre	19	0.8	2	0.8
Private Practice *	355	15.9	74	28.9
Home Care	262	11.7	4	1.6
Industry	3	0.1	2	0.8
School Board	18	0.8	-	-
Arthritis Society	34	1.5	4	1.6
University/Education Inst.	16	0.7	7	2.5
Government/Other Official Agency	8	0.3	1	0.4
Other	54	2.4	1	0.4

* Number given includes owners and employees

Note: the percentages given in the table are the percentages of men or of women physical therapists.

Table 2A summary of university programs

University	date program began	class size
Toronto	1929	66
McGill	1943	88
Alberta	1954	40
Montreal	1954	60
Manitoba	1960	22
British Columbia	1961	40
Dalhousie	1963	30
Queens	1964	25
Saskatchewan	1965	20
Laval	1965	50
Western Ontario	1967	30
Mohawk/McMaster	1970	26

Source: Williams and Gelmon 1982:259

Note: a bilingual program in physical therapy began at the University of Ottawa in 1985, but no classes have yet graduated.

Table 3

Population per Active Member of the Canadian Physiotherapy Association, by Province of Residence, 1970-1980. Source: Health and Welfare Canada 1981.

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Provinces	1970	1972	1974	1976	1978	1980
Newfoundland	19,222	22,267	28,758	15,186	16,357	14,967
P.E.I.	22,200	14,200	10,600	11,800	8,757	8,864
Nova Scotia	12,661	12,522	10,746	9,582	8,811	8,647
N. Brunswick	19,091	18,386	19,432	13,416	14,868	11,442
Quebec	18,069	25,086	25,973	22,120	26,929	25,100
Ontario	7,733	6,916	6,231	5,667	5,922	5,792
Manitoba	9,196	7,938	7,062	5,698	5,761	5,707
Saskatchewan	11,036	11,623	10,615	9,354	9,265	8,483
Alberta	8,000	7,388	6,832	5,390	6,160	5,435
B. C.	5,940	6,687	6,249	5,172	4,779	3,662
Yukon/N.W.T.*	26,000	19,633	30,850	12,860	16,275	10,717
Canada	9,713	9,632	8,833	7,556	7,861	7,130

* In addition to the distortion caused by the very few, and fluctuating supply of therapists in the Territories, the inaccuracy of population census figures for the Territories must be considered. This line should be interpreted with extreme caution.

Note: The apparent drop in the population per therapist in 1976, which is especially remarkable in B.C., Newfoundland and Quebec, is due to increased enrollment in the Canadian Physiotherapy Association which followed passing of a resolution making a university degree the minimum qualification for membership, to be effective in 1980. A "grandfather" clause allowed people who were members of the C.P.A. before 1980 to remain members. The sharp rise in C.P.A. membership in 1976 was caused by the enrollment of members of the Chartered Society of Physiotherapists (England) who had been practising in Canada but who had not previously joined the C.P.A.

Table 4

Vacancies reported by employers to the Ontario Ministry of Health Survey of Rehabilitation Staff in Ontario.

	Current Vacancies		Positions Vacant 60 days or more		
	No.	% of FTE positions	No.	% of FTE positions	% of vacanc.
Physiother.	160.3	7.2	110.1	4.9	68.7
Occup. Ther.	91.5	8.3	110.1	4.9	68.7
Speech Pathology	59.7	9.0	46.3	7.0	77.6
Audiology	16.4	12.0	9.8	7.2	59.0

Table 5 Summary and comparison of sources of information about physical therapists in Canada

Source	number surveyed	full time	part time	senior pos.	staff pos.	comments
Gelmon & Williams 1983	804	no inform.		34%	53%	sample of C.P.A. memb.
O.P.A. 1980	1401	68%	30%	no inform.		sample of Ontario C.P.A. memb.
Ont. Minist. of Health 1984	3136	2226	910			37% of vacancies suit new grads
		71%	29%			
Ontario Board of Directors of Physiotherapy (licensing body)	2485	no inform.		19%	68%	remainder faculty and other

APPENDIX B: FIGURES

Population in
thousands

ch chiropractor
de dentist
gp general practice physician
pt physical therapist
rt respiratory technologist
rx pharmacist

Figure 1.
Comparison of growth rates for selected occupations. Data
obtained from Canada Health Manpower Survey (Statistics Canada
1981).

1971

Figure 2. Blishen's socioeconomic index scores for selected health professions for men and women. Note: the Blishen score for male osteopaths and chiropractors is 70.25, placing them well above therapists, and just below pharmacists in perceived status.

