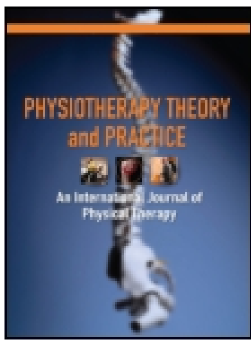

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PERSPECTIVE

Post-structural conceptualizations of power relationships in physiotherapy

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ABSTRACT

This paper uses a post-structuralist lens to explore the nature of power relationships within the patient–physical therapist relationship. To ground the discussion, I begin with an overview of the salient aspects of the traditional evolution of Western medicine. I then draw from the philosophy/history of Foucault to challenge traditional thinking and consider the applications to physiotherapy. The analysis reveals that the application of a Foucauldian frame of reference has the potential of modifying the therapeutic relationship to one that is more equitable as opposed to the hierarchical one. I conclude with a discussion of the implications for the development and education of physiotherapists.

INTRODUCTION

Physiotherapists, like other health care practitioners, are taught how to treat patients' bodies, but not necessarily how to delve beneath the material surface of a therapeutic interaction. As physiotherapy (PT) students, we were taught to see patients through a biopsychosocial framework (Alonso, 2004; Engel, 1977), which "regards social and psychological aspects as giving a better understanding of the illness process" (Alonso, 2004; p. 239). Despite the putative emphasis of the framework on the relationship between biology and the psychosocial aspects of illness and disease, it does not account for the power relationships and inequities that form and inform the bodies and minds of both patients and clinicians. PT necessarily involves a clinical relationship between the therapist, patient, and often others, and this relationship can be complex.

The primary focus of the biomedical framework remains that of a body with a diagnosis/dysfunction, with clinical treatment delivered in a particular way. More recently, and especially with the introduction of the International Classification of Functioning, Disability, and Health (ICF), physiotherapists have begun to think about their practice in different ways that include a consideration of participation in "life situations" (Stucki, Cieza, and Melvin, 2007). Nevertheless, the focus on fixing the body remains central to PT practice (Nicholls and Gibson, 2010). Moreover, how power relationships shape interactions is largely absent from any of the dominant models that underpin current practice including the ICF or the biopsychosocial model. Evidence-based practice, which is increasingly dominant in health care discourse, de-emphasizes the importance of relationships in shaping clinical encounters and decision-making. As health professionals, our views of the world and of the ill or impaired body are formed and dominated by how we are taught to view and thus treat our patients. The biopsychosocial framework suggests a compartmentalization of the patient and clinician who each have specific roles within the health care encounter (Nicholls and Gibson, 2010). It provides little space for the negotiation of power relationships and fails to acknowledge that power struggles exist within the patient–clinician relationship.

There has been little discussion in the PT literature about the multiple ways of understanding bodies beyond the physical or about the effects of power within the patient–practitioner relationship. Because of this, individual physiotherapists may not fully

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appreciate how biomedical knowledge of the body puts them in a position of power in relation to their patients. By the aspects of the power that they hold, and how, by viewing their patients in a particular way, they may further contribute to their marginalization within the therapeutic relationship and, on a larger scale, the health care system.

This paper seeks to explore some of the origins of the power held by health practitioners by drawing on the work of French historian and philosopher Michel Foucault. Foucault's writings explore the invisible nature of power relationships and, consequently, their existence plays a role in shaping the outcomes within the therapeutic relationship. I explore how power relationships play out in patient–practitioner relationships and discuss how PT educational processes might influence and improve these relationships. I begin with a review of the development of contemporary medical and health care practices to situate the discussion of post-structuralism and the critique inherent in some of Foucault's work. In doing so, I outline some of the dominant understandings of health, health care, and the body that have pervaded modern health care discourses and how Foucault's ideas can be used to challenge these ingrained perspectives.

Humanism and the development of "modern Western medicine"

It is helpful to understand that modern Western medicine has been in a relatively continuous evolution during the past 300–400 years (Alonso, 2004; Engel, 1977).

