Health and ‘I’: An analysis of curricular phenomena in health professional education through the focus of critical pedagogy

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Declaration

I declare that this thesis is my own account of my research and contains as its main content work which has not been previously submitted for a degree at any tertiary education institution.

Wendy Lowe
I would like to thank the participants who took part in the study, for generously giving their time and energy whilst working under such huge constraints. I would also like to thank Dr. Irene Styles, Dr. Dorit Maor and Dr. Wayne Martino for their help in supervising this project at different times. I especially thank Dr. James Bell and Dr. Jane Pearce for their ongoing clarity, encouragement and support in seeing this project to the end. Coming in at the end of a research process cannot have been easy and I appreciate their commitment to me. I thank Dhara Stuart for being there with me and I would especially like to thank my family, Patrick, Ellen and Lauren for their continued support and encouragement throughout the journey of this study.
ABSTRACT

The education of health professionals is based on a series of discourses of professionalism that privilege notions of control and choice (Riggs, 2004a; Titchen and Higgs, 2001). These discourses are expressed through both explicit and implicit curricula, which encourage the enactment of a particular construction of the ‘self’ of both health professionals and clients or patients. This thesis adopts a feminist poststructural analysis of relations of power to explore some of the effects of the enactment of these curricula, drawing on three case studies of education in rural health settings and interviews with 17 health workers.

The results indicate that the enactment of these curricula seems to produce a particular sense of self for health workers – one that is bound up with notions of control and choice, and one that may require struggle on an inner level with the self-regulation and self-policing (O’Grady, 2005) required to fit this norm. The struggle for female health workers to link the abstract theorizing with the actualities of their lives (Williams, 2002) seems to produce a paradoxical type of relationship with themselves and their clients. On one hand there is a discourse of conformity, compliance and obedience, which suggests more of a slippage of self while at the same time the expert-novice relationship characterizing the health professionals’ interaction with clients emphasizes autonomy, control and empowerment of self. Further, while health workers see themselves as having high levels of internal locus of control this is in direct contrast to the helplessness and powerlessness they experience at work, and revealed through the research.
The curriculum reform taking place within all health professional education at the moment emphasizes evidence-based practice and scientific content, and thus reinforces the dominant norm of the neo-liberal individual capable of self-regulation and self-policing. This research suggests the limitations of this approach, given the practices of power that continue to disadvantage women in general and patients in particular in relation to their health and the institution.
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<td>AH</td>
<td>Allied Health</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>CBT</td>
<td>Competency Based Testing</td>
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<tr>
<td>CUCRH</td>
<td>Combined Universities Centre for Rural Health</td>
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<tr>
<td>DOE</td>
<td>Department of Education</td>
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<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>DSC</td>
<td>Disabilities Services Commission</td>
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<tr>
<td>MHT</td>
<td>Manual Handling Training</td>
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<tr>
<td>OT</td>
<td>Occupational Therapist</td>
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<tr>
<td>PCA’s</td>
<td>Patient Care Assistants</td>
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<tr>
<td>PT</td>
<td>Physiotherapist</td>
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<tr>
<td>SP</td>
<td>Speech Pathologist</td>
</tr>
<tr>
<td>TA</td>
<td>Therapy Assistant</td>
</tr>
<tr>
<td>%</td>
<td>Percent</td>
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<tr>
<td>SOAPIER</td>
<td>Subjective, Objective, Assessment, Plan, Intervention, Evaluation, Review</td>
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CHAPTER ONE

INTRODUCTION

Health professional training has been undergoing a transition in Australia (Health Workforce Australia, 2007; Australian Health Workforce Institute [AHWI], 2007; Harris, Heard and Everingham, 2005; Klinken, Whelan and Black, 2007) and overseas (Department of Health, 2008; National Health Service, 2000). It may be that the reform is an effort at stemming the exodus of staff from health service delivery, addressing the worldwide shortage of healthcare staff (World Health Organisation [WHO], 2006) as well as trying to improve patient outcomes (Department of Health, 2008; National Health Service, 2000) and reducing the inequities in health status (Commission on Social Determinants of Health [CSDH], 2008). Most of the reform is driven by government policy with little evidence to support the direction in which health training is evolving.

A model of training for health professionals has evolved that focuses on risk management (AHWI, 2007). There is a greater focus on prevention of ill-health since health and health service delivery are increasingly seen as a problem or a risk to be managed (Petersen and Lupton, 2000). Health promotion theories are emphasized at the undergraduate and postgraduate level building on the assumption pervading health and health care delivery that health is merely a matter of information provision despite the evidence that people need supportive environments in which to make healthy choices (Baum, 2007). This is a technicist-rational approach to the education of health professional practice. In such an approach, curriculum issues are concerned mainly with
what to include or the content of the curriculum (see Crosbie, Gass, Jull, Morris, Rivett, Ruston, Sheppard, Sullivan, Vujnovich, Webb, Wright, 2002), along with the evidence base to support such an inclusion.

Rarely is health professional training and practice explored from a position of trying to understand how the curriculum is enacted and the impact this may have on the student and then on the patient. One exception to this is the Community Partnerships in Health Professional Education (CPHPE) which is based on the assumption that “the essence of health professions education is less a matter of knowledge acquisition and more a process of socialization influenced by experience, professional setting and role modeling” (Henry, 1996). This thesis aims to foreground how health professionals are educated and the consequences of that education, in the context of these competing approaches and conceptual bases.

The ‘how’ of health professional education involves relationship, between the expert teacher and student novice, as well as between the health professional and client or patient. Health professional practice involves:

… the manner in which practitioners perform the roles and tasks of their profession in conjunction with individuals who are their clients or patients. … The difficulty for practitioners lies with the ‘messy’ nature of these problems, unlike their ‘sanitized’ textbook counterparts upon which much professional preparation is focused (Higgs, Titchen, and Neville, 2001, p. 4).

Inherent in any ‘messy, real’ relationship are relations of power and this is especially so between a well-resourced privileged health care provider and a vulnerable dependent
patient. An analysis of the ‘how’ of the curriculum must include an analysis of the relations of power. This thesis includes an analysis of power relations between health professional, expert, and patient or client using a critical pedagogical approach.

Critical pedagogy acknowledges that pedagogy (teaching/learning) forms relations of power (Gore, 1993) between the two (or more) selves within the relationship. Critical pedagogy is used in this thesis to challenge conceptions of self within the healing relationship which fail to recognize the effects of social structures and forces (Usher, Bryant and Johnston, 1997). Within any conception of self are two structuring binary opposites (Usher, Bryant and Johnston, 1997) – the order of these (social positioning) or the role of the individual is determined by the epistemic casting (Foucault, 1973) or how the knowledge is formed. Foucault (1973) explored relations of power in the health service industry over the 17th, 18th and 19th century in Europe and his work will be drawn upon in the analysis within this thesis.

Little is written in the health literature about the effects of power/knowledge (Foucault, 1980) within the healing relationship as health professionals are generally not encouraged to embrace a critical pedagogy (Germov, 2002). Power/knowledge manifests in the relationship between the healthcare provider and the patient or client by the use of such terms as the individual, self, control, choice, identity and autonomy, for example. These terms are widely used when discussing exercise regimes or healthy lifestyles and social determinants of health. These terms interfere with the choices an individual may make in
relation to their health and are thus a form of biopower\(^1\) (Gastaldo, 1997). This thesis foregrounds the use of these key terms in its analysis of power relations in the enactment of health professional curricula and practice.

In order to clarify the structure and themes of this thesis, a schematic diagram (Figure 1.1) is shown overleaf which shows that this thesis, with its aim of exploring and understanding how health professionals are educated and the consequences of that education, is concerned with a curriculum issue. Since the structure and themes of this thesis are concerned with curriculum issues, a wide variety of epistemologies, methodologies and writing styles are drawn upon in order to address the complexity of curriculum issues and therefore be inclusive of a range of contingencies (Kendall and Wickham, 1999). Moreover, embodiment and the self have been highlighted as issues central to curriculum development in the health professions. Further there is a requirement to be more inclusive and integrative when re-presenting qualitative research in relation to the health professions (Todres, 2008). How health professionals come to know what they know in relation to their practice is a process that is contextual, technical, subjective, objective, scientific, embodied, relational, ethical and value-based whether that is realised or not. In relation to health professional practice, for example; “embodied relational understanding draws on ongoing personal resources that are experiential and preconceptual, that are located in the way the body knows, where

\(^1\) Biopower (power over life) of health education – it is educational in nature because it promotes behaviours that should be adopted by the entire population and interferes with individual choice, providing information to foster ‘healthy’ lifestyles; biopower is a code of normalization since it promotes norms of behaviours; health education represents a singular contribution to the exercise of biopower – the biological and political existence start to interface with each other in a web of micropowers that are subtle, continuous and ubiquitous – Gastaldo, 1997.
language is never alone and always mixed with what is more than language” (Todres, 2008, p. 1573). The notion of embodiment leads me to suggest that poetry and metaphor assume a larger significance as part of the language of the body knowing, where being and knowing come together. There are examples of the use of metaphor and poetry in this thesis. Similarly narratives for reflexivity are also important for professional practice (Pearce, 2008). In this thesis, curriculum analysis is inclusive of a wide range of issues and knowing as described further in Chapter Two. It seems vital to understand core issues and concepts of the curricula before reform takes place.

Curricular reform is being driven by a number of groups including governments, professional associations, consumer groups, workers, managers, and institutions such as universities and health services themselves. Different drivers emphasize different aspects of the curricula. On a global level, the Commission on Social Determinants of Health (CSDH, 2008), a subsidiary of the World Health Organization (WHO), advocates:

16.5 Educational institutions and relevant ministries make the social determinants of health a standard and compulsory part of training of medical and health professionals.

16.6 Educational institutions and relevant ministries act to increase understanding of the social determinants of health among non-medical professionals and the general public (CSDH, 2008, p. 188, 189).

Curricula reform of medical and health professionals is gaining momentum both nationally and globally.
Figure 1.1. Schemata showing structure and themes of thesis

Curricular Reform
In Health Professional Training

What, how, why, when, who, where of curriculum phenomena

How curriculum is enacted

Power/knowledge

Relationship

Core constructs of choice, control, self, individual, power, relationship, choice
The foundations of health training and education require examination and reform. Health professionals recognize the problems in health service delivery and see training and education as major issues (Health Workforce Australia, 2007). In a recent forum, 13 out of 20 groups of stakeholders identified clinical education and training as the major priority issue to address the problems in the Australian health workforce (Health Workforce Australia, 2007). The four other key issues identified were the divide between the education and health sectors, models of service delivery, recruitment and retention, and maldistribution of the workforce (Health Workforce Australia, 2007). It was suggested that the present paradigm needed changing through a breakdown of the current biomedical model and funding arrangements.

In this thesis I argue for a radical reform of health professional training and practice. I believe that the technicist rationalist approach to education of health professionals in the positivist biomedical model is simplistic, limited and outdated. Most curricula in the health professions draw on a limited pool of knowledge from the positivist foundations of knowledge production using evidence based practice as the benchmark for good practice (Freshwater and Rolfe, 2004):

Evidence-based practice is now widely accepted as the benchmark of good practice in most healthcare disciplines. There is little evidence, however, that evidence-based practice results in better patient care. Furthermore, what makes up the evidence base is still contested – is it only findings from randomized controlled trials, or the integration of such findings with professional expertise and the views of patients? (Freshwater and Rolfe, 2004, back cover).

This masculinization of knowledges (Richardson, 2001) has resulted in loss of the feminine in professional practice and development. The need for methodological
pluralism and epistemological variability has been highlighted (CDSH, 2008; Baum, 2007; Kelly, Bonnefoy, Morgan and Florenzano, 2006). I argue for a more inclusive approach to education in health that can draw on postpositivist feminist critiques as well as positivist forms of knowledge making.

It has been suggested that more work needs to be done to legitimize a new core knowledge of practice and to give it academic credibility (Titchen and Higgs, 2001). The knowledge required is:

1. Propositional, theoretical or scientific knowledge – e.g. knowledge of pathology;
2. professional craft knowledge or knowing how to do something;
3. personal knowledge about oneself as a person and in relationship with others (Higgs and Titchen, 1995 cited in Higgs, Titchen and Neville, 2001, p. 5).

These authors suggest that if all three forms of knowledge were valued equally then remapping of the curricula content and process (the ‘how’) would have to occur. This thesis is located in the professional craft knowledge sphere of knowledge production. I argue that for the remapping of curricula to occur, power relations must be made more explicit.

This thesis explores these core constructs and subjectivities (or positioning) within the health professional practice and training in Australia. This thesis tries to hold the binary opposites, contain the polar extremes in such a way so as to allow the emergence of different forms of practice much like Lather’s (1991b) meeting the obduracy of problems head on so that different knowledges may be produced differently. O’Grady (2005) suggests “This type of linguistic practice allows more of the complexity of lived
experience to be acknowledged and articulated” (p. 12). Titchen and Higgs (2001) refer to this holding as the dialectic relationship between knowledge and practice in the healing relationship. They suggest that part of the development of professional practice lies in professionals being able to hold and deal effectively with the contradictions they face such as the dialectic between knowing and doing (Titchen and Higgs, 2001). This thesis also tries to hold the relationship between education and health as both are explored in the *how* of health professional curricula. An interdisciplinary thesis that draws on education as well as health runs the risk of being marginalized by both disciplines (Eraut, 1994). But it seems as if both are necessary in order to fully explore the enactment of the curricula of health professionals.

This research draws on a number of different data from which to explore the constructs and subjectivities of the health professional such as training documents, literature, professional association publications, policy and interviews of health professionals working in rural W.A. A critical pedagogical approach encourages the inclusion of the self in knowledge production (Usher, Bryant and Johnston, 1997) therefore I have also used myself as reflective practitioner and critical autoethnographer. I am practising the self (McLaren, 2002) through a methodology that values the epistemological importance and relevance of subjectivity (Walkerdine, Lucey and Melody, 2001).

Having outlined the interdisciplinary nature of this thesis and the focus of my work, namely the health professional practice and training in rural W.A., I am going on to outline my interest in or motivation to study health and education, health professional
practice and the self. The rest of the chapter outlines the context of my study – health service delivery in rural W.A. – under the umbrella of neo-liberal governmental policy within which most health services in the U.K., Australia, America and New Zealand are submerged. Finally the methodology of this thesis will be reviewed followed by an outline of the chapters that make up the rest of this thesis.

1.1 My motivation

My motivation for embarking on this study was fired by many experiences throughout my life, both personal and professional. I had originally trained and worked as a physiotherapist in London and then returned to Australia in 1989. Here, I am choosing to explain specifically the difficulties I experienced teaching and adhering to current health education and health promotion norms. At the time I was in a responsible position in a public health unit in rural W.A. where my task was to promote physical activity across a land area that was over 40,000 sq. km. with a population of approximately 55,000, 3% of whom were Indigenous (Department of Health, 2008). Government policy was and is to target disadvantaged groups of people with the aim of reducing the cost burden of illness and disease to the state health service (Report of the Health Reform Committee – HRC, 2001). I questioned my right to be teaching and promoting such norms and practices if I myself could not conform to mainstream health education and practices. I knew that if I, as well resourced as I was, had difficulty complying with such practices then other people might also be struggling too. Furthermore, I had been trained in the discipline of education which promoted social justice in learning, much akin to the social
determinants of health literature (CSDH, 2008) and I had great difficulty implementing a strategic plan that was socially responsible and just.

With my background in education, health and psychology, I tried to develop and implement a strategic plan that reflected social justice principles and critical pedagogy. However, I found the task very stressful given the entrenched attitudes in the field towards maintaining the status quo, which is only natural considering the dominant paradigm within which I was working. While the critical pedagogy rhetoric was concerned with empowerment and an assertive self, in practice this resulted in increased conflict and issues that were undoubtedly about the circulation of power. I did not know how to deal with these issues effectively. I was naturally viewed as disruptive and I was ill-equipped to deal with these projections.

At the level of fundamental concepts I was confused about issues of self, choice and control and there was no-one who could advise me on how to work my way through implementing a critical pedagogical approach to health. Whilst critical pedagogy was eminently valuable to me at this time in addressing inequities of power, of which there were many examples in the health care system and between target groups and health professionals, I was positioned in an untenable way and again experienced a limited form of subjectivity just as I had when I was working as a health professional.

I enrolled in my PhD with a view to exploring empowerment education with health professionals. Over the years I have gone through a journey that encompasses
biomedical scientism, poststructural feminist analysis and the writings of Foucault. I have seen health as a pedagogy that is used as a means of self-regulation that is both rational and in control in the technicist rational form of education. I have moved to using critical pedagogy as a means of challenging conceptions of the self in a relationship that fails to recognize the effects of social structures and forces (Usher, Bryant and Johnston, 1997).

The effects of social structures and forces make the construction of self a continual social practice that takes place within the healing relationship or meeting place (Foucault, 1973) of the health professional and client or patient. Therefore I have shifted from my view of developing a form of empowerment or liberating education in health that recognizes the impact of social determinants on health to one that involves a continual practice of the self through writing the self as in this thesis, much as Foucault (1988a) advocated. In later chapters (Four and Seven), this shift is explored in greater detail.

Foucault (1973) argued that development of practices of freedom needed to operate at the level of developing techniques designed to incite individuals to relate to themselves and others, according to a different set of designated norms for governing conduct. Thus Foucault (1973) is concerned with working at the limits of existing regimes of practice to invent alternative modes of relating to ourselves in an ethic of care for the self. I see myself as always having been working at the limits of existing regimes of practice so this approach suits me and provides me with motivation to continue to develop my practice and theory as a health professional working at the limits of health education.
My motivation for carrying out this work included a fascination and curiosity about the self as constructed by different theories in health and learning and I explore my forays into this topic in detail in Chapter Seven. The dominant construction of the self is the neo-liberal self in health, one in pursuit of freedom from oppressive forces – the motivation provided by much of neo-liberal’s destructive rhetoric (Harvey, 2005).

The biomedical individual has been constructed by psychology and the medical and social sciences as one who is able to control their behaviours in an attempt to achieve freedom from outside control (Ogden, 2002). This self has become increasingly constructed as autonomous, detached and self-reflexive (Ogden, 2002) whilst also coming increasingly under the control of institutional surveillance (Petersen and Lupton, 2000). Health is framed in terms of compliance and evidence-based practice (Daly, Hughes and op’t Hoog, 2002; Freshwater and Rolfe, 2004) of the health professionals’ self.

Further definitions or constructions of the self include:

- The self as an experiential integration (Nathanson, 1992)
- The self is one that makes meaning i.e. has agency of meaning (Lather, 2007)
- The self is a knot in a web of relations – no relation means no self (Bingham and Sidorkin, 2004)
- The self is consolidated largely through the body (Niranjana, 2001)
However, these definitions are not mainstream and their use is restricted to post-positivist social sciences. I will review the construction of the self through the educational and health literature in Chapter Two in greater detail.

I have wanted a model of health care that could take into account the complexity of health and human being. It is only very recently that some health literature has been able to acknowledge the complexity of health promotion, which:

……often falls into a zone of complexity that leads to uncertainty about what works and consequently to a lack of agreement among policy makers and practitioners. Stacey stresses the need for non-linear and creative thinking when organizations are working at the edge of chaos and dealing with complex information to obviate issues emerging from lack of consensus (Baum, 2007, p. 90).

I admit I am attached to a model of health care that is able to show compassion and integrity to those in need and that can contain and hold the tragedy and sadness of some of life’s major transitions. In this way I am positioning my self in alignment with feminist ethicists.

Feminist ethicists argue that subjectivity and morality are inseparable and that what is needed is a radically different notion of the subject to that offered by “the strictly individualistic, rational, moral subject of modernist thinking” (Usher, 2000, p. 22) and to that offered by the patriarchal biomedical model. I have chosen feminist methodology to analyse health education and training in order to ‘do’ and ‘know’ health differently (Lather, 1991b). With this in mind, I will now move on to the major research aims and
questions. I will link these aims and questions with methodologies in order to provide clear connections between epistemologies, research questions and methodologies.

1.2 Aims

The aim of this research is to understand how health professionals are educated and some of the consequences of that education on the interaction between the patient and the health professional. More specifically:

1. The aim of this research is to understand the constructions of self of both the health professional and client/patient while engaged in training in health within the context of a neo-liberal dominated professional practice and to develop alternate perspectives on health care education and practice.

2. I also wanted to explore how practices to discover the truth about myself and my body affected my life (Lather, 1991b). This point works at the theory/practice juncture and explores the dilemma or tension between experience and authenticity in a socially shaped self (Usher, Bryant and Johnston, 1997). This point also works at the interface between the individual and the social (cultural, economic and political).

Understanding how health professionals are educated means to lay out some of the process of that education as understood by participants in the education. In this respect there is no separation between the researcher and the researched as both are involved in explicating their understandings of how health professionals’ are educated. The case studies demonstrate the researcher’s (my own) understandings of a training situation
within health in which I was involved. The case studies are situated within feminist
poststructuralist methodology within education, as described by Lather (1991a), and as
such are an attempt to lay out my own subjectivity within the field alongside the
textuality of discourses with which I was engaged. The relation between the researcher
within the field and the intertextuality of different discourses be they policy documents,
interview or questionnaire responses shows the territory or striations within which I was
engaged and stuck (Fox, 1999). This is the first step of engaging with research that aims
to be responsible and ethical; to demonstrate how my own subjectivity informs the
further analysis within the thesis. This situating of the researcher is linked to the question
of how I know what I know (epistemological analysis) and the second aim of the research –
how practices to discover the ‘truth’ about myself and my life affected my life. The
research questions, subsequent methods and analysis are heavily influenced by Lather
(1991a and b; 2007) who writes from a feminist poststructural methodological standpoint.

1.3 Major research questions

How is it that health professionals are educated? What are the consequences of that?
These questions assume a connectivity between the researcher and the researched as I
was also a health professional and underwent educational processes. I acknowledge that
the fact that I was a health professional mediates my knowledge of the subject and
therefore I engage with the processes of exploring and analysing the education of health
professionals reflexively (Fox, 1999). I carried out a great deal of reflexivity and
thematic analysis (Braun and Clarke, 2006) whilst writing the thesis and exploring the
topic through many different avenues including modernist approaches to health, poststructuralist analyses of health, spiritual and indigenous accounts of health practice. Some of these are written in Chapter Four of the thesis. Some are not due to constraints of space within an academic thesis. These thematic analyses were distilled into three subsections of technologies of self, power/knowledge and critical pedagogy. For further explication of the development of themes and subsections see Chapter Four.

Technologies of Self

- How do health professionals come to understand themselves and the work they do within health?
- How are health professionals incited through training to embrace a particular understanding of health and well-being?

Power/Knowledge

- What understanding do health professionals have of the power relations in their field?
- How is training a site for reproducing or challenging certain power relations in the health field?

Critical Pedagogy

- What pedagogies are being legitimized? What pedagogies are being silenced and marginalized? How does this determine what we know and teach about health and our body?
• To what extent can training act as a site for transgressive pedagogies and practices within the field?

1.4 Context of study

I decided to be inclusive in my study by gathering data and research papers from a wide range of health professionals and publications. As mentioned previously, there is little work on education of physiotherapists; the majority of work studying education in health professionals is concerned with nurses and doctors (WHO, 2006). Physiotherapists make up only a small minority of health workers therefore in order to provide a depth and breadth to the study I have included research and data from a broad range of health professionals.

The professionals directly involved as participants in this thesis include physiotherapists, occupational therapists, speech pathologists, dieticians, nurses and doctors. The different groups of professions are represented in different proportions – registered nurses account for 51.1% of the health workforce, other nurses account for 18.0%, doctors 14.2%, physiotherapists 2.6%, occupational therapists 1.3% and speech therapists account for 0.6% of the health workers in Australia (du Toit, 1996). In 1986, 83.8% of physiotherapists, 93.1% of occupational therapists and 96.2% of speech therapists were women (du Toit, 1996). Thus any analysis of the health professions cannot be separated from gender issues since there is a division of labour by gender in the workforce with women performing jobs that are an extension of perceived female roles. It has been
suggested that gender be integrated into the curriculum of health personnel as part of the training on the social determinants of health (CSDH, 2008). Furthermore, the division of labour is also hierarchical with the doctors (predominantly male) at the top and with the other professionals such as occupational therapists, physiotherapists and speech therapists having less autonomy (du Toit, 1996). The professionals’ knowledge reflects class, gender, and probably also race and ethnicity issues since most health professionals tend to be white, middle class women.

A profession is an occupational group that has autonomy, practices competently, and is accountable to the patient or client whilst also having a distinct body of knowledge to claim to and contribute to itself (Higgs, Titchen and Neville, 2001). The following characteristics of a profession demonstrate the social practice of learning about health:

A profession, then, is an occupation in which members have to obtain specialized technical skills based on a theoretical foundation extended by continuous research. A professional requires formal training at an academic institution. A profession also displays particular structural characteristics and a form of organization which is characterized by monopoly and autonomous control over professional activities, and the development of a professional organization (du Toit 1990, cited in du Toit, 1996, p. 277 – 278).

Professional (individual) autonomy is emphasized at the expense of social change. Each professional group described above draws on specific discipline knowledge grounded in the biomedical model and is usually referred to as a discipline. Each discipline is expected to contribute to its own knowledge base by the practice and research of evidence-based healthcare.
Evidence-based practice is the benchmark for good practice in healthcare but it is a deeply contested site of professional practice (Freshwater and Rolfe, 2004). Evidence-based medicine is deeply individualized and not able to take into account the wider social context of the patient or client. In spite of this, evidence-based healthcare is said to be a discipline in itself centred on evidence-based decision making about groups of patients or populations, which may manifest as evidence-based policy-making, purchasing or management (Muir Gray, 2001). More recently arguments have been made for use of a wide range of evidence gained from methodological plurality (Baum, 2007). The context of health professional training and practice is one characterized by fragmentation in terms of discipline specific knowledge that is underpinned by contested sites of evidence-based practice.

1.5 The neo-liberal context of health service delivery

The meeting place of the health professional and the client and or patient is embedded in the social, cultural and political sea of neo-liberalism. A brief explanation of neo-liberalism follows in order to provide the context for the rest of the thesis. Neo-liberalism is focused on the individual and encourages practices that promote freedom, choice and control (Harvey, 2005).

Neo-liberalism is in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices (Harvey, 2005, p. 2).
Here human well-being is directly linked to political economic practices. Health: human well-being: is therefore an economic matter. Most health professionals learn the WHO definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948) as the benchmark for health at some time during their training. This definition focuses on an individual’s health. But what the health professionals do not tend to see is that this individual health is related to the entrepreneurial self that is the product and target of neo-liberal reforms of rule (Petersen and Lupton, 2000).

This entrepreneurial self uses ‘health’ as a technique for governing one’s self and keeping one’s self in control as a dutiful citizen. ‘Health’ is seen as:

….a kind of shorthand for signifying the capacity of the modern self to be transformed through the deployment of various ‘rational’ practices of the self. Health is viewed as an unstable property, something to be constantly worked on. It is in the process of working on the self, and of demonstrating the capacity for self-control of the body and its emotions, that one constitutes oneself as a dutiful citizen, and hence as governable (Petersen and Lupton, 2000, p. xiv).

The neo-liberal discourses suggest that we have complete personal freedom in choosing health promoting behaviours with no mention that the range and kinds of practices taken up are imposed by the broader sociocultural and political context (Petersen and Lupton, 2000). These discourses are deeply gendered, although this is masked by reference to a disembodied subject.

Neo-liberal discourses also mask the moral judgements made in the name of science, and deny the real material effects of discrimination and the limiting of access to resources
such as health care (Petersen and Lupton, 2000). The political strategy of privatization, the key neoliberal policy, is:

….facilitated by the use of legitimated means – using the language of economic rationalism – in order to transfer public monies to the private sector, thereby creating the illusion of good management while further increasing inequality, enhancing private wealth, and reinforcing class-based health access (Grbich, 2002, p. 88).

Thus the government through its focus on efficiencies, throughput, and profit has increased inequities by encouraging an increasingly divided two tier system with those in greatest need being made more reliant on a stressed, overburdened and underfunded public health system whose only mechanism of coping seems to be emphasizing the individual responsibility of health. Health professionals play a major role in emphasizing this personal responsibility and the individual’s freedom to choose health-promoting behaviours. They are thus deeply implicated in the promulgation of neo-liberal policy.

Neo-liberalism has involved much ‘creative destruction’ since its emphatic inception in the 1970’s (Harvey, 2005, p.3): one aspect of this destruction could be seen as the constraining and limiting of the interaction that takes place between the health professional and the patient or client. Health professionals have been reduced to working as technicians as they carry out recipe like interventions and education on healthy lifestyles because of the dominance of economic rationalist managerialism (Grbich, 2002). They are also paradoxically involved in a highly moral, far-reaching invasion into people’s lives which has tended to be accepted uncritically by both the patient and the health professional (Petersen and Lupton, 2000). Neo-liberalism rules through experts and elites (Petersen and Lupton, 2000).
Having given a brief overview of neo-liberalism as it relates to health, I will now go on to outline the governmental policies in relation to health (informed by neo-liberalism) in Australia. Here, health has been rationalized and the government policies show this through their determination to reduce the burden of disease (cost) in the community. Most of the burden of disease comes from target groups such as low income earners, ethnic minorities, single parent families, the aged, smokers and drinkers (Grbich, 2002). When working with people from the target groups, the constructs that the health professionals and the patient or client have between them are rooted in the neo-liberal rhetoric of freedom, choice, self-control and individualism.

The inequity in health status between target groups and advantaged groups of people reflect the global picture in health. The health status of the global population has experienced huge advances in human well-being alongside extreme deprivation and unprecedented reversals in life expectancy (WHO, 2006). The gap in health between the rich and poor has widened as some nations and people have experienced a collapse in life expectancies, with some of the poorest countries having half the life expectancy of the richest (WHO, 2006).

In Australia, rural and remote health is generally worse than urban health on all indicators (Australian Bureau of Statistics [ABS], 2006a). For example, in selected health risk behaviours, the percentages of people engaging in so called risky behaviours increased the further away the people lived from major cities in Australia (ABS, 2006a). Furthermore, whilst Australian males can generally expect to live 70.9 years of life
without reduced functioning, and females can expect to live 74.3 years, thus placing Australia’s life expectancy amongst the highest in the world (ABS, 2006b), this is not the case for all Australians. There is a significant divide between the Indigenous and non-Indigenous health status, and between the most and least disadvantaged areas. The life expectancy for Indigenous males born in 1996 – 2001 is 59.4 years and that for females is 64.8 years after adjustment for the underestimate of the number of deaths reported as Indigenous (HealthInfoNet, 2006). Indigenous people overall are almost twice as likely as non-Indigenous people to report their health as only fair or poor (ABS, 2006c).

In Western Australia specifically, mortality rates among males and females from areas defined as the most disadvantaged are significantly higher than those from the least disadvantaged areas for most age groups and both genders (Department of Health [DOH], 2005). Socioeconomic disadvantage is highest in remote areas of Western Australia. Nationally, in disadvantaged areas, males and females aged 25 – 64 years experience mortality rates 75% and 52% higher respectively than those people in the least disadvantaged areas in 1998 – 2000 (DOH, 2005). In Western Australia, mortality rates in the disadvantaged areas are 56% higher for males and 26% higher for females in comparison to those from least disadvantaged areas of the state (DOH, 2005).

However, it is important not to conflate the effects of ‘living in a remote area’ and the effects of ‘being Indigenous’ (Australian Institute of Health and Welfare [AIHW], 2005). With some rural health issues, it is suggested that they have more to do with Indigenous status rather than rurality or remoteness. But in other health issues, remoteness is
suggested to play a substantial role regardless of the Indigenous status of the population (AIHW, 2005). Most of the land in Western Australia is considered to be either very remote or remote with only a relatively small area in the south-west considered to be rural, extending from just east of Albany to north of the metropolitan area, but not including an area around Walpole. Since Indigenous people make up 44% of the population of very remote areas and 13% of the population of remote areas i.e. most of Western Australia, the life expectancy for remote and very remote areas is less than that in major cities (AIHW, 2005).

However, there are major difficulties in producing an accurate picture of Indigenous mortality in Australia due to the incomplete identification of Indigenous status in death records and the ‘experimental nature’ of the population estimates (ABS online doc 2005). This is an example of the ‘technologies of invisibility’ whereby people become absent in epidemiological data which allows further domination through the power of statistical representations, particularly through medico-forensic-political language (Biehl, 2005). So whilst the picture is not crystal clear because it too is obscured and dominated by technologies of invisibility, the health status of people in Western Australia can be seen as a microcosm of the global picture whereby some people have experienced huge advances in human well-being whilst others experience extreme deprivation and much lower life expectancies (WHO, 2006).

Life expectancies are seen as a reflection of engagement with ‘risky behaviour’ by health professionals who are determined to share their specialized knowledge in order to reduce
those risky behaviours (Petersen and Lupton, 2000). Engagement in ‘risky behaviour’ is higher for Indigenous people in remote areas than for the national average of selected health risk behaviours (ABS 2004 – 2005, ABS 2006). For example, Indigenous people have a percentage of daily smokers of 52% in remote and 49% in non-remote areas (ABS, 2006c) compared with 19.9%, 23.0% and 26.2% in the major cities in Australia, inner regional Australia and outer regional Australia and other areas (ABS, 2006b). In spite of the evidence that smoking is linked to higher rates of illness and death in Aboriginal people (DOH, 2005) by the institutions concerned with health and welfare there is no in-depth discussion by these institutions of the complexities surrounding engagement with risky behaviours.

Consequently the health professionals who are trained to deliver the messages of healthy living are unprepared for the work they have to do. For example, the ‘New Vision’ for community health services (those particularly relevant in rural and remote areas) is to ‘provide a new direction with a focus on an effective prevention and early intervention and a broad understanding of health and its determinants for individuals, families and communities in Western Australia, with particular benefits for those at risk’ (HDWA, 2000, p. 2 – 3). Health professionals in these areas have an added difficulty since they are responsible to people over large areas and practice with limited resources.

Supply of health workers is less in regional and especially remote areas of Australia (AIHW, 2005). It was usual for most medical and allied health staff to work longer hours in remote and very remote areas. The age of different health professionals showed a
varied picture with only the average age of podiatrists and physiotherapists decreasing with increasing remoteness (AIHW, 2005).

So the picture for the vast majority of Western Australia, except for a relatively small corner in the south west including metropolitan Perth, is of increasing socioeconomic disadvantage with rurality and remoteness, an increase in engagement in risky behaviours, higher mortality rates and lower life expectancy, and a greater proportion of Indigenous people who have a low life expectancy (58.5 years (males) and 62.7 years (females) (HealthInfoNet, 2006) compared to the national average of 70.9 years and 74.3 years respectively (ABS, 2006b)). There is a divide in Western Australia between the rich and poor, or advantaged and disadvantaged, that is reflective of the global situation, along with a similar inability to sustain a health workforce in rural and remote areas (SARRAH, 1999) that might improve people’s chances of survival and well-being.

This picture develops in the context of a government that is intent on health reform, fuelled by fear of escalating costs of health service provision, an ageing and growing population, widening gaps in health status and health access between the wealthy and poor, and between the Aboriginal and non-Aboriginal population, and a shortage of health workers, amongst other reasons (Report of the Health Reform Committee [HRC], 2004). The current health reform focuses on health promotion and prevention of diseases, both of which involve a substantial educative role for health professionals, in order to reduce the growth in demand for hospital emergency care and beds, since “much of the demand for hospital services is for conditions that are clearly preventable with
appropriate health promotion and preventive strategies” (HRC, 2004, p. v). Furthermore, health professionals are expected to adhere to “clinical guidelines to bring greater consistency to clinical practice” (HRC, 2004, p. vi). These comments have a strong disciplinary tone. Whilst acknowledging the inequities in health status and in service provision, the recommendations of the report focus on a neo-liberal approach to reform without acknowledging that this approach may in itself be increasing the inequities it so desires to change. For example, Recommendation 1 in the document “The Need for Change” is as follows:

- Promote and protect the health of the people of Western Australia
- Reduce inequities in health status
- Provide safe, high quality, evidence based health care
- Promote a patient centred continuum of care
- Ensure value for money
- Be transparent and accountable
- Optimize the public/private mix
- Be financially sustainable, and
- Have a sustainable workforce (HRC, 2004, p. 20)

Whilst the intention is to reduce the inequities in health status and provide a patient centred continuum of care, the majority of points are directed towards a neo-liberal reform of the health service in order to reduce costs which could actually increase the inequities as suggested by Grbich (2002), Petersen and Lupton (2000) and Harvey (2005).

Moreover, those with the worst health status are then targeted by these health reforms in order to reduce the cost to the state. Recommendation 2 of the document shows the targeting of ‘at risk’ groups.
Recommendation 2 – Population Health, Primary and Community Care
A major, co-ordinated, long term health promotion program which has an integrated lifestyle approach to prevent cardiovascular disease, cancer and diabetes should be implemented. This program should include a particular focus on Aboriginal communities (HRC, 2004, p. 24).

The majority of the rest of the recommendations (4 – 86) address infrastructure and governmental processes, and include the promotion of evidence-based clinical guidelines for practitioners (HRC, 2004). Nowhere does the report recommend examining the inequities in health in terms of the societal disadvantage that is associated with neo-liberal reform. The major emphasis is on individual behaviour change and the role of the health workforce in promoting health and preventing disease.

Health workers are employed to address the outcomes of major diseases or causes of death such as diabetes, cardiovascular disease and cancer but are not encouraged to look beyond the recipe like application of techniques in the name of ‘care’ of the patient. Thus the workers are trained to see the disadvantaged through a veil of neo-liberalism, with concepts such as individual freedom, choice and self-control playing a major role in the health education rhetoric. There is no consideration that the healthy subject position might be a cultural production or an enticement to greater self-regulation, or that self-control and self-regulation themselves might be a trait that is produced in relationship (Riggs, 2005) as opposed to the idea that it is something that all individuals inherently possess. The picture of widening disparity in health status and access to health services is complicated by the crisis in retaining health workers across the globe, including Western Australia.
1.6 The training context

There is currently a crisis in human resources within health services across the globe (WHO, 2006). The chronic shortage of well-trained health workers is felt most acutely in countries and areas within countries, such as rural and remote Australia, that need them the most. For many reasons, “countries are unable to educate and sustain the health workforce that would improve people’s chances of survival and well-being” (WHO, 2006, p. xiii). The investment in training of health workers is seen as a key issue in sustaining the workforce – both the loss of that investment when workers leave, and the cost of that investment in terms of time, money and hope (WHO, 2006). There is no consensus on how to address the human resource crisis in health services across the world but it is clear that it is a key problem in inequitable access to health services particularly in poor areas and countries.

Taking into account the crisis in health service provision, both in terms of human resources and in terms of funding, inequitable access and inequitable health status, the time has come to look at the health situation differently. In contemporary Western societies, the health status and vulnerability of the body are central themes of existence (Petersen and Lupton, 2000). If these central themes of existence are so important to us, then why have we not managed them in a way whereby people who are ill are seen as deserving of the best health care, instead of looking at ways to cut costs and reduce the health workforce to technicians? Little attention has been paid to analyzing the basic principles, discourses and practices of public health reform from an epistemological
position so that health professionals, who have remained impervious to any such analysis and have accepted the fundamental tenets uncritically, can continue to intervene in private lives and undermine established rights in their role as an ‘expert’ (Petersen and Lupton, 2000).

I will now give a brief overview of the education or training situation of health professionals in Australia in order to identify the major issues. I have concentrated on the field of physiotherapy since this is where my experience lies. The main emphasis in physiotherapy undergraduate education is in attaining competency (safety and effectiveness) in clinical skills and in gaining the knowledge required in the fundamental basic sciences such as anatomy, physiology, biomechanics, psychology and sociology (Crosbie, Gass, Jull, Morris, Rivett, Ruston, Sheppard, Sullivan, Vujnovich, Webb, Wright, 2002). Since there has been an exponential growth in the knowledge particular to the physiotherapy profession, especially in terms of evidence-based practice, there is concern from the Schools of Physiotherapy nationally that it is not possible to cram in every piece of information necessary to graduate as a physiotherapist (Crosbie et al, 2002). For example, they cite the fact that there are 2300 papers concerned with Randomised Clinical Trials (RCT’s) alone which is vital when considering evidence-based practice.

The main issue is that there is not enough time to cover everything in the undergraduate curriculum and that perhaps one way ahead is to identify “absolute ‘core’ competencies and attributes we desire in our graduates” (Crosbie et al, 2002, p. 7). Undergraduate
training takes place within a transmission model of learning much like Friere’s (2000) banking metaphor of learning. There is no mention of a critical approach to learning, which is a shame because this could help in the “judicious pruning” of “dead wood” that the authors believe is necessary (Crosbie et al, 2002, p. 6). They acknowledge that there is a shortage of physiotherapists in regional, rural and remote settings and in areas such as gerontology but fail to carry out any epistemological inquiry into why this may be so. There is an absence of any in-depth analysis of the complexity of health service delivery, so the status quo is maintained with the physiotherapists needing to be experts in their field once they graduate.

From reading the few papers that discussed the delivery of undergraduate education in physiotherapy, the main issue for me seems to be an absence of any critical inquiry particularly in relation to the social and political context in which the physiotherapists will be working. The focus is always on evidence-based practice (Moseley, Herbert, Sherrington, and Maher, 2002) with physiotherapists believing that this gives them the mandate to intervene in peoples’ lives. Critical appraisal is seen as akin to evidence-based practice in medicine (Norman and Shannon, 1998) and also in physiotherapy. Thus any idea of being critical is only concerned with choosing the most effective and efficient treatment technique, not with examining the social and political context in which the health professionals work as in critical pedagogy.
There is “a lack of sound scholarly work on Australian physiotherapy educational practices” (Chipchase, Dalton, Williams, and Scutter, 2004, p. 133). The authors believe that there are three main reasons for this:

- The focus on clinical practice for research
- The perceived risk of lowering educational standards if changes were made to educational practices, given the complexity of educational intervention
- The lack of collaboration between different universities makes the sharing and comparing of different models of educational practices difficult

Chipchase et al (2004) believe that educational practices in Australia have been based on intuitive and historical beliefs about what promotes effective learning. They want greater research into educational practices as they see these as having a significant impact on the physiotherapists’ practice and on health outcomes themselves. Along with greater educational research, they also want more collaboration between the Australian universities and an acknowledgement of “the complexity of the learner/teacher/client interaction” and an acceptance “that evaluating educational outcomes in terms of grades and student satisfaction alone is unlikely to assist in understanding the best educational practice” (Chipchase et al, 2004, p. 134). Whilst there is an acknowledgement here of the complexity of the learner/teacher/client interaction, the paper stops short of mentioning a critical approach to learning that includes an analysis of the social and political context of health care, and a view of pedagogy as constitutive of power relations (Gore, 1995a).
It is interesting to note that along with the emphasis on clinical practice and the absence of any critical approach to learning, there are signs that the occupation of physiotherapy is attached to the power that such training brings. For example, a study of undergraduate Australian physiotherapy students found that they ranked the prestige of their profession highly, allied with the ‘big three’ of doctor, judge and solicitor (Turner, 2001). For the level of education, level of social standing, level of usefulness, and level of responsibility, students ranked physiotherapy within the top three occupations. Physiotherapy students in England were more likely to rank physiotherapy in the middle of a range of professions ranging from cleaner to judge. This is interesting because it is a direct reflection of the training and entrance requirements. Physiotherapy students, because of the high score required for admission to schools of physiotherapy, see themselves as more allied to the medical fraternity than to the nurses who do not have such high entry requirements.

From the inception of training in the forerunner of what was to become physiotherapy in 1906, the Australasian Massage Association (AMA) sought allies in the medical fraternity (Bentley and Dunstan, 2006). The curriculum was developed by medical professors of anatomy and physiology in order to gain acceptance of the profession by the medical establishment. This acceptance was of paramount importance to the profession and the struggle to gain acceptance is described by the Australian Physiotherapy Association (APA) as “the tensions, pressures and contentious times regarding the medical profession, and how the physiotherapy profession was brought from beyond the mainstream to a place of legitimacy and inclusion into the medical pantheon” (APA,
2006, p. 1). This desire to be in the ‘temple of the gods’ along with the medical doctors is an undercurrent theme within the physiotherapy training as the profession sees itself as having to strive for a legitimate place within the medical hierarchy.

Evidence-based practice, or evidence-based medicine, is a core attribute of the medical training (Norman and Shannon, 1998; Freshwater and Rolfe, 2004; Conroy, 2001). Likewise, physiotherapy trainings emphasize evidence-based practice. However, the evidence base for much of physiotherapy practice is fragmented and missing; thus while undergraduates are schooled in the importance of evidence-based practice, the reality that the evidence is not there can lead to confusion and, ultimately, disillusionment with the profession. Evidence-based practice is a deeply contested site (Freshwater and Rolfe, 2004). This is one way in which the training constructs physiotherapists (evidence-based practitioners) in order to be included in the medical hierarchy, which only sets up the physiotherapists and the patients or clients for difficulties later on.

Physiotherapy training is developed from the medical model. Most of the literature about education and training in the health professions is from the fields of medicine and nursing (WHO, 2006). Most of the literature on critical pedagogy (in relation to pedagogy as constitutive of power relations) is published within the nursing academy. Little if anything on critical pedagogy is published within the field of physiotherapy and physiotherapists are generally not encouraged to be critical (Germov, 2002). Within the health hierarchy, there are differences in the level of critique encouraged in the training which may reflect something about the position of each profession within that hierarchy.
The emphasis on clinical skills and evidence-based practice to the detriment of critical pedagogy (pedagogy as constitutive of power relations – Gore, 1995a) means that the health professionals generally are very busy doing, and trying to ‘do’ it competently, safely, effectively and efficiently, as per the neo-liberal philosophy. This has been called “the doability of medicine” (Kickbusch, 2006 cited in Baum, 2007, p. 91). Health professionals are in danger of becoming technicians as the moral and ethical aspects of their work are forgotten and yet they are taking an increasingly moral stance within society as they proscribe people’s behaviour on a daily basis. I have wondered whether there is a link historically on the colonization of Australia as a penal colony with its punitive measures and the incitement of women to act as ‘God’s police’ (Summers, 2002) to the excessive moral emphasis on individual responsibility and behavioural change by mainly women health workers.

1.7 Thesis overview

I will now go on to provide an overview of the thesis in terms of the following chapters. Using a critical pedagogical approach to analyzing training of health professionals and professional practice, I have drawn on feminist poststructuralist theory (Lather, 1991a and 1991b, Weedon, 1987) to develop a theoretical or conceptual framework in Chapter Two. This framework travels through predictive, understanding, emancipatory and deconstructive lines of inquiry in education and health (Lather, 1991b) in an effort at epistemological variability (Baum, 2007; Galvin, Emami, Dahlberg, Bach, Ekebergh, Rosser, Powell, Edlund, Bondas and Uhrenfeldt, 2008). Here the main issues in training
are discussed in the context of the political and social constraints of practice since in poststructuralist theory the texts we read are always located in and constructed by culture and history, etc (Lather, 1991b).

Poststructuralist theory draws on deconstruction whereby “the goal of deconstruction is to keep things in process, to disrupt, to keep the system in play, to set up procedures to demystify continuously the realities we create, to fight the tendency for our categories to congeal” (Lather, 1991b, p.5). The process of deconstruction aims to focus on discourses in order to identify the components of those discourses and also the silences in the discourses – the gaps and omissions – so that we can begin to try to understand what it is that constitutes and mediates the experience of the health professional and the client and patient.

Chapter Two summarises the dominant theories promoted in the field of education and health along with the constructs implicit in these theories related to self, identity, agency, power, learning and health in order to demonstrate the local and contingent preoccupation with control, that is, how the curriculum is enacted. The dominant theories chosen were those included in two local university curricula concerned with training health professionals. In addition to demonstrating the local dominant theories I have also included more marginalized theories of health in order to demonstrate theoretical and methodological pluralism (Baum, 2007) and to demonstrate the inclusion of differences (Fox, 1999). I have included epistemological variability (Baum, 2007; Galvin et al, 2008) in order to make links between the different disciplines of health and education,
and also to establish any unity or similarities present at the level of study of these fields. This chapter sets up the thesis for an interdisciplinary study of professional practice.

Chapter Three of this thesis discusses the methodology and methods used to gather data. The methodology is firmly situated within feminist poststructuralist theory and a critical pedagogy approach to learning and theory. Feminist poststructural theory is concerned with the principle of situated knowledges – “the idea that the context in which knowledge is produced makes a difference to the product” (Hollway, 2007, p. 121). Learning and the professional self cannot be explored without reference to four threads – situated knowledges, power relations, individual-society dualisms and agency or structure in the explanation of action (Hollway, 2007). Chapter Four is concerned with connecting knowledge claims with methods, epistemology with ontology, and how the knowledge presented in this thesis is a ‘re-presentation’ (Fox, 1999) of how health professionals are educated. The knowledge produced within this thesis resonates with that described in critical health psychology – phenomenological-discursive model, qualitative methods, meaning, morality, experiences of health and illness, contextual, relational and understanding (Crossley, 2000).

Chapter Four is an exploration of my experiences and praxis as a learner and teacher within the health field. This chapter demonstrates my reflexivity and as such it is a form of critical ethnography (Foley, 2002), a looking back on myself in the field as I grappled with different academic theories about health and learning. I explore my praxis during this time in relation to different frameworks and lenses I was working with which have
subsequently informed this thesis and the knowledge making I have been concerned with here. I follow the disjunctures I experienced at this time in rural W.A. and explore theory making in relation to the binary of individual versus social determinants of health. Rural health is so complex that I have drawn upon my experiences to try to tease out elements of the complexity as I see myself as an example of the interface between or the meeting place of the individual and the social.

In Chapter Five I take these themes further in relation to their juxtaposition with issues of self, identity and agency by looking at three case studies of professional practice training with which I was involved over the period 1998 – 2001 in rural W.A. I completed the Graduate Diploma in Adult and Tertiary Education in 1998 and these three case studies are used to foreground the difficulties I experienced in trying to bridge the two cultures of health and education. The conceptual framework is developed as a way of naming the difficulties that I experienced.

Chapter Six goes on to present and discuss the results of the interviews and questionnaires. The results are discussed in terms of the research questions shown above and show that there is a high degree of congruency in the different health professionals’ responses particularly in relation to constructs such as health and control. This is surprising given the diverse groups and locations of the health professionals involved. However, most had difficulty articulating relations of power and critical pedagogy had generally not been encouraged in their undergraduate training. If critical pedagogy had been named during a participant’s training, it was generally subverted and turned in on
the health professionals themselves in order to enforce greater self-regulation and self-policing. These concepts are then discussed further in Chapter Seven.

Chapter Seven discusses and develops the constructs identified in the results. The implications of a health service delivery workforce that is entrenched in heightened self-policing, disembodiment and isolation is explored as it interfaces with the health rhetoric of increased individual responsibility for health. The constructs of freedom, choice and the individual self within the (neo-liberal) training are interfaced with the data in order to tease out the effect of neo-liberalism. Notions of health and well-being and what it means to be both health professional and client or patient in such a system are laid out in the health care landscape.

Chapter Seven also discusses the implications of the results in terms of professional practice for health professionals. The journey of the health professional is believed to require a reinscription by drawing on critical pedagogy in order to tease out the impact of neo-liberal rhetoric. The relevance of the study and contributions to the field are discussed along with ideas on how to promote a critical pedagogical approach to health care given the constraints existing currently within the field. Recommendations for further study are included along with the constructs that need further deconstruction and analysis.

Chapter Eight concludes the thesis with a brief review of the main issues and the outcomes of the research. This thesis has shown that analyzing the training of health
professionals from a poststructuralist perspective has opened up a rich and rewarding field of inquiry. Whilst it is impossible to say at this stage what effect such a field of inquiry might have on outcomes for patients or clients, one could imagine that some sort of transformation of health service delivery must be possible. It seems as though by analyzing causes and instances of oppressiveness within the training of health professionals, we do indeed have the possibility of becoming more than who we are (Foucault, 2004), and of moving beyond the contingencies that have made us what we are (Kendall and Wickham, 1999).
CHAPTER TWO

Sites of change in educational and health theories

In chapter one, I mapped out the context for studying how health professionals are educated and some of the consequences of that education. There is little research evidence to support the direction in which health professional training is currently evolving through evidence-based practice (Freshwater and Rolfe, 2004; Stagnaro-Green, 2004) into a risk management model of health (Peterson and Lupton, 2000). It seems more likely that this dominant model of service delivery is being driven by neo-liberal government policy that has at its core the notion of the autonomous self, able to control his or her own health related behaviours. The lack of evidence that this approach is effective, the proliferation of risk management models of service delivery and the notion of the neo-liberal autonomous self are implicit in how health professional curricula are enacted and yet these assumptions are rarely explored in mainstream texts about health curricula. This leaves major gaps in theorizing about health professional curricula. Moreover, although there is movement afoot to include social determinants of health into health professional training in order to reduce health inequity and address the social gradient of health (CSDH, 2008), there is little analysis of relations of power and core constructs in use in such a proposed training.
Both education and health have the neo-liberal individual as the dominant site of change alongside the less dominant theorizing about social determinants of health and the social construction of the individual in education. This chapter reviews the main theories in use in education and health that therefore form the curricula for change or learning, in order to tease out the complexities of the health and education experience. These curricula mediate the experience of health and education.

The curriculum is the conduit in the relationship between health provider and client and between the educator and educated. The context for that relationship is different in health and education fields. Educational theories have been transposed uncritically into the health field without examining the effect of context on application of theories. Educational theorists tend to assume that education takes place within groups so that there are group effects impinging on the individual’s (both educator and educated) experience of the theories. In spite of the health service drive towards a more consultative and population based approach to health care, most health encounters tend to take place within a more personal individual context where personal experiences and narratives assume a greater visibility. Therefore in terms of professional practice the meeting place of the health professional and client or patient is more likely to be one-on-one. For educational theories whilst the discourse may be based on the individual the theories are enacted in group situations where there is perhaps less opportunity for relationship.
However, since both fields focus on the individual as the site of change and learning both construct the individual as autonomous and capable of change, without taking into account the particular context and constructedness of the individual. By reviewing some of the theories in use in education and health, this chapter becomes a discussion about the implicit curriculum which is concerned with the site of change.

Studying ‘how’ curricula are enacted means studying what kinds of learning occur as a result of the curriculum. Many more and different kinds of learning occur than just the intended or explicit curriculum – “student’s learning is a complex interaction between teachers and students, materials and experiences, institutions and society, time, place and intent” (Tripp, 1994, p. 22). The explicit curriculum is that found in curriculum documents – it is the content: the core, propositional and predictive knowledge. ‘How’ curricula are enacted means exploring the implicit and meta-curriculum by looking at the methods of teaching/learning, management and relationships.

The implicit curriculum is learning that occurs without having been directly and intentionally planned, taught or learned. It consists of various messages the meanings of which are inferred and subconsciously absorbed by learners and teachers. What is learned of the implicit curriculum forms a ‘naturalised’, unchallenged and taken-for-granted view of the world.

Some of the implicit curriculum is produced by the formal class and school rules (such as only speaking when told to do so) and informal routines (such as girls taking the lunch orders to the canteen and the boys the class roll to the principal’s office). Much of the rest of the implicit curriculum is produced by the meta-lingual messages of formal and informal discourse …. (p. 38).

In general, most of the implicit curriculum concerns the development of learners’

- Social roles (particularly with regard to gender, class, age, and ability);
- Personal self image (such as confidence, diligence, motivation, interests, creativity and aspirations); and
- Behaviour (when to talk, about what, to whom, and how) (Tripp, 1994, p. 39)
The professional practice of health professionals, in particular the performance of health and health professional identity, is informed by the implicit curriculum. The implicit curriculum is formed by rules that delimit the sayable (Kendall and Wickham, 1999) and these will be explored in detail in the case studies in chapter seven.

The meta-curriculum refers to what is learned implicitly by students from learning the health curricula. A curriculum can be encoded with an implicit curriculum (what is inscribed on the learner in practices and rituals of healthcare) and a meta-curriculum (what the learner learns by participating with the curriculum) (Tripp, 1994). There are major differences in what is learnt at the meta-curriculum level depending on how health is framed by the curriculum. The current neo-liberal approach to health seems to produce a meta-curriculum statement that ‘health is a simple matter’, and that one only needs to change one’s behaviour when one finds out the required knowledge to do so. The meta-curriculum is believed to powerfully influence the learner’s remembered learning and is therefore important in determining the residue of what people think about health such as where the responsibility lays for health. It maybe that part of the residue is embodied as a feeling or felt sense, such as shame if one does not lead a healthy lifestyle. The table below, adapted from Tripp (1994), shows how the different elements of the ‘how’ of curricula fit together.
Table 1. Curriculum phenomenon with an emphasis on the ‘how’ of curriculum

<table>
<thead>
<tr>
<th>Question</th>
<th>Categories</th>
<th>Phenomenon</th>
<th>Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>What?</td>
<td>Content</td>
<td>Skills, facts, concepts, experiences, attitudes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Materials</td>
<td>Books, worksheets</td>
<td></td>
</tr>
<tr>
<td>How?</td>
<td>Methods</td>
<td>Learning/teaching Management Relations of power</td>
<td>How is curriculum encoded?</td>
</tr>
<tr>
<td>What kinds of learning occur as a result of curriculum?</td>
<td></td>
<td></td>
<td>Positivist – Explicit (core, propositional and predictive), Written down. Postpositivist – Implicit and meta-curriculum. Read and inscribed through practices</td>
</tr>
<tr>
<td>When?</td>
<td>Context</td>
<td>Historical, physical, psychological and social, macro and micro environments</td>
<td></td>
</tr>
<tr>
<td>Where?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who?</td>
<td>Learners/Teachers</td>
<td>Individual differences, peer group values, power professional and personal history, values, experiences, intentions, knowledge, abilities</td>
<td></td>
</tr>
<tr>
<td>Why?</td>
<td>Rationale</td>
<td>Learning theory Aims of education View of subject</td>
<td></td>
</tr>
</tbody>
</table>

The explicit or core curriculum (also referred to as propositional, theoretical or scientific knowledge, Titchen and Higgs, 2001) is the dominant form of curriculum in health professional training at the moment. Learning in the core curriculum of scientific knowledge is dominated by evidence-based practice even though there is little researched evidence to justify this domination (Freshwater and Rolfe, 2004). The generation and legitimation of knowledge in the core curriculum takes place within a positivist
framework. That is, the knowledge is posited on the idea that it is possible to predict events and an individual’s behaviour. Within health professional training this type of knowledge generation and legitimation is generally all there is within the core curriculum.

This thesis analyses ‘how’ the curriculum of health professionals is enacted through relations of power, which are part of the implicit curriculum. In order to analyse relations of power I need to draw on postpositivist forms of inquiry (including the work of Foucault, 1973, 1977, 1980, 1988): forms of inquiry that keep relations of power and the construction of self at the forefront. Postpositivist inquiry (Lather, 1991a and b) keeps the constructed nature of knowledge and self at the forefront of its analysis through deconstruction. Texts or discourses are thought to provide the link between knowledge and power, and refer to ways of thinking and speaking about reality (Cheek, 2000).

Thus, a discourse consists of a set of common assumptions which, although they may be so taken for granted as to be invisible, provide the basis for conscious knowledge.

Discourses create discursive frameworks which order reality in a certain way. They both enable and constrain the production of knowledge in that they allow for certain ways of thinking about reality whilst excluding others (Cheek, 2000, p. 23).

Certain discourses and therefore knowledge are promoted and gain ascendancy over others. For example, in the health field of training, the scientific biomedical model of health is dominant and forms the primary discourse that informs health workers’ understanding of their practices. Thus both the existing structures of social institutions such as health and the subject positions offered for workers within these structures
operate primarily through the language of the dominant discourses through which knowledge is produced (Weedon, 1987).

The production and legitimation of knowledges about adult learning are important to review both because of what they have to say about the self and because these theories have been transferred uncritically at times into the health field to promote learning about health. I am therefore making bridges between the disciplines of education and health in order to identify unifying principles at the level of study of these fields, even though at the level of practice of these fields or disciplines the knowledges may seem thoroughly fragmented (Tripp, 1994). One such unifying principle at the level of study of these fields is in terms of the implicit curriculum, because relations of power and the constructed nature of knowledges and the self are reproduced through the curriculum in both education and health.

How knowledge is generated or legitimated in education and health determines the relationship between the subject and the object, and between the individual and the structural or social (Foucault, 1973). In the explicit curriculum, positivist discourses construct a type of subject that produces a knowledge of individuality or self, both normal or abnormal, and conforming or non-conforming (Foucault, 2000). This knowledge originated in social practices of control and supervision [surveillance] (Foucault, 2000). Positivist discourses are concerned with issues of what is normal, who conforms or adheres to medical advice, and invite practices of supervision and control.
These practices are inscribed implicitly in the practice of healthcare professionals and have resonances in educational theories of adult learning.

While the core explicit curriculum may be positivist in origin its effects, or how the curriculum is encoded and therefore what kinds of learning occur as a result of the curriculum, can only be decoded by drawing on postpositivist forms of inquiry. For example, in all constructions of self there are two structuring binary opposites: individual/social and voluntarism/determinism (Usher, Bryant and Johnston, 1997). The positions taken up by each of the teacher/learner players in the curriculum demonstrate the constructed nature of the relationship. The relationship between the teacher/learner can be seen as mirroring the relationship between the health professional and the client in terms of power relations. This review of the literature on learning starts with the positivist predictive forms of inquiry and moves on to postpositivist forms of inquiry in order to demonstrate the implicit constructed nature of the disciplines of education and health.

The theories reviewed in this chapter are chosen in order to make explicit the constructedness of the theories and the individuals constructed by them. The theories are reviewed under different headings of ‘predictive’, ‘understanding’, ‘emancipatory’ and ‘deconstructive’ lines of enquiry in order to draw on Habermas’ three categories of human interest that underscore knowledge claims and Lather’s (1991b) category of ‘deconstruction’. While I do not want to create ‘categories that congeal’ (Lather, 1991b), I believe it is helpful to use such headings in order to give some structure to the literature.
review and analysis. However, it must be said that some learning theories apply across the different categories and it is hard to differentiate the theories completely into a single framework.

I have included most of the learning theories within the predictive category since predictive lines of inquiry are applied to predict a learner’s behaviour without necessarily understanding the specific social and personal contexts in which learners learn. The understanding category includes theories that I see as attempting more to understand the process of learning, with a fleshing out of the relational aspects of learning. The emancipatory category of enquiry or pedagogy includes critical pedagogy with its analysis of power relations but it is not until I reach the fourth category of deconstruction that I believe any in-depth attempts are made at understanding the complexity of learning in social and personal contexts.

I believe it is important to keep all the theories in play when attempting to understand both how learning takes place and the construction of the learner. I hold that all these theories are useful and they all add to understanding what learning involves. There is a necessity for methodological pluralism and epistemological variability (Baum, 2007; Galvin et al, 2008). There is a potential for seeing a finality in any theory, when that is taken up as ‘the solution’ and used without reference to anything else.

The biomedical model, the dominant model of learning in health training, is situated very much in the prediction category of knowledge generation and legitimation. In contrast,
this thesis is situated in the emancipatory and deconstructive categories of knowledge generation and legitimation with emphasis on critical pedagogy, poststructural and postmodern analysis. All emphasize the continual critique of assumptions and knowledge so that learning is kept continually in process. Table 2 summarizes these different approaches to knowledge generation and legitimation in a continuum from epistemological to ontological forms of inquiry. This continuum forms the conceptual framework on which the discussion of theories of learning and health takes place here: from a focus on knowing to a focus on being.

The following discussion of theories of learning and health is not meant to be a complete and exhaustive review of all theories since there is not the room to be inclusive. A decision had to be made and a line drawn on what to include and what not to include. In the materialization of this thesis, theories included were based on the content of two local universities’ health professional curricula. Thus the theories reviewed are selective and demonstrate a particular bias in the field of health towards predictive learning and control. However, because the thesis itself is located in a feminist poststructuralist account of learning and therefore tried to integrate and make connections within different disciplines, the following discussion also draws on theories that are not mainstream in health curricula.

The difficulty of structuring a literature discussion of this scope without positioning the thesis or myself exclusively as positivist or postpositivist at this stage is reflected in the size of this chapter. When downsizing the original writings to fit university
requirements, a form of subjectivity was performed. In order to continue to be both/and (individual vs social, positivist vs postpositivist), integrative, and acknowledging of differences in theoretical positions, some theory had to be excluded. The knowledge making that was included could only be partial and perspectival and yet it was also intertextual (Fox, 1999) in that it related different theories or discourses to others. As part of this process I had used a metaphor of a labyrinth to journey around the four quadrants of knowledge making which had been part of my sense making and relating the different quadrants of predictive, understanding, emancipatory and deconstructive forms of human inquiry to each other and myself. The journey had been important: “Using the notion of framing to explore this further, subjectivity comes to be seen as something dynamic, always in flux as intertextual readings contribute to a continuous process of becoming-a-self” (Fox, 1999, p. 29). The intertextuality of this chapter informed the knowledge making of this thesis and research process and may have had some impact on participant responses. The chapter still gives a representation of the journey of intertextuality but the dynamic nature of the ‘review’ perhaps needs to be emphasized. The movement of the literature reviewed was from a focus on knowing as a form of control to a focus on being or becoming – a movement from how I know what I know (knowledge claims) to how I am (a knowing).

In the literature review that follows I first focus on what I see as the more simplistic learning models (predictive) that discuss one aspect of a learner’s being such as behaviour or motivation (section 2.1). I also include in this section understanding models of learning and health such as sociocultural theories of learning and humanist and
affective models of learning, since I have found it hard to separate out the application of such theories in a predictive manner from their origin as attempts to understand learning and the relational processes contained therein. Section 2.2 discusses understanding models of learning from the point of view of understanding the relational contexts of teaching and alludes to humanist and affective models but its main focus is on relational pedagogy. The corresponding theories in health are seen as the biopsychosocial model of health, and the patients as teachers and practice-based evidence in health professional education and practice. Included in this section is a brief overview of recent publications on embodied relational understanding in health care practice. Section 2.3 reviews emancipatory pedagogies such as critical pedagogy, feminist learning theories and socioeconomic determinants of health, and includes a section on Indigenous health in Australia, whilst section 2.4 reviews deconstructive approaches to learning. The professional practice literature is relatively sparse but there is hope for progress in professional practice in that there are developments in embodied reflexivity in education (Lather, 1991a; Pearce, 2008) and health (Kushner, 2005; Edvardsson and Street, 2007; Oien, Iversen and Stensland, 2007; Galvin and Todres, 2007; Todres, 2008) although these approaches are not yet mainstream. Having summarized these approaches, I move on to discuss examples of literature in health professional education and professional practice.
Table 2 Postpositivist Inquiry – approaches (Adapted from Lather, 1991b, p. 8)

<table>
<thead>
<tr>
<th>Predict</th>
<th>Understand</th>
<th>Emancipate</th>
<th>Deconstruct</th>
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</thead>
<tbody>
<tr>
<td>Epistemology</td>
<td>Positivism</td>
<td>Interpretive</td>
<td>Critical</td>
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<td></td>
<td>Scientism</td>
<td>Naturalistic</td>
<td>Neo-Marxist</td>
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<td></td>
<td>Biomedical model</td>
<td>Constructivist</td>
<td>Feminist</td>
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<td>Modernism</td>
<td>Phenomenological</td>
<td>Hermeneutic</td>
<td>Praxis-oriented</td>
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<td></td>
<td>Microethnography</td>
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<td>Freirean</td>
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<tr>
<td>Educational theories</td>
<td>Behaviourist</td>
<td>Sociocultural theories of learning</td>
<td>Critical pedagogy</td>
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<td></td>
<td>Theories of motivation</td>
<td>Relational pedagogy</td>
<td>Reflective practice</td>
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<td>Social cognitive theory</td>
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<td></td>
<td>Cognitive theories</td>
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<td></td>
<td>Affective theories</td>
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<td></td>
<td>3P Model of learning</td>
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<td></td>
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<tr>
<td>Health theories</td>
<td>Health locus of control</td>
<td>Biopsychosocial model of health</td>
<td>Socioeconomic determinants of health</td>
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<td>Health beliefs model</td>
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<td>Radical health pedagogy</td>
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<td></td>
<td>Theory of reasoned action</td>
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<td></td>
<td>PRECEDE-PROCEED model</td>
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<td>Social ecological theory</td>
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<td>Salutogenic model of health</td>
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<td>CDSM program</td>
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<tr>
<td>Health professional education and practice</td>
<td>Evidence-based practice</td>
<td>Patients as teachers</td>
<td>Embodied context</td>
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<td></td>
<td>Reflective practice</td>
<td>Vulnerable story telling</td>
<td>Rememorialising</td>
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<td></td>
<td>Problem based learning</td>
<td>Practice-based evidence</td>
<td>Embodied reflexivity</td>
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<td></td>
<td>Critical thinking</td>
<td>Practitioner-based research</td>
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<td>Concept mapping</td>
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EPISTEMOLOGICAL ONTOLOGICAL
2.1 Predictive and understanding models of learning and health

In education, most models of learning focus on the learner and try to make the learner a better receiver and responder to information (Biesta, 2004). Thus how the curriculum is enacted is by viewing the learner as in need of expert advice on how to learn. This seems to be because:

the dominant tendency in educational theory and practice has been to privilege the agency of the autonomous self and exclude any social determinism on the grounds that to admit this would be to render educational work impossible (Usher, Bryant and Johnston, 1997, p. 99).

The following models of learning subscribe to a humanistic discourse that privileges the autonomous self. There is a danger in the psychologism and individualism of humanistic discourse in that, paradoxically, it “leads to dehumanization through substitution of covert for overt regulation under the guise of ‘being human’ ” (Usher, Bryant and Johnston, 1997, p. 98). Thus while the discourses promote autonomy and control it is only through a passive, conformist learner that this can be achieved. The discourses inevitably invoke the oppositional structuring binary.

It was noted previously that in all conceptions of self there are two structuring binary opposites (Usher, Bryant and Johnston, 1997). This is the case in the following models of learning. Socioculturalist learning theories (Vygotskian in origin – Martin, 2004b) e.g. Bandura (1986) emphasize the social effects on learning while constructivist learning theories (Piaget, metacognition and self-regulation of learning) emphasize the individual
learner’s self and agency. Bandura (1986) sees self-regulation as being socially constituted (Martin, 2004b) whereas other theorists see self-regulation as an internal feature of the learner (Schunk, 2005; Schunk and Zimmerman, 1997; Bodrova and Leong, 2005). Inscribing structuring binary opposites about control and self-regulation in constructions of the self is how a curriculum is enacted.

For example, people unwittingly become located on a continuum between the binary of internal control – external control as perceived by the player who has the most power in this case the teacher, expert or health professional. The emotional tone of such a judgement based on their perception of the learner or object can be coloured with hues of shame, pride, etc. This is how the curriculum can be enacted with different emotional tones that carry some sort of perception/judgement about the ‘other’ or the object that can be known.

