Professionalism and Expertise: A Case Study of the Occupation of Physical Therapy

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PROFESSIONALISM AND EXPERTISE:
A CASE STUDY OF THE OCCUPATION OF PHYSICAL THERAPY

A THESIS SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
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MASTER OF ARTS

DEPARTMENT OF SOCIOLOGY AND ANTHROPOLOGY

BY
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During any lengthy endeavor there are bound to be times when the person taking on the activity feels overwhelmed and isolated. This thesis began in the Spring of 1995 and there are many times when I have felt myself to be quite alone in its creation. However, there are many individuals without whose assistance this thesis would not have been possible.

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CHAPTER 1
INTRODUCTION

The case examined here explores the ways in which physical therapists, as an occupational group and as individual clinicians, attempt to gain recognition and cooperation in regard to their claims of professional and expert status. The field of sociology has generally left unexamined the ways in which non-physician medical practitioners make professional and expert claims. In this paper I explore the ways in which physical therapists assert these claims on both a societal and an individual level. It is my argument, that as members of an occupational group and as individuals who practice physical therapy, physical therapists use a variety of methods to gain acceptance of their claims. Specifically, I investigate the communication strategies used by physical therapists to gain patient cooperation. I also examine the strategies and techniques used by physical therapists, to maintain and expand the boundaries of their occupation in the minds of the public, in therapists' places of work, and in laws and policies.
Many of the strategies used by physical therapists are utilized by other aspiring occupations as well as accepted professions, but some strategies appear to be unique to physical therapy. The information I accumulated during this research and also a preliminary ethnographic study of the rehabilitation center (which will be detailed in the Methods and Site section) is used to describe the ways in which physical therapy and physical therapists attempt to maintain, expand, and obtain acceptance of their claims.

Physical therapy is an ideal medical occupation to study for understanding the strategies used to make professional and expertise claims within the medical hierarchy. Physical therapists are similar to physicians in regard to both the content of their work and their symbols of professionalism. However, therapists differ in that they do not have the same public or political acceptance that doctors have achieved. Physical therapists justify and defend their expertise to physicians who dominate medical hierarchies, to physical therapy assistants who are subordinate to physical therapists, and to insurance companies that control reimbursement. Researching this occupation adds to the body of sociological knowledge in medical sociology, occupations and professions, and
sociolinguistics. My work on how physical therapists express their expertise to non-professionals differently from physicians examines an area that has been understudied by the above areas of sociology.

This work is divided into three sections. The first section explains the multiple methods used to research this topic and the locations both physical and literary where research was conducted (Chapter 2, Methods and Sites). The second section explains the nature of physical therapists' work and looks at why this is of interest to sociologists. These chapters will explain the goals of physical therapy and the actual work of physical therapists (Chapter 3, Background and Significance). Also examined are the contributions and vacancies in the fields of the sociology of occupations and professions, medical sociology, and sociolinguistics in regard to understanding physical therapy's claims (Chapter 4, Review of the Literature). Section three discusses the data accumulated through this research. First is a discussion of strategies physical therapists were observed to use in order to obtain compliance and acceptance of their expertise and professionalism in individual encounters (Chapter 6, Analysis of Observations and Interviews). This is followed by the
content analysis of the physical therapy occupation's literature which identifies the strategies used to gain acceptance of their claims on a societal level (Chapter 5, Analysis of Physical Therapy Literature). Lastly, the implications and contributions of the information obtained from this research is discussed (Chapter 7, Conclusion).

Exploring the occupation of physical therapy and the ways in which physical therapists express expertise to audiences in the legal/administrative arena, in the work place, and with patients provides valuable information on how an occupation situated in the middle of the medical hierarchy actually maintains, defends, and works within its jurisdiction. The methods discussed in the next section explain how I studied the strategies used by physical therapists to gain acceptance of their expertise on both a societal and an individual level.
CHAPTER 2

METHODS AND SITES

The research I undertook for this project used multiple methods to examine and understand expertise and professional claims made at both the societal and work place levels. The research I conducted of physical therapists' strategies for acceptance at the individual level included participant observation at a rehabilitation site that extensively utilized physical therapy and therapists, directed semi-structured interviews with physical therapists. I also performed a content analysis of the occupation's literature in order to analyze claims made on a societal level.

I conducted approximately 50 hours of minimally intrusive participant observation at a private, hospital affiliated, rehabilitation center that will be known as Western Rehabilitation Center. The center provides a variety of services including physical, occupational, speech, and psychological therapy; pool therapy; orthopedics; and sports medicine. Observations were be performed in three areas of the center that are primarily utilized by physical therapists. These areas
are the orthopedics clinic\(^1\), work hardening\(^2\), and general rehabilitation\(^3\). All departments were agreeable to having an observer present. Patients generally came to the facility on a referral basis from the hospital it is associated with, the physiatrists\(^4\) who have offices in the same building, or other physicians who are not connected with the center.

The various departments within Western Rehabilitation Center differed not only in the types of patients or injuries that were treated, but were also extremely different in their physical designs. The orthopedics clinic consisted of a large room subdivided by light blue partitions of the type generally seen in offices, except much taller so that they could not be looked over. Each subdivided area was referred to as a

\[\begin{align*}
1&\text{The orthopedic clinic treats issues pertaining to disorders and injuries of musculoskeletal tissues (rheumatology and bone disease as well as fractures and injuries) specializing in, but not limited to, neck and low back pain and sprain/strain type injuries.} \\
2&\text{Work hardening primarily treats work related injuries and provides up to a full day of work related rehabilitation which is intended to physically prepare the client to return to the role of worker.} \\
3&\text{General Rehabilitation treats neurological and orthopedic dysfunctions. Specializations are in traumatic brain injury, strokes, and amputees.} \\
4&\text{Physiatrists are medical doctors and are also referred to as Doctors of Physical Medicine. They specialize in the branch of medicine dealing with physical therapy.}
\end{align*}\]
booth and contained a desk for the physical therapist to write; a straight back chair; a rolling stool; an examining table that could be raised and lowered; a shelf with towels, sheets, pillow cases, and gowns; and a heater for ultrasound gel and isopropyl alcohol. The area as a whole was dimly lit and the partitions did little to obscure sounds from the other booths. It was in this area that much of the therapy for orthopedic patients was carried out. Not in the booths, but close by were assorted instruments and materials used to treat patients including traction equipment, moist heating pads, ultrasound machines, and electro-stimulation machines.

When I first entered work hardening it was difficult to determine the purpose of the room. Against one wall there is exercise equipment, near by is a VCR and TV placed in front of an exercise platform that is waist high and constructed of boards and covered with two exercise mats. Various work modules to simulate an environment where a person would be working with plumbing, wiring, roofing, or doing detailed hand work are also in this room. In other areas there are bricks, stones, tools, and other items that look like they might be found in a factory, warehouse, or at a construction
site. Finally against one wall is stationary exercise equipment.

General rehabilitation was a larger brighter room with windows and no partitions between treatment areas. The room contained two large platforms with mats on them for the treatment of patients. Each platform could accommodate two patients at a time. Within the general rehab room were a variety of items for treating patients. These items included parallel bars for assisting patient balance when walking and canes. Also present were items that would be encountered and negotiated by patients in everyday life: beds, shopping carts, a ramp, and stairs. Hand held exercise equipment was also present. I also noted a radio softly playing music in the background.

It was in the above settings that I was able to gather data regarding the interactions and communication strategies physical therapists use with patients as they actually occurred. Whenever possible I tried to observe the same patients and physical therapists over time in order to see how relationships were sustained and changed during the course of treatment.

Detailed field notes taken on the site provided in-depth accounts of the actions and discussions that occur in the therapist/patient encounter. Analysis of my
observations identifies four different types of communication strategies used by physical therapists to gain patient cooperation. The first strategy is the use of an interview structure for communication. Therapists using this strategy communicate with patients in a manner similar to physicians. Physical therapists ask questions, generally with fixed possible responses, in order to obtain information from patients. Physical therapists used three strategies that were dissimilar to those used by physicians: emphasis on the daily living and environment of patients, attempts to collaborate with patients in regard to diagnosis and treatment, and stressing similarities between themselves and patients.

