Science in Our Hands:

Physiotherapy

at the

University of Melbourne 1895 – 2010

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Abstract

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At a time when medicine could offer little therapeutic benefit, physiotherapists cured medical conditions by increasing circulation, strengthening muscle, breaking down adhesions, improving metabolism, affecting the nervous system, and restoring symmetrical and normal development and movement. Physiotherapy cured whilst medicine waited for nature to heal. This untold story of physiotherapy education in Victoria, Australia, is seen through the bifocal analytical lens of professionalisation and embodiment in the development of physiotherapists. As narrative and autobiographical history it identifies key physiotherapists and the relationships with medicine and medical sciences. It provides the background to the emergence of practitioners in the nineteenth century and their local recognition by the end of the century. The major professionalisation milestones include the formation of an association and education in conjunction with the University of Melbourne in 1906, and the expanding clinical roles of women and men physiotherapists in the two World Wars. The itinerant physiotherapy services, commenced in the 1930s to treat people with poliomyelitis, extended its services to a wider community, becoming the forerunner of primary contact autonomous practice in 1976. These significant events influenced education.

Whilst continuing to undertake biomedical sciences subjects at the University of Melbourne, the School of Physiotherapy became established initially at Fairfield Hospital and then Lincoln Institute. The proposal to transfer Lincoln to La Trobe University in the 1980s induced the members of the physiotherapy profession to campaign successfully for the University of Melbourne to commence its School of Physiotherapy in 1991. The development of comprehensive education and research programmes and an expanding physiotherapy epistemology conclude this exploration of the professionalisation journey.

Declaration

This is to certify that

i) the thesis comprises only my original work towards the Doctor of Philosophy

ii) due acknowledgement has been made in the text to all other material used

iii) the thesis is less than 100,000 words in length, exclusive of tables, the bibliography and appendices.

Acknowledgements

When I formally retired from the School of Physiotherapy of the University of Melbourne in 2007 I contemplated writing a history of physiotherapy education. As I continued with almost full-time professional obligations I sought advice from historian colleagues. Professor Janet McCalman suggested she could co-supervise if Dr James Bradley joined her. Janet and James have shared their knowledge and provided collegial mentoring throughout the period of the thesis. The privilege of exploring new ideas and discussing them with these two colleagues in particular has been immensely satisfying. I am grateful for the advice of Dr Michael Arnold and the assistance of Professor Antonia Finnane, Chair of my doctoral committee, Dr Richard Trembath and Ms Sarah Gloger. Stella Mary Langford through her scholarship, a grant from the Faculty to visit the Wellcome Institute in London and undertake reviews in England, and the excellent resources of the University have facilitated the thesis process.

As foundation Professor and Head of the School of Physiotherapy at The University of Melbourne from 1991 to 2007, I commenced this research to elucidate the progress and process of physiotherapy education and clinical practice in Victoria, Australia. In 2013, in conjunction with many of my fellow graduates I celebrated and reminisced with them of our fifty years as physiotherapists. We had completed a three year Diploma of Physiotherapy. Subsequently, when our children Anthony, a few months old, Kim two years old and Rodney four years old, I began a BSc (Hons) part-time and when the children were teenagers completed my MSc research in physiology.

My greatest appreciation is to those who are no longer here - my parents. Freda Kimpton and George Bolwell provided me with a happy childhood and a breadth of educational opportunities, which like most children of middle-class parents I did not realise at the time were exceptional. Moreover the wave of female liberation that emerged when I was in my late twenties had existed within our family for at least two generations. My paternal grandmother and my mother were professional women contributing to my father's perspective on the role of women and men. Compared to many of my contempories I was even more fortunate in the man I married. Kel also grew up in a family where

his mother worked in responsible professional roles. For our long married life I have been engaged in clinical practice and university academic programmes as learner and teacher. Kel, Rodney, Kim and Anthony, their families, my sister Kaye and brother John have all provided support over the decades.

I have appreciated previous works of physiotherapy history. These include the history of the Australian Physiotherapy Association (APA) by Phillip Bentley and David Dunstan. As a member of the Reference Committee for this book I was privileged to read all of Phillip's drafts and make comments at that time. Other authors, Jane Wicksteed, June Barclay and my friend Marian Tidswell have told some of the British story with Marian's history of her School of Physiotherapy in that cradle of orthopaedics, Oswestry, being the closest example of the one I have tried to write. Joan Cleather and Wendy Murphy describe the experiences in Canada and the United States of America. Louise Shaw contacted me as she wrote her history of the centenary of physiotherapy at the University of Otago. Her new book has been inspirational reading.

On 8 February 1978 Anne Hodges Hall (Borthwick), then editor of the Australian Journal of Physiotherapy wrote to the President of the APA, Doreen Moore, that she and Margaret Nayler proposed a history committee to begin collecting oral histories. The first reported meeting to discuss the matter was held on 21 June 1977.[1] Physiotherapists were invited to participate in interviews: the reasons for undertaking physiotherapy, the prerequisites and selection requirements, their experience of education and that of subsequent clinical practice. With over one hundred Victorian interviews summarised there is sufficient information to follow much of the educational story. These oral histories, collected for the Association as a result of the driving enthusiasm of Anne Borthwick, Margaret Nayler, Bea Burke and Betty Fussell form the body of the local story with my recorded conversations adding further support. Sadly there is much missing. Nevertheless, those that have been prepared to share their physiotherapy world have been generous. Others, not physiotherapists who have fostered physiotherapy over the decades are thanked for their

[1] Australian Physiotherapy Association, "University of Melbourne Archives National Office 1987.0061 'History'."

contribution. Key people in my experience were Keith Bradley, Howard Toyne, Jennifer Lake, Eric Glasgow, David Penington, Graeme Ryan, Richard Larkins, Glyn Davis and James Angus.

Many people were prepared to share taped conversations about their experience of physiotherapy although time precluded the opportunity to speak with them all. How I wish I could have shared this writing and reminiscing with my mother and those others who were influential in my early physiotherapy education such as Marjorie Farnbach, Bea Burke, Betty Fussell, Ruth Green, Dena Gardiner and Monica Martin-Jones. Fortunately Geoff Luke and Basil Robinson provided extended stories as did Cynthia McLoughlin, Chief Physiotherapist at the Alfred Hospital when I was a physiotherapy student, Margaret Nayler, an eminent historian as well as a physiotherapist and Patricia Cosh, Director of the Victorian School of Physiotherapy from 1960 until 1985. I sincerely thank all those who have generously contributed: academic and clinical colleagues, former postgraduate and undergraduate students.

I thank the archivists at the University of Melbourne, Sophie Garrett, Coordinator, Repository and Collections Systems, Katie Wood, Access and Outreach and Curator, Leanne Dyson Minutes and Administration Officer University Secretary's Department and Dr Jacqueline Healy Curator, Medical History Museum, Brownless Biomedical Library. Archivists at the Public Record Office, Victoria and in London the Chartered Society of Physiotherapy and the Wellcome Institute provided advice and retrieved materials as did librarians at the Royal Australian Nursing Federation, Victorian Branch, the State Library Victoria, the Administrative staff in the APA office and former colleague, Professor Keith Nugent who organised access to some of the La Trobe University archives through Rebecca Bramwell, Manager, Governance.

Many other colleagues have helped in a variety of ways. In particular, I thank Lin Martin, Juliet Flesch, Anders Ottosson, David Nichol, Stephen Martin, Prue Galley and Ben Kreunen.

Presentations during the thesis

'Wind in the Bones' *Work in Progress Day*, School of Historical and Philosophical Studies, Faculty of Arts, The University of Melbourne 31 May 2012.

'Celebrating a shared past, planning a shared future: physiotherapy in Australia and New Zealand ' Platform presentation at the Conference *100 years of Education, Research and Practice School of Physiotherapy 1913 - 2013* University of Otago, Dunedin, New Zealand, 3 - 6 April 2013.

'A Peripatetic Physiotherapist - Basil Andrew Robinson' Platform presentation at the *U21 Health Sciences Group Annual Meeting*, University College, Dublin, Ireland, 2 - 6 September, 2013.

'They didn't all die: Physiotherapists in World War 1' presentation at *Work In Progress Day*, School of Historical and Philosophical Studies, Faculty of Arts, The University of Melbourne 1 November 2013.

'Physiotherapy Education at the University of Melbourne 1895-2010 - Applied Anatomy and Kinesiology' presentation at *Work In Progress Day*, School of Historical and Philosophical Studies, Faculty of Arts, The University of Melbourne 30 October 2014.

'Mr Robinson: Introducing physiotherapy education and practice' presentation at *World Confederation in Physical Therapy Congress 2015*, 1-4 May 2015, Singapore.

With Elizabeth Williams 'Meeting challenges in rural postgraduate paediatric education while building workforce capacity' presentation at *World Confederation in Physical Therapy Congress 2015*, 1-4 May 2015, Singapore.

'How would they have managed without us? Poliomyelitis and the physiotherapy volunteers in Victoria, Australia' presentation at *EAHMH Conference 2015 Cash and Care: Economics and Values in the History of Medicine and Health* 2-5 September 2015 Köln, Germany.

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McMeeken Joan M 2014 Celebrating a shared past, planning a shared future: physiotherapy in Australia and New Zealand *New Zealand Journal of Physiotherapy*. 42:1-8.

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McMeeken Joan M 2016 A colourful personality *InMotion* August 34-35.

McMeeken Joan M 2016 The pursuit of registration *InMotion* September 40-41.

McMeeken Joan M Recognising a founder of physiotherapy education in Australia, Frederick Teepoo Hall 1 September 2016 http://mdhs.unimelb.edu.au/news-and-events/recognising-a-founder-of-physiotherapy-in-australia,-frederick-teepoo-hall.

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List of Figures

Abbreviations used in the thesis

AMassA	Australasian Massage Association
AAMC	Australian Army Medical Corps
AAMWS	Australian Army Medical Women's Service
AAH	Australian Auxiliary Hospital
ACD	Australian Convalescent Depot
ACOPRA	Australian Council of Physiotherapy Regulating Authorities
AGH	Australian General Hospital
AMA	Australian Medical Association
APA	Australian Physiotherapy Association
APC	Australian Physiotherapy Council
ASCED	Australian Standard Classification of Education
ASP	Australian Standards for Physiotherapy
AWM	Australian War Memorial
BCE	Before the Common/Current/Christian Era
BMA	British Medical Association
CSP	Chartered Society of Physiotherapy
CEC	Clinical Education Committee
CEQ	Course Experience Questionnaire
EBP	Evidence Based Practice
WW1	First World War
HWA	Health Workforce Australia
ICT	Information and computer technology
IPS	Itinerant Physiotherapy Service
LIHS	Lincoln Institute of Health Sciences
MRB	Masseurs Registration Board
MP	Member of Parliament
NSW	New South Wales
PIT	Phillip Institute of Technology
PRB	Physiotherapists Registration Board
PBL	Problem Based Learning
RFM	Relative Funding Model
RAAF	Royal Australian Air Force
RCIG	Royal Central Institute of Gymnastics
RMH	Royal Melbourne Hospital
RMIT	Royal Melbourne Institute of Technology
WW2	Second World War
STM	Society of Trained Masseuses
UMAT	Undergraduate Medicine &Health Science Assessment Test
USA	United States of America
VIC	Victorian Institute of Colleges
VMPA	Victorian Massage and Physiotherapy Association

VMA	Victorian Massage Association
VPSEC	Victorian Post Secondary Education Commission
VAD	Voluntary Aid Detachment
WCPT	World Confederation for Physical Therapy
WHO	World Health Organisation

Chapter 1 Introduction

> *The record of how historians worked with the idea of profession provided an unusually rich set of models for historians who were trying to resolve divergent narratives and combine different discourses.*[1]

Figure 1.1 Physiotherapists on the march

In 1989 I marched with fellow physiotherapists through the City of Melbourne to the steps of Parliament House (Figure 1.1). Feeling strongly that physiotherapy's educational autonomy and science base were threatened, academics, clinicians and students with Australian Physiotherapy Association (APA) members conducted a sustained political campaign to secure physiotherapy education in the University of Melbourne, which we perceived as our educational home. The University had contributed to physiotherapy education since 1906. Finally, in 1991 the University undertook full responsibility for a School of Physiotherapy following a successful termination

[1] John C Burnham, "How the Idea of Profession Changed the Writing of Medical History," *Medical History Supplement* 18(1998). 173.

to our campaign. As its Foundation Professor and Head of School from 1991 to 2007, I commenced this research to elucidate the largely unknown and undocumented history of physiotherapy education and clinical practice in Victoria, Australia.

In this thesis, which takes the form of narrative history, I demonstrate the centrality of education to the integrated processes of physiotherapy's professionalisation and the development of practitioners' professional identities. In investigating the roles of individuals and organisations in the professionalisation of physiotherapy, the theoretical constructs explored are those of professionalisation and embodiment, which enabled the transformation of students into physiotherapists. Intertwined with this story is physiotherapy's relationship with medicine and the importance of scientific knowledge. In 1906, when the story begins, medicine could offer few tangible therapeutic benefits to patients while physiotherapists' ministrations could ameliorate many problems.[2] In this chapter, I reflect on my purpose for undertaking this research, justify the choice of narrative history and outline the methodology that I use.

'A serious life, by definition, is a life one reflects on, a life one tries to make sense of and bear witness to', said Vivian Gornick, providing an epigraph that summarises the balance between self and history that is central to this thesis.[3] In what follows, I will always be close to the surface. I grew up in a household where my mother, who spent her lifetime as a practising physiotherapist, was taught by the first Melbourne graduates. My immersion continued as a student, a clinician and an educator. In undertaking this research my moral values and sense of ethics cannot be divorced from the process of interpretation, evaluation and representation where I reflectively analyse the data and consider it from the perspective of my knowledge and ideas. Such processes 'are always

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[2] "Australasian Massage Association 30 May Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1907). 35.
[3] Vivian Gornick, *The Situation and the Story: The Art of Personal Narrative* (New York Farrar, Straus, and Giroux, 2002). 91.

ongoing, emergent, unpredictable and unfinished'.[4] They are enmeshed within a dynamic historical, geographical and social context influenced by my life experience, but in particular as a physiotherapist and academic.

My aim is to write a plausible, credible and relevant story of an essentially local world of physiotherapy with a core around education.[5] By embedding myself throughout the process I have endeavoured to use a thick and complex interpretation to crystallise an integrated story.[6] The sense of indulgence and privilege in this form of writing, where I am, in effect, an historical participant-observer, is a narrative that contrasts rather sharply with the research I undertook and supervised in the past: programmes grounded in hypothetico-deductive positivist laboratory and clinical discourse. This history has been a voyage of discovery, explicitly incorporating me in the story.[7]

I agree with David Altheide and John Johnson 'that individuals and groups create meaning in this world (and that) all theories, concepts and findings are grounded in values and perspectives; all knowledge is contextual and partial; and other conceptual schemas and perspectives are always possible'.[8] Corporeal realism as enunciated by Chis Shilling shares a version of realism that human life is meaningful and that our beliefs, values and emotions must be considered

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[4] Norman K Denzin and Yvonna S Lincoln, *The Sage Handbook of Qualitative Research*, 4th ed. (Thousand Oaks California: Sage Publications Inc, 2011). P563.
[5] M Hammersley, *Questioning Qualitative Inquiry: Critical Essays* (London: Sage, 2008).
[6] Clifford Geertz, *The Interpretation of Cultures: Selected Essays* (New York: Basic Books, 1973).
[7] These examples of my earlier work include interviews but I am hidden within. Sara Carroll and Joan M McMeeken, "Establishing the Value of Rural Clinical Placements During Undergraduate Allied Health Education," (Melbourne: Coordinating unit for rural health education in Victoria, 2000); Joan McMeeken et al., "Learning Outcomes and Curriculum Development in Australian Physiotherapy Education " (2005); Joan M McMeeken and Bev Phillips, "Drivers of Attrition from the Physiotherapy Workforce in Victoria. A Qualitative Research Project," (Report to the Victorian Government Department of Human Services 2007); Andrew J Hahne et al., "Outcomes and Adverse Events from Physiotherapy Functional Restoration for Lumbar Disc Herniation with Associated Radiculopathy," *Disability and Rehabilitation* 33(2011).
[8] David L Altheide and John M Johnson, "Reflections on Interpretive Adequacy in Qualitative Research," in *The Sage Handbook of Qualitative Research*, ed. Norman K Denzin and Yvonna S Lincoln (Thousand Oaks California: Sage Publications Inc, 2011). 581-582.

in our interpretations and theories.[9] My personal values include a dedicated work ethic and empowerment and liberation of others through political action and practical support.[10] I bring to the study, as Judith Preissle suggests, a bricolage of research approaches with an enhanced understanding of philosophy, theory and my fellow physiotherapists.[11]

Whilst nature can never be fully understood, I believe a real physical world exists. Multiple individual realities also exist: these are socially and self constructed through the experience of life; perhaps 'co-created by mind and the surrounding cosmos'.[12] In this thesis my peers participate with knowledge co-created by (mostly) fellow physiotherapists. Such interpretivist co-creation of data speaks to the postmodern understanding of experiential, propositional, presentational and practical knowledge with a degree of pragmatism that accepts many viewpoints.[13]

Research for this thesis began with conversations with academic colleagues in the humanities, and academic and clinical colleagues in physiotherapy. The conversations did not result in a fixed *a priori* position on a research approach. Instead I further developed my ideas as I read, searched the archive and began talking to my supervisors and others. To encompass a time frame of more than a century, the thesis would comprise archival information, including material collected by myself, oral history conducted with colleagues and peers, some of whose lived experience of physiotherapy began before the Second World War (WW2). The thesis emerged through this process as a narrative interpretive

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[9] Chris Shilling, *The Body and Social Theory* (London: Sage, 2012).
[10] Yvonna S Lincoln, Susan A Lynum, and Egon G Guba, "Paradigmatic Controversies, Contradictions, and Emerging Confluences, Revisited," in *The Sage Handbook of Qualitative Research*, ed. Norman K Denzin and Yvonna S Lincoln (Thousand Oaks California: Sage Publications Inc, 2011). 111.
[11] Judith Preissle, "Envisioning Qualitative Inquiry: A View across Four Decades," *International journal of qualitative studies in education* 19(2006).
[12] Lincoln, Lynum, and Guba, "Paradigmatic Controversies, Contradictions, and Emerging Confluences, Revisited." 103.
[13] John Heron and Peter Reason, "A Participatory Inquiry Paradigm," *Qualitative inquiry* 3(1997); "The Practice of Co-Operative Inquiry: Research 'With'rather Than 'On'people," *Handbook of action research* (2006); "Extending Epistemology within a Cooperative Inquiry," *The Sage handbook of action research: Participative inquiry and practice* (2008).

history informed by philosophical and theoretical constructs shared with the social sciences. Following an iterative process I refined the research objectives to:

- elucidate the historical development of physiotherapy education in Victoria, Australia
- identify the major players and their influence on education and hence professional development
- engage with the archive and people who became physiotherapists and embody a physiotherapy identity
- describe and reflect on my involvement as a physiotherapy student, a clinical physiotherapist and an academic in physiotherapy education
- analyse the development of physiotherapy education and physiotherapists through the bifocal lens of professionalisation and embodiment
- employ a reflective analytical approach whilst writing a narrative history.

But why narrative history over other theoretical approaches? Laurel Richardson wrote: 'narrative is the best way to understand the human experience because it is the way humans understand their own lives'.[14] Narrative imposes a structure upon events that exhibit the logic of connectedness, causation, significance and meaning implicit in the narrative's unfolding. Conceptually broadened across disciplines from the 1950s, following the work of the French literary theorists, narrative now has many different interpretations: as discourse, as personal and constructed, as a mode of inquiry and epistemology and as a story. Narrative has influenced

[14] Laurel Richardson, "Narrative and Sociology," *Journal of Contemporary Ethnography* 19(1990).

postmodernism and historiography's literary turn.[15] This thesis is, therefore, shaped by the complex contemporary debates in historiography.

Turbulent times have changed the meaning of writing histories. Geoffrey Elton favoured empiricism. He considered that truth could be determined by critically examining the archives for evidence of people's (invariably politicians) actions in the past. It was the historian's responsibility to analyse the traces remaining and to understand people's actions, ideas and motives without consideration of the historian's own beliefs.[16] For Elton, objectivity was something that could be achieved by the thorough historian. Elton's contemporary E.H. Carr took a more or less diametrically opposed position. He indicated that historians could not be truly objective, because they decided what was significant in events and the relationships between them and history was 'an unending dialogue between the present and the past'.[17]

Considering a reflective narrative history I investigated alternative approaches and multiple justifications.[18] The 'narrative turn' coined by Michel de Certeau, has meant researchers in medicine, law, anthropology and not least sociology have viewed their works as narratives.[19] Philippe Carrard recently reviewed historical narrativity describing the nineteenth-century approach to narrative as a dissertation: its form was that of a logical demonstration and its content the historian's own thoughts about the events: the dissertation an interpretation of

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[15] Liora Bresler, "Embodied Narrative Inquiry: A Methodology of Connection," *Research Studies in Music Education* 27(2006). Citing amongst others D Bridges, *Fiction Written under Oath? Essays in Philosophy and Educational Research* (Dordrecht, The Netherlands: Kluwer, 2003). 105-107. See also Denzin and Lincoln, *The Sage Handbook of Qualitative Research*.
[16] Geoffrey R Elton, *The Practice of History* (Sydney: Methuen, 1967).
[17] Edward H Carr, *What Is History?* , 2 ed. (London: Penguin, 1984). 18.
[18] Liz Stanley and Bogusia Temple, "Narrative Methodologies: Subjects, Silences, Re-Readings and Analyses," *SAGE Biographical Research* 8, no. 3 (2012).
[19] Michel de Certeau, *The Writing of History*, trans. Tom Conley, European Perspectives (New York: Columbia University Press, 1988 (original 1975)).

the true story.[20] In my interpretation David Carr and Jerome Bruner's linking of everyday living and experience with narrative history resonated.[21]

David Carr furthermore considered a narrative approach reflected an event from the actor's perspective within a temporal continuum, relating it to previous actions and events that preceded it; and in relation to potential future events.[22] Liora Bresler paraphrased 'stories have ... ends that satisfy some tension generated by their beginnings'.[23] The story was not 'a mere chronicle', but 'selects the relevant and leaves out the irrelevant'.[24] Geoffrey Roberts, working within this framework of a human action account of the past, thought narrative history aggregated the results of research as stories about connected sequences of thought and action, explicating reasons why past actors 'did what they did'.[25] Such relationships between history and narrative had generally been taken for granted, but subsequent debate amongst philosophers, historians and social scientists contested the validity of historical narrative. So many entered the debate it is impossible in this overview to consider all positions. I outline some of the main features of the continuing discourses.

Philosophers like Karl Hempel and Karl Popper queried whether narrative provided legitimate knowledge analogous to predictable laws of physical science. History only provided descriptions and explanations, not predictions.[26] Furthermore telling stories hardly seemed intellectually respectable, much less scientific.[27] Carrard considered Anglo-American analytical philosophers, citing

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[20] Hayden White, "The Question of Narrative in Contemporary Historical Theory," *History and theory* 23, no. 1 (1984).
[21] David Carr, *Time, Narrative, and History* (Indianapolis: Indiana University Press, 1986); Jerome Bruner, *Actual Minds, Possible Worlds* (Cambridge, Mass: Harvard University Press, 1986).
[22] David Carr, "Narrative Explanation and Its Malcontents," *History and Theory* 47, no. 1 (2008).
[23] Bresler, "Embodied Narrative Inquiry: A Methodology of Connection."
[24] Carr, "Narrative Explanation and Its Malcontents."
[25] Geoffrey Roberts, "Narrative History as a Way of Life," *Journal of contemporary history* 31, no. 1 (1996).
[26] Philippe Carrard, "History and Narrative: An Overview," *Narrative Works* 5, no. 1 (2015).
[27] Carr, "Narrative Explanation and Its Malcontents."

William Dray, William Gallie, Morton White, Arthur Danto and Louis Mink, sought to reinforce the epistemic status of narrativity, stressing its role in communicating informative and explanatory messages through the events described. Their concept of historical narrative as 'truth' was paramount.[28]

Conversely, social-scientifically oriented historians, particularly the French Annales School, attacked *histoire-récit* and *histoire événementielle* accusing such history of being non-scientific, overly dramatising or novelising.[29] Early positivists in the social sciences also wanted to find science in human events. However the 'revolution' of the 1960s and 1970s in Western countries, civil and women's rights movements, protests against the Vietnam War and environmentalism challenged established authority including that claimed for science and medicine. In these unsettled times a new social history of medicine drove historians to understand people and events in the context of their own times and to assess what made them meaningful.[30]

The appearance of AIDS early in the 1980s further drove these changes. Socially constructed cultural values, prejudices and power relationships integrated with the biomedical aspects of AIDS reinforced the need to consider biological and social factors and their interaction.[31] The influence of the Annales School though spread. Ironically the Annales-influenced Michel Foucault died of AIDS. He and his followers demonstrated the sciences, including the human sciences, mobilised power and knowledge to produce power.[32] Critics of modern reductionist medicine, particularly feminists, also perceived narrative as a tool by which medical elites exercised control over the

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[28] Carrard, "History and Narrative: An Overview."
[29] Ibid.
[30] Roy Porter, "The Patient's View: Doing Medical History from Below," *Theory and Society* 14(1985).
[31] Roger Cooter and Claudia Stein, *Writing History in the Age of Biomedicine* (New Haven, London: Yale University Press, 2013).
[32] White, "The Question of Narrative in Contemporary Historical Theory."

body and the way people led their lives.[33] Many studies revealed science as a tool and ideological construct employed by and serving the interests of an affluent, white male elite hegemony.[34]

These developments countered the focus on individuals and their actions that were central to traditional narrative history. Both the structuralists, who perceived historical events within broader systems, and the post-structuralists, who focussed on critique, deconstructed narrativity. Claude Levi-Strauss represented the perspective that traditional, narrative historiography was the myth of modern, Western, bourgeois, industrial, and imperialistic societies. Narrative could be the 'basis for a kind of cultural self-delusion'.[35] Roland Barthes equated historical narrative with fiction.[36] Hayden White, a highly influential figure in postmodernist historiography, asserted that Barthes's purpose was 'the dismantling of the whole heritage of nineteenth-century realism'.[37] White defined narrative as the mode of discourse common to cultures. That narrative 'predominates in both mythic and fictional discourse made it suspect as a manner of speaking about "real" events'.[38] He preferred the non-narrative form of the sciences for representing 'real' events.

Debates about the nature and function of narrative in history continued. White wrote: 'Historians have systematically built into their notion of their discipline hostility or at least a blindness to theory and the kind of issues that philosophers have raised about the kind of knowledge they have produced'.[39] Roberts suggested a more profound reason for the aversion to theory.

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[33] Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York: Oxford University Press, 1986); Virginia Olesen, "Feminist Qualitative Research in the Millennium's First Decade," in *The Sage Handbook of Qualitative Research*, ed. NK Denzin & YS Lincoln (Thousand Oaks California: Sage Publications Inc, 2011). 129-146.
[34] John Harley Warner, "The History of Science and the Sciences of Medicine," *Osiris* (1995).
[35] White, "The Question of Narrative in Contemporary Historical Theory."
[36] Roland Barthes, "Le Discours De L'histoire," in *Rhetoric and History: Comparative Criticism Yearbook*, ed. Elinor Shaffer (Cambridge, England: 1967 reprinted in English 1981). 7.
[37] Richard J Evans, *In Defence of History* (London: Granta, 2000). 11, 354. White, "The Question of Narrative in Contemporary Historical Theory."
[38] "The Question of Narrative in Contemporary Historical Theory."
[39] "Response to Arthur Marwick," *Journal of Contemporary History* 30, no. 2 (1995).

Historians considered their discipline 'coterminous with the common sense discourse of modern everyday life'. They felt 'a self-conscious, separate and distinct theoretical analysis of their discipline unnecessary'.[40] Judith Leavitt viewed the task of historians was to explicate the reasons for past actions.[41]

White popularised the idea that historians gave their data a narrative structure and in this respect this was little different from fiction.[42] He represented a constructivist position that our experience of the world cannot be equated with a narrative, thus the historian's role as to construct a fictitious story using the available data. White queried whether historical events could be truthfully represented or were allegorical, imaginative constructed discourses, transforming historical events into literary patterns of meaning. White considered that the facts of the narrative were displaced into a literary genre and not 'productive of genuine knowledge'.[43] Conversely in Paul Ricoeur's view, history's documentary sources separated it from fiction.[44] Richard Evans indicated that White modified his earlier views drawing a clearer distinction between history and fiction.[45]

Historians and philosophers still disputing narrative's epistemological value argued the coherence of historiographic narratives was repressive. Sande Cohen and Keith Jenkins represent these postmodernist views. Cohen considered that narratives conferred artificial homogeneity upon the data, concealing 'cognitive dissonance'.[46] And Jenkins, in some respects following White, viewed narratives as a textualised discourse imposing an unrealistic

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[40] Roberts, "Narrative History as a Way of Life."
[41] Ibid. Judith Walzer Leavitt, "True Facts and Honest History: A Review of Certain Practices, a Mea Culpa, and Other Thoughts About the Writing of History," *Historically Speaking* 14, no. 4 (2013).
[42] Hayden White and Robert Doran, *The Fiction of Narrative: Essays on History, Literature, and Theory, 1957-2007* (Baltimore, Md: Johns Hopkins University Press, 2010). Originally in Northrop Frye (1957) *Anatomy of Criticism.*
[43] White, "The Question of Narrative in Contemporary Historical Theory."
[44] Alun Munslow, *Narrative and History* (New York: Palgrave Macmillan, 2007). 3.
[45] Evans, *In Defence of History*. 11, 354. White, "The Question of Narrative in Contemporary Historical Theory."
[46] Sande Cohen, *History out of Joint: Essays on the Use and Abuse of History* (Baltimore, MD: Johns Hopkins University Press, 2006).

historical order on the past, which had ideological implications preventing social change.[47] Nevertheless many historians claimed that a narrative historiographical genre was widely shared, even celebrated. William Cronon in his presidential address at the 2013 meeting of the American Historical Association praised narrative as the most ancient and essential of historical tasks.[48] Similarly, Alun Munslow, the British theorist of historiography and a self-professed postmodernist, wrote in *Narrative and History*, his objectives to describe the 'goals', 'procedures', and 'compositional techniques' that historians follow in order to turn 'the past' into 'that narrative about it' that we call 'history'.[49] However Munslow termed his approach 'deconstructionism', fully recognising that history was an authored narrative reflecting the 'theories, attitudes, values, judgements and ideologies of the historian'.[50]

In the context of writing a physiotherapy story I too recognised that my perspectives would be reflected and hoped to emulate Leavitt's call for an integrated, complex and less reductionist historical narrative to elucidate the complex interactions of discipline, power, gender and class in my history.[51]

The perception of such an expanded view of 'narrative' made me return to the committed narrative historians for whom a nuanced, theoretically informed, reflective narrative history is a perfectly legitimate technique.[52] For Roberts 'narrative is lived by them as well as their subjects', while Cronon reminds me of the importance of engagement with theory.[53] Evans asserted that what happened in the past was real and historical writing can be informed by

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[47] Keith Jenkins, *On the Limits of History* (New York: Routledge, 2009).
[48] William Cronon, "Storytelling," https://www.historians.org/about-aha-and-membership/aha-history-and-archives/presidential-addresses/william-cronon. Accessed 19 July 2016.
[49] Munslow, *Narrative and History*. 1.
[50] Ibid. 3. 14-15.
[51] Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950*. "Medicine in Context: A Review Essay of the History of Medicine," (JSTOR, 1990).
[52] David Carr, "Getting the Story Straight: Narrative and Historical Knowledge," in *The History and Narrative Reader*, ed. Geoffrey Roberts (New York: Routledge, 2001). 197-208.
[53] Geoffrey Roberts, *The History and Narrative Reader* (London, New York: Routledge, 2001). 15-17. Cronon, "Storytelling". Accessed 19 July 2016.

theory.[54] Narrative history's proponents reiterate its cognitive value if historians provide evidence, interpret their material, and justify the story.[55] All available evidence must be collected, primary sources critically analysed and those chosen must be derived directly in time and place from the people and events studied.[56] Whilst newspaper articles, meeting minutes and oral histories are all socially and culturally situated and therefore carry the social and cultural hallmarks (including political alignments) of their production, corroboration of evidence is practised wherever possible. Yet all recognise there can be no absolute objectivity in history, not least because, as reinforced by Richard Rorty, narratives translate knowing into telling, and research texts could be 'acts of meaning'.[57]

Whilst noting these views, the knowledge that I would be writing the narrative and writing about my profession and my part in its development, made me more aware of Munslow's perspective. Narrative history is thus one of the possibilities that post-modern theory opens up as a way of doing history. And this is demonstrated by Julia Kristeva who introduced the term intertextuality to signify the relationship of an author's story to that of other stories.[58] Additionally Carolyn Ellis and Arthur Bochner emphasised subjectivity, self-reflexivity, emotionality, dialogue, and the goal of connecting social sciences to humanities through storytelling.[59] Using these insights, I would employ narrative history in my exploration of education in the development of physiotherapists.

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[54] Evans, *In Defence of History*. 253.
[55] A Megill, *Historical Knowledge, Historical Error: A Contemporary Guide to Practice* (Chicago, IL: University of Chicago Press, 2007). 96-98.
[56] Leavitt, "True Facts and Honest History: A Review of Certain Practices, a Mea Culpa, and Other Thoughts About the Writing of History."
[57] Richard Rorty, *Consequences of Pragmatism* (Minneapolis: University of Minnesota Press, 1982).
[58] Pat Sikes and Ken Gale, "Narrative Approaches to Education Research," University of Plymouth. 12-14. Nicholas J Fox, *Beyond Health Postmodernism and Embodiment* (London: Free Association Books, 1999). 123-151.
[59] Carolyn Ellis, Tony E Adams, and Arthur P Bochner, "Autoethnograpy: An Overview," *Historical Social Research* 36(2011).

From considerations on writing narrative I turned to qualitative inquiry where narrative research investigates the stories of people's lives and experiences and presents their meanings within a cultural and social context.[60] Jean Connelly and Michael Clandinin indicated that many disciplines including history, literature, sociology and education have developed approaches to narrative inquiry.[61] In this complex dynamic of interdisciplinarity, historical research has borrowed from disciplines such as philosophy, sociology, anthropology and psychology and been influenced by theoretical discussions in feminism, post-colonialism, queer theory and others.[62] Such eclecticism permits a wide diversity or bricolage of elements to be incorporated into historical research.[63] As alluded to above, all evidence should be viewed with some scepticism, although an interpretive analysis of documents triangulated with a collection of oral histories and conversations could enable some validation of events.[64]

Narrative inquiry thus obtains data from many sources to deepen research understandings. Whilst individual's stories form the basis of narrative, aspects of grounded theory are reflected in the confirmation of perspectives from multiple individuals and the wider view of physiotherapists as a socio-cultural group.[65] I would be one of the individuals and part of the group, thus making part of this thesis an autobiography.

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[60] D Jean Clandinin and F Michael Connelly, *Narrative Inquiry: Experience and Story in Qualitative Research* (San Francisco: Jossey-Bass, 2000).
[61] F Michael Connelly and D Jean Clandinin, "Stories of Experience and Narrative Inquiry," *Educational researcher* 19(1990).
[62] Ludmilla Jordanova, "The Social Construction of Medical Knowledge," *Social History of Medicine* 8(1995); Evans, *In Defence of History*.
[63] *In Defence of History*.
[64] Alessandro Portelli, "The Death of Luigi Trastulli: Memory and the Event," in *The Death of Luigi Trastuli and Other Stories: Form and Meaning in Oral History* (New York: State University of New York Press, 1991); Nancy L Leech and Anthony J Onwuegbuzie, "An Array of Qualitative Data Analysis Tools: A Call for Data Analysis Triangulation," *School Psychology Quarterly* 22(2007).
[65] John W Creswell, *Qualitative Inquiry and Research Design: Choosing among Five Approaches* (SAGE Publications, Incorporated, 2012). 146-148.

> 'Autobiographical memory is that uniquely human form of memory that moves beyond re-call of experienced events to integrate perspective, interpretation, and evaluation across self, other, and time to create a personal history'.[66]

Autobiography is recognised as a legitimate and critical approach to interpretive research.[67] Mark Freeman wrote, 'one can only imagine from the vantage point of the life that has been lived'.[68] Wolff-Michel Roth considered that autobiography demonstrates the interconnectivity of the individual within society in a dialectical relationship.[69] Thus my autobiography, combined with other biographical narratives, has the potential for describing a culture such as physiotherapy, 'through narrating the past with others, through joint reminiscing, that we come to have a sense of ourselves through time'.[70] Nevertheless, as Sara Delamont and Keith Hugill indicated, autobiography carries an inherent risk of self-indulgence unless the process is analytical.[71] Norman Denzin emphasised self-reflexivity but not self-obsession.[72] Hence through this narrative I have, as far as possible, been mindful of subjectivity, self-reflexivity, emotionality and the vagaries of dialogue.[73]

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[66] Robyn Fivush, "The Development of Autobiographical Memory," *Annual review of psychology* 62(2011).
[67] Denzin and Lincoln, *The Sage Handbook of Qualitative Research*. Ellis, Adams, and Bochner, "Autoethnograpy: An Overview."; Tami Spry, "Performative Autoethography," in *The Sage Handbook of Qualitative Research*, ed. Norman K Denzin and Yvonna S Lincoln (Thousand Oaks California: Sage Publications inc, 2011).
[68] Mark Philip Freeman, *Rewriting the Self: History, Memory, Narrative*, Critical Psychology (London; New York: Routledge, 1993). 113.
[69] Wolff-Michel Roth, "Auto/Biography and Auto/Ethnography: Finding the Generalized Other in the Self," in *Auto/Biography and Auto/Ethnography: Praxis of Research Method*, ed. Wolff-Michel Roth (Rotterdam: Sense: Sense Publishers, 2005). 3-4.
[70] Robyn Fivush and Katherine Nelson, "Parent-Child Reminiscing Locates the Self in the Past.," *British Journal Developmental Psycholology* 24(2006).
[71] Sara Delamont, "The Only Honest Thing: Autoethnography, Reflexivity and Small Crises in Fieldwork," *Ethnography and Education* 4(2009). Kevin Hugill, "The 'Auto/Biographical' Method and Its Potential to Contribute to Nursing Research," *Nurse Researcher* 20(2012).
[72] Norman K Denzin, "Analytic Autoethnography, or Déjà Vu All over Again," *Journal of Contemporary Ethnography* 35(2006).
[73] Ellis, Adams, and Bochner, "Autoethnograpy: An Overview."

This narrative history is set within the contextual framework of a particular place, Melbourne, Victoria, Australia. Originally an outpost of the British Empire, the chronological timeframe moves from the end of Queen Victoria's reign to beyond the Golden Jubilee of her great-great-granddaughter Queen Elizabeth II. It includes the final days of Britain's Empire, as Australia became a federated nation, through the first wave of feminism, the World Wars separated by a devastating depression and the scourge of poliomyelitis, the post WW2 period of recovery, reconstruction and rehabilitation to the globalisation and neoliberalism of the late twentieth century and the new millennium.

The history reflects my interests and experiences: my generation, my gender, and my mother. It reflects my activism in politics and feminism and determination to achieve equality of opportunity in education. Even more, this history of physiotherapy reflects my commitment to tell the story of those who had the foresight to establish and sustain educational programmes. Leavitt wrote, 'in order to write honest history, we need to worry about the truths of our sources and the truths of the whys and wherefores of our own interest in them'.[74] In trying to tell stories of the past we seek observable and verifiable information. However some information, including that from primary sources, is more slippery than others, more subject to distortion and 'historians must walk a virtual minefield to determine true facts from contrived facts or fiction'. My history will be 'personal, particular and specific' inevitably containing my personal values and perspectives.[75]

Thus as Roy Pascal noted that while autobiographical truth is often elusive

> not only does the reader expect truth from autobiography, but autobiographers themselves all make more or less successful efforts to get at the truth … or … persuade us they are doing so.[76]

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[74] Leavitt, "True Facts and Honest History: A Review of Certain Practices, a Mea Culpa, and Other Thoughts About the Writing of History."
[75] Ibid.
[76] Roy Pascal, *Design and Truth in Autobiography*, History and Historiography (New York: Garland Pub, 1985).

Philippe Lejeune also argued that narrative autobiography with its self-centered life-story is a commitment by the author to speak truthfully – an autobiographical pact.[77] Although verification of my primary sources is possible, as Alessandro Portelli demonstrated memory can be partial, selective and shaped into accounts which are meaningful and influenced by the passage of time.[78] Alistair Thomson indicates how employing memory has gained credence as a tool for elucidating how people make sense of their lives.[79] Stephen Katz agrees that recalling a memory is akin to re-collecting stored images and traces into a coherent picture, with individual agency and active interpretation fundamental to good memory and not impediments to it.[80] Furthermore as Jaume Aurell has noted, historians of my generation have effectively developed a new genre of autobiographical historiography.[81]

Nevertheless as I have decided what, when, where and how to research as well as consciously or unconsciously what to recall, my story can only ever be interpretive. Following considerable and concentrated reflection this thesis is my opportunity to bear witness to a period that has seen physiotherapy change from a few individual practitioners to a professional discipline. With most of my academic life spent as a somewhat sceptical positivist quantitative researcher, I needed to broaden my understanding of a participatory worldview as an integral contributor to the process.[82]

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[77] Philippe Lejeune, "The Genetic Study of Autobiographical Texts," *Biography* 14, no. 1 (1991). See also Mary Jo Maynes, Jennifer L Pierce, and Barbara Laslett, *Telling Stories: The Use of Personal Narratives in the Social Sciences and History* (Ithica: Cornell University Press, 2012).
[78] Portelli, "The Death of Luigi Trastulli: Memory and the Event."
[79] Alistair Thomson, "Four Paradigm Transformations in Oral History," *Oral History Review* 34(2007).
[80] Stephen Katz, "Dementia, Personhood and Embodiment: What Can We Learn from the Medieval History of Memory?," *Dementia* 12(2013).
[81] Jaume Aurell, "Making History by Contextualizing Oneself: Autobiography as Historiographical Intervention," *History & Theory* 54(2015).
[82] Heron and Reason, "A Participatory Inquiry Paradigm." Kathy Charmaz, "'Discovering'chronic Illness: Using Grounded Theory," *Social science & medicine* 30, no. 11 (1990); *Constructing Grounded Theory* (Sage, 2014).

In determining the theoretical framework for the research, I grappled with many qualitative paradigms and concepts. As Norman Denzin and Yvonna Lincoln wrote 'qualitative research is a set of complex interpretive practices. As a constantly shifting historical formation, it embraces tensions and contradictions … (across) … all of the human disciplines'.[83] Qualitative research shares flexibility and openness with physiotherapy clinical practice: both occur in dynamic situations within a social context having potential ethical dilemmas. Both require inductive thinking.[84] Valerie Janesick emphasised description as the foundation of qualitative research.[85] The vividness of description should enable the reader to share my historical narrative.[86]

All qualitative interpretive research focuses on the lived experience, interaction and language of human beings. The interpretive paradigm searches for meanings.[87] Approaches relevant to this thesis include phenomenology, biography and autobiography, grounded theory and participatory, cooperative and interpretive inquiry. As an integral part of the story I contribute my understanding of becoming a physiotherapist.[88] Within the participatory paradigm, practical knowing, including that of the researcher, is of central intrinsic value, compared to critical theory or constructivism where practical knowledge, John Heron and Peter Reason claimed, was not recognised.[89]

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[83] Denzin and Lincoln, *The Sage Handbook of Qualitative Research*. 6.
[84] Immy Holloway and Stephanie Wheeler, *Qualitative Research in Nursing and Healthcare* (Chichester, West Sussex: Wiley-Blackwell, 2010).
[85] Valerie J Janesick, "The Choreography of Qualitative Research Design," in *In Handbook of Qualitative Research* ed. NA Denzin and YS Lincoln (Thousand Oaks: Sage, 2000). 379-399.Valerie J. Janesick, *Oral History for the Qualitative Researcher: Choreographing the Story*, Oral History for the Qualitative Researcher: Choreographing the Story. (New York: Guilford Press, 2010).
[86] David A Erlandson, *Doing Naturalistic Inquiry: A Guide to Methods* (Newbury Park, Calif: Sage, 1993).
[87] S J Taylor and R Bogdan, *Introduction to Qualitative Research Methods: The Search for Meanings* (New York: John Wiley and Sons, 1984).
[88] Arthur W Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995). Laura L Ellingson, "Embodied Knowledge: Writing Researchers' Bodies into Qualitative Health Research," *Qualitative Health Research* 16(2006).
[89] Heron and Reason, "A Participatory Inquiry Paradigm."

Increasingly the concept of the *bricoleur* resonated, bringing together old and newfound pieces of material to make a quilt.[90]

As I had undertaken this time-consuming exercise by hand several times I knew what was involved in searching for the pieces and bringing them together to make a pleasing, durable whole. Denzin and Lincoln introduced the concept of bricolage, but Joe Kincheloe further elaborated the concept into a method using several research approaches concurrently to make meaning.[91] The bricolage, with its diversity of methodologies enables postmodern, interpretive and critical analyses.[92] It is pertinent to a thesis spanning a long time frame with data collected from many sources.

Interpretive bricolage brings together a set of representations that fit the specifics of a complex situation. It is an emergent construction that developes as new approaches and interpretations contribute. Multiple approaches enable the postmodern form of triangulation – crystalisation – to reflect an indepth understanding of the phenomena considered.[93] Bricoleurs, however, need a plan such as using a scaffolding process to create a transparent research design.[94] Michael Crotty's scaffolding encourages researchers to reflect on ontology, epistemology, theoretical perspectives and methodology that underpin and frame a specific study.[95]

Thus I borrow from phenomenology in my interest in the experiences of physiotherapy students and graduates, grounded theory to ensure saturation and

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[90] Joe L Kincheloe, "Describing the Bricolage: Conceptualizing a New Rigor in Qualitative Research," *Qualitative Inquiry* 7(2001); "On to the Next Level: Continuing the Conceptualization of the Bricolage," *Qualitative Inquiry* 11(2005); Simon Duncan, "Personal Life, Pragmatism and Bricolage," *Sociological Research Online* 16(2011); Denzin and Lincoln, *The Sage Handbook of Qualitative Research*.
[91] Joe L Kincheloe, *Beyond Reductionism: Difference, Criticality, and Multilogicality in the Bricolage and Postformalism*, Educational Psychology Reader: The Art and Science of How People Learn (New York: Peter Lang, 2010).
[92] Denzin and Lincoln, *The Sage Handbook of Qualitative Research*.
[93] Holloway and Wheeler, *Qualitative Research in Nursing and Healthcare*.
[94] John W Creswell, *Qualitative Inquiry and Research Design: Choosing among Five Approaches*, 2 ed. (Thousand Oaks: SAGE Publications, 2006).
[95] Michael Crotty, *The Foundations of Social Research* (Sydney: Allen and Unwin, 1998).

some generalisation of the data, and aspects of participatory, cooperative and interpretive inquiry in conversation with colleagues. In the latter and in interaction between the archive and myself there are elements of biography and autobiography in understanding physiotherapy's history. An overview of these methodological approaches is warranted.

The interpretivist model and descriptive research are founded in philosophy with the methodology centred on the contextual way in which human beings make meanings of their lives. Believing that understanding human experiences is important, I considered the philosophical tradition of phenomenology founded by Edmund Husserl, Martin Heidegger, Maurice Merleau-Ponty, and Jean-Paul Sartre. They viewed phenomenology as philosophy's foundation, focused on ontological questions of meaning and lived experience. Phenomenology considers experiences ranging from perception, thought, memory, imagination, emotion, desire, and volition to bodily awareness, embodied action and social activity. Phenomena are whatever we observe (perceive) and seek to understand and explain.[96] Phenomenology provides rich descriptions and interpretations such as of physiotherapy's education, culture, ideologies, values and modes of thought.[97] The whole phenomenon is the subject of interest and understanding within the context of a socially constructed world where my values and experience and those of my participants are integral to the research.[98]

Denzin and Lincoln consider 'social construction' a central metaphor in qualitative research.[99] Social constructionism, critical theory, hermeneutics, pragmatism, poststructuralism, and postmodernism are all loosely

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[96] David Woodruff Smith, ""Phenomenology", the Stanford Encyclopedia of Philosophy," <http://plato.stanford.edu/archives/win2013/entries/phenomenology/>. Accessed 2 September 2013.
[97] Martyn Hammersley and Paul Atkinson, *Ethnography: Principles in Practice*, 3rd ed. (London; New York: Routledge, 2007).
[98] Joan W Scott, "The Evidence of Experience," *Critical Inquiry* 17(1991).
[99] Denzin and Lincoln, *The Sage Handbook of Qualitative Research*. 3.

constructionist.[100] In order to detect commonalities of experience and perception in my sources grounded theory offered one methodology. Founded in phenomenology and initially proposed by George Mead and elaborated by Herbert Blumer, symbolic interactionism, is the primary theoretical framework for grounded theory.[101] Symbolic interactionism considers human action as dependent on meaning derived from social interactions.[102] The symbols of language provide a method to consider meaning and thought.[103] Symbolic interactionism believes in multiple realities and offers a flexible theoretical structure.[104] Also 'loosely constructionist', postmodern understanding of experiential, propositional, presentational and practical epistemology accepts many viewpoints, blurring distinctions between subjectivity and objectivity.[105] This interpretivist perspective initially proposed by Heron and Reason resonated. It facilitated a methodology of cooperative inquiry with me as the participating researcher in conversation with colleagues as well as being a co-creator of data.[106]

The meanings and answers to my research questions developed from an iterative, reflective, analytical and critical consideration of the data and

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[100] Kaysi Eastlick Kushner and Raymond Morrow, "Grounded Theory, Feminist Theory, Critical Theory: Toward Theoretical Triangulation," *Advances in Nursing Science* 26, no. 1 (2003).

[101] Kathy Charmaz, "Grounded Theory: Objectivist and Constructivist Methods," in *Handbook of Qualitative Research*, ed. NK Denzin and Y Lincoln (Thousand Oaks, California: Sage, 2000). P Jane Milliken and Rita Schreiber, "Examining the Nexus between Grounded Theory and Symbolic Interactionism," *International Journal of Qualitative Methods* 11, no. 5 (2012).

[102] Charmaz, "Grounded Theory: Objectivist and Constructivist Methods." Milliken and Schreiber, "Examining the Nexus between Grounded Theory and Symbolic Interactionism."

[103] Herbert Blumer, *Symbolic Interactionism: Perspective and Method* (Englewood Cliffs, NJ: Prentice-Hall, 1969); George Herbert Mead et al., *Mind, Self, and Society* (Chicago: University of Chicago Press, 2015).

[104] Blumer, *Symbolic Interactionism: Perspective and Method*; Mead et al., *Mind, Self, and Society*. Kushner and Morrow, "Grounded Theory, Feminist Theory, Critical Theory: Toward Theoretical Triangulation."

[105] Heron and Reason, "A Participatory Inquiry Paradigm."; "The Practice of Co-Operative Inquiry: Research 'With'rather Than 'On'people."; "Extending Epistemology within a Cooperative Inquiry."

[106] "A Participatory Inquiry Paradigm."; "The Practice of Co-Operative Inquiry: Research 'With'rather Than 'On'people."; "Extending Epistemology within a Cooperative Inquiry."

context.[107] Data crystallisation, through the archives and different conversations, enabled investigation of the same issue from many perspectives.[108] Using a crystal reflective analogy is increasingly employed in qualitative research where flexible theoretical structure such as symbolic interactionism enables, for example, grounded theory combined with feminist and critical theory.[109] Kaysi Kushner and Raymone Morrow proposed that sensory experience and evidence, coupled with linguistic representation, deconstructed dichotomies between objective and subjective experience, creating a bridge between empiricist, interpretive, and critical programs.[110] Feminist theory with its empirical research orientation from the perspective of women in sociocultural, political and everyday contexts enables some consideration of gender in the physiotherapy narrative.[111] Power can be embraced through critical theory.[112]

With my research objectives and this interpretive framework in mind, literature searches began with 'physiotherapy', 'education/teaching', 'history' and 'methodology', followed by those pertinent to 'professionalism', 'identity', and 'embodiment'. Broadening searches ranged from archeology to Zen philosophy. Performing multiple and repeat searches often yielded serendipitous findings, and I used further references within journal papers and books. Online databases employed frequently included Google scholar,

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[107] Geertz, *The Interpretation of Cultures: Selected Essays*; "Thick Description: Toward an Interpretive Theory of Culture," *The interpretation of cultures* (2002). Barney G Glaser, *Basics of Grounded Theory Analysis* (California: Sociology Press, 1992). As cited in Creswell, *Qualitative Inquiry and Research Design: Choosing among Five Approaches*; Delbert C Miller and Neil J Salkind, *Handbook of Research Design & Social Measurement*, 6 ed. (Sage, 2002).
[108] Holloway and Wheeler, *Qualitative Research in Nursing and Healthcare*; Gerard A Tobin and Cecily M Begley, "Methodological Rigour within a Qualitative Framework," *Journal of Advanced Nursing* 48(2004).
[109] Kushner and Morrow, "Grounded Theory, Feminist Theory, Critical Theory: Toward Theoretical Triangulation."
[110] Pierre Bourdieu and Loïc Wacquant, *An Invitation to Reflexive Sociology* (Cambridge: Polity Press, 1992).
[111] Barbara L Marshall, *Engendering Modernity: Feminism, Social Theory and Social Change* (Boston: Northeastern University Press, 1994).
[112] Kushner and Morrow, "Grounded Theory, Feminist Theory, Critical Theory: Toward Theoretical Triangulation."