APPENDIX C: METHODS

The Proposed Research

The theory and the methodology of the dissertation evolved slowly. The proposal to the research committee is on file in the Department of Sociology and Anthropology at Carleton University. An earlier proposal submitted to one of the research hospitals is shown in Appendix D. The plan was to study the work process of physical therapists, looking at the relationship between changes in the work process and changes in care delivered. The study actually examined changes in the work process over time, and predicted changes in care. Because therapists think there is a difference in conditions of work for specialists and for general physical therapy, it was decided that a specialized setting and a general hospital physical therapy department should be studied. The intention was to study the labor process of employed physical therapists; therefore hospitals, rather than private practices, were selected for study. The investigator's position as a faculty member at the University of Toronto program in physical therapy and experience as a physical therapist helped overcome the problem of gaining entry to research settings in a strange community.

Contacts

Physical therapy department heads in the Toronto area were approached through their professional organization, the Toronto Unit, Directors of Physical Therapy Services. This group is a part of the Canadian Physiotherapy Association. At the time, the investigator belonged to the Canadian Physiotherapy Association and to the national Directors' group, but not to the Toronto unit. She had virtually no personal contacts among physical therapists in the Toronto area. The letter to the Directors' group is shown in Appendix E.

Gaining access to the research sites

The letter to the physical therapy directors resulted in a number of telephone calls. It was decided to conduct the research in one downtown specialist hospital. Not only were the physical therapists eager to have research about physical therapy done in their department, the hospital was located conveniently near the investigator's university office. The director of physical therapy from a suburban general hospital was approached by the investigator. This department head agreed to discuss the proposed research with her staff. They invited the investigator to present the proposal to a staff meeting in the physical therapy department. That was done, questions were answered, and after three weeks the department

head informed the investigator that the staff had voted to go ahead with the research.

The downtown hospital required the proposed research to be reviewed by a research and education advisory committee. This committee required that the principal investigator be a member of the staff who was actively involved in either the clinical or diagnostic program of the hospital. The Director of Physiotherapy agreed to be the principal investigator for the submission.

The investigator, the Director of Physiotherapy, and the research physiotherapist from that hospital attended a meeting of the hospital research and education advisory committee. The committee, which appeared to be dominated by doctors, expressed skepticism about the need for "paramedicals" to conduct their own research, and asked why the many nursing studies already published could not simply be applied to physical therapy. Eventually they agreed to permit the research to be conducted.

Patient consent

Therapists in both hospitals had been given an opportunity both to hear and to read about the proposed research and to question the investigator/observer before giving their consent to the project. It was important that patients, who would also be observed, should be informed

about the project and consent to being observed. The investigator, however, wished to minimize her impact on the settings in order to be sure of seeing normal working life, and argued against having patients sign consent forms such as they do before a study of experimental drugs or before surgery. The clinical staffs of both hospitals, and the research and education advisory committee agreed that such a cumbersome procedure was unnecessary.

The investigator drafted a short notice about the project (appendix F). In one physical therapy department, it was posted on the notice board in the patient waiting area. The other physical therapy department handed the notice to patients when they checked in with the receptionist for their first visit to physical therapy.

The research sites

The downtown hospital (Hospital A) is a relatively small (135 bed) hospital with a large physical therapy staff. Patients from a large area of Ontario may be referred. The medical staff are all specialists, and the physical therapists all have advanced training and experience of one area of physical therapy practice. The majority of patients in this hospital come into contact with physical therapy during their stay and many receive extensive physical therapy.

Physical therapy is a department within a hospital. It

has a department head called the Director of Physical Therapy. This person is considered middle management in the hospital hierarchy, and reports to someone in upper management, usually the hospital administrator or executive director. As hospitals reorganize their management methods, they make changes to the names of positions, and shuffle upper management duties. This happened during the study in Hospital A. The Director of Physiotherapy was responsible directly to the hospital Administrator when the study began, and she was responsible only for managing physical therapy. During the field work period, reorganization of the department which would combine physical therapy, occupational therapy, chiropody, and prosthetics departments under one department head was planned, but had not taken effect. By 1987, this reorganization had been accomplished, and the former Director of Physiotherapy won the new management position. Her new title is "Manager, Rehabilitation Services". She now reports to a vice president, but soon that will change again, and she will report to the president of the hospital.

The physical therapy staff in Hospital A now consists of:

- 1 manager (shared with other rehabilitation services)
- 1 part time research coordinator
- 3 physical therapy supervisors (each carries 3/4 caseload)
- 15 staff therapists

2 aides, trained on site in routine departmental duties, are shared between physical and occupational therapy.

1 secretary, and

2 receptionists are shared with the other rehabilitation services.