In addition to coding my field notes according to the four communication strategies listed above, I also analyzed my field notes using conversation analysis techniques. Conversation analysis stresses the underlying as well as the surface structure of communication. This analysis was primarily utilized to determine if interactions were occurring in symmetrical or asymmetrical patterns. A symmetrical interaction has "an expectation of balanced participation. Participants talk, introduce topics, and respond to topics in about the same quantities." (Fisher, 1983: 141). However, the sociological literature indicates that in medical
encounters an authoritarian asymmetrical interview style of interaction is the most likely communication strategy. "...research has found that...medical interviews are social events, organized from beginning to end by medical...tasks-tasks shaped by institutional setting in which they occur and the authority of those with dominant roles." (Fisher, 1986: 15)

Conversation analysis is typically used with either audio or video recordings. Unfortunately, it was not possible to use recording equipment at the physical rehabilitation center as it was felt that this would violate the privacy of the patients. However, I found that conversation analysis adapted easily to the examination of my field notes and was useful for identifying symmetrical and asymmetrical conversational structures.

Semi-structured interviews were conducted with physical therapists to gain insight into how they act, think, and feel in regard to their work. The semi-structured format stresses a conversational tone guided by different topics and questions. This way the answers given by therapists should reflect their own perceptions and beliefs and not pre-coded categories. Interview topics included professionalism, expertise, relations with other health care providers, and relations with
patients. Questions addressed the therapist/patient relationship, strategies used to gain cooperation and acceptance of expertise, and the positions of physical therapists in relation to physicians, third party reimbursers, and physical therapy assistants. Interviews were conducted only with physical therapists, since therapists did not wish the physical therapist/patient relationship interrupted through the recording of encounters. A preliminary interview guide (Appendix A) was utilized for interviewing physical therapists.

The site I chose for researching the ways in which physical therapists attempt to gain societal acceptance of their claims was the literature distributed by the American Physical Therapy Association (APTA). It is my belief that due to the membership and goals of this organization the APTA represents physical therapy as an occupation. The APTA has a membership of 70,000+ physical therapists, physical therapist assistants, and students and a mission that includes "effecting beneficial legislation at state and federal levels;" "enhancing the image of physical therapy;" and "advancing the profession by setting standards, encouraging research, and promoting diversity within the field."
I also conducted a content analysis using literature published by the APTA through its journal, Physical Therapy and information distributed on the APTA world wide web site, HTTP:\WWW.APTA_ORG. Specifically I examined eighteen months of Physical Therapy, January 1995 through June 1996, and the APTA web site for text concerned with professional and expert development of physical therapists and physical therapist assistants. Strategies as well as claims related to the professional development of physical therapy were identified and coded according to the nature of the claim or technique utilized. Three major areas were found each with several subgroups. The three strategies used to seek expert/professional recognition are: 1) using objective criteria to identify itself as a profession, 2) the seeking of recognition in various arenas that are able (to differing degrees) to grant physical therapy recognition of its claimed status, and 3) scientific-style claims to legitimacy. In the first strategy physical therapists attempt to gain recognition as a profession by claiming possession of traits recognized as being possessed by professions. Objective criteria used to claim expert and professional status include displays of altruism, regulation of entry into the occupation, high levels of education, and organized
representation of the occupation. The second strategy to make expert and professional claims includes three arenas where claims are made: the legislative, workplace, and public arenas. Also included in the coding scheme for arena based claims is the active creation and maintenance of an occupational jurisdiction. The last strategy used is the making of scientific-style claims of professional/expert authority, this strategy was divided into two sections. The first section concentrates on the creation and maintenance of a base of expert knowledge. The second section focuses on the research and methods used to create scientific claims.

Before examining the data gathered by observing and speaking with physical therapists and through the literature of the APTA it is first necessary to provide a background of the field of physical therapy. In addition to providing background information the following chapter will also show why a sociological investigation of this understudied field is both appropriate and valuable.
CHAPTER 3

BACKGROUND AND SIGNIFICANCE

Physical therapy as an occupation possesses many of the attributes commonly associated with professional status: entrance into highly competitive academic programs, college and post-baccalaureate degrees, state licensure, codes of ethics, and an organization that represents the occupation and its members (Abbott, 1988: 4 and Becker, 1973: 94). The field of physical therapy is characterized by a high level of education. It is necessary to obtain either a bachelor's degree or more and more frequently a masters degree. Doctorates are also available. Degrees must be completed from certified programs that place their emphasis on the physical sciences, medical evaluation techniques, therapeutic procedures, and clinical experiences. Sitting for state licensing is required and only possible after a bachelor's or higher level degree has been obtained.

Despite these similarities between the occupation of physical therapy and other occupations that are acknowledged as professions, physical therapists have
not accrued the benefits of professional status. Physical therapists do not have the status and prestige that physicians have achieved and more importantly they also lack acceptance, by society and patients, that as physical therapists they are highly trained experts who can be trusted to work for their patients' best interests. Instead physical therapists must work within the narrowly defined boundaries placed upon them by government agencies and under the directions of physicians. This is in spite of the APTA's contention that physical therapists are highly trained in both formal and clinical education and are capable of evaluating a patient's condition and then providing appropriate treatment or if warranted referral to more specifically qualified care givers (HTTP://WWW.APTA.ORG/DIRECT_ACCESS.HTML). According to the APTA physical therapy as an occupation is committed to improving the health and well being of those that benefit from its knowledge and abilities.

The APTA states that, physical therapy is concerned with maximizing physical potential and human performance. Potential can be optimized through the promotion of physical therapy to prevent or to treat patients. Physical therapy can promote optimal
potential directly through clinical services or also through efforts in education and research.

Physical therapists in academia prepare students to directly improve human performance by training them to be clinicians with the ability to treat acute and chronic conditions. Furthermore, therapists in educational settings share the skills and knowledge of physical therapy with other health care professionals in order to facilitate team work. In research settings physical therapists plan, conduct, and report research that will contribute new knowledge, techniques, and technology to their field. Research generally has an applied focus and aims to establish increasingly efficient patient care.

In clinical settings physical therapists work with a variety of health care providers; i.e., physicians, nurses, occupational therapists, vocational counselors and others to increase patients' human potential. This work may be performed in hospitals, physicians' offices, rehabilitation centers, industrial settings, patient homes, or private practices. Regardless of the setting, physical therapists attempt to increase potential by assessing patients' condition, determining individual patient goals, developing and implementing treatment programs, and applying therapeutic modalities to
patients. Modalities may include heat, ice, electricity, traction, exercise and therapeutic massage. Physical therapists also provide instruction to patients so that they are able to assist in their own recovery.

As a field physical therapy is growing both in numbers and in its applications to peoples' lives. Physical therapy is the fastest growing health care occupation in the United States with an expected increase from 76% to 88% by 2005 (HTTP://WWW.APTA.ORG/PT_PROF/PROFESSIONALPROFILE.HTML and United States, 1994: 156). Physical therapy has grown due to an increasing need for rehabilitative services. Demand has been fueled by the disabilities occurring within our aging population and advanced medical technologies that are treating previously fatal conditions. In the foreseeable future, greater numbers of patients will be enlisting the services of physical therapists.

In the past, sociologists have studied the occupations of doctors and nurses and how these groups interact with patients in medical encounters. However the ways in which other medical care givers, including but not limited to physical therapists, express expertise or try to gain authority has remained relatively unexamined. Researching unstudied and
understudied health care professions increases the sociological knowledge regarding how resources, power, and control are vied for in the medical hierarchy. Preliminary research conducted in 1995 and further explorations undertaken for this research show that it is not possible to generalize from the experiences of physicians or nurses to the occupation of physical therapy. Despite the similarities in professional characteristics that physical therapists share with physicians (degrees, licenses, etc.), the strategies used by the two groups to obtain patient acceptance of expertise and cooperation differ.

Summary
Physical therapy as an occupation has many of the traits laypeople associate with professional status. Despite, the similarities between physical therapy and other occupations that are publicly and politically recognized as professions, physical therapists do not have status or prestige of accepted professions. Physical therapy is however growing in the both its membership and the numbers of patients treated and sociologists have not explored the ways in which this occupation claims expertise or attempts to gain authority.

Given the growth of the occupation of physical therapy both in size and applications, and the lack of
knowledge of physical therapy by sociologists, exploration of this occupation will benefit sociologists knowledge of physical therapy and the medical hierarchy. Related to this research are several existing areas of sociology: occupations and professions, medical sociology, and sociolinguistics.
Early work in the area of occupations and professions attempted to create definitions of a profession by identifying key characteristics and traits that were possessed by professionals. Professions were identified by having 1) organized bodies of experts who applied esoteric knowledge to that profession's particular cases, 2) elaborate systems of instruction and training generally involving the obtaining of a degree, 3) consent to practice the profession only permitted after certification by examination was completed, and 4) possession of a code of ethics whose enforcement is carried out by the profession (Abbott, 1988 and Becker, 1973). Other definitions included these properties, but also stressed the sole possession of an esoteric body of knowledge by a profession (Abbott, 1988; Becker, 1973; and Parsons, 1939). Abbott also states that technical skills and practical experience were not recognized as being important elements of the professional identity or knowledge (1988). Instead, the scientific basis or abstract principles of the body of knowledge the
profession monopolized was judged by sociologists to be the most important trait. Practical experience and possession of skills may be considered important to the practical application of professional knowledge, but is not sufficient to claim professional status.