JSTOR, PubMed and the University of Melbourne's library searching facility with access to all Australian university libraries. I also accessed previously used databases, CINAHL, OVID, Medline, EBSCOhost, and ScienceDirect.

The theoretical lenses of historical narrative, professionalisation and embodiment summarised in the following chapter will provide a guiding perspective for organising the structure for the study and developing the story. The primary research data included my mother's archive, an extensive personal archive and my reflective journal. Additional pertinent archival material included meeting minutes, photographs, 122 APA oral histories of Victorian physiotherapists and my fifty-six recorded conversations.[113]

Memory is the basis of such oral history, a practice that Linda Shopes defined as

> a recorded in-depth interview – someone telling a story in response to the queries of another, a detailed, expansive, reflective account. ... It is historical in intent. ... Oral history is ... a subjective account of the past, which in itself requires interpretation.[114]

Oral history like all history reflects the situated position of those who record or relate the past. Oral history has been criticised as not producing history, but myths.[115] In riposte oral historians reminded the naysayers that all history was constructed and subjective, as those of us who have participated in thousands of committee meetings and later read the minutes, will attest. Ronald Grele defined oral history as 'the interviewing of eyewitness participants in the events of the past for the purposes of historical reconstruction ... an invaluable and

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[113] Miller and Salkind, *Handbook of Research Design & Social Measurement*. 148-152. Creswell, *Qualitative Inquiry and Research Design: Choosing among Five Approaches*.
[114] Linda Shopes, "What Is Oral History?," in *The Sage Handbook of Qualitative Research*, ed. Norman K Denzin and Yvona S Lincoln (Thousand Oakes California: Sage Publications Inc, 2011). 453. See also Robert Perks and Alistair Thomson, *The Oral History Reader* (London: Routledge, 2006). *Passim*.
[115] Patrick O'Farrell, "Oral History: Facts and Fiction Quadrant, November 1979," *Oral History Association of Australia Journal, The*, no. 5 (1982).

compelling research method for twentieth-century history'.[116] Oral history is now an accepted form of data collection and interpretation and employed by many academic disciplines.[117]

Official documents generally reflect interests of the powerful, but the papers, ephemera and stories of most people and small organisations are less likely to survive. Oral history can delve into the experiences of people whose lives are rarely recorded and 'offer rich evidence about the subjective or personal meanings of past events'.[118] Therefore I recruited my participants to reflect a range of ages and physiotherapy experiences, several with interstate perspectives on Melbourne and non-physiotherapists with an outsider's view. Access to these stories contributed to a richer construction of physiotherapy's history.[119] I was conscious that 'the privilege of listening to another person's life story narrative is a gift we receive'.[120] In preparing for my conversations I developed open-ended trigger questions, which I modified to suit individuals. The University of Melbourne Human Research Ethics Committee approved the project (Appendix 1). An MP3 Olympus Digital Voice Recorder DM-550 recorded all conversations, which I transcribed *verbatim*. My purpose was to capture significant elements of physiotherapy education through the memories of people who had been involved.

Making oral histories integrates both participants. Previous associations compounded my conversations with participants who were friends, staff members, professional colleagues and former students with many qualifying

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[116] Alistair Thomson, "Making the Most of Memories: The Empirical and Subjective Value of Oral History," *Transactions of the Royal Historical Society* 9(1999).
[117] Paul Thompson, *The Voice of the Past, Oral History*, 2 ed. (Oxford: Oxford University Press 1988); Perks and Thomson, *The Oral History Reader*.
[118] Thomson, "Making the Most of Memories: The Empirical and Subjective Value of Oral History." See also Thompson, *The Voice of the Past, Oral History*; Shopes, "What Is Oral History?."
[119] Thompson, *The Voice of the Past, Oral History*; Patrick O'Farrell, "Oral History: Facts and Fiction," *Oral History Association of Australia Journal* 5(1982). See also Portelli, "The Death of Luigi Trastulli: Memory and the Event."; "What Makes Oral History Different," in *The Oral History Reader*, ed. R Thomson Perks, A (London and New York: Routledge, 1998).
[120] Marianne Horsdal, *Telling Lives: Exploring Dimensions of Narratives* (Abingdon: Routledge, 2012). 144.

within several categories. Some researchers celebrate such subjectivity.[121] Lorraine Sitzia indicated, ‘a good friendship is not enough to generate productive and useful interviews’.[122] I recognised the importance of maintaining professional and ethical standards. We negotiated on a professional level, but I remained aware of my privileged position in building relationships, which enabled us to explore in an enjoyable fashion often beyond the anticipated agenda. Oral history exemplified the meaning captured within the memories.[123]

As memory develops within a sociocultural context, whose members share similar representations, I listened for hidden tensions or disinclinations to explore some aspects and issues.[124] Being a fellow physiotherapist appeared to generate a level of trust with those people I did not already know. Nevertheless I remained alert to maintaining professional and ethical standards.[125] I strove to achieve a thinking-out-loud perspective looking for details, returning to clarify or look for meaning. In analysing our stories I needed to not overstate 'individual agency and obscure the workings of political and cultural power'.[126]

Oral history is interpretive from the outset in the questions asked and the narrator's responses and extemporising. Additionally, current beliefs and attitudes influence our perception of what we remember.[127] However Ira Hyman and Elizabeth Loftus state 'most memories will be generally accurate'

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[121] Sally French and John Swain, "Telling Stories for a Politics of Hope," *Disability & Society* 21(2006).
[122] Lorraine Sitzia, "A Shared Authority: An Impossible Goal?," *Oral History Review* 30(2003).
[123] Thomson, "Making the Most of Memories: The Empirical and Subjective Value of Oral History."
[124] Robyn Fivush and Katherine Nelson, "Culture and Language in the Emergence of Autobiographical Memory," *Psychological Science* 15(2004); Fivush, "The Development of Autobiographical Memory."
[125] Sitzia, "A Shared Authority: An Impossible Goal?." Carol Roberts, "And You're Still Speaking to Each Other?' Drawing the Line between Friendship and Oral History," *Oral History Association of Australia Journal* 35(2013).
[126] Linda Shopes, "What is Oral History?"
[127] M Ross, "The Relation of Implicit Theories to the Construction of Personal Histories," *Psychological Review* 96(1989); AG Greenwald, "The Totalitarian Ego: Fabrication and Revision of Personal History," *American Psychologist* 35(1980).

but some details may be less so.[128] During analysis I compared the veracity of accounts with other conversations and documentary evidence. For some participants a two decades old oral history from the APA archive enabled recapitulation of parts of their stories.

I perused all the archival material on physiotherapy that is available in Victoria and most of that available in the Chartered Society of Physiotherapy (CSP) in the Wellcome library in London in hard copy onsite. I made extensive notes of the content relevant to my research questions and began analysis by considering its meaning.[129] I used the same approach with material accessed online. As data from all sources accumulated, analysis and interpretation were iterative processes. I organised the data from the oral histories and conversations with Excel software.[130] Reflecting a grounded theory approach, the text of oral histories and conversations were coded into themes and notes kept on key concepts and my developing ideas. Initially tentative ideas and later more secure conclusions were discussed with both supervisors.[131] But it was not as straightforward as that. My ideas changed as I read more and thought more and aspects of the conversations changed. I reread my notes, the transcriptions and listened again to the conversations to relive the experience of the conversation and further interpret tone and volume, range and rhythm, which carry implicit meaning and social connotations and relied on my interpretation.[132]

Data analysis and my interpretations were re-storied into this narrative, which includes a discussion of the core ideas to provide a thick description of the

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[128] Ira E Hyman Jr and Elizabeth F Loftus, "Errors in Autobiographical Memory," *Clinical Psychology Review* 18(1998).
[129] Paper documents in Australia at the University of Melbourne, the Australian Physiotherapy Association archive, the Australian Nursing Federation Library, the Victorian Public Record Office, the Victorian State Library and in England at the Chartered Society of Physiotherapy Library and the Wellcome Institute Library.
[130] Microsoft Excel application.
[131] Stacy Blythe et al., "The Challenges of Being an Insider in Storytelling Research," *Nurse researcher* 21, no. 1 (2013).
[132] Portelli, "What Makes Oral History Different." P34.

setting, context and meaning reflecting the research questions.[133] As a bricoleur I considered more than one interpretive approach and managed a variety of tasks from the textual and photographic archive to conversations and self-reflection.[134] Nevertheless all elements remain shaped by my own history as a white, middle class, older woman interpreting and making a bricolage.[135] Such a fabric quilt relies on foundations of additional fabric: a backing sheet, internal padding material and a border. The analogy continues to fit the thesis's theoretical framework with professionalisation as 'backing' and embodiment within. Around the edges aspects of gender and power constrain and integrate the bricolage.

In this chapter I have demonstrated that narrative history is an effective way of describing what happened in the past, despite its shortcomings relating to subjectivity and the fictive structure of narrative that may obscure the situated-ness of the author. However, my situated-ness is revealed through my explicit participation in the story through autobiography and other forms of self-reflection. At the same time, any narrative needs specific organising theories that elicit the conclusions I wish to propose. And it is these that I discuss in the following chapter.

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[133] Charmaz, "'Discovering'chronic Illness: Using Grounded Theory."; *Constructing Grounded Theory*. Jennifer Fereday and Eimear Muir-Cochrane, "Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development " *International journal of qualitative methods* 5(2008).

[134] Heron and Reason, "A Participatory Inquiry Paradigm."; "The Practice of Co-Operative Inquiry: Research 'With'rather Than 'On'people."; "Extending Epistemology within a Cooperative Inquiry."

[135] Denzin and Lincoln, *The Sage Handbook of Qualitative Research*. 3.

Chapter 2 Professionalisation through embodiment

> *I want to link the bodies, the minds, and the stories in interaction.*[136]

An analytical narrative history of physiotherapy education is intimately connected to the theories of professionalisation and embodiment. From a range of possible theoretical positions that I could take on these interconnected issues, ultimately the theoretical constructs of Eliot Freidson enmeshed with those of Chris Shilling provided the most effective grounding. This chapter is a critique of theories of professionalisation and embodiment that reveal my pathway to this viewpoint.

Physiotherapy theorists have embraced Eliot Freidson's theoretical perspective of professionals as licensed by the state, with an organisation with codes of conduct, ethical standards and ability to discipline members who contravene codes or standards. Members possess exclusive knowledge and skills, which are protected by law. Autonomous in work, physiotherapists are responsible to those who need their assistance. Such characteristics are said to justify a position of power within society.[137] Ideally professionals are motivated to deliver a service to others, adhere to a moral and ethical code of practice, strive for excellence, maintain an awareness of limitations and scope of practice and, are committed to empowering others. Professions should be accountable, transparent and open.[138] Physiotherapy modelled its professionalisation on medicine, the discipline which has received the most concentrated sociological attention on professionals and professionalism.

The professional ideal emerging in the nineteenth century considered that professionals possessed knowledge and skills of great social value and self-

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[136] Horsdal, *Telling Lives: Exploring Dimensions of Narratives*. 3.
[137] Barbara Richardson, "Professional Development: 1. Professional Socialisation and Professionalisation," *Physiotherapy* 85(1999).
[138] David A Nicholls and Barbara E Gibson, "The Body and Physiotherapy," *Physiotherapy Theory and Practice* 26(2010).

regulated through tradition.[139] By 1933 some viewed the professions as a stabilising force in society.[140] Since then a plethora of theoretical approaches, structuralist, functionalist, interactionist, neo-Weberian, neo-Marxist, neo-system, social constructionist, poststructuralist and feminists have addressed the topic.[141]

The market-oriented society of the USA significantly influenced sociological theorising about the professions with particular attention to the medical profession and its power. In countries with nationalised medicine, sociological focus addressed organisations and class.[142] Australia began with a private system supported by charity hospitals. Since the 1950s Australia provides both public and private systems. In the latter, medical practitioners receive significant financial reimbursement for patient care and other health practitioners limited reimbursement.[143] Physiotherapists are distributed approximately half in each system.

Australian physiotherapy has received little sociological attention, despite extensive examination of professional attributes and the cultures of many health professions.[144] An overview of the theories of professionalism follows, from Carr-Saunders and Wilson who studied the ancient professions in theology, law, academia and medicine, to the twentieth century occupations such as physiotherapy, more recently professionalised.[145]

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[139] Eliot Freidson, "The Changing Nature of Professional Control," *Annual Review of Sociology* 10(1984). Citing Herbert Spencer, *Principles of Sociology*, vol. 3 (New York: Appleton, 1896).
[140] David Armstrong, "Medicine as a Profession: Times of Change," *British Medical Journal* 301(1990). Citing AM Carr-Sanders and PA Wilson, *The Professions* (Oxford: Clarendon, 1933). 403-404.
[141] Elianne Riska, "Health Professions and Occupations," in *The New Blackwell Companion to Medical Sociology*, ed. W Cockerham (2010). 391-411.
[142] Julia Evetts et al., "Sociological Theories of Professions: Conflict, Competition and Cooperation," in *The Isa Handbook in Contemporary Sociology*, ed. Ann Denis and Devorah Kalekin-Fishman (2009). 140-155.
[143] Tony S Pensabene, *The Rise of the Medical Practitioner in Victoria* (Canberra: Australian National University Press, 1980).
[144] Riska, "Health Professions and Occupations." 391-411.
[145] Carr-Sanders and Wilson, *The Professions*.

By the mid-twentieth century Talcott Parsons, influenced by the writings of pioneering sociologists Emile Durkheim and Max Weber, theorised that a profession's status and authority derived from their knowledge and service-orientation inducing a relationship of trust with patients/clients, and maintaining professional reputations through collegial control of standards.[146] Such norms of professional behaviour separated professionals from other occupations.[147] Parsons and Bernard Barber described a functionalist approach where professionals required a high degree of general and systematic knowledge, primary orientation to community rather than self-interest, with a code of ethics and tangible and honorary rewards denoting work achievement.[148] This functionalist normative perspective dominated sociologists' consideration of professions, although Everett Hughes presented alternative interactionist views on work and Erving Goffman on service relationships.[149]

In the 1970s, Terence Johnson's neo-Marxist perspective considered professions in relation to power and class relationships. He argued that professional evolution was dynamic and variable, and unable to be explained by trait and functionalist approaches. He offered alternatives, theorising the variety of professional organisations and the power relationships between professionals and clients. Johnson introduced the concept of indeterminacy to describe the medical professional's status as being a function of who controlled

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[146] Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (Chicago: University of Chicago Press, 1988). Citing Talcott Parsons, *The Social System* (London Routledge & K Paul, 1951). 472.

[147] "The Professions and Social Structure," *Social forces* 17(1939); *The Structure of Social Action*, vol. 491 (New York: Free Press, 1949); *The Social System*. See also Eric Hoyle, "Professionalization and Deprofessionalization in Education," in *The Professional Development of Teachers: World Yearbook of Education 1980*, ed. E Hoyle and J Megarry (London: Kogan Page, 1980).

[148] Terence James Johnson, *Professions and Power* (London: Macmillan, 1972). 33-34. Citing Parsons, "The Professions and Social Structure." Bernard Barber, "Some Problems in the Sociology of the Professions," *Daedalus* (1963).

[149] Everett Hughes, *Men and Their Work* (Glencoe: Free Press, 1958); Erving Goffman, *Asylums* (Garden City: Anchor Books, 1961).

the uncertainty in the doctor–patient relationships.[150] Building upon this work, Nicholas Jewson identified an evolution from patient control and patronage in the eighteenth century to doctor control in the nineteenth. High status patients initially identified their symptoms to the socially inferior medical practitioner. As the pathological basis of many illnesses became identifiable, medical practitioners gained control over uncertainty.[151] Johnson viewed such medical control as the foundation of a collegiate professionalism.[152]

Following in the neo-Marxist/structuralist tradition perspectives of medical control expanded. From their early identification by Irving Zola to Vicente Navarro and Peter Conrad drawing attention to medicine's associations with capitalism and biomedical and pharmaceutical industries, social constructionists concentrated on medicines' social control and the medicalisation of social issues.[153] The radical Marxist Ivan Illich bellowed the risks of increasing medicalisation and compromised patient safety.[154] He castigated professionals.

> the bodies of specialists that now dominate the creation, adjudication and implementation of needs are a kind of cartel without precedent. … The professional claims special, incommunicable authority to determine not just the way things are to be made but also the reason why their services are mandatory.[155]

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[150] Johnson, *Professions and Power*.
[151] Nicholas D Jewson, "Medical Knowledge and the Patronage System in 18th Century England," *Sociology* 8(1974); "The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870," *Sociology* 10(1976).
[152] Johnson, *Professions and Power*.
[153] Irving Kenneth Zola, "Medicine as an Institution of Social Control," *The Sociological Review* 20, no. 4 (1972); Vicente Navarro, *Medicine under Capitalism* (New York: Prodist, 1976); Peter Conrad, *The Medicalization of Society* (Baltimore: Johns Hopkins University Press, 2007).
[154] Ivan Illich, *Medical Nemesis* (London: Marian Boyars, 1976).
[155] "Disabling Professions," *India International Centre Quarterly* (1978).

Medical scandals, including in Australia, drew attention to patient safety, leading to increased ethical surveillance of clinical practice and research and enhancing governments' regulatory powers.[156]

Michel Foucault's work on the disciplinary power of medicine and the medical gaze influenced post-structuralist theories.[157] David Armstrong theorised from a Foucauldian perspective that medical autonomy, established in the nineteenth century and extended during the first half of the twentieth, had decreased as governments increased their role in health care funding, intervening in professional/patient relationships and imposing ever-increasing management control on health professionals.[158] The 1980s corporatisation of medicine in the USA, Elianne Riska wrote, led to a decline in medicine's power, compounded by other health professionals undertaking some previous medical responsibilities.[159] Similar changes have occurred in Britain, Canada and Australia.[160] Such changes both acknowledge expertise in other disciplines and demonstrate strategies to reduce health costs by replacing the more expensive medical practitioner. The politically influential Australian health economist

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[156] Jayant Patel https://en.wikipedia.org/wiki/Jayant_Patel Accessed 20 December 2015. National Statement on Ethical Conduct in Human Research (2007) National Health and Medical Research Council https://www.nhmrc.gov.au/guidelines-publications/e72 AHPRA, "Australian Health Practitioner Regulation Agency," http://www.ahpra.gov.au/Education/Approved-Programs-of-Study.aspx?ref=Physiotherapist Both accessed 11 August 2013.

[157] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. AM Sheridan Smith (New York: Vintage Books, 1975); "Body/Power," in *Power/Knowledge*, ed. C Gordon (Brighton: Harvester, 1980).

[158] David Armstrong, "Professionalism, Indeterminacy and the Ebm Project," *BioSocieties* 2(2007).

[159] Riska, "Health Professions and Occupations." 391-411.

[160] Tracey L Adams and Ivy Lynn Bourgeault, "Feminism and Women's Health Professions in Ontario," *Women Health* 38, no. 4 (2004); EO Pearse, A Maclean, and DM Ricketts, "The Extended Scope Physiotherapist in Orthopaedic out-Patients–an Audit," *Annals of the Royal College of Surgeons of England* 88(2006); Yann Bourgueil, Anna Marek, and Julien Mousquès, "Three Models of Primary Care Organisation in Europe, Canada, Australia and New Zealand," *Questions d'économie de la santé*, no. 141 (2009).

Stephen Duckett has been a strong advocate for such changes.[161] Patients too have approved.[162]

Additional to government and corporate intervention, the patient, now the 'consumer', influences decisions regarding choice of therapeutic intervention and health care provider (to whit the growth of 'alternative', now 'complementary' practitioners). Medicine, through elite medical colleges' power and influence within universities and governments Armstrong contends, responded by offering evidence-based clinical practice (EBP) with its gold-standard randomised controlled trials to regain power.[163] Furthermore medicine hoped this would slow the onslaught of alternative practices. Armstrong considered such men (and they were nearly always men) could promote EBP, thus garnering research grants to do so and simultaneously promising best patient care. However, despite a burgeoning of clinical guidelines based on EBP and statistical inference, for many clinicians this helped little in practice. Clinicians could also be confronted by patient's own knowledge garnered from the Internet or elsewhere. The rhetoric of patient-centred care became another mechanism to manage challenges to collegiate professionalism.[164] Armstrong acknowledged such issues but contended that EBP could reduce the indeterminacy between patient and professional. Now the interpreter of EBP, patient, professional or government, controls indeterminacy and hence power .[165]

Power through personal control has worked in additional ways. As biomedicine and bioscience with their associated technologies have become all pervasive

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[161] Stephen J Duckett, "Health Workforce Design for the 21st Century," *Australian Health Review* 29(2005).
[162] For example see AE Weale and GC Bannister, "Who Should See Orthopaedic Outpatients--Physiotherapists or Surgeons?," *Annals of the Royal College of Surgeons of England* 77, no. 2 Suppl (1995); Gavin Daker-White et al., "A Randomised Controlled Trial. Shifting Boundaries of Doctors and Physiotherapists in Orthopaedic Outpatient Departments," *Journal of epidemiology and community health* 53, no. 10 (1999).
[163] Armstrong, "Professionalism, Indeterminacy and the Ebm Project."
[164] "Clinical Autonomy, Individual and Collective: A Qualitative Study of Changing Gps' Behaviour," *Social Science and Medicine* 55(2002).
[165] "Professionalism, Indeterminacy and the Ebm Project."

they act as unseen mechanisms of social control as promulgated by Foucault, Illich, and more recently Shilling who viewed biopolitics as leading to internalised self-governance.[166] Nikolas Rose termed such self-governance as 'ethopolitics', which expects community members to maintain and improve personal health.[167] Nevertheless as Armstrong indicated, individuals still consult professionals. Whilst professionalisation has been associated with power and knowledge and the construction of Foucault's 'docile bodies', Nicholas Fox contended these analyses do not adequately recognise how ethics and regulation exert pressure on health professionals such as physiotherapists: internal self-regulation combined with potential external sanction.[168] Many professionals, Rose stated, continue to reflect their care through empowerment, enabling and meeting the needs expressed by their patients.[169]

Ministering to the patient's needs remained within the purview of those theorists who followed the implicit functionalism of the Weberian-Parsonian tradition. Eliot Freidson, arguably the most influential theorist of the professions, informed sociological thinking from the 1970s. His perspective has developed over time and has promoted a sociology of occupations that systematically addresses the nature and variety of specialised knowledge and skills and the role that these play in determining occupations and the manner these occupations organise themselves. With his primary focus on medicine, Freidson viewed medicine's power as based on knowledge and dominance over other health professions.[170] By the 1980s he considered that medicine's increasing specialisation remained sufficient to retain its status.[171] Freidson's work provided a stimulus to others, including seminal work in Australia by

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[166] Shilling, *The Body and Social Theory*.
[167] Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton University Press, 2009).
[168] Nicholas J Fox, "Refracting 'Health': Deleuze, Guattari and Body-Self. ," *Health* 6(2002).
[169] *Beyond Health Postmodernism and Embodiment*. Foucault's docile bodies in Michel Foucault, *Surveiller Et Punir. (Discipline and Punish: The Birth of the Prison)*, trans. Alan Sheridan (New York: Random House, 1977).
[170] Eliot Freidson, *Profession of Medicine* (New York: Dodd Mead, 1970); *Professional Dominance: The Social Structure of Medical Care* (Transaction Publishers, 1970).
[171] "The Changing Nature of Professional Control."

Evan Willis.[172] In the USA neo-Weberian theory, initiated by Magali Sarfatti Larson, investigated medicine's capacity to maintain its unity and to close the market to other health professions.[173] Robert Dingwall and Paul Fenn also questioned whether professions were developed for public interest or were anticompetitive monopolies exerting power and control in society.[174] Furthermore, Johnson incorporated a Foucauldian conception of professional disciplines exerting their power within state-delegated recognition.[175] Freidson agreed that professionals and state must act in concert for the wielding of professional control.[176]

Freidson elaborated his concept of the 'ideal' profession against which emerging professional groups could be measured. Members of such a profession controlled recruitment and education and their practice required them to make discretionary judgements. Professionals were further distinguished by their capacity to undertake research or scholarship to advance their profession's concepts, knowledge and skills. As professionals exercised discretionary judgement, their formal education had significant profession-specific theoretical content, usually delivered in a university, but parts might be taught in the workplace. Professionals actively sought autonomous practice in the public interest. An assuredness of 'good character' evolved into codes of ethics requiring education in ethics and professional conduct.[177] Furthermore legislative controls, ostensibly to protect the public from those not within the professional group, also enhanced the status and protected the exclusive work

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[172] Evan Willis, *Medical Dominance: The Division of Labour in Australian Health Care*, Studies in Society (Sydney: Allen & Unwin, 1989).
[173] Magali Sarfatti Larson, *The Rise of Professionalism: Monopolies of Competence and Sheltered Markets* (Transaction Publishers, 2013 (first published 1977)).
[174] Robert Dingwall and Paul Fenn, "'A Respectable Profession'? Sociological and Economic Perspectives on the Regulation of Professional Services," *International review of law and economics* 7(1987).
[175] Terry Johnson, "Governmentality and the Institutionalization of Expertise," in *Health Professions and the State in Europe*, ed. Terry Johnson, G V Larkin, and Mike Saks (London: Rooutledge, 1995).
[176] Eliot Freidson, *Professionalism: The Third Logic* (Cambridge: Polity Press, 2001).
[177] "Theory and the Professions," *Indiana Law Journal* 64(1989). *Professionalism: The Third Logic*.

practices of the profession. Professional associations persuaded the state that they were worthy of legislative sanction.[178] The professional privilege of autonomy combined with a sense of contributing to the public good. [179]

New theories of the professions have emerged, such as Andrew Abbott's development of a neo-functionalist or neo-system theory 'that could reconcile the historical continuity of professional appearances with the day-to-day discontinuities of professional reality'.[180] Notwithstanding the other theoretical positions mapped out above, at the turn of the millennium Julia Evetts and colleagues argued that Freidson had returned to Parson's normative view and continued to influence sociological perspectives.[181] Freidson's initial and later 'ideal' conceptions of professionalism remain relevant to an understanding of physiotherapy's transition from a turn of the century aspirational group of individuals to today's physiotherapists in an advanced industrial society where Western states focus on competition and deregulation. Thus, Ruth Heap and Patricia Evans employed Freidson's theoretical model to consider the necessary elements of the physiotherapy professions in North America and the influencing contingencies, over multiple points in time.[182] Such a model is still pertinent to the long aspirational professional projects of many emerging professional groups.[183]

Having argued for using Freidson's model I am aware the while addressing a profession's engagement with the state, it does not address the complexity of

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[178] *Profession of Medicine*; "Theory and the Professions." See also Andrew Abbott, "The System of Professions: An Essay on the Division of Labor," (1988).
[179] Freidson, "The Changing Nature of Professional Control."; "Theory and the Professions."
[180] Andrew Abbott, *The System of Professions: An Essay on the Division of Expert Labor* (University of Chicago Press, 2014). See also *Processual Sociology* (Chicago: University of Chicago Press, 2016).
[181] Evetts et al., "Sociological Theories of Professions: Conflict, Competition and Cooperation." 140-155. Freidson, *Professionalism: The Third Logic*.
[182] Ruth Heap, "Training Women for a New" Women's Profession": Physiotherapy Education at the University of Toronto, 1917-40," *History of Education Quarterly* 35(1995); "Physiotherapy's Quest for Professional Status in Ontario, 1950-80," *Canadian Bulletin of Medical History/Bulletin canadien d'histoire de la médecine* 12(1995); Patricia R Evans, "Physiotherapy and Professionalism: 1990-2004" (Fielding Graduate University, 2005).
[183] Freidson, *Professionalism: The Third Logic*.

relationships between professional and patient, nor does it consider individuals and professional groups who do not fit the 'ideal', are exploitive or tied to capitalist control.[184] Mike Saks asserted that 'welfare occupations ... claim to be mitigating the worst effects of monopoly capitalism and yet serve to uphold the very principles of social order on which it is based'.[185] However Saks's perspective denied the activism and advocacy frequently undertaken by health professionals. Rosemary Crompton argued that both positive and negative aspects of professions are simultaneously present in a capitalist society.

> 'Work' is intimately bound up with the ownership and control of productive resources, relationships of authority and power and consequent exploitation, at the same time such divisions also incorporate co-operation, the satisfaction of material and non-material human needs, and so on.[186]

Caring has been traditionally associated with women, but professionalisation theory focussed on men. Robert Merton, a student of Talcott Parsons, investigated socialisation of American medical students into 'medical men', a clear statement of medicine's gendered disposition.[187] Initially Anne Witz's views on professions considered them as institutions designed to maintain male, as well as medical, dominance.[188] As the theory of professions and their associations expanded to include gender, class and social mobility, appeals to professional ideals were appropriated for managerial or political purposes,

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[184] Stephen Pattison and Roisin Pill, *Values in Professional Practice: Lessons for Health, Social Care, and Other Professionals* (Oxford: Radcliffe Medical Press, 2004). Mike Saks, *Professions and the Public Interest: Medical Power, Altruism and Alternative Medicine* (London: Routledge, 2005). 26-28.
[185] Ibid. 27.
[186] Rosemary Crompton, "Professions in the Current Context," *Work, Employment & Society* 4(1990).
[187] Robert K Merton, *The Student-Physician: Introductory Studies in the Sociology of Medical Education. A Report of the Bureau of Applied Social Research of Columbia University* (Cambridge, Massa chusetts: Harvard University Press, 1957).
[188] Anne Witz, "Patriarchy and Professions: The Gendered Politics of Occupational Closure," *Sociology* 24, no. 4 (1990).

perhaps most successfully with women, Stan Lester wrote.[189] Judith Lorber, trail-blazed feminists' perceptions of female medical practitioners in the USA, and Rosemary Pringle undertook a comparative investigation of these women in Australia and the United Kingdom demonstrating the fields they occupied and through the women's eyes their challenges and successes.[190]

Women predominantly occupied their traditional assumed gender roles, ministering to the young and old rather than heroic surgery. Only recently have women medical students in these countries outnumbered men, whilst more generally in the health professions women have filled subordinate roles.[191] There is now growing interest in female health professions.[192] Physiotherapy has been considered gendered, but as this thesis will demonstrate up to half current student intakes are male. Whether the structural and voluntarist explanations will be adequate to explain gender preferences in work will require time for an equalising of genders in the work environment.[193]

Despite the challenges of Marxism, structuralism and post-structuralism, Freidson's approach remains an effective tool for exploring the development of professions in general, and physiotherapy in particular. Freidson explained that 'profession' meant: 'a special kind of occupation' and 'an avowal or promise'.[194] To fulfil such a promise, professionalism signifies a set of values,

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[189] Stan Lester, "Professional Versus Occupational Models of Work Competence," *Research in Post-Compulsory Education* 19, no. 3 (2014).
[190] Judith Lorber, *Women Physicians: Careers, Status, and Power*, Social Science Paperbacks (New York: Tavistock Publications, 1984). Rosemary Pringle, *Sex and Medicine: Gender, Power and Authority in the Medical Profession* (Cambridge: Cambridge University Press, 1998).
[191] Elianne Riska, "The Feminization Thesis: Discourses on Gender and Medicine," *NORA—Nordic Journal of Feminist and Gender Research* 16, no. 1 (2008).
[192] Anne Witz, *Professions and Patriarchy*, International Library of Sociology (London; New York: Routledge, 1992); Pamela Abbott and Liz Meerabeau, *The Sociology of the Caring Professions* (London; Philadelphia: UCL Press, 1998); M Wearing, "Medical Dominance and the Division of Labour in the Health Professions," in *Health in Australia: Sociological Concepts and Issues*, ed. Carol Grbich (Sydney: Prentice Hall, 1999).
[193] Riska, "Health Professions and Occupations."
[194] Julio Frenk et al., "Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World," *The lancet* 376, no. 9756 (2010). Citing Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge*.

behaviours, and relationships that underpin public trust. Physiotherapy education, therefore, must inculcate responsible professionalism through explicit knowledge and skills, by promotion of an identity and adoption of the values, commitments, and disposition of the profession.[195] Freidson's 'ideal' type of professional was and remains pertinent to the aspirational professional project of physiotherapy. Furthermore it is the concept of professionalism I promoted explicitly and implicitly in physiotherapy education.[196]

In this thesis I consider that these attributes, derived from a functionalist perspective, acknowledge professionals require a body of expert knowledge with a theoretical foundation, an ethical requirement to serve the public and the capacity for and ability to think independently and act autonomously. These matters will form the basis of my analysis. However, the work of post-structuralist cannot be ignored with issues of gender, power and control more contentious and problematic for the female and male physiotherapists. Individuals may be a member of a profession providing health care in a complex system still dominated by medicine, or a practitioner simply working with the patient.

Embarking on the educational journey to become a physiotherapy practitioner is a process of 'becoming' of embodying a physiotherapy identity. In order to argue that becoming a physiotherapist requires a unique engagement of mind and body, I borrow concepts from other disciplines.[197] Within the encompassing frame of professionalisation, theoretical ideas on identity and embodiment emerge from René Descartes through Maurice Merleau-Ponty, Michael Polanyi and Pierre Bourdieu to Chris Shilling. The theory of embodiment is complementary to professionalisation in understanding the development of physiotherapy. 'Embodiment' describes the multiple properties

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[195] Frenk et al., "Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World."
[196] Freidson, *Professionalism: The Third Logic*.
[197] Evans, *In Defence of History*. *Passim.*

and capacities of the thoughtful body subject.[198] Embodiment refers to the biological and physical presence of our bodies, which are a necessary precondition for subjectivity, emotion, language, thought and social interaction.[199]

Descartes, the early modern mathematician, philosopher and physiologist, argued that the body should be considered separate from the mind. The mind, the seat of the soul, sacred and God-like, was concerned with thinking. The machine-like physical body was profane and vulnerable.[200] By 1928 John Dewey wrote,

> The very problem of mind and body suggests division; I do not know of anything so disastrously affected by the habit of division as this particular theme. … The evils, which we suffer, … all testify to the necessity of seeing mind-body as an integral whole. ... The full realization of the integration of mind and body in action waits upon the reunion of philosophy and science in the supreme art of education.[201]

By the mid-twentieth century French philosophers such as Maurice Merleau-Ponty, Jean Paul Sartre and Simone De Beauvoir, Michel Foucault and Pierre Bourdieu theorised the unity of body and mind.[202] Their ideas resonate with the intellectual physicality of physiotherapy.

Merleau-Ponty's philosophical phenomenology of the body recognised individuals' experiences, their body image projecting itself as identity, their social relationships and the objectified bodies health professionals observed.

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[198] Shilling, *The Body and Social Theory*. xv.
[199] Embodiment from The Cambridge Dictionary of Philosophy, Cambridge University Press, http://www.embodiment.org.uk/definition.htm. Accessed 17 May 2015.
[200] David Robson, "Your Clever Body," *New Scientist* 212(2011). Citing Rene Descartes, *Meditations on First Philosophy*, trans. Michael Moriarity (Oxford: Oxford University Press, 2008 original 1641). Gideon Manning, "Out on the Limb: The Place of Medicine in Descartes' Philosophy," *Early Science and Medicine* 12(2007).
[201] John Dewey, "Preoccupation with the Disconnected. A Reprint from a Talk Given to the New York Academy of Medicine," (Champaign, IL: NASTAT., 1928/2002). 24.
[202] Sarah Nettleton, *The Sociology of Health and Illness* (Cambridge: Polity, 2006).

Merleau-Ponty's phenomenology emphasising the role of the conscious experienced body enlivened interest in body studies.[203] Bodily experience, its physicality and emotions were the means of the body being and acting in the world. There was no division between subject and object or mind and body.[204] Furthermore the development of identity was experienced through such integrated embodiment.[205] Merleau-Ponty stated:

> ...We can only think the world because we have already experienced it; it is through this experience that we have the idea of being, and it is through experience that the words 'rational' and 'real' receive a meaning simultaneously.[206]

Merleau-Ponty insisted that our material bodies enable cognition. Sensory, perceptual experience preceded knowledge and understanding of intellectual concepts: 'we can only think the world because we have already experienced it; it is through this experience that we have the idea of being'.[207] The body is a precondition of all perception.[208] Merleau-Ponty's ideas echo within physiotherapy, a discipline where sensory experiential learning is integral to practical and clinical education, and where physiotherapists can experience the body's space, sensuality, movement, sexuality, its relationship to others, its freedom and its mortality.[209] Furthermore, movement perception and action are neurophysiologically linked and movement initiates axonal sprouting and neuronal connectivity. Physiotherapist researchers are currently at the forefront

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[203] Maurice Merleau-Ponty, *Phenomenology of Perception*, trans. C Smith (New York: Humanities Press, 1962 original 1945).
[204] *The Structure of Behaviour*, trans. A L Fisher (Pittsburgh, PA: Duquesne University Press, 1963 original 1942).
[205] *Phenomenology of Perception*; *The World of Perception*, trans. O Davis (London and New York: Routledge, 2004 original 1948).
[206] "The Primacy of Perception and Its Philosophical Consequences," in *The Primacy of Perception and Other Essays*, ed. J M Edie (Evanston, IL.: Northwestern University Press, 1964 original 1947). 17.
[207] Ibid. See also *Phenomenology of Perception*; *The World of Perception*.
[208] Roth, "Auto/Biography and Auto/Ethnography: Finding the Generalized Other in the Self." 3-4.
[209] Smith, ""Phenomenology", the Stanford Encyclopedia of Philosophy". Accessed 2 September 2013.

of such investigation.[210] Physiotherapy students marry theoretical understanding of neurophysiology with personal bodily experience of movement and control, to in clinical practice, that of the most exquisite performance of artists and sportspeople to the most severely physically compromised individuals. Yet as David Nicholls has asserted, physiotherapists' understanding of the theory of embodiment is limited.[211] This thesis will, I anticipate, contribute to expanding physiotherapists' views.

Sarah Nettleton argued that Foucault more than any other theorist, advanced socially constructed understandings of embodiment.[212] Jane Louis-Wood agreed Foucault's work, fused historical and philosophical theory 'to provide a rational, evolutionary framework for the human story'.[213] His work analysed how subjectivity, individuals' understanding and experience of their own bodies, their phenomenology, becomes both the product and source of knowledge and power. Bryan Turner and Chris Shilling have further theorised such embodiment and its meaning for individuals and society.[214]

Late last century Turner indicated that little attention had been focused on the ways that specific social worlds shape human bodies, and authors such as Shilling increasingly described the body as a project to be developed as part of an individual's self-identity.[215] Embodiment now interested many disciplines.[216] Roy Porter recognised the benefits to medical historiography once the body

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[210] For example Henry Tsao, Mary P Galea, and Paul W Hodges, "Driving Plasticity in the Motor Cortex in Recurrent Low Back Pain," *European Journal of Pain* 14, no. 8 (2010).
[211] David A Nicholls, "Body Politics: A Foucaldian Discourse Analysis of Physiotherapy Practice" (PhD, University of South Australia, 2008); Nicholls and Gibson, "The Body and Physiotherapy."
[212] Nettleton, *The Sociology of Health and Illness*.
[213] Jane Louis-Wood, "Michel Foucault's Madness and Civilisation," http://www.cf.ac.uk/socsi/undergraduate/introsoc/mf2.html.Accessed 15 June 2014.
[214] Bryan S Turner, "Disability and the Sociology of the Body," *Handbook of disability studies* (2001); Shilling, *The Body and Social Theory*.
[215] Bryan S Turner, *The Body and Society*, vol. 24 (Oxford University Press, 1984); Shilling, *The Body and Social Theory*.
[216] Sarah Nettleton, *The Sociology of the Body. In: Cockerham Wc (Ed), the Blackwell Companion to Medical Sociology* (London: Blackwell, 2005); *The Sociology of Health and Illness*.

was recognised as both biological and social.[217] Nicholas Fox indicated sociologists modified social constructionism and postmodern theory and embraced biocultural perspectives.[218] The intensely personal and private human body became integrated with the structure and organisation of society and calls to 'bring the body in'.[219] Frédérique de Vignemont interpreted embodiment, as a sense of ownership where perceptual experience preceded knowledge and understanding of intellectual concepts.[220]. Embodiment became an important area for theory development and examining its fit with phenomena related to the culture of disciplines such as nursing.[221]

Apparently innate cultural practices were learned and embodied, thus fitting Bourdieu's concept of the development of habitus. He understood that physical capital developed through social processes.[222] Although introducing critical dimensions to theorising, social constructionism viewed bodies as circumscribed and bounded by external social effects and the body's representation was a function of socio-cultural power. Shilling argued that social constructionism did not address the body's sensuality: the body's corporeality hid behind discourses that could only be comprehended and articulated by the mind. Shilling reinforced the idea that Bourdieu's theory of the body as physical capital could address the relationship between our embodied socialisation and our cultural beliefs.[223] Although post-modernist thinkers demonstrated the centrality of language and discourse in scientific explanations, embodiment could only be mediated through the body.[224] Such

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[217] Roy Porter, "The Historiography of Medicine in the U.K.," *Medicina nei secoli* 10(1998).
[218] Fox, *Beyond Health Postmodernism and Embodiment*. 3.
[219] LF Monaghan, "Fieldwork and the Body: Reflections on an Embodied Ethnography," in *The Sage Handbook of Fieldwork* (2006). 227-229.
[220] Frédérique de Vignemont, "Embodiment, Ownership and Disownership," *Consciousness and Cognition* 20(2011).
[221] Mary H Wilde, "Why Embodiment Now?," *Advances in Nursing Science* 22(1999).
[222] Pierre Bourdieu, "The Forms of Capital," in *Handbook of Theory for the Sociology of Education*, ed. J Richardson (New York: Greenwood Press, 1986).
[223] Shilling, *The Body and Social Theory*.
[224] Denis J Walsh, "Childbirth Embodiment: Problematic Aspects of Current Understandings," *Sociology of health & illness* 32(2010). Fox, *Beyond Health Postmodernism and Embodiment*.

concepts resonate with physiotherapists' engagement of a cognate mind and active body in the complexities of clinical practice.

Physiotherapists would perhaps agree with Simon Williams and Gillian Bendelow who noted that the 'sociology of the body' theorised bodies in a largely disembodied cognitive manner whereas a truly embodied sociology considered the lived body with its all complexities. 'Embodied' sociology treated the bodily basis of social order and action as central, additionally acknowledging the embodiment of researchers and research participants.[225] Shilling elucidated how our bodies reciprocally shape experience and society.[226]

By the latter half of the twentieth century, medicine, Armstrong asserted, increasingly explored the patient's mind and social context demonstrating the ongoing Foucault-theorised 'gaze'.[227] Feminist writing too, such as that of Jane Ussher, drew attention to the social regulation of the body through the ways in which medicine controlled the bodies of women.[228] Medicine's public involvement in debates on abortion, euthanasia and organ transplantation and their clinical involvement in such processes reinforced medicine's power. Thus whilst the law still plays a role in body regulation, with the exception of some rituals around birth and death, that of religion has declined and medicine has gained increasing prominence.[229]

Social controls on human behaviour can be at the level of populations, smaller groups or individuals, with the body, Anthony Giddens proposed, becoming

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[225] Simon Johnson Williams and Gillian Bendelow, *The Lived Body* (London: Routledge, 1998).
[226] Shilling, *The Body and Social Theory*.
[227] David Armstrong, "Gaze in Medical Perception. Answers.Com. The Oxford Companion to the Body," Oxford University Press, http://www.answers.com/topic/gaze-in-medical-perception. Accessed 5 June 2014. Walsh, "Childbirth Embodiment: Problematic Aspects of Current Understandings."
[228] Jane M Ussher, *Managing the Monstrous Feminine: Regulating the Reproductive Body* (London: Routledge, 2006).
[229] Turner, "Disability and the Sociology of the Body."; *The Body and Society: Explorations in Social Theory* (London: Sage, 2008).

increasingly important for social and self-identity. As the self becomes embodied, control of the body becomes a foundation of self-identity.[230] As physiotherapy students become physiotherapists through the education process they embody and present a new version of themselves.

The self is thus an evolving reflexive project aimed at building 'a coherent and rewarding sense of identity'.[231] Reflexivity extends to the body where experiencing the body enables the individual to feel an 'integrated whole'. Planning an individual's life – 'the reflexive construction of self-identity depends as much on preparing for the future as on interpreting the past'. [232] The body remains an essential part of self-identity as a physical entity, an action system and a mode of praxis. Its appearance, demeanour and sensuality are part of identity. [233] Shilling perceives the body as an unfinished project always in the process of becoming.[234] Sociology includes the lived experience of the body – an elaboration of the phenomenology of the body through the study of embodiment throughout everyday life. Aside from the often catastrophic intervention of accident or illness, changes throughout life present challenges in negotiating new practices to manage the interactions between the self, the embodiment experience and biological changes.[235]

Embodiment challenged the persistent Cartesian dualisms of mind/body, culture/nature, and reason/emotion. As Ian Hacking stated, 'Descartes is absolutely out of fashion'. Hacking identified 'a different sort of dualism'. He viewed types of mental events – 'beliefs, emotions, feelings, thoughts, intentions, thinking, reasoning, reflecting, imagining, choosing, deciding and so forth' – did not match types of bodily events (sensation, movement, action potentials, biochemistry) and cannot be expressed as bodily activities. He also

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[230] Anthony Giddens, *Modernity and Self-Identity* (Cambridge: Polity Press, 1991).
[231] Ibid. 75.
[232] Ibid. 85.
[233] Ibid. 70-108.
[234] Shilling, *The Body and Social Theory*.
[235] Turner, "Disability and the Sociology of the Body."

elaborated on the growing potential for body replacement parts with bodies becoming 'other' and for mind-altering drugs to influence minds: a 'simulacrum of Descartes's dualism'.[236] With the increasing opportunities to image the brain in action, Antonio Damasio theorised even further into a triad of mind, brain and body.[237] Hacking concluded however, 'there is only one stuff': the mind in the brain, which is in the body.[238]

Yet Williams and Bendelow indicated that dualisms remained in the gendered division of labour, with men 'allied with the mind, culture and the realm of public production, whilst women were tied to their bodies, nature and the private sphere of domestic reproduction'.[239] Women were more likely to perform 'body work': occupations with hands-on activities such as those undertaken by physiotherapists, both men and women.[240]

In the time frame of my research, nineteenth century society constrained women, although some sought to redefine themselves through education and the professions creating a new woman who did not fit male-dominated society.[241] Nevertheless in the first half of twentieth century, girls' education stressed domestic skills for their future positions in society alongside future husbands. The rigid separation of gender roles for men and woman stabilised society, democracy and economic welfare.[242]

Drawing on Richard Ankers review of the three overlapping theories of occupational segreagation by gender: neo-classical and human capital, institutional and labout market segmentation and feminist, the first two

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[236] Ian Hacking, "The Cartesian Vision Fulfilled: Analogue Bodies and Digital Minds," *Interdisciplinary Science Reviews* 30(2005).
[237] Antonio Damasio, *Looking for Spinoza: Joy, Sorrow, and the Feeling Brain* (New York,: Harcourt, 2003).
[238] Hacking, "The Cartesian Vision Fulfilled: Analogue Bodies and Digital Minds."
[239] Williams and Bendelow, *The Lived Body*.
[240] Julia Twigg et al., "Conceptualising Body Work in Health and Social Care," *Sociology of Health & Illness* 33, no. 2 (2011).
[241] Sara Delamont and Lorna Duffin, *The Nineteenth-Century Woman: Her Cultural and Physical World* (London: Routledge, 2012). 4-10, 16-20.
[242] Ibid. 19-22.

perpetuated gender bias without explaining occupational segregation. Feminist theories addressed this through a central thesis that women's disadvantages were due to patriarchy and women's position in society. Such perceptions and societal norms influenced behaviour. Gender theory assisted in explaining how 'female' occupations mirrored common positive and negative stereotypes of women. The positive stereotypes of housewifely skills and experience, caring, manual dexterity, honesty and attractive appearance fitted women for domestic duties and caring. Nurses, social workers, teachers and midwives fitted this stereotype. The negative stereotypes of less inclination for supervision of others, less physical strength, less ability in science and mathematics, less willing to travel, face physical danger or use physical force disqualified women for managerial roles, and occpations such as engineering. A considerable amount of research supports such sterotyping and subsquent employment opportunties and low incomes for women. Vertical segregation demonstrated women at the lower end of pay scales as seen in health care occupations. [243]

Masculine stereotypes reinforced such discrimination as evidenced when men entered 'female' professions such as nursing and women entered medicine. Leonard Stein's oft-sited opinion piece in 1967 considered that a 'doctor-nurse' game characterised their relationships. Female nurses appeared to defer passively to medical authority whilst actually demonstrating considerable initiative and frequently making accepted recommendations. The rules of the game were learned through education processes. Nurses taught and guided medical practitioners without receiving credit: that went to the medical practitioners, but Stein claimed (on their behalf), nurses gained self-esteem and professional satisfaction. Stein made a telling comment - not all disciplines in health care were prepared to play this game.[244]

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[243] Richard Anker, "Theories of Occupational Segregation by Sex: An Overview," *International Labour Review* 136(1997).
[244] Leonard I Stein, "The Doctor-Nurse Game," *Arch. Gen. Psychiatry* 16, no. 6 (1967).

In 1990 Stein revisited the game in a different milieu, more women in medicine, more men in nursing and increased specialistion. Scandals reduced medicine's omnipotence, whilst nurses' recognition rose through nursing shortages, their additional education and the promotion of practice collaboration. Stein viewed the move towards nursing autonomy as driven by feminism with nurses (and others) prepared to challenge medicine. 'The medical profession itself has been one of their main sources of oppression, exerted through institutionalised sexual discrimination and hospital bureaucracy.[245] Whilst acknowledging patients' dependence on both professions, Stein and colleagues believed the hierarchical model offered security for health profesionals in 'knowing their place'.[246]

Barbara Zelek and Susan Phillips confirmed gender as a factor in the complexity of nurse/medical pracititioner interactions, determing medicine's 'traditional omnipotence' arose both from their male gender and their professional attributes.[247] Pringle corroborated such views from the perspective of female medical pracititioners.[248] Christine Williams addressed the issue of gender from the perspective of men in traditionally female occupations including nursing and social work. Although men were less likely to enter these occupations than women are to enter male-dominated ones; in 1992 social work was thirty two per cent male. Women were discriminated against when working in 'male' roles but men in 'female' roles were advantaged through positive discrimination. Men travelled a 'glass escalator' into better-paid and more prestigious positions. Williams reported positive discrimination in academia too for men in nontraditional professions with close mentoring from male professors of male students. Furthermore male nurses perceived that they

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[245] Leonard I Stein, David T Watts, and Timothy Howell, "The Doctor–Nurse Game Revisited," *New England Journal of Medicine* 322, no. 8 (1990).
[246] Ibid.
[247] Barbara Zelek and Susan P Phillips, "Gender and Power: Nurses and Doctors in Canada," *International Journal for Equity in Health* 2, no. 1 (2003).
[248] Rosemary Pringle, *Sex and Medicine: Gender, Power and Authority in the Medical Profession* (Cambridge: Cambridge University Press, 1998).

were treated diferently to female nurses by male medical pracititioners.[249] Ben Lupton proposed that male nurses defined their work to create a more 'acceptable' masculinity by emphasising its decision-making in contrast to the caring components.[250]

Whilst agreeing with Lupton, Barbara Ehrenreich and Deirdre English considered examples of predominatly female becoming predominantly male occupations were rare and redefiniton as 'masculine' was necesary befor men joined.[251] By contrast Cynthia Epstein wrote women flocked to male-identified occupations when opportunities were available.[252] Students of both gender flock to study physiotherapy where body work is performed.