Hospital B is a large (425 bed) general hospital which serves patients who live in the community which surrounds it. General practitioners and specialist doctors refer patients to physical therapy. Not all the doctors who refer patients to physical therapy are on the staff of the hospital. Patients who live in the community which surrounds the hospital who prefer to have physical therapy near where they live may bring their referrals with them and receive physical therapy in Hospital B's department. Hospital B serves a rapidly growing town on the outskirts of a large city. In addition to general hospital beds, it has a chronic care unit (where patients who require ongoing nursing care live) and a rehabilitation unit (where patients receive intensive rehabilitation and stay six to twelve weeks). Physical therapists treat most patients on these two units, but in the remainder of the hospital they treat only patients whose particular health needs require physical therapy expertise. In terms of its workload and the lines of communication within the hospital and outside it, Hospital B's physical

therapy department is typical of most general hospital physical therapy facilities.

Of the total staff complement of 27.87 positions, the arrangement is as follows

- 1 Director of Physiotherapy
- 4 senior physiotherapists
- 12 full time staff physiotherapists
- 4.5 part time physiotherapists (3 work 5hr/week evenings, 1 works every second weekend)
- 6 staff therapists "job share" 3 jobs (each works 18.75 hours a week)
- 1 assistant (trained on the job) supervises
- 2 aides
- 1 secretary supervises
- 3 clerical/receptionist staff

Extensive use of part time staff in Hospital B makes the number of people on the staff very large, and the logistics of communication among them very complicated.

The Physical Therapy Departments

The physical therapy facilities in both hospitals are similar, even to the color of paint on the walls. Hospital B has a larger area devoted to physical therapy than Hospital A. Both have pleasant reception desks where several clerical staff work behind 4 foot high counters (like a modern bank). The reception areas overlook waiting areas furnished with padded chairs, end tables, and piles of magazines. The waiting areas are larger than the average doctors' office waiting room, but the atmosphere is similar. Outpatients

arrive for their appointments, and wait until the therapist is ready for them. When the therapist is ready, she notifies the receptionist who tells the patient to go in. In Hospital A, often the physical therapist walks to the reception area and tells the patient to go in to the treatment area.

Both physical therapy facilities share the waiting rooms with other rehabilitation services. The waiting room in Hospital B is larger. Both appear crowded at certain times of the day, and empty at others. The waiting room in Hospital B is used as a holding area where patients brought from the wards to physical, occupational, or speech therapy by the hospital porters or therapy aides wait until their therapist is ready for them. Thus, outpatients in street clothes sit side by side with patients dressed in night attire and sitting in wheelchairs.

The "main department" in both hospitals consists of a large room with ten to fifteen "treatment tables". Treatment tables are usually 30 inches high, 30 inches wide, and 6 feet long. They are padded on top with a 2 inch foam mattress covered with vinyl. Each treatment table is in a "cubicle" around which curtains (like the curtains around a hospital bed) can be drawn for privacy. Each "cubicle" may contain, in addition to the treatment table, a wooden chair, a step stool, a small table or shelf, and a bell or calling system. In Hospital A physical therapy department, the curtains are

always pulled back except when the patients are changing from street clothes into shorts and tops for therapy. Therapists in Hospital B keep the curtains closed, but have an intercom system similar to the ones that can be seen in hospital rooms. If a patient presses the call button, someone can talk with the patient without walking to the cubicle.

In the "main department" of both settings there are designated places where electrotherapy machines are kept. This equipment is usually about the size of a portable television; it is kept on wheeled trolleys about 25-30 inches high, 24 inches wide and 15 inches deep. When they wish to give electrical treatments, therapists wheel the machine to the patient, whom they have placed in a comfortable position, sitting or lying on a treatment table.

The main department also has several sinks, counter tops, and cupboards, a hydrocollator (machine in which moist packs are kept constantly hot) and an ice machine. These "service areas" look a bit like a kitchen without the stove and refrigerator. In these areas, moist hot packs are prepared by taking them out of a hydrocollator machine and wrapping them in towels. This work is often done by the aides, but therapists may do it as well. Ice packs, which consist of chipped ice taken from an ice machine and wrapped in damp towels, are also prepared by aides and therapists in the service area. Towels from the moist heat and ice packs

are hung on racks. Hospital laundry sacks on wheeled frames are kept near the service areas.

The "physiotherapy gym" is an area of the main department divided from it by walls and dividers. It does not have cubicles. It contains exercise equipment such as weights, straps, and sandbags, stationery bicycles, wall pulleys, and parallel bars. Parallel bars thirty inches high and six to twelve feet long are used for helping patients learn to walk. Gyms are well supplied with mirrors. Hospital B's gym is larger than Hospital A's. It usually contains two to ten patients and one to four therapists; therapists and patients come and go frequently from the gym area. Hospital B's physical therapy department is on the ground floor near the entrance, and the gym has a wall of windows. Hospital A's department is in the basement, but it is almost as bright because of a generous supply of overhead fluorescent lights. Physical therapy gyms have an assortment of treatment tables, small tables, chairs and exercise equipment whose purpose seems obscure but which patients learn about when they are shown how to use it by their therapist.