In his foundational work, Engel (1977) described the traditional biomedical model of disease as being based in molecular biology. Engel suggested that during the Enlightenment period (~1650–1800), biomedicine "assume(d) disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables…. [T]he biomedical model embrace(d) both reductionism…and mind-body dualism" (Engel, 1977; p. 130). By "mind–body dualism", Engel referred to the separation of the physical body from the person. This idea was first introduced by Enlightenment philosophers such as Rene Descartes and was a key philosophical shift that helped form modern ideas of the body as akin to a biological machine. Engel's critique of a biomedicine that was designed to study organic disease was anchored in the idea that it only allowed for behavioral illness as being rooted in somatic processes. "Science" as the basis of biomedicine implied observation where the object of observation is the patient as object.

Engel (1977) stated that "… [C]lassical science readily fostered the notion of the body as a machine, of disease as the consequence of breakdown of the machine, and of the doctor's task as repair of the machine" (p. 131). Once this kind of duality was established and accepted, biological processes became the focus of early Western medicine, and behavioral or psychological processes were ignored or excluded from study.

These ideals were reinforced by Enlightenment philosophers such as Descartes, Hegel, and Comte, whose ideas have evolved and influenced contemporary health care and the way we think and behave as clinicians today. Each of these three philosophers, along with others, has contributed to the way we have generally come to accept the division of the mind and body in the twenty-first century. A full discussion of their work is beyond the scope of this paper, but the reader may refer to St Pierre (2000).

The ideas sometimes referred to as "mind over matter" or "the power of the mind" can be thought of as colloquial references to the work of Descartes, who was a key proponent of mind–body duality, and this challenged the temporal teachings of the Church, since *Cogito ergo sum* (I think therefore I am) separated and placed the mind in a superior position to the body.

Descartes' ideas of rationalism were echoed in the work of Hegel, who was a key proponent of the *dialectic*, which linked binaries and their evolution together (St Pierre, 2000). Like an upward-reaching spiral, he described how each idea (thesis) evolved with a response (antithesis) that led to the formation of a new idea (synthesis). Furthermore, Hegel believed in the concept of knowledge as a stable construct. The later work of Auguste Comte held that "true knowledge of the world could only be gained by observation" (cited in St Pierre, 2000; p. 495). Comte's work thus emphasized the importance of the neutral observer who gathered facts about the world through rigorous empirical methods. This required careful attention to the observation of the task at hand.

The philosophies of these three men together were tremendously influential in the development of the modern-day scientific method where the idea of what is true and what is contingent was constructed as stable, permanent, and objective. This position dominates contemporary medicine and health care and pervades the way patients are, by and large, reduced to malfunctioning machines that can be repaired through interventions. Biomechanical discourses are prominent in PT's preference for objective research paradigms, and they lie at the heart of PT's theoretical and practical approaches. Nicholls and Gibson (2010) provided an excellent discussion of how the body has come to be seen by PT and suggested that non-traditional views of the body have

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been rejected, reinforcing the prominence of the biomedical model.

As discussed in more detail below, these assumptions about mind–body dualism and truth exert effects on the clinical encounter. A clinical focus on pathology and movement dysfunction, for example, may come at the expense of engagement with the patients' or therapist's experiential knowledge.

A Foucauldian frame of reference

Foucault's work radically challenged the persistence of the enlightenment model of medicine and his work underpins an emerging body of post-structural scholarship that examines how power mediates the health care enterprise. His work carefully traced the evolution of modern medicine to illuminate how current ideas became dominant. Foucault (1980d) discussed how during the eighteenth and nineteenth centuries, a newly emerging recognition of health became a political and economic challenge in light of the Industrial Revolution. The political sources of power extended beyond the monarchy and the ideas of "war and peace" to include "peace and justice", and this expanded the role of the police, who were assigned the responsibility of enforcing rules of hygiene (Foucault, 1980d). Hygiene became an apparatus of medicine to establish some element of social control, and the hospitals and prisons became the physicians' early laboratories for observation.

