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## Emancipatory practice: a model for physiotherapy practice?

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**Abstract** This paper explores the notion of emancipatory practice as a model for physiotherapy. Key characteristics of emancipatory practice are to question taken-for-granted practices, to critically reflect on one's current practices, and to transform practices as a result of questioning and reflecting. Emancipatory practice challenges biophysical-centred meanings and values, and the dominant ideology of physiotherapy practice. A number of current trends and findings warrant an examination of emancipatory practice, including: emerging conflicts between patient-centred and therapist-centred clinical roles; evidence generated from randomised controlled trials and case studies; and professional identities of physiotherapists ranging from technical scientists to caring patient advocates.

The educational and practice implications of these challenges are that there is a need to rethink the status quo by addressing professional knowledge, the professional ideology underpinning education and practice, and clinical power inherent in practice from an emancipatory perspective. Adopting an emancipatory model of practice would change physiotherapy practice towards a more collaborative and egalitarian approach, with the emphasis on emancipating physiotherapists as well as patients. This paper, while focused on physiotherapy, has relevance for educators and practitioners of other health professions.

**Keywords** Emancipatory practice, physiotherapy, critical social science

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## Introduction

There is a crisis in clinical practice across health care professions including physiotherapy (Dalley 1999, Higgs et al 1999). This crisis can be categorised into three facets which are intimately linked: the changing clinical role of health professionals (Ewing and Smith 2001, Jorgensen 2000), the widening gap between theory and practice (Hurley 2000, Parry 1997), and the challenges to professional identity of

clinicians (Centre for the Advancement of Interprofessional Education, 2002, Dalley 1999, Higgs et al 1999).

## Practice Issues

### *Clinical Role*

Firstly, there is conflict within the clinical role between a patient-centred and a therapist-centred approach to practice. On the one hand, there is an expectation of effectiveness in long-term outcomes, increased quality of care, and patient-relevant care which epitomises the values of the patient-centred movement (see Fulford et al 1996). In this approach, clinical practice is influenced by patients' perceptions and what is most suitable for them. The term patient is used in this paper (even though 'client' or 'customer' could well suit the argument better). This is an intentional choice to prompt re-examination of how clinicians interact with their patients. The emphasis is on good therapist-patient rapport and interpersonal skills. The aim of patient-centred care is to be responsive to patients' felt needs (Jorgensen 2000) and to achieve patient-centred goals while at the same time contributing the practitioner's expertise to patient management goals, treatment and evaluation.

On the other hand, there is increasing attention paid to accountability and efficiency, which characterises the traditions of therapist-centred management. In this approach to physiotherapy practice, decision-making emphasises considerations of efficiency and technical achievement. Efficiency refers to practice that uses minimal resources (including time) to achieve set

goals. The goals relate to bio-physical outcomes and quantitative measures, and these goals are predominantly short term. In their extreme versions, the therapist- and patient-centred movements are in direct conflict with each other. The former has a technical orientation, the latter a psychosocial one. The key question that underpins this crisis is: should clinicians be scientific technicians or humanistic patient advocates? Beyond simply responding that the answer should be 'AND' - that there's a place for technical competence, scientific knowledge underpinning practice, humanism and patient advocacy in practice, we note that this question actually asks us to consider what are the theories, principles and values which underpin our practice. So often these are taken for granted, tacit, unchallenged or unknown. The 'and' view also implies that we need to equip practitioners with a way of moving between the various roles with their different assumptions, as the need arises.