Body work can involve violating cultural norms verging from managing cleaning another's body after an episode of incontinence to maintaining a 'professional' attitude in potentially sensuous handling. Practitioners have knowledge of the body and the person, but are frequently viewed within power dynamics as 'either a demeaned body servant or an exerciser of Foucauldian biopower'.[253] Shilling and Witz noted the necessity for conforming to practitioners' norms of appearance and control and self-disciplining the body.[254]

Practitioners who touch the patient's body must address particular challenges and ethical dilemmas, wrote Julia Twigg and her co-researchers. Furthermore such work was often physically demanding and emotionally draining.[255] Whilst not denying that emotions affect both men and women, such work is frequently

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[249] Christine L Williams, "The Glass Escalator: Hidden Advantages for Men in the "Female" Professions," *Social problems* 39, no. 3 (1992).
[250] Ben Lupton, "Maintaining Masculinity: Men Who Do 'Women's Work'," *Br. J. Manage.* 11, no. s1 (2000).
[251] Barbara Ehrenreich and Deirdre English, *For Her Own Good: 100 Years of Expert Advice to Women* (Garden City, New York: Anchor Press, 1978).
[252] Williams, "The Glass Escalator: Hidden Advantages for Men in the "Female" Professions."
[253] Ibid.
[254] Shilling, *The Body and Social Theory*. A Witz, C Warhurst, and D Nickson, "The Labour of Aesthetics and the Aesthetics of Organization," *Organization* 10, no. 33–54 (2003).
[255] Twigg et al., "Conceptualising Body Work in Health and Social Care."

relegated to women by the privileged, predominantly male professions.[256] Much emotional work involves the suppression, rather than expression, of emotion. However emotion can also contribute to making work meaningful and rewarding. Nurses, according to Sally Gadow, share the patient's sense of vulnerability through a shared embodiment.[257]

Nettleton considered all work a set of bodily practices, reflecting Michael Polanyi and Bourdieu's delineation of tacit knowledge, habitus and embodied practice, and the conceptualisation of such phenomena as Shilling and Mellor's 'body pedagogics'.[258] Polanyi had argued that tacit knowledge appeared and felt intuitive, but was difficult to explicitate, requiring empathetic observation and relied on 'hands-on' experience.[259] This perspective resonated with Merleau-Ponty and Bourdieu who argued that knowledge was acquired through experience. Thus Polanyi's notion of tacit knowledge is conceptually aligned with Bourdieu's of 'habitus'. [260] Christopher Lawrence indicated education and acculturation facilitated absorption of this tacit or incommunicable knowledge in the practice of elite nineteenth- and early twentieth-century physicians.[261]

Physiotherapy education and acculturation requires such embodied tacit learning. Understanding movement through theory and personal sensory perception, Hubert Dreyfus emphasised, was a unique form of knowledge. [262] Furthermore Merleau-Ponty's philosophy of embodiment assists in explaining the importance of perceptual experience and embodiment in knowledge

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[256] R Graham, "Lacking Compassion – Sociological Analyses of the Medical Profession," *Social Theory and Health* 4, no. 43–63 (2006).
[257] Sally Gadow, "Body and Self: A Dialectic," *Journal Medical Philosophy* 5, no. 3 (1980).
[258] Nettleton, *The Sociology of the Body. In: Cockerham Wc (Ed), the Blackwell Companion to Medical Sociology*. Sarah Nettleton, Roger Burrows, and Ian Watt, "Regulating Medical Bodies? The Consequences of the 'Modernisation' of the N.H.S. And the Disembodiment of Clinical Knowledge," *Sociology of Health & Illness* 30(2008).
[259] Michael Polanyi, *The Tacit Dimension* (New York: Ancor, 1967).
[260] Pierre Bourdieu, *The Logic of Practice* (Cambridge: Polity Press, 1990). 66.
[261] Christopher Lawrence, "Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914," *Journal of Contemporary History* 20(1985).
[262] Hubert L Dreyfus, "Intelligence without Representation–Merleau-Ponty's Critique of Mental Representation the Relevance of Phenomenology to Scientific Explanation," *Phenomenology and the Cognitive Sciences* 1(2002).

acquisition. However education has generally privileged theory over practice in assuming the body does not participate in cognition.[263] The highly proficient (physiotherapy) practitioner ignores much of the perceptual information in performance of techniques, juxtaposing embodiment and the body, the biological and social.[264] In contrast, physiotherapy educators explicate the importance of perceptual information in learning techniques.

Physiotherapy researchers too have considered the importance of the body as a practical epistemological source. Gunn Engelsrud argued in physiotherapy the body is 'the focal point in the production of the lived experience'.[265] She proposed shared bodily experiences as opportunities for therapist and patient learning.[266] Physiotherapy was a socially constructed process in which meaning was created from bodily experiences.[267] Lynn Clouder argued for theorising using social construction.[268] Tobba Sudman indicated that communication, self-presentation, performance and gender intersect as physiotherapists challenge and negotiate cultural, medical or personal boundaries. Physiotherapy represented a field of practices where 'contradictory and covert social expectations reside'.[269] In physiotherapy's complex environment my

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[263] Steven A Stolz, "Embodied Learning," *Educational Philosophy and Theory* 47(2014).
[264] Dreyfus, "Intelligence without Representation–Merleau-Ponty's Critique of Mental Representation the Relevance of Phenomenology to Scientific Explanation."
[265] Steven A Stolz, "Phenomenology and Physical Education," *Educational Philosophy and Theory* 45(2013).
[266] Gunn Engelsrud, "The Lived Body as Experience and Perspective: Methodological Challenges," *Qualitative Research* 5(2005); Finn Nortvedt and Gunn Engelsrud, ""Imprisoned" in Pain: Analyzing Personal Experiences of Phantom Pain," *Medicine, Health Care, And Philosophy* (2014); Øyvind F Standal and Gunn Engelsrud, "Researching Embodiment in Movement Contexts: A Phenomenological Approach," *Sport, Education and Society* 18(2013).
[267] Tobba Therkildsen Sudmann, "(En) Gendering Body Politics. Physiotherapy as a Window on Health and Illness" (University of Bergen, 2009). Cites these theses by Engelsrud and Rosberg written in Norwegian.
[268] Lynn Clouder, "Becoming Professional: Exploring the Complexities of Professional Socialization in Health and Social Care," *Learning in Health and Social Care* 2(2003).
[269] Sudmann, "(En) Gendering Body Politics. Physiotherapy as a Window on Health and Illness." 5.

interpretation builds on Nicholls and Holmes's celebration of 'the fully embodied possibilities'.[270]

Jocalyn Lawler viewed parallel challenges in theorising embodiment from the perspective of patients and their nurses. She acknowledged people's experiences of embodied existence, particularly during illness and incapacity. Yet the body, so much to the fore, was taken-for-granted as nurses learned professionally appropriate social roles and how to minimise embarrassment.[271] Learning through explicit and tacit education contributes to the embodied physiotherapist and the physiotherapy identity, which is traced through this thesis. From 1906 students used their minds and bodies in theoretical and experiential learning of themselves and one another. They commenced embodying physiotherapy professionalism, becoming physiotherapists and developing a physiotherapy identity.

Embodiment has a complex relationship with identity. The expression 'the body' has become problematised and replaced by 'embodiment' as 'a way of living or inhabiting the world through one's acculturated body'.[272] If embodiment is the condition in which the body is the source or location of experience, then embodiment incorporates culture, history, the sensate material body and experience.[273] Charles Christiansen defines identity as the person we think we are, the self we know: beginning with awareness of our body and augmented by our sense of being we make choices and initiate action. Identity encompasses the abstract and complex ideas that embellish the self. He asserts that occupations are critical to becoming, embodying a particular self and creating and maintaining an identity. Professional practice brings individuals

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[270] David A Nicholls and Dave Holmes, "Discipline, Desire, and Transgression in Physiotherapy Practice," *Physiotherapy Theory and Practice* 28(2012).
[271] Jocalyn Lawler, *Behind the Screens: Nursing, Somology, and the Problem of the Body* (Melbourne: Churchill Livingstone, 1991).
[272] Thomas J Csordas, "Embodiment and Cultural Phenomenology," in *Perspectives on Embodiment: The Intersections of Nature and Culture* (Routledge, 1999). xiv.
[273] Ibid. 143.

into relationships with others providing a sense of purpose and structure. It begins with education.[274]

Physiotherapy education relies on experiential learning and in the period described in this thesis students relied on the gift of clinical physiotherapists for a significant component of their explicit and tacit learning. Anthropology's understanding of the gift is therefore pertinent. Marcel Mauss's theory of the gift exchange identified three enduring, related obligations: to give, to accept and to reciprocate.[275] The relationships between physiotherapy students, their educators and patients can be partly understood through this concept. Lewis Hyde emphasised the continuing transmission of such gifts, 'the gift must always move' developing cultural cohesion in relatively small cultural groups such as physiotherapy.[276] The two most significant elements are in student/educator relationships and in physiotherapy's licence to touch. Components in the gift relationship that are integral to education include the interplay of power dynamics, participants' identities and their sense of obligation.[277] The giver has a personal investment in creating the gift which is 'the labour of a lifetime ... a way of thinking and living'.[278]

The second element is the gift of touch. Physiotherapists have the licence to touch and 'hands-on' is an expectation of patients and a distinguishing feature of practice.[279] Bourdieu's theory of embodiment is reflected in student's

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[274] Charles H Christiansen, "Defining Lives: Occupation as Identity: An Essay on Competence, Coherence, and the Creation of Meaning," *American Journal of Occupational Therapy* 53(1999).
[275] C. Levi-Strauss, "Thr Principle of Reciprocity," in *The Gift: An Interdisciplinary Perspective*, ed. Aafke E Komte (Amsterdam: Amsterdam University Press, (1949) 1957).Citing Marcel Mauss, *The Gift: Forms and Functions of Exchange in Archaic Societies*, trans. Ian Cunnison (Mansfield Centre CT: Martino Publishing, 1925 trans 1954).
[276] Lewis Hyde, *The Gift: How the Creative Spirit Transforms the World* (Edinburgh: Canongate Books, 2006). 4.
[277] Lynn Clouder and Arinola Adefila, "The 'Gift Exchange': A Metaphor for Understanding the Relationship between Educator Commitment and Student Effort on Placement," *International Journal of Practice-based Learning in Health and Social Care* 2(2014).
[278] Nathalie Gehrke, "Toward a Definition of Mentoring," *Theory into Practice* 27(1988).
[279] John Harvey Kellogg, *The Art of Massage: Its Physiological and Therapeutic Applications* (Battle Creek Michigan: Modern Medicine Pub. Co, 1895). Noël M Tidy, *Massage and Remedial Exercises in Medical and Surgical Conditions*, 2 ed. (Bristol John Wright, 1934).

learning through touch, on one another and their patients, whilst professional behaviours are challenged by the sensuality of touch.[280] Students generally begin with heightened awareness of corporeal existence termed by Jacquelyn Allen-Collinson as 'intense embodiment'.[281] Hands-on assessment contributes to diagnosis through tissue palpation, determining range and quality of movement, muscle action, and skin temperature. Hands-on treatments are features of massage, facilitated and assisted movement, mobilisation and manipulation. Close bodily contact occurs in assisting patients in functional movements such as guiding ambulation. For patients, already aware of their bodily dysfunction, the physiotherapist and physiotherapy is likely to heighten corporeal awareness. Being-in-the-world, the mind-body-world, corporeal or carnal knowledge are descriptors for sensory experience.[282] The senses of sight, sound, smell, taste, touch, kinaesthesia, balance, proprioception, pain and temperature 'mediate the relationship between self and society, mind and body, idea and object. The senses are everywhere'.[283] Despite receiving little attention in social scientific study, touch is a primary sense for physiotherapists.[284]

Ideas such as these promulgated and debated by philosophers, psychologists and sociologists were not part of the learning environment of physiotherapy students at the turn of the twentieth century. Nor could physiotherapy in Australia be construed as a profession. Now members of this occupational group commenced striving for a status and recognition that would become the profession of physiotherapy.

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[280] Michael McCarthy, "Skin and Touch as Intermediates of Body Experience with Reference to Gender, Culture and Clinical Experience," *Journal of Bodywork and Movement Therapies* 2(1998); Alberto Gallace and Charles Spence, "The Science of Interpersonal Touch: An Overview," *Neuroscience & Biobehavioral Reviews* 34(2010).
[281] Jacquelyn Allen-Collinson and Helen Owton, "Intense Embodiment Senses of Heat in Women's Running and Boxing," *Body & Society* (2014).
[282] Merleau-Ponty, *The World of Perception*; PA Mellor and Chris Shilling, *Re-Forming the Body* (London: Sage, 1997). 39-56.
[283] Michael Bull et al., "Introducing Sensory Studies," *The Senses and Society* 1(2006).
[284] Mark Paterson, "Introduction: Re-Mediating Touch," ibid.4(2009).

Where did it begin? The professional beginnings of physiotherapy were arguably in early nineteenth century Sweden.[285] Medical historians, historians of medicine and sociologists have generally neglected physiotherapy's development.[286] Jane Wicksteed in 1948 wrote of physiotherapy's origins in Britain and since 1994 Britain, Canada, the United States of America (USA) and Australia have commissioned histories of their associations.[287] Recently Beth Linker has theorised aspects of physiotherapy's emergence in the USA.[288] Anders Ottosson in Sweden and Thomas Terlouw in the Netherlands also reflected on their local professionalisation of physiotherapy.[289] This thesis represents the first Australian study of a much wider profession.

The world body representing physiotherapists, the World Confederation for Physical Therapy (WCPT) states physiotherapy provides

> services to individuals and populations to develop, maintain and restore maximum movement and functional ability throughout the lifespan, ... within the spheres of promotion, prevention, treatment/intervention, habilitation and rehabilitation. This encompasses physical, psychological, emotional, and social wellbeing, ... interaction between the physical therapist,

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[285] Anders Ottosson, "When the Orthopedist Was a Physical Therapist (Author's Translation)," *Manuelle Therapie* 14(2010).
[286] William F Bynum et al., *The Western Medical Tradition 1800 to 2000* (New York: Cambridge University Press, 2006). Recognition of physiotherapy in Roger Cooter, *Surgery and Society in Peace and War Orthopaedics and the Organization of Modern Medicine, 1880-1948* (London: MacMillan, 1993).
[287] Jane H Wicksteed, The Growth of a Profession. Being the History of the Chartered Society of Physiotherapy 1894-1945 (London: Edward Arnold & Co, 1948); Jean Barclay, In Good Hands: The History of the Chartered Society of Physiotherapy 1894-1994 (Oxford: Butterworth-Heinemann, 1994); Joan Cleather, Head, Heart and Hands the Story of Physiotherapy in Canada (Toronto: Canadian Physiotherapy Association, 1995); Wendy Murphy, Healing the Generations: A History of Physical Therapy and the American Physical Therapy Association (Alexandria Va: APTA, 1995); Phillip Bentley and David Dunstan, The Path to Professionalism: Physiotherapy in Australia to the 1980s (Melbourne: Mercury, 2006).
[288] Beth Linker, "Strength and Science: Gender, Physiotherapy, and Medicine in Early-Twentieth-Century America," *Journal of Women's History* 17(2005).
[289] Ottosson, "When the Orthopedist Was a Physical Therapist (Author's Translation)."; Thomas J A Terlouw, "Roots of Physical Medicine, Physical Therapy, and Mechanotherapy in the Netherlands in the 19th Century: A Disputed Area within the Healthcare Domain," *The Journal of Manual & Manipulative Therapy* 15, no. 2 (2007).

> patients/clients, other health professionals, families, care givers and communities in a process where movement potential is assessed and goals are agreed upon, using knowledge and skills unique to physical therapists.[290]

Australia, a founder member of WCPT in 1951, offers physiotherapy education in universities, where both tertiary education and the profession are regulated by accreditation, national registration and through examination for specialist practice.[291]

Such regulations did not exist when early in the twentieth century in Victoria, physiotherapists, then known as masseuses and masseurs, came together to form an association. With the patronage and support of medical men they commenced the Australasian Massage Association (AMassA), (the predecessor to the APA) and in 1906 began a formal education programme with the University of Melbourne and the Melbourne Hospital. Over the ensuing century physiotherapy has become one of the larger clinical health professions. Most Australian physiotherapists belong to the APA.[292] Members are required to abide by a code of conduct and are supported by an internationally leading physiotherapy journal, research grants and resources, professional development opportunities, advocacy, lobbying and marketing, and insurance.[293] However, these formal requirements provide little insight into the evolution of physiotherapy education.

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[290] See also World Confederation for Physical Therapy, "Policy Statement: Description of Physical Therapy," http://www.wcpt.org/policy/ps-descriptionPT. Accessed 25 January 2013. Shirley A Sahrmann, "The Human Movement System: Our Professional Identity," *Phys. Ther.* (2014).

[291] "Australian Standards for Physiotherapy," (Canberra: Australian Physiotherapy Council, 2006).19-22. Australian Health Practitioner Regulation Agency, https://www.ahpra.gov.au Accessed 15 March 2015. Australian College of Physiotherapists, https://www.physiotherapy.asn.au/APAWCM/Careers/Career_Paths/ACP.aspx. Accessed 15 March 2015.

[292] The AMassA became the APA in 1938, the VMA joining after rescinding the medical ethic in 1976.

[293] LO Costa et al., "Core Journals That Publish Clinical Trials of Physical Therapy Interventions," *Phys. Ther.* 90(2010). Australian Physiotherapy Association, http://www.physiotherapy.asn.au. Accessed 15 March 2015.

The role of university education is, according to Franziska Trede and colleagues 'under-researched (in a climate of) evidence-based practice, pressures of accountability, performativity and risk management'.[294] Addressing Randall Albury's encouragement for collaboration between disciplines, this narrative history using a bricolage of qualitative methods explores the sociological concepts of professionalisation and embodiment in physiotherapy.[295]

In the chapters that follow, these theoretical constructs thread through the narrative history. The physiotherapy story commences in Chapter 3 with the evolution of physiotherapy as a distinct occupation. Chapter 4 traces the acquisition of the initial markers of professionalisation with the formation of the AMassA and the beginnings of Victorian physiotherapy education. Chapter 5 explores the First World War years with a drive for recognition. War's aftermath is traced in Chapter 6 with the achievement of registration followed by the challenge of depression. Epidemics of poliomyelitis spanned the years from physiotherapy's formal beginnings in Victoria until the mid 1950s. Poliomyelitis's influence in consolidating physiotherapy's position in health care, introducing changes in education, driving professionalisation including autonomous practice, is considered in Chapter 7. Physiotherapists' expanding roles in the Second World War and their enduring influences are the subjects of Chapter 8. Chapter 9 reviews the period when physiotherapy education achieved stability and accommodation. Intermittently for eighty-five years, physiotherapists sought to have physiotherapy education within the University of Melbourne. In the late 1980s a sustained political Campaign for the University contravened the expectations of the behaviour of middle-class conservative physiotherapists. This story is addressed in Chapter 10. Chapter 11 summarises the new beginnings of the School of Physiotherapy at

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[294] Franziska Trede, Rob Macklin, and Donna Bridges, "Professional Identity Development: A Review of the Higher Education Literature," *Studies in Higher Education* 37(2012).
[295] W Randall Albury, "Broadening the Vision of the History of Medicine," *Health and History* 7(2005).

Melbourne and its evolution over the next twenty years. Revisiting the objectives and theoretical constructs of the thesis, Chapter 12 reconsiders the theoretical constructs and analysis and draws the strands of the story together.

Chapter 3 The evolution of physiotherapy

> *Physical therapies, active treatments which depend for their effect on application from without rather than within, have been used from time immemorial to relax or stimulate, to prevent deformity or to remedy it. ... The tradition has been continued not only by their medical heirs but by rubbers and bonesetters, who were often highly skilled, and 'quacks' who pretended they were. ... After the European Enlightenment ... they began to develop a rational basis, method and machinery'.*[1]

Alfred Peters and Frederick Teepoo Hall arrived in Australia late in the nineteenth century and established themselves successfully in Melbourne as masseurs, attracting patients of high repute. They advertised in newspapers and employed prominent patients' testimonials. Peters wrote authoritatively about his craft and operated independently.[2] In contrast Hall only accepted medically referred patients, taught his skills to medical students, provided free services to Port Melbourne Football Club and at reduced fees to friendly societies' members (Figure 3.1).[3]

These two men would collaborate in the professionalisation of physiotherapy through building the AMassA and formal education. However within a decade, Peters would start his own association, the Victorian Massage Association (VMA), refusing to bow to the dictates of the AMassA's medical patrons who demanded members only treat on medical referral. When the Victorian Registration Act passed in 1922, the members of these associations gained the legal sanction of registration. The AMassA had a growing percentage of women until they predominated; the VMA beginning with approximately equal numbers of men and women eventually comprised more men. Thus the power

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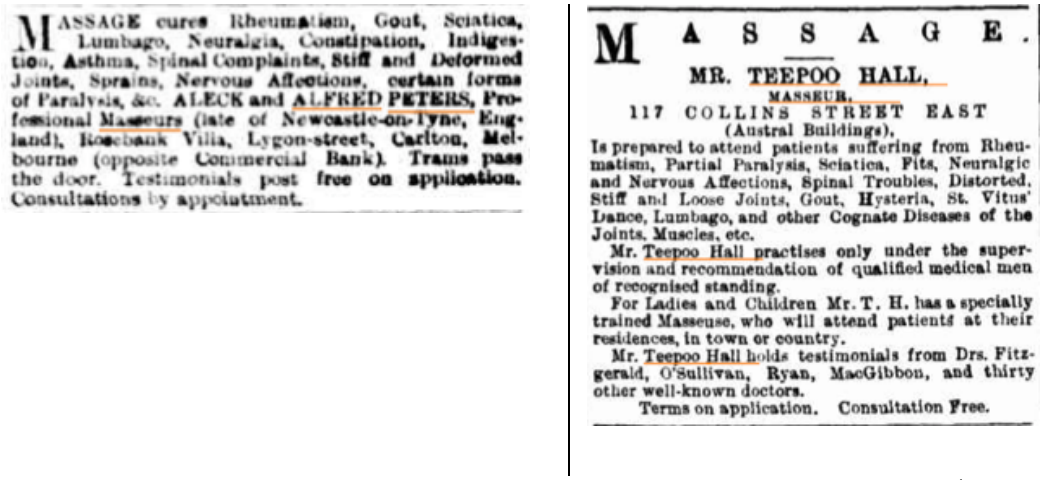
[1] Barclay, *In Good Hands.* 1.

[2] Alfred Peters, *Massage, Its History, Its Curative Uses and Its Practical Results* (Melbourne: Pater & Knapton, 1890); *The Massage Cure: Additional Facts and Testimonials of Alfred Peters, Duly Qualified Masseur* (Pater & Knapton, 1892).

[3] "Advertising," *Brighton Southern Cross*, 2 April 1898. 4. http://nla.gov.au/nla.news-article166115421 "Correspondence," *Standard*, 30 September 1905. 2. http://nla.gov.au/nla.news-article164440225. Both accessed 13 April 2015.

play between medical practitioners and physiotherapists and between men and women is enacted through the history of physiotherapy education and practice in Victoria, Australia.



MASSAGE cures Rheumatism, Gout, Sciatica, Lumbago, Neuralgia, Constipation, Indigestion, Asthma, Spinal Complaints, Stiff and Deformed Joints, Sprains, Nervous Affections, certain forms of Paralysis, &c. ALECK and ALFRED PETERS, Professional Masseurs (late of Newcastle-on-Tyne, England), Rosebank Villa, Lygon-street, Carlton, Melbourne (opposite Commercial Bank). Trams pass the door. Testimonials post free on application. Consultations by appointment.

MASSAGE.

MR. TEEPOO HALL,
MASSEUR,
117 COLLINS STREET EAST
(Austral Buildings),

Is prepared to attend patients suffering from Rheumatism, Partial Paralysis, Sciatica, Fits, Neuralgic and Nervous Affections, Spinal Troubles, Distorted, Stiff and Loose Joints, Gout, Hysteria, St. Vitus' Dance, Lumbago, and other Cognate Diseases of the Joints, Muscles, etc.

Mr. Teepoo Hall practises only under the supervision and recommendation of qualified medical men of recognised standing.

For Ladies and Children Mr. T. H. has a specially trained Masseuse, who will attend patients at their residences, in town or country.

Mr. Teepoo Hall holds testimonials from Drs. Fitzgerald, O'Sullivan, Ryan, MacGibbon, and thirty other well-known doctors.

Terms on application. Consultation Free.

Figure 3.1 The first newspaper advertisements, Peters (left) Hall (right).[4]

This chapter provides an overview of physiotherapy's epistemological foundations at the beginning of the twentieth century, advances and retreats in professionalisation, identity formation and embodiment in physiotherapy. Knowledge of therapeutic exercise, baths and massage had existed since ancient times and contemporary medical writing from the Middle Ages elaborated their value. By the nineteenth century, discoveries in electricity and sophisticated approaches to exercise occurred. These therapeutic interventions would form the basis of physiotherapy's professional practice and its requirements for education. Physiotherapy's recognition in Sweden as a male profession sanctioned by the state, attracted medical men who believed they should learn about, then own and control physiotherapy knowledge. As male practitioners expanded in Western Europe and to the British colonies, women also became physiotherapists. Issues of status, gender and power interacted as medical men established practice boundaries and controlled physiotherapy

[4] Peters "Advertising," *The Argus*, 27 August 1889. 3. http://nla.gov.au/nla.news-article6273876, Hall "Advertising," *Advocate*, 22 June 1895. 13. http://nla.gov.au/nla.news-article170165731. Both accessed 13 April 2015.

practitioners. The chapter ends as Hall and Peters cooperate in developing the AMassA.

Physiotherapy, as with most heath practices, has inherited the Hippocratic legacy of *primum non nocere*, and a long tradition of physical therapies.[5] Rubbing an aching back, assisting a paralysed relation to walk, applying a counterirritant to relieve pain, have always been practised.[6] Recently several authors have written theorised accounts of the events surrounding physiotherapy's emergence. [7] Physiotherapy is indebted to Pehr Henrik Ling, arguably the individual most responsible for demonstrating physiotherapy's benefits.[8] For a period in the nineteenth century physiotherapy was viewed as a profession with male status and power, however its scientific base and clinical applications were rapidly usurped by and incorporated within medicine.[9] Ling's influence spanning the Western world is reflected in national stories of physiotherapy's professional development.[10] Although physiotherapists occasionally exist as an aside within medicine's historiography, only recently have historians begun to explore physiotherapy's development within a social,

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[5] Daniel K Sokol, "'First Do No Harm" Revisited," *British Medical Journal* 347(2013). Roy Porter, *The Greatest Benefit to Mankind a Medical History of Humanity* (London: W W Norton & Company, 1997).73-82. Kellogg, *The Art of Massage. passim.*

[6] Barclay, In Good Hands. Bentley, The Path to Professionalism. Cleather, Head, Heart and Hands. Murphy, Healing the Generations.

[7] Linker, "Strength and Science: Gender, Physiotherapy, and Medicine in Early-Twentieth-Century America." David A Nicholls and Julianne Cheek, "Physiotherapy and the Shadow of Prostitution. The Society of Trained Masseuses and the Massage Scandals of 1894," *Social Science and Medicine* 62(2006). Terlouw, "Roots of Physical Medicine, Physical Therapy, and Mechanotherapy in the Netherlands in the 19th Century: A Disputed Area within the Healthcare Domain." Ottosson, "When the Orthopedist Was a Physical Therapist (Author's Translation)." Sudmann, "(En) Gendering Body Politics. Physiotherapy as a Window on Health and Illness."

[8] Ottosson, "When the Orthopedist Was a Physical Therapist". Sudmann, "(En) Gendering Body Politics."

[9] Edgar Cyriax, *The Elements of Kellgren's Manual Treatment* (London1903). Edward Cyriax, "Body Mechanics," *British Medical Journal* 2(1942); Sarah Bakewell, "Medical Gymnastics and the Cyriax Collection," *Medical History* 41(1997). James Cyriax, *Textbook of Orthopaedic Medicine* (London: Bailliere Tindall, 1947).

[10] Barclay, In Good Hands. Bentley, The Path to Professionalism. Cleather, Head, Heart and Hands. Murphy, Healing the Generations.

cultural, political and economic context.[11] Anders Ottosson wrote 'physiotherapists rarely use history as a means of legitimating their efforts to achieve their professional ambitions ... indeed they have even been described as suffering from "collective amnesia"'.[12] Only Marian Tidswell's tale of Oswestry and Louise Shaw's of Otago provide comprehensive local histories of physiotherapy education.[13]

Physiotherapy's primary therapeutic role is to maintain, regain or improve people's capacity to move. Specific individualised exercise based on rigorous diagnostic assessment is the primary intervention. Early recorded origins of exercise for therapy derive from Indian yoga teachers around 8000 BCE and Middle Eastern and Chinese practitioners before 3000 BCE.[14] From Hippocrates to Caelius Aurelius the Greeks made distinctive contributions using exercise, heat, cold, water, light and massage to treat patients.[15] In the Middle Ages, Ambroise Paré defined massage techniques such as 'petrissage', rolling of muscle tissue and 'tapotement', tapping or pounding on the body.[16] The 1569 treatise *De Arte Gymnastica* by Italian physician Gerolamo Mercuriale included principles of physiotherapy by advocating specific

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[11] Cooter, *Surgery and Society in Peace and War Orthopaedics and the Organization of Modern Medicine, 1880-1948*. 122, 125, 134-135,142-145, 203, 227-228. Lucy S Chipchase et al., "Looking Back at 100 Years of Physiotherapy Education in Australia," *Australian Journal of Physiotherapy* 52(2006).

[12] Anders Ottosson, "One History or Many Herstories? Gender Politics and the History of Physiotherapy's Origins in the Nineteenth and Early Twentieth Century," *Women's History Review* (2015). Prepublication. Thomas JA Terlouw, "How Can We Treat Collective Amnesia?," *Physiotherapy* 86(2000).

[13] Tidswell, *Adversity the Spur*. Louise Shaw, *In Our Hands 100 Years of the School of Physiotherapy in Otago 1913-2013* (Dunedin New Zealand: University of Otago School of Physiotherapy, 2013).

[14] *Veda Books of Wisdom*. By 1800 BCE massage knowledge became part of Hindu tradition: exemplified by Ayurveda. webmanmed.com/historical.html Accessed 5 May 2012. See Roberta E Bivins, *Alternative Medicine?: A History* (Oxford: Oxford University Press, 2007). Katherine Callaway and Susan Burgess, "A History of Massage," *Foundations of Massage* (2003). PU Unschuld, "Traditional Chinese Medicine: Some Historical and Epistemological Reflections," *Social science & medicine* 24(1987). Porter, *The Greatest Benefit to Mankind a Medical History of Humanity*. 158

[15] Murphy, Healing the Generations. 7-9.

[16] BMG Copestake, *The Theory and Practice of Massage and Medical Gymnastics*, 5th ed. (London: HK Lewis and Co Ltd 1933). 11-14.

exercise in preventing illness, preserving health, developing functional activities and treating disabilities. Skilled practitioners foresaw the effects of exercise and prescribed the most useful for preventative and curative purposes.[17] Mercuriale's work spawned similar writings such as that of the Elizabethan author Richard Mulcaster who renewed interest in developing physical and mental capacities in children 'for skill in their booke, or health in their bodie'.[18]

Seventeenth century medical practitioners and natural philosophers recognised the body as a source of knowledge.[19] Anatomy was its foundation, further advanced by physiological investigations such as Harvey's circulation of the blood and Charles Bell and François Magendie's neurological expositions.[20] René Descartes proposed man as a mechanical being and Giovanni Borelli, a renaissance polymath interested in both the body as a machine and the contractile properties of muscle, recorded his observations arguably founding biomechanics.[21] Investigating the evolving understanding of muscle contraction in ancient and medieval times, William Croone endeavoured to explain muscle contraction in terms of current mechanical and chemical theories.[22] As theoretical understanding developed, Thomas Sydenham extolled bedside clinical observation and the monitoring of therapy, transforming Galenic nosology as the burgeoning European universities adopted scientific methods

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[17] Edward Ford, "The De Arte Gymnastica of Mercuriale," *Australian Journal of Physiotherapy* 1(1955). C Pennuto, "Pliny the Elder and Medical Gymnastics of Jerome Mercuriale," *Arch Int Hist Sci* 61(2011).

[18] Richard Mulcaster, *Positions Wherein Those Primitive Circumstances Be Examined for the Training up of Children* (London: Thomas Vautrollier, 1581).

[19] Ofer Gal and Charles T Wolfe, *The Body as Object and Instrument of Knowledge: Embodied Empiricism in Early Modern Science* (Springer, 2010).

[20] Porter, *The Greatest Benefit to Mankind a Medical History of Humanity*. 212-216. Russel C Maulitz, *Morbid Appearances* (Cambridge: Cambridge University Press, 1987). 13-15.

[21] Porter, *The Greatest Benefit to Mankind a Medical History of Humanity*. 218, 227-228.

[22] Margaret Anne Nayler, "A Thorny Problem: Galen, Fabricius and Harvey on Muscle " (MA, University of Melbourne, 1975); "The Insoluble Problem: Muscle in the Mid to Late Seventeenth Century" (PhD, University of Melbourne, 1993). William Croone, *The Reason of the Movement of the Muscles* trans. Paul Maquet (London: F Hayes, 1664).

using observation, hypothesis testing and experimentation.[23] Elite university-educated physicians however decried the 'manual' work of apprentice-trained bone setters/surgeons and apothecaries. Working with the bonesetters were practitioners who applied exercises and massage, beginning the close associations between orthopaedists and physiotherapists who undertook the time-consuming manual work.[24] Such now collegial associations continue, as is demonstrated through this text.

Before the eighteenth century Chinese, Indian and Western cultures shared the Hippocratic/Galenic traditions of humoural aetiology, believing changes in the cosmos affected the world, the human body or mind and thus health.[25] In Western thought interactions between body, mind and the environment were mediated by the humours, which, if imbalanced caused disease. The stars, seasons, ageing and emotions affected the humours (temperaments persisting as sanguine, phlegmatic, melancholic, choleric). Healers sought to restore or preserve the balance of the humours of blood, phlegm, black and yellow bile.[26] Whilst exercise or massage practitioners have left few records, medical scholars wrote of the benefits of such treatments.[27]

By the age of the Enlightenment there was intense preoccupation with the body and its health in Europe and Britain.[28] Nicolas Andry de Bois-Regard emphasised the straight child.[29] Francis Fuller and John Pugh extolled the

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[23] David Harley, "Rhetoric and the Social Construction of Sickness and Healing," *Social History of Medicine* 12(1999). Andrew Cunningham, "Thomas Sydenham: Epidemics, Experiments and the "Good Old Cause"," in *The Medical Revolution of the Seventeenth Century*, ed. R French; A Wear (Cambridge: Cambridge Universtiy Press, 1989).
[24] Barclay, *In Good Hands.* 12.
[25] Bivins, *Alternative Medicine.* William Bynum, *The History of Medicine a Very Short Introduction* (Oxford: Oxford University Press, 2008). 16. Vivian Nutton, "The Fatal Embrace: Galen and the History of Ancient Medicine," *Science in Context* 18(2005).
[26] Harley, "Rhetoric and the Social Construction of Sickness and Healing."
[27] Irvine Loudon, "The Nature of Provincial Medical Practice in Eighteenth-Century England," *Medical History* 29(1985).
[28] Porter, The Greatest Benefit to Mankind. 245.
[29] Nicolas Andry de Bois-regard, *L'orthope´Die Ou L'art De Pre´Venir Et De Corriger Dans Les Enfants Les Difformite´S Du Corps. Le Tout Par Des Moyens a La Porte´E Des Pe`Res & Des Me`Res & Des Personnes Qui Ont Des Enfants a` E´Lever* (Paris: Lambert & Durand, 1741).

science of exercise to promote, maintain and restore health in 'gout, rheumatism, colds, paralytic causes, chronic affections, contractions, or sprains, or weakened by other accidents'.[30] Emil Kleen identified similar German exercise and massage texts.[31] Clément-Joseph Tissot in 1780 published *Gymnastics Medicinale et Chirurgicale* with his physiotherapy ideas based on anatomy.[32] About 1800, William Balfour's assistants in Edinburgh employed rubbing, percussion and compression for sprains, gout and rheumatism and John Grosvenor, at Oxford's Radcliffe Infirmary, trained 'rubber nurses' to massage fractured limbs and stiff joints, additionally providing hydrotherapy and splints for patients.[33] Thus working associations of medical men with practitioners performing therapy began in Britain. Furthermore, contemporary changes in medical education and practice would influence the future education of physiotherapists.

Many medical historians have viewed the period of medical and surgical unity in the Parisian *Ecole de Santé*, and the development of Giovanni Battista Morgagni's post-mortem pathological investigations and of pathological anatomy by Marie François Xavier Bichat, as revolutionary whilst Roy Porter promulgated a rather more progressive change. [34] Nevertheless the significant changes, with adoption of a biomedical theoretical and clinical model, affected

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[30] Cooter, *Surgery and Society.* 11-12, 14. Porter, *The Greatest Benefit to Mankind.* 382. John Pugh, A Physiological, Theoretic and Practical Treatise on the Utility of the Science of Muscular Action for the Restoring the Power of the Limbs, (1794), nla.gov.au/nla.cat-vn4866306. Accessed 9 May 2012.

[31] Emil AG Kleen, *Massage and Medical Gymnastics*, trans. Mina L Dobbie, 2 ed. (London: Churchill, 1921).

[32] Elizabeth Licht and Sidney Licht, *A Translation of Joseph Tissot's Gymnastics-Clément Et Medicinale Chirurgicale*, trans. Elizabeth; Licht, Proceedings of the Royal Society of Medicine (New Haven, Connecticut: Licht, 1965).

[33] Barclay, In Good Hands. 12. Citing Illustrations on the Power of Compression and Percussion on Rheumatic Gout and Debility of the Extremities, by Dr Balfour, Edinburgh, 1809. A Full Account of the System of Frictions as adapted and pursued with the greatest success in cases of Contracted Joints and Lameness from various causes, by the late eminent surgeon, John Grosvenor, Esq., of Oxford," by William Cleobury, 1825. Kleen, Massage and Medical Gymnastics.

[34] Jewson, "Medical Knowledge and the Patronage System in 18th Century England." Roberta E Bivins and John V Pickstone, *Medicine, Madness and Social History: Essays in Honour of Roy Porter* (Basingstoke: Palgrave Macmillan, 2007).

physiotherapy's development through education, the hospital clinic and professionalisation.[35] As nineteenth century societal changes of industrialisation and urbanisation crowded the cities, their increased population density compounded existing health problems.[36] In a period of many health practitioners: self-taught healers, the apprenticed surgeon/apothecaries and university-educated physicians, medical men became increasingly important, although the path was often fraught for individuals.[37] Some medical men achieved prominence in institutions as the medical market altered from the patronage of those who could choose their practitioner to one where practitioners became more influential.[38] Fissell claimed that medical practitioners no longer shared the understandings and language of their patients but progressively understood illness in terms of anatomy and pathology.[39]

Australia's early medical traditions derived from Britain, where in the mid nineteenth century surgeons and physicians were becoming organised and established nationally with the General Medical Council and regulated through the Medical Act of 1858.[40] However there was 'ferocious competition among the qualified'.[41] The 1885 Amended Medical Act required both medical and surgical qualifications for medical practitioners and with growing scientific

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[35] Ludmilla Jordanova, "Has the Social History of Medicine Come of Age?," *The Historical Journal* 36(1993).
[36] "Married Women in Factories," *Reynold's Newspaper*, 18 November 1894.
[37] Roy Porter, *Quacks Fakers and Charlatans in English Medicine* (Stroud, Gloucestershire: Tempus, 2001). 31-62.
[38] *Middlemarch* by George Eliot reflects the earlier status. "The Patient's View: Doing Medical History from Below." Loudon, "The Nature of Provincial Medical Practice in Eighteenth-Century England." Jewson, "Medical Knowledge and the Patronage System in 18th Century England."
[39] Mary Fissell, *Patients, Power and the Poor in Eighteenth Century Bristol* (Cambridge: Cambridge University Press, 1992). *Passim*.
[40] Anne Digby, *The Evolution of the British General Practice 1850-1945* (Oxford: Oxford University Press, 1999). 24. Bynum, *The History of Medicine a Very Short Introduction*. Also Anne Digby, *Making a Medical Living Doctors and Patients in the English Market for Medicine 1720-1911* (Cambridge: Cambridge University Press, 1994). Richardson, *Death, Dissection and the Destitute*. *Passim*. MJD Roberts, "The Politics of Professionalization: Mps, Medical Men, and the 1858 Medical Act," *Medical History* 53(2009).
[41] Digby, The Evolution of the British General Practice. 27.

knowledge and laboratory skills medical education expanded.[42] These legislative and educational changes influenced medicine's professionalisation. British medical men brought their knowledge to Australia, where Victoria's first Medical Act was passed in 1858.[43] Contrasting with medicine, qualified physiotherapy practitioners in mid-century Britain were likely to have trained in Sweden or by Swedish-trained practitioners, but others may have been apprenticed as 'rubbers'. [44]

From Australia we can glimpse the British situation. Peters wrote,

> John Beveridge of Edinburgh was the first to practice massage ... in 1849. ... In 1874 Mr Andrew Drummond (uncle of the writer) ... succeeded to his business ... Migrating to England in 1865 Mr John S Peters with his wife and children established themselves in Newcastle-on-Tyne and was thus the pioneer of the system in England. He died in 1887, his widow and children still carrying on the business at home with the exception of the eldest and youngest sons who are now in Melbourne.[45]

The 1861 English census lists John Smith Peters as a forester and from census 1871 onwards as a medical rubber. His youngest son, Alfred, educated at George Watson's College Edinburgh, left for Australia in 1887 commencing massage practice in Melbourne.[46] In Australia and Britain unregulated practitioners provided physical therapies, yet colonial Australia did not look to the mother country for guidance. Physiotherapy required a more secure

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[42] *Making a Medical Living.* William Bynum and Roy Porter, *Medical Fringe and Medical Orthodoxy 1750-1850*, The Wellcome Series in the History of Medicine (London: Croom Helm, 1987); Bynum et al., *The Western Medical Tradition 1800 to 2000*.
[43] Pensabene, *The Rise of the Medical Practitioner in Victoria*. 101-107.
[44] Ottosson, "The Manipulated History of Manipulations."
[45] Phyllis Peters, "Alfred Peters Oral History Record," (Australian Physiotherapy Association, 1987). See Peters, *Massage, Its History.*
[46] John Smith Peters, birth in Scotland. English census 1861, 1871, 1881 and England and Wales Death Index 1837-1915 death in 1887.

foundation accessible to men and women through the work of Pehr Henrik Ling consolidated sixty years earlier.[47]

The Swedish government appointed Ling in charge of the Royal Central Institute of Gymnastics (RCIG) in 1813, to instruct gentlemen and military officers in the sciences of human anatomy with dissections, physiology, biomechanics, pathology and his gymnastic system (Figure 3.2). Their knowledge and high status ensured a leading role in health care for Ling's physiotherapists.[48] Terlouw claimed Ling's epistemology incorporated ideas of John Locke, Jean-Jacques Rousseau and Friedrich Schelling to develop the integrated civilised body and mind and achieve physical fitness, blending humoural pathology with iatromechanics. Health required a balance between the intellectual and emotional life: movements and postures, physical education and physical therapy were the responsibility of the physiotherapist (*sjukgymnast*), and food, dietetics and drugs the responsibility of the medical practitioner.[49]

Early nineteenth century governments of Western European nations involved in the Napoleonic and Russian wars, worried about the fighting fitness of their armies, which encouraged the spread of Ling's approaches including his military gymnastics.[50] Rising nationalism and the RCIG's growing reputation attracted students from many countries and graduates established clinics as

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[47] Ottosson, "The First Historical Movements of Kinesiology." Terlouw, "Roots of Physical Medicine, Physical Therapy, and Mechanotherapy."
[48] Ottosson, "The Manipulated History of Manipulations." Ling wrote little and his major text is in Swedish: Pehr Henrik Ling 1840 *Gymnastikens allmänna grunder (The General Principles of Gymnastics)*, graduate Augustus Georgii wrote *Kinésithérapie; ou, Traitement des maladies par le mouvement, selon la méthode de Ling: Suivi d'un abrégé des applications de la théorie de Ling à l'éducation physique*. Mathias Roth, *The Prevention and Cure of Many Chronic Diseases by Movements* (London: John Churchill 1851); Matthias Roth, Movements or Exercises, According to Ling's System, for the Due Development and Strengthening of the Human Body in Childhood and in Youth (London: Groombridge & Sons 1852).
[49] Ottosson, "The Manipulated History of Manipulations."
[50] Terlouw, "Roots of Physical Medicine, Physical Therapy, and Mechanotherapy."

physiotherapists. Often their treatment incorporated massage, promoted as scientific by the Dutch physical educator/physician Johan Metzger.[51]

Figure 3.2 Pehr Henrik Ling.[52]

In 1864 the Swedish government sanctioned physiotherapy as an independent science with physiotherapists entitled professors. Physiotherapists had achieved professional hallmarks of specialist knowledge, educational recognition and state sanction. That year the RCIG accepted women for a two-year course of pedagogical and medical gymnastics: physical education and physical therapy.[55] Tobba Sudman identified that unlike the men, women graduates depended on additional financial support due to their very low wages, reflecting their gender and middle-class origins. These early female physiotherapists established a sustained culture of giving to those in need.[56] Nevertheless, passing the RCIG's examinations entitled all graduates to work

[51] Obituary BMJ March 27 1909.
[52] "Pehr Henrik Ling," en.wikipedia.org/wiki/Pehr_Henrik_Ling. Accessed 12 October 2012.
[55] Ottosson, "When the Orthopedist Was a Physical Therapist."
[56] Sudmann, "(En) Gendering Body Politics." 39.

as Directors of Gymnastics responsible for 'curing sick people with physical therapy'.[57]

Medical practitioners flocked to the RCIG, studying with Ling, then his successor Lars Gabriel Branting.[58] As medicine increasingly perceived the therapeutic and financial value in physiotherapy, in Sweden a tussle for professional control developed between male physiotherapists and medical orthopaedists. Physiotherapists effectively treated neuromusculoskeletal disorders, chronic and internal diseases and orthopaedic deformities, affording practitioners significant recognition. Orthopaedists at the Karolinska Institute argued with physiotherapists over the discipline most appropriate to diagnose and cure illness with physiotherapy for nearly eighty years. Eventually the numerically larger and ultimately politically more powerful orthopaedists who had absorbed Ling's epistemology prevailed, and Swedish physiotherapists became dominated by medicine.[59] Ottosson interpreted the contest between the orthopaedists and physiotherapists as a homosocial conflict, concerning entitlement to masculine attributes – control, autonomy, science and upper-class status, which led eventually to almost complete feminisation of the physiotherapy profession in Sweden.[60] Swedish-trained medical practitioners commenced programmes in Norway, taking control and admitting few men.[61]

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[57] Ottosson, "When the Orthopedist Was a Physical Therapist." Terlouw, "Roots of Physical Medicine, Physical Therapy, and Mechanotherapy." Terlouw cites Westerblad CA *Ling. The Founder of Swedish Gymnastics. His Life, His Work and His Importance.* London, UK: Sampson Low, Marston & Co. Limited, 1909. See also Kellogg, *The Art of Massage.* Ottosson, "When the Orthopedist Was a Physical Therapist." Digby, *Making a Medical Living.* In particular part 3.

[59] Anders Ottosson, "Sjukgymnasten - Vart Tog Han VäGen? En UndersöKning Av Sjukgymnastyrkets Maskulinisering Og Avmaskulinisering 1813-1934" (Göteborgs univeristet, 2005). Personal communication. "When the Orthopedist Was a Physical Therapist." Earlier work on gender makes no mention of the conflicts. See Birgitta Bergman and Staffan Marklund, "Masculinisation and Professionalisation of the Physiotherapy Profession: A Study of Swedish Physiotherapists," Physiotherapy Theory and Practice 5(1989).

[60] Bergman noted female physiotherapists employed male professional strategies. Birgitta Bergman, "Being a Physiotherapist. Professional Role, Utilization of Time and Vocational Strategies" (Umeå University, 1989).

[61] Sudmann, "(En) Gendering Body Politics." 36-37.

Swedish and German approaches to physiotherapy (*heilgymnastiek* in Dutch) also interested the Dutch where conflict arose between physiotherapists, physical educators, orthopaedists and physical medicine practitioners. Again numerically stronger and politically influential, medicine gained legislative control over health care. However *heilgymnasten* continued treating patients, with 'deformities of the spine, chest, shoulder blades, and limbs, paralysis, bad innervation, insufficient breathing, neuralgia, chorea minor, gout, rheumatism, headaches, chlorosis, scrophulosis, tuberculosis, adipositas, and general weakness'.[62]

Despite achieving control, Dutch medical practitioners, as their counterparts in other countries, were less enthusiastic about actually practising physiotherapy. It was too labour intensive and although founded in biomedical science did not subscribe to newer discoveries in chemistry and histology.[63] If lower status female physiotherapists, with smaller salaries, would work for them, medical men could claim treatment success and higher incomes. This threat to autonomy prompted the Dutch in 1889 to form the first physiotherapy association, to protect members' interests, improve their status and to bring *détente* between physicians and physiotherapists by members agreeing to only treat on medical referral.[64] Terlouw contended this interprofessional wrangling delayed the development of all the Netherlands' disciplines involved until the mid-twentieth century.[65] Indeed, subservience to medicine influenced physiotherapy's professional development worldwide. Similar appropriation occurred as medicine invaded obstetrics relegating midwives to a subsidiary role.[66]

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[62] Terlouw, "Roots of Physical Medicine, Physical Therapy, and Mechanotherapy."
[63] Ibid.
[64] See "Royal Dutch Society for Physical Therapy (Kngf)," http://www.fysionet.nl/english.html. Accessed 10 February 2015.
[65] Terlouw, "Roots of Physical Medicine, Physical Therapy, and Mechanotherapy."
[66] Barbara Ehrenreich and Deidre English, *Witches, Midwives, and Nurses: A History of Women Healers* (New York: The Feminist Press, 2010).

In London, RCIG physiotherapist Jonas Henrik Kellgren established one of his many practices.[67] His family, medical daughter and son-in-law, Edgar Cyriax, practised too as physiotherapists, as did his grandson, Julius Henrik Kellgren Cyriax, (James Henry). Renowned in physical medicine and physiotherapy worlds, James Cyriax taught Ling's manipulation techniques to physiotherapists in the twentieth century without any acknowledgement.[68] A variety of techniques became recognised as part of physiotherapy practice. I describe the historical establishment of these interventions before exploring the foundations of British physiotherapy.

Massage/physiotherapy became synonymous with treatment modalities including electrotherapy, remedial gymnastic exercise, hydrotherapy, massage and manipulation.[69] Techniques that became absorbed within physiotherapy by the beginning of the twentieth century interested both orthodox medical and lay practitioners. Following the 1740 invention of the Leyden jar, in London the Middlesex, then St Bartholomew's Hospitals used static electricity, as did non-medical men for curing ailments.[70] Introduced in 1800, galvanic current's effectiveness for pain relief or muscle stimulation was soon exploited and later the faradic induction coil, a more effective muscle stimulator. In 1867 Guy's Hospital opened well-equipped electrical rooms. Therapeutic use of infrared, ultraviolet and X-rays began. By 1892 medical diathermy for cautery and therapeutic long wave diathermy were introduced.[71]

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[67] Wellcome library: Kellgren archive box MS 5408 Jonas Henrik Kellgren 1875 also MSS.5406-5409 and 7869-7872. Edgar Ferdinand Cyriax (MSS.2001-2025 and 6054-6060). Kellgren established clinics in Europe, New York and Cairo. See Frederick A Floyer, *Outlines of the Study of Kellgrenism* (London: Griffith, Farran, Okeden & Welsh, 1888).

[68] Cyriax, *Textbook of Orthopaedic Medicine*. Cooter, *Surgery and Society,* Porter, *The Greatest Benefit to Mankind,* Bynum et al., *The Western Medical Tradition 1800 to 2000*. All ignored Ling.

[69] John MacIntyre, "Recent Electrotherapeutics," *British Medical Journal*, no. June 6 (1903).

[70] Barclay, *In Good Hands.* 8. Iwan Morus, *Shocking Bodies: Life, Death and Electricity in Victorian England* (The History Press, 2011). Wendy Moore, *The Knife Man* (London: Bantam Press, 2005). 258.