Over time members of various occupations have attempted to improve their status by claiming possession of professional traits and by virtue of these traits the right to refer to their work as a profession. As Hughes points out "the language about work is so loaded with value and prestige judgements, and with defensive choice of symbols..." (1958: 43). Hence, claims to possess professional traits has been viewed by sociologists as attempts by members of occupations to increase their status. As the concepts and language surrounding work are value-loaded it was necessary to be careful in the way in which I described fields of work within this study. Both Hughes and Becker state that the term "professional" is used in society not to indicate an occupation that is necessary to the smooth functioning of society or has obtained all of the properties listed by sociologists of occupations and professions; rather, the term professional is used by lay people and by occupations to describe a type of work that is morally desirable (Becker, 1973 and Hughes, 1958). As the very
words professional and profession connote certain desirable traits and characteristics that are not of provable nature, I use the term occupation to describe the various fields of work discussed in this study. However, the occupational groups mentioned in this study all claim the title of professional for themselves.

The sociology of occupations and professions has moved beyond checklists of traits and characteristics as a means of defining and understanding professions. However, these traits are still important for understanding the strategies and techniques used by occupations to claim professional status. As Becker states, the conceptions lay people have of the professions are of the symbols associated with professional fields (Becker, 1973: 91-2). Regardless of a symbol's value to social scientists of identifying a profession, the use of the symbols and traits claimed by occupations is important for analyzing the ways in which members of occupations attempt to gain the lay public's support in making professional and expert claims. Symbols used in the making of jurisdictional claims before the public to create an image of expertise and authority can later be used to make claims before legislative bodies (Abbott, 1988: 59-60). Indeed, this very technique will be explored as part of physical
therapist's attempt to be recognized as experts and professionals.

Physical therapy's move from an undergraduate program to a graduate level program because, "experts are coming to believe that a master's degree is better for teaching a growing body of knowledge..." (United States, 1994: 156) can be seen as an example of an occupation gathering unto itself the traits and characteristics that are associated with a profession in order to claim that status. By taking note of the professional characteristics physical therapy currently possesses it is possible to analyze the actions taken by physical therapists to make claims of expertise and authority.

Claims made through the possession of professional symbols can be investigated with Abbott's system of professions. Abbott claims that professions maintain boundaries through abstract knowledge systems, special training, and legal claims to diagnose, infer, and treat certain problems (1988: 40). Physical therapists claim to possess a high level of knowledge and special training that overlaps the medical specialty of physiatry (Halpern, 1992: 1000) and also skills not possessed by most physicians (Ayers, 1990: 83). In claiming a jurisdiction Abbott states that an occupation
asks society to recognize it as a profession within an area of expertise by granting it exclusive rights, including an absolute monopoly over practice; public payment; self discipline; and control of training, recruitment, and licensing (1988: 59). Using Abbott's theory of professions, physical therapists would be expected to maintain or expand their jurisdictional boundaries in relation to other medical fields that border physical therapy in regard to knowledge, skills, or types cases handled. The traits associated with professionalism would likely be utilized to defend the boundaries of physical therapy. Physical therapists may also use the characteristics associated with professionals to create boundaries that differentiate themselves from the subordinate occupation of physical therapy assistants. Physical therapy is an ideal site for expanding knowledge of how a field that is both subordinate and dominant attempts to defend and expand its boundaries based on claims of expertise and professionalism.

Expertise, professionalism, and acceptance of claims has been studied by both sociologists of occupations and professions and medical sociologists. In the doctor/patient model it has generally been assumed that the esoteric knowledge and special
techniques possessed by the physician give him or her authority over patients who out of necessity must place their faith in the doctor (Abbot, 1988; Fox, 1989; Freidson, 1970a; and Hughes, 1958; Parsons in Fox, 1989; and Parsons in Freidson, 1970b). Often the source of a physician's authority is said to be his or her, "incumbency in an expert status." (Freidson, 1970a: 120) and no further investigation is made. This presents a problem to the occupations and professions literature in that it assumes that any profession, even one who belongs to a group that is being contested for control of an area, possesses the authority to gain client cooperation.

By studying actual doctor/patient encounters medical sociologists have expanded knowledge on how practitioners express their expertise to patients. Fisher points out that because patients physically go to medical practitioners, practitioners begin in a position of power (1986: 46). Practitioners possess a "home court" advantage in that they understand and possibly control the medical/institutional bureaucracies. Practitioners also speak medical jargon which displays their superior knowledge as well as the skills they possess and patients generally do not have (Fisher, 1986 and Waitzkin, 1991). In addition to the possession of
medical jargon, Fisher also notes that doctors display visual and behavioral symbols of authority (1995: 174-5). Symbolic importance is demonstrated through white coats, stethoscopes, and the typical practice of patients waiting in examining rooms.

In addition to the physical and institutional displays of authority/expertise, physicians also possess a socio-economic advantage over their clients. Freidson claims that a "...common solution to the problem [of obtaining patient obedience] lies in the socio-economic position of the [sic] professional and the prestige of his [sic] profession." (1970a: 113). Freidson implies that patients comply with the physician on the basis of his or her status alone. Abbott, on the other hand, claims that high-status clients may make better patients since, "At the least, they understand and recognize the basic professional rights of diagnosis..." (Abbott, 1988: 122) and therefore are more likely to comply with physician wishes.

However, most medical sociologists have not looked at how non-physician practitioners solve their problems of expertise and compliance. It is not possible to generalize from the information given on doctors to physical therapists (or the other allied health fields). Unlike physicians, many physical therapists (and other
health care workers) work at the patient's home and do not possess a "home court" advantage. Others, like the ones I observed, do have a "home court" advantage but do not have the other authority symbols or statuses of physicians. The physical therapists I observed did not adorn themselves with the symbols of medicine such as white coats and stethoscopes. Instead, the physical therapists dressed in a manner that facilitated their work which often included bending, crouching, lifting, and kneeling. Therapists also escorted patients to examining and therapy rooms rather than meeting them there, as would be expected with physicians. Finally and perhaps most important, physical therapists do not possess a publicly recognized high socio-economic or status position and therefore cannot use this as a method of obtaining compliance.

Communication strategies for obtaining compliance are apparent from results of the ethnographic studies frequently performed by medical sociology. Further research in this area using the methods of sociolinguistics can be used to better understand the different techniques used by physical therapists to gain patient cooperation. The communication strategies used by physical therapists are different from the methods used by physicians. Sociolinguists believe that speech
in and of itself constitutes acts and constructs reality. This reality is partially found in the meanings of words, but also in the way in which discourse occurs. These researchers have found that doctors use speech, consciously or subconsciously, to control the topics of inquiry, to evaluate patients' competence, and to exhibit their status and power (Fisher, 1986; Fisher, 1983; Richman and Lord, 1984; and Waitzkin, 1991). Sociolinguists have not studied physical therapists, but my observations of physical therapists suggest that they use communication differently from doctors. Sociolinguistic methods may be useful for examining this occupation.

Summary

The three areas of sociology occupations and professions, medical sociology, and sociolinguistics all possess theories and methods that can be used to investigate and better understand the occupation of physical therapy. The area of occupations and professions contributes valuable insight into the how jurisdictions compete with one another, and the information gathered regarding physical therapists shows that they participate in this system. This can be seen in the attempts to increase their claims' legitimacy by acquiring symbols of professionalism and through claims
made in the legal arenas. Medical sociology contributes the idea of grounding theory in actual observations of the subject population. Observations completed for this study illustrated that physical therapists did not communicate with patients in the same ways as physicians. Rather than using symbols of authority or wielding a recognized high social status, physical therapists used communication strategies in order to obtain patient acceptance of therapists as experts and to gain compliance in medical encounters. Sociolinguistic techniques provide a method for analyzing discourse between therapists and patients in order to understand how communication is used as a strategy for gaining acceptance of expertise.