Behaviourist learning theories focus on the learner and try to make the learner a better receiver and responder to information. Thus the theories focus on the one who is being educated whilst trying to control and manipulate the learners into being effective receivers of information (Biesta, 2004). The gap between the educator and the educated is seen as a hindrance for the “efficient and effective flow of information from the teacher to the student” (Biesta, 2004, p. 17). Learning is seen as a transmission of information, a practice that Freire has described using the banking metaphor of education (Freire, 2000). This form of teaching and learning is dominant within training in the health professions.
The health theory landscape is dominated by behavioural theories such as the health belief model (Becker, 1974), the health locus of control (Wallston, Wallston, Kaplan and Maides, 1976), the theory of reasoned action (Ajzen and Fishbein, 1980; Ajzen and Madden, 1986), the theory of the diffusion of innovations (Rogers, 1983), peer based support and education (whereby group behaviour and behaviour change become the focus) community change and action (communities become the focus of behaviour change), and social cognitive theory (Bandura, 1986). Each of these regard an individual’s behaviour, control, attitudes, values, and beliefs as more or less important in determining adherence to health regimes. The health locus of control theory will first be reviewed in detail as it provides a good example of the focus on one aspect of the object of health professionals’ attention.

2.1.1 Health locus of control

The health locus of control (HLC) theory draws on Bandura’s (1986) social cognitive theory of learning and self-efficacy. Concepts closely tied in with this theory are ‘adherence’ to regimens and ‘compliance’. Adherence is the extent to which a patient’s behaviour is consistent with the health care provider’s recommendations (World Health Organization, 2003, cited in Burkhart and Rayens, 2005, p. 404). The client or patient is seen as having self-control and self-efficacy in as much as they are able to comply with instructions and adhere to regimens. Compliance is defined as “the extent to which a person’s behaviour (taking medicines, following proper diets, or executing lifestyle
Compliance is said to involve two steps. Step 1) is self-efficacy (a belief in one’s own ability to complete a course of action) along with an internal health locus of control (IHLC), which is a personality trait that leads one to view his or her health as personally determined as opposed to being determined by external factors. This in itself seems such a strange way to frame health – as a personality trait that is personally determined. Both self-efficacy and IHLC are believed to affect intention. Step 2) develops the idea that intention can affect behaviour (Takaki and Yano, 2006). Thus greater self-efficacy or IHLC is thought to result in increased compliance. This universalized concept has been applied across different patient groups with the assumption that the more self-efficacy and IHLC a person has, the better it is for them in terms of treatment outcomes.

People have been categorized according to their levels of self-efficacy and IHLC. Those with higher levels of self-efficacy serve as role models for those with lower levels. Prescriptions of how to improve self-efficacy through enhancing self-concept have been suggested (Burkhart and Rayens, 2005). Gender differences have been highlighted that suggest there is a bias towards ascribing greater self-efficacy in women, who it has been suggested may give answers in relation to dietary questions that are socially desirable instead of their true preferences, so as to avoid criticism (Takaki and Yano, 2006). IHLC as a personality trait has been seen as variable over time whereas personality “is by definition reflective of stable traits or dispositions to act in a consistent and predictable
manner over time” (Krause and Broderick, 2006, p. 113). Self-efficacy and IHLC have been co-constructed with personality and categorized in more or less socially acceptable scales. The dominance of positivist rhetoric is apparent here with the individual having a knowable identity that is stable over time and able to make rational choices (Klage, 2003).

The concept of health locus of control, in its assumption of universal personality traits and in prioritizing control and self-efficacy, can be seen as a means of enforcing neo-liberal rhetoric. In the gap between the educator and the educated, the concepts of control and self-efficacy are what float between the participants and construct both. Riggs (2005) closely examines the construction of control as an *a priori* intra psychic phenomenon along with other personality traits and believes that the focus by researchers on ‘discovering’ LOC masks the way in which such research activity produces psychological concepts. He sees ‘control’, along with self-esteem, as buying into the neo-liberal discourse of freedom as it represents the privileged position that white middle class males occupy.

Riggs (2005) prefers that control is seen as reflecting important sites of difference in Western culture rather than as a fixed stable intra psychic phenomenon. Concepts like LOC reinforce the binary nature of understanding, as subjects are located at either an external or internal locus of control. The autonomy of the liberal male is also reinforced as the behaviours of individuals are separated out from the context in which these behaviours are performed (Riggs, 2005). Thus cultural practices that shape constructions
of personality traits such as LOC are masked, and instead are positioned as representing real objects that can be objectively measured by psychologists in the area: “A focus on the individual as having a locus of control effectively denies the social and cultural contexts in which discourses of control circulate” (Riggs, 2005, p. 2). This denial of the social and cultural context in the construction of the individual is one of the major characteristics of the Western health care system.

The lens of cultural critique is necessary to understand constructions of and within health:

Through this lens, health is recognized as a social practice, where particular bodies are positioned as being ‘healthy’; whilst others are designated the role of being either ‘unhealthy’ or ‘ill’. Moreover, constructions of health are used to manage people through the production of intelligible healthy subject positions… (Riggs, 2005, p. 3).

As a result, measures of locus of control may more correctly be understood as measures of the experimenter’s and participants’ shared knowledge of certain social constructs (Stainton Rogers, 1996). Thus, in everyday language we talk about ourselves as ‘having or lacking control’, as being ‘victims of fate’, and as things being ‘beyond our control’. And it is because of this that locus of control may be more usefully conceptualized as a set of shared meanings that we perform to warrant our actions/non-actions within a society that valorizes control (Riggs, 2005, p3).

The idea of locus of control as being a set of shared meanings between the educator and the educated fits in with a relational pedagogy (Biesta, 2004). “Locus of control is something we do in order to manage the ways we are positioned in relation to other people, and within the social order more generally” (Riggs, 2005, p. 7). Riggs (2005) speaks to a relational pedagogy, what is in-between the educator and educated, but goes further by including relations of power through an analysis of the constructedness of theories especially those that focus on the neo-liberal individual.
The neo-liberal discourses surrounding health are regimes of truth that govern ways in which individuals may position themselves in relation to health and well-being. Thus, good (mental) health is the result of individual work – of the personal mastery of control (Riggs, 2005). The neo-liberal conceptualization of control has two outcomes – institutions are not to blame and self-government is taken as the defining aspect of freedom in the constitution of healthy subjects (Riggs, 2005). In this way, “we enact control over ourselves when we strive to achieve freedom on the terms set within a neo-liberal society” (Riggs, 2005, p. 8) and this way become complicit with neo-liberal understandings of self-regulation.

Social practices of exclusion inform discourses of control and “these practices often work to co-opt us precisely at the point where we attempt to resist them” (Riggs, 2004 cited in Riggs, 2005, p. 8). For example, it may be that attempts to make visible practices of exclusion and discrimination by speaking out about inequalities in health, by refusing to perform acceptable performances of what it means to be a health professional and by rejecting the social stereotypes of a health professional, can lead to job loss or exclusion from the community of acceptable health professionals. This could lead to feelings of loss of control that only make sense if control is privileged as an important site of critique (Riggs, 2005). The acting out or externalization of control still means that the basic tenets of neo-liberal control are accepted as central to any challenges to the status quo.

Riggs (2005) suggests a focus on how control may be reconceptualized so as to generate a more productive political response to exclusionary practices of health and subjectivity:
If we are to understand control as something that is produced relationally, then we may be better placed to understand the practices of governmentality that shape intelligible healthy subject positions. In other words, instead of positioning locus of control as being an intra-psychic phenomenon that is causally related to health care outcomes, it may be more productive to examine the ways in which performances of expected personality traits impact upon health care outcomes. Thus, psychologists may find it more useful to research the ways in which an individual’s complicity with psychological regimes of truth affects the way they perceive the situations in which they are located []. In this way, an understanding of the context of culture is an important point to consider when exploring practices of control (Riggs, 2005, p. 9).

There is a universalizing of control and personality traits as transcendent of culture. Alternate ways of accounting for how and why people perform certain subject positions in health care have not been developed to a large extent. Perhaps the pre-occupation with control by health professionals is more of a reflection of their own position in relation to freedom and the neo-liberal discourses of the individual.

Control is such a central concept in the discourse about health that it requires in-depth exploration of the meaning and implications of making such a concept so central to the enactment of curricula. As Riggs (2005) suggests, an individual may or may not comply with psychological regimes of truth and so trade in the currency of control resulting in limited subject positions for the individual. This limited subject position could become materialized on the body (Butler, 1993) as an individual may end up in a rut of subjectivity. Subject positions and materializations on the body related to the performance of control are made explicit in this thesis so that the effect of context can be clearly teased out and progress made on the development of health professional practice.
Both the health professional and the patient or client are limited by adherence to psychological regimes of truth relating to control. In an enactment of health professional curricula, the how, a shared understanding of what control is at this level could mean that both health professional and client share what they mean about control so that neither is positioned as having control or not, adherent or compliant or not: Control is a “set of shared meanings that we perform to warrant our actions/non-actions within a society that valorizes control” (Riggs, 2005, p. 3). The concept of control is thus a major factor in the meeting place of the health professional and client at the individual level.

Even at the social level of social determinants of health, control is seen as a major determining factor in causally related health outcomes. In section 3.2.2, 3.3.1 and 3.4, the discussion expands to demonstrate that the most recent thinking on social determinants of health emphasizes the lack of control exhibited by people who share the worst health indicators, and that it is this that must be addressed to change the inequity in health (CSDH, 2008; Oldenburg, McGuffog and Turrell, 2000). Inequity in health status has become conflated with lack of control and a lack of material buying power in a consumerist society. The control rhetoric is all pervasive. Galvin et al (2008) offer a different caring science perspective with the emphasis of the person as a citizen first and foremost rather than the person being viewed as a consumer. Even the seemingly polar opposites of individual lifestyle determinants of health and the social determinants of health are unified at the conceptual level of control.
In discourses of health locus of control, the individual is constructed in positivist tradition as being stable and having a knowable self that is rational, autonomous and detached (Klage, 2003). Ogden (2002) traces the construction of the individual in the health literature from the 1960’s through to 2002 and describes how during that period the construction of the individual evolved from being an active and interactive agent (with the environment) to being more focused on the individual’s inner self, as having an intra-active identity as constructed by the health theories. The emphasis on self-efficacy (Bandura, 1986) meant that the individual was constructed as having an inner self which may or may not exert self-control in the face of possible relapse of risky behaviour (Ogden, 2002). These two major shifts in construction of the self have been tracked through the literature on addictions, stress and pain.

In summary, the health locus of control is a form of knowledge generation in health that attempts to predict the learner’s or patient’s response to education or health information. The main points from this section are that control is a major preoccupation in the health literature and that it constructs the meeting place between the health professional and the client or patient. If the performance of control is a manifestation of people managing how they have been positioned by and in relation to others, then it needs further exploration in health professional practice in order to determine how complicity with this regime of truth affects practice (Riggs, 2005).

Further theories that emphasize the individual’s role in changing their health related behaviours include the health beliefs model, the theory of reasoned action and the
PRECEDE-PROCEED model of health planning and promotion (Green and Kreuter, 1991). Even though the latter model is slightly more complex and does involve educational and organizational diagnosis in the planning stages the rhetoric is still based on the assumption that individual(s) need to change their behaviour in order to make themselves healthy. In addition, the salutogenic model of health promotion (Antonovsky, 1996) focuses on salutary factors that actively promote health and rejects the focus on a one-faceted particularity of health but still does not examine the basic tenets of the neo-liberal discourse.

In the following section I move away from theories that see an individual’s learning and health as occurring solely in relationship with the teacher/health professional (even though this is not acknowledged), and focus on theories that consider the social aspects of learning and health. This is thus a move away from the individual as the site of change to a more inclusive model of change that takes into account the social context.

2.1.2 Social cognitive theory

A social cognitive theory of learning assumes a high level of importance in both the education and health fields. This theory of learning acknowledges that learning occurs in a social context through observation of social agents, called observational learning (or vicarious learning), or social learning theory (Kearsley, 1994 – 2002). Emphasis is placed on social variables as determinants of behaviour and personality (Thomas, 1996). This theory is based on Bandura’s (1986) work of social cognitive theory and is the basis
for learning strategies such as peer modelling and collaborative learning. Whilst Bandura’s (1986) work has been used as a basis for group work with its emphasis on social variables, there is also a large amount of theorizing on the self or individual learner within social contexts of learning.

I have difficulty fitting Bandura’s (1986) social cognitive theory into either predictive or understanding models of learning as it could be positioned in both. Bandura’s ideas seem to lean more towards understanding learning, the self, and behaviour, but the application of his ideas in education and health are presented more in a predictive manner in order to control behaviours of learners. Bandura’s (1986) self-regulation of learning through the agency of learners is an example of how the theory, which appears to be part of a process of understanding learning, has been applied in a predictive capacity. These ideas are compared with cognitive theories about self-regulation in section 2.1.4. Suffice to say now that the self as agent has great currency in these theories.

Bandura’s social cognitive theorizing developed the concept of agency of the learners (Martin, 2004). The self as agent is implicit in most writings on the topic of self-regulated learning (Schunk and Zimmerman, 1997; Martin, 2004b; Schunk, 2005), which have been derived from Bandura’s social cognitive theory and are reviewed in a later section (2.1.4). The self as agent forms one part of a structuring binary opposite (Usher, Bryant and Johnston, 1997) with the less emphasized term perhaps being self as passive object. Bandura apparently rejected any dualism that might separate self as agent from self as object and firmly believed in the reciprocity of causation: that self and society,
interpersonal factors, behaviour, and environmental factors “operate as interacting determinants that influence each other bidirectionally” (Martin, 2004b, p. 138).

However, applications of social cognitive theory tend to be appropriated by behaviourists who want to change people’s behaviour by drawing on self as agent, whether it be in relation to learning or health management.

Bandura’s rejection of a dualism that might separate self as agent from self as object was grounded in his protests about the too strong duality of constructivist versus sociocultural construction of learners (Martin, 2004b). Most work on self-regulation in learning is constructivist in orientation but Martin (2004b) suggests that Bandura tried to go beyond this with his emergentist theorizing:

To summarize, Bandura’s social cognitive theory of agency understands agentic capability as self-determination exercised as self-regulation, the most important volitional component of which is self-efficacy. Such self-regulating capability is socially constituted and biophysically enabled and realized, yet because of its emergent features, exerts a generative, reciprocal influence on both social systems and neurophysiological requirements or sociocultural constituents, even as it continues to be shaped by, and to shape, both. ….. Agency is thus both determined and determining (Martin, 2004b, p. 139 141).

Here, self-regulation of learning is presented as a mutually determining activity that takes place in a context (Martin, 2004b) thus both constructivist and sociocultural approaches to learning are considered and included in the presentation of Martin’s paper. However, this presentation of both constructivist and sociocultural approaches to learning are not carried through in applications of Bandura’s social cognitive theory in the health field.
An example of health education strategies based on Bandura’s social cognitive theory can be found in chronic diseases self management (CDSM) programs (Lorig, Stewart, Ritter, Gonzalez, Laurent and Lynch, 1996) which focus on the strength of belief in one’s self to change one’s behaviour. These authors build conceptually on Bandura’s (1986) work to develop self-efficacy theory within social psychological theory and use this to promote changes in behaviour, motivation, thinking patterns, and emotional well-being (Lorig et al, 1996). However the focus on motivation and behaviour change is in the end about disciplining bodies and making people docile (Foucault, 1977), to the exclusion of social factors. It is no surprise to see that one of the outcomes from the CDSM programs is a decrease in use of health professional services (Lorig, et al, 1996) and a replacement of sparse health professional services with peer group modelling and education (Gartner and Riessman, 1977; Lorig, 1993; Lorig, Mazonson, and Holman, 1993; Lorig, Sobel, Stewart, Brown, Bandura, Ritter, Gonzalez, Laurent, and Holman, 1999).

### 2.1.3 Cognitive theories of learning

Cognitive theories of learning focus on the way knowledge is constructed by the thinking subject and are based on the work of Piaget and Bruner (Thomas, 1996). Although Piaget’s work focused mainly on children, it has been used in adult learning theory when consideration has been given to the structure and sequence of learning events (Thomas, 1996). Some limitations of this theory are its lack of consideration of the effects of context or power/knowledge and the way the learner is constructed through this theory.
Theories of metacognition and self-regulation include meaning making and reflection on learning in order to plan and monitor the learning. Thus the learner is active in their learning, leading to the construction and reorganization of knowledge structures internal to the learner. These cognitive tasks of construction and reorganization of internal structures account for why Piaget is credited for the constructivist approach to learning and why learning is seen as primarily a cognitive task in constructivist theories (Thomas, 1996).

These theories construct the learner as active in their learning, with self-regulation including "self-generated thoughts, feelings, and actions for attaining academic goals" (Zimmerman, 1998, p. 73). Psychological dimensions of self-regulation include motive, method, time, behaviour, physical environment and social influences (Zimmerman, 1998). These dimensions are said to be context specific and include an element of relation with the social. However, the approach seems more positivistic than not as it relies on self-regulatory processes such as goal setting, task strategies, imagery, self-instruction, time management, self-monitoring, self-evaluation, self-consequences, environmental structuring and help seeking in the enactment of a curriculum (Zimmerman, 1998).

Epistemic casting (how knowledge is generated and legitimated) determines the role of the individual (Foucault, 1988a). For example, human information processing theorists (Biehler and Snowman, 1997; Vosniadou, 2001) generate knowledge about learning through a step by step task analysis of a problem which is to be solved. The student’s
role is to follow these steps, process data and carry out any required action whilst not
deviating from the norm. This requires a certain amount of flexibility on the part of the
student since in the real messy world (Schon, 1987) problems or learning do not
necessarily follow a clear logical step-like process and so it is up to the student to adapt
to the circumstances.

The role and construction of the learner seem to depend on the use to which a theory is
put. In other papers self-regulation is presented as just another means of controlling
behaviour (Schunk and Zimmerman, 1997; Schunk, 2005). For Bodrova and Leong
(2005) self-regulation:

… is a deep, internal mechanism that underlies mindful, intentional, and thoughtful
behaviours of children. It is the capacity to control one’s impulses, both to stop doing
something (even if one wants to continue doing it) and to start doing something (even is
one doesn’t want to do it). Self-regulated children can delay gratification and suppress
their impulses long enough to think ahead to the possible consequences of their actions or
to consider alternative actions that would be more appropriate (Bodrova and Leong,
2005, p. 2).

Here self-regulation is believed to be an underlying skill that makes learning possible, yet
it seems important to be aware of how learning theories can be appropriated as a means
of controlling behaviour as an end in itself. This is why I have positioned self-regulation
of learning from a constructivist perspective in the predictive category of knowledge
claims, even though Lather (1991b) has positioned constructivist learning models in the
understanding category. At times, there is still no mention by constructivists of the
relational aspect of self-regulation: that self-regulation is developed in the relationship
between the teacher and the learner. Theories which seem to me to allude more to the
relational aspect of teaching and learning include affective theories of learning.
2.1.4 Affective theories of learning

I am including affective theories of learning within the predictive category because the focus is still on the individual and what can be done by teachers to facilitate a positive self-esteem in the learners in order to enhance learning. Affective theories of learning include those proposed by the humanistic schools of psychology with the emphasis on feelings, attitudes, self-esteem and emotions in order for an individual to develop a strong, integrated self-concept (McInerney and McInerney, 2002). There is an allusion here to a learning environment that is equal, safe, transparent and participatory, and in these ways somewhat akin to the emancipatory learning environments.

A criticism of a progressive-humanist approach is that reality may not always match the ideal of a democratic liberatory learning environment (Brookfield, 2005). He holds that there may still be instances of disciplinary power and surveillance operating in a supposedly democratic environment. Brookfield (2005) suggests that one of the prime purposes of a critical theory would be to analyse educational practices that are believed to be power-free or that attempt to democratise power. While humanist theories of learning do start with valuing emotions and nurturing relationships in order to promote learning, the theories are incomplete without including an analysis of power relations. There is still a singularity operating within these theories as they focus on the learner and what must be done to them to promote learning in a way that is reductionist in its attempts to describe the learning process. I will now go on to review a model of learning that analyses the learning process and includes more complexity in its approach.
2.1.5 The 3P model of learning

The 3P model of learning (Biggs and Moore, 1993) considers learning as a system or process and is one of the more complex learning theories. It includes ‘presage’ factors such as student characteristics and the teaching context, the ‘process’ including metalearning and metateaching processes, and the ‘product’ which is the outcome of learning. The process focuses on approaches to learning such as deep, surface and achieving. However, there is little exploration of how individuals are constructed in the system of learning. While being a useful schema for the systemic nature of learning and thus providing a checklist of points for consideration the authors do not include a deconstruction of their assumptions about learners who are assumed to be engaged to differing extents in order to achieve the expected outcomes. The discourse focuses mainly on the learner’s conceptions of learning, their abilities, their locus of control, and their experiential background (Biggs and Moore, 1993).

Internal locus of control (assuming control over one’s self) is seen as a (preferred) prerequisite to metalearning activity, increased participation, being reflective and attentive, seeking and using information in problem solving, having an awareness of how information may affect future behaviour and more effective achievement (Biggs and Moore, 1993). There is no consideration given to the idea that self control may be a relational trait (Riggs, 2005). The 3P model of learning can be likened to the Precede/Proceed model of health promotion planning (Green and Kreuter, 1991) which will be discussed more in chapter three.
The discourse of the 3P model of learning describes learners whose presage characteristics have a particular nature: one that is integrated, job-oriented, (economically) rational and perfectible, in line with much of the organizational behaviour discourse (Jackson and Carter, 2000). This is not surprising when much of the educational discourse has been driven by political and economic discourse that seeks to form ideal workers out of learners (Dawkins, 1990; White, 1990; Marginson, 1993; Candy, Crebert and O’Leary, 1994). From a Foucauldian perspective, the 3P model of learning may be seen as more about a form of self-policing that fits in with the notions of individualism created to strengthen the functioning of the state (Foucault, 1988a).

The individualism promoted by such theories suits the purpose of economic rationalism – “the economic individual is self responsible but not self determining” (Marginson, 1993, p. 77, emphasis in original). If the individual learner and/or worker is considered to be fragmented, inconsistent, incoherent, unfixed, in a state of flux, unpredictable and differentiated as in much contemporary social theory (Jackson and Carter, 2000) then the models of learning that focus on individualism do not take into account the complexity of the self, the individual and behaviour as relational. This problem is further explored below as the main points of predictive learning theories are critiqued and summarised.

2.1.6 Summary of predictive learning theories

This section has reviewed behavioural, affective, motivational and cognitive theories of learning and health including social cognitive theory, self-regulation of learning and
health locus of control, and metacognition. The 3P model of learning was also described. The main criticism of these theories is the focus on one or a few aspects of the learner in order to improve these aspects so that more can be learnt (received) in a transmission approach to learning and health. The lack of complexity of these theories seems to be related to the limited focus on the individual as a rational autonomous human being in line with positivist assumptions. There is silence on issues of power/knowledge and in the end most theories seem to be about producing docile bodies (Usher and Edwards, 1994) through the enactment of disciplinary power (Foucault, 1977) on the individual learner.

This means that in considering the relationships between the following constructed players – pedagogue/expert/teacher/doctor, practitioner/health professional/student/learner and patient/client/child/learner – it is the learner who is the focus of the theories. This type of focus is oppressive in Freire’s view:

In the banking concept of education, knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing. Projecting an absolute ignorance onto others, a characteristic of the ideology of oppression, negates education and knowledge as processes of inquiry. The teacher presents himself to his students as their necessary opposite; by considering their ignorance absolute, he justifies his own existence. …. Banking education maintains and even stimulates the contradiction through the following attitudes and practices, which mirror oppressive society as a whole (Freire, 2000, p. 72/73).

The learner’s self is constructed as being in control and self-regulatory, which fits in with the teacher’s need to control and regulate in the above relationships. The teacher and student are positioned as polar opposites with the teacher knowing everything, thinking, talking, disciplining, choosing, acting, enforcing, and being the subject of the learning
process while students are objects who are thought about, taught, disciplined, compliant, adaptive, listening and passive (Freire, 2000). The relationship between the teacher and the taught is mirrored in health with the health professional being the teacher and the patient being the student.

The social practice of health rests on constructs of control, self-efficacy, self-esteem and motivation that are all described in relation to behaviour change. The meeting place of the health professional and the client and or patient is a place where struggles can take place over constructs such as these, with the health professional sitting in the position of self-mastery. The patient or client by default, because they are more vulnerable, can be positioned as lacking control or self-efficacy. Thus they can be positioned as passive and inactive similar to the situation in education.

The irony of this form of education is that while the student or learner is expected to be passive and compliant in order to learn, they are also constructed by different learning theories as individuals who are in control and have agency as befits the self-responsible individual of neo-liberal rhetoric. This state of affairs is mirrored in the health field and is of grave concern when complex relationships are reduced to something that is so oversimplified. As Baum (2007) reminds us, working in the health field is like working on the edge of chaos because of the complexity involved, and a deeper and more complicated approach is required to address this complexity.
The dominance of theories of learning that can be positioned in the predictive category in origin and application has serious limitations because whilst these theories are important to practice, generally no other approaches are considered. By focusing exclusively on these theories with little reference to anything else, learning remains ‘predictable’ in the sense that it can be controlled and manipulated in stable ways. Teachers or health workers can assume a final position by believing they are at the centre of the learning/healing. Thus they have a solution to learning difficulties, and yet confuse the authority of the knowledge with their own professional authority (Freire, 2000). The singularity of such an approach seems dangerous to me in that there are few positions available for the learner’s or patient’s self except within the narrow confines of accepted pedagogy. Meanwhile, little is understood about the learner, the teacher or the relational gap between them.

The key themes emerging from this discussion are:

- In the relationship between the educator and the educated there is an asymmetry of power with the teacher (pedagogue/expert/health professional) positioned as the necessary knowing opposite to the passive student (learner/client/patient).
- The teacher is presented as the one who thinks, does, disciplines, chooses, acts and enforces in the dominant learning theories whilst the learner is thought about (Freire, 2000).
- Teaching is seen from a privileged position as a mastery project that can know the object; the learner or student health professional or patient or client.
The constructed position of each is due to the dominance of learning theories that fall into the predictive category of forms of inquiry thereby attempting to predict, control and manipulate learning.

This suggests that learning and health as social practices have become more about control, supervision and surveillance.

In the dominant transmission model of learning, knowledge is seen as a gift to be bestowed or facilitated by the teacher upon the learner.

The self in these dominant positivist learning theories is constructed as knowable, stable, autonomous, rational, detached, objective and as having agency that is both determined and determining.

The (deconstructed) self is presented as a disembodied, disembedded subject of masculinist thought upon which disciplinary practices are enacted to produce docile bodies.

The learner’s self is required to be a better receiver in the transmissionist models of learning and is therefore reduced to a technicist within a neo-liberal approach of economic productivity.

There is a paradox that while the learner is treated as passive in the dominant transmissionist models of learning, he or she is also expected to be agentic.

There is a tension between the constructivist and sociocultural theories of learning.
2.2 Theories of learning to assist understanding

I take these theories to be about the promotion of understanding the learner’s self within the wider context of learning that includes a consideration of both sociocultural and relational influences. I include here a brief overview of sociocultural theories of learning and a more detailed discussion of relational pedagogy.

2.2.1 Sociocultural theories of learning

Sociocultural learning theories are Vygotskian in origin and emphasize the learner’s embeddedness in sociocultural practices that constitute both the learner and the knowledge available (Martin, 2004b). While these theories take into account the effect of culture and environment on the learner, in the literature in the education or health field they are generally not presented as a counterpoint to oppressive practices in teaching institutions.

2.2.2 Relational pedagogy

I have included relational pedagogy in this section since it attempts to understand the process of learning and assumes that learning takes place in the gap or dynamic spaces between the educator and the educated (Biesta, 2004). Unlike previous theories, which focus on what is happening to the educated, the pedagogy of relation emphasizes the gap between the educator and the educated, and speaks of what is normally silent. The gap is
seen as a dynamic space with potential for interaction and enunciative agency; it is not an empty space. Proponents of the pedagogy of relation see the process of learning being primarily about communication in relation and what happens in the gap between the educator and the educated (Biesta, 2004).

Education takes place in the interactive spaces between the teacher and the learner; it cannot be fully controlled by either the teacher or learner but is a movement towards a shared understanding of a shared world. This understanding depends crucially on the process of communication itself and meaning is placed inside the process of communication (Biesta, 2004). The space where people can communicate allows people to come “into presence”:

This is the opportunity provided by the space of enunciation, by the gap between the teacher and the student. It is the opportunity of agency, both, so I want to emphasize, for the student and teacher. This is not the agent-subject that exists before the social. Nor is this the agent-subject that needs to be liberated or emancipated by the teacher. The agency that becomes possible in the gap is a fragile “enunciative agency” (Biesta, 2004, p. 22).

A pedagogy of relation includes an analysis of power relations in terms of realizing that the teacher’s role is not to liberate and students need not to be liberated or emancipated; but rather that they do have an agency albeit a fragile enunciative (coming to voice) one. This pedagogy also sees that domination is as relational as love and that since relations are embedded in a range of discursive practices they are not necessarily good (Bingham and Sidorkin, 2004).
In the ‘Manifesto of Relational Pedagogy: Meeting to Learn, Learning to Meet’ (Bingham and Sidorkin, 2004, p. 5), the authors suggest that schools are at a turning point since economic models (with their focus on behaviourist learning theories) are producing a crisis in education from a growing problem of alienation. Symptoms of this crisis include the production of a void where there is no meaningful human contact and people experience extreme frustration and anonymity (Bingham and Sidorkin, 2004). The same could be said of health services with their emphasis on economic productivity (evidence-based practice) to the exclusion of all else. This idea will be developed further in the critical summary to this section.

The pedagogy of relation is a move away from an epistemological understanding of learning to a more ontological understanding. With this move, there is a consideration of how one’s being is constructed relationally whilst being embedded in a range of discursive practices that include relations of power. Embodiment and materialization (Butler, 1993) become important considerations in an embedded relational pedagogy. This point will be discussed further in section 2.6 whilst reviewing the literature on health professional education and professional practice under the heading of embodied relational understanding (Todres, 2008). In education relational pedagogy is a move towards a critical pedagogy that views pedagogy as constitutive of power relations (Gore, 1993). It is the analysis of these relations of power that is important – the specific forms of relation both within health and within education. The significant relations of teacher/student and health professional/client will be discussed in the next section in relation to the site of change – the individual versus the social – in relation to health.
2.2.3 Biopsychosocial models of health

The biopsychosocial model of health encompasses a wider discourse on health and explores the tension between behaviourist and the structuralist perspectives in relation to the determinants of health. While there are resonances here of the educational debate between constructivist and sociocultural learning theories, there has been little explicit cross fertilization of ideas between health and education fields from a critical perspective. The biopsychosocial model of health tries to incorporate all the dimensions of the causal factors in health and is an attempt at countering the reductionism of the biomedical model of health, which bases diagnoses on the physical signs and symptoms at the level of clinical anatomy and physiology and ignores the social and behavioural dimensions of health (Albrecht, Higginbotham and Freeman, 2001). This is a systems approach to illness and health which works in a hierarchy, not that any one level is privileged over another, and sees these factors as both determining and determined.

In this way the biopsychosocial model of health is said to work in a dynamic relational sense with subatomic particles at the bottom of the hierarchical model and society/nation and biosphere at the top (Albrecht, Higginbotham and Freeman, 2001). The person is located in the middle and is described in terms of their experience and behaviour, thus relying on psychology as a discipline to explain the causal factors in ill-health as far as the person is concerned. There is still an emphasis on the causal problematic with the implication that something or someone can be blamed for ill-health. There is no examination of the ways in which individuals may be complicit with psychological
regimes of truth (Riggs, 2005). The limitations of this model are that the means have not been worked out among theorists for systematically drawing together the different fields of knowledge except to call for multilevel analysis that combines individual change strategies with system change strategies (Albrecht, Higginbotham and Freeman, 2001). So while health professionals may be encouraged to adopt the biopsychosocial model of health in their training, there is as yet no clear way to operationalise the complexity of this model.

The political economy perspective of the biopsychosocial model is understood as a conflict model of society, whereby inequalities in health are analysed in terms of power relations shaped primarily by social class, race, ethnicity and gender (Albrecht, Higginbotham and Freeman, 2001). This model focuses on the power relations surrounding the discourse of medical science itself:

For example, in capitalist society, alcoholism is redefined from a personal sickness to a feature of the economic system whereby the pursuits of profits (and taxes) promotes alcohol’s use and abuse. Supporting this perspective is a large body of research that consistently shows a clear gradient linking social class position and health status; society’s privileged enjoy the best health while those with increasingly less power and wealth have increasingly worse health (Albrecht, Higginbotham and Freeman, 2001, p. 39).

However there is no mention of how the individual is constructed within those discourses or the limited subject positions available to people within the health-illness continuum. The universal application of this political economy perspective has been criticized because not all countries are capitalist to the same degree and because the focus on the macro social, political and economic determinants of health depersonalizes health
promotion by suggesting that there is little the individual can do to protect themselves from illness (Albrecht, Higginbotham and Freeman, 2001).

Further criticism of the political economy approach is that it is blame seeking and that it acts as a barrier to sorting out health problems:

A central argument of some political economists is that biomedicine maintains rather than alleviates inequality and that researchers who use biomedical categories have been ‘co-opted by the intellectual hegemony of Western biomedicine’ (Brown and Inhorn, 1990, p. 109). This has led to criticism that political economy is a blaming or culprit-seeking perspective (Morsy, 1990, p.32). Such a stance represents a barrier to integrating material from the basic sciences or from frameworks that draw from the biomedical model (Albrecht, Higginbotham and Freeman, 2001, p. 40).

This dismissal of the political economy model of health would seem to act as a barrier to the integration of material from the political economy model and prevent the ongoing discussion of how the individual is constructed within dominant models of health. Both sides of the debate accuse each other of blaming or culprit seeking – at the individual level (Crawford, 1977; Blaxter, 1997; Lynch, Kaplan, and Salonen, 1997; Baum, 1998) and at the political economy level (Albrecht, Higginbotham and Freeman, 2001). It also neglects the role of privilege in maintaining inequities through the construction of different subjectivities within relations of power (Riggs, 2006).

At present, it seems as if the theorizing about determinants of health or the site of change is at an impasse with behavioural explanations on one side and structuralist accounts on the other:
Cultural/behavioural explanations focus on differences in how the various social groups make lifestyle choices. They maintain that people in less well-off groups typically adopt lifestyles that are likely to be damaging to their health. The materialist or structural explanation focuses on the material conditions under which people live, maintaining that health inequalities stem from the less affluent social groups being the victims of unhealthy environments. They have less income for healthy food, engage in more dangerous occupations, have worse housing, more risk of unemployment and fewer resources with which to cushion themselves from illness. These two sets of explanation are often seen as opposing (Baum, 1998, p. 206–207).

The differences are seen as a reflection of the different philosophical positions of individualism and collectivism (Baum, 1998). The debate between the two different positions is seen as a matter of emphasis. In the end Baum (1998) concludes that the division between the two is artificial as each influences the other and that relational factors such as social support, stress levels and social networks are just as important. However, these are the two structuring binaries of the health’s ‘self’ (or site of change) at the moment.

The duality here reminds me of the duality between the constructivist versus the sociocultural construction of learners (Martin, 2004b). Perhaps what is needed in the health field is the concept of emergent agency whereby agency is both determined and determining (Martin, 2004b). Baum (1998) alludes to this when she says:

> Public health reflects choices about living conditions and behaviours, which are constrained by people’s social and economic circumstances. Consequently, attempts to create healthier lifestyles by changing people’s behaviour recognize and try to overcome these constraints (Baum, 1998, p. 290).

However, it is hard to see this happening when health professional training curricula still focus on behavioural models of health. And there is still the focus on health as a
disciplinary technique as evidenced by the huge numbers of journal articles advocating behaviour change with no mention of structural constraints.

The duality between structuralist versus behaviourist determinants of health, with the dominance of the behaviourist approach in training curricula, gives a limited repertoire of subject positions for people ‘doing’ health. It is almost like the discourses take on an identity of internal locus of control (behaviourist) versus external locus of control (structuralist) with people being positioned as either self-determining agents or victims of an oppressive society. Both are co-opted into the discourses of control precisely at the point where the structuralists try to resist the notion of individual determinants of health. These positions are limiting: much more could be achieved in health if the complexity of the social practice of health was teased out in all its relational forms.

2.2.4 Critical summary of understanding lines of inquiry in health

The complexity of the social practice of health or the enactment of health curricula involves a conceptual reliance on what it means to be human, to have a self or identity and to have agency with its determined and determining nature. The debate between behaviourism and structuralism in health has been likened to the constructivist versus the sociocultural construction of learners. Butler (1993) suggests that “the inquiry into the kinds of erasures and exclusions by which the construction of the subject operates is no longer constructivism, but neither is it essentialism” (p. 8). She believes the debate between constructivism and essentialism misses the point of deconstruction:
... for the point has never been that “everything is discursively constructed”; that point, when and where it is made, belongs to a kind of discursive monism or linguisticism that refuses the constitutive force of exclusion, erasure, violent foreclosure, abjection and its disruptive return within the very terms of discursive legitimacy (Butler, 1993, p. 8).

While Butler (1993) is discussing gender, her comments could equally apply to health. The point is not that the subject of health is constructed through either behavioural or structural determinants but to look at the kinds of exclusionary practices that work to define what health is and, perhaps more importantly, who has health and who does not. It is this naming that “is at once the setting of a boundary, and also the repeated inculcation of a norm” (Butler, 1993, p. 8). The conceptual boundaries of health define who has health and who does not in a binary that also carries connotations of blame through behavioural versus structural approaches to health. Exclusionary practices follow on from the setting of a boundary around control and who has it, since people who are deemed not to have control risk exclusion from medical practice (The West Australian, 2004). I take the position that a shift is required to go beyond the binaries and consider health without engaging in the causal problematic which is positivistic in its location.

The shift required means engaging with deconstructive lines of enquiry in health. This means that agency (determined and determining – Martin, 2004b) could be displaced by an agency of meaning (Lather, 1991b). And control could be displaced by different meanings of what it is to be human. Moreover the focus could shift from one part of the binary, almost to the exclusion of the other, to an inclusion of both parts of the binary. Focusing on one part of the binary is an imbalance in power and empathy in itself. Theories in learning tend to mirror those in health in terms of the primary relationships
whereby the teacher (health professional) has the power to talk, think and teach whilst the
student (client) listens and is thought about. The imbalance in communication
reproduces relations of power in and of itself with the teacher (health professional)
confusing their professional authority with the authority of knowledge (Freire, 2000) in
the enactment of a curriculum.

The relations are seen as complex and necessitate a multivoiced text (Bingham and
Sidorkin, 2004). Relations between different aspects of care in the health service require
collaborative multidisciplinary studies and multifaceted approaches (Galvin et al, 2008).
While relational pedagogy is presented as a counterpoint to simplistic behaviourist
theories, it lacks a developed analysis of the structural relations of power such as
institutional constraints and constructions of self through theories.

The third category, of emancipatory lines of enquiry in relation to learning and health,
will now be reviewed.

2.3  **Emancipatory theories of learning**

Emancipatory theories of learning include critical pedagogy, feminist theory, and
participatory learning such as action research, which tend to have a focus on neo-Marxist
and Freirean theory whilst being praxis-oriented (Lather, 1991b). Freire’s (2000)
liberatory approach to education has been applied in a limited sphere within health,
usually with populations that are marginalized by mainstream society. Freire (2000)
described the pedagogy of the oppressed, which is an instrument for critical discovery of both the oppressed and the oppressors’ manifestations of dehumanization:

The oppressed suffer from the duality which has established itself in their innermost being. They discover that without freedom they cannot exist authentically. Yet, although they desire authentic existence, they fear it. They are at one and the same time themselves and the oppressor whose consciousness they have internalized. (Freire, 2000, p. 48).

Freire (2000) seems to me to be speaking to the entrapment of binary opposites and the oppressiveness that this brings. He draws on neo-liberal discourse about freedom to make a link between authentic experience and the associated fear. The desire for freedom and authentic experience battles with the inner fear in a context defined by neo-liberalism. These words can be likened to the inner battle of self-policing that O’Grady (2005) describes. The paradox that the oppressors are also the oppressed is important to consider in relations of power.

Ellsworth (1992) warns against “oppressive simplifications” (p. 114). By this she doesn’t mean that we are all oppressed but she does mean that even people who outwardly seem to fit the current mythical norm’s socially constructed characteristics of privilege can be oppressed by oppressive ways of knowing and oppressive knowledges:

If you can talk to me in ways that show you understand that your knowledge of me, the world, and ‘the Right thing to do’ will always be partial, interested, and potentially oppressive to others, and if I can do the same, then we can work together on shaping and reshaping alliances for constructing circumstances in which students of difference can thrive (Ellsworth, 1992, p. 115).
Health professionals are generally positioned as privileged and free from oppression. However, they may be suffering from the same constraints and entrapments through oppressive neo-liberal knowledges and ways of knowing just as ‘other’ people are. Thus whilst a social justice approach to learning and health is vital, it is easy for the rhetoric to become co-opted by the dominant paradigm of neo-liberalism to produce further oppression.

For example, a liberatory education aims to emancipate people from perceived constraints and entrapments. *Conscientizacao* is a term referring to “learning to perceive social, political, and economic contradictions, and to take action against the oppressive elements of reality” (Freire, 2000, p. 35). Freedom seems to be a motivating construct in critical pedagogy (Walkerdine, 1992; Freire, 2000; hooks, 1994; Kendall and Wickham, 1999), which is promoted as self and social transformation (Gore, 1993). However, as Riggs stated “we enact control over ourselves when we strive to achieve freedom on the terms set within a neo-liberal society” (2005, p. 8). Unfortunately critical pedagogy can read sometimes as if it is another manifestation of neo-liberalism. This critique will be further explored in the following sections.

### 2.3.1 Critical pedagogy

Critical pedagogy takes into account pedagogy as being constitutive of power relations (Gore, 1993). It is used as a means to challenge a conception of the self in education which fails to recognize the power effects of social structures and forces (Usher, Bryant
and Johnston, 1997). ‘Critical’ inquiry takes into account how our lives are mediated by systems of inequity such as classism, racism, and sexism (Lather, 1991a). Liberatory education aims to emancipate people from the constraints and entrapments of unrecognized forms of power by identifying and exposing this power in people’s lives (Olssen, 1999). However, critical pedagogues are always implicated in the work they do (Ellsworth, 1992) and there is a danger that at times critical pedagogy’s agenda reads as a humanist discourse of progressivism (Luke, 1992). To avoid this danger, it has been suggested that there needs to be a continual awareness of one’s role in the enactment of power (Ellsworth, 1992).

With its emphasis on social change rather than personal autonomy, critical pedagogy can be used as a central means of analysing the encounter between the health professional and the client in the enactment of a curriculum. Furthermore, by describing the means of learning through the lens of critical pedagogy, the use of competency based testing and evidence-based practice can be exposed for the practices of gate-keeping that they are. Disciplinary power is enacted in these forms of training to exclude certain forms of learning and to produce docile bodies, in an enactment of power to exclude or include that speaks about belonging (or not) to a certain (professional) group. The location of the learner as belonging or not belonging depends upon their enactment of the curriculum.

One of the major tensions within critical pedagogy is the location of learning or the site of change. As shown in sections 2.1 and 2.2, most adult learning relies heavily on concepts such as self-regulation to bring about desired change. Self-regulation, agency
and autonomy have all been identified as inner features of an adult learner in the dominant rhetoric. For example, autonomy is:

[the] goal of self-awareness, of empowerment in the sense of an ability to exercise choice in relation to needs, and to an approach to learning of active personal involvement and self-direction. The government of the self by the self, a freedom from dependence, a situation where one is influenced and controlled only by a source from within oneself. What prevents autonomy is therefore that which is outside or “other” to the self (Usher, Bryant and Johnston, 1997, p. 93).

The dominant concept of self in adult learning is therefore that of individual autonomy and self-control, and includes self-regulation from a source within one’s self. It is important to note that this description of the dominant discourse in education again speaks of freedom and can therefore be seen as an invitation to the enactment or performance of control and complicity with the terms set by the neo-liberal environment (Riggs, 2005).

In contrast, critical pedagogy locates learning as a social practice (Usher, Bryant and Johnston, 1997). This practice is constituted by institutional forces and constructed by different texts on learning. Critical pedagogy can be presented as occupying different spaces from other more mainstream pedagogies. However, there is a danger with critical pedagogy in that the discourse can sound very much like neo-liberal colonizing discourse that still accrues privilege to white middle class professionals more so than to the ‘disadvantaged’.
As mentioned previously, a criticism of critical pedagogy is that it can sometimes sound like a humanist discourse in progressivism (Luke, 1992). Feminist critiques of critical pedagogy have noted that:

women in other universities, in other classroom contexts, and other countries were experiencing similar theoretical, political and pedagogical ‘dissonance’ with what the ‘founding fathers’ had conceptualized as a pedagogy for self- and social empowerment and for freedom from oppression (Luke and Gore, 1992, p. 1).

From a feminist perspective, power and liberation are intimately connected to the idea of a self-regulating individual who is instrumental in forming the modern state and the modern concept of democratic government, which embraces the notion of freedom as freedom from overt control (Walkerdine, 1992). It has been said that such notions have actually served to keep women firmly entrenched as carers: “women teachers become caught, trapped, inside a concept of nurturance which held them responsible for the freeing of each little individual, and therefore for the management of an idealist dream, an impossible fiction” (Walkerdine, 1992, p. 16). Furthermore, “the conventional view of freedom as some kind of final, power-cleansed state tends to encourage an all or nothing approach. This can have the effect of resurrecting or intensifying the very self-policing practices (or enactment of control – Riggs, 2005) we want to diminish” (O’Grady, 2005, p. 24). Even critical pedagogy needs to be deconstructed so that core concepts like freedom, the individual, and the role that women play are not misused.

Critical pedagogy is sometimes associated with reflective practice and action learning with the active part of learning being the praxis (action and reflection = word = work = praxis – Freire, 2000, p. 87). Praxis, a process of reflection and action, is part of the
learning and part of the becoming. Freire (2000) sees the pedagogy of the oppressed as a process of becoming, with education constantly being remade by women and men who are “unfinished, uncompleted beings in and with a likewise unfinished reality” (p. 84). Similarly, Brickhouse (2001) sees learning being required in the process of becoming a person and not merely being a matter of acquiring knowledge: “it is [a] matter of deciding what kind of person you are and want to be and engaging in those activities that make one a part of the relevant communities” (p. 286).

This process of becoming reflects a more ontological view of learning. The self is not considered a fixed, stable, autonomous entity as in neo-liberal rhetoric. In the enactment of a curriculum which considers the self as a process of becoming, there would be less emphasis on control and self-regulation and a more ontological view of learning i.e. that focuses on being and becoming. There is a difference that needs to be made explicit between the critical pedagogy that aims to liberate every oppressed person and the critical pedagogy that uses discourse to describe education and health as a social practice as a means of emancipation in and of itself. There is a slightly different focus here and it seems as if the focus latterly is more on describing the subjective experience of the social practice of health and education. This micro/macro approach challenges the depersonalization that can occur with critical pedagogy and makes the practice of critical pedagogy more local and in process.

The next section reviews the literature on reflective practice as a learning tool. Since reflection is considered part of critical pedagogy and together with action forms the
praxis or becoming in learning, it is important to review the literature on reflective practice in order to see how it fits with the more ontological view of learning.

2.3.2 Reflective practice

Part of the enactment of a curriculum in education and health can involve reflection on teaching and learning practices. Teaching and learning theories that relate to awareness and a self-consciousness about teaching and learning include reflective practice and action learning. Reflective practice can be seen as part of ‘how’ professionals are educated as it can enable professionals to locate their practice in a particular frame.

Reflective practice has become the major focus for professional education in the U.K., especially with predominantly female workers such as in teacher education, social work and nurse education (Clegg, 1999). However, there have been some major critiques of reflective practice as a disciplining process (Clegg, 1999; Fendler, 2003) that thwarts reform because of the reproduction of the “‘disembodied and disembedded’ subject of masculinist thought” (McNay, 1999; cited in Fendler, 2003, p. 95):

These days the meaning of professional reflection is riddled with tensions between Schon’s notion of practitioner-based intuition, on the one hand, and Dewey’s notion of rational and scientific thinking on the other hand. These tensions between intuition and science are combined with Cartesian impulses towards self-awareness and feminist interventions (Fendler, 2003, p. 5).

This tension between reflection as expert knowledge and reflection as anti-expert knowledge (Fendler, 2003) has been likened to a system of self-surveillance where
professional autonomy is under attack due to the normalizing function of reflective practice (Clegg, 1999).

Reflective practice is seen as limiting in that as it collapses back into an uncritical notion of expertise it seems unable to engage with issues of power and difference (Clegg, 1999). The focus on individual practice can lead to an apolitical introversion. Thus a major criticism of reflective practice has been that it does not engage in the complexities of class, race or gender, etc. Clegg (1999) suggests that reflection be considered as part of a double loop whereby the knower’s social being in terms of gender, sexuality and class form part of the basis of knowing. This is similar to standpoint pedagogy whereby the social position of the knower influences what is known (Brickhouse, 2001) and also to the notion of the double consciousness of one’s spatiality as described by Lugones (2003).

It seems strange that a learning theory that was offered by Dewey and Schon as an alternative to the positivist model of reflection as technical rationality (Waks, 1999) is often used to support the positivist biomedical model with its causal problematic and evidence-based practice. It is argued that reflective practice in this context has been used as part of a disciplining process that thwarts reform in health. Thus the use of awareness and a self-consciousness about learning and teaching can be problematic when it focuses on the self in isolation, and without reference to gender, class, race and relational issues. Unlike critical pedagogy which emphasizes reflection as part of a process of becoming,
reflective practice that is used as an isolated self-consciousness seems to prevent being and becoming.

Part of the difficulty with reflective practice in health is that it has not been adequately defined (Heidari and Galvin, 2003). One suggestion is that:

Reflection is initiated by an awareness of uncomfortable feelings and thoughts which arise from a realization that the knowledge one was applying in a situation was not sufficient to explain what was happening in a unique situation (Palmer, Burns and Bulman, 1994, p. 13 cited in Heidari and Galvin, 2003, p. 49 – 50).

This definition emphasizes the being and practice of the practitioner and links reflective practice relationally by the conduction of action learning groups. The important components of reflective practice seem to be the inclusion of the body, awareness of the social being of the reflector in terms of the context (gender, race and class issues) and an awareness of the co-option of reflective practice by dominant neo-liberal rhetoric into another form of discipline.

An embodied response to reflection takes on anxiety as a natural symptom of qualitative research. For example, “An anxious situation arises when the self-understanding in which one is genuinely invested is rendered problematically uncertain and hence, possibly untrue” Fischer 1989 cited in Todres, 1998, p. 123). Reflection works as both an individual and social mediator in learning and research but the dangers are the generalisability and the loss of particularity of experience in that process of reflection. Such a situation requires a constant negotiation during reflection between the self and the
social/institutional milieu that does not result in an erasure of a learner’s sense of self (Pearce, 2008). Further definitions of reflection and reflective practice are required.

Further definitions require teasing out the differences between reflection, critical reflection and reflexivity. For example:

But, in brief, reflection can be defined as thinking about practice, critical reflection as thinking about how you are thinking about practice, and reflexivity as thinking about how you are thinking about practice in the political, social, ethical, and historical context; reflexivity is essentially a constructivist activity and in principle is a process of inquiry/research activity that originates in the desire for social action, agency and change (Freshwater, 2008, p. 216).

Not all papers concerned with reflective practice or reflexivity demonstrate an awareness of the social context within which professional practice is operating. This can be limiting in relation to the construction of the health professionals’ self.

2.3.3 Socioeconomic determinants of health

Emancipatory health theories tend to be framed in terms of socioeconomic determinants of inequalities in health. These theories could be seen as forming the necessary opposite to behaviourist theories of health. Recently, there has been the formation of collaborative groups that seek to address health inequalities by looking at complex biological, behavioural, cultural and geographic factors (Health Inequalities Research Collaboration, 2001; CSDH, 2008).
In 2005, the WHO set up the Commission on Social Determinants of Health (CSDH), whose task it was “to collect, collate and synthesize global evidence on the social determinants of health and their impact on health inequity, and to make recommendations for action that address that inequity” (CSDH, Foreword, 2008).

The report suggests addressing the inequities through improving daily living conditions, with an emphasis on gender inequity, tackling the inequitable distribution of power, money and resources, and finally, measuring and understanding the problem and assessing the impact of action (CSDH, 2008).

These far-reaching suggestions are inspiring in their commitment to reducing health inequity. As a form of inquiry, or theoretical stance, to take in relation to health, the commission uses social injustice and inequities in health as the basis for major reform across policies, governments and countries. Health as an institution is used for introducing major reform on a scale not seen in other disciplines such as education or the social sciences, even though these disciplines have elements of social justice within them such as expressed in the idea of the pedagogy of the oppressed (Freire, 2000). In the report health is presented as the vehicle for addressing injustice and it is presented as a
matter of life or death. Health as an institution is given the mandate to use health education as a policy for the management of the poor as health education becomes a social science and health policy expands its domain to include housing, behaviours and wages (Gastaldo, 1997). Health institutions and the health professionals within them are then used as part of a policing process to strengthen the state (Foucault, 1973). Perhaps the emphasis placed on health is a long overdue recognition of the power that health professionals can wield in relation to social injustice.

However, the point must be made that health professionals are implicated in the work they do and the structures they are trying to change (Ellsworth, 1992), be that individual behaviourist or social determinants of health. Unfortunately while the commission’s report is inspiring, it lacks detail on how to achieve utopian moments of health and equality given the fact that health professionals and policy makers are implicated in the work they do. There is some attempt at this:

The evidence base on health inequity, the social determinants of health, and what works to improve them needs further strengthening. Unfortunately, most health research funding remains overwhelmingly biomedically focused. Also, much research remains gender biased. Traditional hierarchies of evidence (which put randomized controlled trials and laboratory experiments at the top) generally do not work for research on the social determinants of health. Rather, evidence needs to be judged on fitness for purpose – that is, does it convincingly answer the question asked.

Evidence is only one part of what swings policy decisions – political will and institutional capacity are important too. Policy actors need to understand what affects population health and how the gradient operates. Action on the social determinants of health also requires capacity building among practitioners, including the incorporation of teaching on social determinants of health into the curricula of health and medical personnel (CSDH, 2008, p. 20).

The report states that there is enough evidence on the social determinants of health to act now. Perhaps what is required now is qualitative research to fill in the gaps so that health
professionals can understand more about how they are implicated in the work they do, especially when trying to change oppressive structures. Otherwise, the report could come across as ongoing colonizing neo-liberal discourse promoting the rise of humans as autonomous individuals progressing upwards towards a state of good health (Riggs, 2004). The ethical imperative to reduce health inequities is without contest. But the implications for and roles of health professionals and privileged policy makers also require elucidation.

Social determinants of health and other forms of empowerment education in health such as critical or radical health education (Gastaldo, 1997) are based on critical pedagogy and Friere’s (2000) ideas e.g Minkler and Cox, 1980; Wallerstein and Bernstein, 1988; Israel, Checkoway, Schulz, and Zimmerman, 1994; Merideth, 1994; Plough and Olafson, 1994; Purdey, Adhikari, Robinson, and Cox, 1994; Baum, 1998; Scheyvens, 1998; Chawla, 2000; Hepple, 2000; Appleby, 2001. Critical or radical health education has had varying success in communities typically seen as oppressed (Gastaldo, 1997). While some short-term, local, structural changes have been achieved, in other cases nothing has changed as the facilitators come and go according to funding allocations (Minkler and Cox, 1980). Unfortunately any funded program or initiative is only as viable as the government that supports it and the people that participate in it. Improving the equity of the healthcare system in terms of access and funding has been shown to be more effective when it focuses on providers rather than funders of healthcare (Oldenburg, McGuffog, and Turrell, 2000). While these approaches have been around for twenty to thirty years, little seems to have changed in terms of empowerment or health.
Empowering individuals and strengthening their social and family networks is the focus of empowerment education which tends to frame empowerment as a gift to be bestowed upon those in need: “health improvement initiatives are likely to have a greater success among people who feel they have control over their lives” (Oldenburg, McGuffog, and Turrell, 2000, p. 490). Emancipatory health theories are focused on empowerment and having control (e.g. Baum, 1998). “At the heart of our concern is creating the conditions in which people can live flourishing lives. People need good material conditions to lead a flourishing life; they need to have control over their lives” (CSDH, 2008. p. 35).

Empowerment is a loaded concept which has as its dependent variable an individual who either has power or who does not. That is, power, like control, is seen from within a dualistic framework. Gastaldo (1997) sees radical health education as focusing on empowering people to control their own health through participation in health services. However when participation becomes another code of normalization, it ends up being a point of subjugation. Health education is an experience of being governed from the outside and a request for self-discipline and this way health education, with its complex system of punishment and rewards, works to construct the identity of the receiver of health services (Gastaldo, 1997).

Lather (1991b) goes against the popular use of the word empowerment as meaning individual self-assertion, upward mobility and the psychological experience of feeling

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Baum (1998) sees empowerment as ‘an individual’s ability to make decisions or have personal control’ (p. 327). She warns against the Loser’s triangle of Victim (community), Rescuer (health worker) and Persecutor (health worker) suggesting instead a Winner’s triangle of the Vulnerable community (“we would like you to use your skills to assist us promoting our own health. You will be on TAP, not on TOP”), Assertive health worker (“How can I use my skills to work with you?”), and Caring health worker (“I will listen to you until I understand your view of the world and how to see your health issues”) (p. 336).
powerful. This populist idea of empowerment ties in with colonizing neo-liberal discourse that sees humans as autonomous individuals progressing upwards towards a state of good health (Riggs, 2004). Lather (1991b) suggests instead developing approaches which empower those involved to change as well as understand the world:

…I use empowerment to mean analyzing ideas about the causes of powerlessness, recognizing systemic oppressive forces, and acting both individually and collectively to change the conditions of our lives (Bookman and Morgan, 1988; Shapiro, 1989). It is important to note that, in such a view, empowerment is a process one undertakes for oneself; it is not something that can be done “to” or “for” someone: “The heart of the idea of empowerment involves people coming into a sense of their own power, a new relationship with their own contexts” (Fox, 1988: 2) (Lather, 1991b, p. 4).

In this way, health professionals and policy makers are implicated in empowering themselves through analyzing causes of powerlessness and acting both individually and collectively to examine the role of power and privilege in our lives. De-stabilizing grand narratives of empowerment and freedom which are neo-liberal discourses about the ‘individual’ allows a different form or materialization of empowerment to take shape. This is one way in which health professionals can be involved in change: by analyzing (and de-stabilizing) how the enactment of empowerment curricula and rhetoric is involved in maintaining structural inequities in health.

Critical pedagogy has its critics in the feminist and poststructuralist literature, who suggest that we need something different than a pedagogy which still relies on the neo-liberal individual. At times, ‘critical pedagogy’s agenda reads as a humanist discourse of progressivism rewritten in the language of critical theory’ (Luke, 1992, p. 38).
Progressivism makes powerlessness, the product of oppression, invisible. Within the naturalized discourse it is rendered “unnatural”, “abnormal”, “pathological” – a state to be corrected, because it threatens the psychic health of the social body. It is therefore very important to reassert the centrality of oppression and its transformation into pathology in terms of a political analysis of the present social order (Walkerdine, 1992, p. 21).

Health is linked to the personal power of the individual, rendering powerlessness invisible. The emphasis on control in social determinants of health could make powerlessness invisible. For example, the commission states:

… heart disease is caused not by a lack of coronary care units but by the lives people lead, which are shaped by the environments in which they live; obesity is not caused by a moral failure on the part of the individuals but the excess availability of high-fat and high-sugar foods (CSDH, 2008, p. 35).

There is a skating over the role of the individual here which in effect renders powerlessness invisible. Powerlessness is embodied by the individual; it is the interface between the structural and the individual. It could be that the individual is the embodiment or the interface of the structural or constructed war between the dualities of individual responsibility (agency, control, empowerment) and social determinants of health (control, empowerment), rendering the individual powerless once again. That is, social determinants of health theory is in fact on the same footing as the healthy behavioural lifestyle approach because of the predominant assumption of the individual who is constituted by and performs control. But a closer examination of the discourse shows that as in educational theory the individual is constructed as having agency and being in control only through being a passive learner. In social determinants, with the emphasis on structural causes of ill-health, the individual is said to need to have control over their lives, but this is only after having constructed them as passive people who are
shaped by the environments in which they live. There is a major tautology at the heart of these disciplines of education and health in the construction of the individual around ideas of control and empowerment. The social determinants of health literature could lead to dehumanization as it substitutes covert for overt regulation (Usher, Bryant and Johnston, 1997).

Strategies such as student empowerment, which treats the symptoms of powerlessness but leaves the disease of neo-liberal rhetoric unnamed and untouched, and dialogue give the illusion of equality while leaving the authoritarian nature of the student/teacher relationship intact (Ellsworth, 1992). Ellsworth (1992) sees her task as one of redefining critical pedagogy so that it does not need utopian moments of ‘democracy’, ‘equality’, ‘justice’ or ‘emancipated’ teachers:

A preferable goal seemed to be to become capable of a sustained encounter with currently oppressive formations and power relations that refuse to be theorized away or fully transcended in a utopian resolution – and to enter into the encounter in a way that both acknowledged my own implications in those formations and was capable of changing my own relation to and investments in those formations (Ellsworth, 1992, p. 100).

Critical pedagogues are always implicated in the very structures they are trying to change (Ellsworth, 1992, p. 101).

The sustained encounter required here is with the oppressive constructs of both individual and sociocultural determinants of health that cannot be theorized away or transcended in a utopian resolution such as ‘health for all’ as mandated under the global auspices of the World Health Organization.
A sustained encounter means engaging with oppressive formations in multiple pluralistic approaches to theory making. At the moment there is minimal engagement by health professionals with the poststructuralist idea that health institutions and the workers within them are used as part of a policing process to strengthen the state (Foucault, 1973). Bell (2002) suggests we talk different spaces by asking ourselves “What does this say about me? How is my position of privilege maintaining this situation? What responsibilities do I have in this position?” therefore shifting the focus away from the ‘other’ to an acknowledgement of our own position of privilege and therefore of responsibility (Bell, 2002). This is a socially accountable practice (Riggs, 2006). It seems as if something radically different is required since none of the health pedagogies mentioned above have been capable of producing sustained positive change except perhaps for the benefit of health policy makers and privileged people, it seems as if something radically different is required. Perhaps the failure of emancipatory projects in health is an outcome of not enough deconstruction or displacement of hegemonic positions (Lather, 1991b).

### 2.3.4 Summary and critique of emancipatory theories of learning and health

Emancipatory theories of learning are about reflection and action on learning with an emphasis on social change. There is less emphasis on the autonomous rational subject and more on the process of becoming through learning. However, critical pedagogy in particular acknowledges the continual implications of being a critical pedagogue: that one may unwittingly participate in oppressive structures even while trying to critique them. It
seems important to note that learning theories offered as an alternative to positivist models are often co-opted by the dominant technical rationality learning models and used as techniques of discipline or normalization. It seems to me that the point of co-option or the moment of subjugation centres around what particular definition of self is used. Learning theories can all be co-opted to preserve the neo-liberal self by being turned, or introverted, into technologies of self (Foucault, 1988a) or into forms of policing and governmentality such as in Biopower\(^3\), for example.

Different views of the self utilized within critical pedagogy have different effects. If a critical pedagogy speaks like a humanist progressive agenda with the freeing of each autonomous individual, then it seems to have serious limitations. If, however, critical pedagogy speaks of a process of becoming with a double consciousness of one’s spatiality and the structural constraints and entrapments that one must move between and within, both structurally and relationally, then this leads to a self that emphasises being and the subjective experience of the social practice of health and education. The spatial self or knot lying at the intersection of structural constraints and relational necessities is a way of being that includes asymmetries of power (Lugones, 2003). Both the becoming and the being (in which only a brief time may be spent) are privileged and part of the dynamic space of becoming. Then, of the different relationships described initially, each person must be a learner and each one must also be an educator with a subsequent decrease in the power differential. That is, knowledge is seen as a shared practice and something that is produced relationally (Riggs, 2006). Each person is acknowledged as

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\(^3\) Biopower refers to the technologies, knowledges, discourses, politics and practices used to bring about the production and management of a state’s human resources. Biopower analyses, regulates, controls, explains and defines the human subject, its body and behaviour (Danaher, Schirato and Webb, 2000, p. ix).
in the process of becoming and embodiment: “unfinished, uncompleted beings in and with a likewise unfinished reality” (Freire, 2000, p. 84). Of course, this process of becoming must also include movement around and within the predictive and understanding models of learning as well as the emancipatory. Emancipatory theories in education can be represented by a dynamic process-orientated discourse that emphasizes embodiment and a continual awareness of the social practice of health and education: in other words the workings of power itself.

In contrast, emancipatory or liberatory forms of pedagogy applied to health tend to be focused on the disadvantaged and underprivileged groups of people with the aim of trying to empower them so that they are no longer sick or unhealthy. There is less emphasis on changing social structures and institutions, with the exception of the work of The Commission on the Social Determinants of Health (2008). Social structures perform as exclusionary practices as is the case in the training of health professionals. There is still a dualistic framework operating here with disadvantaged unhealthy people positioned as the necessary opposite to the ideal of healthy privileged people. However, the paradox is that even though there is dualistic thinking which positions healthy as opposite to unhealthy, and behavioural determinants as opposite to social determinants, there is a tautology in that both sets of determinants refer to ‘individuals’ and emphasize control as per neo-liberal rhetoric through passivity of the individual. Both carry the message that somehow the individual is wrong and needs to change.
An example of how the dualistic thinking pervades the framing of health problems, is found in literature relating to Indigenous health in Australia. The following analysis is used as a bridge towards deconstructive lines of inquiry, since while some approaches to Indigenous health have been framed as emancipatory, there is also a movement in Indigenous health towards deconstructive pedagogies that examines the constructs implicit in these approaches.

2.3.5 Indigenous health in Australia

At present, exclusionary practices are operating within health that define non-Indigenous Australians as having health while generally speaking Indigenous people do not. This is a setting of a boundary and the inculcation of a norm (Butler, 1993). Indigenous Australians have been positioned as ‘other’ to the non-Indigenous Australians in health whilst also being banished from the mainstream health services. Indigenous health is an example of how the imposition of colonizers’ ideologies continues to disadvantage Indigenous people at the same time as it accrues advantage to non-Indigenous people (Moreton-Robinson, 2003, cited in Riggs, 2006).

Indigenous health has been the subject of many papers that seek to identify why Indigenous people continue to show the worst indicators of health of all Australians (ABS, 2006a, 2006b, 2006c, HealthInfoNet, 2006). An overview of Aboriginal health policies is given here to pay attention to the discourses surrounding Aboriginal health so that this thesis might demonstrate a socially accountable practice (Riggs, 2006), as well
as honouring the fact that white colonization in Australia has resulted in such a shameful picture of Indigenous health. Health professionals have minimal contact and information sharing with Indigenous people during their training, as ascertained by reviewing two local West Australian health professional course outlines for this chapter. This role of privilege in perpetuating health inequities needs to be examined in the context of ongoing practices of ownership and belonging on the part of white people, and exclusion from white society on the part of Indigenous people.

The curricula of both local university courses studied during the course of this research paid minimal attention to issues surrounding different genders, races and ethnic groups. There is a silence on the impact of white colonization of the health of Indigenous people. One could think that because Indigenous people are most sick more often they would form a greater proportion of the work of health professionals. And therefore that more of the curriculum would be devoted to the way that white colonization/behaviour has impacted on Indigenous peoples’ health. But this isn’t so. It is an optional extra – in one course, Indigenous health is but one option to choose from amongst many topics given for choice of presentations, and Indigenous health just merits a mere mention in the other course. Not only are Indigenous people excluded from Australian mainstream society (Eades, 2000) they are also excluded from the curricula of at least two health professional training courses in Western Australia.

The exclusion of Indigenous people from Australian society is said to be the root of the shameful current state of health of Indigenous people (Eades, 2000). The exclusionary
practices experienced by Indigenous people form the process of materialization (Butler, 1993) that give shape and boundaries to the body of the Indigenous person and meaning to them about what it means to be human. The life course perspective, a theory referred to in relation to Indigenous health, agrees with the process of materialization and sees the physiological status as a marker of the past social position of Indigenous people (Eades, 2000). Thus diseases that are endemic today in Indigenous people include obesity, hypertension, diabetes, renal failure, coronary heart disease, cancer and arthritis (Jackson and Ward, 1999) and could be seen as largely auto-immune diseases, i.e. as the body attacking itself. The prevalence of auto-immune diseases could also be seen as the biological stress response being activated too often and for too long (Eades, 2000). These are not mutually exclusive suggestions.

The stress response and the view of the body attacking itself make sense in a life where exclusionary practices have been the norm. Indigenous people who have survived being a part of the ‘Stolen Generations’ show clinical pictures that are “consistent with a contemporary understanding of the harmful impact of chronic trauma on the developing self” (Petchkovsky, San Roque, Napaljarri and Butler, 2004). The degree of distress experienced by these people was suspected to be “merely the tip of a monstrous iceberg” (Petchkovsky et al, 2004) that encompasses trauma, re-experiencing (recollections, dreams, flashbacks, cues/triggers with emotional or physiological responses), overwhelming threat, hyperarousal and dissociation, intrusive recollections, recurrent nightmares, avoidance or numbing, loss of memory, diminished interest in life activities, estrangement from others, affect restriction, foreshortened future, hypervigilance,
insomnia, concentration difficulties and irritability, lifelong duration often with exacerbations to major depression proportions, not feeling at home in either culture, somatisation (chronic headaches, irritable bowel syndromes, chronic body aches and pains), alexithymia (a characterological style which struggles to identify emotions and allow an inner life of fantasy and imagination) (Taylor, 2000 cited in Petchkovsky et al., 2004), self-harm, chronic shame, suicide, social withdrawal, chronic fatigue or tiredness, feelings of pessimism, despair or hopelessness and feelings of inadequacy (Petchkovsky et al., 2004). Such experiences made up the fabric of these people’s lives. The process of materialization for Indigenous people who were part of the Stolen Generations ends up making them abject in relation to the white culture:

… what is abject, on the contrary, the jettisoned object, is radically excluded and draws me toward the place where meaning collapses. A certain “ego” that merged with its master, a superego, has flatly driven it away. It lies outside, beyond the set, and does not seem to agree to the latter’s rules of the game. And yet, from its place of banishment, the abject does not cease challenging its master. Not me. Not that. But not nothing, either. A “something” that I do not recognize as a thing. A weight of meaninglessness, about which there is nothing insignificant, and which crushes me. On the edge of non-existence and hallucination, of a reality that, if I acknowledge it, annihilates me. There, abject and abjection are my safeguards. The primers of my culture (Kristeva, 1982, p. 2).

Indigenous people play a role in white culture through the process of materialization of abjection. They and the symptoms they can exhibit have been radically excluded from white society, and continue to be so. There must be a collapse of meaning for people who experience such extreme symptoms as listed above, which means there can be no agency of meaning (Lather, 1991b). By being merged with a non-Indigenous culture where the position of being Indigenous carries with it a passivity and a victim role, there must still be a sub-text that Indigenous people are somehow wrong and must change
either through behavioural or social determinants of health policy. It is no wonder then that Indigenous Australians display the worst health indicators in the nation which is a cause for national shame (Eades, 2000).

It seems as if not much has changed since mainstream services appear unable to take on board the notion that such exclusion may be harmful and practices such as those of the Stolen Generations produce major and serious consequences for (mental) health (Petchkovsky et al, 2004). Some bureaucrats argue that the Stolen Generations never happened (Loff and Anderson, 2000), and even if they did happen the events only affected 10% of a generation, not a whole generation or a number of generations that had been removed from their parents. This writing out of history seems to be reinforced by curriculum documents that do not consider such events and the effect that they might continue to have on people.