According to Foucault (1975, 1980a), the modern medical clinic arose during the eighteenth and nineteenth centuries in post-revolutionary France and Europe. In France, hospitals had previously functioned as vessels for the sick poor, sponsored by foundations and religious organizations affiliated with the hospital. With the advent of the Industrial Revolution, poverty became equated with idleness, and the political power structures of the day were determined to utilize the poor as human capital in the factories; thus, the health and well-being of the population became central to industrial progress.

Foucault identified that it was during this time that the era of what he termed "bio-power" emerged. He outlined the "explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of bodies…embodied in institutions such as the army and the schools" (Foucault, 1978; p. 140). These techniques gave the state and its agencies considerable control over individuals' bodies. The apparatus of medicine gave the physician considerable freedom to examine and "medicalize" social phenomena. It allowed the physician to emerge from a gentleman to an authority figure who studied the biology and pathology of disease in an environment that concentrated these elements. Foucault identified how the relationships between doctors and patients were being considerably changed.

The development of a claim to scientific authority and legitimacy was paralleled in PT. Nicholls and Cheek (2006) discussed the evolution of PT in Britain, in the latter part of the nineteenth century, where prostitution was sometimes masked as therapeutic massage. This necessitated the development of legitimate ties of the masseuses to physicians, which eventually led to the formation of the Chartered Society of Physiotherapy in the early twentieth century.

Engel (1977) similarly outlined how biomedicine acquired "the status of *dogma*" (p. 130):

> Thus taxonomy progresses from symptoms, to clusters of symptoms, to syndromes, and finally to diseases with specific pathogenesis and pathology. This sequence accurately describes the successful application of the scientific method to the elucidation and classification into discrete entities of disease in its generic sense.

Engel was not a Foucauldian, but his critique of biomedical dogma resonates with some of Foucault's key ideas. He argued that the physiological findings of disease may be incongruent with the experience of illness. "Patients", he suggested, may be feeling fine and so do not apply the label of disease to themselves. Bodily experience is unchanged prior to the blood test, until the physician intervenes. He believed that psychological and social conditions helped to frame the patient's experience of the disease, and this has been widely embraced in nursing and psychology (Alonso, 2004) and to some extent in the practice of musculoskeletal PT (Main et al, 2011).

Modern Western medicine evolved into what we today might refer to as the practice of the scientific method.[1] This movement was historically important in bringing humankind from the medieval to the modern era. But like all systems of thought, it facilitated one way of knowing and acting in the world while limiting others. Enlightenment thinkers acknowledged only one kind of truth that was contemporaneously relevant. An example of this may be found in Rembrandt's painting "The Anatomy Lesson of Dr Nicolaeus Tulp" (Figure 1). The image of the physician and his students dissecting a corpse can be seen as an illustration of

[1] Scientific method refers to techniques of investigation of phenomena. It requires the gathering of observable, empirical, and measurable data that can be evaluated through a reasoning process. It starts with an idea "a causes b", and then "a" is tested through an experiment to see if it in fact causes "b".

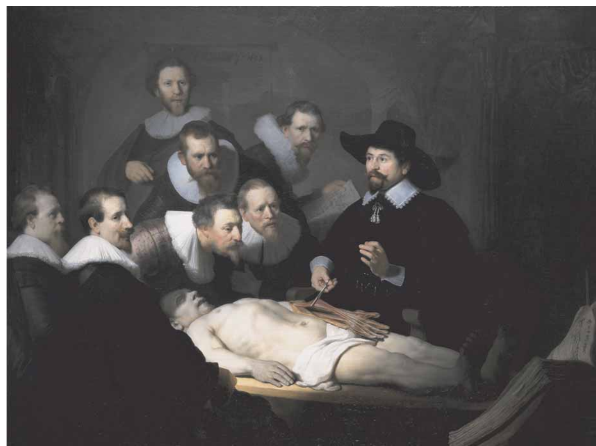

FIGURE 1 Rembrandt, The Anatomy Lesson of Dr Nicolaeus Tulp, 1632, Mauritshuis Museum, The Hague, Netherlands.