Given the lack of investigation into any of the occupations within the medical system (with the exceptions of doctors and nurses), this research expands the knowledge of sociologists into layers of the medical hierarchy previously unrecognized. The research into physical therapy illustrates that despite the some similarities between physical therapists and physicians, therapists' strategies to gain recognition and acceptance of their expertise are not generalizable from what is known of either doctors or nurses. The following sections analyze the strategies used by
physical therapists to gain acceptance of their expertise on both an individual level and a societal level.
CHAPTER 5
ANALYSIS OF OBSERVATIONS AND INTERVIEWS

Physical therapists use various and sometimes unique communication strategies in their interactions with patients. One communication strategy used was similar to those used by physicians; using interview techniques to obtain information. However, many of the different types of communication were not typical of those used by physicians and have not been studied by sociologists. These types of strategies include soliciting information regarding the daily living of the patient, collaborating with the patient regarding treatment, and identifying similarities between the therapist and the patient. It is my belief that these strategies are intended to encourage patient cooperation and the acceptance of therapist expertise and professional status.

Physical therapists' relationships with patients begins in a manner similar to other health professionals. Typically a patient is evaluated and a diagnosis is made, or often the physician's diagnosis is confirmed. The process through which this is done is the asymmetrical medical interview where therapists do.
the majority of the talking and patients generally respond to questions, but do not initiate discussion. The interviews I observed consisted of patients being asked a series of structured questions often with preset answer categories. The patient being interviewed is female, over 65, does not work outside the home, and lives alone, but has a son in the area. The encounter was observed in the Orthopedics department.

Physical Therapist: I have to fill out some Medicare forms to start with. When did the pain in your knees start.
Patient: Started in 93....
PT: Does walking make it worse?
P: Standing does.
PT: How long do you have to stand for before it starts to hurt?
P: Five, ten, fifteen minutes. Who knows? I don't time it.
PT: I'll put 5 down. Walking?
P: --Not recorded--
PT: I'll put 4 or 5 minutes. (Writes on form.) (Field Notes 02/22/95)

The following is an excerpt from field notes taken in work hardening. The physical therapist is performing a functional capacity assessment in order to determine the extent of the patient's capabilities in regard to work and daily living. Once again the therapist initiates the topic of discussion and asks questions in such a way as to limit the possible responses. When the patient gives more than the strictly necessary information the therapist continues with the structured interview rather than talking to the patient about his answers. The
patient is a white male who was seen the previous year for a work injury and is known to the physical therapist:

PT: Before we begin testing I want to ask a few questions. I reviewed your history before you came in. We're going to mostly test your physical mobility and strength: lifting, carrying, sitting, standing, walking. We'll go through the whole test even though they may not relate to your job. You might want to know when you look for a new job.

P: I'm not going back to that crap ass job. Excuse my language, but I'm not going back there. You said last time when I left here that I wasn't ready to go back and then I got hurt again....

PT: Well everything we do today is too tolerance just what you can do. When you went back you were on light duty?

P: I was supposed to be, but that didn't last. Somebody went to Mexico and they want stuff done and I'm the one there.

PT: When did you stop work? Two weeks before you started therapy.

P: I was off all of March and April and then I started physical therapy and I started circuit training this week.

PT: And you had a cat scan?

P: I had a ct scan, a cat scan, epidural stimulation injections, they said I have nerve damage.

PT: What are your/

P: //Soreness in my lower back.

PT: major complaints?

P: My leg aches.

PT: Which leg?

P: Left leg. It twitches at night.

PT: What about now?

P: It hurts.

PT: On a scale from 0 to 10 what would you rate it? Zero being nothing and ten being in the emergency room.

P: Five, five an a half.

PT: Where in the leg?

P: The whole leg. Down the front.

PT: The top of the thigh?
P: The front of the back is sore, hurts. From the buttocks where the nerve comes down....
(Field Notes 06/06/96)

Initial communications that occurred between physical therapists and patients took place in an interview structure and were typically asymmetrical with the therapists controlling the interview. However, the social or everyday world of the patient was frequently incorporated into the interview. Therapists showed concerned not only with making a diagnosis, but with how the condition was affecting the life of the patient. The following is an excerpt from a patient's initial evaluation within which it is possible to see an emphasis on the patient's ability to handle daily living. The patient being interviewed is the elderly woman who observed in the orthopedics clinic discussed earlier:

PT: Do you do your own grocery shopping?
P: Yes.
PT: You know a lot of the stores have services now where you call in what you want and they deliver it to your house.
P: I'd rather go myself.
PT: Ok. Does the pain affect your sleep?
P: No.
PT: How about stairs; can you walk up and down them?
P: I take them just one step at a time.
PT: What kind of house do you have?
P: A ranch style.
PT: So you don't have a lot of stairs?
P: No, I don't have any except to the basement and I don't go down there.
PT: What about when you're at a friend's house, do you use the railing and your cane?
(Field Notes 02/22/95)

The work hardening department also showed concern with daily living by attempting to prompt patients to think of ways in which they could handle their pain without medical assistance and in ways that would minimally disrupt their work routines. The following two excerpts are from an occupational therapist and a physical therapist who work together.

Occupational Therapists: A lot of people come in here and they're used to more passive therapy like massage and ultrasound. This is the end of the line. They either have to live to work with pain or/
Observer: //to make decisions.
OT: Yes, about whether or not they can go back to work. We try to get people back into the worker role.....(To a patient) Is your leg starting to hurt you?
P: Yeah, a bit.
OT: I'll get you some ice....You have ice machines where you work don't you? You have an ideal situation, you can get up and get a bag of ice and just hold it against your leg while you do paper work. I tell other people to hold a can of soda against them.
(Field Notes 02/08/95)

5Occupational therapists assist patients return to daily living by designing exercise programs and teaching patients to adapt to their conditions. In the work hardening department they work with physical therapists in order to return patients to work. They do not, however, apply the specialized modalities associated with physical therapy: ultrasound, electro stimulation, or therapeutic massage.
Similarly a physical therapist in this department spoke with a patient regarding ways in which he could "independently manage pain":

P: I missed out on my massage tomorrow my dt [deep tissue massage] and ultrasound. I think that ultrasound really helps. I'm kind of nervous about this weekend about pain.
PT: What can you do? I mean it sounds like you know what to do.
P: I can put a heating pad on it, but it's not the same.
(Field Notes 06/06/96)

Physical therapists did not immediately prescribe a treatment plan after a diagnosis was reached, but attempted to collaborate with patients in regard treatments and goals. Physical therapists attempted to bring the patient's everyday life into the setting of goals:

Physical Therapist: So if it's a new patient I do an evaluation determine what the problems are make up a problem list, a goal list, and a treatment plan. Go through that verbally with the patient and then start in.
Interviewer: How do you decide what the goals are?....
PT: I guess an overall goal for a lot of our patients, just because we see a lot of patients that seem to be deconditioned they've been you know been off work for a while or had their injury a while ago so they become very deconditioned, so a common goal among many of the patients is independent home exercise program, increase their endurance, try to get them on a regular work out program that's suited for their needs, if possible in a health club atmosphere....try to get an idea of what their hobbies and sports are and relate it back to that. So as an outpatient that's what I do. I look more at what they want to get back to doing and say ok this is
important so that eventually you know you can get over here and attain this goal: playing golf or playing basketball or whatever return to work/

I: //Ok.
PT: whatever their goal is.
(Interview with Physical Therapist 03/08/95)

As therapy proceeded past these initial stages, physical therapists also engaged in conversations with their patients which appeared to recognize the patient's own understanding of their conditions. This is different from medical interviews with physicians in which doctors are rarely reported to incorporate the opinions or knowledge provided by patients (Fisher, 1995 and Waitzkin, 1991). In contrast physical therapists appeared to be willing to acknowledge and include patients' awareness of their conditions in creating treatment plans. This collaboration can be seen in the following observation of a male patient, over 75, is semi-retired, and is living with his wife in a retirement/nursing community. This encounter was observed in the orthopedics department.

PT: Ok...How long have you had Paget's disease?
P: I was diagnosed with a bone scan in 87, but I probably acquired it in 82.
PT: Do you think you can bring in the article you saw linking Paget's with Canine Distemper. I haven't seen that anywhere.
P: It was in [unrecorded journal title]. I can xerox a copy of it for you.
PT: If you bring it in I'll copy it; that's no problem.
(Field Notes 01/25/95)
Later during his therapy session this patient also collaborated in his treatment by volunteering information on Paget's disease that he thought might affect his treatment plan:

PT: Pace yourself so that it doesn't cause any pain....Do you have any heart problems?
P: No, but Paget's disease multiplies blood vessels and that makes the heart work harder.
PT: Ok, I don't want you going in the whirlpool then, because it's hot and that will affect your heart...