This editing of reality is frightening when considering the question “‘how could this have happened?’”. How could responsible caring people have overridden so much evidence of extreme emotional distress, and their feeling responses, for these policies to have been systematically implemented for over half a century?” (Petchkovsky et al., 2004, p. 11). The fear is that by health professionals remaining ignorant of the distress of these events, history is repeating itself as Indigenous people are confronted with health professionals who exhort them to exercise (“It’s not a big exercise campaign”) or give up smoking or who just can’t understand why they can’t lose weight. Dis-remembering is the denial, rationalisation and trivialization of cultural forces, and, it may be said,
feelings, which work to systematically edit the reality of inflicted harm (Petchkovsky et al., 2004, p. 11). Over-riding of distress in order to get a job done seems to be the implicit rationalization in the health professional curriculum that is silent about cultural events such as this.

The silence on the reality of inflicted harm is part of the in-between, of the space or gap, between the educator and the educated. Another part of the space in between educator and educated could be what Petchkovsky et al., call the ‘attacks on linking’ with culture, family, and emotional connection of Indigenous people:

> Emotion is hated, emotional connections are actively attacked. A style of function that is ‘logical, almost mathematical, but never emotionally reasonable’ prevails. Consequently, ‘the links surviving are perverse, cruel and sterile’ (Petchkovsky et al, 2004, p. 12).

What is in-between the educator and educated includes the materialization of the bodies and the negative effects of chronic trauma along with possible attacks on linking, and emotions. It could be that any encounter with a white middle class health professional who espouses advice and information based on the idea of an individual who is a rational autonomous human being, without contacting or connecting to their feelings or subjective experience, will only re-enact the trauma experienced by Indigenous people, as it has been said that “it is the systematic attacks on all this linking [with extended feelings, family, land, animals, dreaming tracks and culture] that constitute the core trauma of the Stolen Generations story” (Petchkovsky et al., 2004, p. 13). This represents the core trauma of a person not being allowed or able to exist within their primary relationship. These points of complexity also lend weight to the idea that even in extreme cases of
materialization where social practices of health and education have been formative, a person’s subjective experience needs contacting, acknowledging and containing within the understanding that the person’s (patient’s or client’s or health professional’s) context is all important.

The failure of mainstream health services for Indigenous people has been widely documented (Saggers and Gray, 1991; Hunter, 1993; Jackson and Ward, 1999; Ellis, 2000; Brideson, 2004; Brideson and Kanowski, 2004; Elliott-Farrelly, 2004; Hunter, 2004; Martin, 2004a; Riggs, 2004; Vicary and Westerman, 2004; Westerman, 2004; Riggs, 2006). Some believe that reconciliation is the answer (Jackson and Ward, 1999; Eades, 2000) but it seems to be an ever-retreating horizon (Loff and Anderson, 2000). It seems that we do need a more socially accountable practice (Riggs, 2006) of health care, one that focuses on the way that racialised understandings of subjectivity are dominant in this country and one that acknowledges the ‘whiteness of psychological epistemologies’ (Riggs, 2004) as well as other epistemologies. The whole idea of an autonomous individual progressing upwards towards a state of good health is closely connected to colonial narratives of civilizing primitive cultures (Riggs, 2004). By disowning parts of Indigenous health, such as feelings, the white health epistemology seems to reject other standpoints. It seems as if there can never be any real change in the location of epistemological standpoints until all that is disowned is taken back and owned by the white people.
The example of Indigenous health is included here to highlight how western ideologies and epistemologies of health have contributed to the exclusion and banishment of Indigenous health and peoples from mainstream training curricula and health services. Part of the banishment could be seen as a result of the imposition of the neo-liberal autonomous individual along with the binary notions surrounding health with its focus on (perfect) health and the consequent banishment or abjection of all imperfection. In such extreme conditions of materialization and abjection, even though the context can clearly be shown to be responsible for the materialization that occurs, the personal subjective experience also needs including in the health encounter. The complexity of the health encounter and health professional practice cannot be overstated. These ideas will now be developed further in the next section.

2.4 Deconstructive models of learning

Deconstructive models of learning include poststructural, postmodern and Foucauldian analyses. Poststructuralism as a theory decentres the rational, self-present subject of humanism (Weedon, 1987). Poststructuralist theorists like Derrida, Lacan, Kristeva, Althusser and Foucault (cited in Weedon, 1987) are interested in deconstruction of texts and language, in subjectivity and in identity, in consciousness as a construct of social relations (and therefore historically and culturally specific), and in the need to foreground discourse analysis, power and resistance. Lather (1991a and b) describes a process of deconstruction and embodied reflexivity. I begin with poststructuralism.
2.4.1 Poststructuralism and learning

Poststructuralism analyses the links between language and meaning, between the signifier and the signified, and sees these as always culturally and temporally located (Weedon, 1987). The links between language and knowledge, subjectivity and identity, and how understanding the links helps the understanding of power, are vital elements. Being human is thus seen as a complex process. It is complicated because while humans are both active in their subjectification/socialization, they are also limited by the social meanings that are historically and culturally ‘available’ (Jones, 1997). Here is the tension between the social and the individual (or between sociocultural and constructivist theories of learning) and hence between poststructuralism/postmodernism and modernism. The semantic construction of the body and individual is the concern of a poststructural analysis.

Poststructuralist theory draws attention to: “the signifying matter, which, instead of making itself transparent as it conveys a particular meaning, becomes somewhat opaque like a piece of stained and faceted glass. Thus in the most basic way the reader is invited to look at rather than through the linguistic surface” (Davies, 1997: p. 272, quoting Levine, 1991).

Poststructuralism focuses on the linguistic surface and what constitutes it in order to read beneath the surface of the text. Attention is also paid to the silences embedded in certain discourses.

Silence can be a powerful controlling force in the formation of identities as learners and workers. Being engaged in a reflexive process of making the constitutive forces visible in ‘the linguistic surface’ (Jones, 1997) is the concern of poststructuralist accounts of
learning. In the enactment of a curriculum, silence as well as the linguistic surface of texts is important in determining the role of the teachers and learners.

Poststructuralism posits that there is a plurality of meanings to language and that these are not fixed but always located in a social order that is historically and culturally contingent:

Once language is understood in terms of competing discourses, competing ways of giving meaning to the world, which imply differences in the organization of social power, then language becomes an important site of political struggle (Weedon, 1987, p. 24).

Since within poststructuralism there is a plurality of meanings to language and subject positions, there is a perception of a competition between the different positions with the dominant or hegemonic position being taken by the one with most power. Critical pedagogy seeks to liberate people from this dominance, which is seen as oppressive since it produces a lack of fit between, for example, the illness experience of the patient and the diagnostic disease focus of the health worker. Here, language in the form of conflicting discourses gives meaning to one set of people over another. ‘Truth’ is thus a discursive construct and “whoever has the power to define Truth in any society also has the power to define others” (Jordan and Weedon, 1995, pp. 547).

Poststructuralism and postmodernism take seriously the differing realities present in the world and try to salvage praxis (reflection and action) as an interruptor strategy (Lather, 1991b):

The question of praxis is at the heart of “getting smart”. … praxis is the self-creative activity through which we make the world; … it is … philosophy becoming practical. The requirements of praxis are theory both relevant to the world and nurtured by actions
in it, and an action component in its own theorizing process that grows out of practical political grounding (Buker, forthcoming) (Lather, 1991b, p. 11 – 12).

Praxis strategies can be learnt about within pedagogy, within teaching and learning, and are seen as an important counterpoint to positivist hegemony (Lather, 1991b). Lather (1991b) is “unabashedly committed to both the open-endedness over truth and reality” (p. 14) and prefers to see the failure of emancipatory projects to enact political and social transformation in education as an outcome of not enough deconstruction or displacement of hegemonic positions.

Analysis of discursive texts within pedagogy is seen as a core activity since this process focuses on the conditions and means through which knowledge and hence power is produced (Lather, 1991b). A pedagogy that is informed by the transformation of consciousness through the intersection of three agencies – the teacher, the learner and the knowledge they produce together – is a relational pedagogy that refuses to objectify these relations or give one priority over the other:

It, furthermore, denies the teacher as neutral transmitter, the student as passive, and knowledge as immutable material to impart (p. 15). The deconstructive text is a point of interrogation where binary notions of “clarity” are displaced as the speaking voice uses its authority to disperse authority. It positions itself as other to a call for a “plain-speaking” voice of reason which assumes that accurate information and clear messages will bring about desired behavioural change (Treichler, 1989) (Lather, 1991b, p. 9 – 10)

Therefore this approach to learning is a counterpoint to the dominance of the learning theories in the positivist tradition whilst also allowing for a pedagogy of relations. I will now go on to discuss postmodern theories in relation to learning, although at times the terms poststructural and postmodern are used interchangeably.
2.4.2 Postmodernism and learning

One way to view postmodernism is to see it as an analysis of the relations of power linking the constructs that form on a linguistic surface. Postmodernism is seen as a response “across the disciplines to the contemporary crisis of representation” (Lather, 1991b).

The essence of the postmodern argument is that the dualisms which continue to dominate Western thought are inadequate for understanding a world of multiple causes and effects interacting in complex and non-linear ways, all of which are rooted in a limitless array of historical and cultural specificities. Truth, objectivity and certainty were displaced by a focus on “regimes of truth”, deconstruction of the binary, linear logics of Western rationality, and a foregrounding of ambiguity, openness and contingency. This movement eventually came to be characterized with the terms “postmodern” in the United States and “poststructural” more globally (Lather, 1991b, 21/23).

Here there is a sense of movement, of the interconnectivity of constructs – power relations can be seen as local, unstable, diffuse and constantly circulating (Gore, 1995).

Power relations are those strands connecting nodes or selves that are elucidated by a deconstruction of theories, ideologies, and paradigms. There are resonances here with relational pedagogy (Biesta, 2004) and Lugone’s (2003) double consciousness of spatiality and power.

Lather (1991b) is inclusive in her description of postmodernism in that she sees it as encompassing (positivist) Enlightenment theory as well as the discourse of emancipation through a reconfiguration that uses strategies of displacement rather than strategies of confrontation. Strategies of displacement of the hegemonic position are grounded in deconstruction:
While it is impossible to freeze conceptually, deconstruction can be broken down into three steps: 1) identify the binaries, the oppositions that structure an argument; 2) reverse/displace the dependent term from its negative position to a place that locates it as the very condition of the positive term; and 3) create a more fluid and less coercive conceptual organization of terms which transcends a binary logic by simultaneously being both and neither of the binary terms (Grosz, 1989:xv). The goal of deconstruction is neither unitary wholeness nor dialectical resolution. The goal is to keep things in process, to disrupt, to keep the system in play, to set up procedures to continuously demystify the realities we create,…… (Lather, 1991b, p. 13).

Thus the goal is for a continual displacement and transcendence of binaries. The displacement of the binaries seems to echo Freire’s (2000) insight about the inner duality of the oppressor and the oppressed so that there is freedom on an inner level as well as emancipation on an outer level of the self. That is, the internalized oppressor and oppressed can be displaced by an awareness of and displacement of binaries as well as an awareness of social and structural constraints enacted by institutional binaries.

The postmodern self has never been and will never be properly identified although postmodernists claim that life is characterized by fragmentation, differentiation, plurality of meanings and subjectivity, reflecting people's differences in terms of their culture, lifestyle and vested interests (Germov, 2002). At times it has been suggested that there is no self (Ball, 1991), or an abstract self (Lugones, 2003), a bodily self (Niranjana, 2001), or there is the fiction of the self-determining subject of modern political, legal, social and aesthetic discourse (Lather, 1991b). What is important is that the self, an embodied self, is assuming a greater importance in the questions asked of theories:

The growing visibility of the body across the disciplines is often seen as a modern (or postmodern?) symptom where questions of the self have become all-important, lending perspective to the idea that a person’s sense of self is largely consolidated through the body (Niranjana, 2001, p. 121).
The subject has become de-centred through the impact of postmodern discourse:

What has “died” is the unified, monolithic, reified, essentialized subject capable of fully conscious, fully rational action, a subject assumed in most liberal and emancipatory discourse. Such a subject is replaced by a provisional, contingent, strategic, constructed subject which, while not essentialized, must be engaged in processes of meaning-making given the bombardment by conflicting messages. ….. Hence, de-centering is not so much the elimination of the subject as it is the multi-centredness of action, a re-conceptualization of agency from subject-centered agency to the plurality and agency of meaning (Lather, 1991b, p. 120). (Emphasis in original).

It seems as though by not engaging with the dualities of binaries or the seduction of agency, learning takes place through meaning making that is multi-centred as in relational pedagogy, in the in-between or gap between the educator and the educated.

Postmodernism encourages a re-mapping of curricula by de-centering the positivist subject of dominant learning theories. If the neo-liberal autonomous individual is no longer in control of the learning and teaching space, then that space has to open up into shared meanings and shared spaces of learning. The enactment of curricula then becomes a shared process of discovery without mastery or ignorance. Likewise, there can be no ‘others’ to mainstream positivist learning because that too has become de-centred. I now move on to review deconstructive discourses as they can be applied to health since there is little literature within health professional practice itself that draws on deconstructive texts.
2.4.3 Deconstructive lines of inquiry in health

There appears to be limited literature from within health professional practice that is deconstructive in nature. The exceptions to this are little known and do not seem to be mainstream e.g. Petersen and Lupton, 2000; Cheek, 2002; Freshwater and Rolfe, 2004. Health professionals in general seem to practice with little awareness of the constructed nature of the health field. However, there are a number of sites of emergence that could operate as part of health professional practice in the displacement of the dominant positivist discourse such as the body, practice-based evidence and discourses about control.

The body as a site of contestation in and of health also needs to be considered in its emergence and operation. Rather than viewing the body as a conception of construction, Butler (1993) suggests:

A return to the notion of matter, not as site or surface, but as a process of materialization that stabilizes over time to produce the effect of boundary, fixity, and surface we call matter. …. Through what regulatory norms is sex itself materialized? And how is it that treating the materiality of sex as a given presupposes and consolidates the normative conditions of its own emergence? (Butler, 1993, p. 9 – 10) (original emphasis).

The materialization of bodies could also be seen to be taking place through the discourse and exclusionary practices of control. In a society that valorizes control (Riggs, 2005) the human body is materialized through the matrix of relations of control that exist prior to the emergence of the ‘human’. Like ‘sex’, control can be seen as “a regulatory ideal, a forcible and differential materialization of bodies, that will produce its remainder, its
outside, what one might call its ‘unconscious’ ” (Butler, 1993, p. 22). The ghosts that haunt the boundaries are the ghosts that haunt our unconscious. That is, the remainder or unconscious is that which has been split off or made abject from the conscious mind. What is left – control or out of control – proceeds to materialization.

It could be that the duality of control (perfection) and out of control (chaos) (Woodman, 1982) is enacted in a self-regulatory way through many of the lifestyle behaviours as a repetition designed to materialize the body, give it boundaries and form. This could be how we are incited by the neo-liberal discourse of freedom to take a particular subjectivity, and it could be the point where we are co-opted by the structural construct of control at precisely the point we are trying to resist it.

In a society preoccupied with control, as evidenced by mainstream health and learning theories, that the gap between the two polarities of in/out of control is becoming bigger is exemplified by health inequalities: the gap between the rich and the poor, between different ethnic and racial groups is getting bigger not smaller (WHO, 2006; CSDH, 2008). Evidence of the pre-occupation with control can be demonstrated by a number of ‘founding fathers’ such as Freud, Jung, Darwin and Foucault.

Foucault (1988a) recognized the importance of self-control as a technology of self that formed part of the policing process operating out of a deep need to mobilize power and impose structure on our behaviour. This will to power (Foucault, 1988a) exists apart
from the meanings we use to justify or explain such authority, such as theories from health psychology or medical sociology:

The truth that we seek about ourselves is a truth we associate with the power of self-control. ….. It is not knowledge of our sexuality that gives us power over ourselves (as Freud taught) but our will to establish power over our sexuality that incites our search for self-knowledge (Foucault, 1988a, p. 131).

Perhaps it is the will to establish power over any aspect of our behaviour or life that is incited by the relational mix of control and exclusionary practices of health services with the promise of neo-liberal freedom.

Health professionals who are trained to focus on behaviours are enacting exclusionary practices. One aspect of the human is amplified over other aspects and then the training (i.e. disciplining – Foucault, 1977) begins. The focus on positivist models of health education mean that simplistic models of health and learning have been developed that deny the complexity of these fields. The complexity of meaning making is also largely denied as theories in general seem unable to make links between the construction of the self by social and structural forces and the subjectivity of the person.

Theories that do take into account the complexity of meaning making include those in social psychology (Holloway, Lucey and Phoenix, 2007; Stainton Rogers, 2003), health psychology (Crossley, 2000; Lyons and Chamberlain, 2006) and nomadology (Fox, 1999). These texts will be explored further in Chapters Three, Four, Seven and Eight. They have not been included in this chapter due to limitations of space and because they were not included in the health professional curricula of two local universities.
2.5 Summary of main points

The hegemonic health theories in health practices are those positioned within the predictive category of knowledge generation and legitimation. The scientific rational positivist tradition is dominant with its focus on individual behaviour change to promote health. Therefore in the meeting place between the health professional and client, regimes of truth emphasize control, self-efficacy, self-help and self-management. There is silence on the harm enacted by governmental policies of exclusion particularly in relation to Indigenous health.

Health as a social practice seems to involve the denial of emotional issues and the complexity of factors involved in health. The dominant construct of self is one that has agency (but only through passivity and compliance); there is no discourse on other aspects of human being implying that there is a dismissal and disremembering of fundamental aspects of being human.

I will now give a brief overview of the literature relating to health professional education and professional practice. I am keeping the review brief as there is little new information to add to the already extensive review presented in this chapter. Points of interest that are in contrast to the mainstream literature will be included as they relate to health professional practice.
2.6 Literature on health professional education and professional practice

In the meeting place between the health professional and the patient or client, regimes of truth are shared (Foucault, 1973). In this chapter, it was demonstrated that the main truth shared was the dominance of the positivist model of health with its reliance on the agency and self-control of the individual to adhere to and comply with regimens of medicine. This meeting place between health professional and client or patient involves a sharing of the professional practice knowledge of the health professional who is positioned as the knower. Professional practice has been described as “the manner in which practitioners perform the roles and tasks of their profession in conjunction with individuals who are their clients or patients” (Higgs, Titchen and Neville, 2001, p. 4). Included in this practice is the application of theory and practice to messy real world problems (Higgs, Titchen and Neville, 2001).

As mentioned in chapter one, professional practice requires three forms of knowledge:

- Propositional, theoretical or scientific knowledge e.g. knowledge of pathology;
- Professional craft knowledge or knowing how to do something;
- Personal knowledge about oneself as a person and in relationship with others.

(Higgs and Titchen, 1995, cited in Higgs, Titchen and Neville, 2001)
The authors allude to a relational pedagogy here, and elsewhere state that addressing the patient’s problem cannot be done without reference to the person concerned and the variety of contexts in which they practice. However, these views are not reflected in the mainstream literature. This section will review the literature as it relates to pedagogy, professionalism and practice of the health professionals. I am keeping the review brief as there is little new mainstream information to add to the broad review presented in this chapter.

2.6.1 Pedagogy of health professionals

The literature on educating health professionals relies mainly on the use of evidence-based learning (Norman and Shannon, 1998; Eitel and Steiner, 1999), reflective practice (Borduas, Gagnon, Lacoursiere and Laprise, 2001; Sobral, 2001; Spratt and Walls, 2003; August-Brady, 2005; and O’Connor and Hyde, 2005), problem based learning (Watson and West, 1996), and critical thinking and/or appraisal (Velde, Wittman and Vos, 2006). There is an emphasis on problem solving using best practice principles as determined by scientific positivist research. Solution-focused nursing has been offered as an antidote to problem-orientated health care (McAllister, 2003). Rarely, a way of knowing such as intuition (Ruth-Sahd, 2003) or embodied relational understanding (Todres, 2008) is described. Thus, practice epistemologies are currently unbalanced “by the masculinization of knowledges” (Titchen and Higgs, 2001, p. 220).
The epistemologies rely on the medical model in order to achieve professionalization of the health professionals (Conroy, 2001). There is still the focus on the health professional, both expert and student, yet no regard for the construction of professional or patient/client within current health discourses. The above epistemologies have a neo-liberal agenda; that of promoting the self-directed and internally evaluative individual who in turn can know and think about the patient or client. Instead patients/clients are thought about in terms of a problem to be solved. The following papers, in contrast, advocate the inclusion of the patient in the process of learning.

2.6.1.1 Patients as teachers

An inclusive pedagogy is one where the patients are involved as teachers of the health professionals (O’Neill, Morris and Symons, 2006). This has been called practice sharing learning and is dependent on building relationships and learning together:

People who live with or care for someone with a long-term illness offer a very different type of expertise and knowledge that is rooted in their own experiences, not only of managing their disease, but also of navigating their journey through the health and social care system and living in a society where discrimination and inequality are still deeply embedded (O’Neill, Morris and Symons, 2006, p. 27).

The authors make the points that health professionals need to change at a much faster rate in terms of addressing the shortfalls of traditional educational practices, that experiential learning and active engagement between teachers and learners, based on Freire’s dialogic encounter, is required to help transform health professional students’ practice, and that it
is important to recognize and value the unique contribution that patient teachers bring to professional education (O’Neill et al, 2006).

It is believed that embedding the patient’s voice at the centre of health professionals’ practice and education is the way forward out of the current crisis in health education (WHO, 2006). Patient centred practice may be difficult for professionals who are embedded within hierarchies of power and who have much invested in their own professional knowledge base. Patients and health professionals are both embroiled in disciplinary and exclusionary practices as this goes with the territory of power relations. In contrast, the Commission on Social Determinants of Health (2008) places less emphasis on acute care settings and the health sector and instead emphasizes addressing poverty and health inequity through dismantling the “toxic combination of poor social policies, unfair economics and bad politics” (p. 35). While this would de-stabilize the investment in hierarchies of power within the health workplace, it also means there is less emphasis on including the patient’s voice at the centre of health professionals’ practice. This is in spite of the rhetoric of ‘putting people at the centre’ (CSDH, 2008). Reflective practice, a form of learning that often ends up being more about disciplinary practices than anything else, is now reviewed – this is in addition to the comments made in section 2.3.2.
2.6.1.2 Reflective learning in health professionals

This section builds on the discussion of reflective practice in section 2.3.2 where it was demonstrated that reflective practice is shadowed by a lack of contextuality and a lack of definition. This means that in its application reflective practice tends to be co-opted by dominant pedagogies that turn it into another form of self-policing. However, this has not dampened the enthusiasm for enlisting reflective practice as a form of professional education and practice.

Reflective learning has been used increasingly within health professionals’ training, particularly that of nursing (Clegg, 1999; O’Connor and Hyde, 2005). Reflective practice has been used interchangeably with critical thinking (Velde, Wittman and Vos, 2006), self-directed learning (Borduas, Gagnon, Lacoursiere and Laprise, 2001), reflective critique (Spratt and Walls, 2003), reflection in learning (Sobral, 2001), deep learning (Laight, 2006), and metacognitive intervention and self-regulation of learning (August-Brady, 2005). All of the literature reviewed here frames reflective practice in terms of professional knowledge, that is knowledge legitimated and generated by the positivist field of science.

For example, Schon’s model of reflective practice (reflection in action and reflection on action) was used with a group of physicians in terms of continuing medical education (CME) (Borduas, Gagnon, Lacoursiere and Laprise, 2001). The discourse is focused on the expert and their zone of mastery. The patient or client (the surprise case) is thought
about and acted on. The gap between the educator and the educated as discussed by Biesta (2004) is not mentioned.

In another paper exploring medical students’ reflection in learning (Sobral, 2001), the discussion was embedded in positivist concepts such as concurrent validity, significant correlations of reflection-in-learning scales (RLS), significant associations and measure of meaningfulness, perceived personal efficacy, etc. This paper was focused on reflection helping students control their learning and influencing their performance. Over a term, the pattern of reflection changed with reflection appearing to be driven more by the motivation to achieve than the motivation to know (Sobral, 2001). This seems to me to reflect the disciplinary nature of learning:

Thereby, it makes sense for a higher level of reflection-in-learning to relate to greater perceived learner self-regulation regarding efficacious reflection (Sobral, 2001, p. 512).

I understand this statement to mean that higher levels of reflection are related to increased self-regulation or self-discipline in order for learners to be more effective. Therefore reflection has been used as an internal regulatory process to improve the discipline of the students. Reflective practice here seemed to be based on a cognitive behavioural model of learning. Although it was acknowledged that reflection was likely to be affected by the limiting factors of the educational context, there was no discussion as to what these might be.

Another paper described a process of curriculum evaluation whereby medical students were encouraged to reflect on their learning experiences (Spratt and Walls, 2003).
paper is different to others in that an understanding of the students’ experience of a
particular course and pedagogical strategies was highlighted. The authors hold that
“pedagogical expertise in our view is embedded in experience and is characterized by a
deeply held view that teaching is central to learning” (Spratt and Walls, 2003, p. 87).
Students appreciated the opportunity to participate in the review, and to let it be known
that they believed the course was fragmented and the information was poorly integrated
into assessment. Whilst this research is admirable in that it focuses on the students’
understanding of their learning experience, it is unusual. Moreover, there didn’t seem to
be any exploration of the context of these understandings of a topic that was seen as
subject oriented and discipline based. It seems as if the literature on reflective practice in
the health field is largely technicist in orientation.

Another example of the technicist approach to reflective practice is given by research into
clinical teachers’ tacit knowledge of basic pedagogic principles (McLeod, Meagher,
Steinert, Schuwirth and McLeod, 2004). Tacit knowledge of pedagogic principles related
to learning, understanding, remembering and assessment is said to be acquired mainly as
a consequence of reflection in action, that is as the educational event is taking place
(McLeod et al., 2004). Tacit knowledge was valued as being more powerful than explicit
knowledge, and was related to doing rather than saying – unconscious competence:

Individuals performing at this level effectively modify their behaviour without reflecting
on how they are doing so. ‘Conscious competence’ can be equated to explicit knowledge
which is accompanied by understanding why what you do is effective or ineffective
(McLeod, Meagher, Steinert, Schuwirth and McLeod, 2004, p. 25).
Reflective practice is used to promote a technicist view of education based on a transmission model of learning. There is no mention of critical pedagogy or the context of medical education or the enactment of the curriculum.

Critical pedagogy is not mentioned in the literature in education of other health professionals either. The development of critical thinking skills in occupational therapy students is said to be fundamental to the profession (Velde, Wittman and Vos, 2006). Guided reciprocal peer questioning (GRPQ) is said to be in direct contrast to the transmission model of learning where the teacher is the ‘expert-knower’ and the students are passive receivers (Velde, Wittman and Vos, 2006):

As the learner ask questions about the experiences and reflects on the experiences, he or she progressively develops knowledge more adequate for a greater variety of situations. This epistemology seems congruent with the needs of therapists who operate in an increasingly client-centred practice that requires them to treat clients as individuals, plan interventions that work in complex contexts, and deal creatively with restrictive reimbursement systems (Velde, Wittman and Vos, 2006, p. 57).

GRPQ is said to be a learning experience that occurs through social participation and relationships. There is acknowledgement of both the constructivist and sociocultural theories of learning and GRPQ is seen as drawing on both and thereby transcending the dominant positivist paradigm. However, there is no mention of the constructed nature of the learner, the teacher or the learning context in an approach that is directed primarily at clinical reasoning skills.

Further examples of pedagogy directed primarily at clinical reasoning skills includes those by Rashotte and Thomas (2002), August-Brady (2005), and O’Connor and Hyde.
(2005) within the discipline of nursing. Rashotte and Thomas (2002) draw upon Benner’s (1984) model of novice to expert learning, Schon’s (1987) theory of reflective practice and Cranton’s (1996) transformational learning theory (all cited in Rashotte and Thomas, 2002). With their focus on an ongoing orientation and a total continuing education programme, the authors describe the development of a complex curriculum designed around competencies of care – what nurses need to know (knowing-in-practice) and what the nurses need to do (knowing-in-action). Core threads were identified based on knowledge and skills required in practice. The objectives (cognitive, affective and psychomotor) were framed in terms of behaviours involved in each phase of the continuing education program. The comprehensive program was designed to fit in with accredited standards, learning needs assessment, and ongoing formal appraisal interviews. Thus the ongoing education was embedded within disciplinary procedures.

Professional nursing regulating bodies in Australia, Great Britain and New Zealand have all advocated the development of a more reflective practitioner through the development of prerequisite competencies (O’Connor and Hyde, 2005) largely as a result of the influential writings on reflection and reflective practice in nursing. O’Connor and Hyde (2005) focused on the nursing teacher participants’ experiences of the manner in which they facilitated reflective learning in the nursing students and the factors that influenced this. There was a lack of discussion on the place of reflection within the nursing curriculum – such discussion is generally not encouraged and in fact ways to impede such a discussion are constructed that induce a sense of powerlessness to change matters:
According to Jarvis (1992) nursing is faced with a dilemma with respect to reflective practice – it wants to encourage reflective practice and to claim that it has it; however, the structures within which it operates seem to inhibit its development (O’Connor and Hyde, 2005, p. 299).

O’Connor and Hyde (2005) discuss at great length the issues of power within the nursing field that inhibit reflectivity and in fact ensure its failure. Issues of power (power over) risk the prospect of reflective practice increasing the theory-practice gap and thereby becoming part of the problem rather than the solution. Unusually, this paper named issues of power within the health field and called for the addressing of power relations within the hierarchical nursing education and practice. It seems that the addressing of power relations is required to make any pedagogy more than just a technical approach to teaching and learning.

2.6.1.3 Critical summary of health professional pedagogy

As discussed previously, there is a tension in the use of pedagogy in health that centres around the denial of complexity of issues involved with health. Most of the above literature positions the pedagogue and health professional as the expert knower, with little mention of the patient or client or the subjective experience of the student. The literature on reflective practice and other pedagogies generally does not engage with issues of power and difference, with the paper by O’Connor and Hyde (2005) being an exception. Reflective practice, evidence-based learning, problem-based learning, critical thinking and concept mapping are used in a limited sense to focus on individual practice therefore leading to an apolitical introversion. The health pedagogue’s (knower’s) social being is
not included in a double loop of knowing (Clegg, 1999) or considered as part of the influences on what is known (Brickhouse, 2001).

The health pedagogies in this section are used to support the positivist biomedical model thus thwarting reform in health. The literature on health pedagogies tends to fall into predictive lines of inquiry and can therefore lead the learner and knower to focus on self-regulation of learning at the expense of critically examining the context of health professional practice. Health professionals can think they are at the centre of learning and knowing by engaging with explicit theories about learning. However, the implicit curriculum is again about control and the autonomous individual. Health professionals learn through the enactment of curriculum that they must self-regulate their learning (and themselves) in order to belong to the elite group of health professionals. I will now go on to consider issues of professional craft knowledge (Higgs et al, 2001) in relation to professional practice.

2.6.2 Professionalism or professional craft knowledge

2.6.2.1 Professional practice

Professional practice is concerned with the manner (knowing how to do something) in which practitioners perform the roles and tasks of their profession (Higgs et al, 2001). Knowledge derived from research and theory positions the health professional as the technicist expert, the knower, within a positivist biomedical model of health. The health professional’s practice or craft is embedded in this dominant hierarchical model of health
where also individuals are positioned as the neo-liberal, autonomous, rational, in control, and objective (male) person. Thus it seems that most of the literature relating to professionalism or professional practice supports these positions.

Different perspectives on professional knowledge are offered by Titchen and Ersser (2001) who describe a range of epistemological concepts used to describe, explain and analyse the different types of knowledge relevant, but not mainstream, to professional health care practice:

1. Practical knowledge – ‘knowing how’ to perform a task of operation or to exercise practical skill. Non-propositional; may be embodied or represented in the mind. Term tends to polarize practical and theoretical knowledge.
2. Knowing-in-practice – practical know-to is imbued with theoretical knowledge – knowing through engaging in action/practicing/from experience without reaching consciousness.
3. Experiential knowledge – knowledge derived through direct encounter with something: a subject, person or thing, an observation of events. Data through sense emphasized.
4. Aesthetic knowledge – concern with the particular, form and style. Professional artistry. Appears to be the mediator between propositional scientific knowledge, practical and personal knowledge – includes using the whole self in care.
5. Intuitive knowledge – understanding or belief without rationale; ‘gut feeling’. Through the senses and through engagement and attunement to the patient and situation.
6. Ethical/moral knowledge – knowledge of right and wrong. Focusing on moral obligation and what ought to be done in the clinical situation and managing value conflict.
7. Embodied knowledge – knowing by the body and not the mind. The body is a knower and interpreter.

These knowledges are generally not discussed in the mainstream literature relating to professional practice nor in mainstream curricula of health training. Certainly there is a silence on the last four types of knowledge which is in keeping with the disembodied disembedded masculine subject of health training. All the knowledges described thus far still have underlying them the assumption of the neo-liberal individual who is autonomous and in control. The individual health professional is therefore disciplined
and a docile body (Foucault, 1973). There is no discussion of knowledge created in and through relationship as in relational pedagogy (Biesta, 2004), the performance of control (Riggs, 2005) nor is there mention of praxis which is the self-creative act of learning (Lather, 1991b). There is still much to be elucidated in relation to these knowledges: the defining properties of the knowledge structures, the interrelationships of these knowledges and how they function in the process of knowing (Titchen and Ersser, 2001).

Similarly concepts about professionalism in the medical literature are ambiguous and definitions are generally not agreed upon (Van De Camp, Vernooij-Dassen, Grol and Bottema, 2004). The authors emphasize the exploratory nature of their research and how there is still much work to be done on defining professionalism. Attitudes and behaviours of professionals have only recently been explicitly recognized by medical educators who see these as legitimate and necessary components of global competence, sometimes encapsulated in the term ‘fitness to practice’ (FTP) (Parker, 2006). The question of the ‘right’ attitudes and behaviours of students seems to be addressed through the practices of curriculum and assessment of the medical training.

This perspective is relevant because it shows how medical training is used to discipline students through the curriculum and assessment procedures. This reduces the medical graduates to technicists who must ‘fit’ the narrow norm of acceptable behaviours and attitudes within a sea of neo-liberal rhetoric. While acceptable standards of practice are extremely important in the medical profession, if the discourses focus on competence not much else is considered such as the social context of practice or relations of power.
The narrow view within which professionalism is seen seems to be missing the point.

For example:

Teaching the cognitive base of professionalism and providing opportunities for the internalization of its values and behaviours are the cornerstones of the organization of the teaching of professionalism at all levels (Cruess and Cruess, 2006, p. 205).

The cognitive-behavioural-values approach to professionalism or professional competence is reductionist in an approach that would seem to be about no more than ‘doing it right’. Embedded in this approach is the doing that enables the student to then graduate into the right kind of member of an elite group. Exclusionary practices of curriculum enactment seem to make the implicit curriculum as read by a student to be predominantly about issues of belonging.

Situated learning theory has been described as the most effective to transform learners into experts:

‘Situated learning’ theory seems to describe the most effective model to assist in the design of programs which have as their objective the transformation of students from members of the lay public (or non-experts) to expert members of a profession, with both appropriate skills and a commitment to a common set of values (Cruess and Cruess, 2006, p. 205).

Situated learning theory is seen as especially appropriate for educating professionals who are joined together in socially constructed webs of belief about science, for example. This discourse seems to be more about the inculcation of norms to enable physicians to enact their disciplinary role on citizens as described by Foucault (1973).
Professionalism is so fundamental to medicine’s relationship to society that evidence that its cognitive base has been learned and its values internalized and reflected by behaviours must be recorded (Irvine, 1997a; 1997b; American Board of Internal Medicine, 2003; Royal College of Physicians of London, 2005) (Cruess and Cruess, 2006, p. 207).

The endorsement of this point of view by the main regulatory bodies in the medical profession provides additional weight to the power in these statements. It is acknowledged that professional status is a privilege granted by society that can be changed if society wishes. But another privilege that medicine has as a profession is that it is self-regulating in that it sets and maintains its own standards, unlike other health professions. With this sort of autonomy it is difficult to imagine how, when or why society could remove any of medicines’ privileges. It is interesting to note that of the papers reviewed, there was no mention of critical pedagogy or deconstruction as useful learning theories to enhance professionalism.

Reeves and Ford (2004) have suggested a more critical exploration of professional practice in education using continuing professional development (CPD) – a strategy also used within health professional graduates. With a political perspective, they introduce complexity and a controversial approach to professionalism by including the following as barriers to changing practice:

- Issues of identity and the social language or discourse in which it is embedded;
- Power and control;
- Political processes involving the contestation of ideas and values;
- Dynamic instability of practices that are new (Reeves and Forde, 2004, p. 90).
Identity includes behavioural expectations and an embodied set of values which can change between the different spaces of learner and worker. The power and authority of the language used and standards adhered to are important when considering change in practice. Internalisation and externalisation of cognitive concepts are seen as one developmental process of personal sense-making much like the agency of meaning described by Lather (1991b). Reeves and Forde (2004) acknowledge that since changing practice is inherently social at every level the:

... conception of social space is critical to practitioner development as it makes the essential link between contestation of discourses and the practical learning of individuals and groups. ... theory and expertise become political instruments in fighting for social space to practice differently rather than simply a matter of individual capability and know-how (Reeves and Forde, 2004, p. 98/99).

This is in direct contrast to the literature on CPD in the medical professions. Reeves and Forde (2004) suggest that workers may therefore need to be equipped for the battle ahead of them. This critical perspective of CPD in the education field is offered as a contrast to the medical literature on CPD in professional practice.

Doctors’ CPD goals have been shown to be technical-rational in terms of updating their clinical skills and knowledge and embedded in a transmissionist model of education (Brigley, Johnson, Bird and Young, 2006). This individualized model of CPD is believed to result in little change to practice and continues unchallenged. Medical educators must therefore contend with:
A continuing preference for didactic methods;
Learning styles that exclude highly interactive sessions;
A lack of appreciation for the potential of learning in practice;
A failure to fully understand and engage in reflective learning (Brigley et al, 2006, p. 380).

Medical professional practice is grounded in a transmission model of learning; more so, it seems, than other health professions. It is not surprising then that the meeting place between the health professional and the patient or client is conducted in a transmissive way with the health professional as the knowing expert and the patient or client as the known-about passive recipient.

2.6.2.2 Summary of the literature on professional practice

The knowledge derived from professional experience, often called professionalism, is lacking in the health literature. There is more literature on how to facilitate and/or change this kind of knowledge, skills and practice in the form of discourses on continuing professional development, which are more about discipline and normalization than learning. The discourses include global competence, fitness to practice, compliance and adherence. This limited view of the dominant form of professional practice means that there is great scope for exploration and displacement of the terms, as research into professional practice is relatively new to the health field. Titchen and Ersser (2001) describe a range of knowledge but these are not mainstream. Perhaps by including the self into the process, science or the medical model will develop an awareness of itself and how the different players in the field are constructed. The concept of social space was introduced as making the essential link between contestation of discourses and the practical learning of individuals (Reeves and Forde, 2004). It was suggested that theory
and expertise become political instruments in fighting for social space to practice differently in contrast to concentrating on individual capability and know-how, but this means there is a battle up ahead (Reeves and Forde, 2004). Until the battle is enacted it seems as if the health field is doomed to go on repeating the (exclusionary) practices currently in place.

The final section of this review focuses on literature that includes personal experience knowledge as part of professional practice.

2.6.3 Personal knowledge as part of professional practice

2.6.3.1 Personal knowledge

Personal knowledge is the third form of knowledge said to contribute to professional practice (Higgs, Titchen and Neville, 2001). There is little in the literature relating to this form of knowledge: “There is a lack of explicit recognition that personal development is a key part of becoming and developing as a health professional” (Titchen and Higgs, 2001, p. 219). This imbalance in practice epistemologies is thought to be due to the masculinization of knowledge:

A professional culture of accepted codes of practice in the workplace will sanction and normalize the professional behaviour within social groups in which the self becomes embedded (Popkewitz, 1994). The emerging health professionals facilitated their earlier attempts at professionalization by embracing a positivist knowledge base at the expense of acknowledgement of their professional craft knowledge. This masculinization of knowledge resulted in a greater value being placed upon propositional, science knowledge and technical rationality of the medical profession than upon practical rationality (Sullivan, 1994, p. 171) of health care, which became unspoken through the process (Richardson, 2001, p. 43).
A focus on scientific reductionism, as opposed to a focus on holistic and caring ethical approaches, is suggested as being detrimental to students’ moral development (Titchen and Higgs, 2001). The fact remains though that professional practice is dominated by a positivist knowledge base with its scientific reductionism. There are very few papers that include the self as a form of knowledge in professional practice except those speaking in an advocacy capacity (Titchen and Higgs, 2001). An exception is embodied relational understanding (Todres, 2008). The self and relationship are absent in the literature, just as in the scientific positivistic approaches to health. Such absences can be detected in several studies of health professional/patient-client relationships.

In a paper describing the interaction between student physiotherapists and patients, different types of relationship were described which positioned the physiotherapy students differently (Dahlgren, 1998). The general trends revealed by the study were that physiotherapy students became more physiotherapy centred after 18 months professional experience. The study also showed some of the different ways in which the physiotherapists took control of and dominated the meeting place between the health professional and the client or patient.

The physiotherapist-patient interaction has also been studied with groups of physiotherapists in order to identify what sorts of training and educational programs are required to improve the therapeutic relationship (Potter, Gordon and Hamer, 2003). This study was framed in terms of ‘the difficult patient’. To assist in their interaction with
such difficult patients, physiotherapists identified communication skills and behaviour modification techniques as the strategies they would like to learn more about (Potter, Gordon and Hamer, 2003). Acknowledgement was made that communications skills and power imbalances in the relationship meant that the patient couldn’t be seen as the primary problem. However, results were framed in terms of identifying attributes (53 in all) of difficult patients.

The feedback given by the physiotherapist to the patient as part of the communication process was the focus of a study by Talvitie (2000). It was acknowledged that how the interaction was carried out can be expected to have an influence on patients’ recovery, although therapeutic elements such as verbal and non-verbal communication and touch are generally ignored in the literature (Talvitie, 2000). The main properties of the feedback given were motivational and reinforcing dialogue. It was interesting to note that physiotherapists gave much more informative feedback to patients who were active and in a good state of health than to those who were depressed and in poor health (Talvitie, 2000). This is an example of the perpetuation of inequities in health through health services. There was no input from the client or patient and how they perceived the interaction. The information gained from these papers gives a fragmented way of knowing how the health professional – patient interaction is enacted but mainly from the point of view of the health professional.

One paper reviewed the way of knowing through the use of intuition. Intuitive knowing is the immediate knowledge about a fact, or truth, as a whole and the awareness of the
past, present or future events without the conscious use of such processes as linear reasoning, rationality or analytics (Ruth-Sahd, 2003). While the literature may support the use of other ways of knowing like intuition, the reality in the classroom and clinical setting is that opportunities are rarely provided to support this type of knowing (Ruth-Sahd, 2003). The dominant form of knowing is still the scientific positivist approach grounded in evidence-based practice.

The use of self in the therapeutic encounter is rarely discussed in the literature in the health field – mostly the focus is directed outwards. Even when the self is discussed in the literature (Titchen, 2001), again the reality in the clinical setting is that opportunities for bringing in the self are not spoken about. Titchen (2001) describes the skilled companionship relationship in nursing care where the self is used therapeutically in a domain that includes knowing (perceiving, intuiting), being (becoming), feeling, engaging, doing and sensing. Such a use of self is characterized by mutuality, reciprocity, particularity and graceful care in the relationship domain, and intentionality, saliency and temporality in the rationality-intuitive domain (Titchen, 2001). The skilled companionship relationship can be developed into the critical companionship relationship by the addition of facilitation domain which includes critique, consciousness raising, problematization and self-reflection through strategies such as critical dialogue, role-modelling, etc. This model of care that is relational and critical is unusual in health care and perhaps is a sign of an emerging relational pedagogy that engages with ideas of self in a context of critical analysis of power relations.
Another emerging theme in the health professional practice literature is the use of the practitioner’s body, or embodiment, as a form of knowing. Related to knowing, understanding and learning with the body is a form of contemplative thinking and being termed the ‘creativity of unspecialization’ (Galvin and Todres, 2007). This emerging theme from within the discipline of nursing is a move towards a more ontological form of knowing. Embodied practices relevant to unspecialization include focusing and thinking at the edge. Embodied relational understanding is a form of professional practice that emphasizes relationality, being, openness and availability, bonding or embeddedness, and ethical and context sensitivity (Todres, 2008). However, these practices of professional nursing are not yet mainstream and there is not yet a clear path of operationalising these strategies within the dominant form of neo-liberal health care.

Embodiment practices together with feminist critical research embrace the analysis of the neo-liberal context of health care. Examples include feminist research into embodied largeness by a nurse practitioner (Carryer, 2001), rural women’s experience of health and embodiment (Thurston and Meadows, 2004), embodied context of mothers’ health decision making (Kushner, 2005), nurses as embodied ethnographers (Edvardsson and Street, 2007); and narratives of embodied experiences in physiotherapy (Oien, Iversen and Stensland, 2007). Embodiment is offered as an antidote to the disembodied disembedded masculinist form of knowledge generation and legitimation.

However, a pedagogy of embodiment has the potential to be co-opted by the dominant neo-liberal discourse to become another form of self-policing if the (embodied)
assumptions underlying practice are not fully elucidated. Embodiment pedagogy can come to sound like another form of individual enlightenment and an upwardly progressive humanist agenda if care is not taken to achieve a socially accountable practice (Riggs, 2005). The social practice of embodiment could be viewed as oppressive if practiced as a decontextualised norm. Feminist research with a critical focus and an eye on the workings of power itself (McLaren, 2002) keeps the context of that lived experience and way of knowing and being in the world at the forefront. Moreover, embodiment could be viewed as a privileged location since people who experience sequestered physiological memories of trauma or such like, may not appreciate for some time the benefits of embodiment.

Embodiment within a neo-liberal context of health care is a complex issue. It seems as if footsteps are needed to bridge the gap between embodied relational understanding and the current practice of health care provision. Some of these footsteps may be the naming of practices that prevent embodied reflective learning (O’Connor and Hyde, 2005). However, embodied relational understanding (Todres, 2008) and the creativity of unspecialisation (Galvin and Todres, 2007) do provide some practices of the professional self which can act as footsteps to reflective practice and a relational pedagogy. An embodiment pedagogy could be incorporated into reflective practice or relational pedagogy when further fleshed out in all its complexity including the materialization of bodies (Butler, 1993) and subjectivity.
The literature on the use of the body or embodiment as a form of health professional pedagogy and practice could be located in either of the previous sections. I have chosen to locate embodiment in the section reviewing personal knowledge in professional practice because I agree with Niranjana’s (2001) position of seeing the sense of self as largely consolidated through the body, as socially constructed and materialized as that may be. Furthermore, I hold that the emerging literature on embodiment falls mainly into understanding forms of inquiry with some movement towards deconstructive as embodiment as a practice of the self is combined with feminist critical research.

As mentioned previously, there are theories and disciplines that do take into account the constructedness of the self that is in the process of knowledge making and legitimation but these tend to come from within social psychology (Holloway, Lucey and Phoenix, 2007; Stainton Rogers, 2003), health psychology (Crossley, 2000; Lyons and Chamberlain, 2006) and nomadology (Fox, 1999). This chapter started with an emphasis on predictive forms of human inquiry that dominate the landscape of the health professionals’ education and practice. As the chapter draws to an end there is a hint of ‘other’ theories and disciplines just over the horizon that have not informed hegemonic practices in health or education. However, it may be that these formations are necessary in making the link between knowing and being in health professional practice and education.
2.6.3.2 Summary of personal knowledge

The self and personal frames of reference (Cusick, 2001) are an important part of the therapeutic relationship but rarely recognized as such. The limited range of literature there is in this section tends to focus on the communication and the health professional-patient interaction in a positivistic sense. The self is thus reduced to a technical performer. The literature is very individualized with little mention of the context of the self in health professional work. These observations take place in a workforce that is highly regulated, compliant and positioned within a medical hierarchy. There is an imbalance in the literature in that although it is recognized that professional practice takes place within the meeting place between the health professional and the client or patient, the patient or client is rarely mentioned in the frame. In the space in-between the educator and the educated (Biesta, 2004), there is much that is unexplored and unnamed.

2.7 Summary of main points on professional practice

- In the relationship between the health professional and the patient there is an asymmetry of power with the health professional/expert positioned as the knowing opposite to the passive patient.
- The health professional is autonomous and self-regulating and draws on reflective practice to ensure that they are providing evidence-based health care; the patient, perceived as neither autonomous nor self-regulating, must be done to.
• Health care work is seen from a privileged position as a mastery project that can know the object: the patient.

• The patient seems to or can represent all that is abject from the perspective of health professionals in their constructed formations.

• The constructed position of health professional and patient-client is due to the dominance of theories in health that are positivistic and transmissionist in nature. Such theories fall into the predictive lines of inquiry and thereby attempt to predict, control and manipulate learning about health.

• This suggests that health, like learning, as a social practice has become more about control and exclusionary practices than about health care.

• Silence is an important force in maintaining the status quo, particularly in relation to the governmental policies of exclusion in relation to Indigenous health.

• Health as a social practice seems to include the denial of emotional issues and the complexity of factors involved in health.

• The dominant construct of self is one that has agency; there is little discourse on other aspects of human being implying that there is a dismissal and disremembering of fundamental aspects of being human.

• While the dominant construct of the self is one that has agency, the self of the health professional is reduced to technical performer through pedagogical practices and the self of the patient is reduced to passive recipient.

• Health professional practice seems to be about compliance and fitting in with institutional and governmental regulatory bodies that enforce norms and codes of practice.
• While health professional practice can be seen as autonomous, it is also highly regulated and disciplined.
CHAPTER THREE

METHODOLOGY

3.1 Introduction

This research aims to explore and understand 1) how health professionals are educated and 2) the consequences of that education. In order to do this I draw on critical pedagogy, reflexivity, feminist critiques of education and Foucault’s theories of power/knowledge. The use of multiple methodologies and methods in this research positions me within a qualitative framework that seeks to understand the complexities of this inquiry (Denzin and Lincoln, 2000) and is in line with current recommendations in health (Baum, 2007; CSDH, 2008). I am writing about the education of health professionals, a field dominated by positivism and neo-liberal discourse on the individual and centred around the construct of control, through a qualitative poststructuralist critical feminist lens. As such the methodologies described in this chapter are crucial in elucidating relations of power as they impact on the gap or space between health professional and client or patient through knowledge generation and legitimation.

The methodologies have been chosen to foreground relations of power through power/knowledge (Foucault, 2000) which hitherto has not been a major focus in the health literature, certainly not within the allied health field. I believe that it is vital to include an analysis of power relations in the field in order to address the crisis in human resources within health services and the widening gap in inequity between advantaged and disadvantaged groups of people (WHO, 2006; CSDH, 2008). To me these two features of the health system are inextricably linked. Perhaps the increasing exodus of
staff from within health services reflects the dissatisfaction with the manner in which
health services are conducted under the umbrella of neo-liberalism rhetoric (that only
serves to increase the gap between public and private ‘health’) and that perhaps what is
needed are ways of working and thinking differently about health. This means to me that
different methodologies are also required to talk about a different space about health
services and health professionals; one that is inclusive of power relations.

In this chapter, I give a brief review of the different methodologies accessed in this
research process and how they relate to each other before moving on to the methods used
in this research. I have drawn myself together as a feminist, poststructuralist, subjective,
critical pedagogical researcher in order to explore how power works in the context of
education and training in rural West Australian health professionals i.e. at the micro level.
I hope that this work will be useful to other health professionals trying to understand the
workings of power at the capillary level (Foucault, 2000) as I demonstrate my
presentation and reading of the data through praxis.

3.2 Research methodologies

It has already been well established in previous chapters (One and Two) that the
dominant methodology associated with health professional practice and learning is the
positivistic way of knowing. “Health professionals have a preference for predictive
theories deductively derived” (Titchen and Higgs, 2001, p. 219). Such theories try to
predict behaviour within a positivist framework which emphasizes rational-choice and
the structural/functional with the ultimate purpose of research being a scientific explanation using universal laws of human behaviour (Neuman, 1997). In positivism, humans are assumed to be self-interested, pleasure seeking, rational individuals.

Quantitative studies conducted within positivist frameworks:

... emphasize the measurement and analysis of causal relationships between the variables, not processes. Proponents of such studies claim that their work is done from within a value-free framework. ... Quantitative researchers use mathematical models, statistical tables, and graphs, and usually write about their research in impersonal third-person prose (Denzin and Lincoln, 2000, p. 8/10).

Quantitative research within positivism can be seen as an empirical approach to research that relies on information collected from the senses through observation or experiment (Scott and Marshall, 2005). Empirical evidence or evidence based on facts gathered by researchers (Sarantakos, 2005) was the forerunner to evidenced-based practice.

Freshwater and Rolfe (2004) describe in detail the advent of evidence based practice as the promotion of a particular group’s special interest based on fallacious assumptions. Their work demonstrates the operation of power/knowledge at a macro level that determines the practice of the health professionals at the micro level. “Methodologies are more than just the defining characteristics of academic disciplines; they are central to the operation of power/knowledge in disciplines, whereby the subjectivities of researchers and researched are ‘in-formed’ ” (Usher, Bryant and Johnston, 1997, p. 214). In positivist research, the researcher is written out in an attempt (Usher, Bryant and Johnston, 1997) to remain detached, neutral and objective about the research (Neuman, 1997). Subjectivity is something to be avoided at all costs as it is seen as something that contaminates the validity of the research (Usher, Bryant and Johnston, 1997). These
attempts at ‘validity’ confirm the power of the technical-rationality model of knowledge production.

The researcher within the positivist tradition is thus seen as detached, neutral and objective (Neuman, 1997). He or she is able to apply logic, rational thinking and systematic observation in a manner that is above personal prejudices, biases and values (Neuman, 1997). “A positivist approach implies that a researcher begins with a general cause-effect relationship that he or she logically derives from a possible causal law in general theory” (Neuman, 1997, p. 67). The positioning of the researcher as detached, objective and neutral is in line with the masculinization of knowledges in health (Titchen and Higgs, 2001) that also positions the individual as rational, autonomous, agentic, self-controlling and increasingly individualized, insular and self-regulating (Ogden, 2002). The irony is that by writing the individual researcher out of positivist research, the opportunity for reflexivity is lost as the researcher as a sense-making agent is ignored (Usher, Bryant and Johnston, 1997). The major tension here between subjectivity and objectivity is a product of the way that knowledge production is viewed; as the process of describing reality is seen as observing something ‘out there’.

Feminists critique research knowledge production by foregrounding the tension between subjectivity and objectivity. Lather (1991b) states that “the overt ideological goal of feminist research is to correct both the invisibility and distortion of female experience in ways relevant to ending women’s unequal social position” (p. 71). In this way, power relations of knowledge production are made visible and the connections between power
and knowledge explored in what is known as feminist standpoint theory (Ramazanoglu and Holland, 2002). The emphasis is on partial visions and situated knowledges, and trying to understand the different constructed positions or subjectivities available through women’s work embedded within patriarchical neo-liberal knowledge generation and legitimation:

Majorie De Vault (1995) asserts that the type of work done by predominantly female allied health professionals is ‘women’s work’ in that it consists of ‘devalued tasks that connect the actualities of people’s lives with more abstract, “governing” bodies of knowledge,’ in this case, the practical application of medical knowledge (Williams, 2002, p. 352).

The issue here is that the positioning of mainly women health professionals within a patriarchical health system offers limited subject positions. Subjectivity (Foucault, 1983) is therefore a key consideration when exploring the construction of self through discourses, ideologies and institutional practices (Danaher, Schirato and Webb, 2000) in this feminist critique of health professional education.

By choosing a feminist poststructuralist critique as methodology for this research I am looking specifically at how women’s subjectivities are enacted and lived through their bodies and what this means within a patriarchical neo-liberal discourse in health. Whilst this research methodology does draw on critical pedagogy because of its potential to liberate or emancipate women from the limited subject positions available to them, I also want to emphasize a research methodology that is grounded in the body and/or feelings rather than just in ideological concepts such as freedom (with its concomitant concepts of control). In so doing, I hope to imagine ways of treating bodies differently within the health system – both the health professionals’ and the patients’ or clients’. 
In this introduction I have summarised the health field within which health professionals practice as I have come to know it both experientially and through the literature. The research question “How are health professionals educated?” makes the health professional the object of my analysis. Therefore in thinking about the object of analysis in the thesis – health professionals’ education and health professional practice – I have described the constructed nature of their work, education and environment. Since I ascribe to a socially-constructed, situated, contingent identity of the person or subjectivity this means that the appropriate methodology is qualitative analysis through discourse analysis framed by feminist poststructuralist critique. Table 3 shows the link between theory, methodology, methods and analysis in this research.

I chose critical pedagogy, feminist poststructuralist discourse analysis and embodied experiential reflexivity (sometimes referred to as phenomenology) as they complemented each other in my analysis of the object of study – the health professionals’ self as shown in Figure 1.1 page 17 – and they could be seen as having slightly different emphases as outlined below:

- Critical pedagogy has an emphasis on liberation and freedom from oppression. It also acknowledges the structuring social binaries that materialize the self;
- Feminist poststructural analysis with the emphasis on deconstruction through discourse analysis places an emphasis on the researcher foregrounding their own subjectivity first in order to know how that subjectivity is informing their research;
- Reflexivity that is embodied and experiential brings the body back into the process of research otherwise it can appear to be sidelined through the focus on discursive analysis as nothing appears to be extra-discursive.
Since the lived experience of being a health professional and how this is informed by education was the focus of the research, these three methodological approaches seemed to me to be the most appropriate containers for the process of knowledge making and legitimation.
Table 3 – Approaches to research “How are health professionals educated?” (Adapted from Hollway, 2007, p. 37)

<table>
<thead>
<tr>
<th></th>
<th>Critical Pedagogy</th>
<th>Feminist poststructuralist Discourse analysis</th>
<th>Phenomenological/Reflexivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theory of the person (ontology)</td>
<td>Structuring binaries of the self within the social practice of education</td>
<td>The socially constructed, situated, contingent identity</td>
<td>The experienced embodied individual in relation with others.</td>
</tr>
<tr>
<td>Methodology and description</td>
<td>Reflexivity - qualitative Discourse analysis informed by Foucault, Gore and Lather</td>
<td>Phenomenological (qualitative through rich description of experience)</td>
<td></td>
</tr>
<tr>
<td>Methods</td>
<td>Reflective practice</td>
<td>Discourse analysis of texts</td>
<td>First person written account of experience, interview, literary text, reflexivity</td>
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<td></td>
<td>Action research – cyclical process of reflective practice concerned with problem solving</td>
<td>Intertextuality between education and health</td>
<td></td>
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<tr>
<td></td>
<td>Discourse analysis of interviews</td>
<td>Discourse analysis of interviews</td>
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<td></td>
<td>Deconstruction – subjectivity of researcher made explicit</td>
<td></td>
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<tr>
<td>Unit and focus of analysis</td>
<td>Location of learning as a social practice</td>
<td>External world of discourse, its meaning and effects</td>
<td>Detailed description of social experience derived through the senses</td>
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<tr>
<td></td>
<td>Critical incident analysis</td>
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<tr>
<td>Examples in this thesis</td>
<td>Threads of critical pedagogy throughout thesis – critical summaries throughout Chapter One, Chapter Two critical incident, Chapter Four, Chapter Seven - Discussion</td>
<td>Chapter 5 Three case studies of training in rural health</td>
<td>Chapter Four – Theory making and social practice: becoming a critical health professional</td>
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<td></td>
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<td>Manual Handling</td>
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<td>Physical Activity</td>
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<td>Therapy Assistant Project</td>
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<tr>
<td>Knowledge claims</td>
<td>Self as researcher is included in the research trajectory as an opportunity for reflection upon social practice of learning. Epistemological arrangements effect relationship between subject-object, educator-learner, health professional-patient/client. Focus on the meeting place and on the regimes of truth shared. Liberation from oppression seen as a motivating force in knowledge claims.</td>
<td>By providing a rich description of power relations in the field at the micro level through deconstruction, then the subjectivity of the researcher is provided as much as possible. From this now stated position the researcher can describe the field and make knowledge claims based on the assumption that the ‘bias’ or subjectivity of the researcher is informing the process. This process accounts for knowledge claims that are already partial and perspectival and account for the socially constructed nature of knowledge making and legitimation. This approach acknowledges the co-construction that occurs between researcher and participant, educator and learner, etc</td>
<td>Reflexivity also provides for an iterative process that includes the learner’s social being in a double loop of reflexivity. There is perhaps more emphasis on the embodiment of the researcher in a phenomenological approach. This approach ‘takes issue with the sidelong of actual bodily experience’ as discourse analysis can appear as if nothing is extra-discursive (Holloway, 2007, p. 185).</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>The approach here is working at the theory-practice juncture – praxis – the self-creative activity through which we make the world (Lather, 1991b).</td>
</tr>
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</table>
Having discussed the links between methodology, method and the research, I now go on to discuss the particulars of critical pedagogy, discourse analysis and reflexivity.

Reflection on my practice as a researcher as I encountered discourse analysis influenced the research process. Therefore I have found it difficult to refer to the methods of research (discourse analysis and reflexivity) without referring to the process I was undergoing at the time. Since the process of determining methods and research tasks was iterative and spiral, it is difficult to demonstrate the steps in my process in a linear fashion. I hope to make this clearer by using a diagram showing the reflexive steps first (section 3.3) before showing the stages or product of each reflective cycle (3.4). Also, critical pedagogy is reflexive which is also mindful of the context of the research so the three methodologies cannot be completely separated out. I will outline the theory associated with each method before discussing the stages and products of the method cycle.

3.2.1 Critical Pedagogy

As mentioned in section 2.3.1, critical pedagogy takes into account the conception of a self in education that is affected by social structures, forces and their power effects (Usher, Bryant and Johnston, 1997; Gore, 1995). The emphasis in critical pedagogy is on social change rather than personal autonomy even though there is acknowledgement of the structuring binaries of the self within social practices of education. Critical pedagogy was chosen in this thesis as a methodology as mentioned previously because of its
emancipatory focus and its ability to encapsulate the duality which the oppressed suffer in their inner most being – that of the oppressor and the oppressed (Freire, 2000).

3.2.2 Discourse analysis

Feminist poststructuralist frames acknowledge the object of research – the theory of the person – as being socially discursively constructed. Therefore the main task is to describe or deconstruct the field, situation, or linguistic surface in order to lay out the contingencies upon which the construction is based. This is the form of knowledge making and legitimation that occurs in feminist poststructuralist theory and is the basis for knowledge claims. Laying out the contingencies is also a form of reflective practice or reflexivity since it places the knowledge formed in context. Initially the case studies form the backdrop for the discourse analysis.

The case studies (section 3.5.2) are redeployments of educational work that I carried out within the health field after having engaged with a university course on adult and tertiary education. The case studies therefore represent my attempt at trying to bridge the education and health fields. The purpose of including a discursive analysis of three case studies is about producing a reflexive knowledge of me as a health and education professional in the field and of me as a researcher and how that intersects in time. The purpose is not to unpack the case studies and then to produce another one that would produce a different knowledge of manual handling, physical activity promotion or therapy assistant training. I am using the case studies to reflect on my position in the
field, to unpack my own positionality or subjectivity and my own journeying or epistemological shift in an explanatory framework. The shift becomes the critical focus and anything that relates to that critical focus will be selectively drawn on. Lather (1991a) recommends putting our own subjectivities on the table and sees this as part of the work of deconstruction. Thus the case studies are a way of operationalizing the methodology as discussed by Lather (1991a). This step is the core characteristic of feminist poststructural analysis in education.

In order to provide some structure to the case studies I drew up a framework (section 3.4.3) based on work by Foucault (1973), Lather (1991a and b), Ball (1991) and Gore (1995) in the main. This enabled me to look at the educational frameworks (and their limits) I had drawn on previously whilst also integrating and incorporating the kind of frameworks I think are useful for analysing texts within the health field. The thematic analysis of the case studies involved reflexivity and an interactive process whereby themes were reviewed through the literature, analysed within the constraints of the case studies, taken back and reviewed again in relation to the literature and then revised further to produce subsections that informed the development of research and then interview questions (see section 3.5.1).

What makes knowledge possible is the rules or discursive practices that operate independently of subjectivity (Fox, 1999). It is hoped that the case studies provide a naming of some of these rules or discursive practices. It is important to carry out such an analysis within feminist poststructuralist accounts because of process of naming
subjectivities (or how we come to know ourselves). The body is implicated in this
process since it can be seen as:

..the metaphorical or metaphysical ‘surface’ which links (and allows the interpenetration of)
psychic experience with the forces of society. By means of this concept they establish a
connection between the realms of the psychological and social, between Freud and Marx (Fox,

It has been suggested that the body is intimately related with territorialisation. The term
territorialisation is used to describe “the outcome of the dynamic relation between forces
(physical and psychosocial) and apply this general conception to the specific arena of the
ascription of meaning to the social relations of life” (Fox, 1999, p. 129). Therefore the
subjectivity formed is directly related to the inscription of physical and psychosocial
forces. It is for this reason that a discursive analysis of the field is necessary for
describing health professional practice and the professional self that is formed in the
process of territorialisation. Likewise:

Deconstruction is deterritorialisation. It follows that part of the project of destabilising power,
authority and control will entail the meticulous unpicking of concepts, beliefs and assumptions, of
questioning why things are the way they are, and suggesting how they might be different. The
politics of such an enterprise is familiar territory for, amongst others, feminist theorists (Fox,
1999, p. 135).

Deconstruction within a feminist poststructuralist analysis is therefore also a form of
resistance. The methodology of feminist poststructural analysis has informed the method
of discourse analysis used to analyse the case studies in order to provide a form of
subjectivity of the researcher in the field. The case studies and their themes went on to
inform the analysis of the participants’ interview responses and the steps in this process
will be reviewed in section 3.4.5.
3.2.3 Reflexivity

Reflexivity forms a part of the multiple perspectives contained within this thesis. From an epistemological perspective, I have reviewed some of the literature within the dominant field of positivist biomedicine and some from within the poststructuralist field of feminist analysis. I hold the view of the object of analysis as the health professional – including participants and myself as a practitioner in the fields of both health and education. I hold the theoretical position that the professional self is both constructed and constructing – actively involved in meaning making, experiential, embodied and relational. From the case studies, I developed the position that the embodied experience tended to be sidelined as the discursive approach tends to view nothing as extra-discursive (Fox, 1999; Holloway, 2007). I wanted to be able to explore the lived experience of being a health professional myself and that of the participants as intersubjective and for this I needed a both/and approach to analysis. There are therefore multiple perspectives to the ontological view of the object of analysis (researcher, participants, professional self) and thus multiple methodologies, methods and data analysis.

The multiple perspectives I have obtained are from the literature reviews, analysis of my own experiences, case studies and interviews with participants. Some of the participants were people I had met in the field previously as part of my work as a health professional, some I had met as an educator and about half of the people I had never met before. Therefore I performed a range of identities with the participants – stranger, researcher,
fellow health professional, participator, colleague, educator, previous employee, academic, etc. I prefer the term researcher participant to describe my role, instead of participant observer, whereby “the researcher participates but is only partially involved or committed to a member’s perspective” (Neuman, 1997, p. 357).

I say this because my position in relation to the research has shifted over time and with the research. Initially, because I had found my experiences in the field so disempowering, I had wanted to develop a framework for learning about health education that was empowering and that was also emancipatory for the disadvantaged people who were so often the target of health professional education. As my reading continued to inform me, I shifted to wanting to understand the role that privilege played in perpetuating the disadvantage experienced by people and to understand the role that training of health professionals played in this. From my reading of Foucault and others, I had a sense then that the relative privilege of health professionals was related to the disadvantage of ‘others’. I was still caught up in the binary of privilege versus disadvantage and individual versus social determinants of health. Now I am in the position where, whilst acknowledging and including both positions within the binaries (the context), I also want to move beyond that to understand oppression and how it works within the ‘privileged’ to perpetuate the status quo in the health field. And I do this to understand further how my role in implementing training programs within health has been affected by these factors.
Understanding requires reflexivity on the part of the researcher. To further add to my understanding of reflexivity I have drawn on the literature from critical ethnography. The ontological and epistemological assumptions of critical ethnography include:

1) All cultural groups produce an intersubjective reality which is both “inherited” and continually constructed and reconstructed as it is lived or practiced. This shared cultural reality is external … a distinct, lived historical tradition “objectified” through structuring practices (laws, public policies, cultural conventions) … marked by a collective memory of particular ecological, geopolitical, embodied, spaces/places;

2) A well-trained, reflexive investigator can know that historical, socially constructed reality in a partial, provisional sense through an intensive, experiential encounter with people who live by these cultural constructions of reality;

3) A reflexive investigator, who has experienced this unfamiliar cultural space and has dialogued with its practitioners, can portray this cultural space and its people in a provisionally accurate manner (Foley, 2002, p. 472 – 473).

Within these assumptions, reflexivity is described as:

…. the capacity of language and of thought – of any system of signification – to turn or bend back upon itself, thus becoming an object to itself. Directing one’s gaze at one’s own experience makes it possible to regard oneself as “other”. Through a constant mirroring of the self, one eventually becomes reflexive about the situated, socially constructed nature of the self, and by extension, the other. In this formulation, the self is a multiple, constructed self that it is always becoming and never quite fixed, and the ethnographic productions of such a self and the “cultural other” are always historically and culturally contingent. … Turning in on oneself in a critical manner tends to produce an awareness that there are no absolute distinctions between what is “real” and what is “fiction”, between the “self” and the “other”. Methodologically, this means that we are forced to explore the self-other relationships of fieldwork critically if we are to produce more discriminating, defensible interpretations (Foley, 2002, p. 473).

The reflections of some ethnographers became published texts in what is called autoethnography, which is a blend of autobiography and ethnography. The characteristic of these texts is the open subjective speaking of the authors; “they seek to undermine grandiose authorial claims of speaking in a rational, value-free, objective, universalizing voice” (Foley, 2002, p. 474). Instead the texts are evidence of a living, contradictory, vulnerable, evolving multiple self author who speaks in a partial, subjective, culture-bound voice. Foley (2002) cites Behar (1996) who believes that ethnography is a “long, irreversible voyage through a tunnel with no apparent exit” (p. 474).
I am including literature on ethnography and autoethnography because it seems to me that I have been involved in a long journey over the years with my reflections on health and learning. As part of the thesis, I am including my reflections on learning and health, particularly in Chapters Four, Five and Eight, therefore I need to include theoretical justification for drawing on this method of knowing. Even though this thesis is not a critical autoethnography, it does have elements of writing about the self. Part of autoethnography is that the very “act of writing itself becomes a way of being and knowing” (Foley, 2002, p. 475).

The importance of including the self as a writer is intended to mitigate against the hegemonic practice of excluding the self out of reflexivity: “The downplaying of the self as a writer is a crucial aspect of the neglect or outright denial of the importance of reflexivity in research” (Usher, Bryant and Johnston, 1997, p. 216). These authors advocate the saving of the self through emphasis on the self as knowledge claimant:

Considering research as the practice of writing, as the pre-eminent means by which one develops understanding rather than as a transparent for reporting the already understood, is now central to the project of extending our own understanding of research as reflective practice. Critical reflective practice cannot be modeled in a conventional way and requires the interrogation of practice as scripted (Usher, Bryant and Johnston, 1997, p. 217).