A piece of furniture called a "high mat" is a table eighteen inches high, four to six feet wide, and six feet long. It is padded with a vinyl covered mattress like a treatment table. In hospital B, two high mats are located

under a suspended grating. From this grating hang pulleys, ropes, and slings which are attached to it by moveable hooks. This suspension apparatus allows patients to lie on the mat and have their affected limbs supported by slings suspended from the overhead grating. Slings and springs can also be attached to a part of the screen which continues down the side of the treatment table or mat. Thus, therapists can arrange slings and springs to provide resistance to designated movement, or they can arrange the slings to facilitate movement in very weak or painful limbs. All the treatment tables have pillows and bolsters which are used to enhance comfort and to position patients precisely for their exercises. Hospital A has its "suspension apparatus" located over one cubicle instead of in the gym.

Both hospitals have hydrotherapy pools located in areas near the main department and gym, but closed off from them. Few observations were made in the pool areas, therefore these places will not be described.

Both physical therapy departments have intercom systems by which the receptionists can call the therapists. In addition, wall telephones located in the departments allow therapists to take incoming calls without leaving the patient treatment areas. The noise level in physical therapy departments is low, but they are not quiet. In addition to the hum of conversation between therapists and patients and

among patients, there is humming, banging, clanking, ringing and beeping from equipment. Patient call bells and paging on the intercom frequently interrupt conversation and treatment.

Therapist "offices" are smaller rooms or areas behind partitions similar to the reception partitions.. Therapists have "stations" located along long table like shelves suspended at desk height from the wall. Each therapist has a place to keep files, and a drawer for keeping pens and other small equipment such as tape measures, scissors, and goniometers (a device for measuring range of motion in joints), and a place to receive messages and new referrals (written information about new patients). Therapists go to their office to "chart", to make telephone calls, to consult reference books, and to do other departmental duties. They repair and maintain small equipment in the office; large equipment is usually maintained by someone from outside the department. Some socializing also occurs in offices, but it is often cut short by a therapist's departure to check on a patient. Therapists in offices were often observed with their heads bent in concentration over their charts, while other discussions went on around them.

Therapist offices are "off limits" to patients; just as nursing stations in hospital wards are. Patients, however, can easily see therapists in their offices by looking over

the partition or in at the open door. Because their offices are open to view, therapists keep patient charts and other documents which contain confidential information closed except when they are working on them.

Bulletin boards crammed with notices about treatments, new equipment, meetings, schedules, and other information are a feature of all therapist offices. Book shelves containing text and technical books are located in therapist offices, as are 3-ring binders containing information about hospital policies and procedures. During the field work, therapists were frequently seen consulting reference books dealing with technical subjects, scanning, adding to, and taking away notices from the bulletin board. The policy manuals were not used.

Because of the variation in therapist schedules discussed in chapter seven, there is no "typical" population of a physical therapy department. At some times during the day many days a department may be crowded, with patients on every bed and chair and therapists with them, while on other days it may be almost empty. Public holidays and poor weather cause many outpatients to miss their appointments; on these days the departments are quieter than usual.

Patients may be treated "on the ward," that is in their hospital room, or "in the gym" or "in the department," that is in the cubicles in the physical therapy department. Many

hospital inpatients see physical therapists, but never see a physical therapy department. Outpatients, on the other hand, enter a physical therapy department and must quickly be oriented to its sounds, sights, and experiences by the reception staff and therapists.

Observation methods

Observation began in both hospitals two weeks after permission had been received. Clothing was chosen both for practicality and to fit into the setting without appearing either as a therapist or a patient. At the time the observations were done therapists in both hospitals wore "uniforms" consisting of slacks or skirt of a designated color (navy in one hospital, maroon in the other) and coordinating tailored blouses. Therapists wear flat or low heeled shoes, usually rubber soled, because their work requires them to have a stable, firm stance with a good grip on the floor. Furthermore, when they walk through the hospital, therapists must minimize the noise from their steps. Traditionally, they have worn minimal jewelry, and in some settings no jewelry other than a plain watch and wedding band are permitted, although these restrictions are disappearing quickly.

The observer sat first in patient areas such as waiting rooms and gyms, listening and openly recording sketches of

the department layouts. These sketches were shown to interested patients and to therapists who inquired, "What are you doing?" Dialogue and descriptions of interactions were also recorded; these were not shown to inquirers but were kept confidential. Only the investigator and her academic advisors saw the field notes.