### *Professional Knowledge*

A second crisis point in health care today is the widening gap between research and practice. Research findings derived from scientific method research are not easily applied to the unique situations and social contexts of clinical practice (Cox 1999). Physiotherapists may know what research-defined best practice should look like in an ideal situation. However, they are also aware that clinical environments vary. Technically oriented physiotherapists who are aware of the many variables within clinical contexts face a dilemma. How can they fill the gap between

research and practice? It appears to them that generalised evidence-based knowledge and the holistic and individual orientation of case studies are incompatible (Camilleri 1999). The key question that underpins this crisis is: should personal and cultural knowledge be equally as important as technical, evidence-based knowledge in making clinical decisions? It is critical for the therapist to utilise the full scope of knowledge available. Personal/cultural knowledge is essential to apply (Jorgensen 2000), to adapt where necessary the research-validated technical knowledge in clinical practice. To do this the therapist must be in tune with his or her personal knowledge relating to psychosocial issues and must be able to explore the patient's perspectives, with the patient, in a way that can culminate in a consensus of understanding and a plan for management.

### *Professional Identity*

A third crisis point that results from the previous two is the unresolved question: what orientation should physiotherapy practice take? Is physiotherapy an applied science, a social science, or a critical social science? There exists uncertainty amongst physiotherapists about their professional identity. Are they technical experts, patient educators, or advocates for patients? And is there room to mix these approaches and identities?

To describe the above practice crises as dichotomies implies that one would have to choose between the two given options. We have portrayed three clinical practice issues in their extreme contrast in order to raise awareness of

the issues and to recognise the fundamental differences in their implicit values and understanding of what constitutes health and health care. However, we assert that limiting discussion to extreme views is not helpful when attempting to find solutions. An extreme therapist-centred approach separates facts from values, objectivity from subjectivity, and medical from social issues in health. Such an approach establishes a hierarchy of knowledge where value-free, objective facts rank higher than value-laden, subjective health beliefs (Bithell 2000). An extreme patient-centred approach has an interest in mutual understanding and in seeking consensus. The emphasis is on interpersonal meaning. Such an approach is based on working with people's perceptions. Various aspects within the biophysical model influence these perceptions. The extreme patient-centred approach does not deal with these aspects and how they possibly distort perceptions (Ewert 1991).

In an emancipatory perspective facts and values are converged, and the distorted communication is made explicit and transformed into democratic dialogue (Habermas 1973). In this paper we postulate that physiotherapy practice is complex because it is based on interpersonal communications and its delivery depends on the clinical and sociocultural context. The goal is to contribute to the discussion comprising education and practice in health care, and physiotherapy practice in particular. We are exploring the notion of emancipatory practice and how it could inform physiotherapy practice. The paper is of interest to health care educators and practitioners alike. On an

undergraduate level we advocate discussion of how having practice philosophies should impact on practice. On a postgraduate level we want to emphasis greater discussion on ethical, diversity health and practice implications The arguments presented are based on the critical social science philosophy literature, the critical pedagogy literature as well as on our collective experiences.

### **What is emancipatory practice?**

Emancipation means setting people free from unnecessary, unreflected, and taken-for-granted assumptions and expectations. Assumptions are no longer hidden but are exposed and questioned. This process of becoming aware of values and assumptions enables people to question their intentions and interest. Emancipatory practice manifests itself when practitioners transform their practice towards more egalitarian approaches. Emancipatory practice strives to attain democratic and sustainable solutions by looking for choices that are realistic and mutually acceptable. While emancipatory practice refers to therapists' emancipation, critical reflection on personal perspectives (e.g. understanding, beliefs, assumptions, emotions and attributions) is equally important for patients in order to free them from views, attitudes or health behaviours that may have become obstacles to improvement of their wellbeing. Although the democratic process is promoted through evidence-based practice and peer review, without inclusion of the patient in clinical decision-making true democracy is lost and the process begins to resemble a benevolent dictatorship. Sustainability of

positive health outcomes requires critically applied evidence-based practice that is sensitive to patient context and perspective. While being critically reflective therapists must not be totally constrained by existing 'evidence'. Rather, therapists must make themselves aware of the evidence and be patient- and context-oriented in applying evidence. When therapists (and patients) challenge their assumptions and look beyond their existing beliefs, new perspectives and new patterns can be discovered.