Enlightenment's European origins, where truth was constructed from the position of being white, male, gentrified, and Christian and other points of view were more or less viewed as illegitimate.

Enlightenment thought has contributed to contemporary Western belief systems and, as alluded to, these thoughts have been challenged by other thinkers. Foucault helped identify some of the challenges of traditional thought in order to bring about social change. Central to his thesis was the concept of the power relationship between a patient and a practitioner and its impact on health care delivery.

Foucault and power relationships within PT

Post-structuralism, as espoused by Foucault, challenged commonly held definitions of what was knowable and posited that truth takes many forms. He challenged the Enlightenment ideals of the stability of truth and that what we know needs to be deconstructed to explore what is not being said or thought and how power circulates to produce particular effects. This approach was utilized to uncover processes of power and marginalization in the health care system. Post-structuralism incorporates what Foucault referred to as "archaeology" and "genealogy". The former looks to understand "the historical conditions, assumptions and power relations that allow certain statements…to appear" (St Pierre; p. 496). The latter examines what is not being said, thus challenging deeply embedded assumptions that underpin how we think about a concept such as health care (Foucault, 1998; St Pierre, 2000). These methods begin to move away from what is expected and instead allow an examination of phenomena from those perspectives that might otherwise have been repressed.

As stated in the introduction, relationships between a patient and a practitioner are complex. Health professionals, including physiotherapists, have knowledge of the disease/dysfunction and how to treat it versus the patient who has the knowledge and experience of illness, pain, or dysfunction. The clinician holds the knowledge and experience of how to help the patient make decisions regarding the treatment; hence the power relationship is inherently unequal. A Foucauldian framework provides an excellent basis for addressing the issues that may arise within this relationship. Foucault's method of archeology provides a historical perspective for understanding the development of current medical practice, and his method of genealogy of the power relationships helps to explain the disconnects that may be perceived to exist between patients and practitioners (Foucault, 1975, 1977, 1980a, 1980b, 1980c).

From the archeological perspective, PT in Britain, Canada, and the USA evolved during the last century as a profession closely aligned to medicine, and curricula were directed by faculties of medicine until the latter half of the twentieth century, when various PT faculties gained autonomy as the profession evolved. Physiotherapeutic relationships were formed initially based largely on the medical model of thinking (Cleather, 1995; Linker, 2005; Murphy, 1995; Nicholls and Cheek, 2006). It was during this evolution that the assumptions of dominant discourse of biomedical thinking became applied to PT.

From the genealogical perspective, physiotherapists educated in the Anglo-American tradition have been taught that there are necessary boundaries in the patient–therapist relationship (i.e., College of Physiotherapists of Ontario [CPO], 2005). Rules regarding maintaining boundaries are in place to maintain therapeutic efficacy and efficiency and preserve the "objective" role of the therapist. They also protect patients from real or perceived abuse by the acknowledged power holder. In Ontario, for example, some professionals are forbidden to have personal relationships with patients (psychiatrists), and for some others (physiotherapists), a suitable time period must elapse before a personal relationship is allowed. Professional power was thus legitimated by professional bodies, which in turn were internalized by clinicians.

As alluded to earlier, the notions of "power" and that of the "power relationship" are not interchangeable. Power is a broadly interpreted construct with many implications. At its most basic, power can be defined as a force that produces a change (Griffin, 2001). It may be a trait of a profession or an

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organizational (political) structure. These forms of power may be easily visible to the observer. Foucault, on the other hand, discussed power relationships as those involving more subtle and invisible characteristics.

Foucault (1980a, 1980b, 1980c, 1980d) explored power relationships in great detail as they related to the medical complex. By extension, these could be applied to the practice of PT. He identified that power is a relational cluster that is coordinated but not hierarchical, and the perspective is mutable (a "grid of analysis") (Foucault, 1980c; p. 199). In the clinic, for example, a physiotherapist holds the balance of power toward his or her patient during treatment, but the patient may have more equal power with the physiotherapist in a different shared context, such as playing together on a sports team. In the first part of the example, the physiotherapist can determine a course of treatment for his or her patient, whereas on the playing field, the therapist and the patient, if they are on the same team, share equally in achieving their common goal: winning the game.