[71] Barclay, *In Good Hands.* 8-11. See also Sidney Licht, *Therapeutic Electricity and Ultraviolet Radiation*, Physical Medicine Library. 4 (Licht, 1967); Tim Watson,

Treatments involving water were popular from Greek and Roman periods (Figure 3.3).[72]

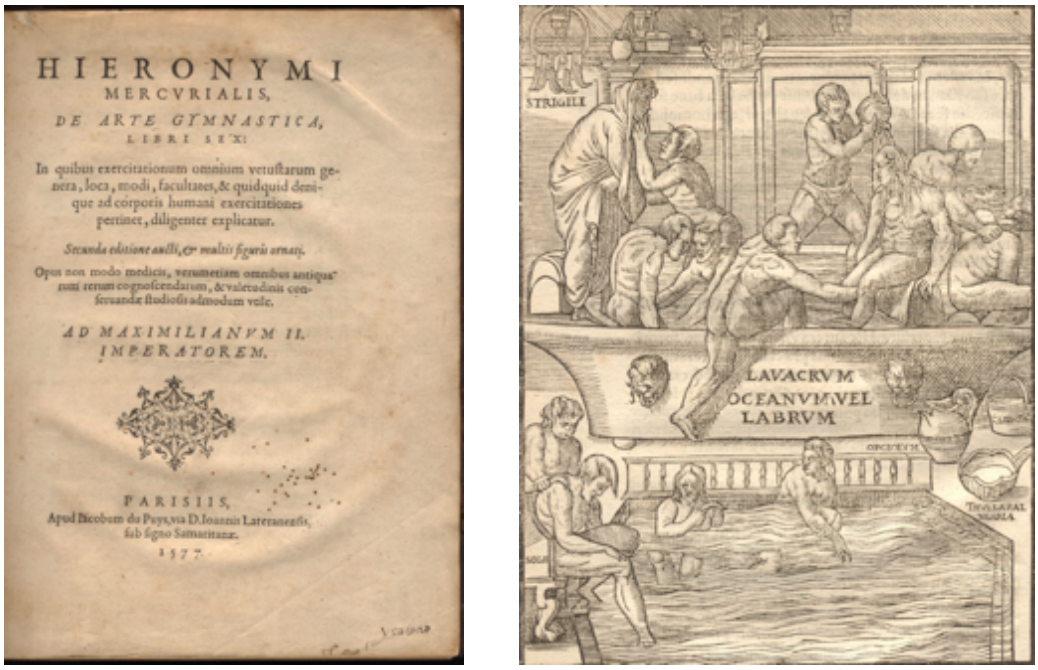

Figure 3.3 Frontispiece of University of Melbourne copy of *De Arte Gymnastica* (left) Roman baths (right).

Early nineteenth century chemical analyses of mineral waters promoted their potential medicinal qualities. Twenty-first century terminology describes spas as mineral springs with health-giving properties. Hydrotherapy is therapeutic exercises in warmed water. Hydropathy treats illness using cold water. Balneotherapy is treatment by bathing in mineral springs, whereas thalassotherapy uses seawater.[73] Water therapy became fashionable in Europe, at Ardennes, Montpellier, Aix-les-Bains and Bad Nauheim. British royal patronage and the opening of associated hospitals in Bath, Harrogate, Droitwich and Buxton between 1738 and 1858 increased usage. Sea bathing

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Electrotherapy: Evidence-Based Practice, Physiotherapy Essentials (Edinburgh; New York: Churchill Livingstone Elsevier, 2008).

[72] A van Tubergen and S van der Linden, "A Brief History of Spa Therapy," *Annals of the rheumatic diseases* 61(2002). CB Cosby, "James Currie and Hydrotherapy," *Journal of the History of Medicine and Allied Sciences* (1950).

[73] "Hydrotherapy," http://en.wikipedia.org/wiki/Hydrotherapy. Accessed 10 October 2013.

became popular at Scarborough, Brighton, Weymouth and Margate.[74] The medicalised use of water generally included exercises, massage and later electricity with therapists delivering treatments prescribed by orthodox and unorthodox practitioners in a period of intense competition.[75]

The science of orthodox medicine now incorporated the physical therapies frequently labelled ‘Swedish’. Fletcher Little enthusiastically espoused massage techniques with 'medical calisthenics', the 'Swedish movement cure' in the *British Medical Journal* (BMJ).[76] Similarly William Murrell provided scientific support for massage, as did Symons Eccles in its influence on heart rate and its value for chronic heart disease.[77] Mathias Roth, whose son Reuter would emerge as an important contributor to physiotherapy in Sydney, Australia, demonstrated muscle restoration without equipment such as Gustav Zander’s exercise machines.[78] Massage became fashionable as part of the treatment of society ladies with neurasthenia. Weir Mitchell's neurasthenia treatment comprised enforced rest, feeding with milk and beef tea, regular massage and electrical stimulation to replace exercise.[79] Swedish exercises and

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[74] van Tubergen and van der Linden, "A Brief History of Spa Therapy."
[75] James Bradley and Marguerite Dupree, "Opportunity on the Edge of Orthodoxy: Medically Qualified Hydropathists in the Era of Reform, 1840–60," *Social History of Medicine* 14(2001); "A Shadow of Orthodoxy? An Epistemology of British Hydropathy, 1840-1858," *Medical History* 47(2003).
[76] J Fletcher Little, "Medical Rubbing," *British Medical Journal* 2(1882).
[77] William Murrell, *Massage as a Mode of Treatment* (London: HK Lewis, 1882). Reviewed in "Massage as a Therapeutic Agent," *British Medical Journal* 1(1886). A Symons Eccles, "The Effect of Massage on the Pulse-Rate," ibid.(1895).
[78] Mathias Roth, *Gymnastic Exercises, without Apparatus, According to Ling's System, for the Due Development and Strengthening of the Human Body* (London: Myers, 1876). Takahiro Ueyama, "Capital, Profession and Medicaltechnology: The Electro-Therapeutic Institutes and the Royal College of Physicians,1888-1922," *Medical History* 41(1997). Nils Hansson and Anders Ottosson, "Nobel Prize for Physical Therapy? Rise, Fall, and Revival of Medico-Mechanical Institutes," *Phys. Ther.* (2015).
[79] S Weir Mitchell, *Fat and Blood: An Essay on the Treatment of Certain Forms of Neurasthenia and Hysteria* (JB Lippincott, 1885); Franklin H Martin, "Hystero-Neurasthenia, or Nervous Exhaustion of Women, Treated by the S. Weir Mitchell Method.: Read before the Chicago Medical Society, March 7, 1887," *JAMA: Journal of the American Medical Association* 8(1887); Suzanne Poirier, "The Weir Mitchell Rest Cure: Doctor and Patients," *Women's Studies* 10(1983).

massage treated fractures, with physiotherapy critical to orthopaedic development.[80]

William Little, founder of London's Royal Orthopaedic Hospital in 1838, specified and prescribed massage and exercises after his talipes tenotomies.[81] Further evidence of the acceptance of massage, exercise and hydrotherapy is noted in Roth's texts, by the appointment of a professor of gymnastics at the National Orthopaedic Hospital, London in 1874, and Guy's Hospital's physiotherapy department in 1888.[82] By the mid-nineteenth century 'physiotherapy', 'massage' and 'physical medicine' described the physical therapies invoked to treat illness and disease by assisting the body's natural healing.[83] The First International Congress of Physiotherapy occurred in Liege in 1905.[84] In this thesis 'physiotherapy' and 'physiotherapists' are the terms used to encompass techniques or practitioners formally educated in using a comprehensive range of physical therapies.

Describing massage's physiological effects of increasing blood flow in muscles and causing gastrointestinal reflexes, eminent physician George Oliver counselled that 'massage should … be applied with due discrimination'. Oliver referred to the 'Swedish system' for exercises and identified the cardiovascular influence of the temperature of therapeutic baths.[85] As science supported physiotherapy, techniques such as Brandt's intravaginal massage were

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[80] William Balfour, *Illustrations on the Power of Compression and Percussion on Rheumatic Gout and Debility of the Extremities* (Edinburgh1809). William Cleobury, *A Full Account of the System of Frictions as Adapted and Pursued with the Greatest Success in Cases of Contracted Joints and Lameness from Various Causes, by the Late Eminent Surgeon, John Grosvenor, Esq., of Oxford* (1825). Barclay, *In Good Hands.* Cooter, *Surgery and Society.* 60-74, 118-125, 128-145, 150, 170-178, 199- 218, 227-237.

[81] Ibid. 14. Cast immobilisation was then uncommon.

[82] Roth, The Prevention and Cure of Many Chronic Diseases. Cooter, Surgery and Society. 258.

[83] Terlouw, "Roots of Physical Medicine, Physical Therapy, and Mechanotherapy."

[84] "First International Congress of Physiotherapy," *Archives of the Roentgen Ray* 10, no. 3 (1905). 70.

[85] George Oliver, "The Croonian Lectures: A Contribution to the Study of the Blood and the Circulation," *British Medical Journal* 1(1896).

questionable.[86] The association of such massage techniques with Swedish gymnastics may have alerted British medical men to the sexualisation of massage. [87]

Massage, seen as a respectable occupation, had attracted women, often from 'good' families, seeking emancipation.[88] In 1894 the BMJ raised concerns regarding massage being offered as a euphemism for prostitution, and calling for an institution to be formed to regulate massage practice. 'Many of these girls have certificates, ... (they) little by little, drift into a mode of life which is often most distasteful to them. … The legitimate massage market is overstocked'.[89] Outraged reports featured in the press and a widely promulgated pamphlet was published (Figure 3.4).[90]

Apparently spurred by this negative press, four nurse-midwives, also trained as masseuses, instituted a process of professionalisation through founding the Society of Trained Masseuses (STM) and seeking to have their massage practices authenticated and purged of the sexual stain.[91] These founding women were midwives with massage skills, not physiotherapists. As they developed further skills they retained the 'massage' descriptor, not changing to 'physiotherapist' for decades.

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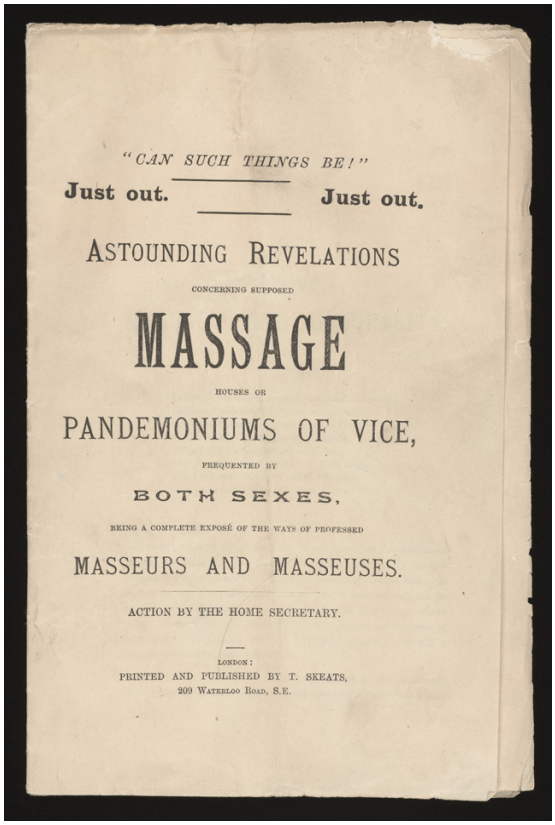
[86] Ottosson, "The First Historical Movements of Kinesiology." Brandt specialised in intravaginal massage of the pelvic organs.
[87] Gustave de Frumerie, "Massage Gynécologique: Méthode Thure-Brandt Gynaecological Massage: Thure-Brandt's Method," (Paris1897).
[88] "Immoral 'Massage' Establishments a Social Scandal," *Birmingham Daily Post*, 14 July 1894.
[89] Ibid. Copied in other papers such as *Cheshire Observer* and the *Western Mail*. "Massage and Morals," *Reynold's Newspaper*, 24 March 1895.
[90] Wellcome Institute newspaper cuttings from July 13-17 1984 in London newspapers *Echo* and *Morning* followed by July 18 Birmingham, July 19 Bradford "Observer", July 20 to Glasgow and *New York Herald Paris edition*. Reporting widely through July and August and continued in 1895.
[91] Wicksteed, *The Growth of a Profession.* 1-18. Barclay, *In Good Hands.* 20-23. The Society became the Chartered Society of Physiotherapy. Nicholls and Cheek, "Physiotherapy and the Shadow of Prostitution."



"CAN SUCH THINGS BE!"

Just out. Just out.

ASTOUNDING REVELATIONS

CONCERNING SUPPOSED

MASSAGE

HOUSES OR

PANDEMONIUMS OF VICE,

FREQUENTED BY

BOTH SEXES,

BEING A COMPLETE EXPOSÉ OF THE WAYS OF PROFESSED

MASSEURS AND MASSEUSES.

ACTION BY THE HOME SECRETARY.

LONDON:
PRINTED AND PUBLISHED BY T. SKEATS,
209 WATERLOO ROAD, S.E.

Figure 3.4. Fifteen-page pamphlet sensationalising massage.[92]

The RCIG graduates in Britain practising as physiotherapists were predominantly men, yet, in 1878, when Britain introduced physical education, Concordia Löfving, an RCIG physiotherapist, became superintendent of Physical Training in Girls Schools.[94] A second graduate, Martina Bergman-Österberg succeeded her in 1881, teaching Annie Manley, one of the four STM founders. Boys' school physical education programmes began later when RCIG physiotherapist Alan Broman, was appointed to organise their training.[95] Whilst

[92] Wellcome Institute massage pamphlet SA/CSP/P - 1/2 [25]
[94] Concordia Löfving, *Gymnastik-Sånger För Flickor* (Palmquist, 1872). See also David Armstrong, A New History of Identity a Sociology of Medical Knowledge, (Palgrave Macmillan, 2002). 37-41.
[95] Barclay, *In Good Hands*. 4-8. Wellcome Institute GC/6/1/2 Medical Gymnastics Volume 2 in Alan Broman's 1898-1901 journal.

the RCIG's legacies influenced British physical education and physiotherapy, STM members aligned themselves closely to the increasingly prestigious and influential medical profession.[96]

Only accepting patients referred by medical practitioners, the exclusively female STM were thus moulding a particularly British professional identity. Treating men required a special medical request, despite orthopaedists relying on masseuses for their therapeutic success.[97] Concerned to provide an authentic alternative to massage parlours and to court medical approval, the women reinforced a biomechanical view of the body in health and illness, a machine rather than a sensual body – a paradigm still influencing physiotherapy.[98]

Whilst the focus of the massage scandal was women's behaviour, men like Kellgren and his colleague Broman practised physiotherapy. Donald Wood's referral letter and Broman's patient notes provide evidence of congenial relationships (Figure 3.5). With Broman's copious notes in Swedish, it is uncertain whether some patients arrived without referrals.

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[96] Bergman-Österberg Physical Training College continues as part of the University of Greenwich.
[97] Barclay, In Good Hands. 26-27. Cooter, Surgery and Society. 14, 28.
[98] Nicholls and Cheek, "Physiotherapy and the Shadow of Prostitution."

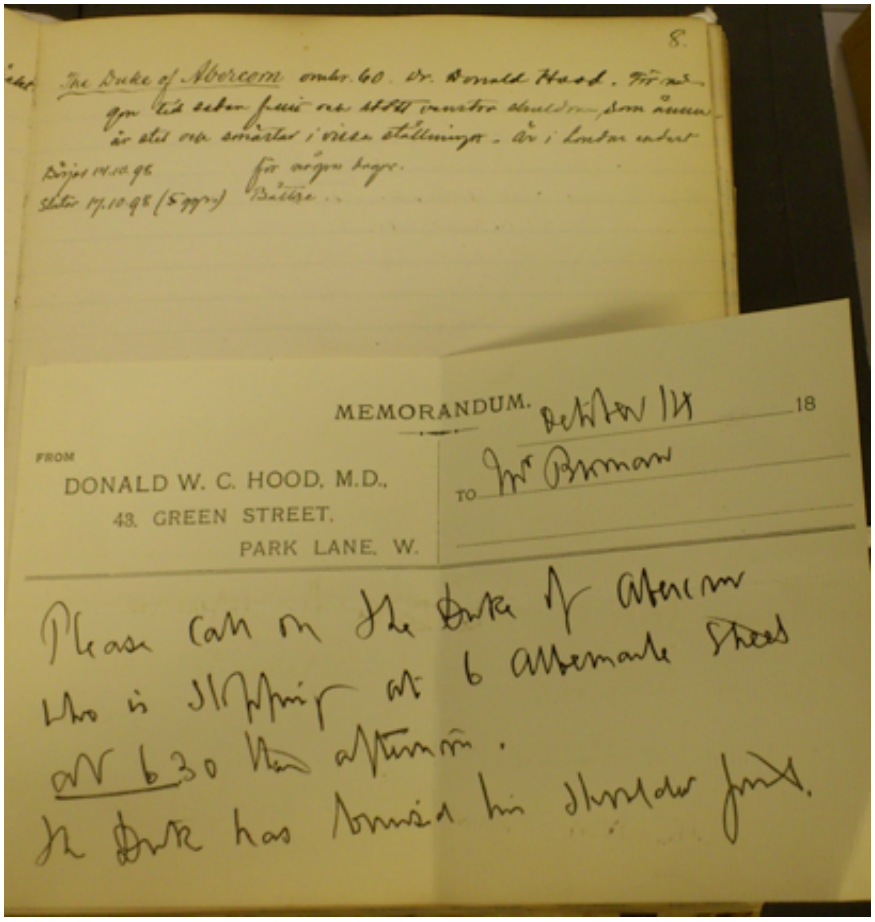

Figure 3.5 A referral note from Donald Hood to Alan Broman, (below). Broman's patient notes (above).[99]

The RCIG's graduates established clinical practices and often their own training academies in Britain, France, the Netherlands and Germany. Their influence, and of STM members can be traced in Britain's colonies and the United States of America (USA).[100] Here too the gender distribution of predominantly high status male medical practitioners and often lower status female physiotherapists was representative of the male and female status in society more generally with male power and dominance and female

[99] Wellcome Institute GC/6/1/2 Medical Gymnastics Volume 2 in Alan Broman's 1898-1901 journals.
[100] Cleather, *Head, Heart and Hands.* Murphy, *Healing the Generations.* Bentley, *The Path to Professionalism.* Ottosson, personal communication, claims physiotherapy as one of Sweden's most successful exports.

subservience.[101] The moral code blamed the women for the British scandal, which unsurprisingly, in the land of damned whores and God's police, reached the press.[102]

> SPECIAL Edition LATE CABLES (From Evening News Correspondents.)
>
> London Society Scandal
>
> IMMORAL MASSAGE HOUSES - SENSATIONAL STATEMENTS
>
> London, July 19. The Home Secretary (Mr H Asquith) has ordered an inquiry with a view to the suppression of immoral 'massage' houses in London. It is reported that these are numerous, and that flagrant cases of their being used by society women are known to be of frequent occurrence.[103]

Australian women physiotherapists did not experience the same taint. Only one newspaper report stated 'before the exposures were made a similar use of quasi-medical "institutes" had been attempted in Melbourne - though it failed, ... because of the rigorous investigations of the Board of Health'.[104] Although such scandals did not occur, they may have influenced the close alliances physiotherapists pursued with medical education and practice in Australasia.[105]

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[101] Patricia Grimshaw et al., *Creating a Nation 1788-2007* (Perth: API Network, 2006). 55-201.
[102] Anne Summers, *Damned Whores and God's Police the Colonisation of Women in Australia* (Blackburn, Victoria: Dominion Press, 1975).
[103] "Special Edition," *Evening News*, 20 July 1894. 5. http://nla.gov.au/nla.news-article113324517 the same article repeated, "News by Cable," *Evening News*, 21 July 1894. 4. http://nla.gov.au/nla.news-article113324220 and "London Society Scandal," *Australian Town and Country Journal*, 28 July 1984. 11. http://nla.gov.au/nla.news-article71262250 All accessed 15 July 2014.
[104] "Massage" and Vice," *Table Talk*, 18 June 1897. 9-10. http://nla.gov.au/nla.news-article145932350 Accessed 15 July 2014.
[105] "Australasian Massage Association 30 March Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1906). 7

In the mid nineteenth century the status of Victorian medical practitioners was questionable. Tony Pensabene summarised

> Professional misconduct, unsuccessful operations and adverse publicity in newspapers…(in conjunction with)…their lack of a clearly defined body of scientific medical knowledge and their public activities and dealings, the registered practitioner was a marginal man'.[106]

Nevertheless, they sought dominance over other practitioners exploiting any treatments which benefitted patients and produced tangible and intangible returns to their practices (Figure 3.6). These were included in the medical armamentarium, particularly at times of economic stress.[107] Orthodox medicine adopted homeopathy, mesmerism, acupuncture, moxibustion and hydropathy.[108] Phillippa Martyr indicated a variety of unorthodox practitioners in Australia at the time and in Victoria a homeopathic hospital existed.[109]

By the end of the nineteenth century medicine was increasingly influential in Victoria, Australia. Pensabene described the progress in power and status of Victoria's medical profession as advances in biomedical science began to alter medical practice, raising professional competence and distinguishing the medical practitioner from competitors.[110] Concurrently Australian physiotherapists, then still termed masseurs/masseuses despite their breadth of practice, were perceived as legitimate practitioners receiving medical endorsement.

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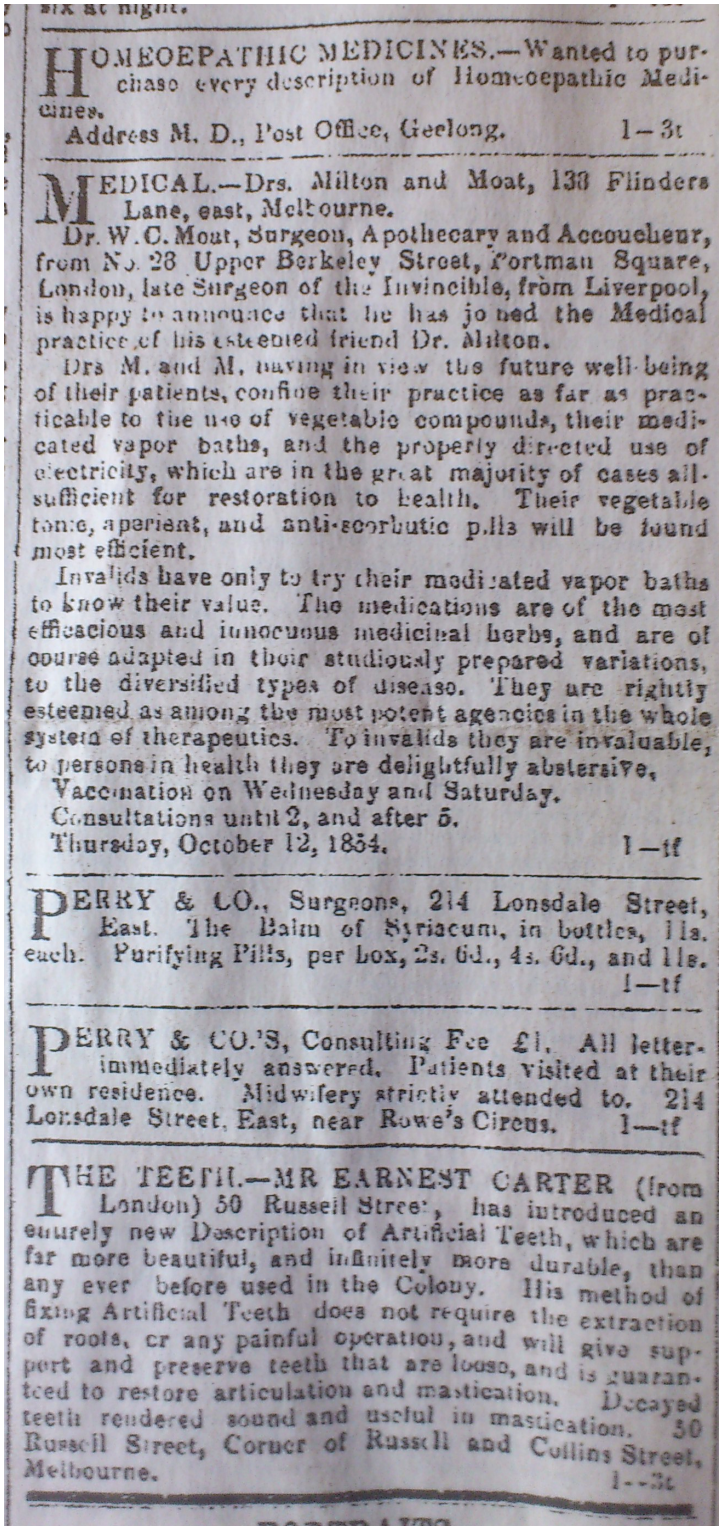
[106] Pensabene, *The Rise of the Medical Practitioner in Victoria*. 30
[107] Digby, *Making a Medical Living.* In particular. 62-68.
[108] Bivins, *Alternative Medicine.* Bradley and Dupree, "Opportunity on the Edge of Orthodoxy: Medically Qualified Hydropathists in the Era of Reform, 1840–60."; "A Shadow of Orthodoxy? An Epistemology of British Hydropathy, 1840-1858."
[109] Philippa Martyr, *Paradise of Quacks an Alternative History of Medicine in Australia* (Sydney: Macleay Press, 2002). *Passim.* Jacqueline Templeton, "Prince Henry's; the Evolution of a Melbourne Hospital, 1869-1969" (MA, University of Melbourne, 1972); *Prince Henry's; the Evolution of a Melbourne Hospital, 1869-1969* (Melbourne: Robertson & Mullens, 1969).
[110] Pensabene, *The Rise of the Medical Practitioner in Victoria*. *Passim.*



six at night.

HOMEOEPATHIC MEDICINES.—Wanted to purchase every description of Homœopathic Medicines.
Address M. D., Post Office, Geelong. 1—3t

MEDICAL.—Drs. Milton and Moat, 138 Flinders Lane, east, Melbourne.
Dr. W. C. Moat, Surgeon, Apothecary and Accoucheur, from No. 28 Upper Berkeley Street, Portman Square, London, late Surgeon of the Invincible, from Liverpool, is happy to announce that he has joined the Medical practice of his esteemed friend Dr. Milton.
Drs M. and M. having in view the future well-being of their patients, confine their practice as far as practicable to the use of vegetable compounds, their medicated vapor baths, and the properly directed use of electricity, which are in the great majority of cases all-sufficient for restoration to health. Their vegetable tonic, aperient, and anti-scorbutic pills will be found most efficient.
Invalids have only to try their medicated vapor baths to know their value. The medications are of the most efficacious and innocuous medicinal herbs, and are of course adapted in their studiously prepared variations, to the diversified types of disease. They are rightly esteemed as among the most potent agencies in the whole system of therapeutics. To invalids they are invaluable, to persons in health they are delightfully abstersive.
Vaccination on Wednesday and Saturday.
Consultations until 2, and after 5.
Thursday, October 12, 1854. 1—tf

PERRY & CO., Surgeons, 214 Lonsdale Street, East. The Balm of Syriacum, in bottles, 11s. each. Purifying Pills, per box, 2s. 6d., 4s. 6d., and 11s. 1—tf

PERRY & CO.'S, Consulting Fee £1. All letters immediately answered. Patients visited at their own residence. Midwifery strictly attended to. 214 Lonsdale Street, East, near Rowe's Circus. 1—tf

THE TEETH.—MR EARNEST CARTER (from London) 50 Russell Street, has introduced an entirely new Description of Artificial Teeth, which are far more beautiful, and infinitely more durable, than any ever before used in the Colony. His method of fixing Artificial Teeth does not require the extraction of roots, or any painful operation, and will give support and preserve teeth that are loose, and is guaranteed to restore articulation and mastication. Decayed teeth rendered sound and useful in mastication. 50 Russell Street, Corner of Russell and Collins Street, Melbourne. 1—3t

Figure 3.6 'Medical' *The Age* 17 October 1854. 7.

The *Australian Medical Journal* recommended Harriet Elphinstone-Dick's Melbourne gymnastic school, indicating her professional training and qualifications to teach

gymnastic exercises. 'The profession may confidentially send such of their lady-patients as require the well-considered application of the sort of exercise that is necessary for the recovery of muscles'.[111] Elphinstone-Dick also taught physiology.[112] Dr Louis Henry wrote supporting the value of the treatments, predicting when 'the general practitioner becomes more familiar with its methods (this will) take a prominent place in our every-day therapeutics.[113] The *Intercolonial Quarterly Journal of Medicine and Surgery* advertised Miss Josephine McCormick's Ladies' Gymnasium in Melbourne, operating from 1881 to 1888, which offered 'Massage, Electricity, and Medical Gymnastics, for the Treatment of Ill-Health, Spinal Affections, and other Deformities'.[114] Medical men recognised and respected such emancipated women as Elphinstone-Dick and McCormick, an uncommon recognition at the time.[115] Newspaper articles and advertisements too drew the public's attention to practitioners such as Peters and Hall. The links with the leading medical men is evidenced in the article about Maurice Krone, who, from the 1880s was the first male honorary masseur at the Melbourne Hospital (Figure 3.7).[116] Scandinavian practitioners such as William Nystrom, from Sweden's RCIG began practising in Melbourne from 1894 'held in high reputation by the medical profession'.[117]

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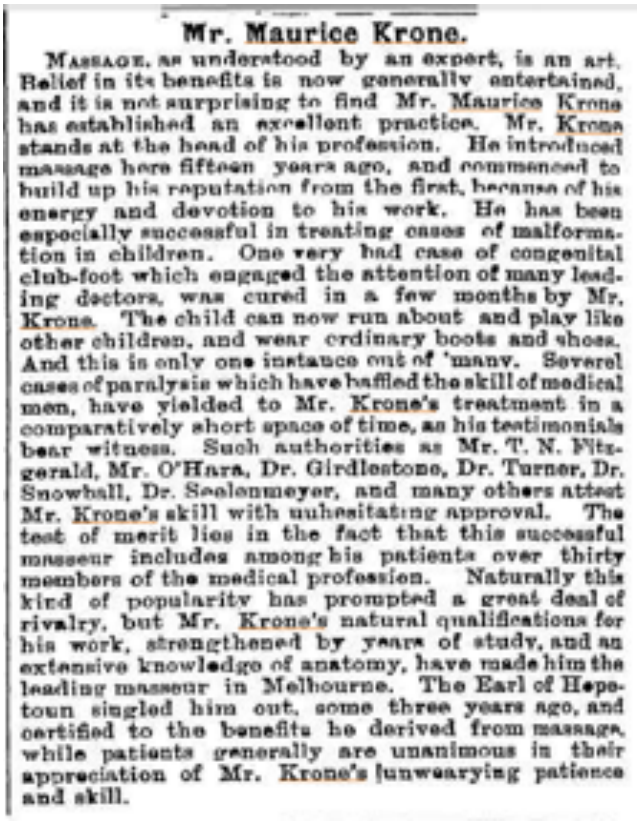
[111] Synapsis, "Short Comments on Current Things," *Australian Medical Journal* April(1879).179-180. Ibid.(1882). 167.
[112] "Local Subjects," ibid., no. August (1881). 383-384.
[113] Louis Henry, "Massage," ibid.August (1884). 337-338
[114] Philippa Martyr, "From Quackery to Qualification: Massage and Electrotherapy in Australia, 1870-1914," *The Electronic Journal of Australian and New Zealand History*, no. 3 March (1997). Citing *Intercolonial Journal of Medicine and Surgery*, 5 July 1900. xxv.
[115] Sara Delamont and Lorna Duffin, *The Nineteenth-Century Woman: Her Cultural and Physical World* (London: Routledge, 2012). 19-23.
[116] Maurice Krone reported as treating His Excellency the Governor, recommended by Dr Turner, the Governor's doctor. "Personal," *Table Talk*, 27 May 1892. 2. http://nla.gov.au/nla.news-article145709066 Accessed 18 April 2015. Alan Gregory, *The Ever Open Door - a History of the Royal Melbourne Hospital* (Melbourne: Hyland House 1998). 152.
[117] James Smith, *The Cyclopedia of Victoria*, vol. 2 (Melbourne: Cyclopedia Company, 1904). 153.



Mr. Maurice Krone.

MASSAGE, as understood by an expert, is an art. Belief in its benefits is now generally entertained, and it is not surprising to find Mr. Maurice Krone has established an excellent practice. Mr. Krone stands at the head of his profession. He introduced massage here fifteen years ago, and commenced to build up his reputation from the first, because of his energy and devotion to his work. He has been especially successful in treating cases of malformation in children. One very bad case of congenital club-foot which engaged the attention of many leading doctors, was cured in a few months by Mr. Krone. The child can now run about and play like other children, and wear ordinary boots and shoes. And this is only one instance out of many. Several cases of paralysis which have baffled the skill of medical men, have yielded to Mr. Krone's treatment in a comparatively short space of time, as his testimonials bear witness. Such authorities as Mr. T. N. Fitzgerald, Mr. O'Hara, Dr. Girdlestone, Dr. Turner, Dr. Snowball, Dr. Seelenmeyer, and many others attest Mr. Krone's skill with unhesitating approval. The test of merit lies in the fact that this successful masseur includes among his patients over thirty members of the medical profession. Naturally this kind of popularity has prompted a great deal of rivalry, but Mr. Krone's natural qualifications for his work, strengthened by years of study, and an extensive knowledge of anatomy, have made him the leading masseur in Melbourne. The Earl of Hopetoun singled him out, some three years ago, and certified to the benefits he derived from massage, while patients generally are unanimous in their appreciation of Mr. Krone's unwearying patience and skill.

Figure 3.7 Extolling the benefits of Krone's treatment.[118]

From 1895, 'Herr Heinrich Best, Electromasseur (Under patronage of several leading physicians), applies massage and electricity scientifically and effectively'.[119] German-born Best established his practice in 1893, spending decades as a sports physiotherapist, still practising in his eighties and dying aged ninety-eight (Figure 3.8).[120]

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[118] "Mr Maurice Krone," *Table Talk*, 10 July 1896. 20. http://nla.gov.au/nla.news-article145931446 Accessed 18 April 2015.
[119] "Advertising," *The Prahran Telegraph*, 23 November 1895. 4. http://nla.gov.au/nla.news-article144629887. Accessed 24 July 2014.
[120] Joan M McMeeken, "Our Longest Lived Pioneer " *InMotion* May(2016).

MASSAGE.—Herr Heinrich Best has established himself at Camden-street, Balaclava, as Masseur Medical Electrician, and teacher of Swedish gymnastics. This gentleman has undergone a careful training at the hands of competent specialists, and holds high class testimonials from Dr. C. A. Griffiths, M.R.C.S. and many other medical gentleman under whose supervision he has operated with pronounced success. Herr Best is also a first class active gymnast and has held the position of master of gymnastics at the Melbourne "Turn Verein" for a considerable period and still has classes for calisthenics at the above Institution. Having made gymnastics a special study, Mr. Best is thoroughly able to help to strengthen the physique delicate by active or passive gymnastics or if required in combination with the masso—electro treatment. We have no doubt that Herr Best will obtain extensive patronage, for as Dr. Th. St. Dowes, says "Massage is truly a factor of energy and the best tonic known."

Figure 3.8 Best c1905 (left). He begins his sustained commitment 1893 (right).[121]

Danish born Madame Frokjar had a Diploma from the College of Copenhagen and used the RCIG method. Frokjar commenced practice in Melbourne in 1901.[122] Locally trained women also practised: Eliza McAuley with her private practice and honorary work at the Melbourne Hospital from 1899.[123] Miss Meares practised at St. Vincent's and Annie Bowden at the Austin Hospital.[124]

Despite female participation and the acceptance of women in medicine at the University of Melbourne from 1887, the prevailing expectations for middle-class women were motherhood and nurturing, altruism and preparedness to

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[121] Photograph copyright Heinrich Best's descendants. "Chronicle, South Yarra Gazette, Toorak Times and Malvern Standard 12 August 1893. 5.," http://nla.gov.au/nla.news-article163665654.Accessed 11 October 2014. Australian Death Index.

[122] The Cyclopedia of Victoria, vol. 3. 153-154.

[123] Eliza McAuley in The Cyclopedia of Victoria,. vol. 2. 223.

[124] Bryan Egan, *Ways of a Hospital: St. Vincent's Melbourne 1890s-1990s* (St Leonards, NSW: Allen & Unwin, 1993). P263. Aura L Forster, "Physiotherapy in Australia," *Australian Journal of Physiotherapy* 15(1969); EW Gault and Alan Lucas, *A Century of Compassion a History of the Austin Hospital* (South Melbourne: MacMillan, 1982).178-179. Annie Bowden worked at Austin until nearly 80. Nancy Prentice (Ashworth), 31 May 1975.

care for the young, old and needy.[125] Volunteering was acceptable for middle-class women who formed benevolent societies, although their largesse generally benefitted the 'deserving poor'.[126] Men were enshrined as breadwinners, but medicine and physiotherapy were defying the convention with women working.[127] The physiotherapy women and men emphasised their medical connections, but prominent patients were also important.

Peters wrote.

> I have been fortunate enough to afford relief to a great number of patients suffering from a wide variety of diseases, and ... upwards of twenty prominent citizens, in proof of the soundness of my claims to public confidence in the exercise of my profession.[128]

Patients included University professors George Britton Halford, inaugural Dean of the Faculty of Medicine from 1876 and John Simeon Elkington, Professor of History.[129] Elkington wrote in 1890 following his fractured femur and subsequent stiff knee 'Acting upon the advice of Mr Girdlestone and Dr Theed, I ... placed myself in the hands of Mr Alfred Peters, with the result that I have, after six weeks' manipulation, recovered much of the natural motion of the joint'.[130] Such eminent connections would have benefitted Peters.

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[125] Stuart MacIntyre and Richard Selleck, *A Short History of the University of Melbourne* (Carlton: Melbourne University Press, 2003). 25-29. Kenneth Fitzpatrick Russell, *The Melbourne Medical School 1862-1962* (Melbourne: Melbourne University Press, 1977).48-49, 59, 74-77. Jacqueline Healy, *Strength of Mind: 125 Years of Women in Medicine Exhibition* (Melbourne: Brownless Medical Library, 2014).

[126] Janet McCalman, *Sex and Suffering, Women's Health and a Women's Hospital, Royal Women's Hospital, Melbourne, 1856—1996* (Melbourne: Melbourne University Press, 1999). 81-83.

[127] Grimshaw et al., *Creating a Nation 1788-2007*. 180-196.

[128] Peters, Massage, Its History. 34.

[129] Russell, *The Melbourne Medical School 1862-1962*. 217. Halford was Dean 1876-1886, 1890-1896. Norman Harper, "Elkington, John Simeon (1841–1922)," http://adb.anu.edu.au/biography/elkington-john-simeon-6100/text10451. Accessed 18 April 2014.

[130] Peters, Massage, Its History. 50.

Britain's early physiotherapists sought close relationships with medicine in order to suppress the prostitution scandal.[131] But Peters, not averse to medical referrals, also actively competed with medical men. In 1891 he was one of twenty-four practitioners, five masseurs and nineteen masseuses listed in the Victorian Census. By 1905, thirty-seven practitioners were listed.[132] One was Eliza Isabella Campbell McAuley, arguably the most celebrated pioneer woman physiotherapist in Victoria. McAuley, born in 1866 the daughter of Irish-born David and Sarah McAuley was educated at Grace Park House, a private college for upper middle-class girls. First employed as a governess, then for ten years with the Melbourne Tramway Company, following the 1890 depression McAuley perceived a more successful career as a masseuse.[133] McAuley sustained this career throughout her life, including when she moved to Healesville to her commodious guesthouse.[134]

Recognising the importance of a detailed understanding of the body, in the 1890s McAuley undertook anatomy studies with women medical students at the University of Melbourne, attended clinics run by surgeon Thomas Fitzgerald and practised at the Melbourne Hospital.[135] In 1901 Misses McAuley and Mead, Messrs Peters and Krone were listed as honoraries at the Hospital, which was then contemplating establishing a massage school. Honorary medical staff believed that apart from its therapeutic value physiotherapy

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[131] Nicholls and Cheek, "Physiotherapy and the Shadow of Prostitution.

[132] Martyr, *Paradise of Quacks.* 189. Provides the 1891 census data for non-registered healers. Martyr, "From Quackery to Qualification: Massage and Electrotherapy in Australia, 1870-1914."

[133] Smith, *The Cyclopedia of Victoria*, 2.

[134] Wendy Dowd (McAuley), *Healesville and Yarra Glen Guardian*, 25 February 1905. 2. 1905 'The Guardian.' Healesville and Yarra Glen Guardian 25 February. 2. 1931 'From Our Notebook.' Healesville and Yarra Glen Guardian 25 July. 1.

[135] W McAuley, "Oral History Record," (Australian Physiotherapy Association, 1987); C Smith, *Cyclopedia of Victoria* (Melbourne1905). 222-223. Patricia Cosh, "Eliza Mcauley Oral History Record " (1987); Forster, "Physiotherapy in Australia." "Grace Park House," https://www.onmydoorstep.com.au/heritage-listing/572/grace-park-house. "Obituary," *Healesville and Yarra Glen Guardian*, 30 May 1931. 3. http://nla.gov.au/nla.news-article60438092. Both accessed 19 November 2012.

would assist the more rapid emptying of beds.[136] McAuley had rooms in Collins Street's prestigious medical precinct next to Dr John Springthorpe's house and consulting rooms. Whilst McAuley enjoyed professional and social connections with Melbourne's elite, her School of Massage offered a nine-month course at the University Medical School and the Melbourne Hospital, as reported in *Table Talk*.[137]

Connections with John Springthorpe and the Hospital would be important for physiotherapy's development. He became a forceful advocate for physiotherapy. Springthorpe completed medicine, an MA and MD at the University of Melbourne (Figure 3.9). Springthorpe participated in successfully professionalising many disciplines - physiotherapy, dentistry, ambulance work, child welfare, mothercraft nurses' education and amateur cycling.[138]

Figure 3.9 John Springthorpe.[139]

When President of the Victorian Trained Nurses Association, Springthorpe relaunched their UNA Journal in 1903, which became the vital vehicle for

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[136] Minutes, Honorary Medical Staff, Melbourne Hospital Vol. 2, 14 June 1901 quoted in Gregory, *The Ever Open Door.* 123.
[137] McAuley, "Oral History Record." "Massage Class, Melbourne Hospital," *Table Talk*, 1 September 1904.Accessed 8 October 2015.
[138] Bryan Egan, "Springthorpe, John William (1855–1933)," http://adb.anu.edu.au/biography/springthorpe-john-william-8610/text15039. Accessed 25 February 2015.
[139] Brownless Medical History Museum MHM00674.

physiotherapy matters.[140] In 1906, in addition to university lecturing, he practised in his Collins Street rooms at the Alfred and Melbourne Hospitals.

The Melbourne Hospital opened in 1846, was the site for the Medical School's clinical studies when it commenced in 1862.[141] As Victoria's mid century gold rush expanded the population to 538,000, a Lying-in Hospital began in 1856, progressively adopting advances in obstetrics and surgery, nursing practice and training and antisepsis.[142] In 1870 the Children's Hospital opened.[143] A year later the Alfred Hospital commenced.[144] The Alfred also recognised physiotherapy when nurses received a demonstration by RCGI trained Miss Wohlfahrt.[145] In 1881 the Austin Hospital, then the Home for Incurables, opened.[146] Annie Bowden, a former pupil of Hall, commenced at the Austin in 1899.[147] By 1902 the Children's sought honorary physiotherapists, as did the Benevolent Asylum. [148] These major Melbourne hospitals that would later accommodate physiotherapy students also appointed medical electricians whose services became associated with their honorary physiotherapists.

Initially electrotherapy and radiography evolved together, beginning at the Children's Hospital in 1878.[149] The Alfred in 1889 appointed Stanley Argyle medical electrician and skiagraphist. Later Josephine Jennings (Chapter 5)

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[140] Springthorpe and Meyer instigated the journal from 1881-1885. Frank MC Forster, "Meyer, Felix Henry (1858–1937)," http://adb.anu.edu.au/biography/meyer-felix-henry-7565/text13203. Accessed 25 February 2015.
[141] Gregory, The Ever Open Door. 2, 34-53. Russell, The Melbourne Medical School.
[142] Geoffrey Serle, *The Golden Age: The History of the Colony of Victoria 1851-1861* (Melbourne: Melbourne University Press, 1963). 369. Grimshaw et al., *Creating a Nation.* 99-102. McCalman, *Sex and Suffering.* 4-9.
[143] Peter Yule, *The Royal Children's Hospital a History of Faith, Science and Love* (New South Wales: Halstead Press, 1999). 54.
[144] Mitchell, *The Hospital South of the Yarra.* 4-41. "The Alfred Hospital," *The Argus*, 27 June 1885. 10. http://nla.gov.au/nla.news-article6084599 Accessed 17 December 2013.
[145] "The Alfred Hospital," *The Argus*, 9 December 1889. 8. http://nla.gov.au/nla.news-article8577267 Accessed 17 December 2013. Wohlfahrt advertised in *the Argus.* 1891-1896.
[146] Gault and Lucas, *A Century of Compassion.* 1-19.
[147] Forster, "Physiotherapy in Australia." Gault and Lucas, *A Century of Compassion.* 178-179.
[148] Yule, *The Royal Children's Hospital*. 54. "Benevolent Asylum," *The Argus*, 5 April 1890. 10. http://nla.gov.au/nla.news-article8598951. Accessed 17 December 2013.
[149] Yule, The Royal Children's Hospital. 53-55.

worked with Argyle as honorary physiotherapist.[150] Such close medical/physiotherapy associations established a long-lasting practice.[151] Argyle, a future State Premier, had continuing involvement with the AMassA and the eventual Registration Board. His niece Nancy was amongst the first graduates.[152]

Physiotherapy had identified its areas of clinical practice and begun establishing itself as a medical ally with some of the functional attributes of professionalism comparable to medicine. By the beginning of the new century medical men were asserting themselves and their scientific status, claiming they no longer phlebotomised patients, used leeches or cantharides plasters, rarely scarified the skin, used cupping or prescribed emetics and other draughts.[153] The medical identity became progressively associated with laboratory science with scientific rhetoric improving status. Harley Warner considered that despite the performative aspects of medicine, its accompanying accoutrements and rhetoric of science, medical practitioners were 'buying time' whilst the patient's bodies healed themselves.[154] Physiotherapy effectively supported healing with massage, electrotherapy, hydrotherapy and remedial exercises. These became increasingly popular, employed by unorthodox and orthodox practitioners alike.[155] Three Victorian physiotherapists now sought to distance qualified practitioners from the quacks, thus setting physiotherapy on

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[150] Mitchell, The Hospital South of the Yarra. 155-159.
[151] Cynthia McLoughlin, Interview 16 November 2012; Ruth Grant and Patricia Trott, Interview 4 August 2014.
[152] 1911 "Wedding Bells", *Kalgoorlie Miner,* 11 August 1911. 1. http://nla.gov.au/nla.news-article91301722 Accessed 13 January 2016.
[153] Pensabene, *The Rise of the Medical Practitioner in Victoria*. 5-37. JE Neild, "Presidential Address," *Australasian Medical Gazette* January(1901). 3. As quoted in Gregory, *The Ever Open Door.* 93.
[154] John Harley Warner, "The Aesthetic Grounding of Modern Medicine," *Bulletin of the History of Medicine* 88(2014).
[155] Pensabene, *The Rise of the Medical Practitioner in Victoria*. 19, 127. Martyr, *Paradise of Quacks*.

a journey of professionalisation in the footsteps of medicine.[156] They also used the rhetoric of science.[157]

The aforementioned Hall with Peters and Best planned an association.[158] These men represented the different physiotherapy backgrounds from the apprenticed son Peters, Best with a probable heritage from RCGI and Hall. Educated at Bangalore College, Hall entered the Indian medical service in 1876, initially engaged in dispensing before studying chemistry, pharmacology, surgical anatomy with dissection, physiology, and pathology. Having arrived in Australia by 1888, Hall established his private practice with honorary appointments to the Austin Hospital and football clubs.[159] He worked closely with Fitzgerald and Springthorpe. Hall sought to raise physiotherapy standards, publishing a pamphlet advocating physiotherapy to aid physicians and surgeons. Hall's advertisements all claimed he treated patients under medical referral (Figure 3.10).[160]

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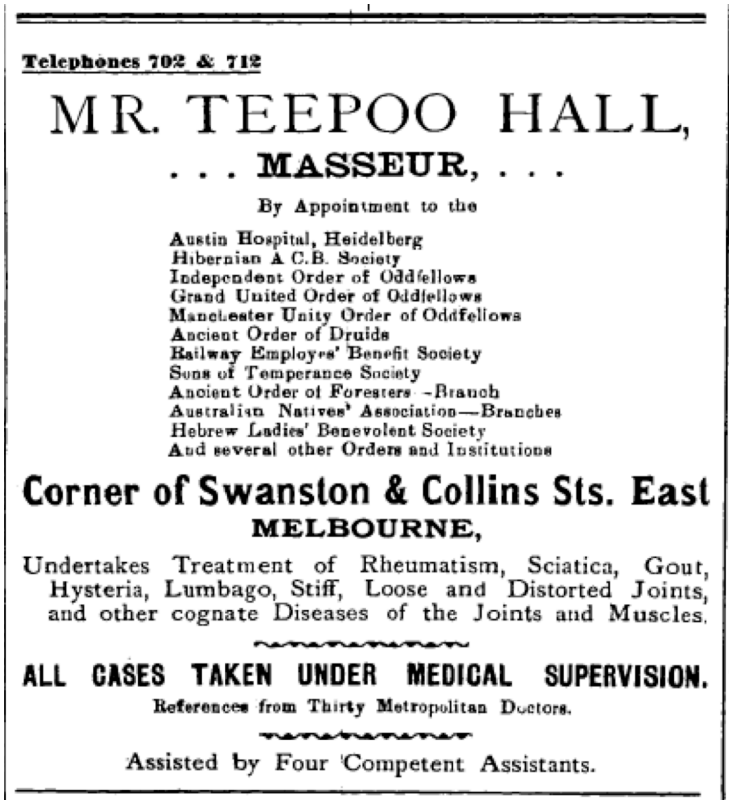
[156] Kevin Neil White, "Negotiating Science and Liberalism: Medicine in Nineteenth-Century South Australia," *Medical history* 43, no. 02 (1999).
[157] Joan M McMeeken, "A Colourful Personality," *InMotion* August(2016).
[158] Marriage to Mathilde Feige in1892, Australian Marriage Index. "Advertising," *The Prahran Telegraph*, 23 November 1895. 4 http://nla.gov.au/nla.news-article144629887. Accessed 24 July 2014.
[159] Hall 1901 appointed masseur to His Excellency the Earl of Hopeton, late Governor General of the Commonwealth of Australia. See "Australasian Massage Association 30 March Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1909). "Fitzroy Football Club," *Fitzroy City Press* 24 March 1905. 3. http://nla.gov.au/nla.news-article65652935 Accessed 10 October 2012.
[160] "Court Williamstown A.O.F.," *Williamstown Chronicle*, 4 July 1896. Hall appointed masseur to the Court. "Massage as an Aid to Medicine and Surgery," *Wodong and Towong Sentinel*, 20 November 1903.



Telephones 702 & 712

MR. TEEPOO HALL,

. . . MASSEUR, . . .

By Appointment to the

Austin Hospital, Heidelberg
Hibernian A.C.B. Society
Independent Order of Oddfellows
Grand United Order of Oddfellows
Manchester Unity Order of Oddfellows
Ancient Order of Druids
Railway Employes' Benefit Society
Sons of Temperance Society
Ancient Order of Foresters -Branch
Australian Natives' Association—Branches
Hebrew Ladies' Benevolent Society
And several other Orders and Institutions

Corner of Swanston & Collins Sts. East
MELBOURNE,

Undertakes Treatment of Rheumatism, Sciatica, Gout, Hysteria, Lumbago, Stiff, Loose and Distorted Joints, and other cognate Diseases of the Joints and Muscles.

ALL CASES TAKEN UNDER MEDICAL SUPERVISION.

References from Thirty Metropolitan Doctors.

Assisted by Four Competent Assistants.