The two main agendas of critical social science are critique and emancipation (Agger 1998). Critique involves questioning and challenging social interactions and practices, and emancipation refers to seeking to free people from oppressive practices (e.g. the highly dependent patient role) (Foley 2000). There are three core themes in critical social science that inform discussion of an emancipatory practice model for the health professions including physiotherapy: the dimension of knowledge, assumptions and ideology, and power and emancipation.

### *The dimension of knowledge*

Habermas (1971), a prominent philosopher and critical social scientist claimed that interests drive all knowledge. Knowledge is generated by exploring questions and questions are generated by interests. The kinds of questions that practitioners ask disclose their interest in a presenting challenge. There are technical, practical and emancipatory interests. Each interest produces different forms of knowledge. Thus knowledge can be categorised into empirical/analytical knowledge serving

the technical interest of control and domination, historical/hermeneutic knowledge serving the practical interest of understanding subjective experiences, and critical knowledge serving the emancipatory interest of liberating people from unreflected, taken-for-granted domination (Harden 1996).

Technical interest serving technical control is embodied in practice that is strongly guided by quantitative measures. Technical knowledge generated from objective observation and investigation commonly serves to reiterate current practices and power relations and marginalise qualitative findings. Technical knowledge on its own is too limited to embrace other ways of knowing such as emotional, personal and cultural knowledge. Critical social science starts from the premise that value-free, objective knowledge is a myth. It rejects the notion that all knowledge should measure up to a natural science way of knowing. It claims that such technical, evidence-based knowledge is incomplete and inadequate as the foundation for meaningful professional practice (Cranton 1996). Whilst technical knowledge plays an important part in shaping professional practice it is not the all-defining base of it.

Practical interest (which is focused on individual and group perspectives) underpins consensus building that are embodied in people-centred practice. Practical interest is driven by the desire to understand current situations and practices. The emphasis is on generating meaning from subjective perspectives. Such meaning and agreed understanding creates social norms and consensus, and determines what is acceptable behaviour.

From a practical interest perspective, knowledge emerges from shared meanings. There are two problems with a practical interest perspective. First, shared meaning and knowledge can be subject to manipulation by a more dominant cultural group. Second, trying to accommodate all interpretations is impossible. However, we do advocate that physiotherapists evaluate and attempt to understand patients' perspectives, even though patients' criteria and professional criteria may not coincide. Understanding the perspectives of others does not necessarily mean that those perspectives are automatically accepted as viable or helpful. Pluralistic perspectives that value all interpretations as equally valid can lead to indecision and paralysis (Ewert, 1991).

Practitioners may be torn between technically and practically centred approaches, as both can be appropriate depending on the clinical context. A clash in shared meanings is viewed as a conflict in interpretations, which requires reconciliation. If we accept uncritically all interpretations as valid, regardless of their foundation, we fail to recognise that knowledge is a product of shared meaning and that knowledge is driven by interests. The critical social science perspective starts with perceptions but does not accept them on face value. Rather, it claims that the basis of people's perspectives needs to be explored, understood and where appropriate transformed. Clinicians and patients need to explore their perspectives with openness that allows for transformation.

Emancipatory interest focuses on change by moving current practices forward

towards more humane, egalitarian and realistic practices. People who are committed to emancipatory interest consider and agree on their intentions and the dimension of the topic before making statements and developing arguments. The highest level of communication is when people try to understand each other's subjectivity rather than trying to force their own subjectivity and motivations into a guise of objective rationality (Dubiel 2001). Therapists cannot just assume that the interaction they may have with a particular patient is successful just because a patient is saying, 'yes' to certain propositions. Thinking of Habermas' ideal conditions for discourse (Habermas 1984), there may be constraints on a patient's ability to participate in discourse equally with a therapist. For example, patients may not feel able to explain to their physiotherapist how their work situation acts as a stressor in terms of relationships with their boss or fellow workers, or work conditions. They may not even know the role of stress in pain modulation, or they may feel that complaining about work conditions will be interpreted as not wanting to go back to work, which is quickly labelled in our society. It has been known for some time that therapists treat (and prefer) acute cases over chronic pain and non-compensable over compensable cases, because of the complexity of these factors (Wolff et al 1991).