Whenever I have come to a sticking point in the process of this research, especially when writing, it is usually because I have forgotten about the self and become entranced with being an ‘absent-presence’ as in much of the scientific literature (Usher, Bryant and Johnston, 1997). To be as reflective as possible, without being co-opted by a dominant
model of reflective practice that is disengaged, disembedded and disembodied as discussed in Chapter Two, I need to hold that “reflective research is a practice which embodies a critique of its own situatedness” and that “reflective practice is the public recognition and interrogation of the effects of affect within action (Usher, Bryant and Johnston, 1997, p. 219 and p. 220). These authors contend that dimensions of the research trajectory can include the experiential as well as the technical in an approach that is both more than the technical-rationality model of research and that has better claims to contextual validity (Usher, Bryant and Johnston, 1997). The diagram below shows the trajectory as envisaged by them:

Figure 3.1 – Adaption of Usher, Bryant and Johnston’s (1997) research trajectory

Technical: (Proposal Design Data Collection Analysis Report)

Internal: specific relations in the research ‘arena’- change over time

Situational

Experiential

The ‘engaged self’ as a researcher reflective practitioner

External: gender, ethnicity, culture, age, etc – Invariant but can be differently theorized over time

Disposition

e.g., level of interest, confidence, tolerance for complexity/ambiguity – change over time
While the technical process shown above is completed by writing this thesis, I am also able to include a contextual embodied self that is reflective as I write and that serves as a knowledge claimant. In order to be reflexive in this research, I include an embodied self that is a practice of the self through a constant turning in on myself that therefore allows me to write the contextual situatedness of my own learning. By practising the self (McLaren, 2002) through a methodology that values the epistemological importance and relevance of subjectivity (Walkerdine, Lucey and Melody, 2001), I hope to become continually aware of the workings of power both in my self and in the field. Taking account of the technical process however, I will now go on to describe the design of the research and the procedural steps taken.

### 3.3 Stages in reflexive cycle

As mentioned previously the development of the research did not follow a linear process. In this section I show the steps in the process as clearly as possible by outlining those steps before demonstrating the products of the steps. Figure 3.2 shows the steps and how they informed each other.

Reference is made to different parts of the thesis in Figure 3.2 in order to show the outcome of that stage of the cycle. Other products of the reflexive cycle are shown after Figure 3.2. in section 3.4.
Figure 3.2 Stages in iterative reflexive cycle

Critical incident 1 – Theory/practice disjuncture when trying to implement education (action research) within health environment – manual handling
See section 5.2.1 of thesis

Critical incident 2 – theory/practice disjuncture – not being able to implement healthy lifestyle in my own life
See section 1.1 and 5.2.2 of thesis

Enrol in PhD in the school of education. Conduct literature review exploring critical pedagogy. Presentation of research to date – curriculum analysis and meta-analysis/statements to peers. Following feedback, review feminist poststructuralist literature. Conduct exploration of works by Foucault, feminist writers such as Lather, discourse analysis, critical pedagogy, again.....

Drew concept map – Figure 3.2 Gestalt of theoretical framework. Identified technologies of power and domination, subjectivity and discourse as three key components of professional self formation. Used these three components as headlines to develop research questions or structured analysis of case studies.
See section 3.2.1

Carried out extensive analysis of case studies to foreground my own subjectivity as a researcher, educator and health professional documenting the shift in epistemology from purely critical pedagogy to discourse analysis. Documenting shift in subjectivity key first step in feminist poststructuralist methodology (Lather, 1991a).
See Chapter Five of thesis

Reflection on theory and data from case studies alongside my own subjectivity at the time produced an awareness that I was looking theoretically for a self that could be described discursively but that was beyond oppressive structures. An embodied experiential self that could have an identity and exercise choice that could be aware of moral and ethical issues alongside the workings of power. As if this could be the case and yet this is what the literature seemed to be suggesting in the discourse analytic theory.
These points seemed to me to be encapsulated by technologies of self (an ethical relationship with self), power/knowledge and critical pedagogy. These subsections were used to further develop the research and interview questions.

Drew up Table 4 Technologies of Domination and Power – Matrix of Epistemologies which showed the intertextuality between the literature of the three epistemologies accessed at the time – critical pedagogy, health and feminist poststructuralist. Reflexivity demonstrated by this continuing iterative process. The table demonstrated that along with data from case studies which foregrounded my own subjectivity, intertextuality produced an emphasis on the individual, sovereign rights, normalization, conflict, body, territory, boundaries, training, relationships, internalization, subjectivity, self-policing, self, and enlightenment.
See section 3.2.4
Research questions
Developed research questions with subsections of technologies of self, power/knowledge and critical pedagogy.
Narrowed them down to remaining six.
See section 3.3.1

Interview questions
Developed interview questions.
Stages in review, pilot study, edit, review, etc changed questions from specific technical questions which were perhaps embedded in too much jargon to those in the thesis which were more general and gentle but could still elicit information on these topics in relation to health professional training.
Pilot study of experiential process to elicit information in relation to power/knowledge discovered to be too complex and difficult to understand by participants.
See Appendix 10.2

Still reviewing the literature – feminist poststructuralist, critical pedagogy......
Still writing......

Critical incident 3
Response from health department staff member who is helping me to arrange interviews with volunteers from that health district. Her email worried me: “We can help but I will be honest my first thought is that the letter and questions may need to be a bit more concrete for staff to see the value in completing your survey. I hope this feedback helps” (3rd August 2005).
See section 7.2.3 of thesis

Writing the data
Ongoing process of writing results
Reviewing thesis, editing, writing, reviewing, editing, writing......

Developed protocol for interview procedures.
Contacted relevant people within the health department.
Feedback from staff member concerned me in relation to the value of this research to health professionals.
Removed headings from interview questions that were circulated prior to interviews as these were not helpful at all.
Do not want to attribute ‘false consciousness’ (Lather, 1991b) to staff. Felt my own lack of confidence more than anything else.

Interviews
Conducted interviews. Experienced further crisis of confidence as power did not seem to be an issue for participants at all. However, I was reassured by the pleasure that some participants expressed in having the opportunity to discuss their work and talk about issues that they think about but do not discuss as a rule.

Thematic analysis
Transcription of interview data.
Review of transcripts for themes.
3.4 Products of the reflexive cycle

3.4.1 Critical Incident 1

I am including an explanation of a critical incident as a first product of the reflexive cycle because this event was influential in determining methodology, method, process and could be seen as a thread throughout the data collection. The critical incident is included because it demonstrates my lack of linguistic ability to describe what was happening (discourse analysis), my lack of awareness of the political situation in which I was embedded (critical pedagogy) and my lack of understanding on an experiential embodied level (embodied reflexivity). Implementing educational strategies within the health field was problematic in that I experienced interpersonal conflict which I was ill-equipped to deal with. This is perhaps best demonstrated by the critical incident recorded in my reflective journal as part of an action research project with the first case study – manual handling training. I felt like I had made a great deal of effort to try to do something worthwhile:

I want to make this idea as relevant to them as possible, because then I feel that I will be doing something worthwhile. That is why I want to see as many people as possible to gain an idea of what they want, and to devise some sort of questionnaire that will provide a focus for finding out what they do want and are prepared to come on board with. I want this to be an opportunity for adult learning (E471 Action Research for Professional Development – Journal 20th March 1998).

I saw the problem as a curriculum development issue and perhaps this is why I focused on a collaborative form of ascertaining learner needs. From there I analysed curriculum phenomena but this is where the divergence or shift occurred between then and now. I did not have the language nor access to discourses that discussed power/knowledge and so my analysis of curriculum phenomenon was limited. The journal discussed many issues associated with implementing manual handling training and these found their way
into the process of collaborative problem solving. However, I still floundered with some incidents and was unclear over what was happening. For example:

Had a number of appointments today with managers to gain their feedback on their training needs regarding manual handling. The day also uncovered a lot of issues. I came away feeling quite overloaded and stressed although that is partly my fault because I try to fit so much into one day. I will certainly have a lot more to add to my curricula phenomena analysis. One huge question I have come away with is, with all the training in teamwork, communication and conflict resolution, how come it doesn’t work? It seems to me that people are only willing to go so far. Maybe it is because I am expecting too much. I am still trying to work in the ideal world and it doesn’t exist. I feel a bit blown about by the strong winds of peoples’ egos (Action Research for Professional Development – Journal 8th April 1998).

These excerpts are included as a form of critical incident because they were formative in setting me on the path I am on now. I really struggled with negotiating the gap between theory and practice in education and health and experienced a great deal of interpersonal conflict which I was ill-equipped to deal with. The excerpts could have been the same for the remaining two case studies. In each case, I walked into a political field of which I was unaware and or did not have the language to describe. The case studies included in the thesis are about tracing the epistemological shift between then and now in that now I am able to name instances of power/knowledge, different types of subjectivities and constructions of health professional workers. The case studies also form local contingent knowledge of health practice in rural Western Australia and as such provide a snapshot of the intertextuality between education, health and professional practice.

3.4.2 Concept map of literature

Further products of the cycle are now presented as they show the steps taken along the way in developing the research and data analysis. The first product shown (overleaf) is the diagram or concept map (Figure 3.3 – Gestalt of theoretical framework) of the main
contingencies of the theoretical framework used to analyse the training of allied health workers. Each contingency is in a dependent relationship with every other contingency; there is no necessary pattern to their relating; and the diagram can be seen as multi-directional or anti-directional (Kendall and Wickham, 1999). Central to the framework is the idea of self and identity. Since Niranjana (2001) states; “the ‘inside’ is never fixed nor unitary, but always the product of its changing relations with the specific constellations of the ‘outside’” (p. 32); the constellations or contingencies on the outside of the diagram of the framework represent the way that gender and femininity have been organized in the health field through social relations and social practices which have been predicated by their training. Thus there is a mapping of the social meanings around the constructs of health.

The body is considered in this thesis since it is about health and health workers. This is a break away from traditional poststructural and postmodern analyses where the focus is on the socialization and cultural construction of gender and identity, thereby ‘implicitly banishing, as a result, questions of the body from their analytical frameworks’ (Niranjana, 2001, p. 16). The theoretical framework has become an integration of postmodern and modern experience and theory since by including the body as a primary consideration, perhaps even the main interface between the structural (social, cultural and political) and the individual, emotional and physiological reactions cannot be ignored. Unfortunately most theorizing about these aspects comes from a modernistic approach.
Thus the epistemic casting (modernistic, postmodern, antimodern, etc – Kendall and Wickham, 1999) of the knowledge is of paramount importance since these determined the relation between subject and object, and the structural and the individual: ‘It is the more general arrangement of knowledge that determines the reciprocal positions and the connection between the one who must know and that which is to be known’ (Foucault 1973, p. 137). The arrangement of knowledge in figure 3.2 circles around self, subjectivity, discourse, and power/knowledge. These components of the gestalt act as surfaces of emergence where complexities can be named within a field of power relations between health workers.

As an aside, I developed different concept maps working with the material I had in order to inform my reflection more fully. For example, one such concept map is drawn around the notion of a spider web (or linguistic veil) with the outermost borders of the web showing statements such as ‘working at the margins’, ‘sites of emergence’, ‘transgressing the borders’, and strands connecting the outermost borders with the inner centre drawing on statements such as ‘juncture of human agency’, beingness is always circumscribed by a set of power relations and self regulations that has been internalized’, ‘power/knowledge’, ‘identity and work on the self’, ‘self and identity in relation to one’s political circumstances equates to a transformative process’, ‘learning, women and critical pedagogy’, ‘how do practices to discover the truth about ourselves change our lives – the will to power’, ‘theory as practice’, ‘no knowledge is neutral’, and so on. The cross-strands connecting the longitudinal centre to outer strands also showed words relating to the longitudinal axes on each side and the outer strand. For example, the
spider was situated on one such strand between the words ‘incited’ and inscribed’. I include this description to demonstrate the many different steps I went through to work with the discursive material to identify themes and the context of health professional education. The responses from participants about their training form the backdrop that is examined to show themes of self, identity, power, health and learning. Each cycle of reflection on the material influenced the next one so that the one that is shown here is one reflection amongst many. This one (Figure 3.3) was chosen to demonstrate the linkages between theory and the structured analysis of case studies. The different sections of the framework will now be discussed and explored.

It can be seen that the figure revolves around three central concepts of discourse, technologies of domination and power, and subjectivity. I related these concepts to the epistemologies of understand, emancipate and deconstruction. The links to the literature review are made here although I have left out predictive forms of inquiry in the three circular concepts. These three concepts themselves enclose ideas about the self. I was looking for a definitive idea of the self that could encapsulate what I had read. However, this proved to be elusive in an embodied experiential form so I took to including more positivist notions of the body and emotions on the outer part of the diagram on the left hand side in order to provide a for this. At this stage my reading was wide and so the figure includes a great deal of theorising alongside some fiction that seemed to me to explain the lived experience more adequately.
It seems strange to me now that I should have considered reading texts for a definitive picture of the self. However, this notion is not at odds with the position that poststructuralists take on the body and self: that is, while poststructuralists deny that there is an essential self, by doing so they divorce the physical body from the discursive body written by power/knowledge and in so doing seem to imply that the discursive body thus forms a self even though it is a discursively written self (Fox, 1999). Reflecting back that statement by considering the notion that a self could be found in the text discursively (keeping in mind the broad meaning of text within discourse) seems absurd now.

However, in terms of health professional education and practice, this is what occurs. Health professionals’ learn their ‘texts’ through a process of socialization and these are inscribed or internalized and practised with clients or patients. This is what I hoped to learn about in the participant responses.
The three core concepts of technologies of domination and power, subjectivity and discourse were used to inform development of a structured process for analysing the case studies from my readings of Lather (1991a and b), Foucault (1973), Gore (1995) and Ball (1991). The structure of the analysis is shown below.

3.4.3 Structured analysis of case studies

Introduction

- A description of the context of each case study – conceptualizing the object of study, bounding the case;

Discourse

- The recognition of a discourse of training as a corpus of statements whose organisation is regular and systematic;

- The identification of rules of the production of statements; how psychological interests shaped the production of statements about the training of health workers;

- Identification of rules that delimit the sayable;

- Identification of rules that create spaces in which new statements can be made; what has been muted, repressed, unheard, silenced;

- The identification of rules that ensure a practice is material and discursive at the same time;

Technologies of domination and power

- Boundaries – between and within disciplines, analysis of how the hierarchical structure gets maintained in the problematic of the training, how women are used
as boundary markers; how women are used as carriers of group identity; how the boundaries of what can be imagined are policed;

- Normalization – how issues become normalized, validated and made concrete through training practices, how particular regimes of truth become inscribed such as the biomedical model and the legal, scientific narrative – as a value-constituting system;

- The ‘objective’ methods employed to maintain patriarchal identity, ways of making sense that privilege male interests over female;

- Surveillance – through supervision including the panoptican effect; the *Gaze*;

- Systems of differentiation – established by law, tradition, and pedagogic status of different workers;

- How power relations are brought into play by different practices – the type of objectives, interpersonal actions and relations enacted through subjectification/objectification; normalization, regulation, disciplines, classification, individualization, totalisation, exclusion and distribution;

- Forms of institutionalization – a mixture of legal, traditional, hierarchical structures;

- The degree of rationalization that endows, elaborates and legitimates processes for the exercises of power; the availability of resistant discourses and subject positions; the concentration of power at any one point;
Subjectivity

- Self-regulation – how workers willingly subjectify themselves in order to maintain standards and how they regulate themselves in order to become a particular type of worker;
- The ‘others’; binaries that structure the research/case study; possibilities for a feminist perspective;
- Issues around choice (related to the policing of boundaries – see above) and power through self control;
- Gaps and spaces between the visible and the invisible and how this relates to the relationship the worker has with one’s self as a health worker

I carried out a detailed analysis of each case study using the above tool. The tool was very structured as I needed a starting point or way in to a poststructural analysis of the field. I was conscious of the fact that the case studies were not my major analysis of the research so the product of the case studies (Chapter Five) included in the thesis is a distillation of the extensive detailed analysis. The key points that have distilled through the process of editing and reflective review reflect my shifted epistemological position in the field. I have legitimated knowledge in the case studies that I could not have written about before thus there is a fuller description of the landscape.

The concept mapping and structured analysis derived from the mapping produced the case studies and showed the epistemological shift occurring at this time. Furthermore, after I had analysed the case studies (see Chapter Five) I was able to draw up a table which showed the epistemological relationship between the different texts of health,
education and poststructuralism evident in the discourse. This table (Table 4: Matrix of epistemologies – see Appendix 10.1) demonstrated the relationships between the different texts and the different ways in which they treated the individual, the body, and subjectivity amongst other concepts. I drew on this table and the key concepts emerging from the case studies to develop further research and interview questions.

### 3.4.4 Epistemological Intertextuality

I desired to implement research that was relevant and as fully informed as possible so it was important for me to tease out the concepts and relations between the concepts as fully as possible. From the intertextuality shown in Table 4 (Appendix 10.1), I distilled the categories or subsections of technologies of self, power/knowledge and critical pedagogy which formed the categories for the further development of research questions and interview questions.

I will now describe the thematic analysis applied to the literature that assisted in forming research questions in order to provide step by step linkages to epistemology, methodology and method.

### 3.4.5 Thematic Analysis

Thematic analysis of different texts was necessary for me to integrate those texts I had read in order to inform the research. I developed a number of concept maps (Trochim, 2000) (section 3.3, 3.4.2, 3.4.3 and 3.4.4) in order to identify some relation between the
‘data’ derived from the different texts I read. This process provided intertextuality whereby different texts inform and are in relation to one another (Fox, 1999). Each stage of the research process is in relation with the following stages. Therefore the thematic analysis of the interview data (using a highlighter pen and post it notes to identify themes) was linked to the development of the research questions which was linked to the case studies and review of the literature. In this way, the interview data was analysed in relation to a particular analytic question i.e. the research and consequently interview questions. This is a theoretical approach to data presentation that requires engagement with the literature prior to the analysis of the data (Braun and Clarke, 2006). A theoretical approach that is in keeping with a constructionist perspective and assumptions provides the sociocultural contexts and structural conditions that enable the individual accounts (Braun and Clarke, 2006). These have been provided in the form of the case studies and analysis of the literature. The case studies and intertextuality presents the territorializations that create the conditions of lives (Fox, 1999). The aim of the data analysis is to give a semantic explicit description of the surface (Braun and Clarke, 2006) of the lived experience of being a health professional. This is not to say that I did not struggle with issues of representation of the interview data.

There is a crisis of representation in the social sciences (Lather and Smithies, 1997). While there is the belief that it is possible to represent the voices of others in a more or less unmediated way (Marcus, 1993 cited in Lather and Smithies, 1997, p. 126), others believe that representation is never unmediated; that there are always assumptions and theoretical underpinnings of any analysis of data (Braun and Clarke, 2006). In order to
adhere to the insight that no knowledge is neutral and no representation of data is ever unmediated, I have tried to be as explicit as possible about my assumptions and theoretical underpinnings and process whilst also not reducing the participants’ responses to analytical categories (Lather and Smithies, 1997). However, in loyalty to the position of unmediated representation, it could be said that there are many possible assumptions and theoretical underpinnings: it is a more positivist assumption that we can be absolutely clear in our process of analysis. There are many readings of the data and this first reading contained within the thesis may be the first of many (Fox, 1997). There is further discussion of this point in Chapter Six (section 6.1).

### 3.5 Method

The method of research is situated within a qualitative feminist poststructuralist narrative of empirical inquiry. Table 3 (p. 172) demonstrates the links between epistemology, ontology, methodology, methods, unit and focus of analysis, tasks within this thesis along with relevant chapters and knowledge claims. The three primary techniques for gathering evidence (examining historical records, observing myself and listening to participants) separate out epistemology, methodology and method in a way that allows the generation and refinement of more contextualized methods in the search for meaning and pattern making as apart from prediction and control (Lather, 1991a).

The techniques for gathering evidence included discourse analysis of three case studies concerning training in the health field, reflexivity of the researcher and the use of open
ended interviews with participants. These will be described in greater detail in the following sections. Before describing the techniques of data collection, I will review the research aims and questions.

### 3.5.1 Aims and research questions

The aim of this research is to explore how health professionals are educated and the consequences of that education. Furthermore this research aims to understand the constructions of self (the object of analysis) of both the health professional and the client/patient through training in health within the context of a neo-liberal dominated professional practice.

A further sub-aim of this research is to understand what was going on during my experiences as a health professional and as an educator within health. I wanted to understand how practices to discover the truth about myself and my body during these experiences would affect my life (Lather 1991b). I wanted to acknowledge the praxis I had been involved with over the years in relation to learning and health by foregrounding the theory making I had been carrying out. Therefore I am privileging reflectivity (Freshwater, 2007; Foley, 2002; Usher, Bryant and Johnston, 1997) as the site where I can learn how to turn critical thought into emancipatory action (Lather, 1991b). I am interested in the theory/practice juncture and have wanted to keep this at the forefront of my inquiry.
As a result of these aims, I also hoped to develop alternate perspectives on health care, education and health professional practice that would be relevant to the world. If “praxis is the self-creative activity through which we make the world” (Lather, 1991b, p. 11), then I hoped to make the world a better place by critical reflection on the training of health professionals, including myself. As a result the major research questions were:

How is that health professionals are educated? What are some consequences of that?

This question was further broken down into subsections of technologies of self, power/knowledge and critical pedagogy as described in section 3.3 and 3.4.

**Technologies of self**

- How do health professionals come to understand themselves and the work they do within health?
- How are health professionals incited through training to embrace a particular understanding of health and well-being?

**Power/Knowledge**

- What understandings do health professionals have of the power relations in their field?
- How is training a site for reproducing or challenging certain power relations in the health field?
Critical pedagogy

- What pedagogies are being legitimized? What pedagogies are being silenced and marginalized? How does this determine what we know and teach about health and our body?
- To what extent can training act as a site for transgressive pedagogies and practices within the field?

While these questions are framed in relation to health professionals, I am aware that I am implicitly bound up with the researched (Lather, 1991b). Not only because I have been a health professional myself but also because I can see that through the process of the research I have been relating these questions to my ‘self’ as well as to the participants. I have therefore been both subject and object. The impossibility of separating out the researcher and researched as subject and object means that they are both co-constituting and co-constituted (Usher, Bryant and Johnston, 1997). While this can be limiting in that I bring with me pre-conceived ideas that mean my interpretation will always be partial and perspectival, it is not that these are wrong (my positivist interpretation) but that the interpretations need explicating. I will now go on to describe the process I went through when conducting the case studies, followed by the process of interviews.

3.5.2 Case studies

The case studies were a way of finding my way into the poststructuralist feminist qualitative research in which I was positioned. The case studies were for me a way of
operationalising some of the thoughts I had had about the health field at the time but had not been able to articulate because I did not have the reading to inform me. The case studies thus formed a theory/praxis juncture because I had been involved in them in the past and identified some issues but had not been able to write these. Then I revisited these times with a more informed approach during this study and was able to further develop theories that then helped to inform other parts of this research process such as the interviews. In this way I was involved in a reflective practice that was iterative, spiral and circular (Usher, Bryant and Johnston, 1997) (see sections 3.3 and 3.4).

The case studies are examples of situations where power becomes capillary (Foucault, 2004) in a context specific training situation. A case study can be seen as a functioning specific: one within a bounded system that is purposive, has working parts, and (often) a self – “functional or dysfunctional, rational or irrational, the case is a system” (Stake, 2000, p. 436). All three case studies are about systems of training within health where I was the trainer or facilitator working within rural health facilities in Western Australia. These case studies provide examples of the enactment of the curriculum and demonstrate rules that delimit the sayable (Kendall and Wickham, 1999). The analyses of the case studies were informed by Foucault, (1973); Kendall and Wickham (1999); Ball (1991); Gore (1995a) and Lather (1991a and 1991b). Specifically, I have decided to focus in on three techniques of power – surveillance, normalization and individualization as these three seemed to me to be the most important currently within the health field. I use these techniques of power within the following definitions developed from Gore (1995a):
• Surveillance – through supervision including the panoptic effect, the ‘gaze’, and
  the way this is enacted or lived by treating different bodies differently;

• Normalization – how issues become normalized, validated and made concrete
  through training practices, how particular regimes of truth become inscribed such
  as the biomedical model and the legal, scientific narrative – as a value-
  constituting system. How have the ‘objective’ methods employed worked to
  maintain patriarchal ideology, ways of making sense that privilege male interests
  over female?;

• Individualization – the pathologisation of workers and patients or clients – the
  ‘difficult’ patient or incompetent practitioner, the subjectivity of the workers,
  researcher, and patient or client (reflected in the expert/health professional/patient
  triad).

These analytical categories were chosen to read the case studies so that the feminist
theoretical lenses I am drawing from as described in section 3.2 could be explored. It
seemed to me that I needed to include an analysis of these case studies in the research so
that I could become aware of and understand where I had been, in a reflexive manner,
otherwise I could not change my practice and work or think differently about health.

3.5.2.1 Case study 1 – Manual Handling Training

In this case study (March – June 1998), I was employed part-time on a short-term
contract to implement manual handling training with a range of hospital staff on behalf of
the physiotherapists at an rural acute care hospital. The project was carried out as an action research project in order to meet the requirements of a Post-graduate Diploma in Adult and Tertiary Education for Murdoch University. Therefore the project was continually reviewed by a number of people such as tutors and supervisory health professional staff – physiotherapists, occupational health and safety officer, clinical nurse educators and nurse educators. The data gathered was a range of documentation in relation to manual handling, interviews/questionnaires with staff, and informal focus group discussions with interested members.

### 3.5.2.2 Physical Activity Health Education

The data for this case study was collected over a period of two years from February 2000 to November 2001. I was employed as a Physical Activity Co-ordinator with the Y Public Health Unit and as part of the requirements for that position was asked to write a strategic plan for the whole of the Y region. The document created is the surface of emergence of complexities i.e. it provides the social space and written discourse for analysis of the difficulties experienced and is situated in the public health arena of health care. Health workers are frequently employed as Physical Activity Coordinators in order to promote health of populations, and health workers within hospitals are also being asked increasingly as part of their everyday work to include a definite percentage of health promotion work. There is an increasing demand for health workers to focus on health promotion in an attempt to stave off rising health care costs.
3.5.2.3 Therapy Assistant Training

Here, I was involved in a project between July 2001 and January 2003 that developed a curriculum for the training of therapy assistants and therapists using the data gathered from questionnaires and focus groups. The project was a joint initiative of the Combined Universities Centre for Rural Health (CUCRH), the Disabilities Service Commission (DSC) and the Department of Health (DOH). Issues pertinent to this current research were the training of Allied Health workers, including therapy assistants, in order to maximize service delivery options to people in rural Western Australia as they have typically been disadvantaged in terms of their health, service accessibility, funding and support structures including recruitment and retention of staff (Australian Institute of Health and Welfare, 1998; SARRAH, 1999).

Permission was obtained from the Director of the Combined Universities Centre for Rural Health (CUCRH) to review the data and the report for the purposes of this thesis. In return it was asked that a tutorial for Allied Health workers at CUCRH be given on the results. Data gained came from questionnaires sent out to Allied Health workers (n = 18 responses out of 22 sent out), and four focus groups for therapy assistants (Total n = 26 therapy assistants) held and participated in across four health districts rural W.A.
3.5.3 Interviews

I included interviews in my data because I wanted to understand other health workers’ lived experience in the workplace. In trying to understand the picture of power in the workplace, I wanted to hear from other workers in the field so that I could add to the complexity of the picture. I chose to employ face-to-face semi-structured interviews that had pre-determined questions that I circulated to participants prior to the interview, but I did not always adhere to the format of the questions since I wanted the freedom to be flexible in the way I was with participants and focus on key points that seemed of interest either to the participant or to me or both. These guidelines place the study firmly within qualitative research (Sarantakos, 2000).

In-keeping with qualitative research, I used open-ended questions where the participant was the expert in their own experience, where I was open and engaged but not controlling, where the format was flexible in relation to the questions and the nature of the interviewing was one of discussion more than anything else (Sarantakos, 2000). Whilst I responded to participants’ discussion in an affirmative way, I tried not to be intrusive or judgmental. Therefore I was more of an active listener and encourager than involved in meaning making with the participants.

I decided to ask people if they would be interested in participating in the research after explaining what it was about. As mentioned, I knew some participants previously either through my work in the health field or in the field of education. Some of the people I
knew were part of the department of health hospital that I approached in two rural areas in W.A. In the end, seventeen volunteer participants from the health field were recruited for the interviews across rural and metropolitan Western Australia. Initially the focus was to be on allied health workers only. However, I decided to include other workers across the spectrum of the health field in order to provide an inclusive range of viewpoints. The recruitment process involved liaison with the Allied Health lecturer at the Combined Universities Centre for Rural Health (CUCRH) and the Senior Project Officer at the W.A. Country Health Service (Department of Health, Perth, W.A.). Information was disseminated relating to the project aims and purposes. Two country health services were then approached to recruit any possible interested participants. The Information Sheets, Letters of Consent and Letters to the Managers of the Health Service are in Appendix 10.2.

Participants were interviewed in a private location at their workplace using a series of open ended questions. The interview questions are in Appendix 10.2. The interviews were tape-recorded, the tapes were transcribed and key themes were identified by the researcher within the structure of the research questions (see section 3.4.5). I decided to analyse the data myself rather than use any computer program such as NUD*IST as I wanted the greater flexibility that this allowed (Neuman, 1997) (see section 3.4.5).

One male and sixteen females participants were included from the different professional groups across different facilities and with different levels of job classification. Ethics approval for the study was gained from the Human Research Ethics Committee at
Murdoch University in October 2004. Participants were shown the information sheet and asked to sign the consent form before they participated in the interviews. Open ended questions were used to generate as much information as possible about health and well-being.

The next chapter (Chapter Four) is written as an account of my reflections on health and learning at the time of the case studies, Chapter Five contains the analysis of the case studies which then formed the basis for the interviews and analysis of the interview data in Chapter Six.
CHAPTER FOUR

Theory making and social practice: becoming a critical health professional

In this chapter, I am engaged in the practice of looking back on myself in order to regard myself as an object or “other” (Foley, 2002, p. 473) so that I might critically analyse the interconnections between my own and others’ social practices and over-arching macro-cultural principles (Sarantakos, 2005). I am specifically choosing to analyse my theory making in relation to health and learning in the enactment of the curricula and in the social practice of being a health professional in rural W.A.

I have chosen this location to look back on myself because health in rural W.A. is most complex and complicated at this extreme (see Chapter One) and because the situation in relation to health of disadvantaged people in rural W.A. is so bad that it seemed overwhelming at the time to me. At that time, the place I thought to begin my attempt at understanding rural health, and my own health in particular, was at the level of theory making.

As a health professional trained in a positivist biomedical model, the power of the attraction to engage in abstract theory making seems obvious to me now. That is, since positivism is a training in abstract theory making, it is no surprise that I turned to this as an antidote to the confusion I experienced in the field. I experienced a level of mental
confusion when I engaged with the different educational and health theories and I wanted to know and understand how best to employ these theories to help my own and rural health. I felt caught between the dominant forms of health theories that focused on changing individual behaviours on the one hand; and critical pedagogy and the associated social justice approach that emphasized the social determinants of health on the other. Government policy reinforced the emphasis on individual responsibility, and hence the social justice approach was less well known at the level of practice of health professionals.

I thought about these two seemingly contradictory approaches a great deal and struggled with issues around choice, control and empowerment. I experienced dissatisfaction at not being able to control my own health related behaviours, knowing there was some benefit of me being able to, and experienced swings between times when I could be in control and times when I was in utter chaos on an inner personal level. I was engaged with an inner battle of self-policing that only produced further isolation and feelings of being wrong (O’Grady, 2005). The abstract theory making with which I was engaged was a way at containing the chaos I experienced when working within social practices of health that tried to incorporate the over-arching macro-cultural principles of healthcare. It seemed as if the more I engaged with and thought about the dilemma of individual versus social determinants of health, the worse my own health became in terms of pre-occupation with control of myself to the exclusion of all else. In this way, I see myself as having embodied or materialized (Butler, 1993) the binary of individual-social
determinants of health. The bottom line for me was that none of the health theories with which I engaged helped me on a personal and professional level.

As I worked on this thesis and read hooks (1994), Foucault (1973, 1988a), Lather (1991a, 1991b), Riggs (2004a and b, 2005, 2006a and b), Ellsworth (1992), Luke (1992), Gore (1995a and b), Walkerdine (1992) and others (Usher, Bryant and Johnston, 1997), as well as developing meaningful ethical relationships with others, I became less concerned with working out the binary between individual and social determinants of health. My focus changed to developing a sense of self that did not rely on the performance of control. Instead I was concerned with developing a sense of self through safe relationship; ones where my needs were responded to in an ethical manner. Such relationships demonstrated what has been called limbic resonance, limbic regulation and limbic revision (Lewis, Amini and Lannon, 2001). These processes are in direct contrast to the notion of self-control as a technology of self that forms part of a self policing process operating out of a deep need to mobilize power and impose structure on our behaviour. This insight seemed to characterize both myself and the theory making with which I had been engaged.

Control was thus brought to the forefront of my attention. The whiteness of (psychological) epistemologies (Riggs, 2004a) that position privileged people as progressing upwards towards a state of good health in colonizing neo-liberal discourse emphasizes and valorizes control (Riggs, 2004a). Different subjectivities that have more or less control are all constructed within relations of power that favour privilege (Riggs,
To see that the individual versus social determinants of health binary was unified at the level of construction of the individual, perceived as being in control, was of great relief to me because it meant I didn’t have to “do” control anymore.

Riggs (2005) suggests that “locus of control is something we do in order to manage the ways we are positioned in relation to other people, and within the social order more generally” (p. 7), and “we enact control over ourselves when we strive to achieve freedom on the terms set within a neo-liberal society” (p. 8). As I look back on myself I think I was unconsciously motivated by a desire to control myself as part of a general policing process and impose structure on my behaviour. I wanted to fit in with what I perceived as the normalized health professional practice and I fixated on control as a means of doing this.

On the other hand, I could also see that control was irrelevant and missed the point for myself and other people engaged in unhealthy lifestyle behaviours. Telling myself to change just would not work as I had a whole host of unmet needs and experiences within my body that determined what I did and didn’t do, and which for the most part I did not understand, could not relate to and had no choice in their enactment. I was positioned externally, visibly, as a privileged white health professional who was in control and an expert on health. Internally, I positioned myself as someone lacking the necessary qualities to belong to the privileged set and generally I felt extremely destitute. Unconsciously part of my motivation to understand the binary of health determinants was concerned with understanding this split within me.
However, over time, I have seen that at the heart of the self (myself) is inscribed the binary which structures the self (Usher, Bryant and Johnston, 1997) and materializes the body (Butler, 1993) in a limited form of subject positions. I believe that if I have a self which is based on long term positive, mutual relationship(s) (Lewis, Amini and Lannon, 2001) then I don’t feel inclined to engage with the construct of ‘control’. In fact it seemed to me that engaging with the construct of control and controlling behaviour only produced more conflict and struggles for power on an inner level.

Riggs (2006) discusses how certain feelings (feeling out of control) in response to a work situation, only make sense in a society that valorizes control. I take this as also meaning that cultural artifacts in education and training also only make sense if read through a lens of control. For example, wanting students or patients to be empowered, assertive, to exercise choice (which in reality is a reactive response to being manipulated) and to experience utopian health and/or learning is only necessary because these same students and patients are disempowered through and by discourses about control. Disadvantaged people are perceived as ‘having’ little control because they have been positioned in this way by privileged people, who now want them to have agency and be self responsible i.e. ‘do’ control. So that then the passive conformist learner and patient or client can also be disciplined, comply with advice and adhere to regimens. On an individual level this is how the nexus of control can be enacted. It seems almost as if the ‘individual’ is placed in an invidious position and then is asked to behave themselves there.
On a training level, competency based training and evidence-based practice enact the same invidiousness on people at a group level. Workers and students are asked to carry out tasks (‘do’ control) which have been reduced to such a simple level in order to reduce the risk associated with such a task. Carrying out tasks that have little or no risk attached to them is demeaning for all involved since most tasks in the real, messy world require some degree of complexity and risk in healthcare. People can be placed in invidious positions because the reality of their situations does not fit the training checklist, or the evidence may not be there to support that practice or it may not support that practice in that context with a particular person at that time. It seems as if competency based training and evidence-based practice only encourages workers to become controlling and to enact personal power which they confuse with the authority of their position (Freire, 2000). Meanwhile everything that does not fit the competency based checklist is abject and there is no room for flexibility or choice or customer/patient centred care.

Individual responses are part of what is made abject by competency-based testing and evidence-based practice. On an embodied level, responses to invidious positions can include a range of emotions and felt senses. For someone who has a real and genuine need, to be placed in an invidious position because of that need can only result in some or all of the above responses. To be told to live a healthy lifestyle when feeling shamed to the core by a well-meaning health professional can only make matters worse since the recipient of such advice can only feel more wrong. Links with chronic stress and physiological mechanisms of the body have been a particular focus of theorists on the social determinants of health (Marmot and Wilkinson, 2000).
At the micro level, the brain has been categorized into three functional regions which include the neo cortex, the limbic system and the reptilian brain (the brainstem and other control centres for the basic functions of life) (Lewis, Amini and Lannon, 2001). The point of this categorization is to emphasize that people cannot will themselves to want the right thing and that any lack in capacity to do so is due to the structure of the brain and not a deficiency in discipline:

Because most people are aware of the verbal, rational part of their brains, they assume that every part of their mind should be amenable to the pressure of argument and will. Not so. Words, good ideas, and logic mean nothing to at least two brains out of three. Much of one’s mind does not take orders. … A person cannot direct his emotional life in the way he bids his motor system to reach for a cup. … Emotional life can be influenced, but it cannot be commanded (Lewis, Amini and Lannon, 2001, p. 33).

Lifestyle behaviours are influenced by the emotional landscape that people carry within them which in turn inscribes and is inscribed by the social fabric within which they are embedded. Any failure by people to engage with healthy lifestyles is therefore a complex interaction of emotional, social and physical factors.

The limbic system of the brain has been attributed with functions such as emotionality, nurturance, social communion, communication and play (Lewis, Amini and Lannon, 2001). It could be said that the limbic system acts as the interface between the social and the individual. However, the emotionality of the limbic system is usually overridden by the (neo-liberally inscribed) neo cortex in cultures where patriarchal institutions dominate. On an embodied level, disjunctures between the social and individual could be reflected in the disjunctures between the rational abstract linguistically competent neo cortex and the emotionality of the social sense organ of the limbic brain. The neo cortex
is said to have a role in modulating, integrating and articulating the feelings of the limbic system (Lewis, Amini and Lannon, 2001). Translation troubles do occur and it could be that the current emphasis on control within the context of neo-liberalism is one way of managing these troubles.

Control and self-regulation have assumed high profiles in discourses about health and learning. However, these discourses can be experienced as oppressive (Gastaldo, 1997). Learning how to have sustained encounters with oppressiveness requires a totally different ‘curriculum’ than an empowerment model of assertiveness with its emphasis on rights and what is normal. There is a bottleneck in the war between sovereign rights and what is normal (discipline) with each jockeying for the position of domination (Foucault, 2004). This war is reflected in curriculum documents and discourses about training. One way beyond the bottleneck is to consider meaning. An emphasis on meaning moves beyond the insistence on rights and normality. An emphasis on meaning is inclusive of a wider spectrum of humanity’s experience: “For us, the meaning of life embraced the wider cycles of life and death, of suffering and dying” (Frankl, 2004, p. 86). In this way, the meaning of any situation, particularly suffering, is important to me. I have needed a curriculum that includes suffering as an ineradicable part of life (Frankl, 2004). It seems to me as if changing my own response to the daily occurrences of power enactment at the individual and group level is what is crucial to my own feeling of well-being.

A new curriculum links health and learning through the workings of power. Such a curriculum pays heed to the space between the two players, or educator and educated, and
values relationship and what is produced relationally. A curriculum like this emphasizes
the self through relationship – a relationship to self and others that is an ethical practice
and socially accountable. This means that transference and countertransference issues
can be taken care of in a safe environment (Freegard, 2007). Both the self and
relationship have been necessary for my well-being. Both seem to be determined and
determining in the materialization of my body and influence my health and health
behaviours. I believe a reconceptualization of the self is required in healthcare to see that
it is both/and – behavioural and social determinants of health. What seems more
important to elucidate is the relationship between the two and to tease out how constructs
and positioning of the individual impact on health.

The link for me between health and learning is deconstruction of core concepts in health,
including how the individual is conceptualised. Control, choice and empowerment have
meant that I no longer need to ‘do’ control and as a consequence my health and well-
being have improved. More than any other form of learning, deconstruction on a
personal level as well as at the over-arching macro-cultural level has altered my sense of
self and given me an increased amount of subject positions to choose from. Placing
power at the forefront of my analysis and my life means that I now have a choice about
whether I engage with instances of oppressiveness: a choice about my own behaviour
finally, which means that I am not behaving in a way defined by somebody else.
Regardless of my material circumstances, being able to name, identify and then to choose
whether or not to engage and at what level has helped my own sense of well-being. This
to me is much like McLaren’s (2002) saying “our own power lies in the continual surveillance of power itself” (p. 96).

In Chapter One of this thesis I begin to argue for a radical reform of the curricula of health professionals. One major reform I would like is to see power and relationship placed at the forefront of the curriculum and for the enactment of the curriculum to receive more attention than anything else. I believe there needs to be an in-depth exploration of the binary of individual versus social determinants of health with reform here to include a both/and approach to health. There will always be instances of individuals needing acute health care and there will always be measures that can be taken at a population level to address inequity in health status and to improve the health of populations particularly those at most risk. Social determinants of health can be addressed but only through careful analysis and emphasis on the workings of power. Otherwise both individual and social determinants of health will continue to fail as projects of self-regulation of the state, since they both ultimately have at their core the construct of the neo-liberal ‘man’ and ‘control’ and therefore cannot help but make ‘him’ wrong since ‘he’ is a myth.

As part of the radical reform of health professional curricula, I would also want a much more inclusive curriculum to have a variety of ways of knowledge making and legitimation with a special emphasis on feminist critiques that keep the moral and ethical implications of their work at the forefront of knowledge making. By working through the
four categories of inquiry (predictive, understanding, emancipatory and deconstruction) I cannot help but be as inclusive as possible and this keeps me grounded and honest.

When I worked as a health professional and educator trying to implement training programs with a critical pedagogical approach, I became embroiled in conflict. At the time I couldn’t understand why, almost as if I had positioned myself as an innocent bystander whilst also in hindsight being disruptive to the status quo of the health system. But I couldn’t see this at the time. All I knew was that I was trying to implement work with an emphasis on social justice because that seemed to me to be the right thing to do. The Commission on Social Determinants of Health (2008) recommends that health professional training programs include social determinants of health. However, I contend that unless the training programs also include knowledge about the workings of power and relationship, then these social justice approaches will be limited in their effect. Just as Ellsworth (1992) asked “why doesn’t this feel empowering?” when implementing critical pedagogical approaches in the classroom, the same will be true for health pedagogues out in the field trying to implement social justice approaches to health. The experience of trying to close the gap in health inequities will be disempowering unless powerlessness is kept at the forefront of the work.

With an emphasis on powerlessness at all times, and a socially accountable approach to health, then more forms of knowledge legitimation must be included. Foucault’s (1973) *Birth of the Clinic* should be required reading for all health professionals so that it can be remembered that hospitals were used as a means of monitoring and isolating
disadvantaged people away from the privileged members of society. Thirty years of neo-liberal reform seems to have reinforced this purpose. A walk around most public hospitals in the western world, with their long queues, interminable waiting, shoddy rooms and crowded wards, shows it is no wonder that staff are leaving in a mass exodus and patients are dissatisfied. The conditions for both health professional and patient after thirty years of neo-liberal reform are appalling. These conditions cannot help anyone feel good about themselves or address the meaning of suffering from any condition. The state of acute care services is a reflection of the over-arching macro-cultural principles of neo-liberal reform.

Having looked back on myself as a theory maker in rural health and reviewed the praxis that took place as a result of that time, I can see that this thesis is the outcome of the original dominance of positivist thinking. When it was a project of the self that enacted control, being engaged with writing about health and learning meant that I could preserve my thinking mind and contain everything else outside of that. However, I now think that the content of the thesis is not what my thinking mind would have imagined all those years ago before I disengaged from abstract theoretical frameworks to become grounded in the workings of power and relationship itself.
CHAPTER FIVE

Three case studies of training within rural health

5.1 Introduction

In the previous chapters, I have outlined some of the ways in which health professional curricula are enacted through the dominance of positivist theories that emphasize the neo-liberal individual, control, autonomy and agency. Students, workers and patients are expected to exercise the ‘right’ choice in relation to health and learning, and to be able to control their related behaviours whilst at the same time be passive and compliant when it comes to learning about health and adhering to regimes of advice or ‘truth’. This expectation is what is in the meeting place between the expert, the health professional, and the patient or learner.

Simultaneously, there is also the sense that health workers are positioned on the edge of chaos and that there is a dire need to take into account the complexity that is health and related services (Baum, 2007). There is the suggestion that control is something that is produced in and by relations and that it is something that we ‘do’ in order to manage how we are positioned by others (Riggs, 2006a) and to manage overwhelming fear and anxiety. There are limited subject positions or subjectivities available for experts, health workers and patients or clients.
The limited subjectivities available for people in the health care system are enacted in part by the structuring binary of individual versus social determinants of health in the curricula of health professionals. However, both parts of the binary have as their major concern how to make people ‘do’ control better, whether it be through individual emphasis or emphasis on the structural determinants of health. The linguistic veil of health consists of constructs around control in the main and this produces limited subjectivities.

The dominance of positivism and the medical model in the field of health produces invisibility of many health workers and clients as they do not fall within the limited subjectivities available within such a model. Furthermore the colonization of Australian health workers and the workplace through fear based policies and training such as ‘risk management’ is rife and co-opted attempts to provide collaborative, reflective student centred learning. The absence of the nurturing feminist critique as a theoretical construct is apparent by the lack of pedagogical status of theories such as the pedagogy of relations (Biesta, 2004).

I have suggested that there needs to be a more inclusive curriculum, one that includes feminist critiques of health and healthcare training. Generally these are absent from the field. It is hard to gain some separation and distance from the linguistic veil of the dominant theories without the aid of feminist theories. The following case studies formed my way in to the analysis of power relations in the enactment of three post-
graduate training programs with which I was involved. I drew on the work of Gore (1995a), Lather (1991a and 1991b), and Kendall and Wickham (1999).

When I first started becoming aware of the scholarly necessity to analyse relations of power I struggled with actually being able to do so. I did not have a poststructuralist approach or language available to name or identify instances of oppressiveness. I found it hard to differentiate myself from the positivist biomedical soup in which I was swimming. The case studies formed my first vital steps at identifying the linguistic veil and were concerned with the implicit curriculum or the rules that delimit the sayable (Kendall and Wickham, 1999).

Kendall and Wickham (1999) emphasize the two poles of knowledge which form relations of power between the visible and the sayable i.e. the relation between what you can see and what you say you can see is a type of relation of power. These relations of power are also formed therefore between scholarly knowledge and disqualified knowledge (Foucault, 2004). These are very important relations to name since whoever defines the ‘Truth’, or what is visible and what can be said, also has the power to define others (Weedon, 1987). There is silence in the medical field about a whole range of contingencies or factors that structure the work and educational environment and that contribute to the construction of who we are or the subjectivities we take in relation to our health. More naming in the health field of relations of power seems necessary otherwise workers will continue to be caught in a positivistic rut. The medical model with its emphasis on evidence-based practice and science for the production and
legitimation of knowledge seems to have produced a situation where the more we ‘know’, the less we ‘care’.

With these key issues in mind, I now turn to three case studies of training within health institutions in rural W.A., where I was an educator, in order to explore relations of power through the lens of technologies of power such as surveillance, normalization and individualization (Gore, 1995). The first case study is the manual handling training I carried out in 1998.

5.2 Case studies

5.2.1 Case Study 1 – Manual handling training

This case study draws on a competency based training program implemented in a small West Australian (W.A.) rural hospital (150 beds, approximately 600 staff) in 1998. I was employed part-time (two days per week) for a short term contract, nine weeks, in order to implement a Manual Handling training program across the different sectors of the health service. I was implementing the training, which drew on the scientific medical model and which was assessed by competency based criteria, whilst also participating in an educational framework as part of the requirements for a Graduate Diploma in Adult and Tertiary Education.
This case study works very much at the limits set by different epistemological frameworks. Working within and at the limits of different epistemological frameworks involved moving between the rigid prescriptive scientific competency based manual handling training program as advocated by the Health Department of W.A., and endorsed by the rural Health Service, to discourses around collaborative learning that were student centred and participatory as promoted by Murdoch University as part of their Graduate Diploma in Adult and Tertiary Education. Also there was an emphasis on Action Learning as a cycle to be used as part of the requirements for completion of a final unit in the Diploma at that time. Critical pedagogy had been included in the discourses within the Diploma but these had become whittled down to student centred learning and an inclusion of the context in an analysis of the learning situation. These formed the ‘scholarly knowledge’ with which I was engaged (Foucault, 2004).

The disqualified local knowledge identified in the case studies (Foucault, 2004) was gained from a variety of sources including but not limited to interviews, questionnaires, informal discussions, meetings and presentations. The disqualified knowledge of the workers can be summed up by saying, “these are the rules but what happens behind closed doors is a different matter”. There was acknowledgement of the rules that delimit the sayable but resistance took place behind closed doors. The disqualified knowledge of the nurses was that they knew conditions at work were not conducive to safe working practices or to looking after themselves and preventing injury to themselves. If they wanted to be a part of the profession, they had to put up with the conditions at work; there was little that could be done. There seemed to be inner conflict between passivity,
powerlessness and helplessness and the rhetoric of empowerment. It is almost as if the workers absorbed the irrationality (Walkerdine, 1992) of the manual handling training in their bodies which then manifested as injuries or back pain. Women’s work and labour and its consequences contributed to the oppression of women through their duty of care, both literally and metaphorically.

Whilst manual handling training can be very useful in injury prevention and in safe handling of patients or clients, it is not enough on its own. After reviewing the Occupational Health and Safety records of the hospital site, it became clear that most of the injuries at this site were caused by unpredictable accidents and not by repetitive ‘bad’ manual handling. There was more involved in the occurrence of accidents and a short course on manual handling training for all the workers was clearly not going to fix the problem. There was a great deal of complexity involved in the issue of manual handling and this needed attending to.

For example, unpredictable accidents could include situations where nurses were transferring a patient who suddenly collapsed through having a heart attack. In the immediacy of the moment nurses are faced with a dilemma about whether they ‘save’ the patient by trying to keep them up, or whether they try and ‘save’ their backs by allowing the patient to fall gently to the ground. The nurses have to consider the patient, themselves, the environment they are in, the consequences of their actions for them and the patient, the equipment, the rules and so on.
Again, as with my earlier comments on positivism in Chapter Three, it is not that there is anything inherently wrong with manual handling training; it is just that generally that is all there is provided in an attempt to address safety and health problems related to lifting in the workforce. And by this being generally all there is, relations of power are produced between the visible and the sayable (Kendall and Wickham, 1999) i.e. what can be said within the context of manual handling training. This is how the curriculum is enacted – by silencing the workers and producing rules about what can be said in terms of scholarly knowledge. The scholarly knowledge on manual handling tends to focus on techniques of lifting and the assessment of competency in lifting of the workers as will be shown below.

Interview and questionnaire responses from the nurses (which are not shown here for issues of confidentiality) showed detailed operational issues where the scholarly knowledge of manual handling conflicted with their disqualified knowledge and produced struggles. Here is a major disjuncture within the training of manual handling that positions the workers invidiously. The scholarly knowledge (Foucault, 2004) consisted of manual handling task analysis and competency checklists (see Table 2) for the carrying out of correct manual handling techniques in order to avoid injury to self and others. In this way the workers were protected by the scholarly knowledge. The disqualified knowledge (Foucault, 2004) of the nurses was that there were not the resources to complete the work safely, that there were dilemmas as to who should have priority in a potential accident situation, the worker or the patient (most often the patient came first at the expense of the worker): and then there was the dilemma of health care
workers supposed to be caring workers and therefore hands-on (but this was at odds with the no lift policy and requirements to use mechanical aids entirely). Another dilemma was that some movement of the patient was helpful to re-educate movement if they had had a stroke or some other movement difficulty but if they were going to be lifted with hoists all the time the opportunities for such re-education were reduced.

The disjuncture in manual handling training was that the simplicity of the competency based checklists did not match the complexity of the lifting situation, including the patient and the worker. Therefore, both or all were placed in an invidious position. Resistance could take the form of doing things differently behind closed doors, with the potential for unhelpful consequences for all. The disjuncture, or invidious position, or moment of subjugation, or point of co-option is at this point. Here is where resistance and/or conflict is likely to occur as it is here that workers become positioned. But this point is rarely talked about in the literature. Instead disciplinary power is enacted, which seems to silence any creative approaches to this type of disjuncture.

An example of the manual handling training competency based assessment follows (Table 4) to show the narrowness of the disciplinary power enacted:
Table 4  The Manual Handling of People Module 1 Transfers

Task Specific Training Skills Check Sheet 1.1A

STANDING TRANSFER OF A PERSON FROM BED TO CHAIR/COMMODE:

INDEPENDENT

<table>
<thead>
<tr>
<th>STEP</th>
<th>MET</th>
<th>NOT MET</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain task to person transferring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Adjusts bed height so feet firmly contact floor. Prepares environment so furniture is in best position for independent transfer. Supplies necessary independence aids. Removes bedrail if necessary.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Removes arm of chair or commode if desirable.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Instructs to lead with shoulder and leg and to roll onto side.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Instructs to push up on arm they are lying on, as they swing legs over edge of bed to sitting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Instructs to hip hitch each side to move bottom to edge of bed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Assists to access independence aid if necessary. Instructs to lean forwards and to push into standing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Instructs transferee to turn using most appropriate leg and utilizing equipment effectively.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Instructs to reach for arms of chair to lower self into sitting (if relevant). Instructs to put chin onto chest and bend forwards to move into sitting.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It can be seen that both worker and the ‘transferee’ i.e. patient or client, become particular types of subject – docile bodies – that seem curiously disembodied rather than embodied. This curious state of affairs has also been noted in nursing research:

It has been argued that in everyday life the body is passed over in silence and not often reflected upon, and that the lived experience of nursing is difficult to describe as the body is silent in the taken-for-grantedness of nursing practice. This habitual body has been described as the absent body, a body that only becomes present when it is hurt or damaged (Edvardsson and Street, 2007, p. 25).
Along with the silence on the body, there is no acknowledgement of the worker’s or the transeree’s disqualified knowledge of their situation and condition.

The local knowledge of the workers about the lack of resources for them to complete their work safely was disqualified by the scholarly knowledge of manual handling training which stated that workers should be able to complete tasks competently in an exact manner. There was no engagement with the complexities of the working situation with the workers being subjugated by the material operational tasks of caring for patients. Here we have an example of how disciplinary power is enacted to produce docile bodies (Usher and Edwards, 1994) through competency based training.

It is noticeable that the discourse of competence marginalizes knowledge and understanding unrelated to workplace performance. Education in general, and competence based assessment in particular exclude certain forms of knowledge in order to enable the maximizing of correct performance. In competence based qualifications, the conditions which would make alternative agendas possible are thereby displaced by the normalizing processes of education and assessment (Usher and Edwards, 1994, p. 103).

The narrowness of the competency based manual handling training was acknowledged by many workers who admitted to ‘doing their own thing behind closed doors’. This was one of the forms their resistance took. Another way to resist is to critically gaze upon the manual handling training from within power/knowledge formations and highlight the forms of surveillance and discipline inscribed within it (Usher and Edwards, 1994) as in this case study.

In order to address the situation identified at the time only as a mis-match between managers’ and workers’ perceptions about manual handling issues, I called a meeting
between a number of the managers and workers in order to clarify the barriers and drivers for the manual handling training. The outcomes of the meeting were support for the staff in terms of the purchasing of new lifting equipment, funding for staff training time, and a clarification of the process for reporting of manual handling injuries which all benefited staff. Since I was committed to a manual handling training that encompassed student centred learning, self-directed adult learning and collaborative consultation, this being the scholarly knowledge of the educational field I was accessing at the time, I saw this as the most effective way to address the mis-match in perceptions but I had no understanding of issues around power and these were never addressed.

Throughout the process there were a number of obstructions including confusion as to the role of the manual handling trainer, obstructions manifested as interpersonal conflicts, and delays in arranging and attending meetings. Overall though, considering the short time frame I was there, I had positive feedback from the nurses on the outcomes of the meeting and the initiation of WISE (Workplace Investigation and Safety Evaluation) teams which were multi-disciplinary teams of workers who volunteered to meet regularly to discuss issues related to manual handling thereby encouraging a response to manual handling that went beyond just training and competency checklists. I would now like to explore this case study in relation to technologies of power including Gore’s (1995a) categories of surveillance, normalisation and individualisation.

Manual handling training is an example of power relations operating at the level of the body, existing in action, and being observable in micro-level practices of pedagogical
events (Gore, 1995a). In this way, it is what Gore (1995a) refers to as disciplinary power – ‘circulating rather than being possessed, productive and not necessarily repressive, existing in action, functioning at the level of the body, often operating through ‘technologies of self” (p. 167). Gore (1995a) draws on eight categories of power circulation in the classroom using them as tools to identify instances of power. These are normalisation, totalisation, individualization, classification, regulation, surveillance, exclusion and distribution. Manual handling is an invocation of a specific power-knowledge nexus or discourse, what Gore (1995a, p. 109) refers to as ‘specific regimes’. Three specific categories of analysis of power – surveillance, normalisation and individualisation – are employed here to describe and enhance the analysis of power in the case studies.

**Surveillance**

Within the hospital ward, manual handling is a major issue since it comprises a large proportion of the daily work of nurses, patient care assistants, and allied health workers (i.e. everyone except doctors). Manual handling is focused on in order to prevent injury and minimize risk to the workers and patients. It is a key discourse in health education and training that focuses on risk management (Petersen and Lupton, 2000). Therefore surveillance of the patients and of the workers forms a key technology of power as each time someone is lifted there is the potential for reporting of the effectiveness and efficiency of the lifter. Moreover, the surveillance is carried out on the worker as well as the patient although, as mentioned previously, the patient tends to have an absent
presence as they are referred to only as the transferee in a disembodied or abstract way or only in parts e.g. to put chin on chest and move forwards to bend into sitting. Here is where the women carrying out the work in the main connect the abstract bodies of governing knowledge with the actualities of tasks or bodies of everyday living (Williams, 2002). Any movement that takes place of the patient and workers together is subject to surveillance which ensures compliance with the regimes of truth inherent in manual handling. Even I didn’t escape the seduction of surveillance as I initiated WISE teams that were all about keeping an eye out for manual handling issues. However, WISE teams did provide an opportunity for workers’ disqualified knowledge to be heard if there were not overriding power issues at meetings. As stated previously, the disqualified knowledge of the workers took place behind closed doors i.e. out of view of surveillance and was a form of resistance to the training.

Normalisation

Competency based assessment of manual handling training ensured the disciplining of docile bodies in order to conform to normalised techniques of lifting. Most research carried out on manual handling techniques tends to be completed in biomechanical laboratories in university departments on fit young men who volunteer for the study (Institute for Fitness Research and Training, 192; Wilson, Hall, McIntosh and Melles, 1999). There is generally an absence of women health workers in the studies or real life situations on the ward therefore positivist research inculcates norms that are exclusionary in their practices. Since the surveillance around manual handling is paramount this
means that women are doubly inscribed within the patriarchal medical model – they are constructed as specific types of male lifters and then they are also excluded from the process of generating knowledge about lifting. This is a further example of where culture both constructs and pathologizes the feminine (McLaren, 2002).

**Individualisation**

Manual handling training has the effect of individualising the risk associated with manual handling since any injury is attributed to the poor performance or incompetence of the worker and patient. Workers are assessed on whether or not they have met the competencies associated with each of the steps of the manual handling transfer. If they do not meet the competencies, they are disciplined by having to undergo further training and/or having their poor performance noted on their performance appraisal. Furthermore, if they were to injure themselves during lifting, the institution is not considered liable if it can determine that the lifter was incompetent. As stated previously, it is not that manual handling training itself is unproductive. It is only so when it is focused on to the exclusion of all other factors involved in manual handling which unfortunately seems to be the case in most health institutions at the time of this case study. In this way, an institution can maintain its innocence in its governmentality of the individual workers.

In conclusion, the normalising processes of the education and assessment surrounding manual handling training reinforce the absence of women in the governing bodies of knowledge. Therefore women health workers are forced to be an absent presence in their
enactment of manual handling through their bodies. Through surveillance, normalisation and individualisation bodies of both the health worker and the patient are enacted and lived in a liminal space (Riggs, 2006a) that paradoxically connects the abstract theoretical knowledge with the actualities of the lived lives.

5.2.2 Case study 2 – Physical activity health education

It can be seen from Case Study One that relations of power infiltrate every interaction within the patriarchal institution of health. Women, in their work as carers, are subjugated by knowledge and regimes of truth into subordination and willingly participate in their own oppression and repression through techniques of power and practices of knowledge-power. While Case Study One looked at the micro mechanics of power enacted through and within the gambit of a manual handling training, Case Study Two looks at perhaps a more global aspect of health – public health – and how the health education in this area promotes a particular type of subjectivity and what this might mean for women. Public health education programs can be seen as more generic and all encompassing of the individual and populations of individuals, and therefore perhaps more innocent of the will to power in the capillary form (Gore, 1995a). However, it is proposed in this chapter that nothing could be further from the truth and that in fact public health education programs are a powerful method of reinscribing systems of power and domination through the enactment of regimes of truth on the body, especially for women since the backdrop for all of health are the patriarchal norms.
I am including this case study as it foregrounds the role of scholarly medical knowledge in defining the individual through technologies of self that include health. The capillary form of analysis is located at the interface of physical activity promotion and the individual, be it myself or co-workers or anyone else in the general population. Physical activity is used since I was employed as the Physical Activity Co-ordinator at a Public Health Unit in rural W.A. This meant my role was to educate people in the benefits of physical activity participation and thereby assist their change in behaviour as it was assumed that people would automatically change their behaviour once they were aware of the ‘facts’. This is one of the primary assumptions of public health intervention – that individuals need to and will change their behaviour for the better once they know the need to do so. This is the interface between the individual and the societal health services that will be examined in this case study; and thus this case study shows the key role that education plays in this interface. Since health professionals are supposed to be becoming more educative in their intervention, the role of education can be assumed to play an even greater role in the formation of the individual – both workers and the general public.

I was employed for two years (from the beginning of 2000 to the end of 2001) as the Physical Activity Co-ordinator which meant that I was responsible for the education of workers and the general public of a vast area covering most of the south of the state of Western Australia. I experienced a great deal of dissonance with the general aims of the physical activity co-ordinator position and the reality as I saw it in rural W.A as I described in Chapter Four. Again, I tried to disrupt the norm by introducing what I believed to be a more holistic framework with an educative and psychotherapeutic
approach into the sterile public health discourse (see figure 4 and appendix 10.3). But in fact little changed, except that the framework produced was a result of greater collaboration with a larger number of people across rural W.A.

I tried to introduce more complexity into the public health discourse because it seemed to me that the public health approach was limited. Issues such as the difference in perception between the publics’ attributing of the causes of ill-health (Blaxter, 1997) to the health professionals’, victim blaming (Crawford, 1977), the politics of the white picket fence (Boardman, 2004), the lack of a policy-process model to generate tangible knowledge about factors and determinants that make a policy feasible and effective (De Leeuw, 1993), the ecological fallacy inherent in making causal inferences from group data to individual behaviours and the problematics associated with the fallacy itself (Iversen, 1974; Schwartz, 1994), and the understanding that targeting low socioeconomic groups of people for behavioural modification has produced less than encouraging evidence for its efficacy:

Perhaps the most striking aspect of these findings is that adult behaviours and psychosocial orientations are patterned by childhood SES, and so do not provide support for the “free choice” conception of adult behaviour, because in this view adult health behaviour would be unrelated to childhood conditions. Socioeconomic status at birth is not chosen, so it seems difficult to argue that the subsequent normative level of education for any particular childhood SES group is freely “chosen”, or in fact that people then “choose” their subsequent occupation. In this light, the concept that individuals somehow choose their socioeconomic pathway through life is too simplistic (Lynch, Kaplan and Salonen, 1997, p. 817).

All these factors and more seemed to point to the need for a more complex analysis of public health so I developed the framework from others as a tool for integrating the available information and as a tool for program planning in the hope that it might also generate some knowledge about public health.
Figure 5.1. An Integrative Framework – Health as a Resource – A model of Learning/Healing

- Global
  - Global economy
- Federal and State Government
  - Policies, laws, to support equality
  - Economic Rationalism
- Local Government
  - Infrastructure for supportive environments
- Interagency collaboration
  - Social Dynamics
  - Power
  - Ecological Fallacy
- Values
  - Attitudes
  - Peer pressure
  - Cultural Norms
  - Prevention Paradox
  - Consumerism
  - Commodity Fetishism
  - Comfort is God
  - Fast food, fast communication, fast cars, fast delivery, fast service, e-commerce, ……
- Psychogenic Effects of Social context:
  - Stress – Flight, Fight or Freeze
  - Psychobiological response
  - Pain
- Participation in physical activity
  - Health Belief Model
  - Health Locus of Control
  - Transtheoretical Model
  - Theory of Planned Behaviour
  - Theory of Reasoned Action
  - Supportive environments
  - Social Cognitive Theory
  - Social Learning Theory
- Salutogenic Model (Antonovsky 1996)
  - Sense of coherence
  - Meaningfulness
  - Comprehensibility
  - Manageability
  - Program development based
- Humanistic
  - Critical Pedagogy
  - Self-directed Learning
- Environmental
- Spiritual
- Inner Body sensations
- Affective
- Cognitive
- Relationships
- Community Family
- Family
- Culture

- Land Rights for Aboriginal People
- Individualism
  - Medical model
  - Reductionist
- Economic Rationalism
- Local Government
  - Infrastructure for supportive environments
- Interagency collaboration
  - Social Dynamics
  - Power
  - Ecological Fallacy
- Global economy
- Global economy
- Federal and State Government
  - Policies, laws, to support equality
  - Economic Rationalism
- Local Government
  - Infrastructure for supportive environments
- Interagency collaboration
  - Social Dynamics
  - Power
  - Ecological Fallacy
- Values
  - Attitudes
  - Peer pressure
  - Cultural Norms
  - Prevention Paradox
  - Consumerism
  - Commodity Fetishism
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  - Fast food, fast communication, fast cars, fast delivery, fast service, e-commerce, ……
- Psychogenic Effects of Social context:
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- Participation in physical activity
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  - Health Locus of Control
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  - Theory of Reasoned Action
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  - Social Learning Theory
- Salutogenic Model (Antonovsky 1996)
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  - Comprehensibility
  - Manageability
  - Program development based
- Humanistic
  - Critical Pedagogy
  - Self-directed Learning
- Environmental
- Spiritual
- Inner Body sensations
- Affective
- Cognitive
- Relationships
- Community Family
- Family
- Culture
The framework drew on the Health Mandala (Hancock and Perkins, 1985; cited in Chu and Simpson, 1994) and the Hakomi method of psychotherapy (Kurtz, 1990b). While I was working with the integrative framework, I was preoccupied with the link between health and learning, thinking that there must be some natural connection that was mutually reinforcing if only I could grasp it. This is represented in the diagram by the use of the different psychological learning theories, and by the centre of the framework that represents awareness; or in other words, reflective practice as applied to and by the individual and then in relationship with the family and community. At that time, this seemed to me the key link to health and learning. I think I was becoming aware of the use of health and learning as major practices of the self. On reflection now, I see that the discourse I constructed at that time made the link between health and learning not a natural phenomenon waiting to be captured or a reality out there waiting to be discovered (Neuman, 1997). It was more like a mapping of the social showing how health, education and learning are used as primary tools in the technologies of domination and power – power/knowledge (Foucault, 1988a).

The creation of expert knowledges, the integrative framework being one of these, is a primary way of controlling and determining individuals’ and groups of individuals’ behaviour – in this way, the power is both individualizing and totalizing which is what gives it its strength (Foucault, 2004). The discourse around health is becoming more and more complicated as evidenced by frameworks which can be hierarchical, transdisciplinary, ecological, collaborative, acknowledging of power relations (but seemingly having little to do about them) and that seek to create emergent conceptual
frameworks (Albrecht, Higginbotham and Freeman, 2001). I certainly developed a complicated integrative framework in order to try and capture the complexity of health, which in hindsight was more about surveillance, normalization and individualization.

**Surveillance**

The biopower (Gastaldo, 1997) inherent in the integrative framework can be seen in its design as a series of cells surrounding the central or key important factor of awareness. The outside cells were supposed to represent different modes of learning, building on the competency based criteria of affective, cognitive, and behavioural learning outcomes (Blooms’ Taxonomy) to further include relationships, environment, spiritual and inner body sensations as sites of learning or practices of and about health; with the central place occupied by awareness. This design can be likened to Bentham’s panoptican discussed by Foucault (1979) in *Discipline and Punish*, with the central guard tower keeping watch over the prisoners who never knew whether they were being watched or not and so had to assume that they were being watched all the time. The guards were also under surveillance and therefore subjected to disciplinary power as well as the prisoners.

Surveillance is a significant form of disciplinary power, even the mere threat of it causes individuals to alter their behaviour and “transform themselves”. Surveillance impacts on actions, behaviour, bodies. Although it begins from the “outside” through the disciplinary gaze of the guard, teacher, or manager, part of its effectiveness relies on its moving “inside” through the self-monitoring of the individual being watched. The model of internalization captures this process much better than the model of inscription (McLaren, 2002, p. 108).
The inner battle experienced by women who have internalized such a form of surveillance has been called self-policing (O’Grady, 2005). Gastaldo (1997) discusses how health education is an experience of being governed from the outside and a request for self-discipline and that what happens in the contact between the population and the national health system in terms of health education activities is far more complex than what is stated in the official policy. Therefore there is a complex relationship between the request for self-discipline on the one hand and the inner battle experienced by women who have internalized norms of self-policing.

The discourses about health have become internalized so that on an embodied level there can be a playing out of the battle between the structuring binary of being in control and being out of control. This playing out of the duality of control is a reflection of the construction of the objective world. The scientific objective world has evolved so that human reason is disembodied and therefore will is curiously perceived as free (Thurston and Meadows, 2004). From a judeao-christian perspective, will can now override the bodily influences of desires, feelings and emotions. The Cartesian dualism separating the inquiring mind from the body in which the mind is located (Edvardsson and Street, 2007) produces an emphasis on will.

Having comprehended the rational structure of the world, people can reason how to maximize their self-interest. “Because human reason is disembodied – that is, free of the constraints of the body – will is radically free. Thus, will can override the bodily influence of desires, feelings and emotions …. Reason is conscious. If it were not, unconscious reason would determine our actions and will would not be wholly free” (Lakoff and Johnson, 1999, p. 554). Lakoff and Johnson (1999) contrast this with the embodied person since “will is reason applied to action, our will cannot transcend the constraints of the body” (Lakoff and Johnson, 1999, p. 556).
Will is described as reason applied to action. There are similarities here with praxis – reflection on action or in action is known as reflective practice. Reflective practice can become another form of self-policing which is the internalized disembodied reason dominating the inner landscape. The internalized disembodied reason asserts itself over the body demanding autonomy and control as a reflection of the social emphasis on will and control.