Figure 3.10 Hall's typical advertisement.[161]

Springthorpe lectured to medical students on physiotherapy, dietetics and hygiene from 1886.[162] Students learned of physiotherapy's beneficial effects and 'its power for evil if ignorantly applied'.[163] Hall taught students about physiotherapy and doubtless received patient referrals from Springthorpe (Figure 3.11).[164]

[161] "Advertising." Darebin libraries 1898. 17.
[162] John W Springthorpe, *Therapeutics, Dietetics and Hygiene an Australian Text Book*, vol. 1 and 2 (Melbourne: James Little, 1914). Russell, *The Melbourne Medical School.* 72.
[163] "The Medical Students' Society," *The Argus*, 7 May 1887. 5. http://nla.gov.au/nla.news-article7860336. Accessed 17 December 2013.
[164] Springthorpe, *Therapeutics, Dietetics and Hygiene.* Includes extensive physiotherapy information.

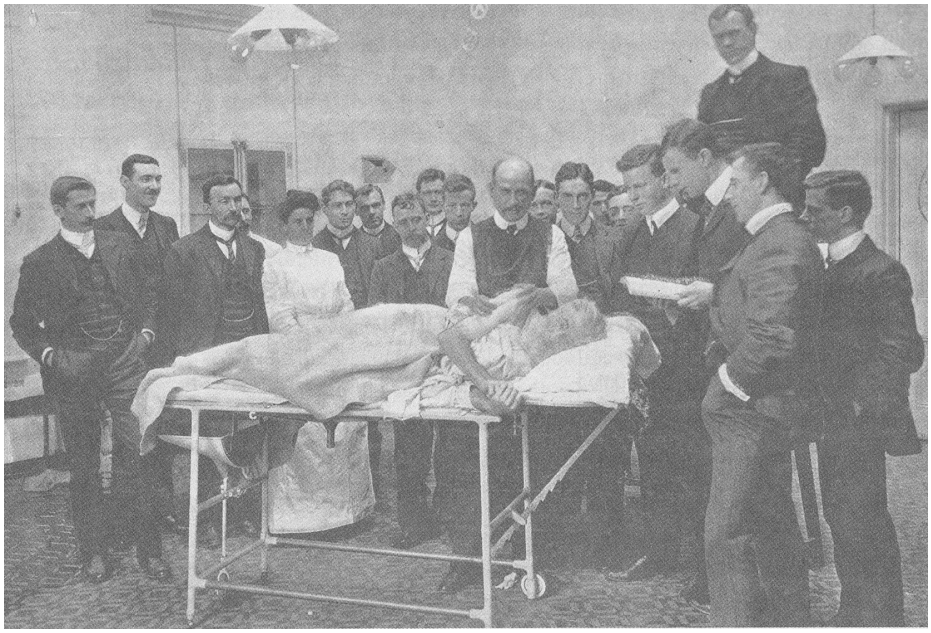


Figure 3.11 Teepoo Hall teaching medical students.[165]

Occurring concurrently in Britain and as would later be repeated in North America and elsewhere, this chapter has demonstrated the increasing importance of scientific knowledge and alliances between physiotherapy and medicine.[166] Physiotherapy's recognition by other influential persons and the potential for educational connections with the University and the Melbourne Hospital began.[167] These relationships, part of an emerging identity, set the scene for the professionalisation of physiotherapy in Australia. The following chapter focuses on the developments of an association and formal physiotherapy education.

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[165] *Weekly Times* 30 September 1905. 12.
[166] Linker, "Strength and Science: Gender, Physiotherapy, and Medicine in Early-Twentieth-Century America."
[167] Re Peters see Punch (Melbourne) 6 October 1916. APA History Collections APAH2012/16:Box 1.

Chapter 4 Science and the making of Physiotherapy at Melbourne

> *Until some twelve months ago neither the public nor the medical profession could place any certain reliance upon its practitioners as a class ... no medically recognised standard of training, of examination, or even of competency. ... The time was thus ripe for a step forward, and the situation found the man in the shape of our worthy Secretary, Mr Teepoo Hall.*[1]

Physiotherapy's professionalisation and its scientific education benefitted from its medical patrons. As physiotherapy's identity developed through these processes, the generous contributions of some individuals who made important commitments are clear, but many who gave their time as clinical teachers or honorary physiotherapists have left no record but provided role models for those that followed. The pioneers had a particular physiotherapist in mind who required the world's best physiotherapy education associated with the University of Melbourne and its teaching hospitals. The new physiotherapist would embody the latest medical, scientific and physiotherapy knowledge: anatomy, physiology, natural philosophy, Swedish remedial exercises, massage and medical electricity, combined with clinical skills. Furthermore the new physiotherapist would be recognised and respected by medical colleagues, the public and through legislation, the State.

In 1906 the first students commenced a new course established by the recently formed AMassA in conjunction with the University of Melbourne. *The Argus* reported that from 1 August 1906 all applicants to the new Association had to complete 'the prescribed course of university and hospital training'.[2] The curriculum included two years of specialised training following a good general

[1] John Springthorpe's 1907 presidential address, Annual Meeting of the Australasian Massage Association. "Australasian Massage Association 30 March Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1907).
[2] Sheba, "The Masseuse," *The Argus*, 18 August 1906. 5. http://nla.gov.au/nla.news-article9654362. Accessed 17 December 2013.

education. Dissection enabled the student 'who is massaging the disabled leg or arm of a hospital patient an opportunity of examining a corresponding limb on the dissecting table'.[3] Visiting a clinic the journalist observed electrical and hydrotherapy equipment and noted characteristics already embodied in physiotherapists' identities - full of energy and vitality and treating each patient as an individual.

Hall had organised Peters and Best to meet in Peters' rooms in February 1905 to form a Victorian association.[4] Thus according to the criteria of sociologists such as Freidson, physiotherapists began to undertake their first steps in professionalisation.[5] The following December, Hall convened a meeting to consider an Australian association, enlisting Springthorpe to preside.[6] At the December meeting letters from prominent medical men and physiotherapists supported forming an association whose objects were:

> to establish a system of registration, ... a uniform system of training and examination, to be of such standard as may be decided on by the medical profession and the executive of the association, and to promote the interests of the massage profession.[7]

The provisional committee appointed to frame a constitution comprised Drs Springthorpe, Macgillicuddy and MacGibbon, Messrs Grundt, Best, Pascal, Peters, Robertson, Doyle, Kyte, and Moody, Mesdames Frokjar, Hacke and Vahland, with Misses McAuley, Robertson, Meares and Mortyn. Following the first general meeting in February 1906, next month a Sydney meeting agreed to amalgamate organisations with similar objects from Sydney, Melbourne and Adelaide.[8] (Western Australia, Tasmania and New Zealand would later join.)

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[3] Ibid.
[4] Peters, "Alfred Peters Oral History Record."
[5] Freidson, Profession of Medicine. 69-70.
[6] "An Association of Masseurs," *The Register*, 30 December 1905. 6. http://nla.gov.au/nla.news-article55658213. Accessed 15 August 2014.
[7] Australian Physiotherapy Association History Collections University of Melbourne Archives APAH2012/16:Box 1. Newspaper cutting 1905 *The Advertiser* (Adelaide) 30 December. 10.
[8] "Australasian Massage Association 30 March Report." 7. Hall invited Springthorpe to lead the Association in Victoria, "Australasian Massage Association 29 June Report," *UNA*

Sydney-based son of Mathias Roth, Dr Reuter Roth, medical practitioner and leading masseur who became the first president of the New South Wales branch of the AMassA, successfully proposed the motion to amalgamate.[9] The aims of the Association were confirmed. The first Federal Council comprised the Victorian Branch Committee of Dr John Springthorpe (President), Dr Hugh Murray (Vice President), Teepoo Hall (Secretary), Heinrich Best (Treasurer), and members Dr Bernhard Zwar, Messrs Lars Grundt, William Nystrom, Alfred Peters and Misses McAuley and Meares.[10] The physiotherapists deferred to medical men such as Springthorpe to build on his extensive previous experience in developing professions and to ensure the patronage from the medical faculties at the Universities of Melbourne, Sydney and Adelaide. These medical academics would facilitate and conduct education in the biomedical sciences, support the Association and increase physiotherapists' status through association. Eminent surgeon Sir Thomas Fitzgerald became patron.[11]

The next step in professionalisation in Victoria, education, moved swiftly. Registered medical practitioners appointed by the Council, certified the fitness of potential students, thus influencing their selection. Professor Richard Berry, new professor in anatomy and Professor William Osborne in physiology at the University, approved the two-year course. First year students would study junior anatomy with dissection, physiology, theory and practice of medical gymnastics and Swedish movements. Students passing all examinations then studied senior anatomy, medical electricity, theory and practice of massage (physiotherapy) and bandaging. Students would attend physiotherapy practice

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(Journal of the Victorian Trained Nurses' Association) (1907). 52. "Australasian Massage Association 30 June Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1906). 7. For Frokjar see Smith, *Cyclopedia of Victoria*. Vol. 3. 153-154.

[9] Roth trained in medicine, University College London, emigrated to Sydney and registered in 1883 advocated Ling's gymnastics like his father Mathias. "Australasian Massage Association 30 June Report." 7.

[10] Ibid. "Australasian Massage Association 30 March Report." 7.

[11] Appointment of Fitzgerald. "Topics of the Day," *The Advertiser*, 27 February 1908. 4. http://nla.gov.au/nla.news-article5126799 Accessed 15 February 2015. Russell, *The Melbourne Medical School.* 48-49, 74-77.

at a hospital recognised by the Council for twelve months. Those passing all exams and fulfilling the prescribed conditions would be admitted to the Diploma of the AMassA.

Subjects were detailed: 'Junior Anatomy comprised thirty-four lectures on bones, ligaments, joints and muscles with special reference to massage, illustrated by recent dissections, wet and dry preparations, anatomical specimens and diagrams. Students were to perform dissections'. [12] University subjects were modelled on the new 1906 medical course.[13] Indeed, physiotherapy's two years shared components of years two and three of medicine. The physiotherapy students would undertake clinical training in the hospitals, as was newly compulsory for medical students.[14] With Berry and Osborne's support, the course was soon established. In May 1906 the Victorian Council appointed lecturers Dr Herbert Hewlett in Physiology and Dr Hugh Murray in Medical Electricity. Whilst physiotherapy students would benefit from the same scientific knowledge as medicine, Norwegian-born physiotherapist Lars Grundt, using Ling's approach, would teach Medical Gymnastics and McAuley, Clinical Practice (Figure 4.1).[15] The University appointed Dr Septimus Strahan anatomy demonstrator and Dr Colin Mackenzie lecturer in Theory and Practice of Massage.[16]

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[12] "Australasian Massage Association 30 March Report." 7. Registrar's Office Correspondence, "University of Melbourne Archives No. 38 Massage Students," (University of Melbourne, 1906). Teepoo Hall forwards proposed course and a copy of a memorandum from Professor Wilson at Sydney University. Hall suggests Berry communicate with Springthorpe 11.5.1906. Letter to Berry from Hall. Professor Laby, natural philosophy participated in discussions.
[13] Russell, The Melbourne Medical School. 98-117.
[14] Ibid. 102-103.
[15] "Australasian Massage Association 30 May Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1906). 39. Grundt, born in Norway in 1861 married physiotherapist Beatrice Jane Firth in Australia in 1897. He suicided in 1909. Information from ancestry.com and "Casualties and Fatalities. Masseur's Suicide," *The Argus*, 3 February 1909. 8. http://nla.gov.au/nla.news-article10701972 Accessed 7 September 2012.
[16] "Australasian Massage Association 30 June Report." 55. Colin Mackenzie developed muscle re-education required in poliomyelitis and nerve injury rehabilitation. Professor Sir William Colin Mackenzie. KB, MD, FRCS, FRS (Edinburgh), (1877 – 1938) director and founder Australian Institute of Anatomy, Canberra, research pioneer, eminent teacher, authority on Australian anthropology and biology. In Monica MacCallum, "Mackenzie, Sir William Colin

Figure 4.1 Eliza McAuley.[17]

These early appointees established traditions of rigorous scientific foundations and contributed to additional aspects of physiotherapy's development as will be noted in the chapters that follow. Edinburgh's traditions of medical education influenced the course. Hewlett completed his medical studies at Melbourne and Edinburgh.[18] Murray, another University of Edinburgh medical graduate with a certificate in massage from an extramural school of medicine in Edinburgh, had studied under 'Kelengren' (*sic*), the 'well-known author' of a work on massage and Swedish movements.[19] Murray had oversight of physiotherapy at the Melbourne Hospital and would become a member of the Registration Board. Grundt would embed the Swedish system of remedial gymnastics until

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(1877–1938)," http://adb.anu.edu.au/biography/mackenzie-sir-william-colin-7392/text12831. Accessed 20 July 2012.

[17] Smith, *Cyclopedia of Victoria*. 223.

[18] Yule, *The Royal Children's Hospital*. 54. See also Malcolm McKeown, "Hewlett, Herbert Maunsell (1872–1957)," Australian Dictionary of Biography, Australian National University, http://adb.anu.edu.au/biography/hewlett-herbert-maunsell-6655/text11281. Accessed 9 October 2014.

[19] Misspelling of Kellgren. See Cyriax, *The Elements of Kellgren's Manual Treatment*; Edgar F Cyriax, "Henrik Kellgren and His Methods of Manual Treatment," *The Boston Medical and Surgical Journal* 157, no. 15 (1907). Ottosson, "The Manipulated History of Manipulations." Edinburgh's private extramural schools emphasised short practical skills training and specialist diplomas for army entry or needs of the empire. Mamatha Oduru, "Extramural Medicine and the Rise of Universities: The Case of Edinburgh, 1790-1840 and 1895-1948" (2005). Australian Physiotherapy Association History Collections APAH2012/16:Box 1.

his untimely death in 1909.[20] Strahan, a Melbourne educated medical practitioner, like the aforementioned men would continue supporting the AMassA through his teaching and lectures to members. Young Mackenzie, then developing muscle re-education required in poliomyelitis and nerve injury rehabilitation, was embarking on a spectacular career. Mackenzie would represent the associationa and play a significant role in the First World War. Professor Sir William Colin Mackenzie KB, MD, FRCS, FRS became director and founder of the Australian Institute of Anatomy, a research pioneer, eminent teacher and authority on Australian anthropology and biology.[21]

Sydney and Adelaide commenced courses in conjunction with their state universities in 1907 and 1908 respectively, hosting the national conference those years. In turn, each state council became responsible for the Association's affairs, but the content of available reports substantially reflected the Victorian branch, including the Melbourne course. Sydney had Reuter Roth's support for New South Wales's (NSW) course and later as honorary medical officer responsible for the medical gymnastics department at the Royal Prince Alfred Hospital.[22]Rivalry and disagreement were to emerge between NSW and Victoria, but meanwhile Victoria forged ahead. A modified course would ensure existing practitioners' knowledge was up-to-date in the University subjects.[23]

The University of Melbourne Council meeting on 11 June 1906 had received Professor Berry's letter ‘reporting negotiations with the Australasian Massage Association for the provision of special teaching for Massage Students at the

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[20] Grundt married physiotherapist Beatrice Jane Firth in Australia in 1897. Information from ancestry.com and "Casualties and Fatalities. Masseur's Suicide." 8. http://nla.gov.au/nla.news-article10701972 Accessed 7 September 2012.
[21] "Australasian Massage Association 30 June Report." 55. See MacCallum, "Mackenzie, Sir William Colin (1877–1938)". http://adb.anu.edu.au/biography/mackenzie-sir-william-colin-7392/text12831Accessed 20 July 2012.
[22] "Australasian Massage Association 30 May Report." 39. Vaness Witton, "'Medical Gymnastics, Massage and Electricity' How Physiotherapy Came to Rpa," *RPA Heritage News* 6, no. 2 (2015).
[23] "Australasian Massage Association 30 June Report." 55.

University'.[24] Council approved arrangements for lecturers, fees and the modified course.[25] As matters consolidated, the Association elected Professors Allen, Berry and Osborne as honorary members and registered Hugh Murray as a masseur.[26]

In their quest for medical patronage for the Association and education, physiotherapists permitted progressive medical control. Peters, who treated significant public figures including ballerina Anna Pavlova, Prime Minister Billy Hughes and Australian test cricket captain Warwick Armstrong, resigned from the Council, for several possible reasons.[27] Peters taught students and may have lost potential students to the new course, which became a requirement for AMassA membership. Furthermore he probably disagreed with medical referral, medical dominance of the Council and perhaps Murray's membership. I will refer further to this matter.[28] In March 1906 Murray supported the Association's commitment to continuing education and self-improvement with the first monthly lecture on X-rays.[29] The University's professors provided lectures to members, such as Berry's 'Muscles in health and disease'.

Members' commitments to receiving updates in theoretical and clinical knowledge, a further hallmark of professionalism, would be likely to benefit patients and students who received members' expertise in clinical teaching. Council lobbied the Melbourne and Alfred Hospitals' management committees regarding facilities in their massage departments and training of future

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[24] "Council Meeting 11 June Minutes," (University of Melbourne, 1906). 217-218.
[25] "Council Meeting 20 July Minutes," (University of Melbourne, 1906). 227. Springthorpe's letter Correspondence, "University of Melbourne Archives No. 38 Massage Students." 12 May, 2 June.
[26] Melbourne had Edinburgh's tradition of rigorous academic and clinical training. See Lisa Rosner, *Medical Education in the Age of Improvement. Edinburgh Students and Apprentices 1760-1826* (Edinburgh: Edinburgh University Press, 1991). Jordanova, "Has the Social History of Medicine Come of Age?."
[27] "Australasian Massage Association 30 April Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1906). 55.
[28] "Australasian Massage Association 30 June Report." 55.
[29] "Australasian Massage Association 30 April Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1907). 26.

practitioners.[30] Setting a pattern that would be sustained for a century, suitable arrangements allowed students to learn, but unlike medical students to also contribute to patient treatment. Furthermore, until the 1930s the hospitals would receive free physiotherapy services. Additionally, in an example of Mauss's cycle of giving and for the whole period described in the thesis, generations of clinical physiotherapists would give their knowledge to students.[31] In 1906 the Melbourne Hospital advertised for AMassA members, five masseurs and ten masseuses, who would treat patients referred from physicians and surgeons. Each practitioner would give two hours on alternate days. Those volunteering to also be clinical teachers would provide an additional hour continuing to supervise student treatments.[32]

Such arrangements for education were thus beneficial beyond the emerging physiotherapy profession. Indeed, for the University of Melbourne, whose finances were compromised, it provided a valued income stream through fees. In 1901 the University accountant Frederick Dickson embezzled nearly £24,000. Reputational damage occurred and belt-tightening was required.[33] Nevertheless, the anatomy and physiology professors each earned £800 for 1906.[34] The Council unsurprisingly approved Berry's physiotherapy fee arrangements, for example first and second year anatomy, each eight guineas, surface and senior practical anatomy, each four guineas.[35] Physiology had

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[30] "Australasian Massage Association 30 July Report," *UNA (Journal of the Victorian Trained Nurses' Association)* 30 July(1906). 74-75. See also Pensabene, *The Rise of the Medical Practitioner in Victoria.* Ross L Jones, *Humanity's Mirror 150 Years of Anatomy in Melbourne Department of Anatomy and Cell Biology* (Victoria: Paddington Press, 2007). Springthorpe's illuminating account of medical practice and Melbourne's social conditions in Springthorpe, *Therapeutics, Dietetics and Hygiene*.

[31] Marcel Mauss, *The Gift* (New York: W W Norton, 1967). See also Claude Lévi-Strauss, "The Principle of Reciprocity," in *The Gift: An Interdisciplinary Perspective*, ed. Aafke E Komter (Amsterdam: Amsterdam University Press, 1966).

[32] "Australasian Massage Association 30 July Report." 74-75. "Australasian Massage Association 29 September Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1906). 102.

[33] MacIntyre and Selleck, A Short History of the University of Melbourne. 42-45.

[34] "Council Meeting 10 June Minutes," (University of Melbourne, 1905). 60.

[35] Report of Springthorpe as Dean, Faculty of Dentistry "Council Meeting 6 March Minutes," (University of Melbourne, 1905). 4.

similar arrangements, although another lecturer was unnecessary, as students would share lectures with dental students and receive an additional six special lectures.[36] Medical students paid twenty guineas a year. [37] Each physiotherapy student paid university fees of £33/4/- for the two years of which the university would make nineteen guineas profit. The University would no doubt have been pleased too with the modified course, which attracted more than forty participants paying five guineas for each subject.[38] Fees for physiotherapy subjects were £7/5/- with physiotherapists who taught being paid little, giving much of their time in a volunteer capacity, thus establishing a component of physiotherapy's sustained identity.[39] Perhaps initially, buoyed by the swift success of their plans, physiotherapists expected many medical referrals of private fee-paying patients.

Enthusiasm of medical men like Septimus Strahan involved with the AMassA's formation and the course establishment justified that conclusion. Lecturing on the especial value of physiotherapy in neurasthenia, Strahan endorsed Ling as developing the treatment's exercise components. Strahan praised the scientific curriculum 'without which no profession can possess the confidence of the public so essential to its success'. He assured members of the sympathy of 'the whole of the medical profession'.[40] Springthorpe noted that the 'curriculum was admitted to be second to none in the world'.[41] Berry too rejoiced

> In the interests of Science, to see ... Australia is one of the first, ... the very first, amongst the nations of the world to place massage on

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[36] "Council Meeting 11 June Minutes." 217-218.
[37] "Council Meeting 10 June Minutes." 60.
[38] "Council Meeting 20 July Minutes." 227.
[39] Correspondence, "University of Melbourne Archives No. 38 Massage Students." Alison McArthur Campbell, "Oral History Record," (Australian Physiotherapy Association, 1978).
[40] "Australasian Massage Association 30 August Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1906). 90-93. The 1904 Fink Commission strongly promoted the practical application of scientific knowledge, recommending the Australian College of Dentistry's (established 1898), 1905 affiliation with the University. MacIntyre and Selleck, *A Short History of the University of Melbourne.* 45-46, 51.
[41] Ibid. 94.

> its proper footing, namely a scientific one, ... I rejoice still more to see that the Association has placed anatomy in its correct relationship to massage – that is, in the very forefront of its curriculum.[42]

Science would continue as a founding discipline in Australian physiotherapy education, now heralded as the Association posted information to universities and all national Consuls in Melbourne.[43]

Edith Pratt, the first student of twelve expected applicants, had a lifelong engagement with physiotherapy education, influencing several generations of physiotherapists.[44] As this story is traced the impact of an ethos of service on physiotherapy leaders becomes apparent. Pratt matriculated from the Methodist Ladies' College, a fee-paying private girls school.[45] Her background reflected many physiotherapy students. Her accountant father supported Edith's eldest sister, Agnes to complete Bachelors and Masters of Arts studying at Melbourne, London, and Oxford universities and in France. Returning to Victoria Agnes became Head Mistress of Girton, Church of England Girls Grammar School, then Morongo Presbyterian Girls' School.[46] Second daughter, Edith stayed home until funds enabled her to attend university where, aged twenty-eight, she began physiotherapy.[47] Hall recorded a letter from the University when Pratt (with distinction) and Bertha White passed Junior Anatomy.[48]

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[42] "Australasian Massage Association 30 October Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1906). 121.
[43] Ibid. 119.
[44] "Oral History Record." Pratt was already studying with McAuley. "Australasian Massage Association 30 May Report." 39.
[45] Ailsa G T Thompson Zainu'ddin, *They Dreamt of a School a Centenary History of Methodist Ladies' College Kew 1882-1992* (Melbourne: Hyland House, 1982). Janet McCalman, *Journeyings: The Biography of a Middle-Class Generation 1920-1990* (Carlton, Victoria: Melbourne University Press, 1995).
[46] Doreen Cowperthwaite, *Morongo; the First Fifty Years a History of the Presbyterian Girls' College, Geelong, Victoria, Australia* (Melbourne: Lothain, 1969). 20, 92.
[47] Australian Electoral Rolls. McArthur Campbell, "Oral History Record."
[48] "Australasian Massage Association 31 December Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1906). 151.

Achievement in science was thus established as the aspirational term 'profession' appeared in AMassA reports. Members demonstrated additional professional hallmarks with a national Association, examination of potential members, education within the University and its teaching hospitals, an armamentarium of clinical techniques and opportunities to update knowledge.[49] State registration eluded them and to ensure medical support members relinquished professional autonomy. However with education a core professionalisation strategy, as expected of professionals they maintained current knowledge through the modified course and monthly lectures. Medical practitioners delivered many, providing opportunities for them to remind members to

> always operate under the advice and sanction of a fully qualified medical practitioner, to learn the indications and contraindications for massage use and to be aware of the risk that in some countries the practice of massage has fallen into disrepute by the folly … of those that have been engaged in the practice.[50]

Physiotherapists also delivered lectures to members. Mary Macpherson, a member of the AMassA and Britain's STM, spoke on 'Medical Gymnastics', useful 'to restore lost or diminished functional power, ... in acute and chronic cases and, in preparation for surgery, in teaching deep breathing'.[51]

The Melbourne course enrolled seven women in 1907. Although more men enrolled in 1908, until the 1990s a higher proportion of women would enter

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[49] Freidson, "The Changing Nature of Professional Control."; "Theory and the Professions."; Victoria Jane Sparkes, "Profession and Professionalisation: Role and Identity of Undergraduate Physiotherapy Educators," *Physiotherapy* 88(2002); "Profession and Professionalisation: Professionalism within Academia," *Physiotherapy* 88(2002). Hall assessed Catherine Bieka in Tasmania suitable for AMassA membership. "A Massage Association," *Daily Telegraph*, 2 February 1907. 3. http://nla.gov.au/nla.news-article151707148 Accessed 20 April 2015.

[50] "Australasian Massage Association 30 October Report." 126. This referred to London's 1894 scandal. See also "Australasian Massage Association 30 November Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1906). 142.

[51] "Australasian Massage Association 31 December Report." 150.MA McPherson, "Medical Gymnastics," ibid.(1907). 167. "Australasian Massage Association 30 March Report," ibid. 4-6.

physiotherapy. Many perceived physiotherapy as a respectable path to independence whereas society believed middle-class women would have the ongoing support of their fathers. They did not need to earn much money. This, as I will demonstrate, was not the reality for many.

Eliza McAuley though had achieved success. She was forty years old and had practised some ten years and conducted her own course when the AMassA prevailed upon her to provide clinical teaching. Doubtless other factors in her appointment included her university studies in anatomy, her appointment as honorary physiotherapist at the Melbourne Hospital with connections to Sir Thomas Fitzgerald, and her professional and social position.[52] She treated the Governor's wife, Lady Hopetoun and when McAuley built 'Woodlands' in rural Healesville and later moved there, her reputation attracted patients such as Sir Alfred Stirling as a child, and she run a salubrious sanatorium/guesthouse.[53] In 1907, with her Collins Street practice, teaching was not a 'money-making concern'.[54] Her graduates would have aspired to be as successful as McAuley. However making money from physiotherapy practice was difficult, complicated by the inter-related issues of requiring medical referrals and preventing competition from unqualified practitioners.

Medicine had also had difficulty distinguishing themselves from the unqualified and in persuading politicians to privilege medical practitioners. Their Medical Defence Association 'solely aimed at protecting the economic and political interests of the profession, applying political pressure for favourable legislation'.[55] The AMassA tried to protect member's reputations and exclusive practice, instructing a solicitor concerning a practitioner in

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[52] "Australasian Massage Association 30 March Report." 6. Smith, *The Cyclopedia of Victoria*, 2. 222-223. McAuley, "Oral History Record."

[53] . 2. http://nla.gov.au/nla.news-article60042913. "From Our Notebook," Healesville and Yarra Glen Guardian, 25 July 1931. 1. http://nla.gov.au/nla.news-article60438348 McAuley left an estate valued at more than £4000 in 1931 when the male basic wage was about £200 per year and females £100. "Wage Rates," *The Sydney Morning Herald*, 9 February 1934. 13. http://nla.gov.au/nla.news-article17046777. All accessed 9 July 2012.

[54] "Australasian Massage Association 30 March Report." 6.

[55] Pensabene, The Rise of the Medical Practitioner in Victoria. 108.

Hobart erroneously claiming connection to the Melbourne Hospital.[56] Erecting occupational borders in a further professionalisation mechanism, the Association was prepared to take legal action to secure members' positions as the legitimate practitioners. As Saks has identified, legitimacy and protection of their occupation, components of professionalisation along with status, brought with it an expectation of a reasonable income.[57]

A further challenge to making money concerned their honorary work in the charity hospitals. Tension between altruistic community good and an adequate income stressed many physiotherapists. Springthorpe advised that as professionals free treatment was expected from this 'important subdivision of medicine', whilst repeatedly reminding practitioners to remain under medicine's aegis.[58] Referral by medical practitioners was a condition of AMassA membership, the first ethical requirement. Furthermore 'unprofessional advertising would disqualify from membership'.[59] Medicine had firmly stamped its authority with these ethical principles.

Whilst physiotherapists enjoyed the status by association with medicine, histories of early graduates indicate few received adequate financial benefits.[60] However their work provided therapeutic benefits to their patients. At a time when medicine could offer little Springthorpe noted that physiotherapists cured problems by increasing circulation, strengthening muscle, breaking down adhesions, improving metabolism, affecting the nervous system, and restoring symmetrical and normal development. Thus Springthorpe reinforced

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[56] The outcome is not stated. "Tasmania," *Daily Telegraph*, 31 January 1907. 5. http://nla.gov.au/nla.news-article151696066 Accessed 20 April 2015. "Australasian Massage Association 28 February Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1907). 182.

[57] Mike Saks, "The Wheel Turns? Professionalisation and Alternative Medicine in Britain," *Journal of Interprofessional Care* 13(1999).

[58] "Australasian Massage Association 30 March Report." 11.

[59] "Australasian Massage Association 30 May Report." 35.

[60] Vair Horwood, "Oral History Record," (Australian Physiotherapy Association, 1979); Edith Adair, "Oral History Record," (Australian Physiotherapy Association, 1978); Floris Chilvers (Wiseman), "Oral History Record," (Australian Physiotherapy Association, 1978).

physiotherapy's curative treatment whilst medicine waited for nature to heal. He applauded 'the greatness of physiotherapy's service to medicine'.[61]

In the Association's first year significant progress in professionalisation had occurred. The University in conjunction with the public hospitals became the only recognised place for training.[62] Springthorpe, citing Berry and Osborne's strong support and the help of the University, advised, 'we propose asking the University to take over the diploma'.[63] University men already taught all subjects except remedial gymnastics and physiotherapy clinical practice and the University offered similar diplomas combining academic science and work-based practice.[64] Members must have been elated at this possibility of achieving a key professional goal to establish physiotherapy formally within the University's educational structure. The Annual General Meeting on 25 April 1907 of 'the first federated professional body in Australasia' would have proceeded with considerable self-satisfaction.[65]

The anticipated acceptance by the University did not occur and as this thesis identifies, physiotherapists' quest for the University's full acceptance took eighty-five years. The Faculty of Medicine blew hot and cold. On 7 May 1907 the University Council noted: 'a report was received from the Faculty of Medicine, stating that it disapproved of the institution of a University Diploma of Massage. This report was adopted'.[66] The AMassA made no mention of this devastating blow. It is possible that Peters, who would later endeavour to distance physiotherapy from University control, influenced his old patient, George Halford in this matter. The outcome is inexplicable with the previously

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[61] "Australasian Massage Association 30 May Report." 35.
[62] Ibid. 35-36.
[63] "Australasian Massage Association 30 March Report." 6.
[64] Registrar's Office 8 and 28 February Correspondence, "University of Melbourne Archives No. 30 Massage Students," (University of Melbourne, 1907).
[65] "Australasian Massage Association 30 March Report." 11. Australian branch of the BMA formed 1907. Pensabene, *The Rise of the Medical Practitioner in Victoria.* 112.
[66] "Council Meeting 7 July Minutes," (University of Melbourne, 1907). 332. Brookes Allen wrote to the Registrar's office Registrar's Office 6 May Correspondence, "University of Melbourne Archives No. 30 Massage Students," (University of Melbourne, 1907).

stated strong support of the Dean Harry Brookes Allen, Berry, Osborne and Springthorpe. Extant records do not provide any answer.

During the remainder of 1907 the AMassA Council discussed the sequencing and content of subjects including recommending specific up-to-date physiotherapy texts. Truls Johan Hartelius, immediate successor to Branting at the RCIG wrote about the Swedish system.[67] American medical practitioner and holistic health promoter, John Harvey Kellogg visited Sweden and his subsequent book detailed aspects of biomedical science and Ling's 'excellent system of medical gymnastics'.[68] Furthermore Australian education, an English medical practitioner considered

> was far ahead of the Old Country ... (masseuses), would be completely out of the running with the masseurs and masseuses qualified by the severe course laid down by the Australasian Massage Association ... (they) ... might be followed in England with great advantage.[69]

Victorian member, Ada Rundell wrote from England 'we are greatly in advance of the English Association with regard to training. ... They hold separate exams ... and they do not admit men'.[70] Although Scandinavia had comprehensive education and examination in exercise and massage, only Australia then included electrotherapy.[71] Australia included all physiotherapy elements, despite Sydney-based Dr Charles Blackburn's proposal for one year spent studying massage, and another year electricity, hot air, medical

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[67] Truls Johan Hartelius, *Swedish Movements or Medical Gymnastics*, trans. Alfred B Olsen (Modern Medicine Pub. Co.: Battle Creek, Mich., 1896). v-vii.
[68] Kellogg, The Art of Massage. v.
[69] "Australasian Massage Association 30 December Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1907). 155.
[70] "Australasian Massage Association 30 August Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1908). 83.
[71] Sudmann, "(En) Gendering Body Politics; Ottosson, "When the Orthopedist Was a Physical Therapist."

gymnastics and baths. His proposal caused a schism in the Association.[72] Victorians considered the maintenance of educational standards and protecting their body of knowledge clear priorities. At the first meeting in 1908, Berry thoroughly condemned Blackburn. Furthermore, Hall reported an AMassA member had offered to teach massage to nurses: Hall 'notified the public that such teaching was not recognised'.[73] Challenges to the integrity of physiotherapeutic knowledge and the rigour of its teaching threatened its fledgling professionalism causing significant concern - any private teaching 'would open the door to all sorts of abuses'.[74]

Thus with the strong support and advocacy of university professors and leading medical men the Association had achieved an excellent educational programme. The importance of science in the context of the time, with medical men emphaissing its importance as an epistemological hallmark, had been adopted. The medical practitioners and hospitals received physiotherapy skills and knowledge and the University a modest additional income and perhaps unknowingly loyal alumni. Melbourne students were exposed to current scientific material whilst undertaking a highly structured education programme, in contrast to the situation in Britain. Despite the failure to formally embed physiotherapy within the university, the combination of medicine and the AMassA had created an education programme superior to that developed in Britain. Conducted in private schools or hospitals, British physiotherapy education appeared highly variable in teaching quality and length of training. Examination reports indicated much work was not properly prepared, of poor quality and low standard.[75] Neither electrotherapy nor

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[72] "Australasian Massage Association 29 February Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1908). 184.
[73] "Australasian Massage Association 30 January Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1908). 169.
[74] "Australasian Massage Association 30 March Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1908). 5-6.
[75] Wellcome Institute SA/CSP/P 1.1.1, "Papers Examinations Committee, October 1908-May 1911, Special Council, July 1908-November 1908, Swedish Remedial Exercises Sub-Committee, October 1908-February 1914, Examinations Sub-Committee, February 1914,

Swedish remedial exercises were examined until June 1909.[76] By then Melbourne had already graduated two cohorts of students well-prepared in remedial exercise and electrotherapy.

In Britain's initial examinations in remedial exercise from 1909 to 1911 students did poorly and the Swedish Remedial Exercises Subcommittee considered asking Mina Dobbie, an RCIG-trained medical practitioner to assist.[77] Britain did not examine electrotherapy as part of physiotherapy until August 1918. In contrast Melbourne students required extensive knowledge in natural philosophy, (electrotherapy and biomechanics required understanding of physics) indications and contraindications for treatment and achieved high examination standards in electrotherapy.[78] The STM finally recognised physiotherapy teachers needed preparation and in 1912, proposed a teacher training college course with physiotherapy teachers studying anatomy, physiology and pathology similar to Melbourne's students, in addition to principles of teaching.[79] The Melbournians had no proposal for training teachers. They benefitted from delivering their course in one programme in the University and teaching hospital environment where teaching was an accepted, but sometimes-fraught part of the inter-institutional relationship.[80] The rigour of the British national examination system, initially useful for setting

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Approved Schools Inspection Sub-Committee March-May 1914," (Wellcome Institute: Chartered Society of Physiotherapy, 1908-1914). Rosalind Paget, a Society founder signs many reports. Ibid. 1908.

[76] Ibid. 1909.

[77] Ibid. 1910. Mina Dobbie translated Kleen, *Massage and Medical Gymnastics*.

[78] Wellcome Institute SA/CSP/P 1.1.2, "Papers Examinations Committee and Associated Committees, Minutes] [Archive Material] 1915," (Wellcome Institute: Chartered Society of Physiotherapy). 1917-1918. "Australasian Massage Association 29 June Report."

[79] SA/CSP/P 1.1.1, "Papers Examinations Committee, October 1908-May 1911, Special Council, July 1908-November 1908, Swedish Remedial Exercises Sub-Committee, October 1908-February 1914, Examinations Sub-Committee, February 1914, Approved Schools Inspection Sub-Committee March-May 1914." 1912. In 1918 London teachers proposed a teachers' association. Eighty years later I established an Australia-wide educators' group.

[80] Some Australians completed Britain's teachers certificate, discontinued when British programmes moved into universities. See Barclay, *In Good Hands.* 312-314. Melbourne teaching hospitals all identify issues at various times between University and hospital.

countrywide standards, was eventually abandoned as inflexible and disadvantageous to development.[81]

Professional development though remained a component of the AMassA's agenda from its commencement with Melbourne's modified course providing participants with opportunities to increase their knowledge and skills. On 10 September 1907, His Excellency the Lieutenant Governor, Sir John Madden, presented their Certificates with all Victorian AMassA office-bearers and other luminaries in attendance at a sumptuous occasion of considerable recognition for physiotherapy.[82] International recognition occurred too at the second International Congress of Physiotherapy held by the Royal Medical Society of Italy in October 1907.[83] Signalling erroneously that medicine had taken the developmental initiative, Springthorpe sent a paper, 'The advance of massage in Australia', and Colin Mackenzie attended representing the AMassA.[84] On his return Mackenzie reported his visit to Professor Vulpus in Heidelberg University, Germany, describing 'a country disciplined for fighting purposes from cradle onwards'.[85] German physiotherapists contributed to orthopaedics, performing massage and exercise, knowing the pathology of conditions, objectives of treatment and the results expected. Mackenzie considered that Melbourne's physiotherapy course would compare with anything in Europe.[86]

The women also promoted physiotherapy: McAuley, Bowden and Meares represented the Association in the Australian Exhibition of Women's Work, 1907. Demonstrating women's increasing involvement in professions, the

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[81] Tidswell, *Adversity the Spur*. 229-268 identifies difficulties imposed by rigid national exams.
[82] "Australasian Massage Association 30 August Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1907); "Australasian Massage Association 30 September Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1907). 106-107. *The Argus* Wednesday 14 August 1907. trove.nla.gov.au/ndp/del/article/10140599?searchTerm=1907%20madden%20massage&searchLimits= Accessed 16 July 2014.
[83] "Editorial 119 Second International Congress of Physio-Therapy at Rome 120," *Archives of the Roentgen Ray* 12(1908).
[84] "Australasian Massage Association 30 September Report." 107.
[85] "Australasian Massage Association 30 March Report." 5-6.
[86] Ibid. 6-7.

Exhibition encouraged women into medicine, nursing and physiotherapy. Miss Martyn under the AMassA auspice, displayed electric beds, vibrators, and plunge and hot air baths.[87] As the women promoted physiotherapy to the public, the Association continued providing lectures to members. Dr Macgillicuddy presented a popular lecture on neurasthenia. Septimus Strahan indicated that guided exercise after fractures accelerated union and relieved pain.[88] As medical practitioners lectured to physiotherapists, Heinrich Best now demonstrated to medical students, possibly increasing the hospitals' recurring demands for more physiotherapists.[89]

At the Melbourne Hospital Hugh Murray and Eliza McAuley discussed this matter with the Hospital secretary. The annual report stated that the Hospital and its patients benefited from honorary physiotherapists and 'large numbers of students are being trained'.[90] This was not strictly accurate. The 1907 University examination results indicated that in first year Nancy Argyle, Jean Lonie, Ella Spinks and Marjorie Vahland passed anatomy, as did Edith Pratt and Bertha White in second year.[91] Celebration of students' results occurred in faraway Western Australia where relatives of Marjory Vahland and Nancy Argyle lived.

> These two ladies were also the only candidates out of all who presented themselves, who passed the first year medical examination in physiology. Miss Argyle's success is the more

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[87] *The Argus* in 1906 reported frequently this initiative of Lady Northcote, Queen Alexandra, patroness. "Exhibition of Women's Work," *The Argus*, 20 September 1906. 6. http://nla.gov.au/nla.news-article9639570 Accessed 16 July 2014. "Australasian Massage Association 30 July Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1907). 60. "Australasian Massage Association 30 October Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1907). 119-120.
[88] "Australasian Massage Association 30 July Report." 76.
[89] "Australasian Massage Association 30 November Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1907). 135. "Australasian Massage Association 30 December Report." 156.
[90] "Australasian Massage Association 30 December Report." 155.
[91] "Australasian Massage Association 30 November Report." 135.

conspicuous, as she was the youngest of the students examined.[92]

As the first students completed, in 1908 several men commenced: Paul Bibron, John Ellis Croad, Mr Craig, and the brothers France and Boleslas Slaweski.[93] The Slaweski brothers will feature again in WW1. In 1908 war was foretold and physiotherapy's role 'in the field and base hospitals of every well-equipped army ... masseurs, first class qualified men ... will be part of any big army taking the field'.[94] The following month the Journal described the Japanese army's physiotherapists contributing to its wartime success against Russia.[95]

The course progressed with theoretical and practical biomedical science subjects at the University and physiotherapy subjects at the Melbourne Hospital. Here McAuley established the first recorded class for eight AMassA members in teaching clinical physiotherapy. Each attendee agreed to devote one year's honorary work to the Hospital and teaching students. McAuley's initiative entrenched the expectation that clinical physiotherapists would give their time to teaching students.[96] It was not until 1991 though that similar in-service preparation of clinical physiotherapists recommenced. The Hospital in 1909 formally appointed McAuley to treat inpatients where her records indicated over 270 patients treated in a year, and forerunning joint

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[92] "Massage Examination," *Kalgoorlie Western Argus*, 10 December 1907. 13. http://nla.gov.au/nla.news-article33095286. Nancy returned to Kalgoorlie five years later. "A Lady's Letter," *Kalgoorlie Miner*, 1 July 1910. 2. http://nla.gov.au/nla.news-article91055999. Both accessed 19 July 2014. Western Australian physiotherapy education commenced in 1950.
[93] "Australasian Massage Association 30 March Report." 8. Reports do not indicate exact student numbers, but remained less than twenty annually. Boris (Boleslas) Slaweski wrote to the APA on 2 August 1962 confirming his lecturer in Theory and Practice of Massage was McAuley.
[94] Ibid. 8. The 1907 Hague Conference agreed on the inviolability of postal services and aspects of shipping. See Simeon E Baldwin, "The Eleventh Convention Proposed by the Hague Conference of 1907," *Yale Law School Legal Scholarship Repository*, no. 4269 (1908).
[95] "Australasian Massage Association 30 April Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1908). 22. In 1904-1905 Japan prevented Russia's expansion into the Far East. "Russo-Japanese War," http://en.wikipedia.org/wiki/Russo-Japanese_War. Accessed 29 July 2014.
[96] Annual Report (1908) Melbourne Hospital. 24. As cited in Gregory, *The Ever Open Door.* 152.

clinical/university appointments, McAuley also now gave her students dissecting room demonstrations in applied anatomy and kinesiology.[97]

As demonstrated within this thesis, applied anatomy and kinesiology is a component of physiotherapy's epistemology, in 1908 reflected in posture and a 'normal' appearance. MacPherson indicated careful assessment should note 'any abnormality, such as spinal curvature, poking chin, contracted chest, bowlegs, knock-knees, flat feet etc'. Physiotherapy case notes should include measurements and the correct breathing, standing and walking taught. She stressed individualised dosages and home exercises.[98] A further indication of the expected student knowledge is through the periodically reported examinations. Medical electricity examinations provided both questions and answers thus being informative for Association members. The 1908 examination included a question on infantile paralysis.[99]

An epidemic of infantile paralysis (poliomyelitis) occurred in 1908 and its management over the next five decades would contribute significantly in the further professionalisation of physiotherapy and the education of its practitioners (Chapter 5). The 1908 Australasian Medical Congress discussed infantile paralysis, tuberculosis and public health, including aboriginal health.[100] Many such conditions kept practitioners busy, as Mackenzie noted when citing McAuley's report as Chief Masseuse of the Massage Department. In one year 471 patients were treated, 174 inpatients and 297 outpatients. McAuley stated that optimising physiotherapy's effectiveness, the Melbourne required some forty staff aware of contraindications to treatment, the need to

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[97] "Australasian Massage Association 30 April Report." 22-23. Eliza McAuley, "Massage at the Melbourne Hospital," ibid.29 May(1909).
[98] "Australasian Massage Association 30 July Report," ibid.(1908). 79-80.
[99] "Australasian Massage Association 30 September Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1908). 101-102.
[100] Ibid. 101. Rohlinger Meyhofer, "Australasian Medical Congress," *British Medical Journal* Jan 2(1909); Desley Deacon, "Taylorism in the Home: The Medical Profession, the Infant Welfare Movement and the Deskilling of Women," *Journal of Sociology* 21(1985); David Thomas, "The Beginings of Aboriginal Health Research," *VicHealth Koori Health Research & Community Development Unit Discussion Paper No. 3* (2001).

individualise treatment and the importance of gaining patient cooperation.[101] Mackenzie and McAuley, jointly responsible for Theory and Practice of Massage, indicated in their examination questions the considerable depth of knowledge required by those entering this new profession.[102]

Both men and women studied physiotherapy, and although subsequent list of members indicate more women than men, no detailed records of students remain. Physiotherapy required significant fees - a possible barrier to some aspirants. It suited middle-class women and a university education was a measure of social status for Melbourne families. Although not a formal University course, physiotherapy was perceived as belonging.[103] In 1908 the AMassA received numerous inquires regarding the course. Capable student, Edith Pratt received Hugh Murray's prize of an inscribed gold brooch, for the best medical electricity paper.[104] As previously noted, Pratt had waited a long time to follow her sister into tertiary study, presumably because of the course fees. Middle-class women like the Pratt sisters explored their professional options. The UNA Journal kept them informed, reporting 'Rebellious Women in Literature' read before the National Council of Women by Elizabeth Lothian.[105] She cited philosopher Mary Astell who began advocating women's education in 1694, Mary Wollstonecraft's 1792 'Vindication of the Rights of Women' and the nineteenth-century writings of George Sand and Olive Schreiner.[106]

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[101] "Australasian Massage Association 30 November Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1908). 132. [101] McAuley's report in Wiliam Colin Mackenzie, "Massage," in *Therapeutics, Dietetics and Hygiene an Australian Text Book*, ed. John W Springthorpe (Melbourne: James Little, 1914). 1039-1040.
[102] "Australasian Massage Association 30 December Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1908). 151-152.
[103] Reflected in oral histories and conversations with physiotherapists.
[104] "Australasian Massage Association 30 October Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1908). 114.
[105] Classics scholar Lothian became principal of Tintern Girls Grammar. Cecily Close, "Lothian, Elizabeth Inglis (1881–1973)," http://adb.anu.edu.au/biography/lothian-elizabeth-inglis-10862/text19259. Accessed 1 August 2014.
[106] "Australasian Massage Association 30 November Report." 132.

A desire for independence may have induced young women to enter this challenging physiotherapy course that required intellectual commitment, physical strength and a genteel nature. It would provide little income but would expect them to give of themselves in significant measure. The young women and men graduating as physiotherapists had the privilege of an education and the opportunity to work in a rewarding profession, despite being hidebound by male medical control and dependent on them for patients. It appears that the requirement for medical referral and the restrictions on advertising now limited fee-paying patients. Physiotherapists needed to promote themselves to the medical profession.[107] Despite the 'world's best' curriculum, Berry, Osborne and McAuley's contributions and the honorary hospital work, more was required to induce doctors to refer patients for private treatment.[108] The Association would later send all Victorian medical men lists of members.[109] Springthorpe reiterated that physiotherapists should not teach nurses or others their knowledge and skills despite the work demands cited at the Melbourne Hospital. Here McAuley now treated 100 patients a day with sixteen students working from 2-8pm on their clinical half-days. Students assisted at the Children's Hospital too. Some abandoned the course due to the heavy work pressure.[110] McAuley continued to exhort members to help, but some who had entered physiotherapy to become financially independent struggled to provide honorary work and earn sufficient from private practice. Such independent women were still relatively rare.[111] One example was the South Australian Josephine Jennings, who came to Melbourne.[112] Male physiotherapists as breadwinners for their families were also conflicted in balancing the expectations of honorary work with treating private patients.

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[107] "Australasian Massage Association 30 March Report." 4-5.
[108] Ibid. 4.
[109] "Australasian Massage Association 30 May Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1913). 63.
[110] Eliza McAuley, "Massage at the Melbourne Hospital," ibid.29 May(1909).
[111] Grimshaw et al., *Creating a Nation.* 154-158
[112] "Australasian Massage Association 28 February Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1909). 182.

The established professional attributes of medical and university connections and honorary hospital positions, all measures of social status and recognition, required a reasonable income if such status could be upheld in Edwardian society. However women were still subservient to men and as will be shown later in relations in the Masseurs Registration Board, women played such a role whilst there were challenges between medical and physiotherapy men (Chapter 6).[113]

By 1909 the AMassA was loosing people who contributed to the profession's early development. Hall remained indisposed, he 'who, amidst great difficulty, and against considerable opposition, [had taken] the preliminary steps which led to the inception of the AMassA'. There is no record of the 'considerable opposition' but we know Hall had served as Federal and State secretary, working indefatigably on behalf of the Association. Grundt had suicided and Best resigned as Treasurer.[114] Clarence Weber, a physiotherapist renowned in physical culture with John Arthur Rice, replaced Grundt teaching medical gymnastics (Figure 4.2).[115]

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[113] For an indication of the subjection of women to male medical practitioners in this period see Toni Schofield, "What Does 'Gender and Health' mean?," *Health Sociology Review* 11, no. 1-2 (2002).

[114] "Australasian Massage Association 30 March Report." 3. "Australasian Massage Association 29 May Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1909); "Casualties and Fatalities. Masseur's Suicide." 8.

[115] Weber and Rice were celebrated for physical culture, strength exhibitions, treatment of postural, foot problems and sporting injuries. Their physiotherapy dynasty lasted at least four generations. See Trevor Gladstone Rice, "Oral History Record," (Australian Physiotherapy Association, 1987). Paul Bibron and Ignace Slaweski incorporated dance in their practice. "Advertising," *The Argus*, 23 February 1910. 16. http://nla.gov.au/nla.news-article10836771 Accessed 20 July 2014.