If one accepts that knowledge is the outcome of human activity, then knowledge is seen as being 'motivated by natural needs and interests', and as occurring within a historical and social context (Carr & Kemmis, 1986: 181). A

critical social science perspective is based on the assumption that we can differentiate between genuine communication and strategic manipulation. This discussion of interests and knowledge leads us to the next core theme of critical social science, ideology.

#### *Assumption and ideology*

Ideology refers to the shared meanings and values of a group. It is socially constructed. Therborn (1999) claimed that a profession is a manifestation of ideological configurations. The way people are in the world and make sense of it is influenced by historical, political and cultural ideology. As long as underlying assumptions and ideologies remain hidden, the status quo will remain unchallenged, stagnant and potentially oppressive (Welton 1995). By assessing assumptions of current practices from a historical, cultural and political perspective, unnecessary barriers to emancipation are illuminated. Practices that are based on unreflected, ideological bias may impede and hinder development. By acknowledging ideology it is possible to question and transform it (Giroux 1983). If the ideology of professional practice remains hidden there must be a reason for it; this reason could be to gain authority, social status and dominance over others. This brings us to the third core theme of critical social science perspective, power and emancipation.

#### *Power and emancipation*

Power and domination are concerned with who determines what actions can be taken, what topics can be talked about, what topics are to be avoided,

who can have a say, and who decides what is going to happen (Inglis 1997). By questioning who has power and why, the critical social science approach works towards equalising power relations. Power relations can change in the process of human interactions and relationships. Emancipation occurs when power relations are made transparent, and when people free themselves from unnecessary power constraints. It is important to understand that critical social science does not provide a licence for anarchy. It is accepted that authority is important for social public life. However, adopting a critical social science perspective distinguishes between unnecessary and essential authority (McCarthy 1994).

Critiquing what we accept as knowledge and ideology is the first step in moving closer to emancipation. Emancipatory interest is nurtured by the desire to mature, to lend a voice to the powerless, and to include historical and political aspects when analysing practices. Such an approach consists of critical self-reflection and an interest in searching for best possible solutions in each individual situation. This brings us to describe emancipatory practice in action.

### *Critical self-reflection*

The tool that transforms an experience into learning with the potential of change is critical self-reflection. We do not learn just by having experiences. There are many practitioners who have been practising for many years who have not become experts in their field. However, there are others who have been practising for a relatively short time and who are recognised leaders in

their field (Trede 2000). To reflect on experiences means to make sense of them, to understand what happened, why it happened and how. The process of reflection will guide us to reconsider our actions, to understand in more depth what happened and to ask ourselves what could have happened. It will help us to question our assumptions and the values that inform our actions. Mezirow et al (1990) focused on critical reflection and the capacity of people to learn from their experiences so that they could transform their actions towards more egalitarian, democratic practices. Emancipatory education is defined as 'an organised effort to help the learner challenge presuppositions, explore alternative perspectives, transform old ways of understanding, and act on new perspectives' (Mezirow 1990: 18). As clinical teachers we could promote critical self-reflection in our students so that they learn to do this with their patients.

The word critical can have many meanings. In the context of critical social science, to be critical is not concerned with searching for deficits and mistakes. We use the term to mean being aware of the diverse aspects of a situation, an idea or a presenting health challenge, and understanding its uses and limitations, e.g. that physical inactivity does not necessarily comprise only a lack of motivation or self-discipline. Critical thinking examines sources and consequences, and recognises assumptions and underlying beliefs that govern our thoughts and actions. Facione (1990: 2) summed it up clearly as follows:

The ideal critical thinker is habitually inquisitive, well

informed, trustful of reason, open minded, flexible, fair minded in evaluation, honest in facing personal biases, prudent in making judgments, willing to reconsider, clear about issues, orderly in complex matters, diligent in seeking relevant information, reasonable in the selection of criteria, focused in inquiry, and persistent in seeking results which are precise as the subject and the circumstances of inquiry permit.