Foucault suggested that a power-based relationship is fluid, that is, the balance of power can shift back and forth over time and in different contexts. An example from my own experience as a patient helps to demonstrate this point. I initially felt like I was floating outside myself during the period of diagnosis and early treatment. I referred to this period as "dual-ling bedrails" whereby I existed simultaneously as a patient (inside the bedrail) and as a clinician (outside the bedrail) and I experienced internal conflict, both *dual* and *duell*-ling. As I progressed through the medical complex, however, my power relationships with the staff shifted. I became more informed about my disease and treatment options open to me. I became better able to advocate for myself and was less vulnerable. The balance of power had shifted, even if slightly, and I felt more in control of my body and my fate. The question, though, is how was that possible? To understand this, it is helpful to understand Foucault's perspectives on health care relationships.

Foucault demonstrated how health care and health care relationships developed through the evolution of health and hygiene controls by the state. As discussed earlier, health became a locus of primary importance for the government during the early days of the Industrial Revolution, and this apparatus acted as a lynchpin facilitating medical participation within the newly emerging economy. As Foucault (1980d) stated, "The doctor becomes the great adviser and expert, if not in the art of governing at least in that of observing, and correcting, and improving the social 'body' and in maintaining it in a permanent state of health" (p. 100). However, as the able-bodied poor were ejected from the hospitals, the physical structure was no longer used for its initial purpose. The hospital was transformed into a place of observation and intervention rather than into that of charitable assistance. As the hospital evolved, so too evolved the "hierarchical prerogatives of doctors" (Foucault, 1980d; p. 104) and, with it, the articulation of knowledge with therapeutic efficiency also evolved. It allowed for the observation of the subject/patient, which was critical for the development of the profession and the professional relationship:

> Doctor and patient are caught up in an ever greater proximity, bound together, the doctor by an ever more attentive, more insistent, more penetrating gaze, the patient by all the silent irreplaceable qualities that, in him, betray – that is, reveal and conceal – the clearly ordered forms of the disease. (Foucault, 1975; pp. 15–16)

Foucault (1975) explained that the rise of medical schools in France during the eighteenth and nineteenth centuries gave the old hospital structures new purpose. He wrote that by observing large groups of patients and submitting them to the "medical gaze" (Foucault, 1975; p. xii), certain conclusions could be drawn about diseases and their progression. Analysis of disease would enable the physician to define it. Observing patients was akin to a painter capturing details in a portrait (Foucault, 1975). Ironically, the closer a physician observed the disease, the farther away the patient became: "(P)aradoxically, in relation to that which he is suffering from, the patient is only an external fact, the medical reading must take him into account only to place him in parentheses" (Foucault, 1975; p. 8). Today, we may continue to unintentionally objectify the patient (e.g., "the pneumonia in room 541"). The patient has been intellectually separated from his or her illness by the very people whom he or she turned to for assistance. Foucault (1975) identified the genesis of this kind of loss of identity:

> …if one wishes to know the illness from which he is suffering, one must subtract the individual, with his particular qualities…if the course of the disease is not interrupted or disturbed by the patient, at this level the individual was merely a negative element, the accident of the disease, which, for it and in it, is most alien to its essence. (p. 14)

Relating this back to my own experience, there were, thankfully, only a few times when I felt that my subjective experience was ignored and my diagnosis and symptoms were the object of care. However, it was

interesting to note that at times when I reported an increase in symptoms, the response was "Well your scans have improved", as if the objective evidence superseded my experience. In these instances, I experienced Foucault's notion of the subtraction of the individual in the health care encounter.