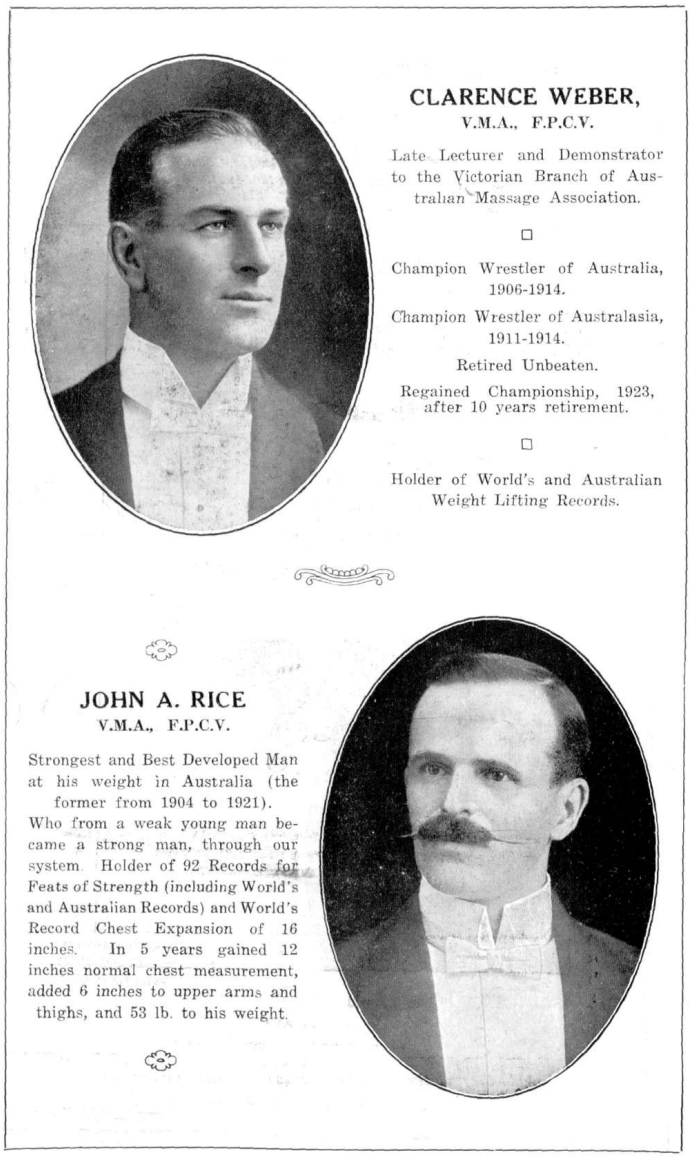

Figure 4.2 Weber and Rice founders of a physiotherapy dynasty.[116]

As McAuley retired, new graduates Pratt, White and Vahland organised physiotherapy matters, supervised practical components and continued McAuley's clinical teaching.[117] Students included New Zealanders whose

[116] Souvenir programme Health and Strength demonstration 26 March 1925 3, State Library Victoria.
[117] "Australasian Massage Association 30 September Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1909). 106.

course did not commence in Dunedin until 1913.[118] The AMassA welcomed students at its lectures. Current topics included physical culture, and treatment of fractures (gentle massage from second day, passive movements soon after and removal of splints at the end of the third week) with physiotherapy 'shortening convalescence by one third'.[119] Further lectures included 'Surface Anatomy', 'Rest in Disease', 'Physiology of Muscle' and 'Curvature of the Spine'.[120] McAuley provided an article detailing 'Massage at the Melbourne Hospital'.[121]

After returning from visiting Sweden Miss Scholfield and Hugh Murray advised that the principal physiotherapy colleges were the Government's free RCIG and Dr Arvedson's fee-paying establishment. The RCIG received applications from students of all nationalities. Massage occupied a small part of their curriculum and electrotherapy none. Students taught pedagogical gymnastics to large classes of school children daily and practitioners were called gymnasts.[123] Under medical supervision students diagnosed new physiotherapy cases, indicating appropriate treatment.[124] Murray visited Dr Giertsen in Christiania (Oslo) as well, noting Scandinavia's larger establishments for teaching and clinical practice.[125] As the members, graduates and students learned about the world of physiotherapy the first graduation occurred.

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[118] Shaw, *In Our Hands.* 1-23. Joan M McMeeken, "Competition or Cooperation," *New Zealand Journal of Physiotherapy* 26(1998); "Celebrating a Shared Past, Planning a Shared Future: Physiotherapy in Australia and New Zealand " *New Zealand Journal of Physiotherapy* 42(2014).
[119] "Australasian Massage Association 30 June Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1909). 53.
[120] "Australasian Massage Association 30 August Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1909); "Australasian Massage Association 30 September Report." 106.
[121] "Australasian Massage Association 29 May Report."
[123] Melbourne introduced educational gymnastics 1937 "Masseurs Registration Board 11 February Minutes," (1937).
[124] "Australasian Massage Association 30 September Report." 106. Frederick F Middleweek, "The Swedish System of Remedial Exercises and Massage as a Means of Treatment," *British Medical Journal* 1(1911).
[125] "Australasian Massage Association 30 October Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1909). 119.

Hall's illness delayed Melbourne's first graduation celebration and presentation of the Diplomas to November 1909. Figure 4.3 displays the women. In this coeducational course men were succeeding too. Messrs Craig, Croad, and the Slaweskis passed medical electricity.[126] Physiotherapy has been beset by the perception of others in elements related to gender as will be seen in wartime, their hands-on practice and with the perception that physiotherapy is a female profession. Yet women and men as students and practising physiotherapists have generally comfortably managed these issues as my experience and that of interviewees and oral historians indicates.

Figure 4.3 The first graduates: standing Misses Jean Elizabeth Paterson Lonie, Bertha Margaret White, Mrs Senior: seated Misses Edith Annie Mildura Pratt, Ella Louise Spinks, Marjorie Vahland, Nancy Kestell Argyle.[127]

[126] "Australasian Massage Association 30 December Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1909). 150.
[127] "Australasian Massage Association 30 November Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1909). 133.

The image of the new graduates in late Edwardian formal attire belies their experiences.[128] Covered from neck to toe, these emancipated women participated in activities outside the home surmounting the difficulties of gaining a professional education.[129] In January and February 1911 the Journal reported lectures describing the evils of letting women study and not focus on childbearing and rearing.[130]

Physiotherapy women had seen the male and female cadavers stripped naked. With their bare hands holding scalpels and forceps, and using the fingers to separate tissues, they had pealed back the skin, lifted and traced the muscles and the nerves supplying them, followed the arteries and veins, lifted out the intestines and solid organs, sawn off the skull cap and inspected the brain, slicing it into sections. They had an intimate embodied knowledge, having dissected every portion of the body. They had embodied this knowledge within themselves in an environment of relative ribaldry amongst predominantly young male medical students with whom they shared anatomy lectures. Their medical colleagues noticed them, considering some suitable for the Hockey Club, indicating already strength and sportiness as part of the physiotherapy identity.[132]

This was part of students' experience and reputation as they embarked on becoming physiotherapists. Familiarity with the living body was essential. Although we have no information of Melbourne students' clothing for exercise classes, instructed by men, firstly Grundt and later Weber, students would need light loose clothing to perform the techniques.[133] Students used their hands on

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[128] King Edward VII reigned 1901-1910, but the era often extends to 1914.
[129] Grimshaw et al., *Creating a Nation.* 105-127. See also A Oldfield, *Woman Suffrage in Australia: A Gift or a Struggle?* (Melbourne: Cambridge University Press, 1992). Marilyn Lake, *Getting Equal: The History of Australian Feminism* (St Leonards: Allen & Unwin, 1999).
[130] "Australasian Massage Association 28 February Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1911).
[132] Medical Student's Society, "Hockey," *Speculum*, no. May (1907).
[133] Weber and Rice Health and Strength programme 1925 depicts young women in loose light clothing, bathing suits. There are many newspaper references.

their fellow students to facilitate movements and massage practice required their hands on fellow student's bare skin. Techniques ranged from the smooth, light stroking of effleurage to firm frictions with deep pressure into joints, pounding of the bared gluteal area and abdominal massage. Such techniques invaded personal space contravening many social taboos. Avoiding sexual connotations whilst acknowledging the sensual pleasure of many treatment techniques would have been an ongoing challenge as students developed their identities as physiotherapists, embodying physiotherapy knowledge, clinical techniques and professional attributes.

Performing techniques on one another would become comfortable and familiar. Practice on one's colleagues before applying techniques to patients is a sustained characteristic of physiotherapy education, uncommon in the education of other health practitioners.[134] When in hospital gaining further experience in patient treatment, these students knew what their techniques felt like and how disrobing and being handled affected them emotionally. Although consideration of the emotional and psychological effects on patient and physiotherapist do not appear to have been formally taught, in contrast to their medical student colleagues, physiotherapy students had experienced 'treatment' themselves. Nevertheless treating real patients introduced whole new dimensions of sights, smells and sounds of bodies to which they would need to become accustomed.

Physiotherapists' personal awareness of the body was arguably greater than that of referring medical practitioners. Physiotherapists embodied both theoretical and experiential knowledge. As well as other's bodies, physiotherapy students

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[134] Freda Bolwell (Kimpton), "Oral History Record," (Australian Physiotherapy Association, 1987); Gillian Webb, 19 March 2014.

become acutely aware of their own bodies.[135] As Shilling would suggest their bodies become ‘projects’.[136]

Margaret Palmer's 1901 student text stated 'descriptions of the body's movement systems and biomechanics exceeded that found within texts used by student doctors'.[137] Physiotherapists also developed the ability to deliver highly specific remedial exercise, a subject not included in medical curricula. Frederick Middleweek, a British medical practitioner who studied in Sweden wrote:

> It is not universally recognised how hard it is to give good or even efficient instruction in any form of Swedish exercise, remedial or educational. The amount of knowledge, skill and tact ... is ...grossly under-estimated, ... proficiency without practice is impossible. ... If only medical men would familiarise themselves with the work done under ... 'massage' ... to their own great advantage as well as to that of their patients. They would also learn to accord the deep respect ... due of the accomplished medical gymnast.[138]

Medical men were unaware of the subtlety of physiotherapy. They supported a detailed biomedical foundation, thought they knew what physiotherapists did and definitely wanted to keep control of physiotherapy practice. Physiotherapists had a unique, privileged, professional identity with their intimate and personal knowledge of the human body in a context shared by men and women. Furthermore patients gave their physiotherapists licence to handle the body frequently over a period of weeks to months. The physiotherapists educating students required sensitivity to these issues, providing role models through their teaching.

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[135] Helen Gordon, "Oral History Record," (Australian Physiotherapy Association, 1988). Kate Lawler, Interview 13 August 2013.
[136] Chris Shilling, "Embodiment, Experience and Theory: In Defence of the Sociological Tradition," *The sociological review* 49(2001); *The Body and Social Theory*. 220-226.
[137] Nicholls, "Body Politics: A Foucaldian Discourse Analysis of Physiotherapy Practice." 113. Citing Margaret Palmer *Lessons in massage*. (London, Bailliere, Tindall and Cox, 1901).
[138] Frederick F Middleweek, "The Swedish System of Remedial Exercises and Massage as a Means of Treatment," *British Medical Journal* 1(1911).

Now it was Melbourne's new graduates guiding the students with McAuley's well-prepared clinicians. Pratt had studied Kellogg's text. He wrote: 'the touch of massage is not simply an ordinary touch or contact of the hand with the body, but is a skilled or professional touch ... applied with intelligence, with control, with a purpose ... capable of producing physiological effects'.[139] Pratt, extremely respectful of medical practitioners may well have fulfilled Louisa Despard's injunctions conveying these to her students: treating under the direction or consent of a medical practitioner; freshness and neatness in person and dress with hands washed before and after treatment; punctuality and quietness.[140] For four decades Pratt would teach and influence students in the new Melbourne Hospital where Springthorpe sought and obtained a good massage department.[141]

The range of conditions physiotherapists treated grew: galvanic current healed, reducing pain postoperatively and faradic current effectively stimulated muscles. The assessment and treatment of Bell's palsy with electrical stimulation was noted.[142] At the Children's Hospital, in addition to poliomyelitis patients, physiotherapists treated children with muscle wasting, post-burns contractures, fractures, talipes and scoliosis.[143] The Children's adopted ultraviolet treatment promoted in Switzerland, initially 'left to lay healers until the remarkable results obtained could no longer be ignored'. [144] Medical men appropriated sanatoria to offer the sun's bactericidal properties, tanning the skin, restoring vitality, improving the blood and reducing pain.

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[139] Kellogg, The Art of Massage. 52.
[140] Louisa L Despard, *Text-Book of Massage and Remedial Gymnastics* (London: Henry Frowde Hodder & Stoughton, 1916).1-2. James B Mennell, *Massage, Its Principles and Practice* (London: J & A Churchill, 1917); Tidy, *Massage and Remedial Exercises in Medical and Surgical Conditions*; Copestake, *The Theory and Practice of Massage and Medical Gymnastics*.
[141] Melbourne Hospital slowly rebuilt on its Lonsdale Street site. Gregory, *The Ever Open Door*. 134-142.
[142] "Australasian Massage Association 30 March Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1912). 5.
[143] "Australasian Massage Association 30 September Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1911). 152.
[144] Ibid.160-161.

Murray advocated treatment of neurological conditions in his lecture on 'Locomotor Ataxia' following his observations of physiotherapy's success with Edinburgher Dr Byron Bramwell's patients.[145] Murray emphasised exercises and functional activities, strongly advocating physiotherapists undertake the long treatment of complex cases: masking medicine's desire to perform the swifter, more impressive, financially rewarding elements of patient management. [146] From the seriously injured and ill to the promotion of physical fitness, physiotherapists participated. Reflecting Governments' emphases on physical fitness in preparing foot soldiers for armies, a Dr Bryant endorsed Ling's 'scientific method of treating deformities and disease, and forming a healthy physical development'. He outlined physiotherapy for diseases of the circulatory, respiratory, digestive, nervous and muscular systems.[147] Heinrich Best gave attention to physiotherapy's involvement in sport since the 1890s. Giving a detailed historical lecture, Best followed Germany's development of gymnastics. He noted that all school students in Germany undertook educational gymnastics, which Melbourne's physiotherapy students would later take as a subject.[148]

After the successful modified course run in the first years of the Association, by 1911 members could share students' education: medical electricity lectures two guineas, practical instruction three guineas, theory of massage three guineas, practice fifteen guineas. Hospitals sought more honorary practitioners urged on by Murray. AMassA member Elise Gundersen retorted that paid

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[145] "Australasian Massage Association 28 February Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1910).186-188.
[146] "Australasian Massage Association 30 April Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1910). 18-21.
[147] "Australasian Massage Association 30 June Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1910). 61-64 "Australasian Massage Association 30 July Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1910). 67-72.
[148] "Australasian Massage Association 30 November Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1910).130-133. For German educationalists see René van der Veer, "School Vs Child: In Search of Mitigating Circumstances," *Culture & Psychology* 11(2005).

Norwegian practitioners achieved better results.[149] Promisingly more hospitals appointed salaried physiotherapists.[150] Springthorpe noted that some thirty practitioners required at the Melbourne Hospital would be impossible to fund.[151] Physiotherapy services though were growing. At St Vincent's Hospital in 1913 the honorary physiotherapists treated patients in the recently acquired Austral Hall.[152]

Recent graduates occupied important roles within the profession and beyond: Pratt taught massage and Frances Bulmer was salaried at the Melbourne Hospital.[153] Annie Ochiltree had received the prize for the best paper read before the Anatomical and Anthropological Society, 'Some Abnormal Musculature of the Lower Limb', becoming only the second woman elected to the Society's committee.[154] Ochiltree's success must have delighted the AMassA.[155] It was still firmly guided by Springthorpe whose continuing connections and advocacy to pursue registration under an Act of Parliament were critical.[156]

With registration anticipated, the AMassA decided that unless physiotherapists had two years education, examinations must be passed. Springthorpe reasserted Australia's standards were the world's most demanding and comprehensive.[157] The Association had written to many international schools to 'lift up the others by delicately and kindly insinuating that they did not think these other trainees

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[149] "Australasian Massage Association 30 March Report." 5.
[150] "Australasian Massage Association 30 August Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1911). 134.
[151] "Australasian Massage Association 30 May Report." 63.
[152] Egan, Ways of a Hospital. 16, 109.
[153] "Australasian Massage Association 30 April Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1912). 33. Report of the Inspector, "Charitable Institutions Victoria," (Melbourne1914). 28.
[154] "Australasian Massage Association 30 May Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1912). 56. Annie Ochiltree was 34 in 1914. She continued working as a physiotherapist until her death, 1939. (Australian Electoral rolls).
[155] "Australasian Massage Association 30 June Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1912). 83-86.
[156] "Australasian Massage Association 30 September Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1912). 163.
[157] "Australasian Massage Association 30 June Report." 82.

were sufficiently trained'.[158] High educational standards, a hallmark of professionalism, worried some members, as two years of fulltime training challenged students who had to earn a living. Claiming Melbourne required a higher standard than Sydney, McAuley advocated for the full course and to prevent charlatans practising, registration.[159]

Victorian physiotherapists and their medical supporters focussed on registration, previously achieved by medicine, chemists and dentistry. All present at a Special open meeting agreed registration, protecting the interests of both practitioners and the public, required an application to government. Peters proposed a subcommittee of himself, Springthorpe, Murray, George Pascall and Pratt.[160] In May 1914 a deputation put the registration proposal to the Chief Health Officer Dr R Robinson who would submit their views to the Minister. But events in Europe would soon delay any proposals for registration and legal recognition of physiotherapy.[161] Recognition would come through WW1 and its ramifications, which would bring physiotherapy to public attention raising their status and identity. Murray had stated graduates would soon be examining young men for their army suitability and ameliorating incipient problems.[162]

It was therefore valuable for Gunderson, to enlighten her colleagues further about physiotherapy in Europe where flat feet in German recruits accounted for forty per cent rejection. [163] Gunderson discussed the flat feet prevalent in school children as measured with tannic acid derived footprints on paper. She recommended exercise correction and a celluloid shoe insert. Soldiers' feet

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[158] "Australasian Massage Association 30 May Report." 60.
[159] Ibid. 63.
[160] "Australasian Massage Association 30 January Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1914). 287-288.
[161] "Australasian Massage Association 30 May Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1914). 74.
[162] "Australasian Massage Association 30 March Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1911). 8.
[163] Sudmann, "(En) Gendering Body Politics. 38. "Australasian Massage Association 28 February Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1914). "Australasian Massage Association 30 May Report." 74-76.

would be a significant issue for all countries involved in the coming war.[164] Reflecting the prevailing concerns regarding national fitness, Gunderson reminded members of the value of school children receiving gymnastic training, advocating properly prepared teachers to train children's minds and bodies. For ideal men, ideal mothers were required and training for girls in childcare was 'as necessary as training the boys to defend the country in time of war'.[165]

On 28 July 1914, Archduke Franz Ferdinand was assassinated at Sarajevo and on 4 August Britain declared war on Germany. The AMassA discussed forming its own service division.[166] By the beginning of 1915 twenty-five physiotherapists had volunteered to go to war, but, despite Springthorpe's interventions, Surgeon General Fetherstone stated it would be impossible to send any masseurs. As related in the next chapter, he would reverse this decision under public pressure. German-born Heinrich Best was ill and depressed and the Council 'sent a letter to cheer him up'.[167] Although physiotherapists were not yet wanted in the Australian services, several joined the armed forces or independently went to England.[168] The war would affect the education and professionalisation of physiotherapists in Melbourne and, through the experiences of rehabilitating the wounded abroad and at home, influence what it meant to be a physiotherapist.

The new AMassA and the education programme begun in 1906 had provided a firm foundation for the emerging profession of physiotherapy. They presented

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[164] Arthur Graham Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, vol. 3 (Sydney: Halstead Press, 1943). 633. Beth Linker, "Feet for Fighting: Locating Disability and Social Medicine in First World War America," *Social History of Medicine* 20(2007); David Armstrong, "Screening: Mapping Medicine's Temporal Spaces," *Sociology of Health & Illness* 34(2012).
[165] "Australasian Massage Association 30 June Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1914).
[166] "Australasian Massage Association 30 September Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1914).
[167] "Australasian Massage Association 30 March Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1915). 12.
[168] Ibid. See also Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3.

a physiotherapy identity of a comprehensive scientific education, an ethos of volunteerism and recognition by the Governor, a significant indication of status in Victorian colonial society. Through their practical knowledge of themselves and their patients they embodied their new profession. Yet they had conceded much authority to medicine. The changes embodied in the physiotherapists will be traced through the influences of the First World War in the following chapter.

Chapter 5 Into the maelstrom: the First World War

'Ave yer heard the latest, matey? There's no more feelin' sore,
Our pals out in Orstralyer have formed a massage corps ...[1]

Australians made a significant contribution to the First World War (WW1). Amongst the Allied forces, Australians were all volunteers: 416,809 of a population fewer than five million. For every five who left, only four would return, three of them sick or injured - numbers never initially contemplated. Of the 324,000 who fought, 59,342 were killed and 152,171 wounded.[2] Recent statistical research demonstrated many errors in these official figures regarding wounding, injury, illness and premature deaths. The war's legacy was worse than reported. Men who survived averaged three hospital admissions, more than half the survivors were discharged medically unfit and many died prematurely.[3]

When war began nobody had predicted the scale of the problem, nor that physiotherapy would be an effective form of treatment for many injuries and illnesses. Men and women physiotherapists volunteered and despite being initially unwanted, were soon sought in the medical services to use their knowledge and skills in alleviating the suffering of wounded and ill men and making significant contributions to their rehabilitation. The war influenced the developing profession by bringing physiotherapy to the attention of the public and developing collegial relationships between physiotherapists and the medical colleagues with whom they worked.

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[1] Fred Porter, "The Latest News," *The Victorian Massage Monthly* 1(1916). 16. A Fussell style of analysis of WW1 Australian literary genre has not been discovered. Paul Fussell, *The Great War and Modern Memory* (Oxford: Oxford University Press, 1975).

[2] Bruce Ford, *The Wounded Warrior and Rehabilitation - Including the History of No 11 Army General Hospital/Caulfield Rehabilitation Hospital* (Melbourne: Caulfield General Medical Centre, 1996). 34. Butler, Official History of the Australian Army Medical Services in the War of 1914-18, 3. 880.

[3] David Noonan, *Those We Forget: Recounting Australian Casualties of the First World War* (Melbourne: Melbourne University Publishing, 2014).

So great did the demand for physiotherapists become that a modified wartime educational programme provided additional physiotherapists, and overseas physiotherapy assistants received dedicated training. But their wartime training would not be sufficient for them to practise as postwar physiotherapists. To maintain professional standards they would be required to complete the whole course. Nevertheless, the variety of injuries and numbers of patients gave all practitioners unprecedented opportunities to expand their expertise and to reinforce the importance of active remedial exercise. This chapter demonstrates the challenges for the physiotherapists, recognition for their clinical contributions and their growing professionalisation and sense of identity.

Claude Stubbings married his physiotherapist, Catherine (Ena) Campbell Bothroyd before his discharge as medically unfit in May 1921. Stubbings is representative of the wounded and ill that physiotherapists treated. Like many, he enlisted aged twenty-two on 21 August 1914. Fighting at Gallipoli, he was promoted to Lieutenant then Captain. On the Western Front in July 1917 Stubbings was awarded the Military Cross when he took command of his battalion after his commanding officer was wounded. Stubbings also suffered wounds. After recovering he returned to France, sustaining a shattered left femur at Villers Brettoneux in April 1918. Dangerously ill, and eventually evacuated to England, Stubbings sailed home in January 1919. He received his Military Cross at 11th Australian General Hospital (AGH), Caulfield (Figure 5.1) where he required eight operations on the leg and prolonged physiotherapy.

The Stubbings lived on their soldier-settlement farm where he continued to improve, doubtless with the support of Ena who had the expertise to continue treatment that was often needed for longer than governments provided or individuals could afford.[4] It is possible that Ena completed the shortened

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[4] "Claude Henry Stubbings B2455, 1868," http://recordsearch.naa.gov.au/SearchNRetrieve/Interface/ListingReports/ItemsListing.aspx. http://www.dva.gov.au/commems_oawg/commemorations/education/wellmeetagain/Pages/Widowhood.aspx. Both accessed 12 October 2014. Australian electoral rolls 1919-1988. See

physiotherapy course introduced to supply sufficient physiotherapists for those repatriated home like Claude.

Figure 5.1 Bedridden Stubbings receives his Military Cross at Caulfield. To the right are more disabled veterans behind those standing.[5]

Prior to WW1 the professionalisation of physiotherapy was consolidating when both activities were disrupted with the outbreak of war. President John Springthorpe, who had guided the fledgling Association, embarked on the HMAT *Kyarra* on 28 November 1914.[6] The first soldiers had left Australia in September 1914 and disembarked in Egypt, before fighting in the Middle East, including at Gallipoli. Australia had limited resources to support the casualties that eventually arrived in Britain, particularly as the numbers arriving from

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Marina Elizabeth Larsson, *Shattered Anzacs: Living with the Scars of War* (Sydney: University of NSW Press, 2009).

[5] Australian War Memorial (AWM) P05139003

[6] The AWM holds details about Springthorpe's war experience. http://www.awm.gov.au/people/rolls/R1811574/ Accessed 14 November 2013.

France escalated. Arthur Butler's medical history of the war identifies the lack of organisation, although medicine's public pronouncements argued it transformed mutilation into restoration with its emphasis on the medical and surgical advances rather than the ongoing disabilities of the wounded.[7] For the army the priority was patient survival followed by a swift return to the front line.[8] Confident in their clinical abilities, physiotherapists knew they could help these men, but early in the war the Australian Army Medical Corps (AAMC) leadership denied their contribution, not realising the potential contribution of these well-educated and clinically experienced people. Within a year physiotherapists like France Slaweski and Lucy Rooke were in demand, working with their medical colleagues.

Melbourne graduate, France Slaweski, could not wait. Enlisting, number 113, he left his Melbourne practice and joined the 1st Light Horse Field Ambulance. His enlistment papers indicate his profession. Embarking in September 1914 Private Slaweski served at Gallipoli before pleurisy invalided him to Lemnos. From the 1stAGH Heliopolis he went to Helouan convalescent camp.[9] Seeing the necessity for his physiotherapy expertise at 1stAGH, from mid July 1915 Slaweski began using his clinical skills. When the AAMC finally recognised it needed physiotherapists, an authorisation cable, Number 25947 from Melbourne, in September 1915, indicated that Staff Sergeant Slaweski would work as a physiotherapist. His subsequent movements are comparable to that of

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[7] Arthur Graham Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, vol. 1 (1938); *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. *Passim.*

[8] Ana Carden-Coyne, *Reconstructing the Body: Classicism, Modernism, and the First World War* (OUP Oxford, 2009). 93-109.

[9] "France Slaweski," http://recordsearch.naa.gov.au. Accessed 7 December 2014. AWM Embarkation Roll http://www.awm.gov.au/people/rolls/R1807594/. Slaweski's practice in Melbourne Directory 1914. 6. http://newsimages.worldvitalrecords.com/books%5C2009JUN14%5CCDAustraliaAU7110-1914_DirectoryVictoria1914Wise%5C62.pdf. Slaweski's Gallipoli experiences would likely parallel Private Arthur James Adams diary at http://www.awm.gov.au/collection/RCDIG0000195/. All accessed 17 October 2013. See Sergeant Major RAMC, *With the Ramc in Egypt (1918)* (London: Cassell and Company Ltd, 1918).

many serving physiotherapists. From September 1915 at 3rdAGH Aldershot to, in 1916, Abbassia. From March 1917 Slaweski worked at Australian Auxiliary Hospital (AAH) Dartford, before going to France in January 1918 with the 2ndAGH. On returning to England he worked at Southall AAH until May 1919, spending his last service period at Sutton Veny.[10] Demobilised 'medically fit class A' in Australia Slaweski returned to France to marry in 1920.[11] His professional experience, much broader as a result of the war, covered acute hospitals, auxiliary hospitals where pre- and postsurgical physiotherapy was required and rehabilitation depots. Furthermore he experienced military life and the different cultures of the Middle East, France and England. Australia did not gain from Slaweski's breadth of knowledge, as he remained in France.

Representative of the young women eager to serve was Lucy Adelaide Rooke, who graduated in 1913, aged twenty-one. She displayed significant persistence in trying to volunteer. After a year working in Brisbane, she wrote to the AGH, Australian Infantry Forces and Commonwealth of Australia, Department of Defence. In May 1915 she was advised there were no vacancies for physiotherapists.[12] When the AAMC sought volunteer physiotherapists in July 1915, Rooke, among the first six women appointed, embarked on the *RMS Morea* on 21 August 1915. She worked first at 1stAGH Heliopolis in Egypt, then 2ndAGH Marseille and Boulogne in France, where she came under fire, and finally at 3rdAAH Dartford (Figure 5.2). In mid-1918 she worked with repatriated men on the New Zealand transport ship *HMNZT Ruahine,* returning home to marry physician Captain Alan Syme Johnson who she met at

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[10] National Archives of Australia http://recordsearch.naa.gov.au/SearchNRetrieve/Interface/ListingReports/ItemsListing.aspx. In December 1916 Sutton Veny became 1stACD. Post Armistice, 1stAGH transferred to Sutton Veny until end 1919. See http://suttonveny.co.uk/1st-world-war.html Accessed 7 December 2014.

[11] "France Slaweski". http://www.awm.gov.au/people/rolls/R1807594/ ibid. Light Horse members who married overseas http://www.lighthorse.org.au/forum/index.php?topic=15.185;wap2. Accessed 1 December 2014.

[12] Lucy Adelaide Rooke 1990.0101 BS2/22/5 University of Melbourne archive correspondence.

Dartford.[13] Staff Nurse Rooke served 1064 days, 1050 overseas. Like her physiotherapy colleagues, Rooke demonstrated a sustained capacity to contribute to the war effort whilst developing as a physiotherapist. Her colleagues' involvement and professional commitment is detailed below.

Figure 5.2 Lucy Rooke at the Citadel in Cairo in dress uniform (left) and at 3rdAAH Dartford in working uniform.[14]

During the lead up to the war, Australia's physiotherapists had expected to be essential in the medical services. In a serious blow to their professional pride and despite Springthorpe's advocacy, Medical Director General Richard Fetherston and Surgeon General Neville Howse initially considered physiotherapists unnecessary to the war effort: nurses or even orderlies could be trained in physiotherapists' roles.[15] 'In Australia, as elsewhere, the medical

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[13] Ibid. Photographs. "Family Notices," *The Argus*, 19 October 1918. 11. http://nla.gov.au/nla.news-article1411998. Accessed 15 June 2014.
[14] Lucy Adelaide Rooke 1990.0101 BS2/22/5 University of Melbourne archive.
[15] "Australasian Massage Association 30 December Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1915).12-14. Obstetrician Fetherston was a Victorian Militia lieutenant colonel surgeon, appointed director-general of medical services, 1914, major general, 1916. Neville Howse led medical services overseas. See Frank MC Forster, "Fetherston, Richard Herbert Joseph (1864–1943)," http://adb.anu.edu.au/biography/fetherston-richard-herbert-joseph-6163/text10587. AJ Hill, "Howse, Sir Neville Reginald (1863–1930)," http://adb.anu.edu.au/biography/howse-sir-neville-reginald-6753/text11671. Both accessed 19 October 2013.

profession was very ill-informed on the exact therapeutic action ... of all forms of physical therapy'.[16]

Australian military medical men followed the British, who made no provision for physiotherapists. Nevertheless in Britain, from the outbreak and throughout the war, the philanthropic couple, the Almeric Pagets funded British physiotherapists. Dr Florence Barrie Lambert had undertaken physiotherapy studies in Sweden and lectured to physiotherapists in London. When war began, she opened a clinic for wounded officers, which Mrs Almeric Paget financed. Lambert in conjunction with Lady Eleanor Essex French, the physiotherapist daughter of the Commander of the British Expeditionary Force, Field Marshall Lord French organised the Almeric Paget Massage Corps.[17] Lady French became honorary secretary of the Corps and Lambert Inspector of Military Massage and Electrical Services and the first woman to wear the Royal Army Medical Corps badge.[18] In December 1916 the Corps became the Almeric Paget Military Massage Corps and received some government funding for its many paid and voluntary physiotherapists. From January 1917 members began serving in France and Italy. British medical women were restricted in their permitted contributions and suffered as the Australian physiotherapists did from a lack of status.[19] British physiotherapists similarly received no official recognition or status and the demands on the service meant that many providing physical therapies had received little or no training.

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[16] Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 593.
[17] "Almeric Paget Massage Corps," *British Medical Journal* January 30(1915). "Obituary of Dame Barrie Lambert," *British Medical Journal* December 28(1957); JD Bennett, "Medical Advances Consequent to the Great War 1914-1918," *Journal of the Royal Society of Medicine* 83(1990).
[18] Wellcome Institute SA/CSP/F1 Almerlc Paget Massage Corps Dec 1915-Jan 1916 Advisory Committee minutes, correspondence with War Office and Almeric Massage Corps. "Obituary of Dame Barrie Lambert."; Leah Leneman, "Medical Women at War, 1914–1918," *Medical history* 38(1994).
[19] Australian medical women were not permitted to serve with the AAMC.

Medical men such as E Bellis Clayton emphasised the need for appropriate training.[20] James Mennell claimed that the lack of training in some practitioners led to poor treatment causing unwarranted pain to rehabilitating men.[21] However American Robert Fortescue Fox considered pain a necessary component of treatment.[22] Ana Carden-Coyne has emphasised that some physiotherapists brutalised their patients and this issue caused concern in Britain during the war.[23] As I indicate below, Australian physiotherapists were very concerned about practitioners with inappropriate or inadequate training, and, although no documented evidence has been found, Australian practitioners could have contributed to patients' pain. Despite these issues, by war's end 3,388 Almeric Paget physiotherapists served, including several Australians.[24] In Australia the evolution of the Massage Service in a more haphazard fashion did not have similar connections with the military leaders such as the Field Marshall's influential daughter.[25]

Philanthropy though played a part in initiating Australia's physiotherapy services. In 1915, the Australian branch of the British Red Cross Society supported the AMassA's endeavours by offering to finance two practitioners

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[20] E Bellis Clayton, "Massage and the War," *The Lancet* 186, no. 4816 (1915); E Bellis Clayton, "Some of the Uses and Abuses of Massage," ibid.188, no. 4845 (1916).
[21] James B Mennell, "Massage in the after-Treatment of the Wounded," ibid.186, no. 4805 (1915).
[22] Robert Fortescue Fox, *Physical Remedies for Disabled Soldiers* (London: Bailliere, Tindall and Cox, 1917).
[23] Ana Carden-Coyne, "Painful Bodies and Brutal Women: Remedial Massage, Gender Relations and Cultural Agency in Military Hospitals, 1914-18," *Journal of War & Culture Studies* 1(2008); "Ungrateful Bodies: Rehabilitation, Resistance and Disabled American Veterans of the First World War," *European Review of History—Revue européenne d'Histoire* 14(2007).
[24] Wellcome Institute SA/CSP/F1 Almeric Paget Massage Corps, Advisory Committee minutes, 6.12.1915, 3.1.1916 , 29.1.1916, correspondence with War Office, 12.1.1916 from December 1915 to January 1916 Wellcome Institute File SA/CSP/F.1. Wicksteed, *The Growth of a Profession.* 62-64, Barclay, *In Good Hands.* 56-63. Myril Lloyd and Roslyn Riordan completed physiotherapy at Sydney University http://sydney.edu.au/alumni/sam/july2014/book-of-remembrance.shtml Accessed 15 May 2015.
[25] Research has demonstrated the significant influence of daughters on their fathers. See Amanda Sinclair, *Doing Leadership Differently: Gender, Power and Sexuality in a Changing Business Culture* (Melbourne: Melbourne University Publishing, 2005). *Passim.*

provided they received military recognition.[26] The public donated to this scheme, recognising that physiotherapy formed an important component of treatment for wounded soldiers.[27] In July the British accepted these women for work in Egypt. By mid-1915 the combined influence of public pressure from wounded servicemen, the Red Cross and the AMassA induced Fetherston to accept male physiotherapists of non-commissioned rank for the AAMC. Soon he actively sought women, approving a permanent Australian Army Massage Reserve of 102 physiotherapists. Newspapers reported the commencement of the Reserve with enthusiasm, stating that physiotherapy volunteers would join the Expeditionary Force going to Egypt and England.[28] A physiotherapist with the rank of lieutenant commanded physiotherapists in each State, with women ranked as staff nurses and men as staff sergeants. Alfred Peters claimed he was instrumental in having the Massage Corps formed and had trained the lieutenant in charge in Victoria, Llewellyn Jones.[29] Peters treated Prime Minister Billy Hughes and may have had some influence in that quarter.[30] Doubtless several matters coalesced and soon physiotherapists were *en route* for Egypt and England. Men such as France Slaweski's brother Boleslas and Wilfrid Leeming enlisted as members of the Special Reinforcements in August 1915.[31] Staff Sergeant Leeming wrote from the 2nd Australian Convalescent Depot (ACD), Monte Video Camp, Weymouth, 'I am thoroughly convinced that massage, as a curative agent, will become recognised by everyone as the

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[26] "The Red Cross," *The Mercury*, 27 April 1915. 6, http://nla.gov.au/nla.news-article10411167 Accessed 29 August 2014.
[27] "The Massage Scheme," *The Brisbane Courier*, 26 July 1915. 8. http://nla.gov.au/nla.news-article20029872 Accessed 29 August 2014.
[28] *Military Order No. 492* dated 24th August 1915 see Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 597-598. "Massage for Soldiers," *Huon Times*, 22 September 1915. 3. http://nla.gov.au/nla.news-article136199019 Accessed 29 August 2014.
[29] Peters, "Alfred Peters Oral History Record."
[30] "Mr Alfred Peters," *Punch*, 5 October 1916. 532.
[31] Boleslas and France Slaweski were Melbourne graduates. Brother Ignace was also a physiotherapist. Boleslas served as a physiotherapist August 1915-November 1918 returning to Australia June 1919. "Boleslas Slaweski," www.awm.gov.au/research/people/nominal_rolls/first_world_war_embarkation/person.asp? and www.awm.gov.au/people/rolls/R1931117/, AWM attestation papers Accessed 8 July 2012.

direct result of this war'.[32] AMassA member Leeming (Figure 5.3) made important contributions to Australian physiotherapists' wartime work, as is noted throughout this Chapter.

Figure 5.3 Staff Sergeant Wilfrid Leeming. [33]

The Massage Corps with both men and women serving contrasted with the male medical and female nursing services. This situation, as noted later, produced unresolved difficulties for the army's management of physiotherapists.[34] In Melbourne too, the absence of several key people made education difficult. Springthorpe, Murray and senior physiotherapists like Josephine Jennings were abroad. The gap in expertise and the additional workload at home doubtless contributed to fewer AMassA reports, but the Journal provided pertinent war news including that British women were replacing men in the workforce.[35] Australian women participated in voluntary

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[32] "Australasian Massage Association 30 September Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1916).212.
[33] University of Melbourne Brownless Medical Library MHM04326.
[34] Honor C Wilson, *Physiotherapists in War* (South Australia: Gillingham Printers, 1995). 1-12.
[35] "Australasian Massage Association 30 June Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1916). 108.

organisations, the Red Cross, the Australian Women's National League and the Voluntary Aid Detachment (VAD). Unions did not want women replacing men in jobs and lowering wages. Australia expected women to give their sons and fulfill the motherhood role.[36] As demand for physiotherapists increased Victorian sons and daughters contributed.

Victorian AMassA members - Jennings, Bulmer, Kyte, Leeming, Quinn, Rundell, Tilley, Ahearn, and the Slaweskis - were on active service. Elise Gundersen also served.[37] Enlisting in August 1915, within a week experienced physiotherapist Josephine Jennings embarked on the *HMT Morea*. Initially at 10thAGH, from October 1915 until February 1919, Jennings was responsible for electrotherapy at 1stAAH, Harefield (Figure 5.4).[38]

Jennings's comprehensive records of her department's work, according to official war historian Butler, are a rare example of extant information regarding the numbers of treatments undertaken by physiotherapists. They also provide an indication of the demand on practitioners and their resultant development of experience (Table 5.1).

Nature of treatment	1916	1917	1918	1919, 1 month	Total
Electrical including ionisation	6,979	9,598	12,219	365	29,161
Massage and hot air	24,246	27,735	22,911	500	75,392
Total	31,225	37,334	35,130	865	104,553

Table 5.1 Jennings's Harefield records of the numbers of physiotherapy treatments.[39]

[36] Grimshaw et al., *Creating a Nation.* Marilyn Lake, "Mission Impossible: How Men Gave Birth to the Australian Nation—Nationalism, Gender and Other Seminal Acts," *Gender & History* 4(1992).
[37] Members serving overseas were listed in each AMassA report of the war years. Gundersen served in Tasmania and Victoria. All checked in National Archives of Australia. http://recordsearch.naa.gov.au/SearchNRetrieve/Interface/ListingReports/ItemsListing.aspx B2455 Accessed 7 December 2014.
[38] "Mary Josephine Jennings," http://recordsearch.naa.gov.au/. Accessed 7 December 2014.
[39] Modified from Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 609.

Figure 5.4 Josephine Jennings preparing to treat a soldier with trench foot using electrotherapy at Harefield.[40]

Harefield housed mainly surgical cases including men with amputations.[43] Physiotherapists prepared the patients' stumps for artificial limbs with massage to reduce oedema and improve circulation, stretches to ensure full joint ranges, exercises to regain muscle strength and endurance and bandaging to shape the stump: ministrations potentially painful. Harefield also offered occupational rehabilitation as demonstrated in Figure 5.5.

[40] AWM P02402.003.
[43] "History of Harefield Park Hospital," (AWM 449/9/302, 1974).

Figure 5.5 Men with amputations learning telegraphy at Harefield.[44] (Occupational therapy's antecedents began with craftwork and did not become established until the Second World War).

In the first five months of 1916, Harefield received 1,548 patients from Egypt and Gallipoli and from June to December 8,539 from France.[45] Lieutenant Colonel Yeatman, Harefield's Commanding Officer wrote to Fetherston:

> I will say without reserve that the work of the Massage Department at Harefield was quite exceptionally good ... In weeks with us (the wounded) did more good than they had in months previous to their coming to us, and in this the Electrical and Massage Department had their very large share.[46]

A humorous indication of physiotherapists' work is depicted by British physiotherapist Dorothy Bliss's contemporary cartoon (Figure 5.6).

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[44] AWM H11710.
[45] Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 609. 651.
[46] Ibid. 610.

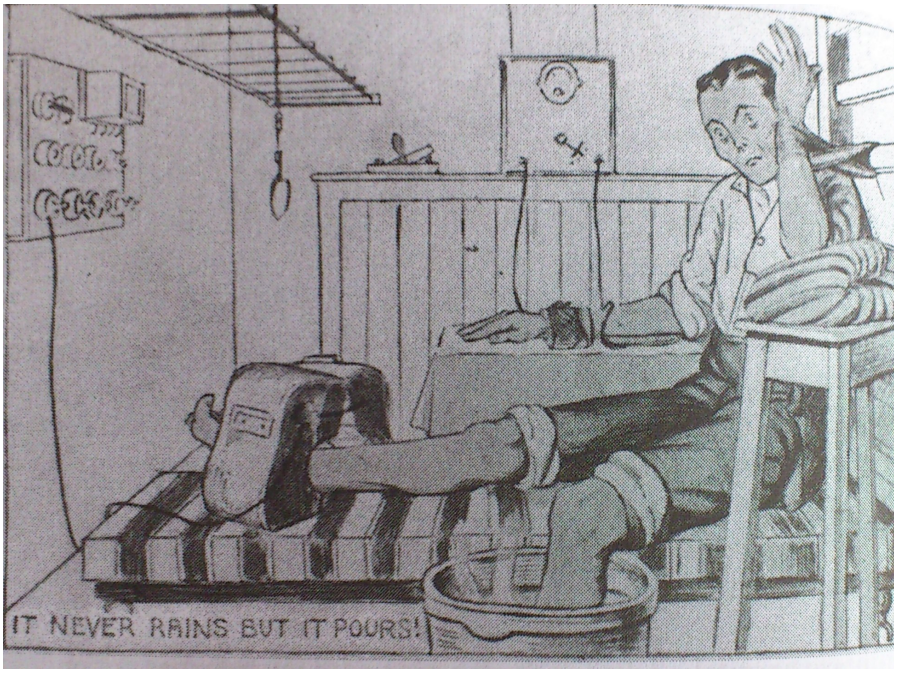

Figure 5.6 Physiotherapy techniques (left to right) heating the right ankle prior to mobilising and exercise; hydrotherapy for the left leg in a Schnee bath, hot or cold for pain relief and/or before exercise; electrical stimulation of the right wrist to assist muscle re-education; active exercise of the left forearm using a rubber strap as resistance. The 'ladder' would be used for suspension of limbs too weak to act against gravity. The caption reads 'It never rains but it pours' implying a multitude of injuries requiring many treatments.[48]

At the AMassA Annual General Meeting in April 1917 Bernhard Zwar described the war's increased demand for practitioners, criticised British physiotherapy education and extolled the virtues of Melbourne's course.[49] The Journal kept readers informed of physiotherapy for the wounded: from James Mennell's *The Lancet* article on massage, to ice for reducing inflammation and

[48] Chartered Society of Physiotherapy collection *Bliss cartoon. Wellcome Archive United Kingdom* WP Spalding, Cambridge. Artist confirmed in Suzanne Evans, "Coming in the Front Door a History of Three Canadian Physiotherapists through Two World Wars," Canadian Military History 19(2010).

[49] "Australasian Massage Association 30 September Report." 237. Benjamin K Rank, "Zwar, Traugott Bernhard (1876–1947)," http://adb.anu.edu.au/biography/zwar-traugott-bernhard-9231/text16315. Accessed 1 September 2014.

pain.[50] Several writers described physiotherapy for flat feet, the bane of infantrymen.[51] Presaging a classic treatment for a common sports injury, active physiotherapy combined with adhesive plaster strapping returned soldiers with sprained ankles quickly to the front, as did walking re-education for wounded men.[52] More complicated though was the management of gunshot, shell and bayonet wounds, gas exposure, fractures, burns, shell shock and many illnesses. For these Australians who had volunteered with enthusiasm, Gallipoli's blooding and France's continuing toll of casualties changed perceptions of clinical practice. As the physiotherapists returned home, these changes would eventually influence practice and education in Victoria.

Physiotherapists had been exposed to trauma before, but not in these numbers, nor with such complex injuries. Treatment was frequently makeshift in tents or Nissen Huts and the numbers requiring attention extraordinary. Although organisation eventually improved, initially the environment for the physiotherapists required them to organise themselves. Katherine Vida Kirkcaldie described her experience on arrival in Heliopolis (Figure 5.7).

> Just a year from the outbreak of war after the numerous delays ... the first detachment of masseuses to go on active service left Australia. One half went straight through to England. The others disembarked at Suez. ... My friend (Rooke) and I went to No. 2 and No. 3 Auxiliary Hospitals at Heliopolis ... we had almost more work than we knew how to cope with ... the first six weeks or so were hopelessly depressing. The majority of cases were of so long

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[50] "Australasian Massage Association 30 December Report." 313-314. James B Mennell, *The Treatment of Fractures by Mobilisation and Massage* (London: Macmillan, 1911); "Massage in the after-Treatment of the Wounded."; *Massage, Its Principles and Practice*. "Australasian Massage Association 30 April Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1916). 78.

[51] "Australasian Massage Association 30 May Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1916). 81-82. "Australasian Massage Association 29 June Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1918). 116-117. Linker, "Feet for Fighting."

[52] "Australasian Massage Association 30 June Report." 113. "Australasian Massage Association 30 April Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1917). 41-49.

> standing, it was practically impossible to see any result from our labours... new ones took their place ... getting tone back into the injured muscles, of loosening scar tissues, of working stiff joints, of gradually breaking down adhesions ... nerve lesions, ... keep the limb in fairly good condition pending operation; cases where injury to the nerve was less severe, we were able to coax back movements to the paralysed muscles, cases of fracture simple and compound, cases of synovitis knee, hysterical paralysis, shell shock, neuritis and insomnia which generally [were treated] with suggestion and re-educative exercise. We had a bit of everything.[53]

The women managed to find an electrical stimulator in Cairo and gave the engineers directions for its modifications and for the manufacture of additional equipment.[54]

Writing from Egypt, Boleslas Slaweski deplored the chaotic working conditions, claiming he could be much more efficient with the authority of rank.[55] Nevertheless, treating thirty-to-forty cases daily, 'most satisfactory results were obtained in partial paralysis from shell shock. Many of these were practically without movement in any part of the body: after a short period of treatment, they were able to get up and walk about'.[56]

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[53] Vida Kirkcaldie, "Oral History Record," (Australian Physiotherapy Association, ~1919); "Report Australian War Memorial," in *World War 1 Massuers File* (Australian War Memorial, Australian Physiotherapy Association, ~1919). See also Jan Bassett, *Guns and Brooches: Australian Army Nursing from the Boer War to the Gulf War* (Melbourne: Oxford University Press, 1992).
[54] Kirkcaldie, "Report Australian War Memorial."
[55] Edgar Lovell, "The Status of Massage," *The Victorian Massage Monthly* 1(1916). 5-6.
[56] Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 599. Joanna Bourke, "Shell Shock During World War One," British Broadcasting Corporation, www.bbc.co.uk/history/.

Figure 5.7 Heliopolis Palace Hotel converted into the 1stAAH for Gallipoli veterans.[57]

Springthorpe was 'expert in heart and nerve cases' wrote Hugh Murray to the AMassA from 3rdAAH, Dartford. Murray visited Robert Jones's exemplar rehabilitation unit at Shepherd's Bush. Jones, nephew of orthopaedist Hugh Owen Thomas and Britain's foremost WW1 orthopaedic surgeon, had developed occupational rehabilitation prewar and during the war introduced and undertook responsibility for soldier's orthopaedic management in Britain.[60] Here too Australia's Colin Mackenzie developed the muscle re-education programme which he had taught physiotherapy students in Melbourne.[61] Shepherd's Bush had fifty physiotherapists. Dartford employed five and

[57] Heliopolis 1915 https://www.awm.gov.au/collection/H18510/.
[60] Cooter, *Surgery and Society in Peace and War Orthopaedics and the Organization of Modern Medicine, 1880-1948*. 31-35. "Obituary, Sir Robert Jones," *British Medical Journal* 1(1933).
[61] William Hanigan, "The Development of Military Medical Care for Peripheral Nerve Injuries During World War I," *Neurosurgical focus* 28, no. 5 (2010).

Murray sought thirty more.[62] After the Somme's carnage, demand for physiotherapists grew.

The women stationed overseas generally worked in the AAHs with men at the ACDs.[63] When wounded men returned by ship to England from the French battlefields they went to British General Hospitals, then to the AAHs and subsequently the ACDs. Although medical men had an increasingly complex system of grading men's fitness for a return to the front, the ACDs returned men fit for fighting again or continued their treatment prior to repatriation to Australia.[64] Physiotherapists in the ACDs were influential in improving management of the wounded at the depots and on the ships repatriating men to Australia.[65] Particularly recognised for this work was Wilfrid Leeming (Figure 5.8).

Leeming and Albert Ahern commenced physiotherapy in the 2ndACD at Weymouth, eventually the main ACD for men requiring repatriation.[66] Here many men with orthopaedic problems had required bone or nerve surgery, but few Australian wartime surgeons had expertise as 'orthopaedic surgeons' or the rehabilitation requirements subsequent to surgery.[67]

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[62] "Australasian Massage Association 1 November Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1916).
[63] William Colin Mackenzie, "Military Orthopaedic Hospitals," *British Medical Journal* 1(1917).
[64] Butler, Official History of the Australian Army Medical Services in the War of 1914-18, 2. 447-449.
[65] Wilfrid Leeming, "Wartime Notes Mhm04477," (Brownless Medical Library Archive University of Melbourne, 1919). 1-8. *Official History of the Australian Army Medical Services in the War of 1914-18. 3.* 616.
[66] Ahern promoted Warrant Officer 1 February 1916, discharged medically unfit (rheumatism and neurasthenia, elbow fracture in earlier service), 8 October 1916. "Albert Ahearn," http://recordsearch.naa.gov.au/. Accessed 7 December 2014.
[67] Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 2. 499-502. Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 3. 612.

Figure 5.8 One of Leeming's patients with arm and chest wounds.[68]

In October 1915 at Weymouth, Commanding Officer Douglas McWhae expressed his considerable dissatisfaction with arrangements and supported the physiotherapists' concerns regarding the poor organisation and the lack of orthopaedic expertise. McWhae wrote, 'treatment of orthopaedic patients at this period therefore was conspicuous by its inefficiency', particularly men's repatriation to Australia. 'There were few medical officers in the British hospitals who knew anything of orthopaedics and still fewer in the AIF'.[69] McWhae's reports included Leeming's aims for functional recovery through physical treatment and remedial exercises.[70] As the numbers of wounded

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[68] University of Melbourne Brownless Medical Library MHM04487.09.
[69] Ibid. 612-613. For dearth of orthopaedic expertise see Hugh C Barry, *Orthopaedics in Australia: The History of the Australian Orthopaedic Association* (Sydney: Australian Orthopaedic Association, 1983).
[70] Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 612-613. Ibid., 2. 819. Butler credits Leeming for aspects of McWhae's writing. Leeming enlisted Melbourne August 1915, at Weymouth until November 1918 then sea transport section. Awarded Meritorious Service Medal, brought to the notice of Secretary of State for War. "Wilfrid Leeming," http://recordsearch.naa.gov.au/. Accessed 12 November 2013.

increased, so did the demands on the physiotherapists, reflected in the growing numbers of men requiring rehabilitation at ACD, Weymouth. To enable the physiotherapy work to be done Staff Sergeants Beck and Cooper joined Warrant Officer Leeming in late 1916 as the toll of wounded grew still further.[71] To relieve pressure on the physiotherapists Fetherston now proposed training orderlies in specific aspects of physiotherapy.