Critical self-reflection is concerned with assessing the way we pose problems and assess our frame of reference; in short, it questions our professional identity. It aims to enable practitioners to rethink their ideas and actions. Emancipatory practice should not be viewed as condemnatory of current practices as such. Rather, emancipatory practice is an approach to freeing mainstream practices from prejudice, habitual routines, power games, hidden ideology and unreflected, unnecessary barriers to emancipation. There is no formula for emancipatory practice. It comes alive with a critical understanding of the influences and consequences of unreflected assumptions, domination and ideology in practice (Foley 1999).

### **Emancipatory practice as a model for physiotherapy practice**

Adopting an emancipatory physiotherapy practice model would mean searching for democratic and sustainable treatment solutions by looking for choices that are realistic and acceptable for both physiotherapist and patient. In this approach, health problems are not described in terms of

biophysical deficits alone, and equal emphasis is given to the broader social challenges. For example, if older people who are not coping at home are admitted to hospital the issue for physiotherapy practice is not reduced to joint stiffness, muscle atrophy and lack of motivation. Physical inactivity is explored as an aspect of social isolation, circumstances underpinning attention-seeking behaviour, and ageist attitudes of society amongst others. This transformation in practice focus is based on awareness and understanding of an ecological model of health in which health is a dynamic and complex phenomenon (Higgs et al 1999). Its influences extend beyond genetics and individual lifestyle behaviours to the wider economic, political and environmental context factors including social justice and social welfare systems (Collins 1995).

Physiotherapists adopting emancipatory practice would not accept mainstream approaches and dominant ways of thinking and practising without reflecting upon them. Their treatment decisions would be based on qualities such as collaboration between clinician and patient, permitting questions, and searching for options.

Physiotherapists operating within an emancipatory model are first of all themselves learners. Through critical self-reflection they become emancipated physiotherapists who then become facilitators of emancipatory learning for their patients. They help their patients to learn to think for themselves, act for themselves and feel more in control of their health. Emancipatory practice brings about an increased awareness of possibilities and potentials. Within a

democratic relationship physiotherapists and patients are creators of their own treatment culture.

It is important to make a distinction between helping patients to comply or passively cooperate with what physiotherapists might think is best for them, and enabling patients to collaborate in a way that actually allows them to participate in treatment and to feel more in control of their health problem. Compliant patients may get better in the short-term but it is anticipated that emancipated patients will also feel in control, and come closer to reaching their full potential. An emancipatory approach expands thinking beyond the one-dimensional, uncomplicated view of health behaviours. The implications are that health is defined neither in purely biophysical terms nor in psychosocial terms, but rather in emancipatory terms. Critical self-reflection promotes a practice framework that embraces biophysical, cultural, social and other influences, and liberates the individual's thoughts and actions from hidden, often unintentional restrictions. Such a practice framework has implications for the role of physiotherapists, the notion of professional knowledge, and professional identity.

#### *The clinical role*

Within an emancipatory approach physiotherapists would adopt the role of facilitator of emancipatory learning. Transforming the clinician's role to that of a collaborator, negotiator and emancipator implies democratising the clinician-patient relationship. A democratic relationship between physiotherapists and patients means that

both partners are actively involved in decision-making and consequent action. 'Democratic' does not mean equal or the same in terms of knowledge or skills; it allows for recognition of different strengths (e.g. physiotherapist's expertise, patient's knowledge of self and circumstances). We concede that an emancipatory practice model is not an easy model in which to work; it may create quite some discomfort in practitioners as they need to let go the professional authority and power which their education inculcates in them. However, the creation of a democratic relationship will lead to increased respect and comfort, reduced misunderstanding and better rapport for patient and physiotherapist.

#### *The notion of professional knowledge*

Although physiotherapists have expertise in their field and possess technical knowledge that helps to define their profession, physiotherapy practice knowledge is not exclusively informed by technical knowledge (Higgs & Titchen 2001). Adopting an emancipatory perspective means that practice knowledge is generated with a critical awareness of barriers to realistic, achievable treatment goals and a readiness to act on identified barriers. It means that subjectivity is integrated and not excluded.