(Field Notes 01/25/95)

Physical therapists also spoke to patients in a way that emphasized the similarities between the therapists and patients, what Fisher calls "discourses of solidarity"(1995: 177). The APTA is also aware that and encourage physical therapists to create common understandings with their patients.

Cultural diversity within the profession of physical therapy is highly valued because physical therapists interacts with patients and their families who of various ages, races, religions, and ethnic backgrounds.

When physical therapists and their clients share a common language and similar background the effectiveness of treatment is greatly enhanced. Patients often prefer care from someone with who they can readily identify.

(HTTP://WWW.APTA.ORG/PT_PROF/FUTURE.HTML.)

In this example the therapist appears to be stepping away from her dominant role in the health care provider/patient relationship and joining the patient in her disgruntled feelings regarding the dominant medical profession of physicians and also insurance companies.
The observation took place in the orthopedics clinic.
The patient is an employed female, she appears to be in her early thirties, and is married:

P: I stopped telling the doctor where things hurt, because he just kept giving me more injections. I didn't think I could stand so many....

PT: Oh my. He did give you a lot of shots. Let's see. [counts the number of band-aids covering injection sites] There are 8 on the left and 2 on the right.

P: That's why I didn't tell him about the pain in my neck I didn't want him to give me any shots there.

PT: You lied to him. (Joking.) I don't blame you. Do you know, are the injections for numbing or relaxing the muscle tissue?

P: I think more for relaxing, so you can work it.

PT: Still then the next appointment is in 2 weeks.

P: --didn't hear--

PT: Is the insurance approving your treatment today.

P: Today they are.

PT: I wonder if it's because it's in connection with the doctor's visit. I've seen it where they'll approve shots from the doctors office, but not biofeedback from a therapist.

P: I don't know. I don't know why they wouldn't approve the evaluation 2 months ago. How could they not approve it when they didn't even know what was wrong yet?

PT: I don't know. They may have just wanted it to be in connection with a doctor. I'm just guessing from what I've observed.

(Field Notes 01/27/95)

Similarly, physical therapists in general rehabilitation sympathized with a patient who was upset regarding a support group she felt forced to attend during a recent hospital stay. The patient is an elderly white woman:

It was a day group which met in order for patients to discuss their ailments. She said that the first time she did all the talking and no one else said
anything. After she got home from the hospital she found out that she had been charged $40 for each of the four times that she went. But no one had told her that there was a charge and that it didn't do any good anyways because there were many "people who couldn't talk and men who wouldn't talk." So after the fourth time she refused to go again and her friend refused to go after the second time and the nurses were mad at both of them. The patient also reported "they had a captive audience since most of us were in wheel chairs." The physical therapist asked if her insurance was paying for it and the patient responded that Medicare was picking it up.

Cl: Still $40 just for talking.
L: It was a rip off.
Cl: No wonder there are so many problems with health care. Lay down. Do 15 hip lifts.
(Field Notes 02/03/95)

Physical therapist/patient discourse also frequently involved conversation that appeared to be friendly and based on common interests. Generally therapists and patients participated in a fairly symmetrical manner with both parties introducing and responding to topics. This does not follow the expectations for medical encounters and has a greater similarity to non-authoritarian speech acts. The following excerpt demonstrates the similarities between this type of discourse and normal conversation in which there is, "an expectation of balanced participation. Participants talk, introduce topics, and respond to topics in about the same quantities." (Fisher, 1983: 141). The following interaction occurred in the
orthopedics clinic with employed female in her thirties referred to earlier:

PT: I went to PetSmart the other night. Have you been there yet?
P: Yeah.
PT: It's like a warehouse. I must say their food was cheaper too. There was a sign saying that you could bring your pet in too. I don't know what my dogs would be like.
P: I've brought my dog in she behaves herself pretty well. They give them a treat when they come inside.
PT: Really? I'm worried mine would run around stealing raw hides. Normally I would have had one of the dogs with me. I just put them in the car with me when I go out at night. Even when it's just to the store I run in and have them wait in the car. I don't like going out at night alone.
P: Neither do I. I try to get everything done during the day if I can.
PT: That's what I try to do too.
(Field Notes 01/27/95)

I also observed balanced conversations that were based on similarities or agreements between patients and therapists in the work hardening department. The following is selected from a conversation that shifts from the patient's plans to move in the near future to job opportunities to the performance of the Chicago Bulls basketball team's performance.

PT: I'll ask you some of these other questions later. (Gets out the blood pressure cuff and takes the patient's blood pressure.) Are you looking forward to moving?
P: I'm glad to get out and go do what I want to do?
PT: Do you have any leads?
P: I'm not going to do anything for a few weeks, but I can work with my uncle.
PT: Good if you can afford it.
P: I'm going to be living with my in-laws.
PT: You get along with them.
P: Oh yeah, we get along great. I got a lead with IBM.
PT: A tad high [the blood pressure reading].
P: It's the excitement of last night. (.) The Bulls winning.
PT: My in-laws have season tickets to the candlelight and we went last night so we missed it, but my father in law brought a radio that he listened to in intermissions. There was a part in the play where it got quiet and you could hear the radio at somebodies table. (Smile.) At the intermission people saw him with the radio and they were coming over and asking the score.
P: It was a good game had a lot of ejections. Dennis Rodman is going to get thrown out maybe in the second or third game.

(Field Notes 06/06/96)

Summary

Physical therapists communication strategies allow them to gain the cooperation of patients, by going beyond diagnosis and treatment to creating a cooperative environment where therapists and patients work together. The development of the physical therapist/patient relationship begins with the asymmetrical interview style of communication that elicits information, but does not allow patients to voice their own concerns. Generally, during the last part of the interview patients are asked to contribute information regarding their lives and goals that are important to or can be incorporated within the treatment plans. Patients may collaborate with physical therapists regarding their own well-being and volunteer information regarding their
health. Physical therapists can create "discourses of solidarity" by identifying similarities between themselves and their patients. This can be done through agreements regarding the medical systems' and insurance companies shortcomings and also by discussing topics of mutual interest to both the patient and the therapist.

The observations regarding physical therapists attempt to gain acceptance of their expert and professional claims through cooperation is also evident in the literature of physical therapists. In addition, to attempting to gain acknowledgement of the expertise and professionalism from patients, physical therapists attempt to gain recognition of their claims by society. The next section illustrates the ways in which physical therapists, as an organized body, make claims of professional and expert status on a societal level.
CHAPTER 6
ANALYSIS OF PHYSICAL THERAPY LITERATURE

Literature of the occupation of physical therapy promotes its members claims of professionalism and expertise. My analysis of the literature identified three general strategies for seeking expert/professional recognition were identified: 1) objective criteria, 2) claims made in arenas, and 3) scientific-style claims. The APTA uses techniques within each of these strategies to differentiate physical therapy from non-professions.

Objective Criteria

According to Abbott and Becker laypeople commonly recognize the following attributes as belonging to professions: displays of altruism, regulation of entry into the occupation, high levels of education, and organized representation (1973 and 1988). While these criteria are no longer used by sociologists to identify professions, they are important in that the claiming of these criteria can allow an aspiring profession to create a public appearance of being an established profession.
Professions are frequently viewed as occupations whose work is necessary for the smooth functioning of society (Parsons, 1939: 457). Because society is thought to be dependant upon the work of professionals, it is necessary that professionals be seen as acting in an altruistic manner towards society and those in it. It is from the altruistic motives of professions that individuals are supposed to be able to trust these groups with the authority that society has endowed them.

Physical therapists, like recognized professionals, maintain that altruistic motives are at the heart of their activities. The APTA does this by claiming as part of its mission and discussing in its literature the need to offer humanitarian physical therapy services to all people. In April of 1995 the editor of Physical Therapy wrote about his disappointment that the United States federal government did not pass a comprehensive health care act for all citizens and need to assist all people in need.

While I may personally decry the failure of our society to obtain universal access and a coherent means for managing our health care services and expenses, I cannot afford to avoid the reality that surrounds me. We must still find the means to care for the underinsured and the uninsured, and for providing the best reasonable care to all segments of our society. (Rothstein, 1995a: 252).

In a more comprehensive statement made in an article regarding the future of the occupation of physical
therapy altruism and physical therapy were tied closely together, the author states, "It is essential to promote the expansion of our profession so that in all of our countries, our citizens with disabling conditions receive our services." (Moffat, 1995: 1020).

In addition to claiming altruistic motives physical therapy as an occupation can also lay claim to the concept of regulating the education that is necessary for those seeking entry into the occupation. An occupations' ability to regulate who enters its ranks is a common trait associated with professional status. It is generally assumed that only the profession itself is qualified to make decisions regarding what knowledge and training is necessary for those who seek to join the profession.