Anything preventing autonomy is seen as outside the self or ‘other’ (Usher, Bryant and Johnston, 1997). Therefore in the Cartesian duality of scientific health discourse anything preventing the enactment of the free will carries the projections of the unconscious disowned aspects of a person’s being. Mixed up in this construction is the spiritual since Cartesian duality and scientific progress arose out of the need to escape religious constraints during the Enlightenment period. It could be that any internalization or materialization of the duality of control also includes free will versus determined will with associations of the spiritual. Since society also valorizes free will along with control, any discourse that threatens free will is made abject.

The discourse that I drew on when describing the integrative framework was a mixture of science, education and psychology. Science contributed the physiological and biological health outcomes, education contributed the idea of the learning health agent with competency based outcomes used as a basis for describing each of the cells, and psychology contributed most of the learning theories with spirituality added in to account
for an holistic structure for learning about health and acknowledge the role that religion has played in the construction of the self and health since Enlightenment.

**Normalisation**

The dangers of this humanistic integrative framework become apparent when “[a]s Foucault notes, the power of normalizing discourse lies in its ability to define experience in a particular way while at the same time masking this particularity” (McLaren, 2002, p. 112). Therefore, I was normalizing the integrative framework through the discourse of holistic health, building on the World Health Organization’s (1984) definition of health that included mental, physical and emotional health, but all the while masking the fact that such a framework was built on a humanist, liberal autonomous idea of what it means to be an individual with a neutral body that ultimately defaulted to that of the masculine.

Women are again an absent presence in this case study through normalization (masculinization) of what health is in the integrative framework. It seems important to consider resistances and what role these might play for women who are excluded or absent from theoretical frameworks of health. Resistance to hegemonic practices and discourses can include being suspicious of the workings of power itself – “If we are under the continual surveillance due to the workings of power, our own power lies in the continual surveillance of power itself” (McLaren, 2002, p. 96). In this way, the medical normalizing gaze is reflected back on itself. There is less chance then that women will collude in their own oppression (McLaren, 2002), and they may become aware of the
identities they become attached to as women, and the cost involved in maintaining those identities.

Resistance to being positioned by silence is a subtle but vital task since it is then that women can be placed in invidious positions and identities. At the moment, by being an absent presence in the training of health care workers, women have a major task in writing themselves from the ground up.

The feminist political and theoretical tasks of rewriting ourselves from the ground up, of dismantling the long history of misogynist epistemology, and of fending off the current double moves of theoretical appropriations of the feminine on one hand and the elimination of the subject on the other, are tasks unprecedented in history. The fathers had it much easier: writing and speaking “truth” from the singular location of insider, an insider with unifocal and monochromatic vision, are no great accomplishments (Luke 1992, p49).

The task ahead in naming instances of oppressiveness within health training curricula, both implicit and explicit, is difficult and circuitous because of the silencing that has occurred previously.

Power operates in and through the body both as discipline and resistance (McLaren, 2002). Hegemonic positivist disembodied limited subjectivity discourses begin with the body as a reductive materialist physical state. Feminist writers suggest the body as a site of resistance in itself through an ethical relationship with one’s self that is consolidated through the body (Niranjana, 2001) that is always already in a context (Lather, 2007). By remaining cognizant of the context, the individualization of health rhetoric can be named. This includes keeping an eye on the workings of power itself.
Individualisation

Health is seen as an individual choice and responsibility; therefore illness is viewed as a personal failure to enact a healthy lifestyle. Individualisation is the pathologisation of the individual and is also called ‘victim blaming’ (Crawford, 1977). Gastaldo (1997) discusses how health education can be seen as both good and bad for people – good in terms of empowerment and bad in terms of the subjugation and pathologisation it promotes. The key point of her work about health education is that:

It is educational in nature because it promotes behaviours that should be adopted by the entire population and interferes with individual choice, providing information to foster ‘healthy’ lifestyles (Gastaldo, 1997, p. 113).

These are the mechanisms by which health education infiltrates the consciousness of the object or target. At the places where health education implants itself, at the moment of subjugation or internalization (McLaren, 2002), people are faced with pre-determined behaviours and thoughts in the forms of ‘choices’ which in fact are not choices at all because the ‘right’ choice has already been made. This is the point at which the technologies of domination and power operate in individualisation.

Individualization promotes the individual experience of health rhetoric by the discourse becoming internalized. The internal or inner discourse of the person represents the moment of subjugation where people are either co-opted by the health rhetoric of self-regulation or self-discipline, or they become positioned as the unhealthy other, a victim – in this way, the inner experience reflects the social surveillance that takes place through
the health sector. The structuring binaries operate to position people both internally (individually) and externally, and provide some form of self-regulation by their entanglement with each other. The individualisation that occurs here is a result of the social surveillance. The self-policing process (O’Grady, 2005) is intimately bound up with the policing process of the ‘other’ as, in such a relation, the pre-occupation with the self-regulation of each other provides self-regulation of the system of structuring binaries.

Health workers participate in the policing process by taking part in different regulatory activities. They are thus creating rules and regulations that govern activities and the behaviours of individuals: “the elaboration of rules and the rebellion against them are bound together dialectically in spiraling definitions of their relationship to one another” (Hutton, 1988; p. 127). Discourses about health incite workers and subjects to participate in the biopolitics (where the emphasis is on economic productivity with the policing process causing some activities and directing others); both become actors in the positive economy of human behaviour (Hutton 1988).

Discourse and action are intimately related through an ethics of self. Technologies or practices of the self form a vital part of the work of health workers and interact with the other technologies to produce the technology of power. The deep need to mobilize power on the individual’s behalf, by and for the individual, instigates the policing process, imposes structure on behaviour and incites the search for self knowledge (Foucault, 1978). The self-controlling individual of social sciences and psychology cannot help but be individualized by the hegemonic form of discourse in health.
Gastaldo (1997) has described the impact of health education as subtle, continuous and ubiquitous – the omnipresence of health as an interface between the individual and the social expresses for me the experiences I had whilst trying to understand both my position and the rhetoric. The experience of health education felt personal for me and that is why I believed it was vital to understand the processes of health education both in myself and in other people. This is why I developed the integrative framework, as a process of understanding health, which was individualising as it still included the construct of the neo-liberal individual within it.

The individualisation in health education of the people is through the construction of identities by categorization of their lifestyle or health. Health education constructs peoples’ identities as they were seen as either healthy or unhealthy, at risk or not at risk (Petersen and Lupton, 2000). Not many people escape categorization, even if they are healthy because everyone could always become healthier. The health education is relentless in its pursuit of people. Scientific knowledge/power gave permission for people to be interviewed and prescribed a healthy lifestyle, even if this is in a shopping centre where healthy lifestyles were often promoted; and even if it meant health professionals chasing after customers with tape measures as the customer’s girth was deemed worthy of a second look as I witnessed at one health promotion event.

Individualisation also occurs with the omnipresent focus on individuals’ responsibility for their health. Even when social determinants were acknowledged and a radical health education approach taken, it was still the subject’s body that had to do the walking or eat the right diet, etc.
Totalisation occurred through health education and public health by the use of statistics and other epidemiological measurements. It occurred through the inculcation of norms of healthy behaviour and the standardization of the WHO’s utopian definition of health. Women became totalized with the masculine. As mentioned previously there is very little discourse about women’s health specific to physical activity promotion. These technologies of domination and power were totally ignorant of the fact of women’s existence. One can see that for the technologies described above, one of the main ways they could work for or against women is the lack of gender inclusion. Health education for women would be much more of an experience of being governed from the outside and a request for self-discipline (Gastaldo, 1997) as the self was emptied out and women tried to conform to the masculine norms. If women have heightened self-policing anyway (O’Grady, 2005), health education would only serve to increase this exercise of bio-power.

In conclusion, in this case study it was shown that health education promotes the body becoming an object of knowledge with projects of the self enacted through the body. The body is generally a gender neutral one which masks the masculinization of knowledges about the body. The body can be seen as the interface between the biological and the political with the conformity or non-conformity triggering physiological reactions associated with stress being a mediator of inequities in power (Wilkinson, 2000). Health education can be seen as a request for self-discipline and an experience of being governed from the outside, thus interfering with choice (Gastaldo, 1997). Since women are both constructed and pathologised by masculine knowledges (McLaren, 2002) through an
internalization of the critical observer, women are perceived as being in greater need of self-discipline and outside governance. This may manifest as heightened self-policing and self-surveillance (O’Grady, 2005) due to the panoptican effect.

This may also be the case for other target groups or at risk groups (CSDH, 2008). The increased emphasis latterly on the social determinants of health through the invoking of social sciences allows for further expansion of the health education domain by targeting the poor, the disadvantaged, ethnic and racial minorities, and gender inequities. These become contingencies (Kendall and Wickham, 1999), which is limiting since the role of privilege is therefore not examined along with the associated construct of choice.

Choice is a major issue here with the dominant belief in health education being that people will make the right healthy choice in relation to their own health if they are aware of the correct information. The rhetoric here includes empowerment through the information, with the health worker playing a key role in the empowerment of the people – something done to and for someone else. There is a focus on the point of subjugation – when an individual becomes tied to his or her own identity by a conscience or self-knowledge, or subject to someone else by control or dependence (Foucault, 2004) i.e. through the notion of choice. Nowhere does the health rhetoric echo Lather’s (1991a) comments that people choose but not under conditions of their own making. It is the notion of choice that plays a key role in the subjugation of the workers and the people; that ties them to an identity or someone else. I will now go on to review case study three which builds on the themes introduced here.
Case study three incorporates both case study one and two in that the third case study provides an overview of a recent finite curriculum for one type of health worker in rural W.A. Both manual handling (case study one) and health education (case study two) are included as part of the role of a therapy assistant and therefore in the curriculum for training. This case study allows a view of the integration of the different components of training, not only because the training combines the different disciplines of allied health workers but also because it draws on the different analyses of this thesis.

The manual handling training showed how women’s bodies could be disciplined in space and time and how the subjugation of the workers’ bodies was relentless in relation to the actual work they performed; by participating in women’s work, the workers were willingly participating in their own oppression. Likewise in case study two, the role of health education in the formation of identities of individuals was considered ‘continuous, ubiquitous and insidious’ (Gastaldo, 1997). For health workers who must enforce such discipline and norms, there is the double effect on themselves as ethical beings and on themselves as health workers. The internalization of these norms and disciplines on and through the body (McLaren, 2002) can produce an incitement to willingly process within the body the interface between the individual and their sense of agency (the request for self-discipline), and the structural constraints within which they live and work (the experience of being governed from the outside). Case study three draws together both of these themes by exploring a curriculum for the training of therapy assistants in rural W.A.
The Rural W.A. Therapy Assistant Project forms the case for case study three. Over a period from August 2001 to August 2002, I was a project officer part-time, working under the auspices of the Combined Universities Centre for Rural Health (CUCRH), which was based in Geraldton, the Disabilities Service Commission (DSC) and the Department of Health (DOH); the latter two organizations having their head office in Perth and regional services spread throughout rural and remote W.A. The role of the project officer was to facilitate the training of therapy assistants working across rural and remote W.A. The project was tightly bounded and prescriptive in its goals, objectives and timeline. The project was considered to be a twelve month part-time project. It was grounded in the scientific medical model with evidence-based practice considered the benchmark for decision making. There was no discussion of epistemological frameworks. The focus was on what the therapists and the therapy assistants did as part of their daily practice.

The data gathered from therapists and therapy assistants were used originally alongside the efforts of working parties and working groups, facilitated by me, to formulate a training curriculum for therapists and therapy assistants that would be useful across rural W.A. The curriculum document is now redeployed for this research for the purpose of analysis of relations of power. This case study gives a clear example of how practices and regimes of truth are formed through training in order to govern the everyday work of the different allied health workers, and thus how most workers continue to live in the interface between the structural and the individual because of the linguistic veil formulated by many things but including training and education.
The text used for analysis is the ‘Therapy guidelines core competencies’ document since this was the culmination of the questionnaires, focus groups, and literature review. It is also the working document for therapists and managers across rural W.A. This document provides guidelines for practice and therefore forms a regime of truth for therapists, therapy assistants and myself. This document was used for the Job Description Form for the employment of therapy assistants. It provides a meeting place between the therapists and the therapy assistants, and hence also between the workers, myself, and the patients.

The document reads as follows:

THERAPY GUIDELINES

CORE COMPETENCIES

These guidelines have been developed in consultation with therapists and therapy assistants across rural Western Australia with the understanding that:-

- All activities are to be carried out under the direction of a suitably qualified and experienced therapist
- Under no circumstances is the therapy assistant to carry out the activities without the direction of a therapist
- The activities are intended as a list of best practice options, from which the therapists can choose the most suitable according to the client, level of experience of therapy assistant and therapist, setting and supervision availability.

COMPETENCIES RELATING TO EMPOWERING CLIENTS

- Support the rights of clients and their families
- Empower clients and their families
- Advocate for and support the rights of clients*
- Participate in policy and procedure development and implementation to ensure the rights of clients are upheld*
- Manage and develop policies to ensure empowerment of clients*

COMPETENCIES RELATING TO COMMUNICATION AND RELATIONSHIP

- Communicate and relate effectively
• Relate and communicate with people having special communication requirements and their families
• Relate and communicate effectively and co-operatively with members of team to enhance outcomes for clients
• Liaise/network effectively within the organization and with the wider community
• Represent the organization within the community as far as the therapy assistant is an employee of that organization

COMPETENCIES RELATING TO ORGANISATIONAL AND MANAGEMENT
• Manage self
• Demonstrate effective time management skills
• Participate in performance management and professional development as directed by therapist
• Participate in quality assurance, maintain statistics and accountability for all activities as directed
• Supervise and co-ordinate other staff*
• Manage staff – prioritise workload, write submissions for therapy assistants, budget management*

COMPETENCIES RELATING TO LEGAL ISSUES
• Demonstrate knowledge of responsibilities under Duty of Care
• Demonstrate knowledge of responsibilities and rights under Occupational Safety and Health
• Demonstrate knowledge of rights and responsibilities under Equal Employment Opportunities and the Disability Services Act
• Adhere to Public Sector Code of Ethics and Code of Conduct
• Develop and implement policies and procedures to uphold legal responsibilities of employer and employee*

COMPETENCIES RELATING TO TECHNICAL WORK
• Assist in client’s treatment programs under the supervision of the relevant allied health professional (following written and verbal instructions)
• Make use of and maintain relevant equipment to carry out client treatment program
• Prepare resources to carry out client treatment programs
• Utilize computer and other technological support to carry out and evaluate work
• Participate in training to assist in carrying out client treatment programs
• Prepare and demonstrate treatment program for therapy assistant to carry out with client (materials, written and verbal instructions, recording techniques, treatment methods)*
• Evaluate service provision and review impact of particular treatment programs*
• Carry out training with therapy assistants and evaluate performance*
• Collaboratively problem solve any program difficulties with therapy assistant*
• Support and supervise therapy assistant to carry out treatment program*
• Carry out Assessments, Program Development and programming as required*

*denotes competencies for therapist only

The Therapy Guidelines have been written in the dominant pedagogical discourse of core competencies. As with the manual handling training, disciplinary power is enacted over the worker’s bodies in order to produce docile bodies (Usher and Edwards, 1994). There is a marginalization of the therapy assistant’s own knowledge and understanding, thus the Therapy Guidelines become exclusionary and normalising. The Therapy Guidelines provide a document that homogenizes, normalises, classifies and centralises medical knowledge (Foucault, 2004). The preamble before the core competencies sets the stage for a theatre about supervision and delegation of tasks to therapy assistants. It was considered necessary to include such a preamble from a legal point of view in order to protect the curriculum writers from any adverse use of the curriculum document i.e. delegation of a task that incurred a high risk. The discourse around supervision and delegation was grounded in legalities and traditional practice that supported the dominant paradigm. This case study clearly shows that the issue of surveillance is at the heart of the teaching practice of therapy assistants in rural W.A.

There is more at stake in case study three than just a simple training document that ‘tells someone what to do’. As Lugones (2003) would say, we are constrained by the map we traverse, all within relations of power. Foucault’s (2000) reference to a knowledge originating in practices of control and supervision that was imperative to the formation of
a new type of subject of knowledge has relevance here – within the circulating capillaries of power of the hospital system, the genesis of a type of subject in the name of ‘therapy assistant’ took place, specifically through knowledge generated by practices of control and supervision.

A relation of surveillance, defined and regulated, is inscribed at the heart of the practice of teaching, not as an additional or adjacent part, but as a mechanism that is inherent to it and which increases its efficiency (Foucault, 1995, p. 176).

The most pressing problem for therapists and therapy assistants from the data and from the literature seem to be about supervision and delegation (CSP, 1989; Aron, 1997; Juel and Shade, 1998; Littell, 1998; Rural W.A. Therapy Assistant Report – Lowe, 2003). The discourse has been around for over thirty years (Whittington, 1999) and yet there has been no progress on an issue that seems to make up the everyday problematics of the therapists and therapy assistants in rural W.A. One has to wonder why this is so, and why such an issue can occupy so many people for so long. This issue has been a source of conflict and has contributed to people leaving the health services as they seem frustrated in their attempts to change anything. The discourse in the literature is emotional and rational at varying times and seems to rouse strong responses from different people. The strength of feeling surrounding supervision and delegation is reflected in the curriculum document by these issues being stated up front as the preamble to the core competencies.

Training is seen as a solution to role clarification through surveillance and supervision of therapy assistants. However, it is a double edged sword since therapists have reportedly
not wanted the assistants to be too educated since this poses a threat to the therapists’ positions. Therapy assistants have been seen as a ‘threat to the existence and development of our profession’ (Belanger, 1998), as ‘assets highly sought by the hospital bean counters’ (Kuchins, 1999), whilst it is thought that ‘empowering the therapists on staff is the key to achieving the most cost-effective staffing ratios’ (Aron, 1997). There has been a push towards using untrained staff in the health service since they are cheaper to employ, compensate for staff shortages and some patient care does not require trained staff (Roberts, 1994). The relations of power run right through the curriculum document as the core competencies are designed to produce docile bodies in the case of therapy assistants who will not usurp the position of the therapists.

The discursive frameworks of delegation and supervision ordered the reality of therapists, therapy assistants and their training and roles in certain ways (Cheek, 2000). In the literature, the link was made between delegation and supervision thus: “Once competence has been established, delegation does not require direct supervision” (Saunders, 1998b, p. 554). The discourses of supervision, delegation and competence gained ascendancy over others through the primacy of the scientific medical legal discourse and evidence-based practice. Order, as opposed to chaos, was reinforced by having clear roles and identities of different workers through different models such as the Constructive Delegation Model (Saunders 1997a and 1997b), Task Analysis (Saunders, 1996; 1998a and 1998b), and the Chartered Society of Physiotherapy Training Model (CSP, 2000a and 2000b). Training therefore becomes a way of enforcing roles and maintaining hierarchies.
Hierarchized, continuous and functional surveillance may not be one of the great technical ‘inventions’ of the eighteenth century, but its insidious extension owed its importance to the mechanisms of power that it brought with it. By means of such surveillance, disciplinary power became an ‘integrated’ system, linked from the inside to the economy and to the aims of the mechanism in which it was practiced. It was also organized as a multiple, automatic and anonymous power; for although surveillance rests on individuals, its functioning is that of a network of relations from top to bottom, but also to a certain extent from bottom to top and laterally; this network ‘holds’ the whole together and traverses it in its entirety with effects of power that derive from one another: supervisors, perpetually supervised (Foucault, 1995, p. 176 – 177).

Having established that the Therapy Guidelines document was grounded in discourse about supervision and delegation, and also that there was a strict hierarchicalization of knowledge, the linguistic veil of the core competencies will now be explored.

The first set of core competencies relates to the empowering of clients and their families. The discourse buys into the current usage of the word empowerment as being assertive and also expresses empowerment as something that can be done ‘to’ and ‘for’ other people. It does not mean analyzing ideas about causes of powerlessness and recognizing systemic oppressive forces as suggested by Lather (1991b). There is also the discourse about rights – the sovereign rights of the individual are to be upheld whilst the individual is also being empowered. This rhetoric only serves to mask the domination that is taking place through the upholding of the system of the right and through the disciplinary power of normalization enacted in the health system (Foucault, 2004). Thus the discourse has invested authority in the conflicting ideologies of empowerment and right.

Another conflicting and contradictory aspect of this section of the core competencies is that the therapists are meant to be involved with developing policies and procedures to ensure the rights of clients are upheld and that the clients are empowered. Thus the
policies and practices are captured by a linguistic veil that only serves to mask the domination of the client within the medical system. Policies and practices are normalized and enact disciplinary power over workers’ bodies as well as the client’s or patient’s body. At the meeting place between the worker and the client, the truth that is shared is one of empowerment and rights which only serves to mask the domination taking place. Therefore both parties in the meeting place could be experiencing dissonance although the worker will maintain a position of privilege since it is they who have the power to define the truth (Weedon, 1987). Thus the core competencies relating to empowerment produce conflicting and misleading authority between the worker and the client.

The core competencies relating to communication and relationship can also be seen as having the potential to produce conflicting outcomes or invidious positions. The subjugation of the workers takes the form of reducing the (mainly) women into the role of carers and nurturers of relationship; of being responsible for the well-being of clients and other workers through effective communication (O’Grady, 2005). The speech of the worker becomes subjugated into a totalising and yet also individualising and normalising form that is always effective and co-operative. This could lead to further isolation and self-policing (O’Grady, 2005) as workers are incited to perform effectively through their speech and non-verbal communication. Such self-policing could in fact result in a self-consciousness around communication that actually works to prevent authentic relationship and a displacement of the worker from themselves.
Further displacement from self could result from the third section of the competencies relating to organization and management. The first core competency in this section is to manage self. This is directly about self-regulation and involves the self-policing that O’Grady (2005) refers to. There are references to institutional requirements that maintain the need for self-regulation such as professional development, performance management, quality assurance and accountability. The first three sets of core competencies—empowerment, communication and organizational management—set up the network of power relations through self-regulation and the subjectivity of the worker. Along with the preamble pertaining to supervision i.e. surveillance, the network of power relations is in place for the therapy assistant to become a type of worker who is docile and self-regulatory. In addition to this, the fourth set of competencies put in place the legal imperative to maintain this type of worker.

The rules of the production of statements regarding the training of therapy assistants and therapists fall under legal, traditional and economic conditions that give the prima facie position for the power relations to be brought into play (Ball, 1991). The legal entities from the documents are clearly stated in the section ‘Competencies relating to legal issues’ e.g. Duty of Care, Occupational Safety and Health Act 1984, Equal Employment Opportunities, the Disabilities Service Act 1993, the Public Sector Code of Conduct and Public Sector Code of Ethics. In addition there are also the professional associations and registration boards responsible for each of the different type of therapists with their own legal stipulations and recommended practice, rules and regulations. The therapy assistants do not have their own affiliated board or professional associations in Australia,
and instead must rely on the hospital union for legal representation. These legal entities provide for a strict hierarchy in terms of who can do what, when, where and to whom. There is the discourse of responsibilities alongside the discourse of rights (Petersen and Lupton, 2000). The medico scientific legal discourse provides the justification for the relations of power in the previous sets of core competencies of the curriculum document.

The last set of core competencies relate to the technical work that therapy assistants are required to do. These are the functions that the workers are to carry out and it is here that the discourse about therapy assistants is centred. Instead of being able to address issues of power, workers (both therapists and assistants) only have the language for talking about what to do and about supervision issues. As seen in the literature, the discourse is about what to do, how there is so much to do, and the support required to do so through supervision – here is where the conflict occurs and seems never to be resolved since this type of conflict, certainly for therapy assistants, has been going on for over thirty years (Whittington, 1999).

Since therapy assistant work and then enactment of the curriculum are grounded in issues around supervision and delegation, there is a certain type of subjectivity set up that unfortunately seems to generate conflict. By focusing on supervision, workers who require supervision such as therapy assistants are always in a position of need and inequity due to the imbalance in power relations and the hierarchy of knowledge which they have minimal access to. The supervisor, usually a therapist, is the holder of the knowledge and power, and thus is more able to determine the granting or withholding of
supervision. While the productive power of supervision is that it can hold, contain and support the supervisee, the less productive aspects of the relation of power within supervision are that unless power relations are recognized, the supervisee can become the type of subject that is always positioned to be demanding, needy, wrong, requiring monitoring and the supervisor is positioned to be the holder of knowledge, power and resources. This can keep the level of the discourse centred around issues of supervision and delegation rather than addressing perhaps more pertinent issues of client care, content of training and function of therapy assistants, and skill development.

Foucault (1994) could see the interplay between function, conflict, rules and language. Foucault describes ‘three epistemological regions, all subdivided within themselves, and all interlocking with one another’ (p. 355), covering the domain of human sciences – biology, economics and language. Biology forms the concepts associated with functions and norms; economics has associations of needs and desires (thereby ‘man’ appears in conflict so he then “establishes a body of rules, which are both a limitation of the conflict and a result of it” (Foucault, 1994, p. 357)); and then there is language with its systems of signs and signification (meaning).
This body of knowledge, human sciences as applied to the allied health field, originates through the social practices of control and surveillance. It can be seen from the document that issues around supervision and delegation infiltrate the statements of core competencies. The therapy assistant journal articles provided a solid basis for grounding any training in issues of supervision and delegation. Therefore the rules of production of statements in this discourse are about supervision and delegation which themselves are issues based in the economic epistemological region of the human sciences. That could be why the literature about supervision and delegation are so much related to cost, efficiency and effectiveness issues (Saunders, 1997a and 1997b – cost effectiveness
model), that is a neo-liberal concept of health service delivery, and also why there is so much conflict associated with these body of rules, and limited by these rules.

Thus it can be seen that the curriculum document for the therapy assistants sets up relations of power by focusing on surveillance, subjectivities through empowerment, communication and management, with legal justification for this approach and, finally, that the document addresses the technical aspects of the work. The curriculum document was about normalization, about producing a standard type of worker across rural W.A. Therefore psychological interests shaped the production of statements in the training of therapy assistants through the adherence to norms of behaviour and the function of the worker. Job description forms and core competencies are as much about norms as they are about functions. There is silence around power, issues related to gender, race and ethnicity, radical critical pedagogy, and there is no critical analysis of the documents. Silence about these issues reinforce the technologies of domination and power since there is not the language to speak about relations of power.

**Surveillance**

As mentioned previously, the training discourse for allied health workers centres around supervision and delegation, techniques of observation, regulation and control that serve to create standards/norms of the roles and functions of different allied health workers. While in some way the hierarchy of the health service may be lessening in that there are interventions to decrease the autonomy and power of doctors, and allied health staff are
working to increase their own autonomy albeit within the same medical system there is a way in which the power relations are being reinforced and strengthened by the discourses of empowerment, collaboration and teamwork through techniques of regulation, control and surveillance. In this way, technologies of domination and power work to pacify, dominate and regulate subjects through discourses about supervision, delegation, empowerment, collaboration and teamwork in the enactment of the curriculum. Case study three pulls together the threads emerging from case studies one and two and provides a useful link to the interview data in terms of the subjectivities of the workers and the technologies of domination and power.

In case study three there is the emphasis on surveillance and monitoring. Since surveillance is inscribed at the heart of the practice of teaching, and since the chief function of disciplinary power is to ‘train’ (Foucault, 1995), it can be seen that disciplinary power through training (enactment of the curriculum) can indeed operate in a relational manner without recourse to excess force or violence. The therapy assistant training was about establishing norms and standards through surveillance, which thus excluded anyone who did not meet the norms or standards. When one considers the many ways in which the workers are subjected to surveillance – through different sub-trainings such as manual handling or through the health education rhetoric, apart from the overall training that a worker participates in within their own field – it is not surprising that workers may internalize a strong sense of self-monitoring and self-surveillance. The fact that workers willingly participate in their own oppression through the subscription to such surveillance makes for a heavily monitored workforce and environment.
The practice of placing individuals under ‘observation’ is a natural extension of a justice imbued with disciplinary methods and examination procedures. Is it surprising that the cellular prison, with its regular chronologies, forced labour, its authorities of surveillance and registration, its experts in normality, who continue and multiply the functions of the judge, should have become the modern instrument of penalty? Is it surprising that prisons resemble factories, schools, barracks, hospitals, which all resemble prisons? (Foucault, 1995, p. 227 – 228).

The overwhelming plethora of technologies of domination and power make for a heavily regulated workforce and one that grinds slowly as it seeks to meet the rhetoric of patient centred care. The rhetoric of patient centred care seems to work to incite workers and patients alike in participating in their own oppression. At present, therapeutic results are hidden within a triangle of authoritarianism, a particular type of relationship with the body and the medical hierarchy (O’Grady, 2005).

Normalisation

The therapy assistant curriculum document describes in great detail the norms required by health services for the production of docile bodies with high degrees of self-regulation. This construction was achieved within the curriculum through the rhetoric of empowerment, communication and relationship, management of self, and the legal imperatives to meet the standards of training. The discourse about rights and empowerment masks the power effects inherent in such a document. Although the intent on the formulation of the document was to produce a curriculum that was sensitive to client needs through relationship, it seems as though this has become subverted through the very process of normalisation since there is silence on the effects of power. I will not go on to review individualisation as I have nothing new to add from case studies one and two.
In conclusion, case study three for me really highlighted the limitations of discourse to discuss the body and the social. It seems at the moment as if the only recourse we have is to the ‘psy’ to discuss the body and/or the inner world which is itself predicated on the liberal humanist subject and goes hand in hand with the medical model. The contingencies, or mapping of the social, seem limited at the moment by the lack of language available to describe experiences and events or materialities. In this way, the governmentality of the workers and the people is heightened through the lack of discourse available. Since the construction of most of the knowledge about the individual or being human is in binary opposites, this seems particularly limiting (O’Grady, 2005).

Having covered the main points from which the interview data will now be explored, I believe the platform on which I am now standing has been described as well as possible within the limitations of the available discourse. There is an emphasis on the absence presence of gender, identity, choice and the individual, and the body and discourse through technologies of domination and power.
CHAPTER SIX

Practices of the self within health professionals’ practice

6.1 Introduction

The aim of this research is to understand how health professionals are educated and what are some of the consequences of that process. This journey of understanding has required trying to understand the constructions of self of both the health professional and client/patient through discourses of professional practice. In order to achieve this aim, I believed I needed to interview health professionals in the field in order to elucidate other peoples’ experiences of their education and professional life. The responses I obtained from people meant that I could detect any resonances between their responses and mine and therefore check the validity of my own knowledge claims. I could also determine the relevancy of this research to health professionals through exploring their response to being involved in study like this. In addition, I hoped that ‘real’ interview responses from ‘real’ people in the field would add to the richness in understanding and meaning making of this work.

Data was collected through interviews from 13 West Australian health workers from two rural health services sites, Albany (n = 9) and Geraldton (n = 4), and four workers from the Perth metropolitan area. The process of recruitment involved liaison with the Allied Health lecturer at the Combined Universities Centre for Rural Health (CUCRH) and the
Senior Project Officer at the W.A. Country Health Service (Department of Health, Perth, W.A.). Information was disseminated relating to the project aims and purposes. Two country health services were then approached to recruit any possible interested participants with some additional people volunteering their participation. The Information Sheets, Letters of Consent and Letters to the Managers of the Health Service are in Appendix 10.2. In total, 17 participants completed the interview, with 16 of those being female and only one male.

Throughout the thesis the information relating to the participants has been kept confidential with pseudonyms used. The breakdown of the information about the different workers is as follows:-
Table 5. Demographic data about the workers.

<table>
<thead>
<tr>
<th>Worker</th>
<th>Location</th>
<th>Occupation</th>
<th>Type of Service</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary</td>
<td>Metropolitan</td>
<td>Medical Officer</td>
<td>Adolescent Mental Health</td>
<td>Female</td>
</tr>
<tr>
<td>Tom</td>
<td>Metropolitan</td>
<td>Associate Professor</td>
<td>University training health professionals</td>
<td>Male</td>
</tr>
<tr>
<td>Louise</td>
<td>Metropolitan</td>
<td>Nurse Educator</td>
<td>Acute Care Hospital</td>
<td>Female</td>
</tr>
<tr>
<td>Alice</td>
<td>Rural</td>
<td>Physiotherapist</td>
<td>Regional Hospital</td>
<td>Female</td>
</tr>
<tr>
<td>Betty</td>
<td>Rural</td>
<td>Therapy Assistant</td>
<td>Regional Hospital</td>
<td>Female</td>
</tr>
<tr>
<td>Cathy</td>
<td>Rural</td>
<td>Speech Pathologist</td>
<td>Regional Hospital</td>
<td>Female</td>
</tr>
<tr>
<td>Donna</td>
<td>Rural</td>
<td>Physiotherapist</td>
<td>Regional Hospital</td>
<td>Female</td>
</tr>
<tr>
<td>Emma</td>
<td>Rural</td>
<td>Occupational Therapist</td>
<td>Regional Hospital</td>
<td>Female</td>
</tr>
<tr>
<td>Fiona</td>
<td>Rural</td>
<td>Dietitian</td>
<td>Regional Hospital</td>
<td>Female</td>
</tr>
<tr>
<td>Gill</td>
<td>Rural</td>
<td>Physiotherapist</td>
<td>Regional Hospital</td>
<td>Female</td>
</tr>
<tr>
<td>Hanna</td>
<td>Rural</td>
<td>Physiotherapist</td>
<td>Regional Hospital</td>
<td>Female</td>
</tr>
<tr>
<td>Ingrid</td>
<td>Rural</td>
<td>Nurse/Manager of Community Services</td>
<td>Regional Health Service</td>
<td>Female</td>
</tr>
<tr>
<td>Joan</td>
<td>Metropolitan</td>
<td>Nurse Educator</td>
<td>Tertiary training Institution (TAFE)</td>
<td>Female</td>
</tr>
<tr>
<td>Katrin</td>
<td>Rural</td>
<td>Occupational Therapist</td>
<td>Regional Hospital</td>
<td>Female</td>
</tr>
<tr>
<td>Nell</td>
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<td>Speech Pathologist</td>
<td>Regional Hospital</td>
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</tr>
<tr>
<td>Polly</td>
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<td>Female</td>
</tr>
<tr>
<td>Veronica</td>
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</tr>
</tbody>
</table>

One medical doctor, one professor involved in training allied health workers in a tertiary institution, three nurses (two of whom were nurse educators), two occupational therapists, one dietitian, two speech pathologists, six physiotherapists and one therapy assistant were included in the study. Two physiotherapists were new graduates within their first year of employment post-training while the rest of the workers had varying levels of seniority and experience. The decision was made to include a variety of health workers and not
just those from allied health in order to provide a mix of views across the spectrum on health worker training. Most rural workers (n = 13) were employed in the regional hospitals although their work took them out into the community.

In addition to completing the interviews (for interview questions see appendix 10.2), the workers also completed a Health Locus of Control questionnaire (see Appendix 10.1) in order to give some information on where they positioned themselves on a locus of control continuum in relation to their own health. It was believed that this information was useful in elucidating the extent of their self-regulation in relation to their own health and how this then related to the work they did and the responses they gave to the interview questions. The level of congruency between the theories they espoused and the theories in use could then be discussed (Freire, 1998).

The interview data was transcribed from tape recordings and reviewed for themes that then provided the platform for later discussion. See Chapter Three for a detailed explanation of the process undertaken to analyse data in the research.

I also looked for binary oppositions since they can become the analytical sites of ongoing struggle and contestation (Cheek and Rudge, 1994). Binary oppositions represent the polarized norms, some spoken and some unspoken, that workers are incited to embrace and the interface between these polarizations. Some of the oppositions include having control/lacking control, presence/absence, autonomy/affiliation, freedom/captured self, belonging/disengagement (or isolation or disembeddedness), and
embodiment/disembodiment. I believed these to be of importance since the binaries also form the structuring of the self (Usher, Bryant and Johnston, 1997) in the constructedness that is health care.

The training of health workers reproduces relations of power and truth games that are then enacted with each individual and group within the community. From the interview data, it became clear that the major subjectivities of both patients and workers revolved around the embedded assumption that as people, everybody has a choice in how they live their lives and how they behave, particularly around health. People can choose to be healthy or not. Therefore health is seen as a practice of the self. The issue around choice also came up for workers as they adapted to struggles at work in terms of overwhelming caseloads and administrative paperwork by stating that they had a choice in how they responded to these difficulties and that there was no point in becoming miserable about the difficulties.

Overall, workers were not able to identify issues related to power, finding it too hard to describe or to even attempt to engage with this question. They were more comfortable describing the difficulties they faced at work in terms of having too much to do, the lack of time in which to do it, the overwhelming paperwork and administrative duties as well as the detrimental impact in terms of how much of their time was taken up due to advances in technology. However, without fail, each worker described their ability or inability to cope with these difficulties as a choice that was their responsibility.
The workers had limited experience of critical pedagogy at the tertiary level and saw any attempt to engage critically with their own practices as negative; that conflict did not go well with the caring professions: critical workers were seen as disruptive scapegoats that needed to pull themselves more into line with organizational and governmental goals.

The next section goes into detail with the workers’ responses and teases out the connections between the ideology and the identity that these predominantly female workers had attached themselves to. For example, the myth of the health professional as ‘someone who knows’ is supported by technologies or practices of self that demonstrate the health professional as behaving in particular ways as somebody who knows. The research questions asked at the beginning of the thesis will give structure to the sections.

Before going on to record the responses of the participants, there is a need to discuss one of the dilemmas I faced as a researcher when recording these responses: how to represent the rich data I had acquired in the field whilst also being of use to the workers who had generously given me their time and energy whilst working under enormous constraints. I want to acknowledge that they are doing the best they can (Kendall and Wickham, 1999) whilst also not wanting to reduce their responses to neat analytical categories (Lather and Smithies, 1997). This is the crisis of representation that Lather and Smithies (1997) talk about where the researcher is positioned as a witness giving testimony to what is happening to women. I am including a long quote in order to show my justification for including the participants’ responses in an unmediated way.

There are many ways that “researchers” could make sense of the ways these women make sense of living with HIV/AIDS. The preceding has used some academic “high theory” to sketch such an effort, but it raises questions about the ethics of reducing the fear, pain, joy and
urgency of people’s lives to analytic categories. George Marcus, a poststructural anthropologist, has wrestled with such issues in his own research. He writes of the move away from such theoretical analysis and toward evocative portraits, a type of data reporting that “emphasizes a direct exposure to other ‘voices’ … unassimilated to given concepts, theories, and analytic frames” (1993). “We are,” he says, in a moment “when the need to chronicle the world seem[s] to outstrip the capacity to theorize it … What we’re saying … is kind of old fashioned: that is it is possible to present the voices of others in a more or less unmediated way.”

This raises issues of what is called the crisis of representation in academic “high theory”. This study of women living with HIV/AIDS provides a laboratory in which to explore the textual possibilities for telling stories that situate Chris and myself not so much as experts “saying what things mean” in terms of “data”, but rather as witnesses giving testimony to what is happening to these women. Methodologically grounded in qualitative/ethnographic and feminist poststructuralist research in the human sciences, this project enacts an interest in what it means to tell the lives of others. Both within and against conventional notions of social science research, the goal is not so much to represent the researched better as to explore how researchers can “be accountable to people’s struggle for self-representation and self-determination (Visweswaran 1988).

Hence this research is situated in efforts toward generative research methodology that register a possibility and mark a provisional space in which a different science might take form. This project is also about science as a contested site and the contributions of feminist research to practices of seeking our answers to a different science in inquiry as it is lived (Lather and Smithies, 1997, p. 126 – 127).

In the following I position myself as a witness giving testimony to what is happening to these mainly female workers. The responses from the participants are from the laboratory of the health services where the textual possibilities for telling stories are explored (Lather and Smithies, 1997; Kendall and Wickham, 1999). Thus a decision was made to keep the interpretation of the data to a minimum in order that the ‘laboratory’ of the participants may be appreciated in its fullness. The answers to the following research questions are embedded in each of the sections below.

**Technologies of Self**

- How do health professionals come to understand themselves and the work they do within health?
• How are health professionals incited through training to embrace a particular understanding of health and well-being?

**Power/Knowledge**

• What understanding do health professionals have of the power relations in their field?

• How is training a site for reproducing or challenging certain power relations in the health field?

**Critical Pedagogy**

• What pedagogies are being legitimized? What pedagogies are being silenced and marginalized? How does this determine what we know and teach about health and our body?

• To what extent can training act as a site for transgressive pedagogies and practices within the field?

There is a thematic structure to the rest of the chapter that explores Technologies of Self – the workers’ understanding of themselves and the work they do, workers’ understanding of health and well-being, self-regulation through subjectification, truth and reality and their effect on our lives, embodiment and the juncture between human agency and structural constraint, Power/Knowledge including an understanding of relations of power in their field, the reproduction of power within the training in health and reinscribing systems of power through training discourse; and finally Critical Pedagogy and the Health Locus of Control.
6.2 TECHNOLOGIES OF THE SELF

6.2.1 Workers’ understanding of themselves and the work they do

The health workers came to understand themselves and the work they do within the allied health field through a number of different sources and experiences. While undergraduate training had a major impact in terms of ‘what to do’ and ‘how to solve the problem’, workers also demonstrated that their understanding of what it meant to be a health worker was also heavily influenced by their family of origin and the work and training they had engaged in post-graduation. Workers saw that values and behaviours such as respect, honesty, listening and caring, were important in defining what it meant to them to be a health worker.

I don’t think it’s actually something I’ve even consciously learnt. It’s umm, I guess I was always brought up with a lot of, umm, respecting other people, respecting umm other people’s knowledge (Alice).

Values such as respect formed this worker’s understanding of what it meant to be a health worker (particularly respecting other peoples’ knowledges) but this was not gained during the training.

There was a difference between the understanding gained during the undergraduate training (skills focused) to that obtained whilst working (fitting into a hierarchy), as Polly suggests:
Umm yeah so that was first year. Second and third year were pretty good and fourth year when all the pracs were on was a bit of a challenge for me I think because it was one thing to be at uni and be learning all the skills and another thing to try and fit in with the dynamic around a hospital or workplace, which is completely different to the skills that they teach you at uni.

Well that’s something that they can’t teach you and so I don’t think there was anything that the uni has done wrong. I think it’s just the fact that I was 20 and just didn’t have a clue about what was going on. But I do a lot more now, but yeah it was quite hard to go from being a student into that workplace and be expected to pick up a role.

Well I guess it’s a bit of an unspoken hierarchy isn’t it and they umm, the position that you’re supposed to fill that no one tells you about. Like you think you are just going in to do your job, but really people expect you to do this and not to do this and no one tells you those things you just have to kind of figure them for yourself.

Polly speaks of the positioning (Riggs, 2006b) that occurs at work and how that occurs in silence. If control is something we ‘do’ in order to manage how we are positioned by other people, then this is manifested in what is done at work or, in other words, the eminent ‘doability’ of medicine (Baum, 2007). Control at work in a hospital is demonstrated by and understood as how much and what is done (the enactment of the curriculum). The understanding of herself as a worker and the work she does is about knowing where she fits in with the hierarchy.

There was silence in the undergraduate training around fitting in with the health care work environment, which was perceived as an impossible task for the university training. This could have contributed to the governmentality of the worker.

Well, I suppose there’s not really a way, as I said before, that the uni can teach you about what exactly to do on the ward and what to do in a hospital, because when you are new you just don’t know what to do really. And umm yeah it’s not quite as easy as just doing a job when you need to interact with others and you are not sure if you are interfering with what they’re doing or who’s the right person to ask or … (Polly).
Polly speaks of learning the relational aspects of her work. It seems as if this is the greatest learning that occurs because it must be this that Polly is referring to when she says “You just don’t know what to do”. To me this speaks of an implicit positioning that is occurring and which Polly knows she needs to know but has not been taught.

As well as understanding the values and positioning underpinning practice, one worker described how she had to learn how to be like her boss, to role model him exactly and not bring herself into it. A great deal of the understanding of the work within the health field was therefore learnt on the job through other workers.

I mean my job was to learn to do it how they did it. It was not about bringing myself into it all. So I would, I mean, I had to learn to think like and be like my psychiatrist boss and to watch how they did it, because that’s how I learnt” (Mary).

The unspoken understanding was that the worker needed to leave herself behind whilst she learnt the correct way to be that particular type of health worker. There were limited subjectivities available for practice and it was up to Mary to fit in. It didn’t seem to matter what type of health worker was speaking; there was consensus that learning to be a health worker involved a whole new learning process once the person had left university and started to try and fit in with the world of work. The learning process involved understanding positioning implicitly and to know the kinds of limited subjectivities available for practice and fit into them.

A manager of the health service workers demonstrated a detailed understanding of this positioning, limited subjectivity and fitting in. By putting the workers into a context of a
government bureaucracy, she was able to articulate the interface between the structural and the individual:

Mmm, I think you need to have a very good understanding of the bureaucracy because umm, when you work for the government, depending on the political party of the day or the government of the day, it may or may not be umm, ahh in line with your particular philosophy. However, if you’re employed you are employed to do a job and so therefore you have to implement enthusiastically whatever the will of the government of the day is. That sometimes creates inner conflict, but you, to get anywhere in a bureaucratic system you need to learn to cope with that and that, not personalize it, but well this is what has to be done and get on do it. I think resilience is something that’s really important, because there’s often not a lot of ahh constructive feedback or positive feedback, so you don’t know whether you are necessarily performing well or where you fit in the organizational ahh structure and so therefore it’s important that you have some mechanisms that you’ve set up yourself for assessing where you are at (Ingrid).

This response speaks of the incitement to adhere to governmental norms with an expected corresponding slippage of self. The practice of the self is to understand the political will and to align oneself with that (enthusiastically). Further practices of the self include coping with inner conflict, not taking things personally and to get on and do tasks. Moreover, the practice of the self is to monitor how well you are fitting in as a worker i.e. performing.

Here there is the intersection of the individual and the structural whereby the sharing of a truth occurs. The knowledge formed in the meeting place between the different workers and the hierarchy of the health service is about subjugation of the workers into a particular type of worker, one that will conform to norms and policies and procedures of a government bureaucracy. The workers are incited to perform as particular types of workers through control and supervision of each other and different levels within the hierarchy. The ideology of the training was that each worker graduated as competent to perform a particular role ‘to be able to do’ and solve particular problems related to health.
The institution then enacted its ideology by putting that task focused training into a context whereby fitting into the norms was most important and yet unspoken.

Some workers spoke of the conflict they experienced if they tried to put across the understanding they had of themselves and their values to the institution or government bureaucracy with most agreeing that they would not do it again. There was a theme of learned helplessness as most workers recognized the futility of trying to fight the system, preferring to leave instead.

… but I realized that with the structure that we have now, very autocratic and so you can really just try to put your input in at the point that you think you’ve got most effect … And then if that doesn’t happen, well, you have to live with that. … And you know, I got out of the health department about 15 years ago… And then I, I’d never work for them again and I came to X it was a completely different structure, but it’s becoming more centralized again. … And I can see it happening. And you’re a cog in the wheel… And I tried to fight it then and I just got burnt so badly, … umm, and I thought, I’ll never do that again because you can’t change that huge wheel. … You can do something else […] … It was a terrible time. It is, it is and that’s why I’ve really, I will battle for, you know, saying my bit to that person and if it doesn’t go any further, and it depends how important it is … If it was really important, look, it’s not going to, I wouldn’t cross the values for, for the bureaucracy (Donna).

The reality for this health worker is that her understanding of what it means to be a health worker and the work she wants to do when not in alignment with the institutional requirements resulted in great stress for her personally. Her experiences are at odds with the rhetoric of empowerment within the health services. Technologies of domination and power include individualization (punishment – she got ‘burnt’), homogenisation, totalisation and centralisation.

A newly graduated therapist recognized the implications of not fitting the norms.
I think that follows through with everything really, you never, you want to, not so much fit
the mould but in an environment like health I suppose you need to be doing the right thing.
… To be doing what’s expected of you because if you are not then there’s legal
implications and social implications and there’s career implications as well, you can’t be
too out there in any part that you are doing. … Umm, I think I always knew that really
(Polly).

Her implicit understanding of what it meant to be a health worker included an urgent
sense of conformity. There was the perception of widespread ramifications capable of
destroying the health workers’ career if conformity was not adhered to.

As well as the bureaucratic and institutional norms that incited the workers to understand
themselves and the work they do in a particular way, there were also the emotional
pressures to conform to a norm of ‘knowing what they were doing’. One worker said that
the isolation of a rural position presented difficulties as they did not always want to get
on the telephone to check with their counterpart in the metropolitan area if they were on
the right track because “you know, you don’t want to feel stupid you want to do the right
thing by your patient and sometimes you just go mmm, it’s not important enough to ring”
(Katrin). The emotional pressures experienced at work and during the undergraduate
training through implicit positioning and limited subjectivities produced invidious
situations that seemed to be a major part of the incitement for workers to embrace a
particular understanding of health and well-being.
6.2.2 Workers’ understanding of health and well-being

The health worker training seemed to incite a particular understanding of health and well-being through processes that included humiliation, shame and fear. For example, Louise explains:

The idea was that basically they would keep you in your place and humiliate you as much as possible.

Well, it certainly made you afraid to make a mistake, you know. And you were always, umm, yeah, it kept you on your toes, but it was hard. It was hard. And you were afraid, to make a mistake. It’s quite different now however out there. I mean, just been working in the ward areas umm with your new graduates and its more about losing face, making a fool of yourself than about fear.

More about ummm embarrassment and “And they going to think I’m stupid?” (Louise).

The pedagogy in use seems to be more akin with Miller’s (1987) dangerous pedagogy in that it was dangerous for the learners because of the fear, shame and humiliation enacted during the training. In such an environment, to talk about social justice or a critical pedagogy in relation to health and well-being seems meaningless. That is, any discourses that fall outside the dominant discourses about conformity bring punishment and humiliation. Therefore social justice approaches to healthcare in an environment that is socially unjust do not mean anything as workers are generally powerless and helpless to enact any form of justice without a form of retribution to themselves.

An extreme example given when talking about the critical pedagogy aspect of the training was that people who didn’t make the mark were failed so that in the end a certain type of health worker (physiotherapist) emerged:
So yeah that’s the only one that I am aware of that, and there were some students that umm, were aware of didn’t meet the mark in terms of their appearance or their personality and some people say, said that they were umm deliberately failed but whether there’s any truth in that, whether they just weren’t mentally able to keep up with the course umm, I don’t have any input (Alice).

For Alice, this is how the curriculum appeared to be enacted, through emotional manipulation and technologies of power that excluded people who did not fit the limited subjectivities available or the understanding of health and well-being. This perception resonated with my own experiences of undergraduate physiotherapy training.

Training incited people to take on a particular understanding of health and well-being where the emphasis is on performativity, on ‘doing’, task focused client care, problem solving, evidence-based practice and competency based testing. The skills-focused training incited workers through its legitimation of performativity at the expense of other ways of being to embrace a clinical model of health with the emphasis on doing and being able to perform at normative levels. Furthermore, the clinical model was transmuted into a consultative model of care due to the scarcity of staff so that often the health worker would only see the client once, engaging in ‘brief interventions’, which meant that a clinical model was often seen as inappropriate anyway. The clinical model of treatment and hands-on intervention was seen as inappropriate because of the lack of staff available to carry out the ‘treatments’.

… you come out trained and you know how to treat the problem … or possibly. .. I actually, I actually think I’ve learnt, well, you learn more once you graduate than before. .. But I mean, sure you know a lot of theory, you know how to look things up and like all of those sorts of things, but in practice it’s quite different. ..(Gill).
I am just a bit concerned about people developing clinical skills when we’re working in such a consultative model these days (Gill).

The emphasis is again on a neo-liberal economic model of health with performativity, efficiency, effectiveness and throughput being the key indicators in this understanding of health and well-being. Health is seen as something that just needs a brief intervention from an expert health professional, a top up of expert knowledges, to tell the person what to do.

Some workers expressed a concern that the training led graduates to believe that since they had passed exams, they had earned the right to be a qualified health worker, an expert in health care with their own particular understanding of health and well-being:

No they, I mean they obviously think they know it all, do you know what I mean. And I suppose that’s an assumption on my behalf, because I thought I was, I knew it all. … You know what I mean, like I mean I knew I didn’t know it all but I thought I had all the theory part you know, I thought I had all of that [ ] … Yeah, I was right up to date, I had just graduated you know (Gill).

The training acts as an incitement for the health professional to see themselves as an expert and this may peak at graduation. Since the ideology of the training was task focused and problem based, this seems to have led the workers to develop a particular understanding of health and well-being that meant that a person could achieve the lifestyle that they wanted to achieve. This fits in with the utopian ideal of a ‘future’ health that only serves to constrain the will to knowledge (Foucault, 2004).

The core (constrained) concepts for the majority of the workers were that an individual was able to choose the quality of life they wanted, and at all times was responsible for the
choices they made in relation to their health and well-being. Ideas around health and well-being included:

Personally, I mean my philosophy about health and wellbeing is just based on the assumption that human beings are an energy system (Mary).

Here the assumption that human beings are an energy system means that again a rational objective knowing about the self can be applied to the body and being-ness of the individual, and appropriate choices made as a result.

And I think what we need to do is make moral choices to ourselves … And to our family, you know, we need to think back and say everything we do in our lifestyle, I think needs to be done in terms of, without neglecting your responsibilities of work, needs to be done in the context of what it is to you as an individual and to the people around you. Those who you are responsible for, you care for and who care for you. And I think we need to do more of that, a lot more of that (Tom).

In life you have to be very much integrated (Tom).

The idea of being responsible for your self and the people around you is concomitant with the idea that everything we do in our lifestyle needs to be put into a context of a moral choice made by an integrated (rational) human being. These comments were made by a university professor so one could assume that this guiding philosophy may well permeate through to the students and hence onto the clients that they would then be involved with.

The idea of health and well-being involving an integrated rational human being was tied in with the idea of responsibility and being a good role model.
Well in this job, in diabetes, absolutely, I love talking about health and wellbeing, cause diabetes is directly related to those issues and being, I don’t think I would talk so convincingly about it if I wasn’t healthy myself you know, and I think my patients umm they know it hasn’t happened so much lately but I used to slightly cycle very often and I would go down to the gym here at work and I’d do the best and I think it makes a difference when they kind of tend to role model against the person they see and I think that is good. .. If I didn’t look healthy, I think they would wonder how I could give sound advice when I am not really being that careful my self, .. (Louise).

The idea of responsibility flows through this participant’s comments a responsibility that is seen and noted. This means that people are very well aware that their actions and behaviours are under scrutiny, surveillance and supervision. The idea that as health workers we have a responsibility to be congruent with the theories we espouse and not to be hypocritical also came through in Tom’s comments. The focus with Louise is on exercise and looking healthy through lifestyle factors, again focusing on the individual and the choices that they make.

Alice also espoused the humanist idea of an individual; that such an individual could make an impact on their world through what they did and the choices that they made. Here, the discourse of empowerment is introduced, as it was with many of the participants, where the notion is that the health worker can help the clients feel empowered. The workers often spoke of empowerment in the reduction of the term as described by Lather (1991b) – “the current fashion of individual self-assertion, upward mobility and the psychological experience of feeling powerful” (p. 3), with the belief that as health workers, empowerment was something that could be done “to” or “for” someone (Lather, 1991b, p. 4).

I think for me, umm, if people feel well in themselves then it doesn’t matter what they’ve got to cope with, they can feel healthy. .. So if I can help them feel empowered, I guess,
using a jargon word, .. But if I, umm if I can help them see what they can do and that they
can make an impact on their world, umm, then that’s healthy, you know (Alice).

Betty and Cathy also describe the idea of health and well-being as looking after them
selves better and participating in activities that include lifestyle changes and individual
self-assertion.

But now that I am sort of you know, into forty, I need to be umm looking after myself a bit
better and I think I am trying to do that now. Like I am trying to lose weight, trying to do
more exercise, trying to plan my umm, holiday to be more orientated towards me than the
kids (Betty).

So that’s just paramount to just getting the most out of each day. Umm my view on
gaining that quality is, you have to get a balance because you know, every now and again
you know, you have your moments where you might overeat or you don’t exercise enough
or umm, or there’s a lot of stress at work .. But I think that’s the same with a lot of people
really in this day and age, I think if you don’t I think you choose, people choose umm,
how, what quality of life they want. .. If they are educated enough they will know what’s,
you know, what’s healthy and what’s not healthy for them, if they are educated enough
(Cathy)

…. My first sort of insight as to oh I am going to get this information .. to get control over
what I am doing. Get control over you know, where I want to go from here (Cathy).

For Cathy, the emphasis was on education and choice. The will to power and control
exerted itself through obtaining the right amount of education so that the appropriate
choices could be made that then gave this participant control over her life (self-
regulation) in order to allow her to choose the quality of life that she desired. Within that
idea of quality of life was the idea of balance and getting the most out of each day.
Foucault might say that through health education, this participant is seeking control over
her life through her will to power. These comments were echoed by Donna and Emma.

I think the individual is important because the individual ultimately has to choose what
their behaviour is. Umm, as we can, we can try to umm, we can try to lead them to change
their behaviour. We’ve got the information there for them at, at the right time and
acknowledge that there are different stages in that process and facilitate that, but it’s
ultimately their decision (Donna).
The definition of their health would then be, be able to cope umm, with what’s happened, yeah, in an optimal manner I guess. Umm, I don’t know if you want to be more specific, but umm, I guess it’s like a balance thing are they’re coping socially, emotionally, physically .. and within their environment. I think health to me is sort of that balance (Emma).

Here there is a suggestion that health and well-being might depend on the ability to negotiate relationships and behave in a way not defined by somebody else.

Fiona’s ideas about health and well-being aimed at providing information that then enabled people to make the right choices. Here we can see, in a number of participants, Gastaldo’s (1997) observations that health education is a major point of contact between the government and the population, and interferes with choice. People are encouraged to embark on projects of the self that are enacted through the body. An interesting addition in Fiona’s ideas was that the clients she saw could then be role models and educators for the people around them at home.

Umm, generally aiming for them to identify from the information that I give what they can do for themselves so I do, I suppose it’s the years of experience, but I do tailor what I talk about to what people have told me their situation is. … Umm, ahh to a certain extent and then sort of build on that and see if it’s just one, one change that they can make, that will, you can hone in on and say well that’s important for your health in the long term. … So umm, yeah, it’s just, umm working on people making a small thing, or a small change to be significant to their health. … Usually when I’m working with groups or individuals I try and do it so that they are doing it with others, do you understand what I mean? So that what they do, they can include others so with older people generally say O.K., if you are doing this, do it when your grandchildren are around or that sort of thing. Then it gives them another reason to do it. But it’s not just for themselves or their benefit, but what they do, even though it’s small will, will be role modelled onto others (Fiona).

This is an example of where doing can be a manifestation of control which is about managing how we are positioned by people in relationship. That is, the clients are positioned by the therapist as educators and role models for performing control, because
they have already been positioned as unhealthy and in need of expert advice. The clients then pass this performance of control onto their family.

Fiona shows how the family, including the extended family, can be mediators between the structural and the individual, with older members transmitting information to and being in an educative role with the younger family members. Fiona also identified quality of life as being important to health and well-being, where she helped people care about what they have and what they do, where doing was associated with being able to do things for themselves and not rely on others all the time. Attitude was also important so again the emphasis was on the individual’s behaviour and emotions.

Fiona was also interesting in that she could identify discrepancies in the way that she approached health and well-being for herself and in the way she approached it with her clients.

Yeah. I don’t do all the things I tell people to do. No, no, no, no. Laughs. Umm, look I always tell people that they should be exercising, but I’m, I don’t do very much at all. Umm, this is what you should do. This is what you should do. Umm, I suppose as far as umm, food and things, that that’s something I think, yes, I’ve been pretty, pretty good with. I reckon I, that’s the only reason I’m reasonably healthy is I look after the food side of things, but not the exercise. Umm, I guess from that little questionnaire you will probably find that umm, I don’t put everything on myself. I don’t, I mean, to me it’s not just, you can’t do everything yourself. And you need others to help you as well. Umm, because there are some things you can’t do. There are things you have no control over .. your age, your sex, your cultural background that will affect you and there are other things, yeah, you just have no control over (Fiona).

Fiona’s honesty towards herself and her ideas in this context about the lack of control in some areas of peoples’ lives is in contrast to her earlier ideas when talking about her clients in that she could see that there were some things that one needed help with and
that one couldn’t do everything one’s self. This is in contrast to the humanist autonomous notion of an individual that was evident when Fiona talked about the clients. The difference in subjectification is important, beyond ideas of hypocrisy or lack of congruency, since through the training, people are being made into particular types of subjects. In this sense some health workers are able to identify the gap between espoused realities for clients and themselves whilst other health workers are not. It seemed as if the workers who are not able to articulate this gap then pushed themselves harder in order to attain the ideal of health education.

The difference apparent in such workers lent itself to differences in approach to health and well-being. Whereas workers who might not have been able to articulate the gap strove towards achieving some ideal goal of health and well-being, others were more interested in the process. Gill had an emphasis on communication, being in relationship and resilience whilst acknowledging the complexity of the topic.

Oh, resilience – huge. But umm, but I think it’s about umm ultimately meeting the needs. It’s about being happy with where you are being what your lot is .. probably. Where you are at and meet that by your resilience and umm, being able to communicate when you need to communicate. But umm, but I think that you really get too powerful with how you, if you like what we were saying earlier about, if you need a mental health day you should probably take it laughs do you know, the powers of what you actually do. .. Yeah, but if you’ve not got good communication and resilience, I think [ ] ..cause you let too much of the outside stuff get on top of you umm. Is that, yeah that’s a difficult question (Gill).

Gill noted the difference between the inner and outer worlds whilst also believing in the importance of acceptance of where you were and behaving in a way determined by your self, as opposed to striving towards some future goal of health and performativity as promoted by the training.
Hanna emphasized education in her ideas of health and well-being.

Umm, I am very ahh, I like to educate as I go all the time .. constant education and sometimes you know you are talking to a brick wall, but you keep trying .. I think we have a duty to educate all the time (Hanna).

Apart from that comment, Hanna did not engage with the question about her ideas of health and well-being. Hanna’s discourse was very much rooted in a colonialisit modernist discourse, mainly because she spoke about an experience where she had travelled overseas to instigate a training course in a developing country. Whilst Hanna spoke about the ‘value of the individual’ and the ‘inclusion’ of the individual and the power of the connection between different individuals she also subscribed to the dominant belief of the centrality of the western world with its emphasis on science, education and humanism.

Ingrid also had a discourse rooted in colonialist centrality of the western world’s beliefs, especially when discussing an intervention in remote Australia that involved an Aboriginal community. Whilst this participant could see the detrimental effect of western culture on this community she was unclear about how to proceed with health care.

And so in twenty years the impact of western culture, food, the way of life had actually, was being realized in the illnesses that these people were then experiencing, which is a terrible indictment on us. But umm, you know, that’s the challenge today is how to how do you get people to eat a healthy diet? .. Exercise, do all of those things. .. You need to find the right button to push. Laughs (Ingrid).
Ingrid believed in the power of information to empower others to make choices, as something that could be done ‘to’ and ‘for’ other people.

I mean that’s that’s part of the job, but it’s, I’d rather have umm a situation where you empower others to make the choices. Umm I think that sometimes ahh we can be disempowered also. The power I have is to try and empower others. I think that’s what I am trying to say. Mmmm. (Ingrid).

And so umm, I can say that I know what I should do and what I tell others is not necessarily always what I do myself laughs I do try, but it doesn’t always work. .. So you find out the hard way. So there’s a willingness, but it’s sort of umm I haven’t actually hit the right button with myself yet laughs (Ingrid).

As with Fiona, Ingrid’s honesty about the difficulty in finding the right button to push in relation to her own health and well-being highlights the gap between the rhetoric and the reality. It seems as if this participant was aware of the potential disjuncture between the binary opposites of empowerment versus disempowerment and perhaps that ‘empowerment’ could mask relations of power. The training transmits a model of health and well-being that incites workers and then their clients to behave and think in a particular way through moral overtones and ideas of an individual’s responsibility and choice. This is directly related to the paradigm in which the training is grounded – modernism with its idea of rational autonomous human being.

Joan struggled with ideas about health and well-being, finding it difficult to put her own ideas into words. She believed in the importance of connectedness and what she called the ‘sparkling moment’, the ‘aha’ moment in learning and where she felt deeply connected to know what it’s like to be human, where the humanity was palpable, in her perception.
And so I suppose consciously or unconsciously I seek those experiences for my own health and wellbeing. Cause I think if I don’t actually have those in my life umm, I don’t get that enjoyment, I don’t get that umm I don’t get that sparkling moment (Joan).

Umm, health is definitely umm, well it can be an experience of seeking life I guess and and umm sharing and ahh experiencing other people’s life that will definitely have an effect on your health. Umm, again back to that you know, nurses don’t do it for the money. Well you know we don’t do it for the money. I, you do it for those moments in life. .. You know, that you can’t pay for .. You know that that real..you feel real .. and that’s that almost becomes a, it can become an adrenalin rush you know and umm you can see people that go out and sort of strive for it and almost like set themselves up to be in that situation, but umm I don’t know it’s a, it’s a hard thing to take on as well ‘cause it’s so individual (Joan).

Joan was able to identify an experience of health and well-being that was not reliant on or related to ideas about diet, exercise or other lifestyle risk behaviours. She was also in a way articulating how she had identified the gap between the rhetoric and the reality and was more interested in pursuing what she saw as real. However, she also struggled with the lack of available discourse to describe this, and struggled with describing ideas about what it meant to be human.

It was interesting because Joan was also able to identify what she called ‘health anxiety’ where she questioned “how do you stop yourself from actually becoming anxious about your own health..?” She saw her health anxiety as stemming from what she believed was her over-developed sense of empathy: to the extent that she had stopped work as a nurse. Her work and her sense of health and well-being were therefore intimately related.

Yeah, I mean a new … I think you create, I know I create my own boundaries to manage my anxiety, but those boundaries are too strict you know. And you can get quite anxious about where your boundaries are and things like that so, I mean they’re not healthy ones at the moment anyway, they’re unhealthy. … Well like you know, I won’t go and work in a hospital because I don’t have the confidence to be able to look after someone really well. Umm so I stop myself from doing it, you know and I don’t think that’s a healthy boundary, because that’s what I’m trained to do and I think I can look after somebody but I’m just so, it’s…but there’s a big there’s a big wall there. .. I don’t know what that’s all about. And that directly affects my, you know my … my health, my wellbeing, because I don’t feel good that you know, I don’t feel good about that. I’d rather be able to do that you know. I
think I would have a lot of confidence in being able to do that. So yeah, it’s fascinating (Joan).

Joan identified the disjuncture between her training and her own sense of health and well-being realizing that the two were intimately related in a negative way in that she was no longer able to work as a nurse because of the wall that existed because of the disjuncture. This situation was in contrast to her earlier thoughts on health and well-being that included a sense of sparkling moments and palpable humanity.

Katrin thought that the success of her work was related to clear boundary definition and that in the rural areas, the boundary definition often expanded to be more inclusive. In line with this, she saw her ideas of health and well-being as including a sense of community which involved some physical activity that enabled her to participate in the community. For the people that she worked with, Katrin identified support and help as an important part of her role in helping clients to maximize “a sense of control and a sense of they can do it” or at least “the control to direct the support that they get” which she directly related to the training she had received, part of the occupational therapy philosophy. She also saw some of the benefits that she incurred as a therapist may be less well able to be defined.

And then they go oh yeah I didn’t think I did anything but maybe I did, or maybe I don’t need to rush in and do the treatment that you know being there and using sort of yourself as a therapeutic medium, laughs … or whatever, is actually treatment in itself and very useful (Katrin).
Katrin seems to be touching on the sense of connectedness and relationship that is important in her definition of health and well-being and therapeutic intervention which does not always come across in the training where there is an emphasis on ‘doing’.

Nell identified her aim when seeing anyone as being to help them achieve better quality of life and again maximizing their full potential whatever that might be. Along with that, her work with children involved helping them to “come up to their peers’ standards” so that children would be able to join in and be included. However, some later comments indicated that she had some difficulties with this in that when the therapeutic process was unsuccessful because the clients did not participate this also impacted on her sense of well-being. The disjuncture was dealt with by referring back to the client’s right to choose.

Umm, certainly plagued by a bit of self-doubt but I think the more experienced you get you just realize that people have a right to choose umm and this is the choice that they’re making and it’s not necessarily anything to do with you. Umm but you need to umm be a bit more open I think and umm, again I think it comes back to like I say I get frustrated when people do these things umm but I am becoming a lot better at getting over it I guess. In that umm you kind of go initially oh can’t believe they’re doing this, but eventually you say well that’s their choice, there’s you know not much I can do about it as long as they know that when they do, if they ever do want assistance that you are here (Nell).

The therapist initially believed that the disjuncture was a personal fault, that perhaps the person didn’t want the help that she could offer or that she had done something wrong, thus there is a tendency to internalize difficulties with the therapeutic process when working with people to achieve a sense of well-being and health. O’Grady (2005) refers to this internalization of criticism and taking personal responsibility as the inner battle of self-policing. Self-policing occurs as opposed to a critical evaluation of the therapeutic
environment highlighting the emphasis on personal responsibility and individual autonomy according to the modernist model of training.

Polly also referred to the internalization of criticism as being a product of performance evaluation that was particularly a characteristic of being a new graduate. Her ideas about health and well-being had a focus on being able to ‘do’.

Umm, I suppose that’s … that’s pretty much my focus generally and in terms of health and well-being, if they can do exactly what they want to do then that’s fine by me. Cause everyone’s got their own opinions on health and just because I’m keen on sport and like to run around like crazy doesn’t mean that’s for everyone. … But at the same time there’s always that line that needs to be crossed with someone that obviously needs to start to get into exercise and just aren’t interested. And where I try and rub my ideas off onto them a bit but everyone has got their own mind set about things and just work within what they’re interested in doing because yeah you can only go so far (Polly).

The connection between the work and the therapist’s own sense of well-being is apparent when the work does not go according to plan or at least according to the espoused theories in training.

I would be fairly critical, I suppose about. So I would go home perhaps and be thinking about what I did with that patient and I could have done better… But I’m not sure if that’s me as such or it may have just been like a new grad thing where you sort of constantly thinking about what you are doing and trying to evaluate your own performance because you are still not quite sure what you are doing .. you are still trying to find your feet (Polly).
Umm, even though I come across as understanding when people don’t want to walk ten minutes a day because they’re [ ] … you know in my head I might think what are you doing like. I understand to them. But I don’t understand within myself. I just think that’s ridiculous. Laughs. .. But I would never tell them that. So, mmm, I’m confused now (Polly).

While on the one hand, this therapist is clear that her ideas and the ideas of the clients about health and well-being may well be different, she is less clear in understanding why that may be so. And while she may maintain a professional demeanor with the client, her
confusion is still apparent along with a gap between her appearance in understanding of the client on an outer level, and between her own inner experience and inability to empathize on an inner level.

Veronica, also a new graduate, had similar ideas about health and well-being.

Umm, I guess health and well-being to me is about having a good balance .. in your life, being able to go to work and enjoy your work. I mean I could .. everyone has days where they don’t like work and they have bad days and stuff like that but being able to balance it with things like playing sport, spending time visiting friends, you know having other interests like lots of different sorts of interests, umm that has to do with, that has to do with health so you are exercising, you are eating well, you are just doing lots of things and you’re keeping your mind focused or active as well (Veronica).

Similarly her ideas about health and well-being translated with clients into assisting them to interact with people and have a role in improving their quality of life, which was about being happy and being able to complete lots of basic functions of life.