Three forms of knowledge are required for professional practice: that from research and theory, from professional experience and from personal experience. "Blurring the boundaries between different knowledges and their generation is an important part of understanding the strength and scope of practice knowledge" (Higgs et al 2001:

3). Practice knowledge is a rich concept informed by different ways of knowing. It is not limited to one approach to knowing only.

### *Professional identity*

Professional identity of physiotherapists adopting an emancipatory model would be firmly based on a critical social science perspective. These physiotherapists would accept that physiotherapy is a complex, highly interactive profession that is based on equality, democracy and emancipation. Physiotherapists would be identified as facilitators of a process that strives towards exploring quality of life with an emphasis on reaching human movement potential. Physiotherapists would critique the technical, social and economic interests that drive theories and 'facts'. Such reflection relates not only to their assumptions about practice but also to their patients' perceptions and interests. Physiotherapists adopting an emancipatory perspective carefully critique their own assumptions and those of their patients with regard to what motivates and drives both parties to act the way they act, to think and make sense of their world the way they do. They would assess a presenting health challenge from an emancipatory perspective of human interests and needs. Emancipation does not promote dependency by making patients adhere to scientific perspectives, and does not refer to independence by setting patients free from scientist perspectives. Rather it advocates interdependence. Clinicians who practise within the emancipatory paradigm are critically aware of but not limited to the technical interest which so easily legitimises clinical dominance.

They abandon unnecessary authoritarian power interests but they maintain necessary authority.

### *Limitations of emancipatory practice*

Emancipatory practice does not meet with universal acceptance; it is complex, ambiguous and continually contested (Foley 1999). There are three potential weaknesses in this approach to practice. First, partnerships where clinicians help patients to help themselves are 'essentially foreign to medicine' (Sasz & Hollender 1956: 588). Advocating a democratic clinical relationship with patients threatens professional authority. Second, critics state that once people are made aware of unnecessary barriers to emancipation they want to change the status quo but are not always in a position to actually do so. Awareness-raising that is not acted upon may lead to a heightened sense of powerlessness rather than empowerment. Third, critics of emancipatory practice argue that emancipatory interest is not realistic but rather utopian, especially in our times of economic rationalism. Emancipatory practices are based on the assumption that most people would like to be more self-reflective and are capable of meeting on egalitarian terms. At least it is assumed that people could negotiate their interpersonal communications. Although this may be perceived as a weakness, it should rather be seen as a strength because it provides a vision that is driven by optimism and democratic values rather than by profit and domination. While not all will choose this option, it is an option they should at least be given. Emancipatory practice in physiotherapy advocates a clinical orientation that strives towards context-appropriate and

egalitarian approaches to practice. Such an approach offers the promise of achieving sustainable treatment goals.

### Conclusion

Emancipatory practice, with its underpinning critical social science perspective, is well placed to address unresolved physiotherapy practice crises as it seizes the opportunity to transform practice. We need to challenge approaches to clinical practice and keep a constructive dialogue open in order to provide appropriate and effective physiotherapy services to patients and help the profession mature. Physiotherapy practice will reproduce its status quo as long as it is characterised by technical interest that dominates patients and restricts clinicians. We believe that a major challenge facing physiotherapy practice is the question of what underpins its interests and ideologies. A physiotherapy practice model based on emancipatory interests has the potential to clarify contradictions, ideologies and tensions, foster critical reflection and result in a mature practice. An emancipatory practice model does not offer easy, simplistic solutions to the contradictions, ambiguities and complexities of practice but it has potential to address these issues in a constructive way. To practise critical self-reflection is intellectually demanding for physiotherapists, but we consider that it is a model that will help physiotherapists and their practice to develop and grow, and gain greater respect in society. Emancipated physiotherapists and their patients would emerge as responsible, self-fulfilled participants in health care.

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