Confidentiality

Notes from each observation period were numbered and photocopied. The segments were stapled together; therefore all the observations from, each observation day were in one segment. The segments were filed sequentially by date.

The field notes were kept in a locked filing cabinet in the investigator/observer's university office. Note books containing observations from the day were kept in the observer's hands or buried in a briefcase. Patients, therapists and other staff expressed interest in what was being found, but accepted the explanation that field observations were confidential and could not be released until they had been summarized and until information that could be used to identify individuals had been removed.

When the dissertation was being written the issue of naming therapists and doctors was again raised with therapists at Hospital A. They had heard several presentations of parts of the findings by then. Several

expressed willingness to have their own names attached to their words. It was decided, however, to change names to protect the confidentiality of those people who had been observed who could not be contacted for permission to release their names.

Ongoing Observation and Beginning Analysis

Notes on the research process and additional information were recorded after each of the observation sessions. A sociologist experienced with participant observation studies of hospitals (Victor Marshall) reviewed the field notes from the first month of observation. Marshall suggested ways to improve the observation and recording; he also suggested lines for further observation and inquiry. At Marshall's suggestion, times as well as dates for each observation were recorded, and direct quotes were recorded whenever possible. Direct quotes were identified with normal quotation marks ("") and approximate quotes were identified with single quotation marks (''). As the observer became more experienced with the technique, storing and recalling long pieces of verbatim dialogue for later recording became easier.

Observation periods varied from one hour to one afternoon in length, and each resulted in twelve to twenty pages of handwritten notes. Observations were conducted at all times of the day and on all week days to ensure a representative sample of physical therapy work. Although

part time therapists in Hospital B work in the evenings and on weekends, no observations were conducted then, however, because of the difficulty of gaining rapport with the part time staff who did not have a chance to observe the observer. It was also felt, both by investigator and hospital staff, that observing in these periods would interfere unnecessarily with the physical therapy duties of these therapists.

After the therapists had become used to the observer's presence she moved into their offices, began to accompany them to the cafeteria for lunch, and arranged to follow several therapists around the hospital wards where they worked. When the observer accompanied a therapist to a meeting with patients or staff, the therapist introduced her:

'This is Carole Miles. She is a physiotherapist who is doing a study about our work for her Ph.D. Do you mind if she watches?'

Patients and staff invariably agreed to the observer's presence.

Preliminary hypotheses

As the field work progressed, it was discussed in a general way, concealing identities, with friends, with colleagues in the physical therapy faculty, and particularly with sociologists experienced with Marxist feminist ethnomethodology. Collective effort led to tentative explanations for observed phenomena. A sociologist who was also a friend reminded the investigator to keep the

explanations sociological, and partly countered the tendency to look for the personal or physical explanations favored by physical therapists. When more information was required to accept or reject tentative hypotheses the observation schedule was modified to make specific data collection possible. One such modification led the investigator to conduct a short period of observation in a private physical therapy practice.

After six months, the decision was made to "withdraw from the field". Several "papers" were written to discuss the findings. No clear overall pattern had yet emerged from the data; there seemed to be too many tentative hypotheses and blind alleys, too many lines of analysis to pursue.

The investigator still had an office and a faculty position at the program in physical therapy in the university. Papers were read to faculty colleagues for comment; this resulted in a great concern with replicability and dismay at the revealing nature of the field notes. The other faculty were very uncomfortable both with the papers' data and their conclusions. They asked "How do you know this isn't just an isolated incident? How can you say that about physical therapy?" The physical therapy faculty all had training and experience in natural science backgrounds. They were not oriented to the theoretical and methodological concerns of the study, and were very uneasy with its critical

stance.

The shift to historical investigation

Ongoing reflection about the data, and conversations with sociologists, convinced the investigator that more information about the background and history of the physical therapy profession was needed. Back issues of physical therapy and medical journals were located and scanned. Physical therapists who had been involved with the profession for many years and who could recall "the way it was" were interviewed. Finally, government documents which concerned physical therapy were located (when possible) and consulted. A trip to England gave the investigator a chance to observe physical therapy in a general hospital in South London, and to acquire further information about the Chartered Society of Physiotherapy. Although the surroundings were older and more dilapidated than the departments where observations were conducted in Canada, the scope of practice and the labor process appeared, on brief observation, to be very similar. Interviews with therapists who had worked both in Britain and in Canada confirmed this impression.

Reorienting the analysis

The end of the term faculty position and the offer of an interesting job in the Northwest Territories led the investigator to request a leave of absence from graduate

studies. That was granted. No further observations of the physical therapy labor process were conducted for one year, but "notes on the research process" which amounted to a journal of the investigator's experiences and musing, was kept. At the end of the year, the investigator returned "South" and began full time work on the dissertation.