In summary, there was an overwhelming consensus that as far as health and well-being were concerned the workers embraced the idea that it was up to an individual and the choices they made, which directly fits in with the way that the workers had been trained in a modernist liberal humanist paradigm. Where there was a lack of congruency between the workers’ own ideas about health and well-being and what they spoke to the clients about, there was a range of subject positions taken up; the workers could believe that the gap between rhetoric and reality was due to their own personal shortcomings so there was an internalized sense of criticism or there was something wrong with the clients. Some people were able to articulate the sense that it was not possible to have control over materialities in their own or their clients’ lives but this was rarely translated
into practice. There was often a sense of confusion when there was a lack of fit between the rhetoric and reality, or a wall that could sometimes prevent the worker from practising in their chosen field. There was an emphasis on being able to ‘do’ which is perhaps a result of the training’s focus on learning skills and being able to problem solve what clients could and could not do. Most workers focused on an idea of health and well-being that was product or outcomes based with an ideal attainable goal of perfect health sometime in the future. This could be directly attributable to a training that is outcomes based as opposed to being process oriented and that marginalizes disqualified knowledge (Usher and Edwards, 1994). Many workers saw their role as being one of information provision which would thereby empower clients to make the right choices, with heavy moral overtones, and where education was primary in achieving the goal of health and well-being. The responses to the questions around health and well-being have been included in great detail because they seem to form the bedrock of the meeting place between worker and client, where the truth that is shared is based on the assumptions of what it means to be an individual and the choices made around that. These assumptions can be directly attributed to the training which is based in a modernist paradigm or humanist model of a stable coherent rational self that is autonomous and universal (Klage, 2003).

6.2.3 Self-regulation through subjectification

It seems as though the main ways that workers willingly self-regulate are through a process of subjectivation that involves fitting in with the norms of the health workforce
and also trying to avoid the emotional consequences of not fitting in with the norms. For example, Veronica, when asked about the critical pedagogical aspect of her training, saw that there was more of an emphasis on critically evaluating one’s self as opposed to the course.

They do, they kind of, they say evaluate everything you do. Like they always encourage you, that when you are on prac to evaluate yourself and criticize and go this is what I did wrong, this is what I should do better. … But it was always more the way you practice or the other people practice rather than the actual don’t criticize the course type thing. We’re doing the best .. job we can so don’t yeah. .. They do encourage you to critically think about problems and things like that, but not the course (Veronica).

Here is an example of where critical pedagogy has been co-opted by the dominant patriarchal culture and turned the workers into the kind of subjects that criticize themselves, and make them responsible for the well-being or the therapeutic outcomes or autonomy of the clients, so once more reinforcing the responsibility that comes with being a health worker.

A new graduate, Polly had a strong sense of the norms in the health environment that she was responsible for fitting into.

No except I’d say my answers would be a lot different to someone that has more experience. Like if you had maybe someone that had graduated I don’t know six or ten years ago would have a lot of very different perspective to what I have. So if I’m an outlier in your study then you can cross me out. .. the dot outside the table just get rid of me (Polly).

Maybe, yeah. I think that follows through with everything really, you never, you want to, not so much fit the mould but in an environment like health I suppose you need to be doing the right thing .. To be doing what’s expected of you because if you are not then there’s legal implications and social implications and there’s career implications as well, you can’t be too out there in any part that you are doing (Polly).
These comments tie in well with the comments made by Louise that new graduates were more worried about “losing face, making a fool of yourself than about fear” (Louise). In the rural and remote areas, the isolation compounded this sense of not wanting to lose face because participants did not want to ask for help because they did not want “to feel stupid” (Katrin). There were expectations of the workers that they believed they needed to live up to. For example, Katrin identified that one of the roles of the occupational therapists was to keep everyone happy:

I think sometimes as OT’s particularly we get into the keeping everyone happy and sometimes we sort of forget who we are, cause I guess we’re a bit more of a profession that’s hard to define, than physio or speech and so sometimes you can get an essence of sort of losing that, but it’s being strong in that and being flexible, which is umm a hard one (Katrin).

The expectations of fitting into a work environment were also seen as structural by Ingrid who identified that the role of any worker was to implement enthusiastically the will of the government of the day. Thus the workers had to willingly self-regulate through a combination of factors. These included internalised criticism, taking into account the emotional consequences of not fitting into the norms, following external structural obligations such as policies and procedures from the institutional setting, being aware of external (and perhaps internal) unspoken expectations about keeping everyone happy and being responsible for people’s health and well-being (empowering them to make the right choices), and acknowledging the legal implications of accountability of being a health worker. Furthermore, there was a pressure stemming from a form of surveillance that ‘“you had to be seen to be flat out the whole time. And that does stick. And if you’re not flat out, people look at you as though you’re being lazy” (Louise). Thus the external
pressure became internalized so that the nurse became a type of worker that was busy all the time.

The type of workers that these health workers made themselves into was responsible for the empowerment of others whilst simultaneously being critical of their own work. Workers also saw themselves as understanding educators who provided information to enable people to achieve the kind of lifestyle they wanted. At the same time the workers saw themselves as someone that appears in control and makes the right health choices. It was important that workers appeared to know what they are doing and that they believed in various constructs of quality of life including an ideal kind of life where balance was achieved. However, there was an emphasis on doing. In this way they seemed to become subjects tied to their own identity by a conscience or self-knowledge, and also subject to someone else by control or dependence through internalized self-surveillance (Foucault, 2004). These are the main ways in which workers seem to willingly self-regulate themselves through a process of subjectification.

6.2.4 Truth and reality and their effect on our lives

The training practices of the workers led them to believe a particular truth about health and well-being that was related to the construct of an individual and the choices that an individual makes. The workers therefore tended to construct themselves in this model even though there was a gap between rhetoric and reality as articulated by some of the workers. This seemed to have affected the workers’ lives by making them into rational
autonomous human beings. Anything that did not fit this mould was rejected or made abject.

One worker cried while explaining her understanding of health and well-being (coping, feeling empowered, making an impact on their world – Alice), but was not able to explain her reaction. She saw her response as a weakness and not as something that was talked about.

*Crying* So sometimes – silence 5 seconds – you do that, you have this, this work, you know, [ ]. *Crying* But then when you start to think about it, it just – silence 6 seconds – *Sob* – silence 4 seconds – Yeah, just having to go under the surface. .. And I am always, tears are one of my weaknesses so they just *laughs* (Alice).

Alice: No, no. No we don’t, umm, yeah you just don’t, cause it – silence 3 seconds – I guess it’s because everybody’s facing the same thing. So therefore you don’t talk about it.

Researcher: It’s also, I was just thinking it’s like another gap isn’t it in the training. Cause I certainly don’t remember, well I remember in my training you know we were always told to be clinical, you know, objective, clinical umm.

Alice: Yes, you had to be able to measure *Laughs*.

The practices included in undergraduate training and postgraduate work clearly had an impact on the ‘truth’ discovered by this worker and had affected her life to the extent that only parts of herself were allowed in the workplace. Emotional responses to work situations were not considered to be appropriate. One worker described how she and other workers were finding work a real battle and that there were difficulties in just coping with the pressure. But again, these were not talked about so that reactions to the pressures seemed to spill over into work. Thus the truth regimes that the health workers participated in seemed to lend themselves to a constraining not only of the will to knowledge but also in the general expression of a person’s life.
Ummm, for my own health, definitely and it’s, and also with colleagues as well, that it’s very often umm, they are out of balance as health professionals. Umm, you know, one of us may just burst into tears .. cause it’s all too much. It’s it’s, there’s not a good balance between rest and activity. There’s too much activity .. umm too many demands on us as, well we are mainly women here, but as … er … professionals, as mothers, as wives. You know there’s the other patients as well (Emma).

The pressure did not seem to be talked about at work except in terms of how much there was to do. Even when describing situations that could have been extremely distressing, Hanna commented on the fact that she didn’t cry – “Every single person’s important and I was, I don’t think I cried, but I could” (Hanna). So there is a sense that whilst participating in practices and training that led the workers to a particular understanding about themselves and their lives, the workers became the constructs to which they were adhering while practising their chosen career. And it seemed as if there was little place for emotions, going deeper beneath the surface rhetoric or being honest in how one was feeling.

There seems to be a link between the construct of a health worker as someone who ‘does’ first and foremost, and as someone who has a lot to do and the lack of discussion around this issue. Any discussion seems to have been prohibited as a perception of a sign of weakness or inadequacy with people having to cope with these difficulties on their own and in isolation. Thus the internalization of self-criticism seems to be a powerful force in the governmentality of the workers.

Oh yeah, I can remember a few years ago I really umm, you know I nearly worked myself into a major depression. And then one day I woke up and I thought “hey this isn’t about me, it’s not my fault that I can’t see all these people” so I just stopped short of actually hitting rock bottom, which was an amazing thing. You can only do what you can do. Oh yeah, I was doing the 4 o’clock, you know, wake up being really tired and going to bed and
then wake up feeling bad but then I thought this is ridiculous, it’s actually not my fault (Gill).

Apart from the perceived sense of inadequacy that workers had internalized, there were also structural reasons that contributed to the norms in place about not talking about the difficulties workers were facing. Thus not only did the training imbibe a sense of not being able to talk about difficulties, but structural factors in the workplace also reinforced the sense that rational autonomous human beings ought to be able to cope with the workload and the type of work that had to be done.

There’s a lot of dislocation now you see. … That you look after those patients so you are solely responsible for those patients. All you’ll do is speak to another staff member if you want to lift. Help with a lift. You are so flat out with getting all your work done. Before there used to be an overlap between one and three, when there was double shift time, and that was a time when you would go to the tea room, talk about all the stuff that happened in the day and really unwind and offload. … But that was a very umm debriefing, very good debriefing time, and staff interaction and social interaction time but of course they’ve changed a lot of that now. .. So they’ve separated to save money. So they don’t have to pay for the double overlap time, but there’s a heap of psychological psychosocial impact on that, doing that. Yeah. It doesn’t matter if you were a secretary but in this kind of job where you really do have to run things by people and umm just empty out what’s happened to you sometimes in the day, its its such an important thing (Louise).

So it seems as though the practices and training in which the workers have participated in order to discover some sort of truth about themselves have tended towards making workers into the types of workers that are dislocated in time and place, unable to speak about deeper issues that are affecting them and working almost as automatons “Nobody said hello to me when I went to work in that first ward. Umm. I was just another body that came in” (Louise). This is in contrast to other comments made by participants about “the human things that make the difference to people” (Louise), and “You’ve got to be a professional, you’ve got to be all these things but you are first and foremost a human”
(Donna). It seemed almost as if these contrasting comments were made about issues that had been learned since the training or in spite of the training:

Yeah, that’s it. I mean just…you wouldn’t have news headlines if you didn’t have umm if you had people that walked up and said you know are you okay? .. You know, just that, are you okay? And I mean it’s such basic stuff (Joan).

This participant went on to say that the expression of the art form of nursing didn’t come through clinical excellence or continuous improvement or quality improvement projects. There is a major gap between the expression of the art form of any health worker and the training received and this impacts directly on the meeting place between the workers and the client and the particular ‘truth’ that is shared. The gap is worsened due to the fact that there is silence about its existence. A few participants mentioned that they had enjoyed the interviews so much because they had talked about issues not normally talked about and had gone deeper than was usual (Tom, Alice and Cathy).

It’s been really interesting this experience laughs you have given me some therapy. .. I am like, oh we’ve done therapy today. .. and I am feeling really happy. .. It’s very therapeutic. Yeah, I think a lot of therapists don’t get a lot of umm ability to do this. .. Umm, these kind of questions are things that we, probably each of us every one of us think about individually but we never voice the. .. And we think about them in our mind and they churn around and they’re huge life issues (Cathy).

You know, it’s not something you would ever normally do. You would never normally sit there and just talk about, almost like a, sort of like having a, a therapist. .. A therapist come in to see and say you know tell us all about your views on this and that, get it out of your system, type of thing. So that’s quite, that’s quite interesting .. (Tom).

Both participants found the process of the interview interesting in that through my practice as a researcher, asking them questions about their practice, they discovered some truths about themselves and their lives. Just having the opportunity to discuss issues that would not normally be voiced was a disruption to the norm of their training and working
life which could be interpreted as the training and environment at work not encouraging this kind of discourse and disclosure. The workers seemed to enjoy having the chance to reflect on and having their subjective reality reflected back to them. This was an unusual practice for them.

6.2.5 Embodiment and the juncture between human agency and structural constraint

The body could be seen as the main site of the enactment of the juncture between human agency and structural constraint although this is a sociological position on the body (Fox, 1999). Before teasing out this focus on the body as the interface between the structural and the individual different theoretical positions will be examined and summarised in order to inform this section of the results. Fox (1999) presents the different theoretical positions – which body? – as follows:-

1. The body as physical body – untenable for Foucault and poststructuralist others. The biological body, the ‘organism’ or ‘body-with-organs’ (Deleuze and Guattari, 1988; cited in Fox, 1999, p. 114) are discursively constructed.

2. ‘Natural body’ underpinning the ‘organism’ – an essentialist position that acknowledges a natural body overlaid with cultural values having an existence that is determined phenomenologically through ‘experience’, ‘faith’ or ‘common sense’.

3. ‘Natural’ body beyond discourse and thus unknowable. Sociologists left with meaningless and pointless construct – ‘the sociology of?’
4. ‘Body-without-organs’ (BwO) – a unified ‘body’ that is the creation of power/knowledge, a social body throughout, a materially constructed always already body. (Fox, 1999, p. 114)

In Fox’s (1999) view the body is the metaphorical or metaphysical ‘surface’ which connects the realms of the psychological and the social. Similarly, in relation to the self: “the anatomical body is not the carapace of the self” (p. 128): the carapace (or BwO) rather is the territory that is constantly contested and fought over (Fox, 1999). Fox (1999) describes a metaphor to explain the social constructionist position.

The BwO is like a ball on a pool table stuck in some ruts or striations. It is not until the pool table is tipped and the ball moves out of one rut perhaps into another or perhaps into ‘smooth space’ that any change can take place. The striations are known as territorializations and are created by the construction process resulting from tension between the forces of the social and the BwO’s will-to-power (Fox, 1999). Fox (1999) eschews any interior-exterior conception of subjectivity and embodiment seeing this instead as an effect of the meaning of socialization.

Similarly Butler (1990) sees the boundaries between inner and outer as a set of fantasies, feared and desired:

What constitutes through division the “inner” and “outer” worlds of the subject is a border and boundary tenuously maintained for the purpose of social regulations and control. The boundary between the inner and outer is confounded by those excremental passages in which the inner effectively becomes the outer (Butler, 1990, p. 170).
The boundary of the body is maintained by the ejection of otherness and is an accomplishment of identity-differentiation (Butler, 1990). The binary of inner-outer, where inner is privileged, is a social construction of the body.

The mind-body binary has also been noted previously as a social construction. The mind-body has been variously represented as a mobius strip by Grosz (cited in Finlay and Langridge, 2007, p. 178) where there is no clear distinction between inner and outer. Instead there is an inflection of the body into the mind and vice versa (Finlay and Langridge, 2007). Merleau-Ponty’s view was “that the body is the mind’s body and the mind is the body’s mind” (cited in Venn, p. 59):

The idea, then, is of an intertwining of the world and the human, of interiority and exteriority, of the I and the Other: it evokes, analogically, the relation of a curve to its hollow. Such a relation is not representable as such; it can be apprehended only in the mode of the sublime .... the ‘throwness of being’ (Venn, 2002, p. 59).

The intertwining of the mind and body and of the social and the individual has also been likened to relations of the exterior being “invaginated, folded, to form an inside to which it appears an outside must always make reference” (Rose, 1998, p. 188). Rose advocates abandoning “this ‘fleshism’ of the body once and for all” (p. 183). He would rather see social constructionism as the dominant concept similar to the BwO. However, Rose has a slightly different metaphor for embodiment even though he also draws on Deleuze to describe the relationship of the inner to the outer using the concept of the fold:

The concept of the fold can give rise to a generalizable diagram for thinking of relations, connections, multiplicities, and surfaces – their formation of depths, singularities, stabilizations. This diagram of the fold describes a figure in which the inside, the subjective, is itself no more than a moment, or a series of moments, through which a
‘depth’ has been constituted within human being. The depth and its singularity, then, is no more than that which has been drawn in to create a space or series of cavities, pleats, and fields, which only exist in relation to those very forces, lines, techniques, and inventions that sustain them (Rose, 1998, p. 188).

These forces and tensions of the social and the individual are active in the formation of the folds or subjectivity. Similarly, in relation to agency: “agency is, no doubt, a ‘force’, but it is a force that arises not from any essential properties of ‘the subject’ but out of the ways in which humans have been-assembled-together (Rose, 1998, p. 187 – 188).

However, Fox (1999) would argue that the folds are not ‘in’ the individual but are the fabric of the external (the pool table metaphor). The fabric of the external is constructed by social forces including pastoral power exerted by most state institutions.

Pastoral power was exerted by the state apparatus and public institutions such as health care services in a totalizing and individualizing manner such that the development of knowledge about ‘man’ took place around two roles; one globalizing and quantitative (totalizing e.g. epidemiology and statistics) concerning the population; the other, analytical, concerning the individual (Foucault, 1983). Pastoral power was thus formative in the territorializations or striations of embodiment. The individualizing techniques of power incited people to act on themselves to become subjects:-

This form of power applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others have to recognize in him. It is a form of power which makes individuals subjects. There are two meanings of the word subject: subject to someone else by control and dependence, and tied to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power which subjugates and makes subject to.

Generally, it can be said that there are three types of struggles: either against forms of domination (ethnic, social, and religious); against forms of exploitation which separate individuals from what they produce; or against that which ties the individual to himself.
and submits him to others in this way (struggles against subjection, against forms of subjectivity and submission) (Foucault, 1983, p. 212).

The subject is tied to him or herself through categorization and imposition of a law of truth which other people then recognize and use. This may have relevance to the practice of health professionals as the subject is tied to him or herself; and they are also divided within themselves and/or from others.

Historically, dividing practices included the isolation of lepers during the Middle Ages; the confinement of the poor, the insane, and vagabonds; the new classifications of disease and the associated practices of clinical medicine; the rise of modern psychiatry and its entry into hospitals, prisons, and clinics; and finally the medicalization, stigmatization and normalization of sexual deviance in modern Europe, according to Foucault (Rabinow, 1984).

In different fashions, using diverse procedures, and with a highly variable efficiency in each case, “the subject is objectified by a process of division either within himself or from others”. In this process of social objectification and categorization, human beings are given both a social and a personal identity. Essentially “dividing practices” are modes of manipulation that combine the mediation of a science (or pseudo-science) and the practice of exclusion – usually in the spatial sense, but always in a social one (Rabinow, 1984, p. 8).

Thus health care is a prime site for the manipulation of individuals through categorization, the mediation of a science and the practice of exclusion in order to produce divided individuals both within and without. The manipulation of individuals and the practice of exclusion may be part of the social construction of health professionals as they become tied to dominant identity norms; preferring to be privileged than not:
Of particular significance is the link between self-policing practices and the maintenance of dominant identity norms. This type of contextual approach offers an important counterbalance to the individualistic impulse in much of western culture whereby, against clear evidence to the contrary, it often is assumed that who we are and how we live is solely a matter of personal decision of will (O’Grady, 2005, p. 14).

This tying to one’s identity through the maintenance of dominant identity norms along with self-policing may have relevance to the following participant comments. Different forces such as individualization, totalization, dominant identity norms, self-policing can all form differends (Fox, 1999).

Differends are described by the participants’ responses. Differends are directly linked to the right to claim ‘knowledge’ (Fox, 1999) and are thus very important in health care and the location of the body.

The creation of a differend is an act of power which works at the margin or limit of a text. It frames that text (which may be a book or a social practice or a subjectivity), fabricating the distance between author and object, self and other, what is and what is not. Deconstruction identifies these framings, exploring the achievement of differends. .... Deconstruction reintroduces what has been left outside the frame (Fox, 1999, p. 30).

Deconstruction as a knowledge claim or process then is constitutive of a different type of embodiment. There is a link between knowledge claims, deconstruction and embodiment. The participants’ comments about health and their bodies construct their bodies and frames them. These constructions are then used to make knowledge claims. However, deconstruction is a knowledge claim based on deterritorialization (Fox, 1999). With these points in mind, I will now review the participants’ comments.

For example, Tom discussed ‘the obesity epidemic’ frequently cited in the media, and saw this as an opportunity to judge people about their level of self-control and laziness:
At the moment there’s … er … almost a paranoia about, what they rave on as being the obesity epidemic and how we’re all going to be scurged with serious diseases and we’re all going to die, cause everyone’s getting absolutely fat and I get a little frustrated with people who I think should know better, professionals in the area, health specialists and health experts. Cause we know the media are just, you know, they are just like sharks, feeding on a frenzy because it sells, it sells articles (Tom).

In contrast, Tom also believed in listening to the cues of your body and letting those determine your behaviour but still with the idea that people needed to be empowered to make the choice easy for them, in order for people to make a moral choice. Here, Tom is rejecting the media frenzy over a supposed obesity epidemic but still supporting the health education notion that people need to be empowered through education to control their own health. In this way, the worker is participating willingly in his own, and that of his students’, subjugation through the tasks that are promoted and through self-surveillance.

The other way in which the body is the site of the enactment of the juncture between human agency and structural constraint is through the participation of the workers in their own oppression through the work they are required to do. The body is the vehicle for carrying out the tasks, there always being so much to do.

So you come back and you got all your other more, more …, you don’t get time to read the patients’ notes. You don’t get time to do the extra things that can make a difference to that patient ‘cos you’re having to attend to the basic requirements of care. No sooner have they gone out the room and somebody’s got some orders about something and the co-ordinator may give them to you, then you’re starting to feed the patients because it’s lunchtime then. Twelve o’clock. There’s all the little older ladies and stuff and people that can’t feed themselves so, if you’re looking at power like in the nurses, you’re so powerless. I felt so powerless I couldn’t even listen in to what the doctors are saying and I, I felt I needed to know because I was the caregiver (Louise).
The majority of participants described the workload as overwhelming, that work was about coping and just trying to get as much done as possible. The structural constraints included an enormous amount of administrative work, often generated by the increased use of technology. The differends in this case can be seen as paperwork including patient notes and administrative work, routines, basic requirements of care – care as something done ‘to’ a patient (care as a vigil – Fox, 1999).

Paperwork can act as a differend because it frames the work that must be done and it writes the person as well as silencing other textualities (Fox, 1999). For example, Mary stated on a number of occasions the frustration she felt at the amount of paperwork she had to complete – admission records, medication charts and so on. These examples supply the control of the situation to doctors and yet they also limit what is considered within the frame of the patient.

I described to somebody on the weekend, I said I work for the government and I do paperwork. *laughs* (Mary).

Umm, so I get, I do get frustrated and I think, I mean the system does what it can because it is a government agency there are so many rules and protocols and safety and medical and legal issues that we just end up tangled in so much of that, that when it comes down to the common sense practical issue of what does this person need and it’s like our hands are tied (Mary).

Mary was clearly able to describe the effect that working in such a system had on her body:

I would find myself being the fine point on which the whole thing balanced, because I would have to say look this patient needs a bed, ring all the different hospitals and be told no bed, no bed, no bed and have the emergency department staff saying we want this person out of here and not being able to find a place for them and that was the most stressful thing. .. Er.. but in the end the reason I didn’t continue is because I just found it, I
was incapable of being the health system. You know I couldn’t be that balancing point that it all hinged on and I got very stressed by that (Mary).

And I am so out of my body, I am so stuck in my head, I am so under time pressure, I am doing three things at once, I have got a pager going off, I have got a phone going off and then I get a call from a community clinic with somebody who needs to come in and that’s the most pressure that I experience at work …. (Mary).

The thing that disembodies me is the time pressure. If I can take my time and just do one task and then another I can stay much more in touch with myself. I can do that (Mary).

So each day when I am driving to work, I am kind of consciously telling myself it’s okay, just relax, just breathe, just keep, don’t worry about your muscle tension, try to keep relaxed, it’s not all up to you, it’s only the system, you can only do so much. I kind of had to say all those things to myself and just go in and try and just be myself and be calm. But through the day, invariably walking back to my car in the afternoon, I have to draw my bits of myself back from the atmosphere laughs cause they have run off during the day. By the time I get home I have usually got it back together again laughs (Mary).

Through time pressures, having too much to do, excessive paperwork, structural constraints, and the emotional pressures of the work, Mary was able to describe how the only way she could survive the system was to become disembodied. That for her, human agency in terms of getting things done and meeting the requirements of the work meant she had to lose her relationship with her self and her body, and participate in what she saw as an unhealthy environment. The way Mary was constructed within the environment was by being absent to herself and taking on the construction of the ‘system’; being “that balancing point that it all hinged on”. Mary became tied to that identity perhaps because it is these points that supplied the control of the situation to her.

The absence of the body was consistent in peoples’ responses to questions about their relationship with their selves, with most people not understanding what was meant by this question. Most were able to talk about their relationship with self, when prompted, in terms of self-talk that was about coping with the system and not being defeated by it.
I think, I think that you just realize that if you, if you moan and groan too much its going to wear out onto other people and you are going nowhere and by, basically you can't change, often we have a defeatist attitude, you just can not change the system. So you have to make a decision. What is it actually better to be? Is it better to be moaning and miserable or is it actually better to be happy and positive? (Louise).

I mean, and they can’t, what’s that saying, you can’t change the way the wind blows, but you can alter the sails (Gill).

Generally, participants’ relationship with self and body was minimal and seemed to exist mainly as strategies (self-talk and beliefs) to cope with work and the structural constraints. A few participants noted that they didn’t look after themselves in the same way that they promoted a healthy lifestyle to the clients. The relationship with self was obviously not discussed during training or participation in the workforce as most participants were unable to articulate any relationship at all. In terms of the body being the site of the juncture between human agency and structural constraint, it seems as though the structural constraints dominate the landscape with most people leaving themselves and their bodies out of the discourse except in terms of coping and balancing commitments and responsibilities through a form of self-talk that enabled them to accept the status quo. The main theme in this section on technologies of the self was that there was a subjugation of the self in service to the health system or structural constraints. Most people seemed to survive through a disembodiment and an acceptance of the status quo. These responses seemed tied in with responses to powerlessness, the subject of the next section.
6.3 POWER/KNOWLEDGE

Questions about power relations in the training or at work seemed to elicit a general response of “there weren’t any”. This response was so strong that I had a sense of my own reality being completely wrong. While the majority of participants did not articulate issues relating to power, they were able to articulate issues associated with problems at work such as having too much to do in too little a time and, as mentioned previously, there was silence around discussing anything that might be perceived as a sense of inadequacy or weakness on their part. This thesis has concentrated on workers within the health service. Therefore the comments about and understanding of power relations in the field represent power manifested in and through a relatively privileged group of people. If a privileged group of people do not understand power relations and cannot relate to it at all, what does this mean in terms of service delivery? What happens to the power that is neither acknowledged nor even spoken about?

6.3.1 Understanding of relations of power in their field

Mary saw the manifestation of power as reflected in her ability and responsibility to make decisions on behalf of client care “Because I have that power I am the doctor, it stops with me at that time” (Mary). Similarly her feelings around disempowerment were about feeling constrained, as if her hands were tied by the system. She described how her self and body reacted to a dilemma she faced at work when she wanted to do something but felt constrained “you want to say something that the system doesn’t say” (Mary):
Oh I can get frustrated, I can get nasty, I can get sarcastic, I can feel just like start dreaming up my next job, cause I don’t want to stay there. *Laughs* I do. I just get to the point where I think help, I can’t do this, I can’t participate in something that is not healthy. How long can I do this for, you know, I am doing it for the money, maybe (Mary).

Like I have to just draw myself in out of the situation and sort of try not to participate so much. Even though I am physically still present. Draw my energy back, hold my breath back and just say okay, this is what’s happening I can’t control it (Mary).

It is interesting to note that Mary was positioned as one of the most powerful (top of the hierarchy) health professionals and yet she also experienced extreme powerlessness. At the point of subjugation, she withdrew herself, acknowledging that she had no control and that she was in an invidious position which she could only react to by feeling frustrated, being nasty and sarcastic, and fantasizing about her ideal job.

When asked whether issues of sexuality or gender or cultural differences were addressed as part of her training, while not mentioning power per se, Mary was able to articulate inequities in how people were perceived and treated.

Well there’s them and us really *Laughs* No its true, those issues, the people with the problems are outside. They’re the clients and I guess we noticed it because you are dealing a lot with people from lower socioeconomic status type suburbs and different, this is the public system. You get people who can’t afford private so you get poverty, they’re your clients, but it wasn’t explicitly discussed or there was no, sort of discussion about how do you think this patient perceives you, do you think there is a difference or, inequality in that area. That’s just what you do . . . But I think, I know that people treat patients differently in private where the patients can afford to pay more. I think there is a lot more equality between consultant and client and there’s a lot more respect I think probably. We had an attitude that well this is what you get if you come here cause this is public. . . And I mean that sounds really awful, but I am sure it is there in the atmosphere. . . It’s unsaid. . . Public and private, yeah, yeah. Yeah, I mean its true, people without money don’t have as much say in what happens to them. Silence ~ 5 seconds (Mary).

Using Gore’s (1995a) categories of power, the comments made by Mary can be shown as examples of distribution – there’s ‘them’ and ‘us’ with people with problems being on the
outside; of classification – the ones with the problems are the clients who are also poor
and without so much say in their care and therefore somehow deserving of less respect;
exclusion – people with problems are not one of ‘us’; and of totalisation – people who are
poor are the ones with problems. These comments are in addition to comments made
earlier by the same participant about the punitive system of care in mental health:

… although in medicine in psychiatry more than general there is a kind of punitive way of
managing people who have got overwhelming distress. It’s not very compassionate, it’s
not very understanding of where the distress comes from. It’s much more like, we have
rules and you can’t behave like that here (Mary).

These are the rules that delimit the sayable (Kendall and Wickham, 1999) and are a
manifestation of power at a time when people most vulnerable. And even though there
are rules that delimit the sayable, there is the sense that such an approach to patients or
clients is out there in the atmosphere; it can be felt and must be part of the mechanism of
positioning.

When discussing the difficulty presented by on the one hand wanting to be
compassionate with people but on the other hand working within a system that was
punitive, Mary made the following comments:

There’s a limit to it, but I am learning all the time and I am learning to watch myself and
my own reactions and how I participate in that along with other nursing staff, you know,
when the doors are closed and we joke about other peoples’ misfortunes and there’s this
kind of rationale, it’s okay to make jokes at the patients’ expense because that’s how we
cope with the stress of working here. .. And that’s part of the environment, and you know,
we know it’s not very nice, but that’s what we do here and it’s okay. And I go in and I
really, the first few weeks I really shudder at that and I don’t want to participate in it, and
then within a few weeks I find I am in it and all of a sudden I am coming in rolling my
eyeballs making a sarcastic comment about that person’s parents and I don’t want to be
like that, but that’s what the system encourages. .. Yeah, and not only an object but
something that is just less, I don’t know you are less respectful of them. You make them
into the subject of humour. And yeah, part of me really doesn’t like that. And yet part of me does that when I am here (Mary).

These comments show that both health worker and client are made into particular types of subjects as ways of being within a punitive system that ultimately does not seem to be helpful to anyone.

The pressure to conform to social norms within the work environment was also explained by Joan in terms of workers policing their own boundaries to maintain their clinical rational unemotional role within the health service.

You know, umm a lot of people wanted to have that caring experience and had that compassion but from a business point of view or from a career point of view it didn’t make sense. So then you’ve got a lot of these people going out into the workplace you have got nurses already policing their boundaries … this is what we do, you do it our way, you socialize to our way or you don’t socialize. You know and .. yeah and it’s very you know it’s very violent umm … umm, so yeah that sense of umm and those boundaries give people power you know. .. You know, you know, there’s I think there’s also a direct relationship between knowing your boundaries but also if you can police them there’s a sense of power about that you know (Joan).

Protecting boundaries, territories and role delineation are all ways in which power circulates within the health service to exclude people who are perceived as not belonging.

As an educator and nurse, Joan was involved with the training of students and was determined to ensure that students experienced what it was like to be on the receiving end of care and to keep powerlessness at the forefront of the training.

No that’s right because you have no concept of what it is to actually feel that powerlessness and umm that umm I mean it’s perfect sort of experiential learning if you like, is that they, they know what it feels like (Joan).
The mismatch in experience between worker and client seems to produce a power differential in the worker’s favour if they are unable to empathize, understand and validate the client’s experience.

There seems to automatically be a power imbalance when there is a lack of empathy since both worker and client are then made into particular types of subjects.

You know, like you have to be hard nosed and you don’t crack and things like that and I thought about it this morning you know when we were talking about anxiety last week and health anxiety and umm I thought I don’t think nurses have another way to cope or don’t know any other way to cope with what they go through. So they literally have to shut down and turn off and you know and just do what they do and I mean otherwise it’s a hard, it’s a very difficult place to walk. I mean if you want to teach people about empathy can you go too far? Where I’m at a stage where I think I have gone too far (Joan).

This participant saw that in order to survive the type of work and situation she was in, she had to shut down or not work in that field, in other words, enforce rigid boundaries between herself and other people in order to survive.

Workers’ understanding of power relations in their field seemed to be articulated in terms of boundaries. The topic of boundaries came up again with three other people seeing success at work as having clearly defined boundaries to their role (Louise, Betty and Katrin). In fact Louise saw that cleaners and patient care assistants had more power than nurses because they had a very clearly defined role and were therefore able to say no.

Everything else but also if you are looking at these sort of power things umm in a way, people … PCA’s [patient care assistants] and cleaners have got more power than the nurses. … They … they know where they are. They know they are working within those boundaries. And they’re more powerful bodies than the nurses are. … Yes, yes. Whereas nurses feel they have to be all things to everyone. Because that’s the expectation in their role. … That’s why they get so stressed. … Feel so responsible. Yep. Because ultimately
they’re responsible for the patient. They’re the one that goes to court if things go wrong. .. And yet the … the less qualified groups, are really the more powerful groups. Yeah. They umm, they say no we won’t do that. No. And that, which is … They’re doing the right thing. They’re less stressed, that’s for sure. *Laughs.* Yeah (Louise).

Both Louise and Katrin identified their profession as having to conform to expectations that they needed to be all things to everyone, with Louise relating this to the holistic approach to care of nurses. There seems to be a conception from doctors, to nurses, to occupational therapists that everyone else has got it easy and has far more power than the worker speaking at the time when in reality all three were feeling the same effects of power. This could be seen as an effect of individualisation (Gore, 1995a) within the health service where each type of worker is individualised and very little communication occurs across the different types of workers, especially about these sorts of issues. The training could be seen as directly responsible for carving up the workers into different ‘disciplines’ or professionals, and also for promoting concepts like holistic care.

Not everyone was able to articulate an understanding of power relations in their field. Emma felt disempowered by lack of time but not so much by people. She felt there was a trust in the workplace that enabled her to manage her own time. When Fiona was asked about her understanding of power in her field or if that was an issue, she stated “No. *Laughs.* When I read that, I thought what do you mean by that?” (Fiona). Later on she referred to a “bit of a power thing, but I didn’t worry about it” in relation to a situation with another staff member. When Gill was asked about her understanding of power relations, she replied “Aww, *laughs,* this is too hard”. For her the main impact of power was the enforcement of risk management policies and other administrative work which prevented clinicians from doing the stuff they were actually trained to do. Later on, Gill
referred to “Umm, well, some people just to, they try to get you to do things by exerting their power. Laughs” (Gill) but her strategy to deal with that was to not take it personally and avoid the person by going elsewhere. If it really became a problem, she would leave. Her sense was that as a health service, all the workers were being imposed on from outside but they needed to deal with it.

I suppose from outside our health service well we are all being imposed but you have to really deal with it. In fact you have to look at you know what I was saying before, about what you can do. .. Sure you have got an overarching thing that has to be done. .. And if you don’t believe in that then you have got to go. .. Cause that’s not what you are there for. You are actually employed in this job and like it or lump it .. and this is the role and the service and it’s not up to me to make that decision. But it is up to me about how I set about meeting the goal. .. Yeah, yeah and if I can’t live with that then you have to go (Gill).

Again, there is an echo of powerlessness with the worker being unable to conceive of a situation where she might be able to negotiate her way out of an invidious position.

Hanna relied on her clinical skills and maturity to negotiate her way through power issues with other people.

Other people don’t do much power play with me now. I use it. Umm, when I was a young physio and I think it can happen to young physios now, they can feel very demoralized on a ward .. and they’ve got to learn their strength on a ward when they are working with people who’ve, there really is a hierarchy. .. It’s flattened now in the hierarchy, but there’s still the odd person. .. So power, I, I umm, yeah it’s still there. [ ] umm, the only way for me to stand up to that is umm, to state at a skill level how something should be or how it should be for you. .. Yeah, mm. Very few of those people left, thank god. .. I don’t think I can answer more than that, I am sure it’s there but because I am older I, I enjoy the respect that the older person gets laughts (Hanna).

The use of clinical skills to stand one’s ground ties in with the use of information as power or power/knowledge (Foucault, 1980). These could be seen as examples of exclusionary power whereby each type of worker has their own body of knowledge and
skills that enable them to exert their will on other people. Ingrid saw that information power was something that could be given to others, much like empowerment.

The power that I have is information that can be provided to people in whatever environment, whether it be from a management perspective or a clinical perspective, I see knowledge and information as being power, because giving it to somebody else enables them to, or gives them options that they might not have had before through that information. Umm, ahh. There’s a sense in which a level of umm autocratic power that goes with the position, because there are some things that have to be done. Going back to that bureaucracy, umm you have no choice about, you have just got to tell people to do and so there’s a power or authority if you like in that. Umm and I don’t like that so much laughs... I mean that’s that’s part of the job, but it’s, I’d rather have umm a situation where you empower others to make the choices. Umm I think that sometimes ahh we can be disempowered also. The power I have is to try and empower others. I think that’s what I am trying to say. Mmm (Ingrid).

Other participants recognized the power in the hierarchies of the health service and saw their role as including knowing how to play the games that you need to in order to get your resources and things (Katrin), knowing how to deal with the feeling of being disempowered when clients didn’t do what you wanted them to (Nell) by not taking it personally, that part of learning what a job involved was to negotiate the unspoken hierarchy that no-one tells you about and the feeling of disempowerment that seemed to go with being a new graduate (Polly), and finally understanding that as a new graduate you were at the bottom of the power hierarchy and that it was scary having the responsibility of being a ‘real’ physio.

But it’s still quite daunting and scary. It’s just more the unknown, you haven’t done that before, you have never been given full responsibility of doing the job before. So it’s just scary. .. And I guess it’s also just partly scary because I was also at the same time I had chosen to move away from my friends and family. So normally you would have them you can go home to and cry and go I don’t know what I am doing .. And you’re up here and you go mm the only people I can talk to are my workmates and I don’t really want to say that to them (Veronica).

You don’t know the way people relate to each other and you feel like interact, I think I had a quick peek at some of these questions before I think it had to do with the power plays and
things like that you don’t know. You realize you’re down the bottom of the sort of power thing and you don’t know how far you can push things and make your own opinions sort of heard. .. Yeah, and I guess the line’s never black and white, it’s always a little bit blurry. Some days you can push someone to his limit and other days they haven’t slept well and you can’t (Veronica).

There is a sense here in which the isolation experienced in a rural position magnifies the impact of the unspoken power in the workplace, especially when the norm is to not show signs of perceived weakness or not to appear as if you did not know what you are doing. In a workplace where information and clinical skills are used as currency in the power market, it would be very scary to admit that you weren’t feeling sure about what you were doing.

6.3.2 Reproduction of relations of power within the training in health

Training seemed to be a site for reproducing power relations in the health field mainly because power was not spoken about; most graduates had no idea of unspoken power hierarchies in place and had to learn to negotiate these on their own. There were many ways in which training was used as a site for reproducing power relations but not one example was given where power relations were challenged through the training. The many ways in which training was used to reproduce the power relations are listed below.

- The enactment of power by the lecturers (Mary, Tom, Louise, Alice, Cathy, Joan, Veronica).
- The emphasis on the clinical skills based model of learning in undergraduate training with the focus on treating problem/pathologies (Donna, Gill, Hanna).
- The gap between the rhetoric of training and the reality of the ‘real’ world (Fiona, Gill) along with the silence about major issues such as power, the body in relationship with self, etc.

- The rhetoric that is employed in training such as empowerment and holistic care alongside obvious inequities and fragmentation of services could be perceived as two different opposing or polarized realities in place at the same time. Such an approach in the training does not challenge relations of power and only serves to reinforce them since there is no ground to confront what is going on. A double speak or a case of the emperor’s new clothes (Joan).

- The sheer amount of training that is required as an undergraduate and in the workplace in order to keep workers up to date with complexities in community and demands of health department (Ingrid).

- The way training was conducted i.e. like a military exercise (Louise, Ingrid, Joan – all nurses).

- The decrease in time spent on practical placements that was framed by the training institutions as a move towards education not training (Tom, Donna, Katrin, Nell). This only reproduces power relations in the health field since undergraduates would have even less exposure to the reality of the workplace.

- The lack of radical critical pedagogy encouraged in the training only lends itself to reproducing power relations. Almost everyone agreed that critical enquiry about the course was not encouraged, only critical enquiry about the health workers’ practice.
The lack of discourse about the body in terms of having a relationship with one’s body, so in fact there was a silence about the body except in terms of its pathologies and how to treat problems associated with the body. Therefore any manifestations of power in the body would not be able to be articulated.

6.3.3 Reinscribing systems of power through training discourse

Discourses in training reinscribe systems of power and domination through a number of different ways that include the structural and the ideology associated with health. Examples include dividing practices by categorization whereby individual(s) can become tied to their own subjectivity by practicing a particular form of identity through the training.

An example if dividing practices includes the organization of the training discourses i.e. fragmentation of the body into different parts and systems and diseases which are then learnt about in isolation.

Yeah, this is a, I mean it starts in the beginning of medical school. You have got cardiology, you’ve got respiratory and you’ve got renal and you’ve got gastrointestinal and it’s all separate and it’s umm, that’s how you learn about it. You learn to separate out the systems and there’s different specialists for different systems and er they don’t really cross over very often. They do in geriatrics, cause they’ve all got something wrong with all of it by then laughs because no one is interested in the whole person earlier.

Umm, I mean I almost feel like why do I need to say more because its so bloody obvious, you know laughs but that’s the way it still is. And I have still got friends who believe that you can separate it out and say well this person’s a renal patient and this person’s a respiratory patient and they’re not. They’re all people who have somehow got their energy out of balance. I mean the molecules affecting all your systems all the time. But it gets divided up like that (Mary).
Dividing the body is one way to ensure social constructionism takes place.

Silence about cultural and structural factors including power impacting on the body and the maintenance of the assumptions that every person (every body) is an individual who is capable of making a healthy choice and being responsible for their own health thus maintaining the viewpoint and opinions of a privileged group of people who are able to do this.

That’s right, that’s right, people will often say oh doctor I know my diet’s not very good, I know I should be exercising and I am not and they give themselves a really hard time for that, because there’s so much judgment about people who are lazy or people who over eat or people who the health….. Oh this is another huge area, I mean obesity, doctors make moral judgments. They are not giving objective clinical advice. They are making moral judgments a lot of the time and it’s, I mean we know the health risks of being obese and we know the guidelines for a good diet. But we don’t know the dynamics that makes someone overeat. We don’t know the psychological part of that, we don’t know the insulin metabolism, all of that, you know, what is it that makes someone lay down more fat. And there is this belief that they are fat because they eat too much and they eat too much because they’re greedy or bad in some way and we make that judgment all the time (Mary).

Mary had some awareness that judgements such as ‘lazy’ or ‘greedy’ were social constructs that were not helpful.

In contrast, Tom, who was involved with implementing the training with an allied health group of workers, was quite ready to make moral choices and believed as health workers that we should be so doing.

Yeah, so we don’t, we don’t lead by example, so there’s a, and that tells me something. It tells me that there’s a laziness component in us and people of our era are too scared to say no. .. To the people who we feel we are responsible to, whether it’s your employer.

And I think what we need to do is make moral choices to ourselves… (Tom).
There is a subtle pressure here to conform to a norm around what is considered healthy behaviour through the use of emotive words such as laziness, being scared and making moral choices i.e. through the use of shame about individual behaviour in order to get people to conform. Therefore the emphasis in the discourse in training is on the individual and not on the structural or cultural/political factors that are involved in the circulation of power.

By filling the training course with content and skills training so that people know what to do but are not capable of nor allowed to debate issues around health service delivery, workers perform a particular type of subjectivity. This will be covered in greater detail in the next section

Reinforcing the use of norms to predict and control individual’s behaviour within the modernist paradigm be it the client’s or the therapist’s was a common practice in one health professionals’ work.

Umm, so there were different norms [ ] so we had to be very conscious of that. If you do use that formal test, you know you have to have a reason for using it. Umm, what, how are you going to use that information with that person, is it that valid to say that they have scored this in this test therefore they’re not up to scratch and therefore you have to get them to this level. And that’s not necessarily appropriate or effective (Cathy).

Umm so the young ones, mostly informal but they, you know you have to have some norms. We do have norms that are a rough guide that are based upon years and years of different umm, data and even all our norms, like I have got a book, a huge book of norms and even on one page of the earliest book … er …, norms of sound development and there will be all these different researchers and they’ll have roughly slightly different months (Cathy).

So I think it, it helps you get a guide as to what generally in the perfect world where people should generally be developing, but it’s more a guide umm, for most of them (Cathy).
The use of science to provide evidence-based practice in isolation from cultural factors and as the privileged form of knowing is a common misuse of ‘science’.

The normative function of psychological tests and ‘research’ especially in relation to gender, culture, ethnic and socioeconomic issues reinscribes systems of power.

Mmm, yeah I do umm, I do appeal to the science side of things. I do know that umm, I mean a lot of that data is, I mean I know that it might not be based upon a lot of people from different cult… I mean it could be based upon people from different cultures if it’s Australian….(Cathy).

When asked about the past physiological research that has been carried out on primarily white males and whether that was still the case now, Tom could not see that this might be a problem.

Do you think that’s a problem? I know, I am not supposed to be asking you questions ..
Are you inferring that that’s a problem though?
You think they might be extrapolated over.

So if you want to look, scientifically if you want to look at say a specific intervention, a drug intervention or a dietary intervention or a lifestyle and you want to know, you want to ask that question for example, whether this intervention specifically improves insulin sensitivity and then you have to have all the other, all the other confounders removed from it… So if we, if we invited women to participate in that study we would have had to have been very very thorough in excluding all the other things which could be leading to their visceral obesity and insulin resistance. So for that reason we chose males only (Tom).

The scientific approach requires researchers to remove ‘confounding factors’ that may upset the results and skew them in one way or another. However, the results of this sort of research are often then applied to groups of people who do not necessarily fit the narrow selection criteria of the research and certainly may have many confounding factors in their lives.
The deliberate separation out of theory and practice within training reinscribes systems of power as one becomes elevated over the other in a binary about knowing and doing. One participant described how a conflict between two lecturers about their different preferences of theory and practice perpetuated a split in the minds of students since there was never any resolution of this polarity until one of the lecturers left.

So I have, I always have these two views in my head so one’s very theoretical base, research base and then another one’s more practical base. But I actually do use theory in my practical as well. So I don’t really, it’s not really divorced from that.

.. I think I have married them. *Laughs* So talking about the divorce before (Cathy).

These examples demonstrate how the dominant medical model through the training, has inscribed disciplinary norms and hegemonic practices through techniques of power such as surveillance and the development and hierarchicalization of a body of skills and knowledges associated with health workers of various sorts. This in turn has made the health workers into particular types of subjects with particular understandings of themselves, especially as docile healthy bodies (Foucault, 1973). Furthermore, disciplinary norms have established the different workers as all having a position (space and rank) i.e. distribution (Gore, 1995a) within the unspoken hierarchy that is omnipresent in the health services.

By having a medical model which splits up the different parts and systems of the body into different categories, specialists have been able to come into being that make them an expert on that aspect of the human body (Petersen and Lupton, 2000). Mary was able to
identify the fragmentation of the training in which she participated, and from where she could then channel herself into any number of different specialities. This shows the power of distribution and regulation to the different workers as they move around the health service, which is a way of enforcing disciplinary norms within each area of expertise alongside the different disciplines. Furthermore, by having different professional groups within the health service, there was further regulation of people’s behaviour according to the identity they attached themselves to at one time or another. For example,

… umm for example, at umm X when I was working on the umm brain injury unit, you would have your … I am a member of the Brain Injury Unit hat on, and then you’d have your well I’m an OT and part of the OT department hat on, and there were often clashes with that, so I guess it’s a matter of understanding that rural as well, you know, where do you fit in the system. And at different times you need to wear different hats (Katrin).

The whole way that the knowledge and skills were set up within the different trainings allowed a hierarchy in workers and knowledges to develop whereby everyone knew their place. This was something that had to be learnt after graduation, as stated by Polly and Veronica. This then allowed hegemonic practices to develop within the different workers as each defined their own area of practice and became preoccupied with maintaining and policing the boundaries of those practices. So the fragmentation of the body and the development of expertise was a major part in the development of disciplinary norms and hegemonic practices.

The policing of practice boundaries can be seen as a form of surveillance that the different workers exert upon each other. Surveillance, although not mentioned explicitly by participants except for Louise, is a powerful force that regulates and disciplines the
workers (Foucault, 2004). Perhaps it is even more powerful in this case because so few people mentioned it as a force that determined their behaviour at work. The dominant medical model reinforced the power of the gaze through the epistemic casting of the knowledge. Workers were continually exerting the gaze upon the clients that they saw and upon each other. There is also the self-regulation that occurred as a result of the constant monitoring of bodies, thoughts, feelings and behaviours (O’Grady, 2005).

Such surveillance is implied but not stated as such by Cathy when discussing how she was told by her line manager what she could and couldn’t do, due to an overwhelming caseload. She complied with the direction and became a docile body that was productive in the workforce, though not without some cost to herself.

Cathy describes the hurt both psychologically and physically as she absorbs the irrationality (Walkerdine, 1992) of the structure of the health services. The role of the individual, both client and worker, seems to be determined very much by the epistemic casting of the dominant medical model.

The role delineation seemed to be such a powerful factor in the development of norms and hegemonic practices because the workers seemed to believe themselves as unable to challenge the status quo. Their role as an individual within this medical model was to learn how to accept the situation and respond appropriately. Many participants talked
about how they had learnt to accept the situation at work and that what was important was how they responded to the situation.

Yeah, it is a lot of juggling. Umm, I guess I just come to work and write up a “To do” list and try and work on the to do list and .. just add things at the bottom, cross things off the top. .. Umm, then I just work, I guess I work out that there is only so much I can do and I do my best – silence 1 second – umm, with what I’ve, then that’s all I can do. I can’t do everything – silence 3 seconds – so I just turn a blind eye or just accept that there’s always limits to what you can do (Alice).

Or is it more important at the moment to let my side drop. Umm, but not really felt disempowered, because to me, it’s been my own decision, my own choice. Umm, and I always think well I can negotiate around this a bit later, but now I can drop it (Alice).

So whatever people do to me is it my choice about how I react to them is my choice. And it’s actually what I’ll be held accountable for later on, so yeah laughs (Alice).

There were many examples of workers learning powerlessness at work. Donna saw herself as a cog in a wheel “And I tried to fight it then and I just got burnt so badly.. umm … and I thought, I’ll never do that again because you can’t change that huge wheel”. In this way, health workers tended not to be active subjects exercising power (Jordan and Weedon, 1995). They were more likely to be subjected to the definitions of others.

Perhaps this could be due to a gender issue whereby the women workers, cast as absent subjects within an epistemology of the medical model, only recognized the ‘masculine’ individual, a rational autonomous being.

Perhaps some indication of how the medical model inscribed such disciplinary norms, such as the workers being subjected to the definition of others, can be learnt from Joan. When talking about the different models in use in the training institution where she was employed, Joan identified that she did not have a background in social justice because it had not been in her training. And that there seemed therefore to be an incongruency
between the idea of a nurse being a compassionate caring worker and the idea of being a confronting conflictual worker.

You know, it’s not in my training and I really annoy her because I don’t have any, I don’t have any social conscience like she does I think. I don’t know if it’s me personally, but you know, ahh it’s not social conscience. Well she talks about, she’s big on advocacy and she loves the fact that students get empowered enough to want to advocate for certain things you know and I thought we weren’t really…advocacy is something that yeah wasn’t really an option for us. You know, it was almost like, well you can advocate for a client but only to this point. Cause when the doctors steps in you do what the doctor says. .. Umm, you know, but if you are going to do this and go a bit further then god help you sort of thing. You are out on your own (Joan).

The authority of the doctor is endowed upon him or her (predominantly him) by the value attached to the knowledge and skills that the doctor has obtained through the training.

The medical model, with its experts and specialists, privileges a certain group of people, mainly upper to middle class wealthy males who then regulate the rest of society. A number of participants identified the fact that the health courses were made up of predominantly white middle class females (Alice, Donna, Gill). In this way, the workers became attached to an identity, through the medical model, that ensured that they played the role they did within the hierarchy. The role of the women health workers was to enforce the doctors’ orders through carrying out the tasks of daily living with the clients, therefore working directly on the body. In this way, the workers became attached to an identity as carers, compassionate carers, but with their own authority that did not allow any room for questioning from people below them in the hierarchy or from clients.

I go from teaching the aged care students who will sit there, take information in, very caring and all that sort of stuff to the community work students that will fight with you. You know they will openly argue with you in the class and I wonder whether just me standing up there being the role, you know introduce myself as a nurse, so they all shut up, you know all that sort of stuff. I introduce myself as a nurse to community work students, they don’t care. You know they couldn’t give a toss. They..you say something wrong and
they’re like, no that’s not right. And it’s really confronting for me to have someone say no that’s not right. What? I beg your pardon (Joan).

The implication here, confirmed by Joan, was that she was a nurse, so how dare she be questioned. The medical model in itself endows the workers with an authority and status that is unlike any other in society.

And I think that starts quite early umm being that in the caring industry conflict is not not dealt with, not encouraged. You don’t criticize management, you don’t criticize doctors, you know. And there’s a, there’s obviously a long history and a lot of literature about that … you know that hierarchy and doctors as gods in the community (Joan).

If the doctors are gods in the community, then all those workers allied to the doctor must also be associated with the prestige that comes from working within the medical model. Whilst the workers could talk about structural constraints such as having too much to do, administrative overload, time pressures, gatekeeping of services, and bureaucratic imposition there was no understanding on their part that this made them into particular type of subjects, or that the structural constraints reinforced a self-regulation and gave structure to their behaviour through self- and other- surveillance, regulation, normalization, categorization, distribution, totalisation, individualization and exclusion (Gore, 1995a). Only one worker was able to identify the effect that these sort of situations had on her body, leading to a kind of disembodiment, whilst others identified the solution of leaving of their chosen field if the conflict became too much. It seems as though little questioning of the status quo is encouraged. Nor is articulation of the issues about the circulation of power encouraged since the workers do not have the language for such an articulation. Such discourse seems to be prohibited within their training as part of the implementation of the medical model.
6.4 CRITICAL PEDAGOGY

This section discusses the lack of encouragement of a critical pedagogy within the health workers’ training. Nearly all the workers acknowledged that they were not able to question the course in which they had participated. The pedagogies legitimized in the health workers’ training are the modernist medical humanist model along with discourses about empowerment, collaborative learning, holistic health, choice and individuals. In effect, this means that disembodiment and fragmentation are legitimized while the rhetoric is about an autonomous, rational, integrated human being. All other pedagogies are being silenced and marginalized.

Power is not discussed, cultural/gender/ethnic differences are not discussed, relationship with self and body is not discussed with the result that any real relationship between other people and self is not possible or only to a certain superficial level. There is a culture of silence about any of the real issues impacting on people at work as exemplified by the relief and enjoyment people experienced by talking about these issues to someone else. There doesn’t even seem to be the language available to people to articulate the issues that were covered in the interview. This means that any sense of agency is lost since the workers are always displaced outside of themselves in trying to be ‘good’ health workers, trying to live up to the norms, and continually being involved in self-regulation and self-surveillance. It seems as though the best the workers can do is come to some sort of acceptance both of self and of the situation. Just as the clients they see may not have a
choice in their behaviours, neither do the workers seem to have a choice about being critical either at work or in their training.

To be successful at work means that in fact you don’t question the norms. Mary had the view that to be successful, one needed to believe emphatically in what one was doing.

To be successful in psychiatry there, I think having a conceptual framework and believing in it, being able to intellectualize and have that understanding of whatever the medical system has at the moment of the brain and psychiatry and so on. If you really have that theoretical framework and believe it, then you can do this thing of categorizing people and giving them labels and giving them medications and you know advising treatment. I guess my problem is I don’t believe laughs and that’s where I have the issue.

Umm, yeah its about believing in what you do. I think the people who do really well, really believe it, they really apply it and in that way it works. People know where they stand, they have got a position, they have got a diagnosis, they have got a plan (Mary).

The power of the positivist paradigm with its reliance on abstract frameworks is seen as a means of successfully enforcing the status and prestige of the profession.

Mary went on to say how the psychiatry training was set up to produce people that were punishing themselves and their protégées; the examination and training ended up being so exclusive that only the most driven people, perhaps, were able to get through. And all this was never allowed to be questioned “I mean, we never look, we never questioned the way it was done, it just was the way it was done” (Mary).

So we didn’t analyze the way it was done at all. It just seems to be so it’s a tradition that’s entrenched, it’s the way it is and so much revolves around that now, that if you started questioning that the whole thing would crumble down.

But I don’t really think that they are examining what it is that they are teaching or the way that they are teaching it. It’s just the way that they are assessing it that has changed a little bit. And the teaching is that, you know, you’re the psychiatrist, you’re the expert, you know the best. .. Yeah, that the psychiatrist is the expert on what’s going on in this
person’s mind. And that they have the limit, they know what’s psychosis and what’s reality and they know where the lines are, I mean they allow a bit of greyness sometimes, but pretty much if the psychiatrist says you are mad, you are mad. .. And that’s the bit that really gets me laughs .. It does, it’s just so not okay (Mary).

Mary is talking about the power to define others giving health professionals the power to define the ‘truth’ (Weedon, 1987). The sense of this is so strong that in the meeting place between health professional and client or patient there is no room for consideration of differing or multiple realities.

The same view came across in the interview with the worker from the tertiary institution. Here was an expert on all the nutritional information but there was little room for greyness or an understanding of the cultural issues that might affect a potential client. With comments like he wanted the students to be empowered by having a full scientific understanding of their discipline so that they could then order blood tests, in other words access the health system without the doctors’ permission, he was more interested in exerting technologies of power than encouraging critical pedagogy. His understanding of cultural/gender/ethnic issues were that the university was “exceedingly sympathetic to people in need” (Tom) and that in fact males were discriminated against by policies designed to encourage participation of traditionally disadvantaged people. He thought that in many instances, students were mollycoddled and that to get anywhere within the university system, one had to be a lesbian. His views on a foundation unit at another university were that it “is atrocious, absolutely atrocious and it’s a women’s lib unit, yes, it’s a women’s lib unit” (Tom). Here again there is reinforcement of the view that his graduates should be experts in their field but the reality is that any policy or practice that encouraged a critical analysis or reflective practice was definitely not part of the agenda.
With views like this, one can imagine that a critical pedagogy would not be legitimized. Such norms were transmitted through a pedagogy of fear, shame and embarrassment (Louise, Alice).

Umm, I guess we were always, umm, some of the lecturers would say, were always saying, you know, if you’ve got any questions then come to me. I tended to be a bit of the umm – silence 2 seconds – the shyer type who didn’t like going and asking questions. And the only time I did, she said “I talked about that”, so she didn’t actually answer my question, so I didn’t ask anymore questions from that laughs (Alice).

From one extreme of a student never asking a question again (in a four year course), there was another extreme of students being left to their own devices and the lecturers passing critical pedagogy off as a reason for leaving the content unstructured and the students responsible for finding out.

Cathy’s view was that the lecturer’s tried to make them think for themselves “and to do that they basically didn’t give us very much resources laughs”.

In terms of critical thinking, so, did they, did they umm, encourage us to think for ourselves. We had to! Laughs We had to! Umm, we had to in the end. I mean, it was like we have got no two ways about it. Umm, probably too much so in my degree.

Umm, they could have made us feel a little bit more secure about our profession and not, because once, when you’re that critical about it, a lot of people, a lot of the students dropped out, because they were just so stressed about it. There’s no umm, there is no right answers in the discipline (Cathy).

It seems as though the students were not supported in their endeavours to be critical about their work, with the emphasis instead being on self-reliance and greater self-regulation which actually worked to foreclose possibilities of agency.
One worker had an understanding of the complexities of working with other people but this was not from her training. It seemed to come more from her experiences post graduation.

But what came out of that was umm, to me was, you can’t you can’t come from a middle class white privileged background and think, even begin to think, you know what those people want and need (Donna).
How do we, how do we start to umm, learn, how do we start to just ask them, I can’t even say work with them, because I mean, how do we, how do we start asking the questions of them that might enable us to work with them (Donna).

This discourse is so different from the discourse around empowerment, which was done to and for the people. Instead the worker recognized that it was the workers that needed ‘enabling’ to work with other people.

A couple of workers (Emma, Fiona) believed that they didn’t know enough at the level of undergraduate training to be able to ask questions but thought that would have been encouraged.

But when you’re in the middle of your training you can’t actually see so much what’s happening and where it’s leading to. You just, you just do it yeah so (Emma).

At that stage, umm, not really, not at that stage, no. And to be honest, I didn’t know enough to be able to ask I don’t think. .. You’re just so busy trying to take it all in. .. And I know, I can’t remember one of the subjects, I hadn’t done at school was completely new and it was like, ahh, a new language. .. Yeah, you know, just trying to get your head around that, yeah. To be able to question or ask, no, and I don’t think that would have been my generation anyway (Fiona).

Other participants (Gill, Hanna, Ingrid) agreed with the view that you were there at university to learn to do it right and not critically think and reflect on what you were doing during your training:
I don’t think so. Never, I don’t think ever. I think I had to learn that recently. .. But I do think that they’re trying to do that like now, you know, you ask a student how they think they have gone or how they went in that particular thing. I mean gosh umm, think about what you have just done, struth, you either did it right or you didn’t do it right and if you didn’t do it right you knew all about it (Gill).

When I was training we certainly weren’t encouraged in critical thinking. .. But the students are now and we all are too. But that’s life, you know generally speaking things have developed that way (Hanna).

Here, critical reflection has become subverted to another form of self-regulation and self-surveillance, a view supported by the two recent graduates (Polly and Veronica).

The ability to be critical or not depended on which lecturer the students encountered (Cathy and Katrin). Some were more of the ilk that their status gave the students no room to ask questions as also described by Joan.

Umm, that varied across the lecturers. We had some very good lecturers who did. Who really encouraged you to know things, not just to rote learn it. .. Umm and other lecturers were “I’m the lecturer and this is what is” you know you were just students. So there was a real mix of both ... umm ... as we went through and I am not sure if that has changed now or not. Certainly when I went through umm a couple of the really good lecturers had gone. Umm … under not such good circumstances. But yeah there was that mix (Katrin).

It seems that the training has not been a site for transgressive pedagogies and practices within the field across all different types of health workers. In fact, what the students seemed to have learnt overall was how to become particular types of subject (obedient docile bodies) and how to translate this onto the people that they saw as clients. Forms of resistance such as approaching the clinical work with the clients in a model that was neither the expert clinical model nor the medical model really only seemed to have come in later on in people’s working lives for a few (Donna and Gill).
The silencing of any other pedagogies means that what was known and taught about health and the body was limited, fragmented and always centred around the pathological causal problematic. The individual was seen as important as being the site of the problem but there was no engagement with the political or structural constraints – the body was just a vehicle for either pathology as a client or as a worker ‘to do’. The body was not involved in the discourse as a possible consolidation of a sense of self (Niranjana, 2001) or as a container for experiential integration (Nathanson, 1992). There was no consideration of the contingencies associated with health and well-being and no consideration of what it means to be an individual or of the rhetoric around choice. In this way, the official curriculum seems to foreclose possibilities of agency to health dilemmas even though it speaks of the individual’s responsibility, control, choice and empowerment. All this serves to mask the relations of power. The official curriculum in fact works to undermine all these aspects since power is never mentioned, and the client would tend to be addressed by workers who could be suffering as a result of working in a system that precipitates fragmentation, chaos, crisis and displacement from one’s self. Since the individual is such a preoccupation, in one sense, for the official curriculum, this issue is further examined in the next chapter as a possible site for transgressive pedagogies.

6.5 Summary

The training of the health workers is based on a positivistic transmission model of learning with an imbalance in power relations favouring first the pedagogue/expert, then
the health professional, and finally the patient or client. The shortcomings of this are that health workers are not encouraged to embrace critical pedagogy and so have a limited availability of subject positions. They tend to be docile workers that focus on what they have to do to the exclusion of all else. Internally they show high degrees of self-policing and self-surveillance since ‘critical’ pedagogy has been misunderstood and mis-used to focus on the workers’ performance alone. Health workers were likely to be subjected to the definitions of others. The authority that their role gave them was translated into a sub-text that no conflict was allowed. The point of subjugation seemed to be in their understanding of what it meant to be an individual in relation to health – one who exercises responsibility, control, choice and empowerment. These concepts masked the relations of power.

However, the official curriculum tended to undermine these concepts of control, choice and empowerment paradoxically producing fragmentation, chaos, and crisis in the health services and displacement from one’s self along with disembodiment, rather than the certainty and order of positivism. These ideas will be discussed further in Chapter Seven. Critical pedagogy does have a role in challenging current understandings and enactsments of power in health. But care must be taken not to re-inscribe workers in similar relations of power. In the enactment of the curriculum, fear, shame and humiliation seem to be the main emotional levers to encourage the workers to (willingly) collude in their own oppression.
Critical pedagogy runs the risk of continually being co-opted to maintain the status quo. Critical pedagogy has been used as means of subjugation whereby the workers internalized heightened self-policing. Critical pedagogy has helped me to name training issues that are constitutive of power relations and thereby reduced the invisibility of these issues. Participants enjoyed talking about these topics which are not normally mentioned in their everyday working life so some of the silence was broken down which participants found helpful.

Overall health professionals seem to struggle with issues of choice, empowerment and control. They seem to have developed a particular sense of self which is bound up with notions of self-policing and self-regulation or balance. This particular type of relationship with the body/self along with the medical hierarchy and authoritarianism of health services (O’Grady, 2005) seems to overshadow the therapeutic results gained within a health environment and diminishes the potential job satisfaction available to the workers. There is a slippage of self in terms of conformity, obedience and compliance. This phenomenon forms a paradoxical relationship with the medical model rhetoric of autonomy, control and empowerment and the positioning of health professionals as experts in the field of health. These results highlight the limitations of the positivist model of health service delivery that enforces the dominant notion of the neo-liberal individual. The emphasis on ‘doing’ that tends to disadvantage the mainly female health workers seems to produce a form of disembodiment at work. The three facets of the health service (authoritarianism, medical hierarchy and a particular type of relationship
with the body) producing an emphasis on doing will be discussed and expanded on in the next chapter. Suggestions will be made for an alternative curriculum.
CHAPTER SEVEN

Reinscribing the professional self through the ‘sea’ of critical pedagogy

7.1 Introduction

This thesis has explored the enactment of the curriculum for health professionals and the impact this has on their professional practice. The different theories in use in the education and health fields have been described and the dominance of ‘predictive’ learning theories noted. Such theories try to predict a learner’s behaviour through such concepts as control and choice. Discrepancies have been noted in the use of the dominant construct of control in order to learn or be healthy, alongside the construction of a learner who is passive and compliant. Inequities in power have been noted with the teacher/health professional assuming a position of mastery over the object: the student/patient/client. The self, whether that of health professional or client or patient, is generally not included in the learning process.

The methodology built on the idea of including the self in the learning process through reflexivity and the analysis of case studies. Data gained from the case studies revealed practices wherein the subjugation of women health workers was inscribed through discourses on manual handling, public health and the curriculum of a therapy assistant. The interview data has been presented through a testimony of how the workers came to
understand themselves as health professionals and how they came to an understanding of health and well-being through the enactment of the health professional curricula: the how of the curriculum. The workers were heavily invested in discourses about control and choice and seemed to be engaged with their own self-policing. There was a focus on ‘doing’ with little room for reflective practice and there was minimal acknowledgement of relations of power. Thus the health professionals’ selves are learned identities characterized by an absence of relational pedagogy, an absence of reflection back of their subjective experience (i.e. mirroring) and a lack of acknowledgement of and little awareness of the need to challenge relations of power alongside the assumption of a position of power/knowledge with regards to the client or patient.

As a consequence the practice of the implicit or hidden curriculum has been formative in the (unconscious) construction of how the health professionals do their work. A particular kind of self has been inscribed. However, there are possibilities to resist this kind of implicit curriculum, and the construction of the health professionals’ self does not have to be in this way. The use of the word ‘sea’ in the title of this chapter is a deliberate play on words because while Foucault emphasized the power of the Gaze (1973) i.e. to see, in constructing the type of self-policing (surveillance) that is evident in the health professionals’ work, the whole body is included here in the discussion of the construction of the self as a form of resistance. The notion of ‘sea’ requires an immersion in something: in this case, the pedagogy: and I am suggesting that there is a different way of being for health professionals that could complement their current practice. But, saying
that, I am wary of generalizing any suggestions because I am all too conscious of the limitations of this study.

While this thesis analyses the current practice of a few health professionals and has been useful in elucidating themes of the implicit curriculum, it is limited in that it took place in a particular context with a very small number of health professionals across rural W.A. The research took place in the context of a model for health professional training that has evolved with an emphasis on risk management and the prevention of ill-health (AHWI, 2007; Peterson and Lupton, 2000). The thesis is therefore grounded in western constructs, even though the population in the areas where the health professionals practiced included a large proportion of Indigenous people. The thesis has been shaped by my own experiences as an educator, as a health professional and as a person living in rural W.A. and also having had the experience of living and working overseas. I have been researcher, health professional, participant and an educator. Therefore my own subjectivity has informed the practice of the thesis and the writing of the self through the text.

My own subjectivity has a particularity to it and this has informed the writing of the thesis. One of the qualities of this research and thesis is that it “links particulars without dispensing their particularity” (Nussbaum, 1990, p. 78 cited in Galvin and Todres, 2007, p. 36). I have been researching a way of knowing that fits for me and this has meant linking education and health through critical pedagogy with an embodied sense of reflection. This thesis demonstrates the complexity of interconnected imaginative
presence through rhizomatic imaginative thinking – a multiplicity of felt connections (Galvin and Todres, 2007) even though it is limited in its generality.

The particularity of this thesis, which has evolved over the years, is partly a consequence of my own experiences. While this limits the thesis, it is interesting to note how my own experiences resonated with the participants; the training they experienced had the same ideological base as my own even though they trained in Australia (for the most part) and I trained in the U.K. Similar authoritarian structures were in place in both health services. I also think that personally I am attuned to noticing absences even though these are often harder to identify and put into words than other more overt contingencies. My attunement to absences has led me to become more aware of self-policing and I think that this has guided me in deciding what to include in this thesis and what to leave out. For me, absence is related to heightened self-policing – I have wanted to explore technologies of self that form the inner domination and power relations as much as the outer in the formation of self.