Entry into the profession of physical therapy requires passing a licensure exam that one is eligible to sit for only after graduating from an accredited program. The APTA maintains a list of accredited programs. Accreditation is granted by the Commission on Accreditation in Physical Therapy Education which works closely with the APTA (physical therapy educators and clinicians sit on the committee) to ensure that students are being prepared to become physical therapists. The APTA states that,
The profession benefits from [accreditation due to] its members vital input into the standards established for entry-level education of future professionals. The commitment to excellence in physical therapy practice is enhanced as the accreditation process brings together practitioners, teachers, and students in an activity directed toward continual improvement of professional education. (Ibid.)

Like lawyers and doctors, physical therapists claim the right to be represented in establishing standards for the accreditation of educational programs within their field.

Related to the previous trait of the regulation of academic programs is physical therapy's emphasis on the field's high educational standards and the baccalaureate and post-baccalaureate level degrees offered in physical therapy. Physical therapists claim professional status through their education by stressing how it qualifies them for their work, the emphasis in the field on obtaining a graduate level degree, and the ability of the occupation to create specialties.

Physical therapists claim a qualification to work independently through both their, "formal education and clinical training to evaluate a patient's condition, assess his or her physical therapy needs and, if appropriate, safely and effectively treat the patient" (HTTP://WWW.APTA.ORG/DIRECT_ACCESS). Physical therapists also refer to physical therapy as a
profession by virtue that it can be, "practiced full-time as a livelihood, requires the application of specialized knowledge to practical problems, requires at least a university degree..., and can support a doctoral program." (Robertson, 1995a: 223) (emphasis added).

While a baccalaureate degree is the minimum requirement for sitting for a physical therapy license the masters degree has become common in recent years and the occupation has stressed this as a sign of growth in regard to knowledge and expertise. Don Wortley, a former president of the APTA, asserted that it would be partly due to graduate education that physical therapy would be able to survive competition from other health care providers and maintain its position in the medical hierarchy:

In the face of encroachment...we reaffirm our place not by argument, but by evidence that we do what we do better than anyone else does!...That's where the post-baccalaureate entry-level degree comes in. If we ensure top quality, highly competent graduates in that future brave new world we're headed for, the PT profession stays on top. (Rothstein, 1996b: 224-5)

Physical therapy displays its expertise and professionalism not only through its degree programs, but also its ability to specialize.

Specialization began in 1985 and has been discussed as a way in which physical therapists can obtain the benefits associated with the status professionals have,
"Specialists often talk of the rewards they have reaped from having obtained their advanced credentials. They speak of increased stature, professional growth, and other positive attributes." (Rothstein, 1995c: 936).

By controlling the accreditation of its educational programs and by encouraging advanced levels of education and specialization within the field, physical therapy claims ownership of a concept deeply associated with professionalism.

Lastly, a key component to the lists of traits and characteristics associated with professions is the creation of a professional organization to represent the interests of the occupations' members. The American Physical Therapy Association was created in 1921. The APTA has over 70,000 members including physical therapists, physical therapist assistants, and students. It is also the goal of the APTA to represent the interests of members in regard to issues of importance to physical therapy and therapists:

Among the Association's objectives are enhancement of physical therapy education, practice, and research; accreditation of physical therapy education programs; communication with members' improving minority participation and representation in the profession; quality assurance; professional development and continuing education; interaction with governmental agencies and legislative bodies; attention to reimbursement issues; and development and implementation of public relations programs. (HTTP://WWW.APTA.ORG/FUTURE).
The creation of an organization to represent physical therapy is a technique for gaining professional acknowledgement in two ways. Simply by the virtue of having a professional organization, physical therapy has claimed a trait long associated with professionalism and expertise. Additionally, the organization itself further makes claims of expert and professional status by representing the occupation to various arenas as a professional body.

**Claims made in Arenas**

Physical therapists also seek recognition in various arenas that are able to grant expert and professional status. These arenas were divided into the legislative, workplace, and public arenas. Also included in the arena coding scheme was the creation and maintenance of an occupational jurisdiction. This scheme closely follows Abbott's theory that professions perform various activities in different jurisdictions. Professions may control their area of jurisdiction completely, or work in it under various different levels of control by superiors (Abbott, 1988: 2). A profession may move from one jurisdiction to another to expand its authority and must be vigilant against other professions attempting to move into its area of control. In claiming jurisdiction, a profession asks various arenas...
in society to accept its control over an area in regard
to practice and reimbursement (Ibid: 59). Physical
therapy, like other professions, moved into a vacant
jurisdiction, expanded and maintained its position, and
has since sought acceptance of expert and professional
status from the legislative, work place, and public
arenas.

Physical therapy began as an occupation during
World War I treating war injuries. Later the advent of
World War II and a polio epidemic brought the skills of
physical therapists into great demand. The armed
services have often served as an entry point for
physical therapy to expand into neighboring
jurisdictions as vacancies occur. In 1972, physical
therapists increased their area of control in response
to:

the Army Medical Department...[being] faced with
vast numbers of patients with NMS
[Nueromusculoskeletal: sprains and strains]
complaints and a shortage of orthopedic surgeons to
evaluate and treat these patients....The use of
physical therapists as nonphysician health care
providers to evaluate and treat patients with NMS
complaints was one solution to this problem.
(Benson, et. al., 1995: 380).

Army physical therapists were able to expand their
jurisdiction from treating patients referred to them by
physicians to the direct evaluation and treatment of
patients with NMS conditions (Ibid.). In addition to
direct access to specific types of patients army physical therapists were also allowed to prescribe certain pharmacological agents and to order tests, normally only within the power of physicians (Ibid: 380-1). The Army physical therapists' role as primary NMS evaluators has been successful with high acceptance from patients and most practitioners.

Expanding on the success of physical therapists movement into physicians' jurisdictions in the military, physical therapists have suggested similar movement outside of the armed forces:

[It has been] pointed out that we could not reach the needed primary care physician targets for more than several decades. These observations have directed attention more recently toward nurse-practitioners and other non physician providers as a potential solution to primary care needs, particularly in underserved rural and inner city areas. 'Remember many elements of primary care reside in physical therapy and physical therapy is primary care...' (Selker, 1995: 35).

Physical therapists have attempted to expand their occupation by moving into jurisdictions held by physicians such as the suggestion of providing primary care and also removing the need for physician referral.

In addition to moving into jurisdictions held by other occupations, physical therapy also maintains its own boundaries from encroachment by other occupations. One way in which the literature demonstrates physical therapists defending their jurisdiction is by creating
an identity to which all physical therapists can adhere. This creation of an identity begins during the physical therapy students' education:

I have heard students in training to become therapists referred to as 'graduate students'....I felt hurt and angered by the peculiar and pretentious terminology. [physical therapy] students enrolled in post-baccalaureate professional programs have more in common with physical therapy students at all degree levels than they do with English and History majors seeking advanced degrees....my concern is not what degree students seek but rather what identity they seek to have and to present to others....So it is with our professional identity and the terms used to describe us. That is why I am offended by anyone within our profession who would use terms to create personae that primarily identify them as something other than a physical therapist. (Rothstein, 1995b: 656) (Emphasis added)

In addition to creating and guarding an identity of what a physical therapist is, physical therapy as an occupation also must guard against the usurpation of any part of their identity and with it their activities by other occupations.

As physical therapy services can take place in a range of settings encroachment can take place by virtue of where the services are being offered. Physical therapy services are frequently offered in physicians' offices or in facilities partially owned by doctors. The location of the services present a problem of control for therapists. Therapists who work in close proximity to the referring physician are under his or
her direct supervision. When services are removed from the physicians office it would seem likely that therapists are able to initiate more treatment decisions of their own. Physical therapy has moved against encroachment by physicians by speaking against "joint-ventures," physician owned physical therapy services:

**APTA POSITION**
The APTA strongly supports the current ban on physician self-referral, prohibiting physicians from referring patients enrolled in either the Medicare or Medicaid program to [physical therapy] facilities in which they have a financial interest. The APTA believes self-referral creates a potential conflict of interest and must be avoided to protect the health care consumer.

(HTTPS://WWW.APTA.ORG/GOVT_AFF/RFP.HTML)

The APTA supports its position by reporting that, "quality of care in physician owned joint-venture facilities was lower than in non-joint venture facilities..." (Ibid.)