All field notes and notes on the research process were re-read several times. Several coding schemes were tried. As thinking about the overall patterns shown by the data progressed, the notes were re-read repeatedly. Small "post-it" notes were used to identify parts of the notes where observations relevant to specific parts of the dissertation were located. When segments of the field notes were transferred into the dissertation, the date and time of the observation were kept as they were in the notes, the hospital was not identified, the names of the people were changed, and the segments were edited for clarity. Necessary explanatory comments were enclosed in brackets within the note if they were short, or added to the text of the dissertation.

During the writing of the dissertation, as during the previous three years, new ideas occurred and the analytical frame continued to shift. Thus, the dissertation must not be regarded as the a final statement about the labor process in physical therapy, or about the nature of women's professional work. It is a representation of one possible way to analyze a very complicated social phenomenon.

APPENDIX D: HOSPITAL RESEARCH PROPOSAL

AN ETHNOGRAPHIC STUDY OF THE RELATION BETWEEN CARE AND ~~CHANGE IN THE WORK PROCESS IN PHYSIOTHERAPY~~

SCOPE AND PURPOSE

The major purpose of this research is to investigate care by studying the effect that changes in the work process have on the care given by physiotherapists and received by their patients. Health care provides a service for all members of society. Existing programs are now being changed on the assumption that they can be improved, or at least that minimum standards of care can be assured for all patients. The new programs inevitably change the work process of health care givers. Restriction of professional autonomy and routinization of tasks is typically resisted by worker groups on the assumption that they reduce the quality of care, but quality of care assurance programs are generally welcomed by physiotherapists. The proposed research will study qualitative and quantitative changes in the work process associated with changes in the organizational environment of two hospital therapy services. Corresponding changes in the care givers' and patients' perception of care will be studied as well.

The analysis will be located within the broader sociological discussions of health care workers in the class structure, professional dominance, and change in the nature of the work.

1. Health Care Workers in the Class Structure

The majority of physiotherapists in Canada are employed in health care institutions. Since these are not profit making institutions, and are funded by the state, the physiotherapists' position in the overall division of labour is a matter for academic debate. However, even though their product is intangible, their employers are subject to the same requirements for efficiency as any profit making enterprise. Thus, their work process is likely to become increasingly rationalized and divided. Observation, interviews with key informants and secondary sources will be used to confirm whether that is the case, and what effect this rationalization has on care.

2. Professional Dominance

Physiotherapists in Canada have officially been "directed" by medicine since the formation of the Professional Association of Trained Masseuses and Remedial Gymnasts in 1912. The professional associations which represent physiotherapists resist this dominance, which seems to be based only partly on control of knowledge, partly on the legalized monopoly on health matters granted to the medical profession in the twentieth century, and partly on a gender division of labour. The physiotherapists' professional associations and educational institutions resist medical dominance mainly by attempting to increase the scientific basis of physiotherapy practice. In doing this, they may be increasing physiotherapy's susceptibility to technical control. This study will explore the extent and significance of medical vs. managerial control for the everyday practice of physiotherapy and its possible consequences for care.

3. Change in the Nature of the Work

Physiotherapists are mid level health workers. They are neither as powerful and autonomous as doctors, nor as subordinated as hospital service workers. Like the other mid level health workers such as technologists and social workers, skill as well as academic preparation is necessary for their jobs, which combine mental and manual work. Audits, a commonly used quality assurance mechanism, centralize the planning function, specifying procedures to be used with specific types of patient problem instead of leaving the decision up to the practitioner. Rationalization for maximum efficiency may leave certain levels of worker with mainly planning, communication, and record keeping responsibilities while another level of worker (such as a physiotherapy aide) performs most of the patient care. The process involved thus seems not only to involve the deskilling that Braverman (1974) predicted, but also fragmentation into a more complex hierarchy of workers and managers. A questionnaire and interviews with physiotherapists will indicate the extent to which this is the case in the settings studied. (If funding is obtained, a national survey will be done so that the representativeness of the study settings can be confirmed.)

METHODOLOGY

The study of changes in the work process, in both qualitative and quantitative terms, is relatively straightforward. Field work will be done in settings in which change is taking place. One of the study hospitals plans to introduce a quality assurance program, while the other is reducing the average length of stay. As these programs, like other changes, affect the way the work is organized, it will be possible to observe changes in the work process of physiotherapists over time. Survey questionnaire, participant observation and interviews with key informants will be used to document the work process.