For Foucault, forms of power existed in a relational fashion, a further example of which might be found in his description of the Panopticon (Foucault, 1977). The Panopticon was described as being an ideal type of prison: a tower in the middle with the prisoners in their cells all around in a circle. There was one window outside and one inside each cell, the former lighting the cell, so the prisoner was always visible to the tower inside. The prisoners knew that they were being watched, but the watcher was invisible, and it was the invisibility of this surveillance that succeeded in enforcing order within the prison (Foucault, 1977). The Panopticon has been used as a metaphor for medical practice wherein the clinician knows and observes the patient, but the reverse does not happen (Filc, 2006; Foucault, 1975, 1980a). Filc (2006) described this as being a literal form: a body was put under surveillance, which in turn *produced* a new body:

> In the medical encounter bodies are not only put under surveillance, they are produced. They are produced not only as an effect of discourse, but in a more concrete sense: they are acted upon and transformed. Bodies are produced and transformed by the medical gaze, by touch, medication, changes in habits, or – the most invasive way – through surgical procedures; even up to the point that scholars working within the Foucauldian tradition claim that the very notion of individuality is linked to the medical practice. (p. 222)

This is crucial: by entering the medical complex, patients may experience a shift in their pre-existing identities in unexpected and potentially unwelcome ways. Once a patient is under the scrutiny of the medical gaze, he or she becomes the subject of the health care practitioner. This changes who the patient is, and a new body is produced through intervention – both metaphorically and literally. I related well to this feeling. At each doctor's appointment, I worried about what my doctors said about me, my blood test results, and my scans, and when I left, I was always just a little different, and I know that I will never be quite who I was before. My (Panopticon) experience certainly coincided with feelings of being powerless and disembodied and of being completely at the mercy of the medical complex and questioning my own identity.

This may be readily extrapolated to PT, where, for example, through the taking of the patient's history, the therapist may gain awareness of the patient's personal issues, without revealing himself or herself back to the patient. Patients' knowledge of a physical reassessment of their symptoms becomes the invisible enforcer of compliance with the therapeutic regimen prescribed by the therapist. Patients come to internalize the authority of the physiotherapist, adhering to treatment regimens, often with little questioning. The "non-compliant" patient who questions the expertise of the PT is thus an exception rather than the norm. Hence, Foucault's point about self-surveillance in relation to the Panopticon is as prominent in PT as in other health disciplines.

The decision to seek out PT care results in engaging in a power relationship and may result in an internal struggle with the medical complex ("I'm in pain; I need help, but I'm afraid of physio, because it might hurt…" or "I know I have to get up and go for a walk, but I just don't feel like it right now; I don't care if I get pneumonia…"). It is here that I would suggest that the models that underpin contemporary PT/health care practice and training have a direct bearing on patients. The clinical encounter is the site where power relations get played out and where patients' bodies are constructed according to different kinds of subjectivities.

DISCUSSION

Application to PT

What is the relevance of these theoretical explorations to PT practice? An example of a clinical scenario of a patient with a chronic neurological illness, multiple sclerosis, helps to illuminate the primary issues. The patient is having difficulty mobilizing and has been referred to the physiotherapist for "gait training". Of note, even before beginning the physiotherapist–patient relationship, other power relationships may be coming into play. Depending on the locale, a physician may be required to initiate the referral, creating a three-way relationship among the physician, patient, and therapist, and this may be a further complicating factor during the clinical encounter.

Using a traditional approach, the physiotherapist would take a history, perform an assessment, and prescribe a treatment regimen based on the available scientific literature and best practice guidelines. The physiotherapist would be well aware of the physiopathology of this condition. Initial therapeutic plans may include short-term and long-term goals measured

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using reliable and valid outcome measures, established through standard scientific methods. What are the consequences to the patient if these goals are not achieved? Where does that leave the patient and the physiotherapist and who is supposed to have "the answers"? Where does that leave their relationship at the time of discharge?