Not only do physical therapists seek to protect their jurisdiction from above, but also from below. Physical therapists must also be wary of encroachment by physical therapy assistants (PTAs). The APTA describes the role of the PTA as follows:

Physical therapist assistants work under the supervision of a physical therapist. Their duties include assisting the physical therapist in implementing treatment programs according to the plan of care, training patients in exercises and activities of daily living, conducting treatments, using special equipment, administering modalities, and other treatment procedures, and reporting to
the physical therapist on the patients' responses. (HTTP://WWW.APTA.ORG/FUTURE)

PTAs play an important part in optimizing the availability of physical therapists, but can be seen as a threat to the dominance physical therapists have over the administering of physical therapy services. Findings from studies of PTAs' work and preferences, "indicate that PTAs generally desire to work under plans of care that leave some of the decision making regarding treatment guidelines in their hands." (Robinson, et. al., 1995: 1062). Physical therapists, on the other hand, are seen as, "want[ing] to design a more prescriptive plan of care that is simply implemented by the PTA." (Ibid.) Increases in the numbers of PTAs has led to a conflict where:

Some might argue that any type of treatment within the domain of physical therapy is an appropriate function of the PTA....[While] Others might maintain that the safe and effective implementation of some treatment procedures may require a level of knowledge in the basic sciences (anatomy and neurosciences) that is well beyond the educational preparation of the PTA...(Ibid.: 1062).

Physical therapy must guard against encroachment from both above, doctors, and below, physical therapy assistants.

In seeking to solidify their control over their jurisdiction physical therapists seek to have their claims of expertise and professionalism recognized in
the legislative, work place and public arenas. The APTA takes an active interest in legislation that affects the occupation including the privileges of the profession and reimbursement issues. Physical therapy has attempted to gain dominant authority over its jurisdiction by lobbying for legislation to remove the need for physician referral of patients. The APTA has expressed a belief that physician referral hampers the ability of therapists to perform their duties and of patients to obtain medical care,

In many jurisdictions, the practice of physical therapy is contingent upon the prescription or referral of a physician. This requirement does not recognize the professional training expertise of the licensed physical therapist nor does it serve the needs of those patients who require physical therapy but must first be seen by a physician. (Emphasis added) (HTTP://WWW.APTA.ORG/DIRECT_ACCESS.HTML).

The solution proposed by the APTA is to, "Amend current statutes at the State level to permit direct access to physical therapy services." (Ibid.) In making this claim to the legislative arena, the APTA frames its desire within the lay concepts of expert and professional symbols by calling attention to the regulation of their field regarding both training and education:

Entry into the profession and practice of the profession are stringently regulated by all States, and as highly trained health care professionals, physical therapists have a proven track record on
effectively treating millions of patients. Physical therapists are well-qualified to recognize when patients demonstrate conditions, signs and symptoms that should be evaluated by other health care professionals... (Ibid.)

The APTA also uses victories in 30 states and the U.S. Army where referrals as a requirement for obtaining services have been curtailed as justification for obtaining greater control of its jurisdiction in the remaining States.

In addition to attempting gain a firmer monopoly on services within its own jurisdiction through legislative means, physical therapy via the APTA also attempts to control reimbursement issues within physical therapy. An example of this is the reaction of the APTA to notify its members and prepare to take action against the Health Care Financing Administration regarding the changing of coding combinations used to bill for physical therapy services:

The Health Care Financing Administration (HCFA) contracted a 3rd party administrator to develop coding combinations (used to request 3rd party reimbursement) that 'adversely affect the provision of physical therapy services.' Policy changes were disseminated to the AMA, but no non-physician group was given an opportunity to comment nor was the APTA given proper notice of the implementation of changes. The APTA has suggested specific changes to the new policy and may pursue legal action if appropriate action is not taken. (HTTP://WWW.APTA.ORG/GOVT_AFF/CODING.HTML.)

Also regarding reimbursement the APTA has supported legal requirements that physicians' offices that offer
physical therapy services be required to offer the same
type and quality of care required of all other out-
patient physical therapy services
(HTTP://WWW.APTA.ORG/GOVT_AFF/GUIDE).

While attempting to gain legal support for their
claims of expert and professional status, physical
therapists have also utilized the work place as an arena
in which they present themselves as members of a
profession with specific roles and functions. Physical
therapists seek to demonstrate their primary role in
outpatient rehabilitation services by maintaining a
dominant role over PTAs, "The current HOD [House of
Delegates of the APTA] policy leaves delegation of tasks
to the PTA largely up to the discretion of the
supervising PT [physical therapists]." (Robinson, et.
al., 1995: 1055). The APTA also makes clear that the,"performance expectations of PTA graduates are a subset
of those identified for the recently graduated P.T.s."
(Ibid.). Physical therapists, such as certain Army
physical therapists, who perform primary evaluations
also take on the privileges associated with physicians
such as, "referring patients to radiology for
appropriate radiographic evaluations and ordering some
analgesic and nonsteroidal anti-inflammatory
medications." (Benson, 1995: 381).
In addition to having their expert and professional claims observed in the work place arena, physical therapists make expertise claims to the public. The field of physical therapy and physical therapists are aware that, "the manner in which the public...acknowledge(s) physical therapy's growing role in this defining of health and health care are both likely to create new opportunities for service." (Selker, 1995: 31). Physical therapy recognizes that the public, as consumers, holds sway over the jurisdiction that physical therapists control and hence it is important to convince the public arena that physical therapists are professionals who hold expertise in rehabilitative medicine. The post-baccalaureate education encouraged for physical therapists plays a part in this as a way of "assuring the public that therapists were adequately prepared to help them." (Rothstein, 1996a: 225). Physical therapists believe that the pressures that can be brought to bear by the public arena will help them make legislative arena gains:

Because of the professional expertise and reputation of physical therapists, increasing numbers of patients are requesting physical therapy services, but are frustrated to find that they must first see a physician. (HTTP://WWW.APTA.ORG/DIRECT_ACCESS.HTML).
The public arena, as noted by Abbott, can be used to gain acceptance of an occupation as a profession that possesses expertise in a certain jurisdiction (1988). This view of the occupation can then be used to ask society to legislate exclusive rights for the occupation.

**Scientific Theories and Methods**

Lastly, my analysis of claims of scientific legitimacy to express professionalism and expertise is divided into two sections. The first section concentrates on the creation and maintenance of a base of expert knowledge. The second section focuses on the research and methods used to create "scientific" claims. Gieryn tells us that,

Construction of a boundary between science and varieties of non-science is useful for scientists' pursuit of professional goals; acquisition of intellectual authority and career opportunities; denial of these resources to 'pseudo-scientists'; and protection of the autonomy of scientific research from political interference. (1983: 781)

The literature of the APTA suggests that physical therapists use scientific claims in order to pursue the goals listed above that are granted to professionals.

The Foundation for Physical Therapy exists to support the declaration that, "physical therapy is indeed a science as well as an art. A problem we have had for a long time is that we simply have not
substantiated the basic body of knowledge necessary to support our methods." (Rothstein, 1996a: 224). Physical therapy has felt a need to document a unique body of knowledge that it can claim in order that it be recognized as a science and not an occupation that merely utilizes special treatments. The difference between applying technology and developing a unique body of esoteric knowledge is viewed as the difference between being technicians and being professionals (Abbott, 1988; Becker, 1973; Freidson, 1970a; and Parsons, 1939). One physical therapist writes, "We can choose to remain nonreflective practitioners...or we can move forward as professionals—with sound theoretical and scientific support underlying our treatment practices." (Harris, 1996: 180). Physical therapists claim that building their knowledge base could have the effect of strengthening the identity of physical therapy (Robertson, 1995a: 228), which would make it more difficult for other occupations to encroach upon physical therapy.