Care "arises from responsibility of affection for other, and may vary from mild concern to profound worry: eg., care for one's children" (Funk and Wagnall's Canadian dictionary, 1980). However, in common usage ("the health care system") the meaning of care seems to have expanded to include not only the human dimension but the physical and material technology of a modern health care institution. This study will explore the process of delivery of care in the dictionary sense: it will study the meanings participants attach to activities known as health care. The relationship between the work process and care is unknown at present, though assumptions about it underly many claims of professional groups for autonomy, of labour unions for better working conditions, and the like. Changes in care (if any) which ensue from changes in the work process at present cannot be measured because care is undefined. A merely quantitative approach to output of the health care system is nothing new. The technology of management now records number of patients seen, cost per patient, number of procedures and the like. The recording technology allows increased managerial control and is presumed to increase efficiency. However, there is reason to doubt whether these quantitative measures capture the essence of health care, its effectiveness, or its meaning for patients. The proposed study will attempt to understand care through ethnographic, interpretive sociological methods; it will study the effect changes in the work process have on the care delivered.

The goal is a better understanding of the meaning of care and the processes by which it is given.

Why Should a Social Scientist Study Physiotherapy?

It is proposed that physiotherapy departments in large health care organizations be intensively studied before and after substantial changes take place.

1. There are about 6500 physiotherapists in the Canadian health care system. Whether they are self employed (about 17%) or work in hospitals (65%) and other institutions, their incomes come from government funds. They are part of the growing public sector, which is increasingly significant in Canadian society. Analysis of the relationship between organizational demands and perceptions of physiotherapists and their patients will contribute to general understanding of the public sector in Canada.
3. Physiotherapy is recognized as one of the self governing professions in Canada. In Ontario, for example, physiotherapists are licenced under the Drugless Practitioners Act. (R.S.O. 1961) While most physiotherapists are employed by others, only 10% are members of labour unions. They think of themselves as "middle class". Physiotherapy is professionalizing by increasing the length

of the training period, by placing more stress on academic courses, and by seeking increased autonomy from doctors. Furthermore, although physiotherapy requires a great deal of skill dealing with people, there is a large technical component to the skill employed in the job. This technical component is emphasized in the educational curricula; the interpersonal skills are taught informally. The position of physiotherapists in the hierarchy of health care is contradictory in several dimensions, and provides an excellent case study in the sociology of occupations and professions.

4. Unlike other health care para- professions, such as nursing, there are more women in physiotherapy but the proportion of men (about 10%) appears to be stable. In Ontario 45% of male physiotherapists but only 26% of the females occupy senior positions which are likely to have considerable control and influence. As in all health occupations, differentiation by gender is present within the occupation. This study will provide the opportunity to examine the relationship between occupational and gender status within a formal organization.
5. Sophisticated treatment techniques and management technologies are changing the work process of physiotherapists. The Canadian Council on Hospital Accreditation has introduced a requirement that quality of care assurance programs be in place in all hospital departments for accreditation. The Canadian Physiotherapy Association has studied quality of care issues in physiotherapy: some quality assurance programs are already in place (Health and Welfare Canada 1979, 1981). New quality assurance programs will be introduced in the next few years. Quality assurance, in whatever form it is implemented, centralizes many decisions about care, reducing the autonomy of professionals and altering their work process. It is important to study the impact of these changes now, while there is still time to do a before/after study.

Why Should a Health Care Institution Participate in this Study?

The study will require a group of physiotherapists to submit to intensive observation of their work, to be interviewed, and to complete a self administered questionnaire. The study will not evaluate individual care, but will try to arrive at a comprehensive picture of the care given and received in one physiotherapy department, the processes by which it changes, and the process by which people arrive at a shared understanding of care. What are the possible payoffs for physiotherapy and for hospitals?

1. Focus on the details of the work process, especially with the assistance of a trained social scientist, may help individual therapists and the departments develop better ways of

accomplishing their goals.

2. A better understanding of care and the process by which it is delivered will enable individual therapists, the hospitals, and the physiotherapy profession itself to enhance care.
3. Much health care research is difficult because methods specifically intended for the investigation of inanimate objects are unsuitable for use with human subjects. This study will apply well tested human science methods to practical problems in health care and particularly in physiotherapy. It will add to the theoretical and methodological armamentarium of therapists wishing to understand their own field.
4. As Mauksch (1970) has shown, a great majority of patients enjoy participating in sociological studies, and welcome the chance to talk to an impartial, sympathetic interviewer about their hospital experience. The interview itself is often therapeutic, and the study may help patients.

Patients and therapists at the Hospital
and at a large suburban general hospital will be the main
"subjects". Other key informants such as officers of the
organizations and doctors will be interviewed.