In an alternative approach that takes seriously Foucault's ideas and the need to attend to power relationships, the therapist would listen to the patient and consider the patient's needs in a different way. He or she would consider looking beyond the role of therapist and its accompanying professional obligations or adherence to concepts of evidence-based practice (American Physical Therapy Association, 2011; Canadian Physiotherapy Association, 2011) and let go of assumptions about what is "best". In conjunction with the patient, he or she would explore meaningful options for the patient even if he or she deviates significantly from typical rehabilitation goals and assumptions of "good" outcomes. This could shift the balance toward being more equitable and, furthermore, add the patient even more deeply into the equation. The maintenance of walking, for example, might not be the "best" option for this particular person, even if it is assumed to be a usual goal for this cluster of symptoms and abilities and even if it is what the patient initially expressed as a goal. Peeling back the layers of expectation and thinking beyond the traditional (i.e., a genealogical approach), the two might agree that, for example, a wheelchair might be a more feasible option for mobility and is not necessarily a "failure". Larger questions would be asked about identity, experience, hopes, and disappointments. How does the patient feel about this change? What kind of freedom or constraints might it grant?

An approach such as this acknowledges the multiple ways power operates in the relationship. It does not try to eliminate power, but works from the strengths of different sources of knowledge and power to creatively seek solutions. Foucault's notion of governmentality helps to illuminate, question, or challenge the traditional norms of professional socialization for physiotherapists and their relationships within the health care system. Professional socialization involves the integration of both formal and tacit learning, which results in a sense of professional identity (Arndt et al, 2009; Öhman and Hagg, 1998). Students and practicing professionals alike are "inducted into the culture of their respective disciplines" (Arndt et al, 2009; p. 18). We are taught to emulate those traits that are deemed desirable. This is governed by the academic champions who "perpetuate and reinforce existing culture" (Arndt et al, 2009; p. 18). Role-taking activities, as well as interacting with significant others, allow a novice to imitate that person from the reference group who is desired (Arndt et al, 2009; Öhman and Hagg, 1998). We are taught that normative behavior is the desired outcome:

> Health care students form an identity through the interaction with others by acquiring…the adoption of social norms (i.e., the standard patterns of behaviour), attitudes and values that govern how to conduct oneself in a variety of settings. (Arndt et al, 2009; p. 19)

In adopting a Foucauldian approach that attends to power relations, physiotherapists need to be willing to be open, vulnerable, and transparent. They need to feel confident to say that "I don't know; I don't have all the answers", mitigating some of their traditional sources of power and building on others. From my own experience, I was frustrated by health care providers always having to feel that they had to have an answer even if it meant twisting my question to suit a ready answer. Being quoted numbers and percentages reduced the experience of my illness to something abstract rather than as a concrete, lived experience.

Paying attention to patients in this way could be considered as a brave and risky path to follow. I am not suggesting that scientific evidence is unimportant; rather, science is only part of the therapeutic equation. I think it is important to acknowledge that each individual experiences his or her body differently as well as the patient who will have an individual experience of PT. As therapists, I think we also need to acknowledge that there are both visible and invisible forms of power within the therapeutic relationship, and attending to this has the potential of helping the physiotherapist become more compassionate and accessible to the patient. There is still an art to being a successful physiotherapist; perhaps sometimes the key to the art is acknowledging one's frailty.

CONCLUSION

In this paper, I have reviewed some of the historical origins of medical power from traditional and post-structural perspectives. I have discussed aspects of the power relationships within Western medicine and how they might be manifested in patient–therapist relationships. Finally, I provided an example of how re-thinking power relationships in the patient–physiotherapist relationship might work.

Physiotherapists learn about the legal limits of power within a therapeutic relationship, but not necessarily about the nature of power relationships, and how they manifest themselves in health care environments. My personal experience with PT students and colleagues

has demonstrated this to me frequently. This is not often covered during the educational experience. Exposing students and professionals to both traditional and post-modern histories of their respective professions can help them understand the multiple fruitful ways of engaging with patients. Physiotherapists would be enriched by an understanding of how they have been constructed as health professionals and become critical of this process. Most of us have little exposure to ideas about how we are taught: to reproduce some tenets and reject others; the construction of our professional power; how our patients as subjects of the health care apparatus are made vulnerable; and regarding their own professional power. This could lead to better understanding and re-imagination of their place in the health care complex and, in the end, can contribute to better patient care.

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