This research showed health workers struggling with the expectation that they be ‘in control’ while at the same time feeling out of control. Discourses on control seem to produce and/or construct absences and constraints. These points will be discussed in the following sections in relation to the three main characteristics of the health professional education described above – an absence of relational pedagogy, an absence of reflection back of their subjective experience (or a form of mirroring) and the lack of acknowledgement of and little awareness of the need to challenge relations of power.
alongside the assumption of a position of power/knowledge with regards to the client or patient. Bearing in mind that discourses on control accrue further privilege and advantage to white health professionals whilst at the same time continue to disadvantage others such as Indigenous Australians (Riggs, 2004), surely the time has come for health workers to ‘come clean’ about the construct of control and admit that they do not ‘have’ it anymore than anyone else does.

7.2 Absences

I am going to discuss the three absences – an absence of relational pedagogy, an absence of reflection back of the health professionals’ subjective experience, and the lack of acknowledgement of or challenge to relations of power – in reference to the participants. These three facets are linked in that the role that the ‘expert’ health professional is expected to play is to provide information on health in an authoritarian manner usually without regard to the relational aspects of the meeting place or the information, in other words without regard to the how of curriculum. The discourses on control and choice seem to produce absences and constraints – there is a relation between these constructs.

Health professional education takes place in a society that valorizes control (Riggs, 2005). Therefore the absences and constraints revealed by the health professionals’ responses to the understanding of their health and well-being and by their experience of health professional education makes sense in an environment that is dominated by constructs of control, choice and empowerment or autonomy. In such a context
performing control in an individualistic sense cannot help but be associated with relational absences and structural constraints.

In the binary of autonomy – affiliation the first term is valorized over the second in health professional practice. That is autonomy is seen as the most important characteristic of the individual self and anything preventing autonomy is seen as outside the self (Usher, Bryant and Johnston, 1997). Therefore participants could speak of the lack of relations in their workplace and demonstrated a lack of connectivity between the elements of their practice. These absences are then associated with constraints. There were the constraints of limited subject positions and roles for the health professionals to perform. The absence of critical pedagogy is associated with reflective practice constraints or reflexivity. Reflective practice seems to be limited without critical pedagogy, as reflexivity becomes subverted into another form of self-policing. This heightened self-policing, in the absence of critical pedagogy, is manifested as a preoccupation with ‘doing’ as described by the participants.

The preoccupation with what they had to ‘do’ was so strong in the majority of the participants that when asked about relations of power it seems as if the workers could not consciously engage in discourses about power. Almost as if there was an aversion to discussing power or a wish not to see “Aww, this is too hard” (Jill). Instead they could only engage unreflexively in what they had to do. Poststructuralist accounts of practice may employ words performativity, perform or performing instead of ‘doing’ in an attempt to acknowledge the context and role playing that takes place with learned
identities. However, performance also carries connotations of some kind of witness or audience to the performance; for example, reflexivity in critical pedagogy or the gaze. Instead, ‘doing’ has been used in this thesis to denote unreflexive performances that centre around discourses of control. In order to note this constraint, the words unreflexive performativity will be used. This constraint in health professionals’ practice is suggested by the absence in relational and critical pedagogy.

Employing the words ‘unreflexive performativity’ seems to be a harsh indictment of health professional practice. The intention in using these words is to draw attention to the emphasis on the practice and action part of the reflective practice cycle, for example, that health professionals seem to be engaged with. The overemphasis of performativity at the expense of the reflexivity could account for the theory/practice disjuncture stated by the participants as the difference between what they say and do. The emphasis on doing means that women have to continuously negotiate what they believe they “should do” to meet expectations and demands, with what they felt they “could do” to work within constraints and resources with the consequence that self-care was often left out of the equation (Kushner, 2005, p. 74).

Being caught in a cultural contradiction between the institutional ideals of a good worker and the good carer can produce invidious positions for women (Kushner, 2005). In a paper discussing embodied context and working mother’s health decision making, Kushner (2005) describes the ‘hurried woman syndrome’ whereby women become medicalized with attention to antidepressant prescriptions rather than health promoting
strategies to address systemic pressures on women. These comments could apply equally well to the participants in this study. Being caught up in existing patterns of thought and or doing may not always be a choice for health workers – reflective practice is only as effective as the level of awareness that a worker and institution brings with them. In such a situation, contemplative thinking or being with their practice (Galvin and Todres, 2007) may not be possible. If workers have not had their subjective experience reflected back to them, then they may not have the opportunity to reflect further on their situation and may remain caught in an invidious position.

The lack of reflection back of the participants’ professional practice seems to also work at the practice part of the theory/practice disjuncture. These aspects of professional practice can only be surmised because of the absences revealed by participants’ responses. Participants seem to have accepted fully as part of their practice the discourses that centre on control. It is they “who haven’t found the right button to push yet” (Ingrid) in relation to their own health. Health becomes a matter of button pushing with mechanical beings, requests for self-governance from the outside (Gastaldo, 1997), and a way of managing how people have been positioned by others (Riggs, 2004). Health becomes a practice of self that is about being a dutiful citizen (Petersen and Lupton, 2000). These ideas – of absence, constraint, and control – will be further explored in the following sections. I hesitate to use the causal problematic by saying that absences cause constraints or vice versa because it seems that these are all contingencies that circulate like technologies of power and domination in order to manage the void associated with the economic models employed by neo-liberal rhetoric. Like education, the ‘loss of control’ and
bureaucratization in health has created a growing problem of alienation where people (health professionals and clients or patients) increasingly find themselves in situations ‘void’ of meaningful human contact (Bingham and Sidorkin, 2004, p. 6).

I will first state the constraint followed by participants’ comments in relation to that constraint and then I will suggest ways in which this limitation could be responded to. Underpinning this section is the assumption that the work of health professionals does not have to be this way.

7.2.1 Absence of relational pedagogy

Health professionals’ experiences suggest that there is a notable absence of relational elements in the pedagogy, which results in a lack of consideration for what exists in the shared space between the two groups of participants – health worker and client or health worker and health worker. There is a lack of consideration of the relational aspects, whereas Bingham (2004) suggests that “each aspect of education needs to be rethought in its relational particulars” (p. 23). The relational components can be thought of as the relation between epistemology and practice, the relation between knowing and doing, the relation between thinking and saying, and the relation or congruency between what the health professional says and what they do. As in education, the dominant pedagogy in health is atomistic, individualistic and treats the single learner as a disconnected individual (Bingham, 2004). The relationality of authority is not considered in terms of
the gap between health professional and client or patient, or even between health professionals.

The gap could be seen to contain facets of the experience such as the discounting of the professional authority by the client or patient as a consequence of a lack of empathy and a lack of responsiveness to incongruency between advice and behaviours. The gap could also contain issues of control and positioning. By considering control as a relational construct (Riggs, 2004) a different perspective on how health professional practice is informed and enacted may emerge. The lack of connectivity in the health professional curriculum may result in a lack of connectivity in professional practice – between health professional and client as well as between health professionals.

For example, Polly appeared to be an isolated body wandering along the wards, “the position that you’re supposed to fill that no one tells you about.” Polly wanted to be positioned as a new graduate and wanted that in a form of relation: “Like you think you are just going in to do your job, but really people expect you to do this and not to do this and no one tells you those things you just have to kind of figure them for yourself”. Where selves are considered as knots in relations of power (no relation, no self – Bingham and Sidorkin, 2004), then Polly’s position could be seen as a lack of connectivity, embodiment and self since there is minimal engagement with her being.

Louise, a nurse educator, was well aware of the lack of relations in health professional practice. She described the changes that had taken place on the ward as reducing the
opportunities to converse and debrief. “There’s a lot of dislocation now you see … that you look after those patients so you are solely responsible for those patients. All you’ll do is speak to another staff member if you want to lift. Help with a lift.” The neo-liberal emphasis on productivity and efficiency has produced structural or institutional discourses and policies that limit relations. The discourses on manual handling are concerned with self-policing, so it is interesting that Louise saw that the only time one staff member might talk to another is when help with a lift (i.e. a form of self-policing) was required. Further evidence of the lack of relationship is when Louise stated, “nobody said hello to me when I went to work in that first ward. Umm. I was just another body that came in.”

Joan sounded indignant and outraged when she talked about the lack of relation between workers’ professional practice and themselves as embodied beings: “You wouldn’t have news headlines if you didn’t have umm if you had people that walked up and said you know are you okay? .. You know, just that are you okay? And I mean it’s such basic stuff.” Joan seemed to be referring to cultural factors that limit relations. Joan came from a nursing background and was at the time of the interviews working in a tertiary education institute. It is poignant to think that Joan stopped work as a nurse because she saw her health anxiety as stemming from what she believed was her over-developed sense of empathy. In other words, Joan’s exceptional ability to be in relationship with people made her feel inadequate to carry out nursing tasks.

And you can get quite anxious about where your boundaries are and things like that so, I mean they’re not healthy ones at the moment anyway, they’re unhealthy. … Well like you know, I won’t go and work in a hospital because I don’t have the confidence to be able to look after someone really well. Umm so I stop myself from doing it, you know and I don’t think that’s a healthy boundary, because that’s what I’m trained to do and I think I can look
after somebody but I’m just so, it’s … but there’s a big there’s a big wall there. … I don’t know what that’s all about. And that directly affects my, you know, my … my health, my well-being, because I don’t feel good that you know, I don’t feel good about that. I’d rather be able to do that you know. I think I would have a lot of confidence in being able to do that. So yeah, it’s fascinating.

I have included this quote at length because I believe it is very pertinent in the current crisis in health care and the retention of staff (WHO, 2006). I think many health professionals including myself leave health care work because of the presence of a “big wall” and because so little is known about that big wall.

Evidence of the lack of consideration of relations between what health professionals think or say and between what they do included the comments made by Tom, Alice and Cathy. They experienced the research interviews as therapeutic because they had the chance to talk about issues not normally talked about and had gone deeper than usual into these issues. “These kinds of questions are things that we, probably each of us every one of us think about individually but we never voice the … And we think about them in our mind and they churn around and they’re huge life issues” (Cathy). There is a reference here to the individualistic nature of the health pedagogy. The usual practice for health professionals is not to talk about their practice often because of a fear of being seen as inadequate or feeling shamed as a result (Veronica). Katrin stated: “At the same time I had chosen to move away from my friends and family. So normally you would have them you can go home to and cry and go I don’t know what I am doing. .. And you’re up here and you go mmm the only people I can talk to are my workmates and I don’t really want to say that to them.”
The lack of consideration of the relation between what they do and what they know is shown by health professionals when they experienced confusion in relation to their work but were afraid to voice this for fear that they would be perceived as ‘not coping’. Health professional staff did not want to be seen as not coping – they would prefer to leave (Gill, Donna, Fiona, Joan).

I don’t think nurses have another way to cope or don’t know any other way to cope with what they go through. So they literally have to shut down and turn off and you know and just do what they do and I mean otherwise it’s hard, it’s a very difficult place to walk. I mean if you want to teach people about empathy can you go too far? Where I’m at a stage where I think I have gone too far (Joan).

So in effect, the health workers were in a double bind. They tended not to want to talk about their practice with co-workers for fear of being judged negatively but not talking about their practice limited their ability to cope at work. Perhaps the participants enjoyed the interviews so much because they had a chance to talk about their practice without feeling judged. This meant that they could be in relationship with their practice.

The lack of relation between what health professionals think, know and do, as embodied beings, with themselves, with co-workers, with clients or patients and with their practice meant that the health workers’ practice was constrained. This could make life at work very difficult for health workers. Coupled with the evidence of the lack of reflection back of the subjective experience of health workers (discussed next) a practice is produced that is under severe constraints. Before going on to discuss the possibilities to resist these constraints, I would like to frame that discussion in terms of a metaphor I have found useful for thinking about the different parts of health professional practice.
The metaphor builds on the quote from O’Grady (2005) outlining the three facets of health care delivery – authoritarianism, hierarchical power and a particular type of relationship with the body – that need challenging. The metaphor is designed to highlight the role of education in the construction of self of the health professional and the relations between the different facets as discussed previously.

Metaphorically I see the phenomenon of the positivist model of health with its origin in patriarchal colonial theory making, or the masculinization of knowledges, as going hand in hand with an absence of the constructed feminine or more relational ways of knowing and practice. Historically, these parents, the absent mother and the patriarchal epistemological father, have produced a child – health service delivery – that is in severe distress and neither parent knows how to ‘be with’ that child, that is, they do not know how to reflect back the subjective experience of health care in their professional practice and have little consideration of relations between epistemology and practice.

Reflecting back the subjective experience of health professional practice could be seen as a form of limbic resonance (Lewis, Amini and Lannon, 2001). Limbic resonance is said to provide a stabilizing effect where balance is achieved through relatedness. The importance of relatedness is acknowledged:

Because our minds seek one another through limbic resonance, because our physiologic rhythms answer to the call of limbic regulation, because we change one another’s brains through limbic revision – what we do inside relationship matters more than any other aspect of human life (Lewis, Amini and Lannon, 2001, p. 191 – 192).
Relatedness is physiology, self-regulation develops through relationship and the power of healthy relatedness cannot be understated. It seems that some form of distress in any health service is inevitable as being ill can be a distressing experience. Likewise working as a health professional can be distressing as evidenced by the participants in the study (Alice). Being in relationship with that distress and providing reflection back in the form of limbic resonance stabilizes and regulates the distress. It is suggested that being with the subjective experience of health professionals’ practice is an important part of future developments in health professional education.

‘Being with that’ (Todres, 2008) is an emerging form of ontological practice in healthcare. Todres (2008) seems to be describing a form of limbic resonance with his suggestions for an embodied relational understanding of professional practice. The textured qualitative research findings from such an understanding produce judgement based care. There is a linking here that includes both subjectivity and objectivity in an epistemology that is also ontological. The limited exploration of the relations between epistemology and professional practice could contribute to the distress experienced by health professionals, and to the global crisis in health care at the moment (WHO, 2006).

Discourses that centre on control and ‘doing’ in an objective, clinical, detached and evidence-based manner at some level cannot help but produce distress because the ontological part of health care is missing. The episteme has both constructed and pathologized the feminine thereby banishing ontological considerations of health. Figure 7.1 shows the three aspects of health care delivery that need challenging and inserts the
constructed self at the centre – the participants’ preoccupation with ‘doing’ or unrelexive performativity. It is the first part of the doing – being binary that is emphasized in a neo-liberal productivity focused form of health care. Distress is a natural outcome of not being able to be in relation with parts of ourselves and can contribute to chaos on an inner and outer level. Baum (2007) alludes to this when she mentions that health professionals are working at the edge of chaos. The banishment or exclusion of an ontological practice of health service delivery means that health professional practice prioritizes ‘doing’ as mentioned by a number of participants and shown in the figure below.

Figure 7.1: Subject formation through positivist rhetoric in health worker education

This situation determines what can be known about health. At present the subject of the health professional is constructed by a particular type of relationship with the self (self-policing), authority and the medical power or hierarchy. These aspects were revealed in participant responses as well as by O’Grady (2005). The health professional’s self circulates around the institution captured in a web that determines ‘how’ they move, so
that they constantly focus on performing with an air of authority that befits a wielder of
biopower. Archetypal images such as the ‘bustling nurse’ fit with Louise’s explanation
of how as nurses they always had to be busy otherwise they would be seen as lazy: “And
if you’re not flat out, people look at you as though you are being lazy.” Images and
attitudes constrain practice as much as epistemes and authority. In order to understand
the fuller picture or meaning of professional practice, images and metaphors can be
drawn on in such a way as to be in relation with the situation and this is demonstrated in
the following paragraphs.

The metaphor used above illustrated how the parents of such a service and training – the
absent feminine and the patriarchal colonizing epistemologies – have produced a
distressed child in the form of the health professionals’ work in the institutions. The
parents are not able to ‘be with’ or engage with the child, that is the parents cannot reflect
back or mirror the health professionals’ subjective experience in the context of their
practice (there are not the epistemological discourses to achieve this), and so the health
professionals have little recourse to anything else but to police themselves. Furthermore,
the ‘child’ has an imaginary ‘other’ that is invisible but that is a vital part of the
structuring of health care and the health professionals’ self. This invisible ‘other’ is the
shadow or opposite of or all that is abject from the white middle class colonial
epistemology (the binary structuring of the self – Usher, Bryant and Johnston, 1997). In
Australia this could be seen as Indigenous health. To add to the above diagram, I now
include the parenting metaphor to flesh out the effects of the neo-liberal context of health
professional practice on subjectivity and provide examples of relations of power.
These diagrams demonstrate the current constraints within which health professionals are working and under which they have been trained. There is an absence of relational pedagogy, an absence of reflection of the subjective experience and a lack of acknowledgement of the existence of and need for a challenge to power relations. There is a denial of the complexity of the factors involved in health service provision and of the complexity of health itself.
However, there are possibilities within this framework. For example, a relational pedagogy that acknowledged relations of power within the training and therapeutic encounter or meeting place of the health professional and client would go a long way towards addressing the current isolation experienced by some health professionals. To make a relational pedagogy the emphasis in health education would mean that health professionals were allowed to be more in relationship with themselves and clients, and be able to study the gap between health professional and client. Making relational pedagogy part of the training gives workers permission to engage in the activity. This is in contrast to the biomedical model where the emphasis is on science and being clinical, detached and objective – “You had to be able to measure” (Alice). If a relational pedagogy was made part of the curriculum, the subjectivity of the worker changes to emphasize more of the being of both the worker and client or patient.

If Bingham’s (2004) advice about rethinking each aspect of education in its relational particulars is followed then a pedagogy in health that encouraged relations would also include the exploration between what health professionals say, think, know, do and be. The relations between health professionals as embodied beings and their work could also be explored in this revised curriculum. It is necessary to keep an eye of the workings of power itself (McLaren, 2002) as any pedagogy cannot be only liberatory; it will also have the potential to be oppressive (Gastaldo, 1997).

Relations could turn out to be the next oppressive formation or territorialisation (Fox, 1999) if issues of incommensurabilities in culture, access and voice prevent relationships
occurring. For example, incommensurabilities in culture, access and voice can potentially prevent relationships occurring or occurring on common ground (Riggs, 2009). Furthermore, relationships may be refused by those in marginal locations – it is important to recognise the rights of people to not enter into mutual relationships of recognition (Riggs, 2009).
In this curriculum, subjectivity, technologies of domination and power, and discourses triangulate to produce a construction of the self by analyzing or foregrounding them. Thus the health professional is able to allow a focus on being and meaning in the relationship between the health professional and client or patient. The role of relational pedagogy will be expanded upon further in the next section (7.2.2) when I discuss the second main absence – the lack of reflection back or mirroring of the subjective experience of the health workers’ professional practice.
7.2.2. Absence of reflection back of subjective experience

The absence of reflection back of subjective experience is related to the lack of relational pedagogy just described but goes beyond relational pedagogy in its nuances. It seems to be worth teasing out the intricacies of reflection and relation as these facets seem to be at the heart of the meeting place between the patient or client and health professional. Consideration of reflection back or mirroring of the client’s position places the client or patient at the centre of the meeting place. Reflection back of the client or patient’s subjective experience in patient-centred care, and reflection back of the health professional’s/learner’s subjective experience in student-centred relational pedagogy is argued to be one of the most important aspects of health education.

A brief discussion on what is meant by reflection back of the subjective experience follows. The subjective experience of a person or subjectivity has been the subject of many feminist critiques and poststructural debates. Whilst a full representation is not included here, the point is made that the social self that is relational and situated within specific historical and political circumstances requires acknowledgement. It seems as if some of the debate on subjectivity has dismissed the subject and subjectivity because of the constructed nature of subjectivity. However, this line of thinking seems to be more in alignment with neo-liberalisms’ emphasis on rationality and reason as being the only firm basis for knowledge generation and legitimation. If the body is taken as central for thinking about subjectivity then some reflection back of that embodied subjectivity is required in order for embodied reflexivity to take place:
There is a certain tension in Foucault’s work between the body as an effect of power and the body as a source of resistance, which some have claimed as paradoxical. I have argued that Foucault offers a variety of ways to think about the body – as material, with a history, interpreted through discourses and power, with the ability to self-monitor and self-regulate, and as capable of resistance through producing counterdiscourses (McLaren, 2002, p. 114).

There are a variety of ways to be in relationship with the body. Section 6.2.5 (Embodiment and the juncture between human agency and structural constraint) discusses the four different ways of engaging with the construct of the body based on Fox’s (1999) analysis. However, there is a gap in this work on relations and the nuances of the poststructuralist self. Unless some attempt is made at relations through techniques such as reflection back of subjective experience then there will be no relationship and the body will remain in a modernist and postmodernist void: the modernist void of valuing reason and rationality over all else and the postmodern void of dismissing subjectivity as merely constructed.

Reflection back of the subjective experience of a person requires another person as well as relations. “Neither the object nor the body have integrity in the sense of being ‘the same thing’ with and without others. Bodies as well as objects take shape through being oriented toward each other” (Ahmed, 2006, p. 54). Reflection back therefore problematizes the notion of the ‘individual’. It seems to be most important because the subjective experience is the level at which health behaviours operate and where ‘control’ is used as a way of managing how one has been positioned by other people. By reflecting back on this aspect of experience, control can then be explored as something that is constructed in relation as part of a way of managing subjective experience. Health
professionals who tell clients or patients how to be healthy without acknowledging and taking account of their own subjective experience of being under control are just providing information in a non-relational controlling manner. This practice is itself a reflection back of the practices of health professionals’ education.

As stated above, reflection back problematizes the notion of the individual. This point acknowledges that we compose each other – the compossibility (Venn, 2002) that occurs in the meeting place between two people. Reflection back of the subjective experience acknowledges that we are known in relation and that knowing is a relational construct (Lewis, Amini and Lannon, 2001). It is a shared understanding that constructs each other and can be seen as part of the enfolding (Venn, 2002) and or internalizing (McLaren, 2002) of the structural or contextual that takes place in relation. Feminist critiques acknowledge the interplay between outside and inside (McLaren, 2002; Butler, 1993; Usher, Bryant and Johnston, 1997).

Reflection back of the subjective experience requires others to be in relationship. The second point to be made here is that reflection back of the subjective experience is a different form of communication than just verbally repeating back the content of what someone has said in a parroting fashion. Reflection back means showing that the health professional has understood the context of the patient or client, and that the educator has understood the context of the practitioner/learner. There is attunement and resonance with each other on a bodily level well as verbal. Health professional practice may be seen as requiring more of an approach like this because health can be seen to be a more
personal experience than education. Taking into account a person’s subjective context does not usually occur in health professional practice where the emphasis is on individual behaviour change. The person’s contextual subjective experience tends to be over-ridden, as a health professional can plough on dispensing advice without regard to the circumstances in which they operate.

Reflection back of the subjective experience of clients or patients does not occur in the professional practice of the participants interviewed. Polly stated that she just did not understand why people could not walk ten minutes a day. And while she maintained her professional demeanour by not showing this to the patient, her lack of response to the patient’s subjective experience must have been noticed by the patient to some degree.

At some level the client or patient will feel wrong or at fault even if nothing is said to this effect. The lack of empathy or responsiveness along with the expectation that everyone can just carry out healthy behaviours at will means that the meeting place between health professional and client is kept at the abstract intellectual level and so control is enacted. The will to power is enacted at this level of control – for both health professionals in their education and clients in the encounter with the health professional. Both sets of players are expected to exercise control in relation to healthy lifestyles as well as being expected to make the ‘right’ choice in relation to health behaviours. Thus the passivity and compliance of the players is ensured through discourses about control and choice. These discourses are then associated with guilt and shame if non-compliance results. This cycle of abstract intellectual thinking about life with associations of doing, anxiety, fear and
shame can come to dominate on an inner level if the person’s subjective experience is not reflected back to them by others.

Reflection back of the subjective experience of the patient does not mean a decontextualised sentimental outpouring of uncontrolled emotions in which people remain stuck (neo-liberalism’s fear of the relational or feminine) – which seems to be the fear underlying Alice’s proclamation that her tears were her weakness. Alice found the experience of talking about work and “having to go under the surface” brought her to tears, which she described as being one of her weaknesses but about which she didn’t talk “because everybody’s facing the same thing. So therefore you don’t talk about it.” The absence of reflection back of subjective experience was seen as an effect of the perception that everybody was facing the same thing.

Emotional outbursts from staff were mentioned almost in terms of an occupational hazard by Emma, who saw emotions as a result of being out of balance “umm, you know, one of us may just burst into tears .. cause it’s all too much. It’s … it’s, there’s not a good balance between rest and activity.” Also Joan stated “you have to be hard nosed and you don’t crack.” There seemed to be no place for emotions in health professionals’ practice. The assumption seems to be that by allowing people’s affect into professional practice, there is less room for objectivity and clinical judgment. Moreover, there also seem to be assumptions that by reflecting back the subjective experience of a person that the whole encounter becomes too subjective, decontextualised and solipsistic. I argue that this does not have to be the case – that it is not a situation of either context or subjectivity but that
there is room for both. In fact, I believe that the reflection back of the subjective experience of another person implies contextualizing.

By including the professionals’ subjective experience as part of their practice and as part of a reflexive spiral in learning it seems more likely that the context of the learner or health professional or client will be included. There is no evidence that this is occurring for participants in the study. Grounding professional practice in an embodied form of reflexivity is a privileged notion that at the moment is lacking in the field. There is silence on how this can be done whereas there is evidence that mostly what is encouraged is a form of disembodied intellectual abstract self-policing type of thinking. Reflection back needs to be contextualized within relations of power and this important point is discussed more when exploring ‘rememorialising’. At the moment suffice to say that part of the role of reflecting back of the subjective experience is to ground professional practice in an embodied encounter. This is currently not occurring with those participants interviewed.

For example, Mary had to leave herself behind when she was learning her job. “I mean my job was to learn how they did it. It was not about bringing myself into it at all. So I would, I mean, I had to learn to think like and be like my psychiatrist boss and to watch how they did it, because that’s how I learnt.” The professional self generally does not include the personal self – learning is about imitating and thinking like someone else and there is no reflection back of the subjective experience of the learner. It is hard to
imagine a reflexive spiral in learning that does not include the learner’s self or any reflection back of the subjective experience of the learner.

The evidence shows that participants are expected to learn and reflect in a disembodied manner, which seems to enable a focus on doing and being busy. Mary described the effect that being so busy had on her. “And I am so out of my body, I am so stuck in my head, I am so under time pressure, I’m doing three things at once.” Furthermore, she describes the disembodiment being as a result of the time pressure she experienced and the effect at the end of the day was “invariably walking back to my car in the afternoon, I have to draw my bits of myself back from the atmosphere laughs cause they have run off during the day. By the time I get home I have usually got it back together again laughs.”

There is a difference between the ability to reflect and learn as part of professional practice, which participants described as a form of self-evaluation, and embodied reflexivity.

Along with disembodiment and a reduction in affect, there also seemed to be no room for a self-reflexive cycle beyond heightened self-policing which meant that workers could stay in their heads: be clinical, detached and objective: by critically evaluating themselves. In the comments about the lack of critical pedagogy in their education, most workers showed evidence of a perception of critical evaluation being in terms of their practice in relation to what they ‘do’ (Louise, Gill, Alice, Mary, Cathy, Emma, Polly). However, this type of ‘doing’ is in the context of a mechanistic approach to health service provision with a lack of reflection back of subjective experience.
Further evidence of the lack of reflection back of the subjective experience of being a health professional and instigating healthy practices was given by Ingrid when she said “I haven’t actually hit the right button with myself yet,” in relation to herself and her own healthy lifestyle. The lack of reflection back seemed to allow incongruency between a worker’s practice and the rhetoric of the health department. This incongruency was reflected in Fiona’s comments as well. Louise, Betty, Cathy and Tom thought it was important to be a healthy role model. It seems almost as if the training encouraged disembodiment and a lack of congruency by its focus on doing and an absence of reflective practice of the subjective experience of the health workers, perhaps in order to manage their (unspoken) affective states. This type of practice forms severe constraints on the professional practice of health professionals.

Any references to the body as part of the professional practice were constrained. Polly stated that “you’re sort of constantly thinking about what you are doing and trying to evaluate your own performance because you are still not sure what you are doing ... you are still trying to find your feet.” Mary described herself as “being the fine point on which the whole thing balanced” and “in the end the reason I didn’t continue is because I just found it I was incapable of being the health system. You know I couldn’t be that balancing point that it all hinged on and I got very stressed by that.” Some of Mary’s strategies included “like I have to just draw myself in out of the situation and sort of try not to participate so much. Even though I am still physically present. Draw my energy back, hold my breath back and just say okay, this is what’s happening I can’t control it.”
The perception of being out of control meant that the workers could not participate in the health system in the sense that they were non-relational, disembodied, disconnected and to a certain extent disengaged.

Similarly Gill found that the feeling of being out of control almost led her into a major depression. “And then one day I woke up and I thought ‘hey this isn’t about me, it’s not my fault that I can’t see all those people’ so I just stopped short of actually hitting rock bottom, which was an amazing thing.” It was also amazing that Gill didn’t talk about these feeling with anyone and she had to work through them on her own.

To refer back to Figure 7.3 (Subjectivity of health professionals with a revised curriculum) although current practice is constrained there are possibilities to respond to this situation. I have already mentioned relational pedagogy. Alongside an emphasis on the relational forms of learning – on the shared space between the learner and educator – is the notion of including the self in the learning and health experience. This allows for a reflection back of the subjective experience of the health professionals’ practice. There needs to be a greater sophistication of knowledge production in health professional practice, instead of arguing about what are essentially practices of the professional self. Since health professional practice and the health professional’s self are constructed by social forces, inscripted, enfolded, then by finding out about individual experience (as in this research) we are ipso facto finding out about contextual experience as each participant can be seen as some reflection of their contextual experience.
Allowing the self as part of the therapeutic medium has been documented in Hakomi (Kurtz, 1990). Here there is an emphasis on the personhood of the therapist but little advice on how to maintain this professionally. Pearce (2008) suggests that all professional educators could benefit from including the self in their professional lives:

A search for authenticity is crucial for professionals who need to be able to distinguish other people’s ‘false voices’ from their own, since the ability to use experience to critique the voices of others is crucial to developing professional agency (Brookfield, 1995, p. 46). Patti Lather’s notion of ‘embodied reflexivity’ (1991, p. 48) provides an alternative pedagogic model that interrupts transmissive models of teaching in which individual’s lived experiences are of little account.

To value ‘embodied reflexivity’ and ‘embodied learning’, which is the ‘knowing that is discoverable in our experiences as embodied beings’ (Gustafson, 1999, p. 250), is to value learning that resonates with lived experience (Pearce, 2008, p. 45).

A starting point for developing a reflexive understanding of the self in professional contexts is suggested in the form of a personal written narrative. In this way, the narrator can begin to reflexively understand how the professional self is constituted in relation to others through such things as curriculum, metanarratives, scripts, and habitus which is the interaction between objective structures and personal experiences (Pearce, 2008). Such an experience is grounded in an analysis of values underpinning practice and of the professional’s relationship both to other people and teaching.

A curriculum for health professionals could benefit from the inclusion of a narrative for reflexivity that included acknowledgement of the health professionals’ social being in relation to objective structures. In some cases this may mean acknowledging the habitual absent body (Edvardsson and Street, 2007). Freire (1998) talks about a testimony of a progressive educator’s practice, saying, “An educational practice in which there is no coherent relationship between what educators say and what they do is a disaster” (p. 55).
I now focus on an analysis of the relationship between educator and learners, a relationship that involves questions of teaching, of learning, of the knowing-teaching-learning process, of authority, of freedom, of reading, of writing, of the virtues of the educator, and of the cultural identity of the learners and the respect that must be paid to it (Freire, 1998, p. 55).

These thoughts apply equally well to health. There needs to be a coherent relationship between what health professionals say and what they do. If their curriculum could include some of the above points as part of the development of being a health professional, then the professions could go some way towards addressing the inequities in power currently present in the enactment of the curriculum. In this way, they could start addressing what it means to be in relationship with clients or patients and the relationship between what they say and do in their practice as health professionals.

Similarly the relationship between subject and object needs exploring in the health professionals’ practice. Health professional practice needs some notion of learning as described by Freire: “to study is to uncover; it is to gain a more exact comprehension of an object; it is to realize its relationships to other objects” (1998, p. 21). This requires some reflection back of the subjective experience which in itself requires some distance: “Immersed in the reality of their small world, they were unable to see it. By taking some distance, they emerged and were thus able to see it as they never had before” (Freire, 1998, p. 21). This has resonances with the integrative capacity of the imagery of a clearing in a forest (Galvin and Todres, 2007). The role of the reflection back of the learning/health experience is precisely to place the subject’s experience in context, which the subject who is in the middle of the subjectivity is unable to do on their own.
Currently this ability to look back on one’s self with the assistance of a reflective relationship is largely missing in health.

This type of learning is in addition to a reflexive spiral even if it is a form of an embodied reflexivity. Embodied reflexivity is said to include and acknowledge the ethical, political, cultural and social dimensions along with the idea that as we act we are also acted upon (Giddens, 1991). The context and social constructedness of self is emphasized here. I would like to emphasize, along with the aforementioned aspects, that for me the reflection back of my own subjective experience by another (that always keeps the context and constructedness in the forefront of their reflection back) has been vital for me in allowing my self in as part of this process of learning. For example, while carrying out critical pedagogy as a form of professional practice as described in the case studies (chapter five) I experienced a great deal of dissonance in so doing. But I had nowhere to go with that observation, which seems very strange now. That is, I could be reflexive about what I was trying to achieve in relation to critical pedagogy and I was aware of the social, political, ethical and cultural factors involved as I had included all of these as part of the assignments, but I couldn’t be reflexive about my own subjective reality because it wasn’t in there. There was an absence which wasn’t even spoken about.

At the time I needed to know the meaning of the acts with which I was involved, and I couldn’t access that in an embodied reflexive way. There is a difference for me between embodied reflexivity and reflection back of the subjective experience. Embodied reflexivity (Lather, 1991b) is the reflective process that includes the body as part of those
reflections and which is the essentially individual practice of reflective practice of action research and praxis. This is the practice that has been co-opted by the dominant neo-liberal epistemological discourses and turned into critical self-evaluation, i.e. more self-policing.

Reflection back of the subjective experience requires another person to reflect back, by which I mean mirror in an ethical manner (and this includes the contextual aspects of the experience) so that people can understand and make meaning out of their experience. Where people’s experience has been grounded in silence and absence, embodied reflexivity is a privileged construct as there are not the words within to describe that experience. The two parts of reflection – embodied reflexivity and reflection back of subjective experience – go hand in hand.

Reflection can be seen as a both/and construct. It is an individual experience as well as a relational construct. Providing health information in a non-relational way, without reflecting back the subjective experience of the patient or client, means that the empty words can just echo around the person’s inner experience subjecting them to a form of further subjugation. Similarly just informing people that their viewpoint is a result of the way they have been constructed by health professional education is another form of subjugation. There is an assumption that embodied reflexivity is a safe experience for people but this may not necessarily be the case and sometimes another person is very helpful in assisting at this point. That is, the inner battle of self-policing requires some outside presence to ameliorate its effects. As Pearce (2008) mentioned “A search for
authenticity is crucial for professionals who need to be able to distinguish other people’s ‘false voices’ from their own” (p. 45). On an inner level, making this distinction may need assistance. This inner battle of self-policing (O’Grady, 2005) is different from understanding contextual matters and wanting to live from a healthy place all the while nurturing embodiment and relationship.

There is a different focus to living when coming from a place that is about nurturance and warmth of embodiment and relatedness. Meaning and understanding are readily accessible: there is a general feeling of well-being and ‘joie de vivre’. In such a place, looking after one’s self is easy and natural. One can imagine following impulses to reinforce and enhance the feeling of aliveness and ‘palpable humanity’ (Joan). Such a scenario is completely different from willing one’s self to engage in healthy lifestyles and behaviour in response to information giving sessions. Self-policing is mandatory in that case and the only motivation is compliance or fitting the norm by applying technologies of self that form relations of power. There is little motivation to engage with this form of self-policing. But there is motivation to engage in warmth of embodiment and nurturing relatedness. This seems to be an area of health professional practice that health professionals could engage with – in enhancing relatedness and well-being through reflection back of the subjective experience which in turn encourages a strong presence in the world.

The health field could benefit from having a purpose to it akin to that described by Freire (1998):
Quite to the contrary, educational practice is something very serious. As teachers, we deal with people, with children, adolescents, and adults. We participate in their development. We may help them or set them back in their search. We are intrinsically connected to them in their process of discovery. Incompetence, poor preparation, and irresponsibility in our practice may contribute to their failure. But with responsibility, scientific preparation, and a taste for teaching, with seriousness and a testimony to the struggle against injustice, we can also contribute to the gradual transformation of learners into strong presences in the world (p. 33).

An approach to health that emphasizes an ethical being with could also help to provide a socially accountable practice (Riggs, 2006). Since health professionals are seeing their role as becoming more and more educative, it seems as though a change in how health professionals are with the patients or clients is required so that practice becomes more relational in alignment with that professed by critical and relational pedagogues.

Critical pedagogues talk about the qualities of educators. hooks (1994) sees a need for educators to be self-actualized and to celebrate with learners the ecstasy of learning. Freire (1998) talks about qualities such as humility, common sense, courage, tolerance, patience, lovingness, decisiveness, security, patience and the joy of living as being important to educators. None of these qualities are sufficient on their own and there is a need to not make these into new oppressive practices (as Gastaldo (1997) describes in relation to participation in the radical critical pedagogy in association with health). However, along with feminist critiques and an analysis of relations of power (Gore, 1993), these qualities do become important as part of the development of the professional practice of health professionals.
The participant who most clearly identified the importance of connectedness, and feeling deeply connected, to know what it is like to be human was Joan. Her perception was that health is an experience of seeking life and that sharing that with other people was beneficial to her own health – the sparkly moment of palpable humanity. There is something deeply important about health but this research indicates we are missing it currently in the health risk management approach. Health as self could be another way of perceiving health and that includes embodiment and a sense of being. But it seems as if these perceptions could only be held in a curriculum that emphasized relational pedagogy and a reflection back of the subjective experience of the health professional. Then personhood could be encompassed in the training which means that health and learning are inextricably linked.

Fox (1999) suggests that health professionals can move out into ‘smooth space’ after ongoing processes of deterritorialization and reterritorialization. By keeping an eye on the constructions of health work health professionals can move out of ruts they may have been stuck in as far as their practice is concerned. Along with suggestions of questions that health professionals can ask themselves, he also has the following definition in relation to health:

So a responsibility to otherness, in relation to issues of ‘health’ and ‘illness’, will suggest a radically different conception of the human potential, and this is what is meant by archē-health. Archē-health is a becoming, a deterritorializing of the BwO, a resistance to discourse, a generosity towards otherness, a nomadic subjectivity. It is not intended to suggest a natural, essential or in any way prior kind of health, upon which other healths are superimposed. ... can never become the object of scientific investigation, without falling back into discourse on health/illness. It is not the outcome of deconstruction of these discourses, it is deconstruction: difference and becoming (Fox, 1999, p. 11).
Fox (1999) posits that deconstruction is health and that lines of flight into smooth spaces become available from reflexivity, de-territorializations and naming of differends. To me this is like saying the link between health and learning is deconstruction.

I discussed in chapter four and chapter five (Case Studies – Public Health) a framework that I had developed in order to elucidate the link between health and learning. After that analysis, and having concluded that the framework was just another form of surveillance or self-policing, I was ready to dismiss it entirely. However, at some point, I decided to resurrect it with the view to integrating the positivist and postpositivist forms of inquiry as discussed in chapter one. I could see that it would be beneficial to have some sort of framework that was interdisciplinary and could speak the language of the different disciplines. I also resurrected it because it seemed important to the development of my own professional self as an educator in the health field. It helped to remind me of the different facets that I would like to see in a health service, and provided a way of reflecting on the different aspects of health. Such a framework was relational, emphasized the inclusion of the self, was aware of the workings of power and was reliant on critical pedagogy. I reproduce it here to show the both/and of reflective practice, reflection back of subjective experience, limbic resonance, context, relations and the physiological felt sense as well as embodiment and positivist approaches to health.
The framework is depicted as a spiral for learning and health, and can be used as an iterative tool for considering the curriculum content and its enactment of the health professionals’ education. Given the existing constraints and absences as mentioned above, I would include the following elements as an attempt at redressing the current imbalance in knowledge production and legitimation. There is more than enough on the cognitive, behavioural and inner physiological sensations within the positivist model of learning about health. Limbic resonance, regulation and revision (Lewis, Amini and
Lannon, 2001) could be included here. What information there is needs re-framing within a feminist critique. The following points need to be included:

- The curriculum to be built on the assumption of a relational pedagogy (Bingham and Sidorkin, 2004). The relationship between the health professional and the client or patient to receive more attention in the education especially from an ethical perspective (Freire, 1998; Freegard, 2007);
- Feminist critique – embodied reflexivity (Lather, 1991b) of the content within education programs including specific units or subjects on critical pedagogy;
- Narratives for Reflexivity (Pearce, 2008) – to assist in the reflection back of the subjective experience of being a health professional;
- Building on this idea is the testimony (a coherent and permanent discourse of a progressive educator – Freire, 1998) that specifically addresses the relationship between educators and learners including an analysis of binaries with an emphasis on congruency;
- An analysis of the meaning of positioning and subject-object binary within the health relationship;
- A specific section of the curriculum to include the performance of ‘control’ (Riggs, 2004) and positioning in terms of social disadvantage (Pearce and Moore, 2002) from the perspective of epistemological dominance;
- A greater emphasis on ethical practice and what this may mean for health professionals – the inclusion of analysis of transference and countertransference issues (Freegard, 2007);
• To take out the word empowerment from current education and practices in its current misused form (Gore, 1992);

• The curriculum to include an exploration on being and what this may mean for health professional practice (Galvin and Todres, 2007; Todres, 2008)

• Specific explorations of embodiment within a context of feminist critical research and what the experience of pedagogy reliant on control, will, choice and agency means.

Critical to using this framework is relational pedagogy drawing on a feminist critique since it is this type of pedagogy which seems to give the different type of connectedness (that is, discourse affects subjectivity which affects power/knowledge) between the different epistemological elements and allows an analysis of relations of power (Gore, 1995a). A feminist critique is vital in order to use deconstruction to negotiate the binaries (see Lather, 1991b) in order to move beyond them so that one is not constructed by them.

A feminist critique also allows a focus on experience, context and reflexivity (see McLaren, 2002; O’Grady, 2005; Pearce, 2008). In this way, the contextual reflexive embodied self is privileged as a source of knowing (Usher, Bryant and Johnston, 1997). Such an approach is not without dangers – “understanding the self in a contextual vacuum is of limited value for a person intending to engage in a set of social practices, such as teaching and other professional activities” (Pearce, 2008, p. 46). While Pearce’s (2008) paper is written primarily about teaching and learning for professional educators, it also has application to the health field which I will now discuss here.
Reflective practice was discussed in chapter two as a tool for professional development. One of the limitations noted there was that reflective practice was often co-opted by dominant positivist discourses that turned reflective practice into another form of self-policing (Clegg, 1999). Thus the health professional becomes engaged in a practice of self that occurs in a contextual vacuum, as shown in figure 7.1. Pearce (2008) suggests two interpretive frameworks of a) curriculum and performance, and b) ‘habitus’ to ensure that the reflective practice in the form of narratives for reflexivity is kept contextual and social – “the use of such frameworks for interpreting the professional context is important in enabling subjects to negotiate reflexively between the self and the social/institutional milieu” (p. 46).

However, when one considers that for many women health workers the habitus or habitual body is the absent body, it is important to remember embodiment:

Acknowledging existence as embodied is central to the field of nursing, where disrupted embodied beings are at the centre of concern. The disrupted or disturbed relation with the body has been described as characteristic of almost all experiences of injury or illness (Edvardsson and Street, 2007, p. 27).

Embodiment needs to be ensured during reflective practice so that reflective practice does not become another instance of disembodied reason dominating the corporeal thereby maintaining the status quo of the mind/body split. In relation to the first two points discussed here – the lack of relational pedagogy and the absence of reflection back of the subjective experience of the health professional – embodied narratives for reflexivity can be seen as a vital part of the curriculum of health professionals.
The ability to negotiate reflexively between the self and the social/institutional milieu is a learned skill that requires the ability to put words to one’s subjective experience. As I have argued, sometimes this needs to be learnt with the assistance of someone outside. Realising that we are subjects within institutions but not of them and understanding how we can be within those institutions, including understanding what is possible in terms of agency and productive engagement is a very important learned skill. Knowing the limitations of ourselves, the curriculum and the institutions whilst remaining in relation with these components is a very important but not often discussed part of professional practice.

The third point to be discussed is the lack of acknowledgement of and the need to challenge relations of power. I will now discuss the participants’ comments.

**7.2.3 Lack of acknowledgement of relations of power**

As discussed in chapter six (Practices of the self within health professionals’ practice) there was a strong perception from the majority of participants that relations of power were not a major issue at work. There was no recognition of the positioning that occurred between patient or client and health professional or between expert and learner. Critical pedagogy in terms of analysis of relations of power had not been mentioned during their training.
Some participants were able to articulate relations of power within the health system. Mary was the most polarizing (“there’s them and us really”) in her understanding of relations of power in the public health system, which does not allow people with less money to have as much say in their encounter with the health system. Furthermore, “there is a kind of punitive way of managing people who have got overwhelming distress. It’s not very compassionate, it’s not very understanding of where the distress comes from. It’s much more like, we have rules and you can’t behave like that here” (Mary). Mary’s comments demonstrate the kind of prison/health system that Foucault (1980) described.

Joan was also able to articulate the kind of socialization that happens at work in relation to power in terms of policing boundaries, territories and role delineation, as was Louise. But generally this was not discussed at work, and a form of individualization occurred whereby different workers perceived that they had it the hardest and every other type of worker had got it easy. The individualization of the perception of power meant that the focus was off the institution and turned towards the different disciplines within health. Therefore each discipline becomes capable of disciplining and normalizing the others.

Neither Emma, Fiona nor Gill had a strong sense of power relations being an issue, Gill perhaps because she thought it was too hard to think through. Hannah’s perception was that she enjoyed the respect that an older person gets that in turn allows her to negotiate her way through relations of power. Other participants recognized the power in the hierarchies of the health service and saw their role as including knowing how to play the
games that you need to in order to get your resources and things (Katrin); knowing how to deal with the feeling of being disempowered when clients didn’t do what you wanted them to by not taking it personally (Nell); that part of learning what a job involved was to negotiate the unspoken hierarchy that no-one tells you about and the feeling of disempowerment that seemed to go with being a new graduate (Polly); and finally understanding that as a new graduate you were at the bottom of the power hierarchy and that it was scary having the responsibility of being a ‘real’ physio (Veronica). Ingrid thought it was her role to empower other people by giving them the right information.

There is a mixture of perceptions of power, with little consensus on whether relations of power exist or not. Generally, I suggest that because health workers do not have access to discourses around power, they have difficulty articulating such relations. Also because there is evidence of a disembodiment occurring at work alongside an absence of affect, there is little opportunity to explore relations of power in an embodied way. This absence becomes a constraint since it is very difficult to discuss power in a curriculum without appearing as if one is attributing false consciousness to health professionals (Lather, 1991b). However, the point must be made that if health professionals are generally unaware of the workings of power then there is little hope for a socially accountable practice that acknowledges power/knowledge.

It seems to me that this is where the link between health and learning is vital. Discourses from critical pedagogy need to be incorporated into the curricula of health professionals in order to provide some social justice inspiration from these texts. Health professional
practice and the health professional’s self are important to keep at the forefront of any consideration of curriculum development in health, as suggested by critical pedagogy. Then the practice of health professionals could be a place where the educators could know with their entire self (Freire, 1998), including starting with where they are at in a form of standpoint pedagogy. This seems to be possible only within the critical pedagogy tradition.

There is a need to include emancipatory dialogue within health professional education that takes seriously feminist debates on the subject, ‘coming to voice’, and the seduction of ‘empowerment’:

What I have suggested here is the urgent need for a serious skepticism of and critical attention to those contemporary educational narratives that claim to be emancipatory, ideologically critical, self-reflexive, and politically conscientious, and yet remain theoretically entrenched in gender- and colour-blind patriarchal liberalism (Luke, 1992, p. 49).

Critical pedagogy has been criticized for further entrenching women in the role of carers and for being responsible for the freeing of every little individual (Walkerdine, 1992). Critical pedagogy can seem like progressivism whereby people are on an upward journey towards enlightenment, as mentioned by Riggs (2004) in relation to neo-liberalism. Critical analysis of key concepts alongside a grounded pedagogy in the everyday problematic (Smith, 1987) is crucial to prevent co-option by neo-liberalism. Empowerment needs to be critically analysed within health professional training as the current form of usage of the word is more detrimental than anything else in the way that it positions the receivers of services. Lather (1991b) refuses the term empowerment in its
upwardly psychological mobile meaning, preferring instead that we know it is not something we can ‘do’ for others.

Health professional training could also benefit from analyzing the way it positions people, both the suppliers and receivers of services. The analysis of the performance of ‘control’ as a response to how people have been positioned would seem vital to erode the authoritarianism of current education and to reduce the effect of the disciplining of the curriculum. The concept of institutional difference whereby institutions and social structures are crucially implicated in systems of power (Pearce and Moore, 2002) seems particularly useful as this does not reinscribe existing systems of power.

To work within a system whilst at the same time strategically transforming the practices/site seems to be a challenge based on the above existing constraints. This basically seems to involve being disruptive to the system in a way which is antithetical to the system and how it has been set up with the purpose of governance of the population. Challenging current health care practices positions professionals to live in the interface between the political and the personal, which can create violence (Anzaldua, 1999). Health professionals, the majority of whom are women (de Toit, 1996), need preparation and support in order to be able to challenge current practices otherwise they may end up ‘burnt’ (Donna) by the system. This means learning the important skill of knowing what can be changed and what cannot – knowing the limitations of the institution and self and working from within an awareness of the constructed nature of our identity. Perhaps as McLaren (2002) suggests ‘the most profound and potentially radical politics comes
directly out of our own identity as opposed to working to end someone else’s oppression” (p. 119). If one was in a position to do so, it seems as if one way would be to develop a curriculum that is more inclusive of differences (such as knowledge production that is predictive, understanding, emancipatory and deconstructive) and the interaction/relationship between them.

Pearce and Moore (2002) advocate an approach to education where ‘disadvantage’ is seen as a result of the difference of the institution and not the individual. In this approach, programme design is based on guiding principles such as “standpoint pedagogy – starting with where the learner is at; a focus on community building; the demystification of university [health] culture; and a focus on affective as well as cognitive aspects of learning” (Pearce and Moore, 2002, p. 1064). In health, a focus on the individual, autonomy, choice, control and agency could be seen as presenting significant barriers to health. Deconstruction is required to explore institutional and other social/cultural practices that privilege autonomy over affiliation. Currently in the enactment of health curricula there is an implicit denial of the affective components of health and the subjectivity of the health professionals and/or patients or clients.

The curriculum needs to also analyse the role of privilege and power in the workers in relation to the patients or clients, since most health professionals are not encouraged to engage in a critical analysis of health and learning (Williams, 2002). As a starting point, such a curriculum needs to name the power and articulate it in such a way that workers can appreciate the value of deconstruction of relations of power. Deconstruction as an
epistemological category seems to be invaluable in any tool that analyses the role of privilege and power. The deconstruction of binary polarities within health and the questioning of what it means to be human need to also be taken into account. Cultural studies therefore seem to be an important part of any learner’s curriculum in health. As O’Grady (2005) discusses, it is important for women to be able to understand the relation of the political and social to their own lives in order to reduce the isolation and self-policing that are seemingly a large part of the gender issue. The counterpoint between power/knowledge, discourse and subjectivity is the self of the health professional and I will now just make a few more suggestions in relation to the professional self.

7.2.4 Being, subjectivity, narratives and health professional practice

As discussed in Chapter Three the methodology of this thesis was chosen to amplify the lived experience of health professional practice in relation to how they had been educated. I chose critical pedagogy, feminist poststructuralist discourse analysis and embodied experiential reflexivity (sometimes referred to as phenomenology) as they complemented each other in my analysis of the object of study – the health professionals’ self. I include the different emphases of each methodology again since they have informed this section:

- Critical pedagogy has an emphasis on liberation and freedom from oppression. It also acknowledges the structuring social binaries that materialize the self;
- Feminist poststructural analysis with the emphasis on deconstruction through discourse analysis places an emphasis on the researcher foregrounding their own subjectivity first in order to know how that subjectivity is informing their research;

- Reflexivity that is embodied and experiential brings the body back into the process of research otherwise it can appear to be sidelined through the focus on discursive analysis as nothing appears to be extra-discursive.

Since the lived experience of being a health professional and how this is informed by their education was the focus of the research, these three methodological approaches seemed to me to be the most appropriate containers for the process of knowledge making and legitimation. Narratives of being and subjectivity are seen as an antidote to the emphasis on empirical knowledge about the individual. However, the epistemic casting and relationship between the object and subject are crucial aspects that need teasing out in a deconstructive approach to knowledge making.

I have emphasized the importance of epistemic casting since it determines the relationship between the subject and object in the meeting place of health professional practice. The subject and object of the self of professional practice is included in this research through a methodology that acknowledges the social constructedness of the self alongside the experiential phenomena of the self. The research therefore has attempted a both/and approach to analysis of the self. While some people believe that this is not possible in that the self is entirely discursive and there is nothing outside of the discursive field (Fox, 1999), others take the position that a both/and approach is an agenda for the future (Hollway, 2007). A both/and approach means holding the obduracy of methodology and its determining effects on the self:
For me, there is something exciting, though unnerving, about this field, because the implications of seeing selves one way or another are fairly momentous. It is as if the self is a core issue, quintessentially social psychological, that is wide open and yet we all have access to it through our own experience. ... The second [way through] is to emphasize methodology: if self can mean this disparate variety of things, it must be a result of how it has been approached, and with what methodological choices, theoretical commitments and blind spots (Hollway, 2007, p. 131).

As a contrast empirical research has focused on control as a manageable construct with the effect that health professionals’ selves and practice is focused on control and ‘doing’. Reflective practice has been demonstrated by the participants as involving self-policing more than anything else. Therefore the relation between subject and object is that of the observed and the observer.

The relationship between subject and object, between the known and the knower, necessarily draws in the process of reflexivity:

... the idea of the self was based on the principles of reflexiveness of the mind: the ability to see oneself from the perspective of another person, or to become an object to oneself in much the same way that one is an object to someone else. ... I am the active observer who monitors me, the observed. By this means, he paved the way for a social self that was not just social in the sense that it was sensitive to the judgements of others, but was positioned by and in the language that surrounds us all. This made “the self” reflexive (Hollway, 2007, p. 124).

Reflexivity is a consistent theme across epistemologies and methodologies as demonstrated in this thesis in Chapters Two and Three. However, reflexivity is not a simple construct. There are nuances within this term that can be teased out such as embodied reflexivity (Lather, 1991b), the notion of the agency of meaning (discourses being the meaning of our longing) (Lather, 2007), the inseparability of morality and subjectivity (Usher, 2000), and the process of becoming (Brickhouse, 2001) and
nomadology which also emphasizes becoming (Fox, 1999). These examples of
reflexivity circle around the relationship between subject and object.

The relationship between subject and object historically has invoked structuring binaries.
The earlier emphasis on consciousness and awareness as being central to the self was
positioned in opposition to feelings as being the core of the self (Hollway, 2007).

Individual-social dualism is reproduced in the split between I and me. ‘I’ is the singular
individual, whereas ‘me’ is the self produced by the social influences of others’ gazes. ‘I’ is also
the active pronoun, the subject where change is located and so represents the agent in agency-
structure dualism. In contrast, the ‘me’ is the object of a verb in a given sentence – done to,
passive, positioned by social influences, rather than choosing to act (emphases in original,
Hollway, 2007, p. 130).

Language has the capacity to have both an ‘I’ and a ‘me’. With any one person, as
demonstrated by the participants, there is the capacity for ‘I’ and ‘me’. The participants
demonstrated a strong agentic belief in themselves: they believed they were in control of
their own health behaviours: and yet they also described situations in which they were
passive and done to. Some also stated that they did not do what they told others to do
thus such a statement can position ‘others’ passively: the health professionals by
positioning the clients, doing to them, were foreclosing any possibilities of the patients’
choosing to act. The health professionals in this case could maintain their agentic ‘I’.
And yet the health professionals also experienced positioning through the social
influences of others’ gazes (for example, Louise when she stated that unless she was flat
out people looked at her as though she was lazy). The dominant concept in the field is
the ‘I’ – the individual autonomous agentic reflexive self. However, the ‘me’ also exists
– feminist poststructuralist methodology, embodied reflexivity, the phenomenological self – are attempts at trying to stay with the experience of the lived ‘me’.

Another structuring binary is that of inner-outer with the assumption that anything preventing autonomy is ‘other’ or outside of the self (Usher, Bryant and Johnston, 1997).

As mentioned previously, Fox (1999) eschews any interior-exterior conception of subjectivity and embodiment seeing this instead as an effect of the meaning of socialization. Interior-exterior fantasies and fears are constructed to give boundary, territory and form (Butler, 1990). I do not see why the four views of the body as described by Fox (1999) cannot co-exist even though this might seem complicated methodologically. If an agenda for the future includes both/and then there must be a way of living with the lived experience of constructionism as well as reflecting on the constructedness of constructionism. In other words, if the body is refused and rejected because of its social discursive construction, then isn’t this another case of the agentic ‘I’ rejecting that which is seen as ‘other’ and preventing autonomy? Epistemologically as well as methodologically, if this rejection is not to occur then there must be a way of staying with the lived experience of the passive, ‘done to’ me.

I suggest that in this way, health could be seen as a way of being or being-in-the-world (Hollway, 2007) that means being able to be with whatever there is on an inner and outer discursively constructed level without being defined by someone or something else. Health is still a process or practice of the self in this case but one that is seen over the long term and not one that aims for utopian moments of complete mental, physical and
emotional well-being. This means in turn that subjectivity is a vital part of health. Perhaps health could be seen as a safe place to be in contrast to enlightenment thinking.

Learning and health together through a feminist critique and critical pedagogy can lead to deconstruction of the territorializations. In this way, I suggest that learning about life in relation gives a feeling of well-being and an ability to be with whatever is there on an inner and outer level. Learning about life in a well resourced ethical relationship gives resonance and meaning is derived from this relational learning. Meaning provides a vehicle for moving beyond the structuring binaries of the neo-liberal self. Health professionals who are especially vulnerable to institutional oppressiveness may find they need to look for meaning in their suffering in contrast to being overly occupied with internalized binaries to the exclusion of all else.

Neo-liberalism invokes the structuring binary opposite of the self through its discourses on autonomy, control, will and choice. By being pre-occupied with these terms and constructs on a professional level and making the opposite terms abject, health professionals are complicit with neo-liberal rhetoric. By enforcing the mind/body split, health professionals encourage disembodiment that can only reinforce the inner battle between the will (reason applied to action) and bodily needs that result in self-policing. Perhaps the internalized battle of self-policing and will invoked by the mind/body split provides the perfect conditions for chronic diseases to manifest as the prevalence of anxiety, depression, raised cortisol levels and chronic stress along with powerlessness increase. Fox (1999) suggests that territorializations are a result of the battle between the BwO’s (body-without-organs) will to power and the social forces that construct the self.
The notion of being or being-in-the-world keeps subjectivity at the forefront when considering the curriculum issues of health professionals. I believe it is important to keep subjectivity foregrounded as part of the professional practice of health professionals; both the health professionals’ and the patients’ or clients’. However, this could be a struggle given the nature of the existing constraints such as the dominance of the neo-liberal individual.

An example of a generic training which keeps subjectivity at the forefront in the education of health professionals includes the curriculum described in appendix 10.4. The focus is on critical pedagogy as a means of learning and revealing the constructs of the self. At the heart of this curriculum is the displacement of the neo-liberal subject with an exploration of the ‘refigured subject’ “produced at the intersection of history, biography and the body. Its intersubjectivity is learned through a system of apprenticeship which is not internalized or willed but rather enfolded, entwined, interior and exterior” (Walkerdine, 2002, p. 9).

The suggested curriculum focuses on subjectivity (the lived experience of ‘me’) as opposed to implicitly focusing on identity (the ‘I’) as in the modernist program of health professional work. The implicit focus on control has led to a situation where:

It is this control of one’s own impulses which … is central to the task of the control of others by those who are allowed to participate in power providing they restrict their own aspirations by efficiently carrying out the controlling and disciplining of the less privileged and less compliant. In turn … this calls for the need to keep oneself aloof from below and
deadening any feelings of sympathy or solidarity with an ‘emotional immunization against the awareness of others’ misery and one’s responsibility for it’ (Walkerdine, 2002, p. 8 – 9).

These sentences resonate with the situation in health professional practices demonstrated in this research. The ‘I’ and ‘me’ of health professional practice could be included as a practice in health professional education. This would demonstrate epistemologically the relationship between the subject and object.

I suggest that one of the roles of the health service is to be healing and rememorialising the past especially in relation to the Other (Venn, 2002). There was an invisibility of the Other in the interview responses with only Donna mentioning “how did we begin to ask the right questions to work with them?” from a social justice perspective. Indigenous health was scarcely mentioned in the interviews which is surprising given that Indigenous people make up such a large proportion of the population in rural W.A. Here, the “theorization of subjectivity which emphasizes the primacy of the relation to the Other in the process of constitution, that is, the idea of the co-emergence or compossibility of the I and the Other” (Venn, 2002, p. 52) is useful in exploring the subject and object of health care. In the meeting place between the health professional and client or patient, there needs to be close attention to the space in between as suggested in a pedagogy of relations (Bingham and Sidorkin, 2004). What this must mean is to pay close attention to subjectivity and the Other.

The Other … is a participant in the work of healing and of rememorialising the past, since the refuguration of the subject must then require a different historicisation and narrativisation of particular selves, so that the process necessarily repositions the ‘who’ (of action and discourse) within an intersubjective network of interactions, as I have explored elsewhere (Venn, 2002, p. 54 – 55).
By employing narratives as a way of knowing (Pearce, 2008) health professionals can be involved with a refiguration and repositioning of the subject in ways that are not happening now. For example, current dominant health rhetoric plainly places responsibility for illness on the individual. However, most people when asked about their own health blamed the hard life they had had for their illness. In other words, they turned to narrative:

In face of the moral imperative in Western society to be healthy, however, it is understandable that it is those who are most exposed to “unequal” health who will be least likely to talk readily about their risk status. Instead, they will talk, as the evidence shows, about coping with illness, about not giving in to illness, and about the principle of mind-over-matter. Taking the responsibility for “health” in these terms – even taking responsibility, perhaps to some extent equivocally, for one’s own health-related behaviour – is accounting for one’s social identity. If one cannot deny the reality of one’s own disease, one can at least respond “healthily” to it (Blaxter, 1997, p. 756).

People’s narratives about their health are therefore a reflection of their storied selves (the ‘me’). Health professionals participate in this construction and in the presentation of their social identity. Therefore health professionals need to be aware of the role they play in the constructions of narratives or biographies about people’s health and illness.

In the meeting place, health professionals have an opportunity to change or rememorialise narratives about health that have been based on the dominant rhetoric of the neo-liberal individual exercising control. By basing the therapeutic relationship on being and a being that is the entity that questions itself as to its way of being (Venn, 2002), health professionals can have access to a discourse that can discuss temporality and construction of selves. The ability of a health professional to be with moments like these, incorporating “loss and anticipation” (Venn, 2002, p. 56), seems important in light
of the illness experience – one that can be characterized by moments of loss and anticipation but more often than not, one characterized by cultural stereotyping.

Illness has been likened to a boundary marker with each ethnic group having its own discourse around illness.

They mark ethnic, class, and recent immigration statuses. They should signal to health professionals major cultural differences that require sensitive evaluation. All too frequently, however, they stimulate traditional ethnic stereotypes that may exert a mischievous influence on care (Kleinman, 1988, p. 25).

If cultural meanings shape the illness experience, it is the role of the health professional to unshape or deconstruct these experiences. “The modern Western cultural orientation contributes to our experience of suffering precisely through this reciprocal relationship between the actual experience qua experience and how each of us relates to that experience as an observing self” (Kleinman, 1988, p. 27). The role of the health professional is to function as an observing self that can translate or decode the cultural and social narratives of the modernist project of health.

Fox (1999) suggests deterritorialization of health care professional practice alongside the notion of care as a gift.

Relationships are based on reciprocity: caring about someone becomes caring for someone (Gardner, 1992). Care is transformed into a vigil (Fox, 1995a) through the activities of theorists (including social theorists) which has the power to territorialize those who care and those who receive it, from cradle to grave.

The second promise of postmodernism is that – despite this disciplining work of the academy and of the practitioners of health and care – it is possible to engage with those we encounter in those environments in ways which are not disciplinary, and which indeed challenge discipline. Such engagements are not about ‘empowering’, because what is involved is not power at all, but love and the gift. It is the antidote to academic or clinical hubris... (emphases in original, Fox, 1999, p. 6).
Resonance and relationship are important particularly for people who are vulnerable to feelings of loss or absence as may be the case for patients in hospitals. It may be that people who find themselves either working in hospitals or being an in patient may have some kind of institutional deference or de-integration (Schaverien, 2004) compelling a continual engagement with oppressive institutions. Characteristic of this de-integration to an institution is the encouragement of intellectual and independent thought but not emotional autonomy (Schaverien, 2004). People subjected to the impersonal oppressiveness that institutions perpetuate cannot help but be split since not only do they have to comply with institutional limitations and loss of self, they also have to cope with amplified internalized self-policing due to the lack of resonance occurring in the institution.

Oppressive social disadvantage is enacted by institutions. The effect on people both health professionals and clients or patients is formative in their subjectivity. Privileged people have greater access to ‘I’. Privileged people may be more able to mask the effects of the social disadvantage enacted by the institutions of health and education, have greater access to resources and status to cope with the enacted disadvantage, can exercise choice in response to the disadvantage and may know implicitly the dangers of engaging with any institution. Mary’s comments resonated with these thoughts.

The complexity of life and health is largely denied. The implicit curriculum of neoliberalism in general carries a sense of nihilism and meaninglessness. Thus institutions are similarly imbibed with an implicit sense of nihilism. Anybody who has suffered at all
will have difficulty in coping with the nihilism inherent in most institutions. Admonishments to behave more healthily will seem meaningless. The implicit curriculum of neo-liberalism is concerned with nihilism. Since implicit learning is the most powerful and enduring the most enduring message coming across to children in schools, health professionals in health services and patients or clients within any government institution is that the neo-liberal life is meaningless and oppressive. This message must change.

Within mainstream health professional education and practice there is an emerging acknowledgement of the complexity of the learning process (Price, 2004; Price and Bowman, 2007). Part of the complexity includes working with core constructs of subject-object in a methodologically congruent way. Methodological congruence includes explication of assumptions. It may be that methods are more useful when core assumptions underlying them have been made explicit and put on the table for debate and discussion. For example, appreciative inquiry is a form of action research that problematizes the notion of action research being based on problem solving (Cooperrider and Srivastva, 2001). Instead the authors suggest that if the miracle and mystery of being were integrated into the process of action research, that acknowledgement was made that for the most part institutional practices did work then the outcome of the action research process could be quite different.

Within this section, I have discussed different subjectivities of health professionals and some different forms that a critical pedagogical curriculum might take, such as the
deconstructive/integrative framework and the focus on being-in-the-world through a revised curriculum for subjectivity that included narratives for reflexivity and feminist critiques. These suggestions would certainly change the approach to health service delivery and they would change the truth or message shared in the meeting place between the health professional and the client or patient.

7.3 Suggestions for further research and recommendations for practice

Suggestions for further research necessarily include further exploration with workers in the field to amplify and consolidate the work in this study. Further exploration could also include the deconstruction of some of the binary polarities in the field and the use of deconstruction as an epistemological framework within health training itself. By creating spaces for a different discourse around health, particularly with the notions of choice, the individual, and contingencies of health, then different knowledge may be created differently. However, at the moment, the medical model is so dominant that any study in this area needs to be constructed so that the workers can appreciate the usefulness of such a study to their field. As this study showed, some health workers found considering relations of power ‘too hard’, were unsure of what was meant or simply did not see the relevance of power to their work. However, this does not mean that inequities should be left unexamined. But neither does it mean that people in the field must be categorized as having a false consciousness (Lather, 1991a).
Further research could be carried out on the role that women and privilege play in the maintenance of status quo. For example, in education, white women’s fears about ‘stepping outside the circle’ of privilege in relational terms has been explored along with the notion “that women tend to be socialized to avoid conflict, often remaining silent when they feel their opinions might cut them off from others or, more dramatically, invite physically violent responses” (Gillespie, Ashbaugh and DeFiore, 2002, p. 241). Women in the health field have absorbed implicitly the idea that the constructs of caring compassionate health worker do not usually include the encouraging of conflict or a critical pedagogy. Workers have become incited to embrace the construct of themselves as caring workers. This attachment to their compassionate identity has meant that conflict and questioning of practice are rarely valued. Perhaps the construct of caring as a gift (Fox, 1999) could be introduced alongside critical pedagogy. The subjective experience of women health workers could be teased out much more in the following ways.

Further research is needed specifically on the role women play in the maintenance of the status quo. Women in the health field have absorbed implicitly the idea that the constructs of caring compassionate health worker do not usually include the encouraging of conflict or a critical pedagogy. Workers have become incited to embrace the construct of themselves as caring workers. This attachment to their compassionate identity has meant that conflict and questioning of practice are rarely valued. If a critical pedagogy was to be implemented, it would need to be done in a way that also explicitly valued the construct of caring.
Themes of women, gender, identity and the body need teasing out to understand more about the subjective experience of female health workers. In particular gendered self-policing could be explored to see how the self-relationship gets played out with clients, with other health professionals and as part of the socialization process of health training. It may be that the attachment to being ‘God’s police’ (Summers, 2002) provides some form of power relation for women who have little else in their lives and which they would be reluctant to let go. In the face of alienation and the production of a void as a result of neo-liberal policy (shown in figure 7.2), health professionals may be reluctant to let go of the only self-structure (self-policing) that they have unless there is something else to replace this activity.

A further area for research is the exploration of the intersection of the social and political in the body and how this is could be manifested through powerlessness, shame, fear and any other contingency. With the rise in incidence of chronic diseases (Commonwealth Department of Health and Aged Care, 1999), it is worth exploring the intersection of this phenomenon with the cultural, economic, political and social structures of our time. It could be that chronic diseases have become another boundary marker (Bottomley, de Lepervanche and Martin, 1991) and it would be interesting to tease out the intersections of gender, ethnicity, socioeconomic status and other contingencies associated with different chronic diseases. Alongside the subjectivity of the experience of chronic diseases, narratives could be revealed that shed some light on the interface between the individual and the social.
Further nuances could be teased out in the role that the body plays in an articulation of the nonverbal manifestations of power within the body. While embodied reflexivity (Lather, 1991b) has been mentioned as a way forward in professional development of educators, there is little detail available on distinguishing between embodied felt senses that are personal manifestations of personal narratives and the collective sources of experiences of relations of power that may be manifested through the body. While it is accepted that the personal can be political and vice versa, there is no doubt that the interaction or relationship between the two need further exploration. This could also be the site of the subject-object binary where ethical help is needed from an ‘other’ in distinguishing between one’s own authentic voice and the voices of others (Pearce, 2008).