The manner in which physical therapy chooses to build its knowledge base is through research. It is through research that physical therapists expect the benefits of scientific credibility to come to their field (Robertson, 1995b: 313). Research is expected to
validate physical therapy's claims of expertise and professionalism:

Specifically, research is expected to contribute to the underlying and unique knowledge base of the profession and to demonstrate the effectiveness and scientific merit of the knowledge base. Through these contributions, research is expected to assist in developing a more distinct identity for physical therapy. (Robertson, 1995a: 223)

The editor of the Journal of the American Physical Therapy Association points to focused and meaningful research conducted in an appropriate manner as a way in which physical therapy can, "ensure our survival, and, more importantly, our patients' continued access to our services." (Rothstein, 1996b: 126). The committing of resources to "scientifically" validating physical therapy's practices through research are seen as being able to "do more than move [physical therapy] away from immediate danger. We can move into a position of safety for ourselves and our patients." (Ibid.: 127). By using scientific research methods and accumulating an esoteric body of knowledge unique to physical therapy the occupation hopes to validate its claims of expertise and professionalism and construct boundaries that prevent other occupations from usurping these same claims and the privileges that they impart.
Summary

Physical therapists use a variety of strategies to promote themselves as experts and to claim professional status. These strategies include displaying the attributes that laypeople associate with the professions: altruism, regulation of entry into the occupation, high levels of education, and organized representation. Physical therapists use these traits to make claims in the different arenas that can acknowledge them as professionals. The attributes listed above can be used to gain acceptance in the public arena and in legislative arenas. By emphasizing their professional attributes physical therapists can claim the exclusive right to treat certain conditions and types of patients. Physical therapists further claim expertise and professionalism by demonstrating their field's body of knowledge and the scientific methods used to accumulate this knowledge. These strategies differentiate physical therapy from other fields and accentuate the claims of physical therapists that they are deserving of being an acknowledged profession that should be granted control over entry into physical therapy, a monopoly over the knowledge and techniques used by physical therapists, and exclusive rights to reimbursement.
CHAPTER 8
CONCLUSION

This case study of physical therapy explored the ways in which physical therapists attempt to gain recognition and cooperation in regard to their claims of professional and expert status. This work examined an area that the field of sociology has generally left unexamined: the ways in which non-physician medical practitioners make professional and expert claims. I explored the ways in which physical therapists assert these claims on both a societal and an individual level. I argued, that as members of an occupational group and as individuals who practice physical therapy, physical therapists use a variety of methods to gain acceptance of their claims. Specifically, I investigated the communication strategies used by physical therapists to gain patient cooperation. I also examined the strategies and techniques used by physical therapists, to maintain and expand the boundaries of their occupation in the minds of the public, in therapists' places of work, and in laws and policies.
I chose multiple methods to examine and understand the expertise claims made at both the societal and workplace levels. I conducted participant observation at a rehabilitation site that extensively utilized physical therapy and therapists, directed semi-structured interviews with physical therapists, and performed a content analysis of the occupation's literature.

I also examined three areas of the sociological literature relevant to this study: occupations and professions, medical sociology, and sociolinguistics. These three areas contribute to the sociological knowledge regarding expert and professional claims making and the ways in which authorities communicate with their clients. Specifically, the area of occupations and professions offers insights into the ways in which occupations compete with one another for jurisdictions. The information I gathered regarding physical therapists showed that they participate in this system by attempting to increase their claims' legitimacy through the possession of professional symbols and also claims made in the legal arenas. Medical sociology contributed the idea of grounding theory in observations of the subject population. Observations completed for this study illustrated that physical therapists used different communication
strategies than those used by physicians, the dominant and most studied medical profession, to gain patient cooperation. Finally, sociolinguistic techniques provided methods for analyzing discourse between therapists and patients.

Investigation into the field of physical therapy supported my thesis that physical therapists assert expertise and professionalism on both the individual and societal level. Within their places of work physical therapists use several communication strategies to obtain patient compliance. On the societal level physical therapists use a variety of strategies to support their claims and also put forth these claims to the public, their places of work, and legislative arenas.

Given the lack of investigation into any of the occupations within the medical system (with the exceptions of doctors and nurses), this research expanded the knowledge of sociologists into layers of the medical hierarchy previously unexamined. This research showed that despite some similarities between physical therapists and physicians, therapists' strategies to gain recognition and acceptance of their expertise are not generalizable from what is known of either doctors or nurses.
The analysis of the observations and interviews with physical therapists showed that their communication strategies allowed them to gain the cooperation of patients, by going beyond diagnosis and treatment to creating a cooperative environment where therapists and patients worked together. The development of the physical therapist/patient relationship began at their initial meeting with an asymmetrical interview style of communication. The interview served to elicit information, but did not allow patients to voice their own concerns. Toward the end of the interview patients were generally asked to provide information regarding their lives and goals. Information regarding the patients' everyday life and goals were then frequently incorporated into the patient's treatment plans. Patients also collaborated with physical therapists by volunteering information regarding their health. Lastly, physical therapists also created "discourses of solidarity" by identifying similarities between themselves and their patients. This was done by agreeing with patients regarding the medical systems' and insurance companies' shortcomings and also by discussing topics of mutual interest to both the patient and the therapist.
The content analysis identified a variety of strategies physical therapists used to promote themselves as experts and to claim professional status on a societal level. These strategies included displaying the attributes laypeople associate with the professions: altruism, regulation of entry into the occupation, high levels of education, and organized representation. Physical therapists used these attributes to make claims in the public, work place, and legal arenas in order to be acknowledged as professionals. By emphasizing their professional attributes physical therapists attempt to claim exclusive rights to treat certain conditions and types of patients. Physical therapists also claim expert and professional status through the demonstration of physical therapy's body of knowledge and the scientific methods used to accumulate this knowledge. By emphasizing the "scientific" aspects of their occupation physical therapists attempt to separate themselves from other medical fields that are not recognized as professionals. These strategies differentiate physical therapy from other fields and accentuate the claims of physical therapists that they are deserving of being an acknowledged profession that should be granted control over entry into physical therapy, a monopoly over the
knowledge and techniques used by physical therapists, and exclusive rights to reimbursement.

The findings discussed in this study were primarily obtained from data accumulated through field research and also content analysis. The field work performed for this study allows for the communications between physical therapists and patients to be analyzed in a way that preserves the voices of the parties observed. The findings gathered from the field research possess a depth that would not be possible utilizing only interviews or quantitative techniques. These observations are not of a random sample and do not represent the voices of all physical therapists. However, the content analysis of the APTA's literature supports my findings that members of the occupation of physical therapy attempt to claim professional and expert status. This happens on both the individual level, as was explored in the field work, and on the societal level, examined in the content analysis.

Sociology has generally only explored the ways in which recognized professions gain consent from clients and how these particular professions gained their status. My research shows that the experiences of physical therapists are not the same as physicians and that they cannot be generalized from knowledge of the
dominant medical occupation. The experiences of aspiring medical professionals, including but not limited to physical therapists, need further investigation that is sensitive to their positions within a medical hierarchy and the difficulties in asserting expertise when it is not publicly recognized through possession of professional status.
APPENDIX A

i. Professionalism
-Can you tell me a bit about the requirements for becoming a physical therapist?
-Why did you decide to become a physical therapist?
-Are you a member of the American Physical Therapy Association or any other professional organization?
-How does/do this/these organizations benefit you?
-Are there any professional activities that you take part in either here at the center or elsewhere? If so, what are they?

ii. Expertise
-Can you tell me what an average day is like for you? When do you come in to work and what is the first thing you do?
-In treating or diagnosing patients, how do patients contribute to the process or do they?
-How are treatment goals set?
-How do you handle patients who aren't motivated?
-How is this similar or different from patients who are motivated?
-Can you describe the type of relationship you have with your patients?
-Questions drawn from observation of the therapist and patients.

iii. Other health care providers
-Can you tell me how physical therapists are similar to physiatrist and other medical doctors? Work/Tasks? Education? Authority?
-In what ways are you different?
-How about physical therapy assistants?
-What are your relations like with doctors?
-How about when discuss patients with their physicians?
-What are your relations like with physical therapy assistants?
iv. Other
-Questions drawn from observations.
BIBLIOGRAPHY


VITA

The author, Katherine Cermak, was born on September 14, 1972 in Berwyn, Illinois. She currently resides in Hinsdale, Illinois.

Ms. Cermak earned a Bachelor of Arts degree from Cornell College in the Fall of 1993. While at Cornell Katherine majored in Sociology and Philosophy. In the Spring of 1994 she enrolled as a Ph.D. candidate in the Department of Sociology and Anthropology at Loyola University-Chicago.

In August of 1995 and 1996 Ms. Cermak was awarded a full-tuition research assistantship by the Judicial Development Project funded by the Illinois Supreme Court. Through these awards she has collected and analyzed survey data on perceptions of circuit court judges throughout the state of Illinois. She has used this data to create reports intended to improve their judicial abilities. Currently Ms. Cermak is assembling data on all judges that have been assessed in Illinois. This information will then be used to create a manual that will be used as a teaching tool for and by judges.
THESIS APPROVAL SHEET

The thesis "Professionalism and Expertise: A Case Study of Physical Therapy" submitted by Katherine A. Cermak has been read and approved by the following committee:

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the committee with reference to content and form.

The thesis is, therefore, accepted in partial fulfillment of the requirements for the degree of Master of Arts.

12/27/76
Date

Judith Wittner
Director's Signature