Fetherston's proposal angered both medical officers and physiotherapists, however at Weymouth Leeming trained these assistants, giving daily lectures on anatomy, physiology, theoretical and practical massage and electrotherapy. To increase efficiency and safety of treatment, he focussed each assistant on a specific aspect of physiotherapy. '(I) was able to obtain reliable assistance. Their training was intensive and the material for practice was there in infinite variety'.[72] Leeming wrote.

> Suitable physical training instructors were ... sent to ... Shepherds Bush, ... for instruction in the methods of remedial gymnastic treatment. In November, 1916 ... a remedial gymnastic department was opened at Weymouth. ... In August 1916, electrical treatment for injured nerves and other disabilities had also been commenced.[73]

At the end of 1916 Weymouth accommodated 2,240 men but during 1917 there were 7,700 with additional tents for up to 10,000 that summer.[74]

Although physiotherapy management of men returning to the front from 1st, 3rd and 4thACDs was eventually in hand, at 2ndACD Weymouth, where invalided men waited to return to Australia, the physiotherapists' work

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[71] "Australasian Massage Association 30 September Report." 212. *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 600. Leeming was appointed Warrant Officer 27 October 1916 after Ahern left Weymouth.
[72] Wilfrid Leeming, (University of Melbourne Brownless Medical Library MHM04477 Series 8). 4.
[73] Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 612-613. An exhaustive search has not unearthed Leeming's original report.
[74] Ibid. 613-614, 655-658.

continued to be overwhelming. The state of wounded Australians arriving at the AAHs and ACDs from British General and Red Cross Hospitals indicated variable previous treatment. Whilst some were well managed, others 'came without splints. ... Cases of foot-drop and wrist-drop with resulting contractures were common'.[75] Foot drop from paralysis of the anterior leg muscles prevents the toes lifting when walking. Wrist drop due to paralysis of wrist extensor muscles causes inability to grip with the hand. Even in the AAHs where Kirkcaldie and Jennings operated well-equipped physiotherapy departments with qualified staff, patients could vanish to the ACDs suffering such deformities and without splints. Splints limited deformity and eventually improved function. They could also be life saving. The Thomas splint developed by Hugh Owen Thomas in Liverpool and introduced by Robert Jones reduced the incidence of fatalities from femoral fractures by eighty percent during the war.[76] Thomas had also made important contributions to the splints for other neuromusculoskeletal conditions including poliomyelitis (Figure 5.9) (Chapter 7).[77]

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[75] Ibid. 612-613.
[76] Laurence Simpson, "Thomas's Splint," in *Compassion and Courage: Australian Doctors and Dentists in the Great War*, ed. Jacqueline Healy (Melbourne: Medical History Museum, University of Melbourne, 2015).
[77] Mackenzie, "Military Orthopaedic Hospitals."

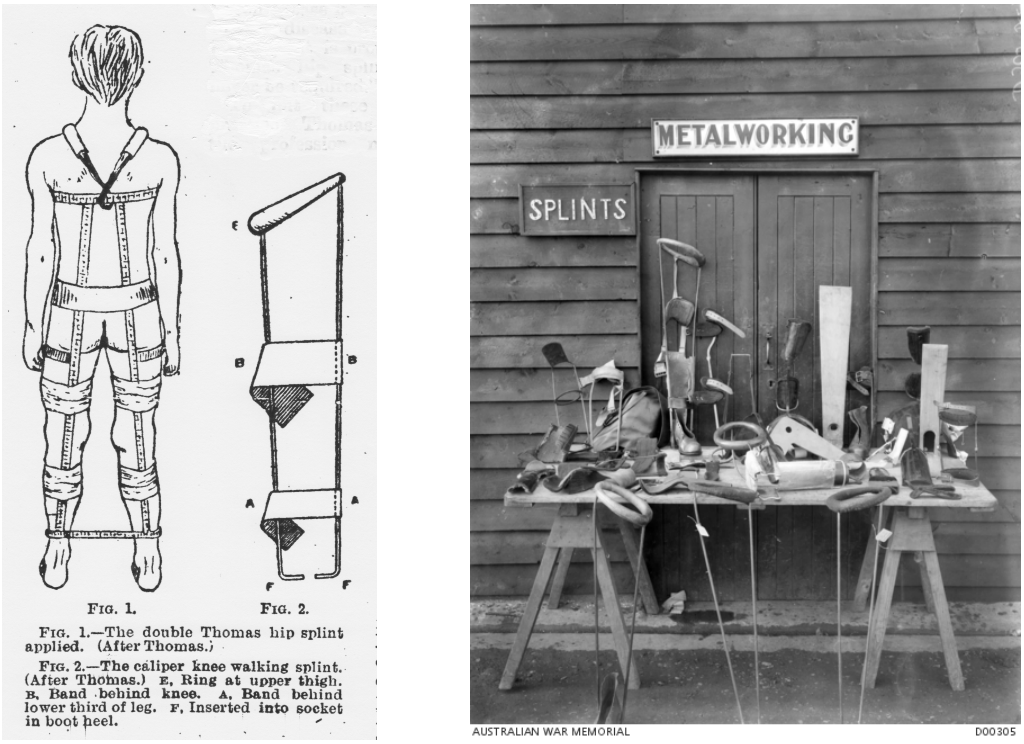

FIG. 1. FIG. 2.

FIG. 1.—The double Thomas hip splint applied. (After Thomas.)

FIG. 2.—The caliper knee walking splint. (After Thomas.) E, Ring at upper thigh. B, Band behind knee. A, Band behind lower third of leg. F, Inserted into socket in boot heel.

Figure 5.9 Thomas splints as described by Mackenzie (left). Splints made at Weymouth (right). Femoral fractures were immobilised in the Thomas splints (foreground and against the door).[78]

Despite these difficulties, the evidence suggests harmonious and efficient working relationships between McWhae and the physiotherapists.[79] However, it took another year for physiotherapy treatment to be provided for all appropriate wounded men in the ACDs. McWhae proposed to Surgeon-General Howse in August 1917 that: 'all soldiers with stiffness of joints, contracture of muscles or tendons and similar lesions will receive remedial gymnastic treatment. ... All special remedial treatment will be given at Monte Video Camp'.[80] McWhae, probably with Leeming's advice, specified physiotherapy staffing - 500 cases required one warrant officer, three staff sergeants, three sergeants and one corporal and additional equipment. Medical officers needed to increase their orthopaedic expertise; a man should learn surgical

[78] Ibid. AWM D00305.
[79] Leeming, "Wartime Notes Mhm04477." 8. Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 616, 659.
[80] Ibid. 614.

bootmaking. To enable more appropriate decisions regarding orthopaedic and physiotherapeutic treatment Leeming went to Robert Jones' Shepherd's Bush Orthopaedic Military Hospital established in 1916 at the previous Hammersmith Workhouse Infirmary.[81] McWhae recommended physiotherapy continue on the repatriation ships, once medical officers became familiar with the treatments for the voyage at Weymouth. A focus on active exercise with staff qualified in massage and remedial gymnastics and appropriate equipment was necessary.

By October 1917 as McWhae and Leeming's recommendations were instituted, Weymouth became the most efficient orthopaedic department. General Howse ensured each State sent medical officers for specialist orthopaedic training. Colin Mackenzie, Victorian surgeon at Shepherds Bush wrote 'Military Orthopaedic Hospitals'.[82] Australian newspapers cited his article, reminding the public that the wounded must be restored to health and strength in the shortest possible time. For those like Stubbings, 'who will never be the same again' other provision would be required.[83] Orthopaedic cases returning to Australia ultimately received better treatment. Case history formats, based on those originally at Liverpool's Alder Hay Orthopaedic Hospital, the first orthopaedic Hospital established by Robert Jones, were developed from the middle of 1918.[84] They included history, operations, associated lesions (including X-ray reports), range of movement, neurological condition - date of examination, voluntary power, sensory loss, faradic response, galvanic response, reaction of degeneration and threshold of excitation.

Extraordinarily these case histories were archived and medical practitioners responsible for veterans in Australia did not receive them, reflecting

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[81] Cooter, Surgery and Society. 105-136.
[82] Mackenzie, "Military Orthopaedic Hospitals."
[83] *The Argus* 25 May 1918. 4.
[84] By May 1917 there were 10 orthopaedic centres in Great Britain and Northern Ireland. Mackenzie, "Military Orthopaedic Hospitals."

organisational inefficiency.[85] Such problems drove war historian Butler to recognise physiotherapists as specialists concerned about the inadequacy of treatment for wounded men. He criticised medical men generally for their lack of knowledge of physiotherapy. Butler extolled the physiotherapy women's 'devotion to their accepted duty and a standard of performance ... put the medical profession to shame'.[86]

In the early period of the war, severely wounded men sailed from Egypt to England, many on the hospital ship, *Karoola*. In December 1915 the *Karoola* had returned the first wounded and ill men to Melbourne, displaying the realities of war.[87] Between October 1915 and November 1918 the *Karoola* carried 8953 men home with more than 1000 physiotherapy treatments each trip.[88] In preparation for the repatriated wounded the Army commandeered mansions such as 'Glen Eira' at Caulfield in August 1916, where barrack-like wards were built, becoming the 11thAGH. Additional wards would soon be needed as many disabled servicemen languished overseas in Egyptian and English convalescent camps. Whilst McWhae and Leeming strove to achieve improved orthopaedic treatment and rehabilitation at Weymouth, Private JC Bollard wrote to Prime Minister Billy Hughes in April 1917 alerting him to the poor conditions for the wounded men at Fovant camp on the Salisbury Plains.[89]

This political action contributed to additional repatriation of sick, wounded, demoralised and angry men. They suffered amputations, gas affected lungs often habouring tuberculosis, typhus and shellshock. Caulfield admitted its first patients in April 1917. From initially 200 beds, two years later there were over

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[85] Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 614, 661.
[86] Ibid. 826, 607-608.
[87] "Hospital Ship Arrives," *The Age*, 3 December 1915. 10. http://nla.gov.au/nla.news-article154918294 "Wounded Return," *The Argus*, 6 December 1915. 6. http://nla.gov.au/nla.news-article1583799. Both accessed 4 September 2014.
[88] Leeming, "Wartime Notes Mhm04477." Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. Ch.14. 696.
[89] Ford, *The Wounded Warrior.* 34. See also George Johnston, *My Brother Jack* (Australia: Harper Collins, 1964). *Passim.*

1000 patients but still too few medical and physiotherapy staff. Convalescent patients worked on site ostensibly as part of their 'reactivation'.[90] There were insufficient physiotherapists to cope with the rehabilitation needs of the men and more must be provided.

In 1917, with the increasing demand for physiotherapists, modifications were afoot to accommodate these needs.[91] Melbourne and the AMassA offered a one-year course. Forty-one women completed this course enabling graduates to focus on one aspect of physiotherapy: remedial gymnastics, massage or electrotherapy. All were subsequently employed in military hospitals: 'the experiment was a great success'.[92]

Vair Ethelwyn Horwood saw the advertisement for masseuses.[93] After leaving the Presbyterian Ladies College Horwood had been a rural governess, then replaced a male teacher who had joined the Army. Horwood's one-year study included Professor Berry's anatomy with second-year medical students, physiology, arranged by Professor Osborne, natural philosophy with Dr Laby and pathology. Drs Elizabeth Barrett, Victor Hurley, Bernhard Zwar and Mr Croad also taught. Edith Pratt and Annie Ochiltree were lecturers and Miss JT Thompson, who had spent five years at Madame Bergman-Österberg's College in England, taught Swedish remedial gymnastics.[94] Horwood completed medical electricity. Her uniform clearly identified the physiotherapists: navy ward dresses with white aprons, navy jacket and skirt with white blouses. Red on the lapels and the hat: the armband displayed 'MASSAGE CORPS'. Graduates were swiftly employed at 11thAGH, at St. Kilda Road Repatriation

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[90] Ford, *The Wounded Warrior.* 54-56. Rehabilitation terms also included reconstruction, restoration, overcoming.
[91] "Australasian Massage Association 30 June Report." 113.
[92] "Australasian Massage Association 30 June Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1920). 46. Similar arrangements occurred in Sydney.
[93] Horwood, "Oral History Record."
[94] Ibid. Nancy Davies, "Oral History Record," (~1979).

Department, McLeod and other hospitals and convalescent homes (Figure 5.10).[95]

Figure 5.10 Exercise equipment for muscle strengthening (above), electrical stimulation probably for a nerve lesion (below).[96]

Many Australian physiotherapists worked overseas from 1915 to 1919, close to military action unlike, as Linker has identified, their British and more latterly

[95] Horwood, "Oral History Record." McLeod see Larsson, *Shattered Anzacs.* Bulmer embarked for England in August 1915, returned to Australia in December 1918 to work at McLeod. "Frances Amy Bulmer," https://sites.google.com/site/archoevidence/home/ww1australianwomen/masseuses. Accessed 28 August 2014.
[96] AWM H18454A and H18756.

introduced North American colleagues.[97] These new wartime physiotherapists enhanced their knowledge and skills of fracture management, nerve injuries, complex and infected wounds, amputations, plastic surgery and burns as well as cardiorespiratory and other illnesses. With strict army style discipline, physiotherapists played significant roles in patient needs but they were low in the hierarchy, noncommissioned officers at best or 'volunteers' at worst.[98]

Despite the Massage Corps establishment, physiotherapy's status remained a bone of contention throughout the war. Leeming discussed the matter with Fetherston who reported to the government that the massage service was 'seething with discontent'.[99] Although Howse disagreed, Fetherston eventually recommended some commissions for the men.[100] Women physiotherapists, already treated as honorary officers, were angry at not being allowed to wear badges of rank as did the nurses with whom they were categorised, to the extent of being labeled 'Staff Nurses'. Recognition of the women's honorary officer status would create problems with the men wanting similar status.[101] Edgar Lovell deplored the low rank, as physiotherapists he considered were as important as doctors in usefulness to the army. 'Massage and hydrotherapy were recognised as curative for many complaints'.[102] Alfred Peters wrote the lack of recognition a 'great injustice' to those who had given up lucrative practices to serve.[103]

The lack of wartime status, the delay in achieving registration for physiotherapists and the requirement for medical referral contributed to Peters

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[97] Beth Linker, "For Life and Limb: The Reconstruction of a Nation and Its Disabled Soldiers in World War I America" (PhD, Yale University, 2006); *War's Waste: Rehabilitation in World War I America* (Chicago: University of Chicago Press, 2011).
[98] Ford, The Wounded Warrior. 34-81.
[99] Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 606.
[100] Leeming was designated as an Honorary Captain in the Reserve of AAMC Officers in 1931. "Wilfrid Leeming". National Archives of Australia http://recordsearch.naa.gov.au/SearchNRetrieve/Interface/DetailsReports/ItemDetail.aspx?Barcode=8197291 Accessed 12 November 2013.
[101] *Official History of the Australian Army Medical Services in the War of 1914-18*, 3. 606-607.
[102] Lovell, "The Status of Massage." 6.
[103] Alfred Peters, "Editorial," ibid.

forming the Victorian Massage Association (VMA) in 1916 (Figure 5.11).[104] Despite the men being clearly in control, thirty-four women joined with forty-one men.[105] Peters wanted all the hallmarks of professionalisation for his members.[106] He actively sought registration to improve status and protect physiotherapy's clinical exclusivity.

Figure 5.11 VMA Council, standing Messrs Mauguer, Llewellyn Jones, D Beck, sitting Edgar Lovell, Alfred Peters and JB Thomas.[107]

Peters editorialised in the *Victorian Massage Monthly* that the VMA would vigorously pursue registration to eradicate those that 'hoodwinked the public' partially blaming the medical profession who 'take a so-called practitioner of massage on trust'. His members practised 'a genuine system of scientific treatment'.[108] Peters exhorted them to approach their politicians regarding

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[104] The VMA accepted graduates from the AMassA/University curriculum, but issued its own diploma. See also Joint Conference, "Proposed Clauses for Insertion in the Massage Bill," ibid.
[105] "Membership," ibid.
[106] Freidson, "Theory and the Professions."
[107] "Membership."
[108] Articles on physiotherapy are included, some by local members: Edgar Lovell, Ignace Slaweski, and Clarence Weber.

registration.[109] Secretary Lovell stated the 'old established and moribund' AMassA had not progressed registration. The progressive VMA planned to follow the dentists whose registration achieved officer commissions, although their work was not as valuable as physiotherapy.[110] Perhaps reflecting Peters's connections, VMA Council member Llewellyn Jones became the lieutenant in charge of Victorian physiotherapists. But that was not enough: lack of recognition and status bedeviled physiotherapists.

Peters raged against the proposed use of orderlies (Leeming's trained assistants) to provide treatment. Army medical men must see that public opinion was behind qualified physiotherapists.[111] The *Monthly* published letters from serving members describing their work and the appreciation of their patients. These professional matters prompted the VMA and AMassA Councils to hold joint meetings during 1916 without any AMassA medical representatives. Peters again pressured attendees to influence their Members of Parliament (MPs). The meetings resolved that four members of each association would work together towards registration: the AMassA's Misses Pratt and Paton, Messrs Blunden and Croad, the VMA's Messrs Peters, Thomas, Jones and Weber. As the male physiotherapists had sought in Sweden and the Netherlands, Peters proposed removing medicine's authority over education, suggesting that physiotherapists should be trained by lecturers and examiners appointed by a physiotherapist-controlled registration board.[112] These wartime meetings enabled the physiotherapists to consider in detail their plans for registration, which would eventuate in 1923.

The contribution of physiotherapists during the war had raised their value in the eyes of the public and of some medical practitioners. War historian and medical practitioner Butler recognised that active rehabilitation should begin promptly after injury and criticised the most senior AAMC men as responsible for the conflict

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[109] Peters, "Editorial." 3.
[110] Edgar Lovell, "The Status of Massage," ibid. 5-6. Alfred Peters, "Editorial," ibid. 68.
[111] "Editorial." 35.
[112] Ibid. 68-70.

regarding physiotherapists' status and recognition. The AAMC leadership had entered the war without physiotherapy knowledge. [113] Butler wrote,

> This much at least is certain: whatever be the future of the Australian Service of Massage, its members can be assured that their art and technique will rest now on a scientific basis of clinical and experimental research. And for this they, and medical science in general, owe tribute to the pioneers of the war of 1914-18. [114]

Those pioneers had fought hard to make their contribution and had soldiered on under difficult and demanding conditions. In some respects their professional project suffered and the fact that physiotherapists included both men and women created confusion in official circles. They demonstrated a collective view in expecting more recognition and were demeaned in the eyes of those in control. Only Leeming received some modest official recognition. The women's role had been ignored, yet they were the only ones recruited to fill the need of more physiotherapists on the home front. The feminising of the profession had begun. In contributing to their developing identity, however, both men and women had embodied tenacity in seeking to serve and a commitment to their patients. Additionally, war experience influenced their treatment techniques. These progressed from the often passive applications of massage and electrotherapy, employed early in the war, to treatments, which still used massage and electrotherapy, but increasingly emphasised the more vigorous and active muscle reeducation and remedial exercise. The war produced further long-lasting gains for Australian physiotherapy. Medical men such as Murray, who worked with Kirkcaldie, Rooke and France Slaweski at AAH Dartford, continued a close working relationship with physiotherapists at the Melbourne Hospital and in the Masseurs Registration Board (MRB).[115]

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[113] Butler, *Official History of the Australian Army Medical Services in the War of 1914-18*, 3.616-617, 620.
[114] Ibid. 625.
[115] Widower Murray aged 46, enlisted 1915, medical officer indicating he wanted to serve 18 months.

Jennings worked with Stanley Argyle, a future Premier) who advocated and eventually becoming instrumental in achieving physiotherapists' registration.

A more general public recognition of physiotherapy's essential role in physical rehabilitation of the disabled was achieved, although physiotherapists would still need to promote their claims before the next war. Furthermore those women and men returning from service had to start again to build up their private practices and seek hospital honorary positions. Thus after the war registration, education and obtaining positions for clinical practice continued to occupy the minds of physiotherapists.

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https://www.awm.gov.au/people/rolls/R2001766/?query=captain+hugh+murray&section%5B0%5D=people&op=Search, http://recordsearch.naa.gov.au/NameSearch/Interface/ItemDetail.aspx?Barcode=7990476&isAv=N Both accessed 28 August 2014.

Chapter 6 Registration and educational advancement in depressing times

> *The year was not lacking in the, customary slab-to-slab romances, the most hectic of which was probably Doug's. He got it real bad, and was to be seen for weeks with an open, upside down, head and neck propped up on the leg he was meant to be dissecting, gazing abstractedly up towards the Massage Students. Such is love I suppose.*[1]

The working and social relationships between physiotherapists and medical practitioners began in the anatomy dissecting rooms of the University of Melbourne. The war demonstrated that many medical practitioners knew little of the role of physiotherapists in acute care, rehabilitation and management of chronic conditions, and, I suspect, few of the physiotherapy students in the anatomy rooms in the 1920s and 1930s knew much about their chosen career (Figure 6.1).

In these postwar years, which included severe economic depression, I explore several inter-related issues in the professionalisation of physiotherapy in Victoria. In particular, I consider the further development of professional education, and its shaping by state legislation and intra-professional rivalry between the AMassA and the breakaway VMA. Physiotherapists experienced from their medical colleagues a mix of competition, undervalued acceptance and enthusiastic recruitment from WW1 until 1939. As I will demonstrate this was a period of two polarised physiotherapy identities. Those represented by Alfred Peters: male, independent and autonomous in practice, separate from medicine and the University. And the subservient, genteel, traditional woman represented by Edith Pratt who wanted a university qualification and to serve medicine. Perhaps most other physiotherapists were somewhere in between, but all had a sense of responsibility to their patients.

[1] Medical Student's Society, *Speculum*, no. April (1938).

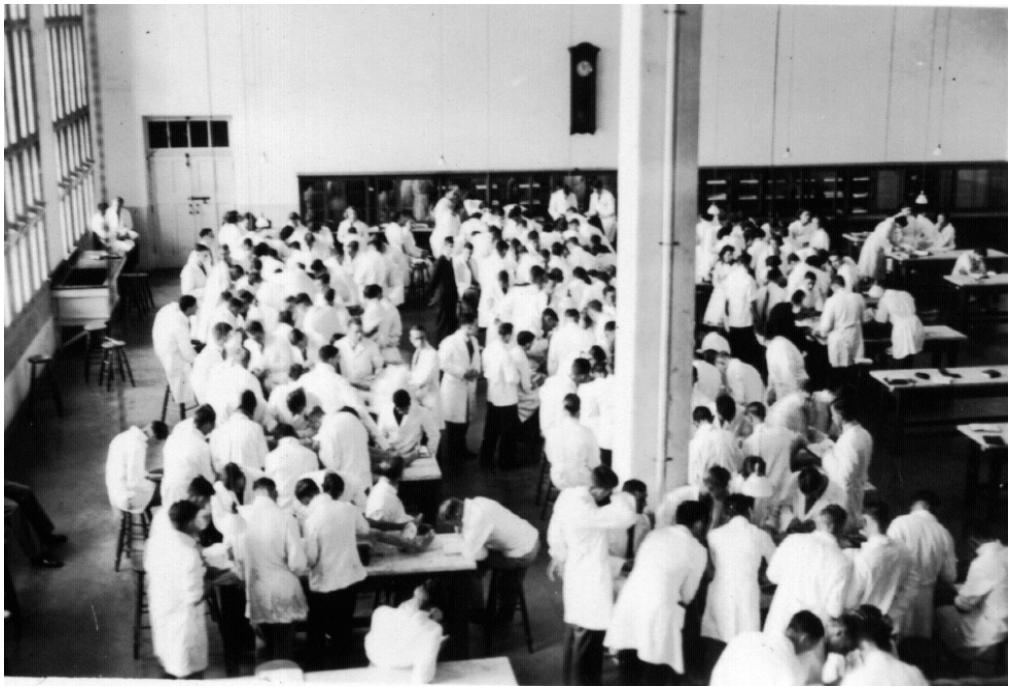

Figure 6.1 Anatomy dissection room University of Melbourne 1930s.[2]

Pratt can be credited with that sense of responsibility, but also possibly with the slow advancement in clinical education in the decade after the war as the AMassA and the University maintained their offerings. To maintain professional standards, graduates of the shortened course were required to complete the missing educational components, or cease practising. Horwood completed, as did Anne Latham, Ruth Billing, Mary McFarlane, Agnes Tregear and Victoria Alice (Vera) Carter, who had been a VAD. Whilst full records of the students are unavailable, *The Argus* newspaper sometimes published University examination results. In 1922 students passing Senior Anatomy included Billing and Latham: presumably then completing their course.[3] As she finished Horwood noted that the physiotherapists experienced with nerve injuries

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[2] Freda Bolwell photograph, author's collection.

[3] "University of Melbourne," *The Argus*, 11 January 1923. 3. http://nla.gov.au/nla.news-article1868150 Accessed 14 August 2014. Students Agnes M J Apperley, Ruth W Billing, Eleanor A Buncombe, Winifred M Gibson, Margaret Green, Gwendolyn Joske, Anne Latham, M Mackerode, Gwendolyn L Price, Marion B Stone.

> were very thrilled to get another chance to dissect and Professor Berry, ... told us that we had a very high standard to live up to because the last few years of massage students, their dissection had been better than the dissections that were being done by many of the medical officers who were doing the Master of Surgery course.[4]

Finally graduating, many of these physiotherapists now needed to volunteer in hospitals; hopeful of being referred private patients from the honorary medical staff. Horwood and others approached Murray, then medical officer responsible for physiotherapy at the Melbourne Hospital, asking if paid salaries were possible as they received few referrals. His response was extremely unpleasant, calling them 'rather nasty trade unionists' for their request.[5] All charity hospitals in Melbourne provided free physiotherapy for patients. Horwood's white coat was identical to those of the financially secure medical practitioners. But behind this symbol of authority hid a thirty-year-old woman who had given her talents for the country and was now, like many fellow physiotherapists, in reduced financial circumstances.

Despite ongoing postwar demands and rehabilitation roles for physiotherapists, many medical practitioners remained ignorant of physiotherapy or treated patients themselves with what they perceived as physiotherapy. Some medical practitioners sought commissions for referring patients to physiotherapists.[6] Attendees at the Belgian (medical) Congress of Physiotherapy in 1920, expressed concern at medicine's lack of physiotherapy knowledge, resolving that every medical school require obligatory training in physiotherapy and radiology.[7] Nonetheless, some Victorian medical graduates, such as Jean Macnamara and Kate Campbell, did know about physiotherapy as they had begun their lifetime associations with physiotherapists when, as prosectors in

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[4] McArthur Campbell, "Oral History Record."
[5] Horwood, "Oral History Record."
[6] "Victorian Massage Association 2 March Minutes," in *Victorian Massage Association 1921-1953* (1922).
[7] Correspondent, "Belgium Congress of Physiotherapy," *Journal of the American Medical Association* 17(1920).

the Anatomy Department at the end of the war, they taught physiotherapy students.[8] (See Chapter 7.)

Edith Adair who completed physiotherapy in 1918 exemplified the difficulties in achieving medical referral. Adair began honorary work at the Children's and Heidelberg Hospitals. She shared a Collins Street room, usually treating one private patient a week. Although the fee was a half guinea, she was lucky to receive 5/-. Money would be left discreetly; it was not discussed. Adair eventfully worked in Ballarat.

> We treated whatever we could get, and we learned as we went. I worked in an honorary capacity at the Ballarat Base Hospital, and built up a private practice. ... I used to tramp for miles around Ballarat carrying a stims machine. It was always difficult to get patients referred, when I first arrived I visited the doctors and only two or three even asked me what I did, but I tried to collect a nucleus that would refer. ... I think the doctors did not want to lose the fee. It was very difficult to earn a living.[9]

Despite their limited knowledge and lack of practical skills, medical practitioners could choose to offer physiotherapy themselves or employ untrained staff to do so.

The wartime publicity about physiotherapy attracted more than twenty students each year when Florris Chilvers and Maree Hancock commenced the course. ‘We attended (Professor Berry's) anatomy lectures at 9am each morning and dissection for the rest of the morning with the second year medical students’.[10] Physiology lectures, delivered by Dr Ian Maxwell continued with dental

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[8] Prosectors were the top medical students in anatomy who received special tutoring and taught their fellow students. See Jones, *Humanity’s Mirror 150 Years of Anatomy in Melbourne Department of Anatomy and Cell Biology*; Horwood, "Oral History Record." Ann G Smith, "Macnamara, Dame Annie Jean (1899–1968)," http://adb.anu.edu.au/biography/macnamara-dame-annie-jean-7427/text12927. Janet McCalman, "Campbell, Dame Kate Isabel (1899–1986)," http://adb.anu.edu.au/biography/campbell-dame-kate-isabel-12288/text22063. Both accessed 10 September 2014.

[9] Adair, "Oral History Record."

[10] Chilvers (Wiseman), "Oral History Record."

students and a medical practitioner gave pathology lectures. Second year students completed anatomy with third-year medical students and Miss Thompson (who had studied with Bergman-Österberg) taught medical gymnastics. After lunch students walked a mile to the Melbourne Hospital for clinical practice with Pratt and electrotherapy from Murray and Ochiltree. 'We started almost straight away treating outpatients' and medical men conducted physiotherapy examinations (Figure 6.2).[11]

Figure 6.2 The Medical School (left) and the Melbourne Hospital (right).[12]

Chilvers said physiotherapy was

> a very hard and exhausting programme. Three years squeezed into two. We all passed our final exams in 1920. ... We had entered a new era. Though we had been excellently taught, we had to teach ourselves an entirely new form of treatment. The days of massage and passive treatment of joints had gone and active movement and muscle re-education had taken its place.[13]

Chilvers indicated that clinical practice progressed faster than Pratt's clinical education, which had no direct war experience. However, three graduates at the end of WW1 influenced physiotherapy education and practice for decades.

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[11] Maree Hancock (Maling), "Oral History Record," (Australian Physiotherapy Association, 1978). The Melbourne Hospital, then in Lonsdale Street a mile from the University.
[12] Medical School www.mh.org.au/royal_melbourne_hospital/www/353/files/5-melbunimedicalschoolc1908.jpg, Hospital www.gallipolilegend.com/images/melb185.jpg. Both accessed 10 July 2015.
[13] Chilvers (Wiseman), "Oral History Record."

Margaret Hutchinson completed physiotherapy in 1919 and was awarded the University of Melbourne's physiology scholarship.[14] Hutchinson spent her professional life in the Physiology Department, teaching all physiotherapy, dental and medical students from 1920 for more than forty years. As was common for University employed women, she never rose above senior demonstrator. 'Her interest was deep and genuine and was directed towards maximising each person's abilities and independence' wrote Diana Dyason of Hutchinson. She taught people to think for themselves.[15]

Hutchinson taught Alison McArthur Campbell, a physiotherapy student from 1922 to 1924. McArthur Campbell later commented that compared to their anatomy lectures with medical students, having physiology lectures with dental students was 'a frightful comedown'. Dentistry did not have the status of medicine and McArthur Campbell, a friend of the Governor's wife, Lady Tennyson was very conscious of status.[16] Physiotherapists Stanley Sievwright, Misses Pagan and Duncan with Murray, now taught medical electricity.[17] Committed and ambitious, McArthur Campbell studied at the Swedish Institute in London and joined the STM's successor, the Chartered Society of Physiotherapy (CSP).[18] She worked with Dr James Mennell in London during 1926 and 1927. On returning to Australia, she commenced practice in Collins Street, the medical street for Melbourne's leading practitioners, while lecturing in Remedial Gymnastics from 1928 to 1939.[19] In WW2, McArthur Campbell

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[14] "Australasian Massage Association 28 February Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1920). 387 and "Australasian Massage Association 30 June Report." 47. See also Juliet Flesch, *Life's Logic 150 Years of Physiology at the University of Melbourne* (North Melbourne: Australian Scholarly Publishing, 2012). 59, 131-133, 180, 186, 217-218.

[15] Diana Dyason, 'Margaret Hutchinson (1899-1982)', University of Melbourne Gazette 1982. 14. Cited in *Life's Logic.* 131.

[16] McArthur Campbell, "Oral History Record."

[17] Ibid.

[18] The Swedish Institute founded in London in 1904 became St Mary's Hospital Physiotherapy School. SA/CSP/P4/1/2 Wellcome Institute.

[19] McArthur Campbell, "Oral History Record." Personal papers. In 1948 in England her thesis on "Scoliosis", gained her CSP Fellowship, an early Victorian physiotherapist with formal

was Senior Physiotherapist in the AAMC (Chapter 8). The third influential graduate, Vera Carter initially completed the one-year wartime course, followed by the additional year and a decade later substantially developed muscle re-education (Chapter 7).

Physiotherapy became increasingly popular, resulting in thirty-five students in the 1921 intake, some already with degrees: Helen Murdoch and Eileen Campbell had BAs.[20] As part of ongoing support for physiotherapists entering practice, and in an important initiative for new graduates, Jennings and Pratt successfully proposed that the Melbourne Hospital annually employ the four leading graduates of the course for one year.[21] This proposal mirrored the appointment of leading medical graduates to intern positions. New physiotherapy graduates joined either the AMassA or the VMA. The former had more women and the latter more men, but all had access to current information about medical and physiotherapy treatments and public health through their journals and continuing education lectures.

As physiotherapy undergraduate education moved into the next decade, the AMassA reinforced the importance of maintaining high educational standards.[22] Early in 1922, Melbourne, Sydney and Adelaide agreed again for national curricula consistency.[23] In Melbourne, perhaps as a result, introductory science was added to the curriculum.[24] Nevertheless despite agreement for reciprocal membership and a common curriculum, each State made its own

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postgraduate qualifications. She lectured in UK and USA on "Modern Concepts of Movement".

[20] Vair Horwood shared rooms in Collins Street, (AMassA Headquarters) with Helen Murdoch (Sir Keith Murdoch's sister and Rupert Murdoch's aunt) AMassA secretary.

[21] "Australasian Massage Association 1 August Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1921). 119. For decades making the Melbourne Hospital first choice for top graduates.

[22] "Australasian Massage Association 30 March Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1921). 211. Refers to Mennell, *Massage.*

[23] Pratt and Murray from Melbourne, Vida Kirkcaldie, Sydney, and Kate Gilmore Reid and Frederic Wood Jones, Adelaide.

[24] "Australasian Massage Association 1 March Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1922).

educational modifications.[25] The educational elements of professionalisation seemed secure with attachment to the Universities of Melbourne, Sydney and Adelaide. The States were fully united in advocating for protection before the law through registration, which Victoria was closest to achieving.

Anticipating physiotherapy control, the AMassA and the VMA had jointly prepared clauses for the proposed Act.[26] Considerable debate ensued regarding the gender balance of Board nominees. Some women preferred equal numbers. Peters argued for a male majority despite more physiotherapists being women. 'If the Parliament saw too many ladies on its Board', he opined, 'they would throw out the Bill'. [27] As a reflection of physiotherapy's professional identity, status and gender were compounded: Peters, and possibly many men viewed women as lowering physiotherapy's status. The final consensus supported four men and two women.[28] The physiotherapists envisaged that they would control the Board. The Bill did not pass the Legislative Council at its first presentation and had to be re-presented.

Stanley Argyle, medical practitioner, State Member of Parliament, now Vice President of the AMassA and physiotherapy advocate, explained political point scoring as responsible and advised that compromises were required to enable the Bill to pass.[29] This included permitting osteopaths to apply for registration, but as they would have to pass physiotherapy examinations this was unproblematic for the physiotherapists.[30] The most significant, unexpected compromise was that medical practitioners or anyone under their direction

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[25] "Australasian Massage Association 1 June Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1922). 70-73.
[26] Peters, "Editorial."68-70.
[27] Ibid.68-70.
[28] Joint Conference, "Proposed Clauses for Insertion in the Massage Bill," ibid.
[29] Sir Stanley Argyle became State Health Minister and Premier. In 1922 Helen Murdoch Honorary Treasurer, Leeming, member AMassA Council. Leeming and Murdoch still members 1930 with Dr Rupert Downes President. Vice Presidents included Sir Stanley Argyle. See AGL Shaw, "Argyle, Sir Stanley Seymour (1867–1940)," Australian Dictionary of Biography, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/argyle-sir-stanley-seymour-5049/text8415. Accessed 7 July 2014. "Australasian Massage Association 1 June Report." 67.
[30] Legislative Assembly Masseurs Registration Bill, amendment to Clause 6.

could perform physiotherapy. Much to the physiotherapists' chagrin this had been occurring for years and they had hoped that registration would prevent medical practitioners from continuing to employ whoever they wished to perform what they perceived as 'physiotherapy'.

> Notwithstanding anything in this Act no medical practitioner shall by reason only that he is not registered under this Act be debarred from carrying on the practice of massage or from recovering in any court any fee or charge for the performance of or for any advice relating to massage.[31]

A time-limited grandfathering clause admitting existing less well-qualified practitioners was also necessary to pass the Bill. Finally, the Masseurs Registration Board (MRB) comprised 'two medical practitioners and four persons, (at least one of whom shall be a woman)', two representatives each from the AMassA and the VMA.[32] Initially the VMA nominated Peters and Mrs Hamilton who declined and was replaced by Ernest Malins.[33] When the MRB commenced in 1923, it included Springthorpe, Murray, Pratt and Jennings all with AMassA affiliations. The first register comprised 195 women and seventy-five men.[34] Peters considered a physiotherapist should Chair the Board. Malins nominated Peters whilst Murray nominated Springthorpe. Pratt seconded Murray's nomination and Springthorpe became inaugural chairman.[35] Peters protested against a medical practitioner and not a practising physiotherapist as chairman.[36] Medical men had established control of

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[31] Victorian Parliament, "Masseurs Registration Act 1922," (Melbourne: Government Printer, 1922).
[32] Ibid. The Massage Bill passed on 20 December 1922.
[33] "Victorian Massage Association 23 January Minutes," in *Victorian Massage Association 1921-1953* (1923).
[34] "Items of Interest," *The Argus*, 14 February 1923. 20. http://nla.gov.au/nla.news-article1875828 Accessed 21 August 2014. T Dimelow, "Victorian Government Gazette Register of Masseurs," (Melbourne: Albert J Mullett, Government Printer, 1924).
[35] Registrar, "Masseurs Registration Board Minutes," in *Public Record Office Victorian Archives Masseurs Registration Board VPRS 1684/P0002. 19 February 1923-20 December 1928* (1923). 19 February.
[36] "Victorian Massage Association 20 February Minutes," in *Victorian Massage Association 1921-1953* (1923). 20 February.

physiotherapy, but throughout the long period during which he remained a member, Peters, an experienced chairman in many public spheres, frequently raised matters related to the conduct of the Act.

As occurred decades earlier in Europe, issues of power and control would continue between medical and physiotherapy men whilst long-serving MRB member Pratt always deferred to medicine.[37] The substantive educational decision at the first meeting was, with the addition of preliminary science and clinical pathology and therapeutics, the acceptance of the University/AMassA curriculum.[38] Springthorpe later reported all 'recommendations of the Board with regard to the curriculum were approved by the Governor in Council'.[39] Almost identical to its predecessor, it matched the curriculum approved by the other States.

In March 1923 the MRB asked the VMA Council whether they wished the University to take over physiotherapy education or it remain the responsibility of the Board. The VMA decided to 'stand firm to the Act'.[40] It is possible that the lack of unanimity in the Board decision was a factor in the University not accepting physiotherapy. Board minutes state that 'a letter be sent to the Registrar of the University setting forth the whole facts of the motion passed at the Masseurs Board meeting in regards to a University Diploma and that the VMA is unanimously against it'.[41] Peters was so outspoken within the wider community that dissension in the physiotherapists' ranks would become public. Such public brawling would be unfavourable to the University's reputation. Other University challenges were shortages of space and academic staff.

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[37] Ottosson, "When the Orthopedist Was a Physical Therapist." Terlouw, "Roots of Physical Medicine, Physical Therapy, and Mechanotherapy."
[38] Registrar, "Masseurs Registration Board Minutes." 19 February. "Australasian Massage Association 1 May Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1923). 54.
[39] "Australasian Massage Association 1 May Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1924). 61-62.
[40] "Victorian Massage Association 20 February Minutes."
[41] "Victorian Massage Association 4 March Minutes," in *Victorian Massage Association 1921-1953* (1924).

Student numbers had doubled from 1204 in 1917 to 2449 in 1922 and the University's government endowment was inadequate. On academic grounds however, diplomas were acceptable university qualifications.[42]

Board members at the AMassA Annual General Meeting planned to appeal to the University to undertake training and issue a diploma. Murray advised:

> Two members of the University Council have assured me there will be no difficulty whatever. They do the whole of the anatomy and physiology in both years at the University; the rest of the education is done at the clinical school of the University, the Melbourne Hospital.[43]

Medical practitioners' recognition of physiotherapy's value worried Springthorpe. He had taught medical students about physiotherapy and subsequently incorporated the substance of his lectures into two massive volumes.[44] Graduates of his teaching years should have been aware of physiotherapy but perhaps many preferred employing unqualified practitioners and gaining the fee.[45] The members of the AMassA considered that physiotherapy as a formal university qualification could improve public recognition, foster collaboration with medicine and improve physiotherapy's status. In October 1923 Murray and Pratt inquired regarding progress in connection with the University and implications for next year's curriculum.[46] Finally the Registrar's Office wrote 'that the Faculty of Medicine had decided that the University does not see its way at present to take any steps in the matter'.[47] A month later with Springthorpe absent, Murray supported by Pratt and Jennings resolved to communicate again with the Dean, Harry Brookes Allen. Peters and Malins strongly disagreed. Their members did not want a

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[42] MacIntyre and Selleck, A Short History of the University of Melbourne. 65-69.
[43] "Australasian Massage Association 1 May Report." 54.
[44] Springthorpe, Therapeutics, Dietetics and Hygiene.
[45] "Australasian Massage Association 1 May Report." 50.
[46] "Masseurs Registration Board 26 October Minutes," (1923). University of Melbourne archivists were unable to find 1923, Box 38 correspondence re Massage students.
[47] "Masseurs Registration Board 25 January Minutes," (1924).

University diploma. Peters considered it was a 'scheme' (a secret plot) whilst Murray resented Peter's use of the term.[48] Peters remained opposed to University medical control.[49] With a thriving practice, he did not need medical patronage; his patronage came from society's elite. His fellow physiotherapists were generally not so fortunate. It is probable that Murray resented Peters' social and clinical success. The tension between these two men continued to simmer, both more intemperate when Springthorpe was absent.[50]

Another challenge with Murray surfaced at the AMassA meeting. Wilfrid Leeming spoke about his discussions with the Red Cross regarding the establishment of a clinic for indigent people run by volunteer physiotherapists. Murray disagreed: he wanted all honorary work done at the Melbourne and Alfred hospitals. Medical men objected to physiotherapists treating patients elsewhere, they wanted to 'keep their patients under their own control'.[51] Springthorpe supported Murray citing how leading medical practitioners gave time to hospitals, despite their 'very large practices'. No consideration was accorded to the physiotherapist's generally much smaller and less lucrative practices.[52] Nevertheless, under Leeming's guidance physiotherapists supported the idea of a free clinic and extension of their voluntary service beyond the hospitals. In 1924 Leeming replaced Ochiltree on the AMassA Council and his physiotherapy colleagues continued investigating a clinic.[53] There is no additional reporting of this initiative: probably given the evidence above, it was quashed by medical influence.

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[48] "Masseurs Registration Board 22 February Minutes," (1924); "Masseurs Registration Board 30 May Minutes," (1924).
[49] "Masseurs Registration Board 30 May Minutes."
[50] "Masseurs Registration Board 22 February Minutes."; "Masseurs Registration Board 12 June Minutes," (1925).
[51] "Australasian Massage Association 1 May Report." 54.
[52] For example Ivo D Vellar, "Leo Doyle, Master Surgeon," *Australian & New Zealand Journal of Surgery* 70(2000); "Hugh Berchmans Devine: Surgical Visionary and Great Australian," *Australian & New Zealand Journal of Surgery* 70(2000).
[53] "Australasian Massage Association 1 May Report." 62.

In May 1924 Springthorpe reminded the AMassA that they were no longer an educational body but were becoming an ethical body.[54] In their first steps towards professionalisation the Association had already developed their first ethical principles of only accepting patients on medical referral, of which their medical colleagues frequently reminded them. Additionally they had agreed to not prescribe remedies and had adopted codes of practice in relation to advertising.[55] However the Association's professional goal was to have the course run by the University.

In pursuing this goal the MRB protagonists representing the AMassA cogitated over their next approach by considering the prerequisite school subjects necessary before commencing physiotherapy study.[56] Murray strongly advocated that the University take over control of the course, a move Peters and Malins vehemently opposed. Springthorpe, who had warned the AMassA against further involvement in educational matters, now voted with Peters and Malins to defer discussion with the University.[57] This vote occurred when Jennings was absent. Her presence would have tied the vote. It is unclear why Springthorpe changed his mind when he had previously expressed enthusiasm, particularly now that the university proposed 'a conference re the education of candidates for Registration as Massage Students'.[58] Perhaps Springthorpe perceived he may lose his control and it may have been in his interests to keep the AMassA and VMA disagreeing. Furthermore Springthorpe may have lost some of his passion for the university: in 1923 aged sixty-eight, the university had refused his reinstatement as a lecturer.[59] AMassA physiotherapists,

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[54] Ibid. For APA history Bentley, *The Path to Professionalism.*
[55] "Australasian Massage Association 30 May Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1905).
[56] "Masseurs Registration Board 2 April Minutes," (1924).
[57] "Masseurs Registration Board 3 May Minutes," (1924).
[58] "Masseurs Registration Board 30 May Minutes."
[59] 1919 Age Moratorium. The Argus 25 March. 4. http://nla.gov.au/nla.news-article1449736. Accessed 27 October 2015.

numerically the largest, aspired to the most advanced university learning.[60] High professional standards were embodied in the MRB women Jennings, and Pratt who

> demanded a high standard of training and great emphasis on the individual physiotherapist's responsibilities to the profession. She set an example with her high ideals and always impressed upon her students the importance of professional ethics and demeanor.[61]

Pratt imbued graduates with a sense of responsibility towards the less fortunate in the community, demonstrated by the commitment to honorary practice.[62] However VMA members such as Peters did not display Pratt's respectful demeanor towards the medical men.

In 1925 Peters continued to challenge the Board to carry out the requirements, such as chair and lecturer appointments as stated in the Act.[63] He proposed that the MRB approve the Alfred Hospital, at which honorary physiotherapists worked from 1903, for training students.[64] He thought the Melbourne Hospital 'a closed borough' and only the Melbourne physiotherapists could become lecturers. Murray claimed the Alfred was 'not ready', perhaps reflecting long-running tensions between the Melbourne and Alfred Hospitals.[65] The Children's Hospital appeared acceptable for training.[66] It is also probable that Murray wished to assert what he viewed as his superior medical authority over any suggestion of Peters. The Board's medical men had already managed to quash Peters's previous concerns regarding application to the University. The Board continued with its other business, making educational decisions,

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[60] "Australasian Massage Association 1 May Report." 51."Masseurs Registration Board 26 October Minutes."; "Masseurs Registration Board 25 January Minutes."
[61] Helen Todd, "Obituary Miss Edith Am Pratt," *Australian Journal of Physiotherapy* 6(1960).
[62] Bolwell (Kimpton), "Oral History Record." Nancy Prentice (Ashworth), "Re Mary Josephine Jennings," (Australian Physiotherapy Association, 1991).
[63] "Masseurs Registration Board 26 March Minutes," (1925).
[64] Mitchell, *The Hospital South of the Yarra.* 157. Stanley Argyle was responsible for the physiotherapists at the Alfred as was Murray at the Melbourne Hospital.
[65] Mitchell, The Hospital South of the Yarra. 3-25.
[66] Milton James Lewis, *Medicine and Care of the Dying: A Modern History* (Oxford: Oxford University Press, 2007). 38. "Masseurs Registration Board 1 May Minutes," (1925).

interspersed with frequent concerns regarding unregistered practitioners. Two months later though, with Springthorpe absent from the July meeting Murray and Peters were at loggerheads over what Murray perceived as Peters's unprofessional advertising.

In August, Peters drew to Springthorpe's attention that at the July meeting Murray had called Peters 'an advertising quack'. Peters strongly resented the insulting remark claiming he was a gentleman and always honourable. He demanded Murray withdraw his remark insisting that future meetings regarding this issue be minuted *verbatim*.[67] Ostensibly the argument was about advertising, but it was about medicine and physiotherapy, male power, status and control. Peters said

> I contend that I have a perfect right to advertise if I like. The British Medical Association have allowed Medical men to put their names to articles which was only another way of advertising. A 'Quack' was a man without knowledge of the business he dealt with and the statement could not apply to me. ... I have been 38 years before the public and am a better-known man than Dr Murray is or ever will be and I am not going to allow him to make assertions against me.[68]

Springthorpe attempted to keep the meeting under control, but Peters threatened to bring the matter before Parliament where 'Murray is looked upon as an old woman'. Springthorpe urged Murray to apologise. As the meeting degenerated further, Pratt resented 'this unseemly behaviour and protest against this ungentlemanly conduct'.[69] Always prepared to be provocative the annual general meeting of the VMA was reported in the press with Peters explicitly suggesting that the University could have a Professor in Massage (Figure 6.3).[70]

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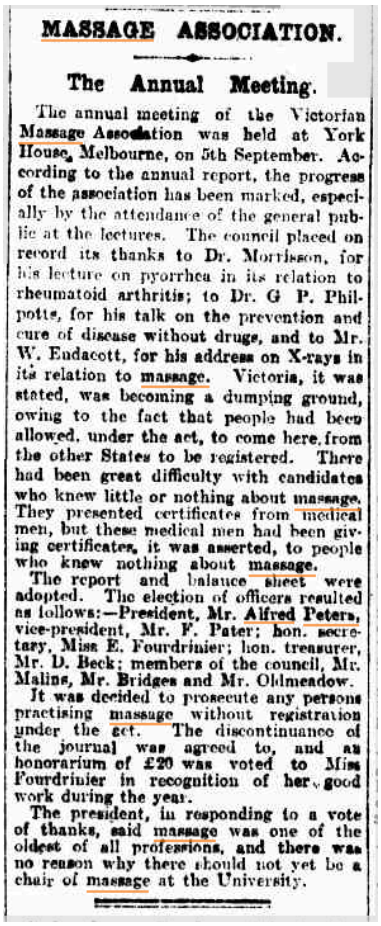
[67] "Masseurs Registration Board 28 August Minutes," (1925).
[68] "Masseurs Registration Board 23 September Minutes," (1925).
[69] Ibid.
[70] "Massage Association," *The Age*, 10 September 1925. 14. http://nla.gov.au/nla.news-article155810871 Accessed 5 August 2015.

From November 1925 through to February 1926 the argument rumbled on with Murray charging Peters with inebriation and issues of ethical conduct in relation to advertising from his address.[71] In this local example of a homosocial conflict Peters held the upper hand. His patients included Melbourne's most eminent; he presided over several Scottish and additional community organisations, had published several books and was frequently mentioned in local newspapers.[72]



MASSAGE ASSOCIATION.

The Annual Meeting.

The annual meeting of the Victorian Massage Association was held at York House, Melbourne, on 5th September. According to the annual report, the progress of the association has been marked, especially by the attendance of the general public at the lectures. The council placed on record its thanks to Dr. Morrisson, for his lecture on pyorrhea in its relation to rheumatoid arthritis; to Dr. G P. Philpotts, for his talk on the prevention and cure of disease without drugs, and to Mr. W. Eadacott, for his address on X-rays in its relation to massage. Victoria, it was stated, was becoming a dumping ground, owing to the fact that people had been allowed, under the act, to come here from the other States to be registered. There had been great difficulty with candidates who knew little or nothing about massage. They presented certificates from medical men, but these medical men had been giving certificates, it was asserted, to people who knew nothing about massage.

The report and balance sheet were adopted. The election of officers resulted as follows:—President, Mr. Alfred Peters, vice-president, Mr. F. Pater; hon. secretary, Miss E. Fourdrinier; hon. treasurer, Mr. D. Beck; members of the council, Mr. Malins, Mr. Bridges and Mr. Oldmeadow.

It was decided to prosecute any persons practising massage without registration under the act. The discontinuance of the journal was agreed to, and an honorarium of £20 was voted to Miss Fourdrinier in recognition of her good work during the year.

The president, in responding to a vote of thanks, said massage was one of the oldest of all professions, and there was no reason why there should not yet be a chair of massage at the University.

Figure 6.3 The VMA challenges the effectiveness of the MRB, medical practitioners professionalism and the potential for independent physiotherapy at the University.

[71] "Masseurs Registration Board 12 November Minutes," (1925).