The relation between space and gender, in particular the use of boundary markers in describing social identity in relation to illness, seems to also require further elucidation. Related to this is the task of making the constitutive forces visible in the linguistic surface of health workers’ discourse. For example, in the rhetoric around empowerment, collaboration and choice the effect of gender and space in determining the choices available to different privileged groups of women health workers could be further explored in order to identify what it is that makes choice more available to some women than others and how this is manifested at work. Women’s position at work could make them more receptive to choices or not – this was shown in the interviews when health workers perceived that colleagues had more choice and power than they did, with some
strange inversions occurring. An example is Mary’s response that she felt she had little choice at work and yet was tired of being the hinge on which all decision making hung. Similarly Louise felt that she had little power herself in contrast to the patient care assistants who she perceived as having the ability to say no to things they didn’t want to do. It would be interesting to make visible the constitutive forces that gave these women the perception of lack of choice about their work.

It seems mandatory to explore the effect of recasting at the level of epistemic knowledge in relation to the role of the individual. If the episteme of the neo-liberal individual was recast to include different ways of being and relation, with always an eye on the workings of power itself, it would be fascinating to see the effect this had at the level of practice of the health professional. I see this as one of the most important aspects of a reform in health. Unless core concepts are examined and held up to the light then there does not seem to be any hope for any lasting change within health service delivery.

In this light, the power of the Gaze (Foucault, 1973) and its effect on knowledge production and legitimation seems to require further exploration. Foucault (1973) describes in great detail how the senses of seeing and hearing were of paramount importance in developing knowledges used in the medical field. If embodied reflexivity were used as an adjunct to seeing, hearing and speaking about health, it would be interesting to find out what this meant in relation to knowledge production and legitimation as the ‘sea’ of critical pedagogy implies immersion within the field. The
impact on professional practice seems to fall into the realm of practice-based evidence (Morgan, 2008) but this is not clear.

Related to this idea of expansion of knowledge generation to include embodied reflexivity is further exploration of the negotiation of the gap between the visible and the sayable. If these form the two poles of knowledge generation (Kendall and Wickham, 1999) then what falls between also seems to belong in a relational pedagogy which brings us back to analysis of the subject-object binary. All of the ideas presented as ideas for further research circle around each other and it seems that exploring each in relation to health and the professional practice of health workers would produce enrichment in the field. Each of the ideas presented here support each other and must be applied in a cross-disciplinary fashion in order to produce the maximum amount of knowledge generation and legitimation possible. One of the benefits of carrying out an interdisciplinary study such as this has been the cross-fertilization of ideas from education to health and including psychology and the social sciences. By pursuing such connections, the practice of health workers could be expanded to include a greater diversity and multiplicity of voices and people.
CHAPTER EIGHT

Breaking the silence in health professional practice:
complexities of the ‘I’

8.1 Introduction

The aim of this research was to explore how health professionals are educated and some of the consequences of that education. A feminist poststructural analysis was carried out in order to deconstruct three examples of framing within education and health (Chapter Five) and analysis of interviews (Chapter Six); critical pedagogy was drawn on throughout the thesis in order to identify structuring binaries of the self and oppressive social practices within health, and finally reflexivity was practiced throughout the research trajectory and specified in Chapters Three and Seven in order to make knowledge claims within a poststructuralist frame. These three epistemological and methodological approaches allowed an analysis of the discursive field within which education of health professionals occurred and developed a surface analysis of the lived experience of health professional practice. Embodiment of health professionals and the relations between subject-object were explored through each of the methodologies.

The exploration of the way that training in health formed the identities of the workers in the field through the constructs of health and learning led to issues about embodiment and subject-object relations. The thesis is about how women in the field of health get constructed as particular subjects through their training and in the context of bio-politics
(Foucault, 1973). There is little information in the field of health pertaining to the critical pedagogical aspects of training as workers are generally not encouraged to embrace a critical pedagogy (Williams, 2002). It was hoped that the study would add to the little information there was available on a critical pedagogy of health professional training.

This thesis is unique because it synthesizes knowledge making claims between a number of different fields – feminist poststructuralism, critical pedagogy, critical health psychology, sociology, health and education more generally. Chapter Two synthesizes knowledge claims from both modernist and post-modernist paradigms while Chapter Three explains the use of feminist poststructuralism to lay out the constraints within which educational practices in health occur. The first step of deconstruction of the researcher’s subjectivity has the purpose of foregrounding that subjectivity (Lather, 1991b). This process provided the differends and intertextuality (Fox, 1999) of different discourses in order to form a theoretical framework for analysis of the research interviews: “As such, deconstruction is thus not only a methodology of qualitative data analysis, but also a political tool which opposes authoritarian exercises of power in the denial of intertextuality” (Fox, 1999, p. 42). This thesis demonstrates a relatively new way of thinking about health practice in its current form that works through exposing the limiting frames or differends thereby reducing the power of these frames to silence. The thesis foregrounds the complexity of how health professionals are educated and some of the consequences of that education.
The purpose of the study was therefore to gather data and develop an understanding of relations of power both within the researcher and within the field of health. In this way, the purpose of the study is to map the social, cultural, political and epistemological framing of health education. The main results will be reviewed as they pertain to the research questions. The strengths and limitations of the analysis will be discussed. The suggestions for improvement of the study will be discussed. Further research for exploring health and learning within the field of health will be suggested along with the implications for training in health.

8.2 Review of main results

8.2.1 Case Study One – Manual Handling Training

The manual handling training enacted a competency based form of examination on the workers in order to homogenize, regulate and centralize practices and knowledge so as to decrease the risks associated with manual handling. In this way, the workers’ own knowledge became disqualified as each worker became responsible for the enactment of an homogenized and hierarchicalized form of manual handling. It seemed as though the workers, mainly women, participated in the disciplining of their bodies at the moment of subjugation and that this could have accounted for a sense of the womens’ bodies acting as containers to soak up the irrationality (Walkerdine, 1992) of the manual handling training with back pain apparently widespread but not reported.
Although I tried to introduce a critical pedagogy at this stage, I ended up utilising a collaborative risk assessment discourse that only served to mask the relations of power and domination. It seemed as though silence was the main way that a critical pedagogy was muted, suppressed and repressed. Both my self and the workers were complicit in a culture that tied the women to the identity of carers and being responsible for the enactment of that care.

8.2.2 Case Study Two – Physical Activity Health Education

Health education was analysed through a lens of technologies of the self with the body becoming an object of study for the health workers and the researcher. The hegemonic practices and dominant medical model identified the individual as the site of the epistemological interventions. Thus the concept of the individual became the vehicle or conduit through which ‘health’ was a major point of contact between the government and the individual. Through the analysis, health education was seen as an attempt at governance from the outside and this was certainly reinforced by the example utilized in the case study. The choice exercised by the liberal humanist individual was seen as a major issue in constructing the subjugation of the individual; the worker, the researcher and the client or patient.

The critical pedagogical aspect of this case study, by focusing on the social determinants of health, allowed for a greater domain of policy management of the poor and disadvantaged; the target groups. There was a suggestion that the contingencies in this
case study needed to be more inclusive and include the role of relative privilege of the workers in the subjugation of individuals as well as considering the body as the interface between the political and the biological.

8.2.3 Case Study Three – Therapy Assistant Training

Case Study Three was a snapshot of the enactment of a curriculum that could be seen as encapsulating the different workers within the allied health field. The construction of both therapists and therapy assistants through the discourses of empowerment, communication and relationship, organizational management and the legal imperatives to follow the curriculum were embedded in the surveillance technology of domination and power. It was suggested that the curriculum encouraged a displacement of the self and that overall the curriculum was about the production of docile bodies. The curriculum reinforced and reproduced technologies of domination and power. And that in fact, the rhetoric in use about empowerment only served to mask the effects of power.

The critical pedagogical aspect of the case study was again muted and repressed with the researcher enacting a collaborative form of pedagogy that only served to maintain the dominance of the medical model.

8.2.4 Interviews

The participants subscribed to a form of health and well-being that reinforced the notion of the liberal humanist individual who had access to choices about and a sense of agency
in relation to their health. In this way, workers themselves also became tied to the identity of an autonomous rational individual in relation to their own health and in relation to their work. Health and work was focused on doing, striving towards an ideal achievable at sometime in the future. This could be because the training was outcomes based and focused on products as opposed to process oriented. Many workers saw their role as of information provider which would thereby empower clients to make the right choices, with heavy moral overtones, and where education was primary in achieving the goal of health and wellbeing. The provision of information (or texts) supplied the power to the health professional. Where there was a gap between the rhetoric and reality in health education in relation to choice and the notion of the individual; a range of different subject positions were taken up.

Generally speaking, the workers had difficulty articulating an understanding of the power relations in the training or at work. They were however able to articulate problems at work associated with having too much to do in too little time. They attributed their ability to cope at work with their own acceptance of the status quo and not letting the situation affect them too much. Since this group of workers can be seen as relatively privileged in relation to the people they see as clients, this finding has implications for the role of privilege in relations of power. That is, if the main way that relatively privileged groups of workers coped with power differentials was to maintain the status quo and not let the situation affect them too much, then implicitly they must experience a disjuncture when talking to clients with the expectation that the clients exercise a choice in relation to their own lifestyles. The main way in which power seemed to circulate was through the
hierarchicalisation of knowledge and skills, the epistemic casting of the medical model with its emphasis on the individual and the anatomo pathological model of health, maturity and experience of the worker, the way in which training was conducted, the amount of training required that the workers had to undergo, and the lack of a critical pedagogy in the training.

As far as critical pedagogy was concerned, the general consensus was that there was minimal inclusion of issues to do with gender, race, ethnicity and culture. Some workers were aware that the training seemed to cultivate a dominant culture of the white middle class woman enacting health care. There is little questioning of the role of social inequality in factors relating to health. The workers seemed rather to have internalized a sense of critical pedagogy with the main target of criticism being themselves. In line with this, the workers seemed to be a highly regulated and monitored workforce that believed in their own internal locus of control as being the main mitigator of health.

8.2.5 Self As Researcher

The process undergone in exploring relations of power and critical pedagogy enabled me as a researcher to articulate what had been the absent subject, my self, in my previous work as presented in the case studies. I was also able to engage in theory making and the exploration of inclusion of a number of different previously unarticulated contingencies that could be said to be contributing to the relations of power in the health field. From my theory making and the combination of theory-practice in my self throughout the
process of this study and thesis, I was able to de-centre the rational liberal humanist individual within my self through a process of deconstruction. This to me emphasized the importance of deconstruction as a means to the production of knowledge and an understanding of relations of power within health. The rules that delimit the sayable seemed to be mainly about silence as the discourses that linked power and knowledge in relation to the body seemed to missing. For me there was a growing visibility of the body as a mediator between the social and the individual whilst at the same time I could acknowledge that there was a lack of discourse in which to articulate the language of the body or non-verbal forms of knowledge. I also found valuable the opportunity to articulate those narratives in which I had invested authority in my exploration of health and learning. These narratives seemed to find resonance in those legitimated by the health workers interviewed as participants in the study.

8.2.6 Summary

Throughout the research, I was involved in an iterative reflexive spiral that exposed the constructions of education and health that I had been working with as an educator in health. The case studies were an important step in deconstruction, laying out my own subjectivity and becoming involved in theory making. Case Study 1 provided the first instance of the absent body in health and exploration of what this may mean for the lived experience of being a health professional. Analysis of this case study exposed the juncture between the social and the individual. Here, critical pedagogy was muted, suppressed and repressed through silencing. Case Study 2 emphasized the role of choice
in relation to the liberal humanist individual. Choice was seen as a major issue in constructing the subjugation of the individual, whether the worker, the researcher, or the client or patient. The relative privilege of the workers and the role this had in the subjugation of individuals led to a call for greater inclusivity. Case Study 2 further developed the concept of the ‘individual’ as the interface between the political and the biological. Case Study 3 developed the idea that the curriculum encouraged a displacement of the self and the production of docile bodies. It was demonstrated that the rhetoric in use about empowerment only served to mask the effects of power. Based on these conclusions, the research questions and interview questions were developed through a reflexive process that included theory making as outlined in Chapter Three. The analysis of the interview data was informed by a theoretical framework which was developed in relation to the key points outlined in the case studies. The choice of methodology included deconstruction, holding of the binaries structuring the self (e.g. control), exploration of the lived experience of being a health professional (embodiment), reflexivity and critical pedagogy. Thus any knowledge claims are made within a feminist poststructuralist field whereby experience is described rather than interpreted and analysed. I will now go on to discuss the contributions to knowledge that this research makes.

8.3 Major contributions to knowledge of research

The major finding of the research was that health professionals do not tend to practice what they tell clients or patients to do. This incongruity tends to develop a type of health
professional subjectivity that is different from embodied experience and how we live our lives. Health professionals may become tied to this subjectivity as the information (or text) provided to the patient or client supplies the power to the health professional. Becoming tied to this subjectivity may be disempowering for the health professional as it limits the discursive field of their practice and may prove to be a dissatisfying form of practice. Such a practice becomes focused on the completion of tasks and unreflexive performativity or doing. Poststructuralists may claim that this is the only valid form of activity – what can a body do? (Fox, 1999). However, there seems to be a contradiction here in that Fox (1999) also states “... technical skills and practical experience are not in themselves sufficient to construct the crucial body of knowledge claimed by a profession” (p. 81). Such practices only serve to enhance the professionalization of care into the vigil which is care as a discipline. The social practice of care becomes focused on a disciplinary enactment of doing that is directly related to the enactment of the curriculum. The enactment of the curriculum has been demonstrated as contributing to the particular type of subjectivity that health professionals become tied to.

Furthermore, the subjectivity that health professionals demonstrate in this research is a site of struggle. Participants identified moments when they struggled with their workload or with political issues as major stumbling blocks for themselves with their body being the focus of struggle. Either depression or anxiety or emotional outbursts or a feeling of being burnt contributed to the sense that they felt powerless to make any difference and yet somehow this situation was their fault. The extent of powerlessness within health professional practice is unknown, yet this study suggests that while health professionals
may become tied to their own subjectivity through the power that information supplies to them, that subjectivity is a double edged sword and may ultimately prove not to be helpful to them. This research opens up the field of study of power/knowledge in an embodied practical way. This finding could represent a way in to further study the effects of power/knowledge which at present health professionals do not tend to value.

By foregrounding how the political is personal, health professionals may become interested in the study of power/knowledge. Power/knowledge divides the meeting place into dichotomous concepts of knower and known, educator and educated, amongst others. The gap between health professional and client could be seen as having been created by the ‘knowledge’ or curriculum that is shared in the meeting place. Similarly there is a gap between theory and health professional practice. This gap between theory and practice is not restricted to health education alone. Generally research findings are only taken up by health professionals in a patchy manner (Fox, 1999). Gaps could be seen as a result of the particular construction of the knowledge which structures itself along artificial binaries. This thesis highlights the gap between theory and practice in a way that could be helpful to health professional practice.

Health professional practice as described in this thesis is local and contingent (Fox, 1999). Therefore any knowledge claims arising from this research are specific to rural Western Australia and the sites I visited. No similar work has been carried out in rural W.A.; in this context the work is unique. In Chapter One I outlined the context of rural health with one major characteristic being that Indigenous health is far worse on all
indicators than that of white Australians. Indigenous people are ‘other’ to health professional practice and privilege. This thesis explores the formation of the subject through the curriculum and educational practices that seem to exclude the ‘other’ or Indigenous health. For the most part there was silence on the presence of Indigenous people in rural health locations and training. Perhaps rural W.A. shows extremes of polarizing between privilege and deprivation which could make it the ideal location for theorizing the subject. Fox (1999) describes the vast alien landscape of Australia: “Here – I knew – was a place where it would be easy to resist, to become, to move beyond whatever had been one’s nature until now” (Preface, p. ix). From a British perspective with embodied experience of class differences and rigid social structures I can understand the desire to move beyond the colonizer mentality.

However, my experience of rural W.A. in hindsight was an experience of being blown away by the harshness of life and a reduction to the bare bones of my existence. In that place, discourses about health and learning seem meaningless. What seems to assume a larger feature is the body and embodiment or disembodiment. I cannot say whether rural W.A. was specifically responsible for this; this would be to assume a causal problematic out of place in a feminist poststructural thesis. Fox (1999) writes: “Those dreaming paintings were both of an external country and an inner landscape of events and places which together constitute a subjectivity, a sense-of-self” (Preface, p. ix). Perhaps the European experience of the landscape of rural W.A. is as a dreaming where people dream of better lives and try to reach that chimera through objects. But the harsh reality of desert conditions is a paradox – a desert is a land of both deprivation and beauty. Since
Europeans cannot assume a heritage from the land then the subject formation is missing something. This thesis has explored what that could be and what that could mean in terms of subject-object relations. A whole parallel process has gone on alongside this research. However that is the subject of a different thesis.

The contribution to knowledge that this particular thesis makes, drawing on the specific methodologies of feminist poststructuralism, critical pedagogy and reflexivity, is concerned with subjectivity. The methodologies are able to include differences and therefore are inclusive practices of the self. This means that the participants were able to talk about the positioning that occurs at work and the relations, both spatial and temporal as well as between people, in an uninhibited manner. These methodologies worked to support the participants in their lived experience. By developing a theoretical framework that was inclusive of differences across fields and disciplines this thesis attempts a synthesis of difference and a demonstration of a both/and approach which participants found helpful. I will now go on to discuss the strengths and limitations of the research.

8.4 Strengths of the research

In order to represent the complexity of health professional education and practice, this research attempted to explore these sites whilst considering a both/and approach to methodology. Hollway (2007) has described how difficult this is to do in a meaningful way and that it is an agenda for the future in terms of understanding the self [of health professional practice]: ... “the individuality and the relationality or sociality of the self
are both essential if we are to see the complexity and richness of humanity. This is an example of using ‘both/and’ thinking” ... (Holloway, 2007, p. 204). One of the strengths of this thesis is that it attempts to hold onto the both/and of the individual-structural binary through its methodology (feminist poststructuralism, critical pedagogy and reflexivity).

As mentioned above, by keeping hold of the complexity through a methodology that values difference, one of the strengths of the research is that supported participants’ lived experience in all its nuances. I believe that the responses from the participants demonstrate that they felt comfortable talking with me and this assisted in drawing out responses which they may not have otherwise felt comfortable making. It was reassuring to hear from four of the participants; Tom, Cathy, Alice and Joan; that they found the interview process to be helpful in understanding the truths they had constructed about themselves in the field. In this way, the utility of the study seems to have been achieved in a small way in that some of the participants had found a space opening up for them in terms of having the opportunity to talk about issues which were rarely talked about in their field. It would be interesting to return to the participants to learn whether or not participating in the study had affected their practice in any way, or even if having the opportunity to talk to an outsider was helpful.

The triangulation of the case studies, along with the interviews, seemed to produce a knowledge in the field that is consistent with the work of Foucault (1973 and 2004), Gastaldo (1997), O’Grady (2005), Cheek and Rudge (1994) and Ogden (2002).
However, one of the strengths of the study is that it can build on the work carried out previously by Foucault to develop a theoretical framework grounded in present day everyday problematic. In particular, by applying a both/and methodology (Hollway, 2007) this research has been able to demonstrate the paradoxical tensions between self and other, between subject and object, and between body and self. I will now go on to discuss the limitations of the research.

8.5 Limitations of the research

However, there are limitations within the research process. As mentioned previously, the number of participants who took part in the study was small. Feminist poststructural claims to knowledge are always local and contingent therefore there is no attempt to generalise these findings. Further research is required to explore the findings in this research with other health professionals in order to strengthen the findings in the field. Claims of external validity or generalizability are rhetorical within poststructuralism (Fox, 1999).

The problem with the validity of this study is the same with any feminist poststructural account of the field. There are no universal criteria for validity:

At the heart of all methodologies of social research is the critical problem that no one can actually establish for sure what social reality is, how it connects to knowledge and experience, or the exact relations between knowledge and power. Feminists have had to abandon claims that they can specify direct connections between feminist ideas and the realities of peoples’ gendered lives (Ramazanoglu and Holland, 2002, p. 57).
Therefore I hold that all feminist research is partial, perspectival, limited and constructed as specific social productions (Lather, 1991a and 1991b; Ramazanoglu and Holland, 2002).

The results of this study will always be related to the fact that the knowledge produced is contingent on the conditions of its production. Just the sheer amount of data available through the case studies and interviews produced problems in choosing which data to include and which to leave out. All seemed useful and valid to include, but I had to make choices about what to include based on the frequency and interest of responses whilst also wanting to make a fair representation of the data collected in relation to the research and interview questions. Therefore the results of the study could be seen as limited by the theoretical framework (more on this later).

I have tried to address the problems of the situated socially constituted self by including analyses of my self as researcher in the field and thereby laying out the platform from which I analysed the data. However, I acknowledge that there will always be contingencies of which I am not aware, that affect my position in the field as researcher and worker. This thesis is therefore a representation of partial visions and situated knowledges (Ramazanoglu and Holland, 2002). I have tried to include as much of the data as is workable in order to represent the multiplicity of voices and positions within the workers and my self. I have thus tried to make visible both the hidden relations of power of knowledge production within my self and within the field. The best that I can
do at the moment as far as validity is concerned is to be part of the struggle and transitional development of a feminist epistemology (Ramazanoglu and Holland, 2002).

A limitation of the research process could be seen as the way in which the interview data was analysed. That is the analysis was derived from the development of interview questions which in turn were developed from a theoretical framework derived from reading in the field and analysis of case studies. While this process does demonstrates intertextuality (Fox, 1999) it does not demonstrate a thematic analysis arising from the interview data itself (Braun and Clarke, 2006). Perhaps unsurprisingly these extracts matched the interview and research questions. A different reading of the data could produce a different text but this could be the case with any text – this is the potency of the data (Fox, 1999). The data in this thesis could represent the first of many readings of the data as it is in flux and dynamic.

A further limitation on this point is that I did not engage with participants prior to the development of interview questions or the research itself in order to gain their views on what was important to them. This presents a serious dilemma to me. As mentioned in Chapter Six and Seven, participants tended not to see relations of power as important at all. Perhaps this is not surprising given their immersion in the modernist field that is health. I was really affected by the strength of this perception in the field. I grappled with the dilemma of how to find the words from within a modernist frame to describe the value of exposing power relations and power/knowledge from within a poststructuralist frame. A major epistemological shift is required. Translating interview questions that
evolved from poststructural notions of power to questions that could elicit information about the lived experience of health professional practice and education was difficult. I am still not sure how I could have started from the modernist field of health and engaged with participants in order to explore relations of power. I don’t think I could since the participants did not see power relations as an issue worth researching. However the lack of engagement with participants at this stage is a major limitation of the research. Fox (1999) sees validity more as the function of the engagement with issues relevant to the participants. The curious aspect of this point is that some participants enjoyed the process and the opportunity to discuss these questions that they normally wouldn’t: “these kind of questions are things that we, probably each of us every one of think about individually but we never voice the … and we think about them in our mind and they churn around and they’re huge life issues” (Cathy). Further exploration is required to make bridges between the dominant modernist project that is health and the marginalised feminist poststructuralist.

8.6 Recommendations for research

Suggestions for further research necessarily include further exploration with workers in the field to amplify and consolidate the work in this study, if possible. Further exploration could also include the deconstruction of some of the binary polarities in the field and the use of deconstruction as an epistemological framework within health training itself. By creating spaces for a different discourse around health, particularly with the notions of choice, the individual, and contingencies of health, then different
knowledge may be created differently. However, at the moment, the medical model is so dominant that any study in this area needs to be constructed so that the workers can appreciate the usefulness of such a study to their field.

Appendix 10.4 describes a curriculum for health professional practice that is inclusive of different ways of learning. It could be said that including the range and variety of learning practices is a healthy practice of the self. Further research could be carried out on operationalizing the theoretical framework developed in Chapter Seven in order to determine the effects this has on health professional education and practice. For example, it could be determined whether or not by being inclusive of a greater complexity the subject-object relations are changed and in what way.

Further research is needed specifically on:-

- The role women play in the maintenance of the status quo in a field that is relatively privileged;
- Themes of women, gender, identity and the body and their intersections;
- The intersection of the social and political in the body and how this is manifested through powerlessness, shame, fear and any other contingency;
- The role that the body plays and an articulation of the nonverbal manifestations of power within the body;
- The relation between space and gender, in particular the use of boundary markers;
- Making the constitutive forces visible in the linguistic surface of health workers. For example, the rhetoric around empowerment, collaboration and choice;
• The effect of recasting at the level of epistemic knowledge in relation to the role of the individual;
• Further exploration of the power of the Gaze;
• Further exploration of the negotiation of the gap between the visible and the sayable.

Through such research the practice of the health workers could be expanded to include a greater diversity and multiplicity of voices and people.

8.7 Concluding thoughts

This research has demonstrated that critical analysis of key concepts and events alongside a critical pedagogy grounded in the everyday problematic could prevent co-option by neo-liberalism. This means knowing the limitations of the institution and self and working from within an awareness of the constructed nature of our identity. Working from within an understanding of the constructed nature of our identity could help to bridge the gap between theory and practice.

hooks (1994) believes that no gap exists between theory and practice;

When our lived experience of theorizing is fundamentally linked to processes of self-recovery, of collective liberation, no gap exists between theory and practice. Indeed, what such experience makes more evident is the bond between the two – that ultimately reciprocal process wherein one enables the other (hooks, 1994, p. 61).
When people have the opportunity to ‘come to voice’ by discussing their experiences and how their learning has impacted on this, bell hooks sees that they practice the integration of theory and practice; i.e. integrating ways of knowing with ways of being (hooks, 1994). In this way, habits of being as well as ideas are interrogated and through this process, community can be built. This point of view reinvigorates theory-practice and justifies a concern with the interface between the structural and the individual. This thesis attempts to tease out the interface between the structural and the individual as it seems vital to understanding health as well as building bridges between theory and practice.

From a sociological point of view, Fox (1999) describes a metaphor for the intersection of the body and the structural that moves beyond health. Deconstruction, intertextuality and reflexivity are important methods of nomadology – a mood or theory of the subject that aims to move beyond feeling stuck within the structural. While I am especially grateful for his insights about becoming and how this process involves deterritorializations and reterritorializations, this research has brought me to a different place in relation to the intersection of the structural and the individual in relation to embodiment. A metaphor I would use that still exemplifies the striations we can all become stuck in, in relation to health, is that of a sea shell sitting on the sea floor. The sea floor can be striated through wave formation building ruts in the sand – these can be seen as the structural discursive fields much like the pool table analogy. However rather than tipping the table, the shell can move from one place to another though not necessarily through the exertion of its own will. It will more likely take a form of
dislodgement by some force such as a wave or other creature perhaps. The sea metaphor gives me the textuality that I desire as I feel the space between people and ideas as thick with descriptions. Moreover the shell or carapace is not the self; it can perhaps be seen as the outcome of discursive constructions which supports the position of the socially constructed or written body. The winding of the shell gives the entwining of the inner and outer – these are discursively constructed also – the duality of inner-outer gives boundary and form like the sea shell. For some people this is a ‘real’ experience albeit discursively constructed. It is a place to start for theorizing about spatiality and the relations between object and subject and the body. Furthermore there is a soft small animal living and moving inside the shell which is not usually seen but is safe. This aspect of safety has been paramount in my theorizing about the subject.

Having a safe space to return to seems to me to be more important than moving beyond discursive fields. One of the features of my reflexivity whilst attempting critical pedagogy within the field of health was astonishment with the way I was perceived when I was trying to attempt something I perceived as worthwhile. Understanding the political field has meant that the astonishment has subsided but only with the realisation that undertaking this kind of work can be dangerous, and that critical pedagogues need to have a safe harbour if they are to remain effective. For me Ellsworth’s (1992) words still ring true:

A preferable goal seemed to be to become capable of a sustained encounter with currently oppressive formations and power relations that refuse to be theorized away or fully transcended in a utopian resolution – and to enter into the encounter in a way that acknowledged my own implications in those formations and was capable of changing my own relation to and investment in those formations (Ellsworth, 1992, p. 100).
A sustained encounter with oppressive formations requires resources if the critical pedagogue is to survive. By providing a metaphor that includes both the social construction of the body and an acknowledgement of the physical which is perhaps beyond discourse and perhaps unknowable, I demonstrate a both/and theorizing about embodiment and the structural. This seems to be more grounded in the everyday problematic and a way to be with the body rather than a moving beyond the body and health.

The focus on how bodies are experienced at the subjective and intersubjective (relational) level provides an awareness of our being-in-the-world (body-object and body-subject) (Finlay and Langridge, 2007). This is a resistance of the body-world dualism. Finlay and Langridge (2007) suggest that perhaps all we have is the intelligent undivided body. This may certainly seem important historically whereby the body has been devalued and written out by health professional discourse.

… What I am primarily concerned with is how to conceptualize or how to constitute the textuality of social phenomena. I am concerned with how to write the social, to make it visible in sociological texts, in ways which will explicate a problematic, the actuality of which is immanent in the everyday world (Smith, 1987, p. 106).

The standpoint of women therefore as I am deploying it here cannot be equated with perspective or worldview. It does not universalize a particular experience. It is rather a method that, at the outset of inquiry, creates the space for an absent subject, and an absent experience that is to be filled with the presence and spoken experience of actual women speaking of and in the actualities of their everyday worlds (Smith, 1987, p. 107).

A feminist writing of the social may seek to write the striations in order to understand the social construction. This may be an important step in deconstruction on order to locate the subject.
Sustained encounters with oppressive formations may mean we are stuck in a rut but this does not necessarily have to be a ‘bad’ thing. Oppressive formations may provide some benefits – power can be productive as well as oppressive. Sustained encounters may require a safe space to return to. For example, I can consider the differences that might have occurred in history if enlightenment instead of being considered as the elevation of rational thought above all else, was instead considered to be the creation of a safe space, the feeling of safety above all else. The impact of that on epistemologies and pedagogies could be huge.

One final thought on pedagogy and health. The two do seem to be intimately related and it is only through the explication of core concepts and assumptions that we might fully understand how the social is written. As another example, action research which takes as its base the miracle and mystery of being (Cooperrider and Srivasta, 2001) is likely to inscribe a different formation on the body. Holding the miracle and mystery of being in the safe place could lead to ecstasy in learning and may provide all sorts of health benefits:

The academy is not paradise. But learning is a place where paradise can be created. The classroom, with all its limitations, remains a location of possibility. In that field of possibility we have the opportunity to labor for freedom, to demand of ourselves and our comrades, an openness of mind and heart that allows us to face reality even as we collectively imagine ways to move beyond boundaries, to transgress. This is education as the practice of freedom (hooks, 1994, p. 207).

Education and health can be a practice of freedom alongside the social constructionism that is part of our world. The concepts are not mutually exclusive.
CHAPTER NINE

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Appendix 10.1 Table 4: Matrix of epistemologies
Appendix 10.2 Information letter
Appendix 10.2 Consent forms
Appendix 10.2 Interview Questions
Appendix 10.3 – Analysis of curricular phenomena – meta-curriculum statements
Appendix 10.4 – Analysis of curriculum phenomenon for health professional development
Table 4 Technologies of Domination and Power – Matrix of Epistemologies

<table>
<thead>
<tr>
<th>Categories informed by Foucault (2004)</th>
<th>Cultural Field of Health</th>
<th>Cultural Field of “Critical Pedagogy”</th>
<th>Cultural Field of Poststructuralism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceptualization of Individual</td>
<td>Liberal humanist – rational, autonomous, free to choose, agency in the world, responsible Self-controlling, reflexive, intra-active, increasingly detached, individualized, insular and self-regulating (Ogden 2002) Attachment to an identity – micromechanics of power Objectivization Submit them to certain domination for good of the state “health” – medicalization as a way to control Individuality constructed based on symptoms, disease or lifestyle. Health education – constructs identities – healthy (at risk) versus sick roles, complex system of rewards &amp; punishments (Gastaldo 1997) No-one can escape construction</td>
<td>“The logic of liberation from oppression and repression is founded upon a (masculinist/universal) subjectivity conceptualized in a life-death struggle with itself and other” (Luke 1992, p42). Patriarchal masculinist egocentric, boundary-dependent self</td>
<td>Individual is one of power’s first effects The critical individual is radical pedagogy’s centered and neutered object of study (Luke 1992, p39) Pluralist, multiplicity of positions, dynamic, moving, performance Irreducible fluidity and complexity of our identities and locations, our insider/outsider locations, knowledges and visions “Rewriting ourselves from the ground up” (Luke 1992)</td>
</tr>
<tr>
<td>Sovereign Rights</td>
<td>Welfare/social justice (equal access to free universal health care) moving into privatization &amp; economic rationalization (user pays) Health for All – WHO, but traditionally focused on individual’s responsibility Health education is an</td>
<td>Humanist discourse of progressivism rewritten in the language of critical theory (Luke 1992) Humanitarian rhetoric on reform and progress</td>
<td>Right is an instrument of domination Suspicious of any universality e.g. justice – used as power over. Discourse of right masked dominations of power Opening up a space that goes beyond right of sovereignty</td>
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<tr>
<td>Disciplinary Theory of Normalization</td>
<td>Exercise of power over life and mechanics of discipline</td>
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<tr>
<td>Health service delivery through workers inculcated through disciplined, hierarchicalized knowledge – task focused</td>
<td>Educational narratives claim to be emancipatory, ideologically critical, self-reflexive and politically conscientious and yet remain theoretically entrenched in gender and colour blindness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biopower inculcates norms of healthy behaviour, promotes discipline for achievement of good health</td>
<td>No universal understandings</td>
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<td></td>
<td>No external position of authority</td>
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<td></td>
<td>Antidisciplinary and emancipated from right</td>
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<td></td>
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<tr>
<td>Conflict</td>
<td>Conflict suppressed, muted, repressed, unheard</td>
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<tr>
<td>What conflict? Health education is good for you “The healthy choice is the only choice”</td>
<td>Conflict occurs between what is my Right and what is Normal</td>
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<td></td>
<td>Epistemology grounded on a foundation of difference</td>
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<td></td>
<td>We are engaged in political struggles all of the time</td>
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<td></td>
<td>Fury is being asked to explain peace and order</td>
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<tr>
<td>Body</td>
<td>Site of battleground between disciplines. Workers become disembodied to be able to continue to work within system. Reinforcement of mind/body split with privileging of mind</td>
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<tr>
<td>Body becomes an object of knowledge. Biological and political interface with each other through health education. Imposition of ‘truths’ about health in which patient loses control of her or his own body. Instead of choice, the subject experiences the government of her or his body or family from outside.</td>
<td>Disembodied self in order to contain the irrationality of the dominant patriarchal progressivist humanist notions of empowerment whilst women are concretely embodied in these relations of power</td>
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<td></td>
<td>What happens at the moment of subjugation that subjugates bodies, directs gestures and regulates forms of behaviour?</td>
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<tr>
<td>Territory</td>
<td>Fiercely contested at the boundaries and over the body. Territory determined by anatomical ownership of different parts of the body –</td>
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<td></td>
<td>Empowerment – treats the symptoms but leaves the diseases unnamed and untouched</td>
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<td></td>
<td>Health domain expands as health education becomes a social</td>
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<td></td>
<td>Situational, perspectival theory of knowledge</td>
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<td></td>
<td>Local</td>
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<tr>
<td></td>
<td>Infinitesimal micromechanics of power, circulating</td>
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</tbody>
</table>
### Boundaries
- Enforced by Job Description Forms, Policies and Procedures, Surveillance, Supervision, Quality processes, Performance Management, Compliance
- Borders between health and illness reshaped and more fluid according to latest ‘scientific’ data
- Drawn even tighter to reinforce ideas of self-regulatory self-reflexive individual
- Exploring the discursive limits
- Limits to difference, uncertainty, partiality, the local and location
- Focus on space – creating new spaces

### Training
- Disciplinarization
- Normalization
- Hierarchicalization
- Centralization
- Homogenization
- As a technique to police the social body
- Health education is educational in nature because it promotes behaviours that should be adopted by the entire population and interferes with individual choice, providing information to foster ‘healthy’ lifestyles.
- Health education enhances power techniques since health is the major point of contact between government and population. Uses all the above techniques to form a code of normalization
- Discipline
- Surveillance – GAZE
- Critical inquiry fixed to gendered privilege with male individualism, liberal concepts of equality and participatory democracy
- Emancipatory
- Ignores women’s concrete embodiments and locations in discursive power relations (Lake 1992)
- Radical health education focuses on empowering people to control their own health through participation in health policies but ends being both empowerment and control through subjugation as participation becomes the new norm – power over life
- No educational process can only liberate because at the same time it disciplines bodies
- Deconstruction
- Analyzing the causes of powerlessness
- Key assumptions, goals, and pedagogical practices fundamental to the literature on critical pedagogy – namely “empowerment”, “student voice”, “dialogue” and even the term “critical” – are repressive myths that perpetuate relations of domination (Ellsworth 1992, p91)
- What are the rules allowing the generation of statements?
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Source</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships</td>
<td>Power relays through intellectual elite, subordination, compliance, surveillance, exclusion, medicalization. Complex – resistance, reconstruction of policies with empowerment, subjugation, norms and deviant behaviour all playing a role. Medical relationship characterized by someone else knowing what is good for you – governable bodies.</td>
<td>Duality of oppressor/oppressed. Women become nurturers, held ‘responsible for the freeing of each little individual, and therefore for the management of an idealist dream, an impossible fiction’ (Walkerdine 1992, p16)</td>
<td>Constant negotiation of power relations. Exploring connections among local systems of subjugation and apparatuses of knowledge.</td>
</tr>
<tr>
<td>Internalization</td>
<td>Perfection of performance, competence, compliance. Internalize negative characteristics of marginalized devalued groups of people. Since identity constructed from the outside, health education is an experience of being governed from the outside and a request for self-discipline. Implies an internalization of failure in meeting norms. Internalization of surveillance medicine.</td>
<td>Internalize negative characteristics of marginalized devalued groups of people.</td>
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<tr>
<td>Subjectivity</td>
<td>Body implicit in subjugation as identity constructed through symptoms, disease, or lifestyle.</td>
<td></td>
<td>Increasingly fragmented and multiplied, decentered and counterposed</td>
</tr>
<tr>
<td>Self-Policing</td>
<td>Women have heightened self-policing as a legacy of caring for other and subordinate status. Self-policing includes surveillance of one’s thoughts, feelings and conduct, ongoing self-judgement, self-criticism, insidious comparisons with others and personal isolation.</td>
<td>Self-policing includes surveillance of one’s thoughts, feelings and conduct, ongoing self-judgement, self-criticism, insidious comparisons with others and personal isolation.</td>
<td>Externalized and related to contextual space.</td>
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<tr>
<td>Self</td>
<td>Enlightenment</td>
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<td>---------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
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<tr>
<td>Divided within self</td>
<td>Chasing Utopias that constrain the will to knowledge</td>
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<tr>
<td>Struggles against domination, exploitation, or against that</td>
<td>Perfect health for all but at the same time still at risk</td>
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<tr>
<td>which ties the individual to himself and submits him to others in</td>
<td>therefore even utopian ideal of health in conflict with itself</td>
<td></td>
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<tr>
<td>this way</td>
<td>Confession bridges micro- and macro-physics of power because it links</td>
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<td></td>
<td>individual bodies to the social body</td>
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<tr>
<td>Self emptied out as health education governs from the outside and</td>
<td>Freedom from oppression – an impossible fiction</td>
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<tr>
<td>subjects willingly engage in their own subjugation through requests</td>
<td>Total autonomy and liberation are not possible for any human being. Health</td>
<td></td>
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<tr>
<td>for self-discipline</td>
<td>education seen as empowering and controlling in that it extends gaze over</td>
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<tr>
<td></td>
<td>entire population, and it covers most of the issues relating to life, and</td>
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<td>is put into practice by a network of professionals from social workers to</td>
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<td></td>
<td>psychologists therefore freedom impossible</td>
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<td></td>
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<tr>
<td>Universalized self and social empowerment</td>
<td>Maturity – refuse what we know ourselves to be</td>
<td></td>
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<tr>
<td>Individual is manipulated into a certain sense of self – fixed to</td>
<td>Individuals might work through, come to terms with, and move beyond their</td>
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<tr>
<td>gendered privilege of male individualism</td>
<td>own historical contexts</td>
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<tr>
<td>A mirror image of infinite regress</td>
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4th August 2005

Dear Participant,

This project was initiated after the completion in 2003 of a project ‘Rural W.A. Therapy Assistant Project’ funded by the Combined Universities Centre for Rural Health (CUCRH) and the Disabilities Service Commission (DSC) which clearly showed that there is a need for ongoing study of all health workers’ needs in terms of training and education.

This project aims to explore issues of power in relation to work and training in the health service industry as this is currently missing in training. This type of exploration may help to understand some longstanding issues related to the training and work of health workers. The way that health training informs how professionals come to understand themselves and other people, and how this then translates into practice is important since this understanding forms the work that health workers do within the health field.

In order to continue this exploration, health personnel and other interested people in your health service will be contacted over the coming months in order to ascertain their interest in participating in this project. Participation will take the form of one on one interviews with the health service buildings. Feedback will be returned to the staff in the form of a summary of interviews.

I look forward to speaking with you in the near future. If you have any queries in relation to this process or would like further information on the progress of the project to date, please do not hesitate to contact me or my supervisor, Dr Dorit Maor, at Murdoch University (Telephone: (08) 9360 7257; email: dmaor@murdoch.edu.au).

Yours sincerely,

Wendy Lowe
Researcher
CONSENT FORM TO TAKE PART IN THE STUDY – INTERVIEWS

Title of Study: A Post-modern Analysis: A Study of Power Relations and personhood with implications for education of health workers in W.A.

You are invited to participate in a study which will assist the researcher in exploring issues of power in relation to work and training in the health service industry across W.A. using a critical pedagogical framework for the analysis. This is currently missing in health training and its use may help to understand some longstanding issues related to training in the health field. Themes of women, identity and power run across the study and the exploration of these themes may lead to a greater understanding of the work that health workers do within the health field.

Risks and Benefits

There are not thought to be any risks associated with participating in the interviews. You are free to withdraw from the study at any time you like. If you participate in the study the results will be available to you at the completion of the study.

Privacy of Records

Any information obtained in connection with this study and that can be associated with you will remain confidential. The interviews will be recorded by a tape recorder and the tapes listened to only by the researcher and the supervisors involved in the study. On completion of the analysis of the tapes, they will be stored in a confidential manner. Any written information pertaining to you will be anonymous, with codes used during data collection. This means that each participant will be allocated a code number. The code number will then be used throughout the study to identify your data. The data will be stored for a period of five years, after which time it will be destroyed.

Conclusion

Your decision whether or not to participate in this study will not interfere with any future work situation. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time. My supervisor and I are happy to discuss with you any concerns you may have on how this study has been conducted, or alternatively you can contact Murdoch University’s Human Research Ethics Committee on 9360 6677.

Researcher: Wendy Lowe – Email: wlowe@murdoch.edu.au
Supervisor Contact Details: Dr Dorit Maor – Telephone: (08) 9360 7257 Email: dmaor@murdoch.edu.au
CONSENT FORMS FOR PARTICIPANTS IN THE STUDY – INTERVIEW

Title: A Post-modern Analysis: A Study of Power Relations and personhood with implications for education of health workers in W.A.

AGREEMENT: I acknowledge that I have been given a copy of the consent form and have read and understood the information provided. Any questions I have asked have been answered to my satisfaction. I agree to take part in this activity, however, I know that I may change my mind and stop at any time. My signature indicates that I agree to participate in this study.

I understand that all information is treated as confidential and will not be released by the researcher unless required to do so by law.

I agree for this interview to be taped.

I agree that research data gathered for this study may be published provided my name or other information which might identify me is not used.

__________________________________  _______________________
Signature                        Date

STATEMENT OF THE RESEARCHER: I certify that I have reviewed the contents of this form with the person signing above, who, in my opinion, understood the explanation.

__________________________________  _______________________
Researcher                       Date

Wendy Lowe, School of Education, Murdoch University, South Street, Western Australia

Email: wlowe@murdoch.edu.au
Supervisor contact details: Dr Dorit Maor – Telephone: (08) 9360 7257 Email: dmaor@murdoch.edu.au Postal address: School of Education, Murdoch University, South Street, Murdoch, W.A. 6150
Appendix 10.2  Interview Questions

Telephone: (08) 9360 7257 Email: wlowe@central.murdoch.edu.au

Wendy Lowe
Title: A Post-modern Analysis: A study of power relations and personhood with implications for education of health workers in W.A.

INTERVIEWS

The interviews will involve willing participants to be involved in a taped conversation around the following questions:

Can you talk about your practice? What (aspects) do you feel passionate about? Can you talk about your ideas about health/well-being? How would you describe your approach? How do you see your role?

How would you define success in your work? What kinds of qualities, skills, capacities do you believe people in your field need to be successful? Tell me about your training? What was it like? What were the strengths/weaknesses? Did you feel adequately prepared? Was there anything missing from your training that you would like to add? Were issues of sexuality, gender, cultural differences addressed as part of your training? Were any social issues such as poverty addressed as part of your training?

Did people have any concerns about the training? Was there anything excluded? Was there anything you questioned about what you learned? Did you raise these questions with the lecturers? What was the response? Did the instructors encourage any critical thinking? Did other students raise any questions?

In what ways do you see power as being manifested in your everyday practice? Do you feel empowered working in the health field? Have you ever felt disempowered? In general terms, can you talk about your relationship with your self? How have your interests in health influenced this?
Appendix 10.3 – Analysis of curricular phenomena

The following statements include some assumptions for the current health worker curriculum development in Appendix 10.4. These are included in order to state the assumptions underlying the ideas in the following curriculum phenomenon table.

1. Life is complex.
2. Life is a process.
3. Change is a part of life.
4. Change is a process.
5. There is no one right way to be.
6. People try and make sense of their experience.
7. People try and organize their experience.
8. People attribute cause and effect (causal associations leading back into earlier assumptions).
9. Helping people understand their process is more important/effective than in helping them to understand the facts.
10. Health and lifestyle are interrelated.
11. Health is a result of the interrelationships between culture, behaviour, environment, cognitions, affect, physiology, relationships.
12. Lifestyle is affecting lifestyle. Health is affecting health. No separation.
Life is complex

There is no one right way of being or doing

Life is a process

People try and make sense of their experience

Health and lifestyle are inter-related

Change is a part of life

People try and organize their experience

Health and lifestyle are not separate

Change is a process

People try and attribute cause and effect (links in with previous assumptions)

Health is affecting health. Lifestyle is affecting lifestyle.

Facilitation of the understanding of change and process is more important/effective than helping people understand facts

Different theories are applied to different situations

Health is a result of the inter-relationships between culture, social, behaviour, cognitions, affect, environment, physiology, relationships.

People attribute their own health to their own life story – personal and universal

Physical activity has an association with the incidence of heart disease, as do smoking, high blood pressure, alcohol, low socioeconomic status, minimal education, social isolation, stress, job strain, poor control at work, etc.

These factors also have an association with physical inactivity, for example.

People try and make sense of their experience

People try and attribute cause and effect (links in with previous assumptions)

There is no one right way of being or doing

Life is a process

Health and lifestyle are inter-related

Facilitation of the understanding of change and process is more important/effective than helping people understand facts

Different theories are applied to different situations

Physical activity has an association with the incidence of heart disease, as do smoking, high blood pressure, alcohol, low socioeconomic status, minimal education, social isolation, stress, job strain, poor control at work, etc.

These factors also have an association with physical inactivity, for example.
Goal is to emphasize that how health professionals are educated is important. Emphasis of congruency between what we say and what we do as health professionals. No separation between subject and object.

<table>
<thead>
<tr>
<th>Phenomena</th>
<th>Categories</th>
<th>Question</th>
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<tbody>
<tr>
<td>KNOWLEDGE</td>
<td>Learning is an important part of health service delivery – inclusion of health professionals’ self as part of the learning process.</td>
<td>CONTENT</td>
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<tr>
<td></td>
<td>Critical pedagogy – structuring binaries, no self that isn’t influenced by cultural, social and political structures.</td>
<td>WHAT?</td>
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<tr>
<td></td>
<td>Political, cultural and historical antecedents of health. Contingency factors.</td>
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<td>Understanding of health – physical, mental, emotional, spiritual well-being.</td>
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<td>Relating how you feel emotionally to physical i.e. interrelatedness</td>
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<td>Understanding of subjectivity, discourse and knowledge/power – formation of the self-policing self – Technologies of self.</td>
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<td>Positioning and power – notions of control and choice.</td>
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<td>Role of personhood of health professional in therapeutic encounter.</td>
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<td>Research/Learning process – qualitative, quantitative, evidence-based practice, practice-based evidence, feminist critiques, critical autoethnography, case studies, RCT’s.</td>
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<td>Understanding of physical health – optimal height: weight ratio, functionality.</td>
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<td>Health associations of overweight, smoking, lack of exercise, gender, culture, drug and alcohol abuse, ageing, housing, income, education.</td>
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<td>Knowledge of specific disease processes if relevant i.e. diabetes, CHD, arthritis, CA</td>
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<td>Anatomy, physiology, biomechanics, physics, chemistry – science.</td>
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<td>Limbic resonance, limbic regulation and limbic revision</td>
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<tr>
<td>SKILLS</td>
<td>Skill of ‘Felt Sense’ – knowing/understanding your body, interpreting inner body sensations (of what it feels like to feel good vs when it feels bad = sluggish, no energy). Tapping into your own inner wisdom.</td>
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<td>Embodied reflexivity, contextual narratives, curriculum performance, habitus – relationship between objective structures and subjective experience especially important in health where traditionally there has been such a hierarchy</td>
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<td>Practices of the self – polishing the mirror of the heart, relationship with the jeweled inner life.</td>
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<td></td>
<td>Recognising appropriate range of supports, to use strategies available – make best choice for the person.</td>
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<td></td>
<td>To negotiate with service providers to get what you want.</td>
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<td></td>
<td>To recognise when you are not getting what you want and how to appeal that without being positioned as ‘outside’. Behaving in a way not defined by somebody else.</td>
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<td></td>
<td>Relations</td>
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</table>
ATTITUDES
Recognising, including and honouring one’s own inner wisdom.
Following impulses – giving yourself permission.
Stop the censor.
Overcoming fear of failure, looking stupid, being subject to ridicule.
Overcoming fear of environment – safety issues (internal, external – government policy).
Cycle/circle of addictions – moving forward to understanding positioning and control
Building on the successes – knowing the difference. What rewards.

EXPERIENCES
1. Safe learning experiences about health
   • Personhood of educator – values emphasized, ethical being.
   • Feminist critiques of power.
   • Practices of the self – becoming, and jeweled inner life.
   • Continual awareness of the workings of power itself
   • Implications of being a critical pedagogue
   • Relational pedagogy
   • Limbic resonance, regulation and revision
2. Experience tailored to different groups/individuals (middle age, elderly, Noongar, school age children, rural, metropolitan, remote, diabetics, people with disabilities, farmers, mothers) thereby meeting different needs
3. Accessibility – whole population approach, no marginalization of different groups. Awareness of social disadvantage of institutions.
4. Experience of being a valued, respected citizen – listening to what people have to say, so that they feel heard (i.e. not being told to do something else, that there is something else wrong with them – Deficit model) (Instead of being well-resourced).
5. Experience of community – getting out and about in your community.
7. Interaction with facilitators of process.
8. Referral to further information if required.

WALKS, DIET ADVICE, ETC
Walking shoes, maps, compass, safe footpaths, watch, signage, etc.
Experience of healthy cooking ‘wholefoods’, shopping for health, role of different foods in emotional well-being, gluten free cooking.
Mental health – well-being through (well-resourced) relationship, ‘Strengths’ assertive Outreach – A review of Seven Practice Development Programmes – decrease isolation – particularly relevant in rural W.A. for newcomers

ADVOCACY
Networks with relevant government groups, local council, ngo’s, etc
Role of inequity advisors.

WORKSHOP FORMAT
Butcher’s paper, crayons, drawing around body – how do they experience body.
Natural environment – represent themselves – leaves, flowers, etc.
Chairs, clear space on floor.

EDUCATION/INFORMATION DISSEMINATION
Overheads, OHP, whiteboard pens, printed matter – copies of relevant journal articles.

LEARNING/TEACHING (Assumption that learning is important to health as a practice of the self)
Principles of adult learning – critical pedagogy, inclusion of the self
### Action Learning and Reflective Practice – embodied reflexivity

- **Discussion/Brainstorming**
- **Experiential**
  - around body, felt sense, drawing
- **Meaningful material**
  - holistic approach – physical, emotional, cognitive, spiritual.
- What can they do? How can they be effective?
- **Provide for early success**

### Deconstructive/Integrative Framework for Health

- Emphasis on being, congruency, ethical socially accountable practice

### Health Promotion/Education Theories in Use

**Based on individual risk factors (from an historical perspective – need to be able to speak the language of the oppressor)**

- Classical learning theories – operant conditioning, classical conditioning
- Health Belief Model
- Health Locus of Control
- Protection Motivation Theory
- Transtheoretical model (Stages of Change/Prochaska & DiClemente)
- Relapse Prevention
- Social Cognitive Theory
- Social Learning Theory
- Theory of Planned Behaviour
- Theory of Reasoned Action (Cognitive Behavioural Intention Model)
- Social Support
- Ecological perspective – multiple levels of influence
- Supportive Environments

### Incidental activity – Inequity Advisors

- Advocacy
- Supportive environments
- Social determinants of health
- Policy change
- Lobby government
- Community action (planned with, not for) – strengthen politically
- Paulo Freire – educating for change – political activism

<table>
<thead>
<tr>
<th>CONTEXT</th>
<th>WHEN?</th>
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<tr>
<td><strong>HISTORICAL</strong></td>
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<tr>
<td>1970’s “Life. Be In It.” ‘Norm’ – average white Australian male. Media campaign.Motivation – death from CHD – increased cost to health service therefore try to reduce costs by decreasing incidence and therefore risks (diet, exercise, smoking, etc)</td>
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<tr>
<td>WHO – Health is “a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity”.</td>
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</table>

Health promotion is the process of enabling people to increase control over, and to improve their health. It is concerned with altering the behavioural and the social risk factors that influence health.

This emphasised education by providing health information. Criticised because of the naïve assumption that knowledge is sufficient to bring about change, and that it is unethical to focus on the individual = victim blaming.

Education through varied audio-visual channels.

Broadening of education strategies to include adult learning into health education.

Strengthening of scientific base of social, behavioural and educational research applied to health.

Education plus environmental change.

Health promotion.

Community participation.

Social Ecological Approaches – the social, institutional and cultural context of people-environment relations. Considers the interrelationship between individual
and their social, physical, institutional and cultural environments.

1974 Lalonde Report – health as an outcome of interacting social and environmental factors suggesting four contributing elements:
- Inadequacies of the existing health care system
- Behavioural factors on unhealthy lifestyles
- Environmental hazards
- Human biological factors

Black Report, U.K. (1979) Inequalities in Health – showed evidence that social determinants of health were more influential than previously thought.

Public Health & Health Promotion – Ottowa Charter (1986):
“Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities” (Ottowa Charter for Health Promotion 1986)
- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting health services

Systems approach emphasising social, economic, political, institutional, cultural, legislative, industrial, and physical-environmental milieus in which behaviour takes place.

WHO 1997 Jakarta Declaration – five priorities for the 21st Century:
- Promote social responsibility for health
- Increase investments for health development
- Consolidate and expand partnerships for health
- Increase community capacity and empower the individual
- Secure an infrastructure for health promotion

Tension between individual vs systems approach. Proponents of the systems view argued that interventions aimed at changing individuals are inadequate because the system is a more powerful determinant of behaviour than the choices made by individuals. Proponents of the lifestyle approach argue that individual behaviour is responsible for a large proportion of the leading causes of death and disability and are under at least some control by those at risk. To deprive individuals of information and skills needed to take action is unethical. Education and persuasion is also needed in order to make changes to the system.

Intersectoral action for health – in order to improve the effectiveness of the health care system, improve the efficiency of the health sectors’ effort to improve health, achieve social justice, enhance sustainability of effects. Conditions for effective intersectoral action – necessity, opportunity, capacity, relationship, planned action, sustained outcomes.

Comprehensive health promotion:
- Methods – preventive health, health education, mass media, sponsorship, coalition building, advocacy, organisational change, healthy public policy.
- Key Settings – home, school, work, community, sport, art, health care
- Target Groups – children, adults, elderly, NESB, Aboriginal, Adolescents.

Capacity Building – building infrastructure, building partnerships, and building problem solving capabilities. Infrastructure required for an effective public health system:
- Surveillance and information systems
- A knowledgeable and skilled workforce
- Research and development capacity
- Legislation
- Policy, planning and management systems
Partnerships require:
- Effective leadership and relationship skills
- Attention to structures, processes, and resources in order to ensure sustainability
- Organisational culture that values learning and innovation

Capacity Building Process and Outcomes Indicator Project – nine checklists used for planning and evaluation:
1. The strength of a coalition
2. Opportunities to promote incidental learning among other health workers
3. Opportunities to promote informal learning among other health workers
4. Whether a program is likely to be sustained
5. The learning environment of a team or project
6. Capacity for organisational learning
7. Capacity of a particular organisation to tackle a health issue
8. The quality of program planning
9. Community capacity to address community issues

Experience in health promotion at a community level may help build a more generalised capacity akin to problem solving capacity. It is believed that developing skills and capacities in communities to affect the issues and decisions that affect their health is what health promotion is all about. Especially considering the social determinants of health. In that sense community development and capacity building at a community level are the same, where issues determined by the community itself drive the agenda. = learner centred.

Commonwealth drive for national priority areas – drug & alcohol, injury prevention, immunisation, nutrition, physical activity.
State HDWA: Nutrition (..... and physical activity, but still no business plan or funding to support program).
State WA: Ministry of Transport (Pedestrian Strategy in Metropolitan area), Main Roads, CALM, Police – SaferWA, Ministry of Sport and Recreation,
State: Victoria – Be Active For Life
State: NSW – the Active Australia Toolkit

Primary Health/Prevention
Medical model – hierarchical information deficit – “we know what is best for you”

**PHYSICAL**

Information dissemination - Anywhere
Local councils
Local meeting places
Community based – away from institutions – hospitals (places of sickness and ill-health, iatrogenic illness). Or anything associated with large all powerful infrastructure.

Advocacy – anywhere. Build community skills. Healthy Communities. Comes from the community first.

Walking – anywhere safe. Footpaths, local areas/suburbs, bush, seaside, Heritage Trails, Central Business District, etc.

**PSYCHOLOGICAL**

Other psychological factors impacting:-
Target groups – low socio-economic group more at risk of detrimental health behaviours – poor nutrition, increased drug and alcohol use, devalued members of society, on the fringe. May be depressed leading to sedentariness, not want to change. Learned helplessness, not empowered, no money. Scared, frightened, anxious. Confused about differing messages from health professionals.
Cynicism about any government department. Institutional oppressiveness – neo-liberal rhetoric

Peer pressure – can work positively or negatively. Negatively – other people may feel threatened by their desire to change and therefore try to sabotage efforts. Goes very much into interpersonal realm, Family Systems, etc.

Family pressures – to look after children, interactive dynamics of family. Too little time, too much to do. Families often in crisis – looking after themselves is the last thing on their mind and often a highly skilled task. Don’t value themselves enough to allow themselves to look after themselves.

STUDENTS
Potential health professional students
Population Approach
Anyone in the community - citizens

Target Groups:

Individual Differences in potential students (Standpoint pedagogy):
- Educational background
- Level of health
- Motivation to exercise
- Beliefs about exercise
- Level of support at home to increase physical activity
- Type of work/industry
- Unemployed or employed
- Family situation
- Home environment
- Income
- Ecological environment
- Local Council
- Culture
- Time available
- Body image
- Self-efficacy
- Locus of control as a construct and shared meaning
- Experience in the past with health professionals

Peer Group Values

Governments – power. How empowered are people to make changes in their life? How/what choices can they make? Power related to funding/money – poorly funded scheme = little chance of success. Picking up on incongruencies in practice and pedagogy

TEACHERS
Health Promotion Officers, Nurse educators (diabetes, immunisation), Project officers, Health Professionals – anyone else in health field.
Education Department
Peer educators – ‘Stay on Your Feet’
Role models in community
Academics
Disease specific organisations - Heart Foundation, Arthritis Foundation
HDWA
Any other government departments
Healthways – funding bodies
International – CDC Surgeon General
Professional differences
Power differential – who has information, money, ability to make decisions, be heard by those who make decisions.
APPENDIX 10.4 – DECONSTRUCTIVE/INTEGRATIVE FRAMEWORK FOR DEVELOPMENT AND ANALYSIS OF HEALTH PROFESSIONAL CURRICULUM

A deconstructive/integrative framework is provided as the abstract manifestation of a program. The framework is linked to a practical concrete program by a process that involves the development of the meta-curriculum as outlined in Appendix 10.4. The meta-curriculum statements are a series of generalisations that ultimately inform practice and the details of any program. Some points are listed below in reference to the linkage between the framework and program development:

- Theory informed practice is a mark of quality and is used to:
  - Identify strategies
  - Identify critical sequences
  - Set limits on what can be achieved
  - Identify essential components or ingredients of key phenomena in capacity Building

- A framework can be used to discriminate between different practices and evaluate outcomes of research i.e. keep in and throw out ideas.

- A framework can be used to develop criteria for accepting information e.g.
  - Must be holistic
  - Evidence based and practice based
  - Non-violent
  - Client centred
  - Not reductionist medical model
  - Enhance community learning
- Promote unity/collaboration

- A set of principles can then be developed from the above.

- Within each strategy – whether individual or population based – framework can be used as a checklist to ensure:
  - Multiply determined nature of health/ill-health is considered
  - Interconnectedness between determinants is acknowledged, measured, evaluated
  - Future – impact of inter-relatedness – research into this
  - Reinforcement of the notion of relationship as an overarching component of any strategy – capacity building.

- Such a framework acknowledges that life is complex and that the big picture needs to be filled out including an analysis of relations of power. Multiple strategies are more likely to succeed and be more effective than a singular approach.

- Building on work such as Blooms’ Taxonomy, each domain of the deconstructive/integrative framework can be an outcome in itself. However, a relational pedagogy is vital.

- As part of a learning process, the framework acts as a curriculum. Because it is integrative and deconstructive, bringing together the curricula of individual programs whilst analysing the discourses, the framework acts as a meta-curriculum which therefore means that the information
  - Becomes transferable
  - Aids learning
  - Increases integration
• Decreases fragmentation

• Ensures transparency of information, process, program development

• Shows inter-relatedness, it is not exclusive

• Can be used for cross-reference

• Aids communication and co-operation

• An example of a meta-curriculum statement is that life is complex. This can be titrated down to a curriculum statement that “Health is a combination of the inter-relationships between culture, social structures, behaviour, cognitions, affect, environment, physiology, relationships”.

• This framework is different in that each domain is shown in a circle, with the seven circles making a larger one. This is to denote that the process is cyclical and ongoing. Unlike linear, causal or hierarchical frameworks (which could also be seen as paternalistic, patriarchal and dualistic), this framework does not try and attribute cause and effect in any particular order.

• Framework is also different because it acknowledges the importance of relationships as a key part of any process. This is different to the Mandala Model of Health as suggested by Hancock and Perkins (1985).

• Benefits of an integrated/deconstructive framework for curriculum development could include:-

  • Integrating the concepts to lessen the likelihood of victim blaming

  • Interrupting the cycle of disempowerment

  • Decreasing the learned helplessness

  • Builds on previous work of a great many fields
Reframing – not just a problem of the individual or just of society

- Disadvantages of an integrated framework for strategy development include:
  - trying to do too many things at once, can be confusing
  - takes longer, therefore
  - consumes more resources in development, planning and implementation
  - not necessarily quick results either (especially when considering short term contracts for jobs)
  - lack of consistency across field – not many other people think like this
  - probably a general lack of understanding and valuing of the process

The following diagram shows the integrative framework with the domains inner body sensations, cognitive, behavioural, affective, relationships, environment and spiritual. It has been adapted from the Health Mandala Model of a health ecosystem. In the centre is awareness which highlights the importance of relationships within context as in the Health Mandala Model. However, the difference is that the relationship between each domain is considered just as important, if not more so, than the domain itself. Each domain will now be discussed in more detail.

**Inner Body Sensations** – relating to the physiological manifestations of disease and health. Limbic resonance, regulation and revision work at this level (Lewis, Amini and Lannon, 2001). Blood pressure, cholesterol levels, atherosclerotic plaques and hormone levels, for example. Marmot and Wilkinson (1999) believe the stress response (with its concomitant inner body response – racing heart, blood diversion away from digestive
system to large muscle groups, pallor, etc) is the mediator between stress in the environment and the eventual manifestation of disease. The biological pathways activated by a stressor involve stress hormones that act directly on the cardiovascular and immune systems. People stuck in a chronic stress response have high levels of hormones and cholesterol and this can lead to disease such as depression, increased susceptibility to infection, diabetes, high blood pressure, and accumulation of cholesterol in blood vessel walls, with the attendant risk of heart attack and stroke. Stress response can be described as flight, fight or freeze. As an example, when evaluating physical activity programs, measurement is usually taken of blood pressure, cholesterol levels, etc (risk factors for cardiovascular disease). Physical activity has been shown to have a beneficial effect on these factors but this doesn’t always necessarily translate into a reduction in the incidence of cardiovascular disease. This could be due to some other over riding factor to do with the lack of perceived control over one’s life (http://www.abc.net.au/rn/talks/8.30/helthrpt/stories/s14314.htm). Most medical programs address the sequelae of the stress response.

**Cognitive Behavioural** – the level of participation in healthy lifestyle is ultimately seen as a behaviour with associated thoughts. Thus historically most health interventions have been aimed at changing the thought and/or changing the behaviour with the concomitant learning models of classical and operant conditioning. The changes in theories of adult education do not seem to have filtered through to health promotion programs. Most programs are directed at changes in peoples’ behaviour and/or cognitions with theories

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4 There are thought to be four ways in which it can be done – a particular type of response may be directly responsible for a disease; reactivity may increase vulnerability to certain illness; the pattern of reactivity may disrupt existing disease processes; and also the response may act as a trigger for acute events such as a heart attack (Brunner and Marmot 1999).
including Health Belief Model, Health Locus of Control, Transtheoretical Model, Theory of Reasoned Action, Theory of Planned Behaviour, Supportive environments, Social Cognitive Theory and Social Learning Theory. The cognitive behavioural strategies have been found to have the largest effect size (Sallis and Owen, 1999). The only disadvantage with focusing on cognitive behavioural strategies is that other major factors seem to be excluded entirely. It has been said that individual risk factors account for 40% of disease manifestation and social determinants account for the other 60% (http://www.abc.net.au/rn/talks/8.30/helthrpt/stories/s14314.htm). Although how this has been determined is not discussed.

**Affective** – Peoples’ value of themselves and of their health will affect the level of participation in physical activity. Behaviour relevant to health is powerfully shaped by childhood experiences and some psychosocial risk factors for poor health are mediated through an individual’s social circumstances such as isolation, lack of social support, poor social networks, levels of civic engagement, low self-esteem, high self-blame and low perceived power (Baum, 1998). For example, pressuring people into more physical activity by making the sedentary appear as slothful robots may not be the most effective way to address physical inactivity in the sedentary. The affective domain is most important on how programs are carried out – are they respectful, are they non-violent in their depiction of people at which they are aiming the strategy, etc. Limbic resonance (Lewis, Amini and Lannon, 2001) works in the affective realm.
Cognitive, Behavioural and Affective components of learning have been used together to denote competency in adult education. These three components could be said to represent embodiment. By combining these components along with the other domains that affect health, it is believed a fuller, more meaningful curriculum in health will be achieved.

**Relationships** – Relational pedagogy is important here in order to be able to consider the relation between all aspects of service delivery and health professional practice (Bingham and Sidorkin, 2004). For full details see main text. Limbic resonance through reflection back of subjective experience is important as is considering constructs such as control relational.

**Environment** – this can include public health notions of environmental factors such as water, food, air pollution, etc. And it can also include the cultural and sociopolitical environment – how the contexts affect health. The environment can be more or less supportive of health through infrastructure, structural changes, policies and programs.

**Spiritual** – some people suggest that spirit plays a larger part in our health than is acknowledged (Tacey, 2000). One definition of spirituality is suggested as ‘relational consciousness’ by which is meant a heightened awareness of being in relationship to God (spirit), people, the earth and ourselves (Hay cited in Wood, 2000). Spirituality is discussed as being rooted in a desire to belong, a desire to connect with the source of all love. For different people this may mean different things. Disconnection from this
source is said to be a result of childhood conditioning that our worth depends on our behaviour, leading to a sense of shame. The focus on behaviour change by most healthy lifestyle programs may only serve to further alienate people, especially those that are perceived as unhealthy, and increase the sense of not belonging within their community.

Fostering a sense of belonging is integral in helping communities to become healthy. “It is a sense of belonging which often allows a rural community to survive against all odds ……. It is often inclusiveness which makes people want to stay in a country town, the sense that everyone belongs in the community” (Sidotti, 1999, p. 5). Involvement in the community creates a sense of belonging for program developers, while involving the community in program development fosters a sense of belonging and ownership of the program. This involvement is essential for any community but is especially vital for rural and remote communities who have often been left out of the loop of local planning and service delivery.

If spirituality is rooted in a desire to belong, then this definition also has implications for Aboriginal health. “To Aboriginal people, ill-health is more than physical illness; it is a manifestation of other factors, including spiritual and emotional alienation from land, family and culture” (Jackson and Ward, 1999, p. 439). It may be that before any health program can be implemented with Aboriginal people, factors such as unemployment, social exclusion, loss of control, and issues of identity will need to be addressed (Hunter, 1993; Jackson and Ward, 1999; Colomeda and Wenzel, 2000; Eades, 2000). Perhaps through community development, socially accountable practices and the incorporation of
culturally secure facilities these factors will be addressed (Office of Aboriginal Health, 1999; HDWA, 2000, Riggs, 2004).

Summary – Cognitive, Behavioural and Affective components of learning have been used together to denote competency in adult education. By combining these components along with the other domains that affect health, it is believed a fuller, more meaningful curriculum in health will be achieved. For example:

It seems probable that a multiple approach, using techniques derived from behavioural, cognitive-behavioural, self-management, and social learning theories, and from social-psychological principles, is likely to be superior to any single approach to promoting exercise. A further important principle is that interventions are most effective when they are specific and designed to fit particular groups of people in particular settings, operating simultaneously at personal, group, and organisational levels (Lee and Owen, 1986).

Theoretical integration in a multidisciplinary field such as the promotion of physical activity has been suggested as an imperative if social, behavioural and biomedical colleagues are to understand one another (Lee and Owen, 1986).

Health is a complex matter to define, full of paradox and confusion:

Health, inside the individual, was seen as the product of harmony, equilibrium and self-fulfilment. Illness, on the other hand was seen as an assault from outside, caused by the wear and tear of modern life. Individual behaviour was also implicated, but this could itself be a product of the assaults from outside (Blaxter, 1997, p. 750).

As a resource, health may be viewed as a measure of capacity to engage in physical activity, and therefore any relationship between the two variables could plausibly be interpreted as reflecting the effect of health on the rate of activity rather than an indication of the beneficial effects of activity on health (Blaxter, p. 194).
It is believed a theory of health is required that encompasses that complex system, the human being and its many relations (Antonovsky, 1996). There are dangers inherent in health promotion because of its lack of theoretical foundation. The integrative/deconstructive framework goes part way to addressing the following question; asked by Antonovsky (1996):

“What can be done in this ‘community’ – factory, geographic community, age or ethnic or gender group, chronic or even acute hospital population, those who suffer from a particular disability, etc to strengthen the sense of comprehensibility, manageability and meaningfulness of the persons who constitute it?” (p. 16).