An observational study should be as inconspicuous as possible, while ethical considerations suggest that all subjects should be informed and allowed to consent. As in all ethnographic field research, it is clear that a stranger in the setting will interact with the participants and disturb the usual patterns somewhat; this is taken into account in the analysis. The interviewer/observer will use as much tact and discretion as possible, and will respect the sensibilities of the therapists and patients about privacy and the like. The information that a study is taking place will be made part of the "background" of the patients' experience by having it mentioned by the physiotherapy clerk when she admits each patient to the department. Informed consent will be obtained whenever patients are subjected to a situation which is unusual (such as an informal or a formal interview).

The physiotherapy staff at both hospitals have been given a chance to examine the written research proposal, to meet with and question the investigator, and to talk it over in private. They were assured that they were free to accept or to reject the research without fear of reprisal. They are free to withdraw from the study at any time by simply informing the investigator; observations will not be recorded about physiotherapists or patients who decline to participate in the study. The physiotherapy staff of both hospital departments have thoroughly discussed the proposed research and agree that it should go ahead.

APPENDIX E: CORRESPONDENCE

61 A Wales Avenue,
Toronto, Ont. M5T 1J3.
May 31, 1984.

Chair,
Directors of Physiotherapy
Toronto Section,
Canadian Physiotherapy Association.

Dear :

I am writing to ask you to bring my request for help with my doctoral research project to the attention of your members.

The proposed research concerns the impact changes in the labour process have on perceptions of care in physiotherapy. I am hoping to find a department or departments which plan to introduce or radically alter their quality assurance programs in the next year or two. In a before/after study design, I will look at changes the quality assurance program produces in the work organization, decision making responsibility, and proportion of time spent in patient care and in other activities (the labour process) of the physiotherapy staff, and at the corresponding changes (if any) in care.

The project would involve the co-operating facilities for about five years. In the first year, (before the quality assurance program begins) I would study the labour process of the physiotherapy staff and perceptions of care by questionnaire, interview and observation. In the next three years, I would check occasionally to see what is happening, then in the final year I would repeat the questionnaires and interviews. .

My base of operations would be the University of Toronto, where I am employed as an assistant professor. The co-operating physiotherapy departments and health care facilities would incur no financial commitment as a result of participation in this project, but would agree to permit me access to staff (at mutually convenient times) and to a representative sample of patients for fairly extensive interviews.

This research offers physiotherapists an excellent chance to evaluate the impact of their quality assurance programs in a detailed and academically rigorous study. I hope some of your members who are planning to implement quality assurance programs will give me a call to find out more about the proposed research.

Sincerely,

Carole Miles-Tapping, M.A., M.C.P.A.

July 9, 1984

Director of Physiotherapy,
Hospital,
W.,
Ont.,

Dear Carol:

Thank you for taking the time to meet with me about my research project. I have a few more questions, but I do think your department would provide an excellent site for my research.

For your information, I have enclosed 1) a copy of the current draft research proposal, 2) A copy of a proposed patient consent form, 3) A copy of the questionnaire as it was used in a pilot study, 4) the results of the pilot study. The purposes of the pilot study were different from the purposes of the research I am proposing to do at Hospital, so the questionnaire is a little different from the one that will eventually be used, but it should give you some idea of the flavour of the questions.

I am looking forward to meeting with your staff at 1230 on Tuesday July 17 to discuss my proposed research. Thank you very much for your interest and support.

Sincerely,

Carole Miles-Tapping

37 Myrtle Avenue
Toronto, Ontario
M4M 2A4

August 12, 1987

Director of Physiotherapy
Hospital

, Ontario

Dear Ms. :

In 1984, the Phyiotherapy Department Staff agreed to permit me access to the department to conduct a sociological study of the labour process in physical therapy. During the fall of 1984, I conducted participant observation, mainly in the physical therapy department of the General and one other hospital. The research was then informed and extended by historical and archival research. I have completed a doctoral dissertation from that research. An abstract is enclosed for your information. If you wish, after the dissertation is defended at Carleton University on August 20, I can provide a copy of it for the use of the physical therapy department.

Thank you very much for your support and that of the physical therapy staff.

Sincerely,

Carole Miles-Tapping

CMT/

encl.

APPENDIX F: PATIENT CONSENT

September 12, 1984

Dear Patient:

I am studying the relationship between the work process and care in physiotherapy. Part of my field work is being done here at General Hospital.

The observation method I am using has traditionally been used by sociologists and anthropologists studying other cultures. I am watching the care that goes on here in physiotherapy and I will be writing my Ph.D. thesis about it. I am interested in the general patterns of what people do, not in individuals, and I'm not evaluating anybody. Anything you say to me will be kept confidential. Later, I will formally interview some patients and some staff.

If you have any questions about my project, or if you would like to talk to me about care in physiotherapy, please feel free to contact me at 978-2765 or 862-8314 days or evenings.

Sincerely,

Carole Miles

END

20/06/88

FIN