[72] See *Punch* 6 October 1916. 532. Peters cited as Australian massage founder, introducing massage to Melbourne, St Vincent's and Homeopathic Hospitals, founded AMassA, promoted registration; ex-student Llewellyn Jones, Lieutenant in the Massage Corps, which Peters instrumental in establishing. Prominent names abound.

In early 1926 Peters attempted to prevent Pratt and Murray, as members of the Board, appointing themselves as lecturers and examiners. Springthorpe indicated medicine had set that precedent and the physiotherapy women supported the medical men defeating Peters.[73] To irritate Peters even further, Murray deputised as Chairman whilst Springthorpe was away. In this tense environment Malins resigned, Fred Porter and Peters represented the VMA.[74]

At the end of 1928 the tension between Peters and Murray evaporated with Murray's illness. Peters eulogised Murray's work for physiotherapy. Murray responded, 'he had been twenty-eight years medical practitioner in charge of the Massage Department of the Melbourne Hospital and ... Peters and himself ... could reasonably claim to be the pioneers of massage in Victoria'.[75] Murray died within three months and the fire went out of MRB meetings. Dr Percy Bona became medical electricity and elementary pathology lecturer and an AMassA Vice-President in 1930.[76] Rupert Downes replaced Springthorpe as Chair of the MRB in May 1928, became AMassA President in 1930 and Director General of Medical Services in the coming war.[77]

The depression of the 1930s following the share market crash of October 1929 hit many families hard and those with paid employment were fortunate. Physiotherapists graduating through these years struggled to find work. Although unemployment was about ten per cent during the 1920s, by mid-1930, it was twenty-one per cent, reaching its peak in mid-1932 when almost thirty-two per cent of Australian men were unemployed. Australia was heavily in debt with international loan obligations to Britain. The soldier settlement schemes following the war were unviable, absorbing yet more funds.

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[73] "Masseurs Registration Board 30 March Minutes," (1926).
[74] "Masseurs Registration Board 3 May Minutes," (1926).
[75] "Masseurs Registration Board 20 December Minutes," (1928).
[76] Percy Arthur Bona graduated in 1901/2. See Brownless Medical Library MHM00493. Russell, *The Melbourne Medical School.* 223.
[77] "Masseurs Registration Board 3 May Minutes," (1928). AJ Hill, "Downes, Rupert Major (1885–1945)," http://adb.anu.edu.au/biography/downes-rupert-major-6008/text10265. Accessed 10 September 2014.

Australia's exported raw materials, then largely wool whose price was low, gained little income and imported manufactured goods were expensive.[78] As well as the extreme deprivation of poor families, many middle-class mothers where family incomes has declined, were still expected to be perfect housewives with many well-nourished children.[79] Feminists Vida Goldstein and Rose Scott indicated that most independent single women, like many physiotherapists, were living in relative poverty.[80]

For those working, in 1931, wage and salary workers had award rates cut by ten per cent. Public service salaries and social service pensions were cut by twenty per cent. Many men were sufficiently aggrieved to take political action through marches and demonstrations.[81] Others like my father, financially supporting his parents and sister, and several university academics, were attracted to the ideals of the Communist party.[82] Women activists sought equality. The bachelor girl and family planning had almost become acceptable, and there were young women, like my mother and many of her fellow physiotherapists who wanted to work and not be tied to a house with children in economic dependency, which could clearly be precarious.[83] The depression years presented challenges both to the MRB responsible for the course and the

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[78] Australian Government, "The Great Depression," http://australia.gov.au/about-australia/australian-story/great-depression. Accessed 5 June 2012.
[79] Grimshaw et al., *Creating a Nation.* 225-247, also McCalman, *Sex and Suffering.* Peter Macarthy, "The Harvester Judgement: An Historical Assessment," (1967); Tim Harcourt, "The Economics of the Living Wage," *Australian Economic Review* 30(1997).
[80] Grimshaw et al., *Creating a Nation.* 233. Financial insecurity features in many oral histories. Shurlee Swain, "Writing the History of Women and Welfare," *Australian Feminist Studies* 22(2007).
[81] Grimshaw et al., *Creating a Nation.* Karen Offen, "Women's Rights or Human Rights? International Feminism between the Wars," in *Women's Rights and Human Rights International Historical Perspectives*, ed. Patricia Grimshaw, Katie Holmes, and Marilyn Lake (Hampshire: Palgrave Macmillan, 2001). 243-253.
[82] George Bolwell, my father's 1930s personal diary. Having completed architecture there was little work, he worked as a Lands Department surveyor. Throughout his life he remained deeply concerned about and actively worked against wealth maldistribution in society. MacIntyre and Selleck, *A Short History of the University of Melbourne.* 75-77.
[83] Alison Mackinnon, "The State as an Agent of Demographic Change? The Higher Education of Women and Fertility Decline 1880–1930," *Journal of Australian Studies* 17(1993). *Love and Freedom: Professional Women and the Reshaping of Personal Life* (Cambridge: Cambridge University Press, 1997). 4-15. Freda Bolwell personal communications.

students. Yet poliomyelitis epidemics were increasing demands for physiotherapists and in these straightened times the Board considered lengthening the course.

Up to this point the course had changed little since its inception and students like Marjorie Farnbach who graduated in 1929 continued anatomy lectures with the medical students and in the dissecting room.[84] If young middle-class women found the experience of anatomy disturbing, this did not last long. Gwen Huon whose love of physiology at school motivated her to enter physiotherapy, said her first week in dissecting gave her a great shock and she lay awake at night wondering whether she could continue: she soon recovered to join fellow physiotherapists for whom this privileged knowledge of the body was part of physiotherapy's identity.[85] As was the development of a characteristic touch, embodied by Pratt. She emphasised massage, however the AMassA wrote to the Board in 1929, advocating educational changes and suggesting muscle re-education and splinting be included in the curriculum. This was not the first time the Board incorporated AMassA recommendations, indicating their tardiness in adopting clinical advances.[86] Students of the time also expressed some concerns regarding the physiotherapy content of the course.

Influenced by her aunt Vair Ethelwyn Horwood, Nancy Davies began physiotherapy in 1930. Students' criticism did not extend to anatomy. Davies said Frederick Wood Jones who had replaced Berry was a magnificent lecturer. Wood Jones taught physiotherapy students at Adelaide University: an AMassA member he was extremely popular with physiotherapy students. Davies 'had the privilege of two years with him'.[87] In her packed two-year course other lecturers included osteology from Mr

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[84] Marjorie Farnbach, "Oral History Record," (Australian Physiotherapy Association, 1987).
[85] Gwen Huon (Langmore), "Oral History Record," (Australian Physiotherapy Association, 1987).
[86] "Masseurs Registration Board 9 July Minutes," (1929).
[87] Monica MacCallum, "Jones, Frederic Wood (1879–1954)," http://adb.anu.edu.au/biography/jones-frederic-wood-6872/text11907. Accessed 3 September 2012. In 1937, Sydney Sunderland succeeded him.

Hughes Jones, physiology, Margaret Hutchinson, and remedial gymnastics, Alison McArthur Campbell. Arguably the problems were in the second year afternoons at the Melbourne Hospital with Pratt's clinical training in physiotherapy and Bona's in electrotherapy. Davies viewed some treatments as rather old-fashioned: whilst massage techniques and the handling of patients were excellent, fracture management had not kept up-to-date with limbs now encased in plaster.[88] Anticipating additional content, Jennings and Pratt proposed lengthening the course. Students needed more time 'to gain a complete knowledge of the science'.[89] Furthermore, in an unprecedented move, Downes, Jennings and Pratt would interview the lecturers regarding the course.[90]

The Board was fortunate that the lecturers were prepared to continue, but perhaps they had no choice. In the midst of the depression, the Board's finances were in deficit. Members agreed students' fees must not be raised; rather they reduced physiotherapist lecturers' fees to 7/6 in the pound.[91] There was no suggestion that fees to the University be reduced. In these straightened times, Victorian physiotherapists needed additional knowledge and skills in muscle re-education, particularly for treating people with poliomyelitis. Vera Carter provided free night classes in her flat for qualified physiotherapists such as Huon.[92] Due to her honorary work and dearth of private patients, Huon was still supported by her family.[93] Notwithstanding such pecuniary challenges for physiotherapists and the course, educational changes would eventually be made.[94]

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[88] Davies, "Oral History Record."
[89] "Masseurs Registration Board 12 December Minutes," (1930).
[90] Hill, "Downes, Rupert Major (1885–1945)". Accessed 10 September 2014.
[91] "Masseurs Registration Board 11 February Minutes," (1931); "Masseurs Registration Board 23 April Minutes," (1931).
[92] Vera Carter working with orthopaedist Charles Hembrow was instrumental in expanding muscle re-education. See Jean Kelsall and Meredith McComas, *A Guide to Muscle Re-Education as Taught by Vera Carter* (Melbourne: Australian Physiotherapy Association, 1966).
[93] Huon (Langmore), "Oral History Record."
[94] "Masseurs Registration Board 23 April Minutes."

The Director General of the Commonwealth Health Department forwarded a resolution to the MRB from the Conference on Infantile Paralysis regarding emphasising muscle re-education in the course.[95] A third year introduced in 1933 added detailed knowledge of and practise in muscle re-education, educational gymnastics and psychology. The latter taught by Dr Alice Barber, a medical graduate who practised psychotherapy.[96]Aura Forster commenced the course in 1931, abandoning her BA after being treated by Vera Carter. Forster completed the new 1933 third year. Charles Hembrow lectured and Vera Carter taught muscle re-education.[97] Forster shared Davies's reflections: 'the course was a good one – the theoretical work at the University of Melbourne was excellent with Professor Wood Jones's wonderful illustrated lectures on broad aspects of anatomy, and two years of dissection'.[98] Forster, later Head of the School of Physiotherapy at the University of Queensland was an extraordinarily experienced Australian physiotherapist who practised in England, Canada and the USA, undertaking many postgraduate courses and a CSP Fellowship. As one of the most knowledgeable and published physiotherapists of her era, Forster was well able to provide an informed opinion on Melbourne's course.[99]

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[95] "Masseurs Registration Board 25 June Minutes," (1931).
[96] "Masseurs Registration Board 14 January Minutes," (1937). Jean Kelsall (Blamey), "Oral History Record," (Australian Physiotherapy Association, 1987). "Alice Barber," https://www.unimelb.edu.au/unisec/utr/pdf/utr6079.pdf. Accessed 10 September 2014.
[97] Victoria Alice (Vera) Carter became an authority in muscle re-education. Kelsall and McComas, *A Guide to Muscle Re-Education as Taught by Vera Carter*. Barry, *Orthopaedics in Australia: The History of the Australian Orthopaedic Association*.96-100. Hembrow graduated from University of Melbourne in 1923, appointed Alfred Hospital 1930 developing close associations with physiotherapists. 99-100.
[98] Aura L Forster, "My Career as a Physiotherapist," (Australian Physiotherapy Association, 1990). Aura Forster, Archdeacon's daughter featured in social pages 1920-1930s. "School Speech Days," *The Argus*, 17 December 1929. 14. http://nla.gov.au/nla.news-article4057360 Accessed 9 September 2014.
[99] "My Career as a Physiotherapist."; "Physiotherapy in Australia."; "Physiotherapy – a Response to Challenge," *Australian Journal of Physiotherapy* 21(1975); Prue Galley, "Aura Louisa Forster Her Career as a Physiotherapist," in *Hygeia's Daughters Pioneer Women in the Health Sciences in Queensland*, ed. Lesley M Williams (Queensland: Unlverslty of Queensland, 1997).

Students in the 1930s entered physiotherapy for a variety of reasons. Mary MacInnes, had wanted to do architecture, but this course was too expensive since she had three younger brothers. And in this era, and with severe financial constraints, MacInnes and others indicated brothers' education took priority.[100] Nancy Davies' choice of physiotherapy reflected a common perspective 'I was not prepared to undertake a long medical course and did not wish to become a teacher after an arts course, so decided to do massage'.[101] Freda Kimpton's friend from Lowther Hall, Nancy Lloyd Green, studied physiotherapy.[102] Freda, my mother, was the youngest of six children. Unlike many, Freda earned her course fees. After attending Ascot Vale State School, as a scholarship student at Lowther Hall, she matriculated in 1929.[103] (Figure 6.4) Graduating dux of Zerco's secretarial college, Freda worked for five years teaching at Zerco's and as a stenographer to earn the physiotherapy fees.[104] Freda choose physiotherapy, as the cost of undertaking medicine was prohibitive. She loved anatomy, physiology and gymnastics, keeping many of her notes. Freda graduated at the height of Victoria's largest poliomyelitis epidemic and was employed full time in the Children's Hospital's itinerant service the day after graduation.[105]

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[100] Grimshaw et al., *Creating a Nation*. McCalman, *Journeyings: The Biography of a Middle-Class Generation 1920-1990*. Frequent references to male priority.

[101] Mary MacInnes (Robertson), "Oral History Record," (Australian Physiotherapy Association, 1992). Medicine was six years from 1931. See Russell, *The Melbourne Medical School.* 156.

[102] See University of Melbourne Brownless Medical Library Archive Nancy Lloyd Green MHM04506-8 Series 8. Younger sister of eminent physician Lorna Lloyd Green.

[103] Photos of Freda in Janet McCalman, *A Hundred Years at Bank Street Ascot Vale State School 1885-1985* (Ascot Vale, Victoria: Ascot Vale Primary School, 1985).

[104] Personal communication. Fellow students were Jean Edwick, Helene Forster, Helen Gadsden, John Stillwell, Ruth McCarthy, Cliff Peters, Brenda Oldmeadow, Charles Baker, Kath Duff and Winnie Buzacott. Most were not school leavers.

[105] Personal communication. Bolwell (Kimpton), "Oral History Record." Freda worked as a physiotherapist until seventy-eight years when her husband's ill health necessitated a full time carer.

SENIOR BASKET-BALL TEAM
N. Lloyd-Green, M. Farnbach, J. Youngman, F. Kimpton,
L. Lloyd-Green, M. Watson (captain), B. Brown

Figure 6.4 Lowther Hall's 1930s contributions to physiotherapy (Nancy Lloyd Green, Farnbach, Kimpton) and medicine (Lorna Lloyd Green).[106]

These interwar years changed education and clinical practice, particularly in the development of close connections between specialist medical practitioners and 'their' physiotherapists. Floris Chilvers worked with Charles Littlejohn as his specialist orthopaedic physiotherapist. Littlejohn began the first Orthopaedic Clinic at the Melbourne Hospital. He encouraged physiotherapists to attend his clinics and orthopaedic operations.[107] Littlejohn, strongly favouring manipulation and exercises, considered physiotherapy essential for complete recovery of orthopaedic cases: prevention of deformities, always part

[106] "Senior Basket-Ball Team," *Lowther Hall Chronicle* August(1926). 11.
[107] Chilvers (Wiseman), "Oral History Record."

of physiotherapy, became of paramount importance.[108] Tubercular joints, particularly spines and hips, osteomyelitis and congenital dislocations of hips remained serious afflictions. Littlejohn revolutionised the Melbourne Hospital's physiotherapy, retiring honorary staff and employing several senior physiotherapists like Chilvers in addition to the four annual newly-graduated physiotherapists. Describing the close working relationship between Littlejohn and herself Chilvers said:

> I was working in close contact with the Senior Surgeon and not just with the resident doctor. I was privileged to do the round twice a week with Mr Littlejohn and his assistants ... I saw the case before Surgery as well as after and heard the discussion between them ... Littlejohn encouraged me to attend the operations. ... At this time internal splinting was taking place and the whole situation changed. The long period in hospital was reduced and the results were much better. There was great excitement when the first Smith-Peterson nail was inserted into the neck of the femur. The patient instead of frequently being faced with immobility for the rest of their lives was able, in the matter of a few weeks, to take their body weight on their own legs.[109]

Chilvers designed a walking machine, probably Melbourne's first. Advances in surgery and daily physiotherapy improved patients in Chilvers' two orthopaedic wards.[110] In 1939, when war broke out, Littlejohn and then Bryan

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[108] Barry, *Orthopaedics in Australia.* 92-96. Littlejohn, captain and dux of Scotch College, won rowing blues at Universities Melbourne and Oxford, where a Rhodes scholar. In WW1 won MC and Belgian Croix de Guerre, WW2 he served at Tobruk, later consultant orthopaedic surgeon to AAMC.

[109] Chilvers (Wiseman), "Oral History Record."See also Gregory, *The Ever Open Door.* 270-271.

[110] Ibid.Littlejohn's assistants were highly qualified orthopaedic surgeons, Price and Keon-Cohen.

Keon-Cohen left.[111] Young Eric Price, an orthopaedic surgeon already involved with people with poliomyelitis, had the work of three men.[112]

Since 1914 physiotherapists' clinical experiences and expertise had grown. Their public profile expanded during WW1 but the ensuing depression and a decade of educational stagnation meant it was not until the 1930s that wartime and later advancements, already in clinical practice became fully incorporated into education, possibly limited by Pratt's control. A major step was legal sanction through registration, but it did not provide the full occupational protection desired or independence and the VMA thwarted the University taking over the course. This power play between Peters's VMA and their medical rivals and the predominantly female AMassA supported by medicine eventually kept medicine in control and the ratio of women to men gradually increasing.

Close respectful working relationships between medical specialists and the AMassA physiotherapists flourished, whilst their ethics kept them under medical control. Honorary work was expected and most physiotherapists chose to give their services rather than contravene professional ethics and seek patients independently. Poliomyelitis epidemics, another World War and student activism presaged changes in education and the status of physiotherapists in the eyes of their medical colleagues, governments with rehabilitation responsibilities and the public. But it was the physiotherapists' response to the poliomyelitis epidemics, the topic of the following chapter that had the next major impact on education and the professionalisation of physiotherapy.

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[111] Bryan Keon Cohen, *Things - and Other Things* (Glebe, NSW: Australian Medical Publishing Company Ltd, 1973).
[112] Chilvers (Wiseman), "Oral History Record."

Chapter 7 Poliomyelitis, physiotherapy and professionalisation

> *For the great part of the century it was polio that spread panic and paralysis in unequal proportions through the populations of the Western world. It created fear because it struck at children and it maimed rather than killed. Its symbol was less the coffin than the wheelchair, ... the 'iron lung' to enable victims to breath, and callipers and crutches to help them walk.*[1]
>
> *So little of the new history of the body has turned to ... the care of the sick, weak, aged or infirm whether in institutions, the family or neighbourhood ... no historical discussion of the body of the loved one. ... A historiography largely devoid of tenderness, of effect and indeed of respect.*[2]

Twelve-year-old Betty Bone admitted to Fairfield, then the Children's Hospital in 1937 was completely paralysed, residing in a double Thomas splint with an upper body and headpiece with 'blinkers' positioning her head. Each day two hours of physiotherapy comprised passive movements, muscle re-education and hydrotherapy. Alison McArthur Campbell, Betty's physiotherapist, fostered her lifelong enjoyment of reading. After three months Betty went to the Children's Convalescent Home at Hampton. Three years later, with only limited movement in her left arm Betty transferred to Austin Hospital to live, confined to a wheelchair. In 1960, now with an electric wheelchair, Betty moved to a hostel for disabled residents. Exemplifying the extraordinary independence of spirit and resilience frequently displayed by people with paralytic polio, Betty completed her Leaving Certificate, studied French, read

[1] Patrick Cockburn, "Polio: The Deadly Summer of 1956," *The Independent*, 27 October 2010. See also David J Wilson, "A Crippling Fear: Experiencing Polio in the Era of F.D.R.," *Bulletin of the History of Medicine* 72(1998); John R. Paul, *A History of Poliomyelitis*, A History of Poliomyelitis. (New Haven: Yale University Press, 1971). Victorian experience Rhonda Galbally, *Just Passions the Personal Is Political* (North Melbourne: Pluto Press, 2004); Joan Smith, *The Calliper Kids* (Victoria: Knox-Yarra Ranges Polio Support Group, 2009); Noel Spurr, *Spurr of the Moment the Story of Noel Spurr Oam* (Burwood East Victoria: Memoirs Foundation Inc., 2007).

[2] Roger Cooter, "After Death/after-'Life': The Social History of Medicine in Post-Postmodernity," *Social History of Medicine* 20(2007). Citing Jenner and Taithe in Cooter and Pickstone (eds) 2003. 199.

prolifically and was employed. She typed with her splinted left arm. By 1990 Betty required respiratory assistance at night. Retiring in 1992 Betty wrote her memoirs.[3] Her physiotherapists as part of her life, were creative in therapy and fostered her engagement with education and other opportunities.[4]

Betty contracted polio in Australia's largest paralytic polio epidemic in 1937-38, when peak notified incidence (39.1 per 100,000 population) occurred: over 4500 cases, half in Victoria. The medical practitioners and physiotherapists who cared for and treated the affected sufferers endeavoured to ensure that they recovered with minimal deformity and impediment to function (Figure 7.1).

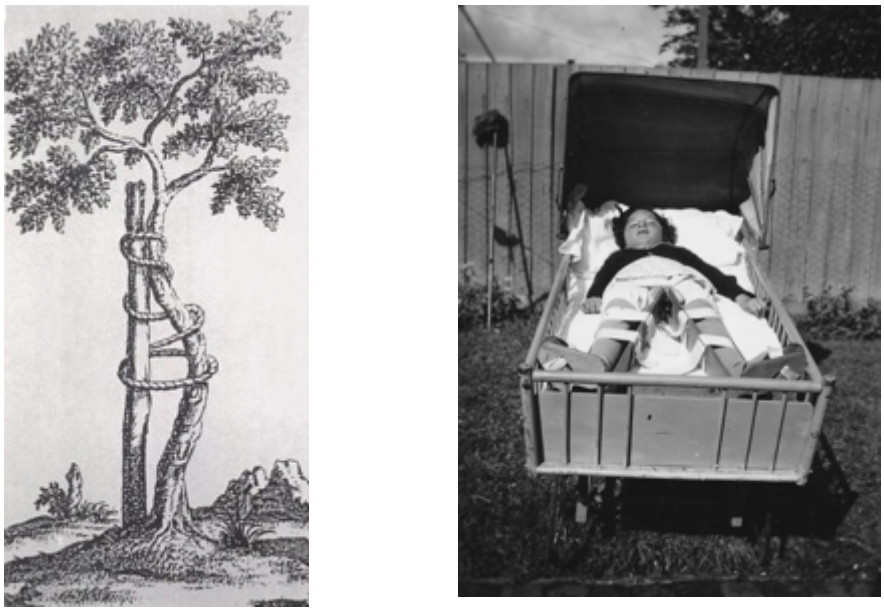

Figure 7.1 Nicolas Andry de Bois-Regard's, *Orthopédie*, 1741 to make children straight (left).[5] Child in a wooden papoose board in a specially constructed pram usually a father's role to manufacture (right).[6]

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[3] Betty Bone, "Oral History Record," (Australian Physiotherapy Association, 1994); Betty Bone et al., *Oyster Grit: Report on the Book Group Project for the Victorian Women with Disabilities Network* (Melbourne: VWDN, 2000).
[4] Ibid.
[5] Frontispiece Andry de Bois-regard, *L'orthope´Die Ou L'art De Pre´Venir Et De Corriger Dans Les Enfants Les Difformite´S Du Corps. Le Tout Par Des Moyens a La Porte´E Des Pe`Res & Des Me`Res & Des Personnes Qui Ont Des Enfants a` E´Lever*.
[6] Margaret Mack, *Photograph Album*, (Australian Physiotherapy Association Historical Collection: 1947).

Yet the experience of polio profoundly influenced affected individuals, their families and the treating physiotherapists whose professionalism mingled with affection. Furthermore this period significantly influenced the education, embodiment and professional identity of physiotherapists and contributed to the professionalisation of physiotherapists. Its effects were arguably greatest on the practitioners in the Itinerant Physiotherapy Service (IPS), established in the early 1930s to treat people with polio at home, where medical oversight was distant and infrequent. It enabled physiotherapists, now with clinical and economic independence, to further develop the personal attributes then considered to embody a 'professional'.[7] The IPS became the ultimate trigger that prompted physiotherapists to rescind the APA's medical referral requirement in 1976: the first in the world to do so.

This chapter outlines polio's story in Victoria from 1908, acknowledging Roy Porter's exhortations to reflect on the patient/family/physiotherapist experience. The interaction of the physiotherapists with their patients during the polio era has received little attention. Porter urged historians to write about these encounters emphasising that much healing occurs within families and communities.[8] Eliot Freidson advocated greater attention to the professional life of individual practitioners.[9] Whilst the relationships between medical professionals and their patients have spawned extensive discourse within philosophical, sociological and historical communities, this chapter draws attention to physiotherapists' interaction with patients.[10] As Terence Johnson examined the relationship of medical practitioners to their patrons, patients and the state, I demonstrate the indeterminacy of physiotherapists' engagement with

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[7] Freidson, "The Changing Nature of Professional Control."; "Theory and the Professions."
[8] Porter, "The Patient's View: Doing Medical History from Below."
[9] Freidson, "Theory and the Professions."
[10] David A Nicholls and Barbara E Gibson, "Editorial," *Physiotherapy Theory and Practice* 28(2012). The student riots in Paris in 1968 were influential on the thoughts of several of the now celebrated academics in the study of professionalisation such as those from the University of Leicester: Johnson, Jewson, Waddington and across the channel Michel Foucault.

medical practitioners, patients and their families and the state.[11] Contemporaneously physiotherapists had some understanding of psychosocial influences on health and pursued restoration of the whole body, in particular its physical function. They focussed on the overall capacity of individuals with specific physical treatment.[12]

The high demand for physiotherapists, who could provide the only treatment, brought everyone who could offer their services into the workforce. As will be discussed later, for a brief period the controversial, unorthodox and self-promoting Elizabeth Kenny, who claimed to be able to treat polio more effectively than physiotherapy, appeared. When tensions were acute around her treatment approach to polio, medical practitioners and physiotherapists supported one another. Most physiotherapists had little time to consider Kenny; they had too many patients. Many capable women emerge, Jean Macnamara, Vera Carter and the physiotherapists who gave much of themselves in managing people with polio.

Polio first came to the attention of Victorians in 1908. *The Argus* reported 'Epidemic Paralysis. Mysterious Infantile Disease' at the Children's Hospital. It began with a slight fever and vomiting followed within days by muscle paralysis and wasting. 'In many cases the affected muscles fail to regain their power and the subject is left a cripple for life. ... Paralysis is subsequently dealt with by massage and the use of special splints to relieve the helpless limbs'.[13] Polio, initially termed infantile paralysis is caused by an enterovirus with infection through the faecal-oral route. It is contagious during incubation and acute phases. Neck and back stiffness indicate central nervous system involvement, with pleocytosis in the spinal fluid, and possible paralysis with subsequent atrophy of muscles ending in contractures and permanent

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[11] Johnson, *Professions and Power*. 41-47.
[12] Beginning with Ling, from Roth, *The Prevention and Cure of Many Chronic Diseases by Movements* to Judith Pitt-Brooke, *Rehabilitation of Movement Theoretical Basis of Clinical Practice* (London Bailliere Tindall, 2012).
[13] Medicus, "Epidemic Paralysis. Mysterious Infantile Disease," *The Argus*, 15 August 1908.

deformity.[14] Polio paradoxically increased from the late nineteenth-century as improved public health reduced bacterial infections and poliovirus exposure reduced in infants.[15] Early exposure would confer immunity on most, as with each paralytic case 100-1,000 apparently innocuous infections occurred. [16] As people encountered poliovirus later, epidemics increased with the incidence of paralysis more common.[17]

In Victoria, infant mortality decreased between 1881 and 1940 from forty-six to fourteen deaths per thousand, attributable largely to improved sanitation, clean water and personal hygiene.[18] The local medical profession capitalised on these reduced death rates, appearing to be responsible for health improvements, but they could not combat polio.[19] Thousands died across the Western world, with sixty million people paralysed.[20] In the 1950s and 1960s, Salk and Sabin vaccines stopped polio epidemics in Westernised countries, however most people must be immunised to prevent epidemics.[21] Global eradication is still in jeopardy and effective treatment elusive. Whilst physiotherapy can maximise

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[14] WA Newman Dorland, *Dorland's Illustrated Medical Dictionary* (Philadelphia: WB Saunders, 1957); Charlotte Leboeuf, *The Late Effects of Polio: Information for Health Care Providers* (Commonwealth Department of Community Services and Health, 1990).
[15] AM Payne, "'Poliomyelitis as a World Problem," in *Poliomyelitis: Papers and Discussions presented at the Third International Poliomyelitis Conference* (Philadelphia: JB Lippincott and Co, 1955). 391.
[16] Paul, *A History of Poliomyelitis*. William H Barlow, "Treatment of Infantile Paralysis," *The British Medical Journal* (1882). Bernard Roth, "The Surgical and Orthopædic Treatment of Infantile Paralysis," ibid.2(1884). "Scientists Seeking a Cure for Paralysis," *New York Times* 1910. Richard Smallwood, "Strategic Planning Workshop - Polio Eradication in Australia," (2001).
[17] AS Evans, *Viral Infections of Humans* (New York: Plenum Medical Books, 1982). 212. 1980s research from Philippines and Egypt demonstrates similar incidence to polio as first half of the twentieth century USA.
[18] Pensabene, *The Rise of the Medical Practitioner in Victoria*. 49. Bryan Gandevia, *Tears Often Shed* (Sydney: Pergamon Press, 1978). 129-133.
[19] Ibid. 33-56. Pensabene cites changes from negative views of medicine to positive public opinion.
[20] Shell, Polio and Its Aftermath. 1-2.
[21] Paul, *A History of Poliomyelitis*. *Passim.* Victorian Percival (Val) Bazeley participated in developing Salk's vaccine, introduced Victoria 2 July 1956 when my siblings and I were amongst the first vaccinated. Oral Sabin commenced 21 August 1968.

function, there is no cure.[22] Now, with the exception of those whose lives were directly affected, polio is almost forgotten.

The first recorded Australian epidemic occurred in South Australia in 1895 and Colin Mackenzie noted Victorian epidemics in 1904, 1908, 1911 and 1914.[23] From 1912, more than 30,000 Australians suffered paralytic polio: those from 1916 to 1978 are depicted in Figure 7.2.

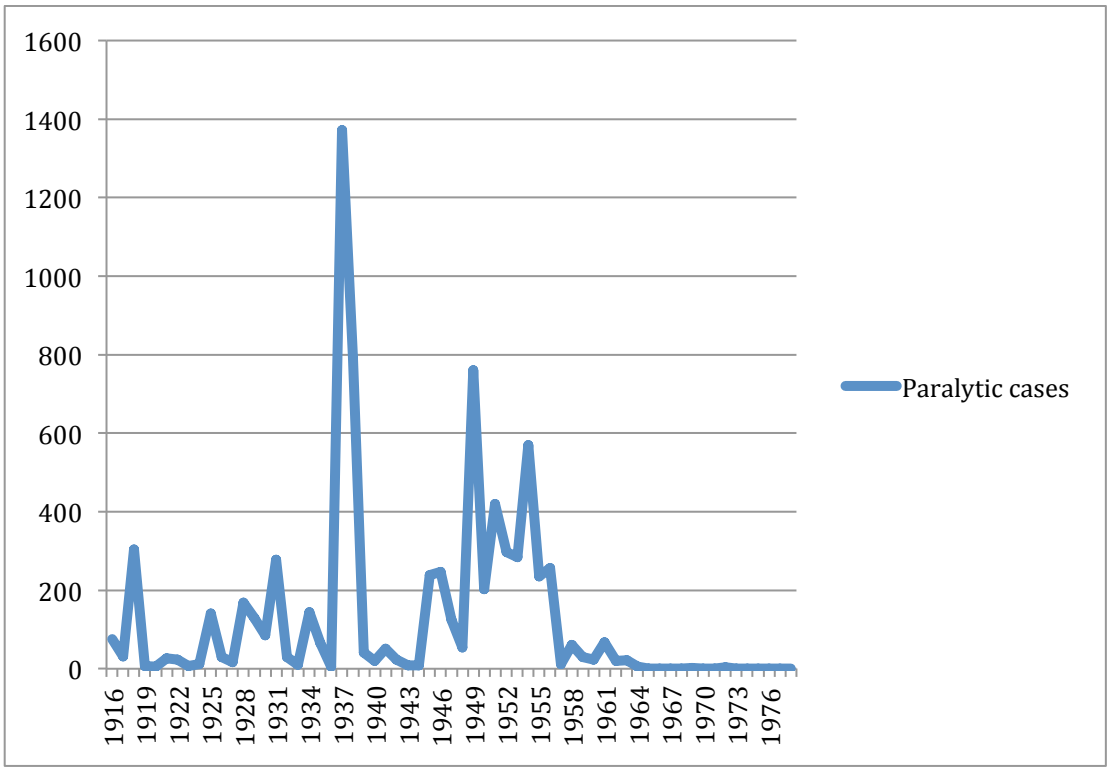

Figure 7.2 Victorian cases of paralytic polio.[24]

New graduates and students cared for people with polio and Mackenzie's 1908 student examination paper included a question on infantile paralysis.[25]

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[22] The World Health Organisation, Rotary and the United Nations Children's Fund continue to attempt eradication. "Polio Global Eradication Initiative," http://www.polioeradication.org. Accessed 14 January 2013.
[23] Charles H Hembrow, "Sir Colin Mackenzie and His Contribution to the Treatment of Poliomyelitis," *Medical Journal of Australia*, no. 1 (1973).
[24] Elizabeth Fussell, "Poliomyelitis and the Development of the Itinerant Physiotherapy Services in Victoria," (Australian Physiotherapy Association archive, 1996).
[25] "Australasian Massage Association 30 May Report," *UNA (Journal of the Victorian Trained Nurses' Association)* (1908).

Physiotherapists were already perceived as the practitioners to provide treatment.[26] Alan Marshall contracted polio in 1908, was hospitalised for two years, bedridden, splinted and separated from his family.[27] Like many authors, Marshall related the emotional trauma to families.[28] Local newspapers and medical journals alike discussed the incidence, symptoms, recovery statistics, potential treatments and the long-term crippling of polio.[29] In 1909, the Children's Hospital treated 130 affected children seeking more physiotherapists and physiotherapy students to work in an honorary capacity, an expectation until the mid 1930s.[30] For the few employed physiotherapists' financial recompense was poor: with no permanent employment and married women subject to dismissal.[31] By the 1917/18 epidemic wartime needs exacerbated the demand for additional physiotherapists.[32] A circumstance repeated two decades later.

Polio influenced some young people to become physiotherapists. Vair Trounson studied physiotherapy because she had suffered polio, later treating people with polio in the 1920s and 1930s at the Children's Hospital.[33] When

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[26] "Australasian Massage Association 30 September Report."
[27] Alan Marshall, *I Can Jump Puddles* (Melbourne: Cheshire, 1955). *Passim.*
[28] Dermod Maccarthy and Ronald Mac Keith, "Points of View: A Parent's Voice," *The Lancet* 286(1965); Dermod Maccarthy and Ronald MacKeith, "Twenty Years Ago: A Parent's Voice," *Archives of disease in childhood* 60(1985); Mary T Westbrook, "Changes in Post-Polio Survivors over Five Years: Symptoms and Reactions to Treatments," in *12th World Congress, International Federation of Physical Medicine and Rehabilitation* (Sydney1995); "Early Memories of Having Polio: Survivors' Memories Versus the Official Myths" (paper presented at the First Australian International Post-Polio Conference,"Living with the Late Affects of Polio", Sydney, 1996).
[29] Anon, "Epidemic Anterior Poliomyelitis," *The British Medical Journal* 2(1908); Medicus, "Epidemic Paralysis. Mysterious Infantile Disease."
[30] "Australasian Massage Association 30 May Report." "Australasian Massage Association 30 March Report." Yule, *The Royal Children's Hospital.* 193-194. See Farnbach, "Oral History Record."; Ivy Matheson, "Oral History Record," (Australian Physiotherapy Association, 1987); Beatrice E Burke, 1983; Chilvers (Wiseman), "Oral History Record."
[31] Summers, *Damned Whores and God's Police the Colonisation of Women in Australia*. Chapters 10 and 12. Grimshaw et al., *Creating a Nation.* 196-200. Abolished in the Commonwealth Public Service 1966.
[32] Yule, The Royal Children's Hospital. 194.
[33] Vair Trounson, "Oral History Record," (Australian Physiotherapy Association, 1988). The Hospital for Sick Children's (later Royal Children's Hospital) was in Carlton until 1966. See Yule, *The Royal Children's Hospital.* 33-41.

1920s graduates Alison McArthur Campbell and Nancy Prentice, became honorary physiotherapists at the Children's Hospital, physiotherapists Misses Nicholls, Stuart and Vivienne Bull, already specialised in polio treatment.[34] They, like their orthopaedic colleagues, subscribed to the importance of correct posture without deformity, the straight child.[35] These physiotherapists involved with polio were almost exclusively women as was the leading Victorian medical practitioner, Dame Jean Macnamara (Figure 7.3).[36]

Figure 7.3 Dame Jean Macnamara.[37]

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[34] McArthur Campbell, "Oral History Record."
[35] Armstrong, *A New History of Identity a Sociology of Medical Knowledge*. 38-40. Alison McArthur Campbell, "Posture Book," (Australian Physiotherapy Association Historical Collection, 1928); Tidy, *Massage and Remedial Exercises in Medical and Surgical Conditions*. 254-283.
[36] Desmond Zwar, *The Dame: The Life and Times of Dame Jean Macnamara, Medical Pioneer* (South Melbourne: Macmillan, 1984).76-78.
[37] 1967 photograph https://en.wikipedia.org/wiki/Jean_Macnamara Accessed 14 May 2015.

Brilliant, eccentric, egotistical, strong, obstinate and committed, Macnamara's influence in polio extended from the mid-1920s for 30 years.[38] Patricia Cosh said

> The Dame ... didn't visit homes, she made the initial decisions. ... She used to send out brief questionnaires with time of arrival and leaving. I used to spend quite a bit of time with parents because I think they needed the help as much as the child and I got abused for wasting so much time. ... So next time I only put in time I spent with child and then abused again for not putting in time with parents.[39]

Fairfield Infectious Diseases Hospital admitted city people with a polio diagnosis and rural people went to local hospitals. Following the acute phase, the Children's Hospital accommodated children who then returned home or had further physiotherapy at branches of the Children's at Hampton or Mount Eliza/Frankston. Those unable to live at home due to their severe disabilities went to Austin Hospital or Yooralla.[40] In 1928 major country hospitals appointed salaried physiotherapists such as Ivy Matheson to manage the influx of people with polio and continue the subsequent two to three years of intensive treatment.[41] Next year after admitting country children, Austin Hospital began employing previous honorary physiotherapists Misses Bowden and McGregor and recent graduate Nance Ashworth.[42]

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[38] Zwar, *The Dame. Passim.* Bolwell (Kimpton), "Oral History Record."; Rhonda Galbally and Patricia Cosh, Interview 21 November 2012.
[39] Patricia Cosh, Interview 23 February 2013.
[40] The Children's received its 'Royal' appellation 1953. Yule, *The Royal Children's Hospital.* 375. Yooralla began 1918 as a disabled children's kindergarten. "Yooralla," http://www.yooralla.com.au/about/history. Accessed 14 November 2014.
[41] Isabel Gill, *The Lamp Still Burns* (Maryborough: Bendigo College of Advanced Education, 1989).
[42] Fussell, "Poliomyelitis." 2. Gault and Lucas, *A Century of Compassion a History of the Austin Hospital*. 179-182. Prentice (Ashworth).

Macnamara successfully applied to oversee the Children's Hospital new physiotherapy department in 1928.[43] Three years later, with a Victorian Government Grant, she established the first IPS.[44] The IPS released hospital beds, reduced tedious outpatient appointments and engaged families in polio rehabilitation. The IPS provided physiotherapists with enhanced professional autonomy. Helen Todd, Gwen Stack and Vivienne Bull began treating patients at home; teaching mothers some physiotherapy and fathers how to manage splints. Stack was pleased to earn four guineas per week, with two guineas for her car to cover 1000 miles each month.[45] Through her physiotherapy colleagues, Macnamara aimed for maximum physical function with minimal residual deformity.[46] Macnamara, a prodigious worker, was also a laboratory scientist and in 1931, with Frank Macfarlane Burnet, determined the poliovirus comprised three serotypes, each with unique autogenic and biological characteristics, thus presaging later vaccine development and influencing ideas about virological and immunological disease.[47] Sir Macfarlane Burnett would receive the Nobel Prize and Jean Macnamara was made a Dame.

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[43] Jean Macnamara, "Preventative Orthopaedics and the Physiotherapist," *Medical Journal of Australia* 1(1951). Horwood, "Oral History Record." See also Jones, *Humanity's Mirror 150 Years of Anatomy in Melbourne Department of Anatomy and Cell Biology*.

[44] Fussell, "Poliomyelitis." See Robert W Lovett, "Fatigue and Exercise in the Treatment of Infantile Paralysis: A Study of One Thousand Eight Hundred and Thirty-Six Cases," *Journal of the American Medical Association* 69, no. 3 (1917); Lovett recommended USA home care in 1917 but there were no physiotherapists.

[45] Gwendolen Stack (Nichols), "Oral History Record," (Australian Physiotherapy Association, 1987). 1932 male basic wage, £4/5/8, female £2/3/11. "Wage Rates." 13. http://nla.gov.au/nla.news-article17046777 Accessed 13 May, 2015. Walter L Slifer, "Income of Independent Professional Practitioners," *Survey of Current Business* April(1938); J A Gillespie, *The Price of Health : Australian Governments and Medical Politics 1910-1960*, Studies in Australian History (Cambridge, Melbourne: Cambridge University Press, 2002).

[46] Yule, The Royal Children's Hospital. 193-224. Zwar, The Dame.

[47] FM Burnet and J. Macnamara, "Immunological Differences between Strains of Poliomyelitic Virus," *British journal of experimental pathology* 12(1931). Jean Macnamara, "Serum Therapy in Poliomyelitis," *The British Medical Journal* 1(1933). AB Christie, *Infectious Diseases: Epidemiology and Clinical Practice*, 3rd ed. (Edinburgh: Churchill Livingstone, 1980). GJV Nossal, "Burnet, Sir Frank Macfarlane (Mac) (1899–1985)," http://adb.anu.edu.au/biography/burnet-sir-frank-macfarlane-mac-12267/text22019. Accessed 24 December 2012.

As Macnamara worked in the laboratory and with her patients, numbers and demand for physiotherapists increased. The Government After Care Committee, of which she was a member, subsequently funded the IPS.[48] In patients' homes, without medical supervision or physiotherapy colleagues to turn to, physiotherapists made independent, autonomous decisions regarding progressing treatment, constructing creative splints or devising ways of teaching parents to undertake daily physiotherapy, mainly highly personalised muscle re-education for their family member.[49] Physiotherapists were pleased to practise unencumbered by a need to extract fees from children's families, although adults' treatment required payment until 1950.[50] Physiotherapists often worked twelve-hour days and longer on country trips. There was neither overtime nor time off *in lieu*.[51] Gradually the State funded more paying positions: married women were actively recruited and employed in contrast to the requirement for public service women such as teachers to resign on marriage.

My mother, Freda Kimpton, who graduated in 1937, exemplified these transformations. She was immediately employed full-time in the Children's IPS. She reported to Molly Lumley, who recollected that because of the overwhelming patient numbers, children were often sent home early, still very ill.[52] Concerned for the children and their families, physiotherapists were too busy to spend time worrying about their own risks.[53] Freda, whilst regretting the lost opportunity to be in a hospital's supportive environment with the guidance of senior physiotherapists, had to negotiate for herself the ethical intricacies of working in patients' homes. The physiotherapist's licence to touch, to move, mobilise and manipulate the patient's body could potentially

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[48] Health Bulletin, "Report on after Care," ed. Health (Melbourne1937-1947).1393-1398.
[49] Freidson, *Profession of Medicine.* 53, 76-79, 91-92. "The Changing Nature of Professional Control"
[50] See Cosh; Beatrice E Burke, "Oral History Record," (1990).
[51] Fussell, "Poliomyelitis."
[52] Ella Remfrey (Molly) Lumley (Gordon), "Oral History Record Itinerant Poliomyelitis Service," (Australian Physiotherapy Association, 1996).
[53] Conversations with my mother.

present ethical difficulties. The domestic environment provided treatment areas very different from the regimented hospital: it was not a clinical space.

Freda's patients lived in North Melbourne's slums: poor, often large families, outside privies - circumstances that could defeat the most conscientious mothers (Figure 7.4).[54] Although physiotherapists wore the professional white coat, it was frequently discarded, as its hospital associations could distress children or because it was too hot and cumbersome. Patients might be treated on the kitchen table, the lounge room floor or the bed. Without the veneer of professionalism afforded by a uniform and the clinical hospital, reducing 'the inherent sensuality of physical contact between practitioners and patients' could present challenges depending on the gender and age of both participants.[55] 'Physical intimacy reinforced emotional intimacy'.[56] Maintaining a professional demeanor through years of interaction could be especially difficult when the physiotherapist became 'part of the family', visiting several times weekly. Whilst the intimate physiotherapy treatment approach emphasised a biomedical view of the body, the physiotherapists empowered families to undertake treatments and patients and their families invariably introduced subjective, personal, social, cultural and economic perspectives.[57] Wikström-Grotell, Eriksson, Nicholls and Gibson have noted the biomedical perspective of physiotherapy and while this undeniably persisted, the socio-cultural aspects of physiotherapy were forcibly foregrounded for IPS practitioners working in patient's homes.[58]

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[54] For perspective of Melbourne's slums Janet McCalman, *Struggletown: Public and Private Life in Richmond, 1900-1965* (Carlton, Vic: Melbourne University Press, 1985).
[55] Nicholls and Gibson, "The Body and Physiotherapy."
[56] Janet McCalman, "The Power of Care: The Women's Hospital 1884-1914," *Nursing INquiry* 5(1998).
[57] Eileen Webster, "Charles Hembrow's Lectures on Muscle Re-Education," (Melbourne: School of Physiotherapy, 1938); Galbally and Cosh.
[58] Camilla Wikström-Grotell and Katie Eriksson, "Movement as a Basic Concept in Physiotherapy-a Human Science Approach," *Physiotherapy Theory and Practice* 28(2012); David A Nicholls and Barbara E Gibson, "The Body and Physiotherapy," ibid.26(2010).

Domestic visits brought many such issues into stark relief. Cosh indicated parents required considerable support.[59] It was the physiotherapists who visited two to three times every week and listened to parents' concerns and assisted with a multiplicity of problems.[60] Cosh's patient, Rhonda Galbally, who contracted polio when thirteen months old, spent many months in hospital, she had:

> Not lots of contact with parents because the practice was a visit once a month ... It was thought that families were disruptive ... when families came children would cry and scream. I didn't come home until I was about three. ... Because she (her mother) wasn't coping.[61]

Figure 7.4 Freda Kimpton second from left. Child in double Thomas splint.

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[59] Cosh.
[60] Betty Bone, "Remembering Alison Mcarthur Campbell," (Australian Physiotherapy Association, 1994); Noel Spurr, "Oral History Record," (Australian Physiotherapy Association, 1996); Fussell, "Poliomyelitis and the Development of the Itinerant Physiotherapy Services in Victoria."; Galbally and Cosh; Cosh.
[61] Galbally and Cosh. Mothers were expected to care for the ill or disabled.

Whilst many physiotherapists appear to have modelled their professional behaviour on Edith Pratt, treatment emphasis was muscle re-education, splinting and restoration of function. Physiotherapists aligned with the orthopaedists' view of minimising deformity through splinting whilst muscles recovered: a perspective relevant to the Kenny controversy (Figure 7.5).[62]

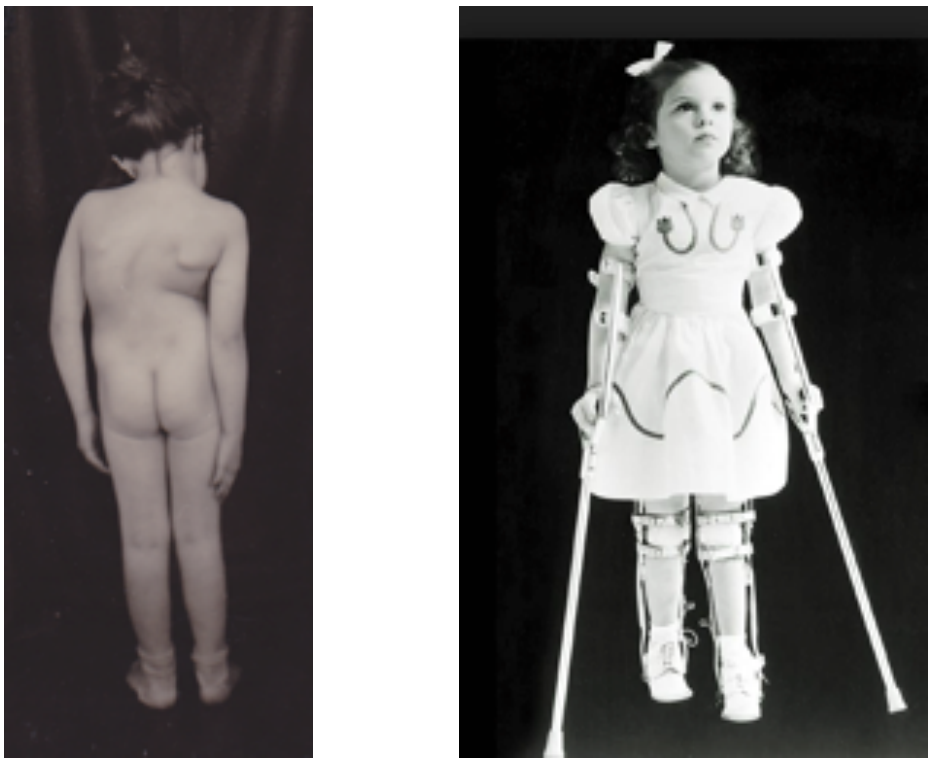

Figure 7.5 Untreated child who probably suffered undiagnosed polio, asymmetrical muscle weakness produced scoliosis, worsening with growth (left).[66] Child with callipers on both legs indicating that both have polio-induced muscle weakness, (right).[67]

[62] Shell, *Polio and Its Aftermath* 15. See also many orthopaedic sections in Yule, *The Royal Children's Hospital.*
[66] Alison McArthur Campbell, "Mcarthur Campbell Photograph Album," (Australian Physiotherapy Association Historical Collection).
[67] Google Images polio.jpg meddlingkids.org Accessed 12 September 2012.

Figure 7.6 Children propped standing in double Thomas splints to improve kidney function. Legs widely abducted to prevent gluteus medii stretching.[68]

Victorian physiotherapists in high demand made unique contributions to treating people with polio; their income remained low but was more reliable.[69] Graduating physiotherapists were required to be conversant with assessment and treatment of polio. Education built on students' already detailed understanding of kinesiology, functional anatomy and physiology of the neuromuscular system.[70] All western countries shared these principles, but Britain had no routine treatment, sometimes using sling and spring suspension exercises and electrical muscle stimulation.[71] However, British medical practitioner Gordon McCracken who suffered polio, considered his physiotherapists, who universally tend to have a sensitivity towards individuals, treated his 'mind as well as his body' more effectively than medical

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[68] Mack, *Photograph Album*.
[69] Fussell, "Poliomyelitis and the Development of the Itinerant Physiotherapy Services in Victoria."
[70] Webster, "Charles Hembrow's Lectures on Muscle Re-Education."
[71] Barclay, *In Good Hands.* 144-145.

colleagues.[72] In North America, as in Australia, polio proved influential especially in physiotherapy's professional development.[73]

Victoria, in contrast to the aforementioned countries, benefitted from a highly organised polio service and focussed education.[74] From 1933 until 1957 Charles Hembrow lectured, whilst Vera Carter taught the practical elements of muscle re-education.[75] Hembrow used polio as his main vehicle for muscle re-education, stating that the most important muscles for recovery and predicating future function were hip extensors, quadriceps and calf. Opposition of the thumb, elbow flexors, deltoid and abdominal muscles were vital. Rest, prevention of deformity, physiotherapy and limited surgery requiring collaboration between doctor, physiotherapist and patient, favoured recovery. Stretching and fatigue of weakened muscle hindered recovery. Hembrow advocated maintaining treatment whilst improvement continued, usually two or more years.[76] He cited Robert Lovett's research demonstrating that expert treatment increased by more than three times the chance of improvement in muscles not totally paralysed by polio.[77] Apparently mild cases also required long-term observation. Hembrow's advice forecast the post-polio weakness such as Betty Bone's challenged respiratory muscles.

Physiotherapists performed muscle grading with patients examined fully undressed, posture noted, joint range checked and functional movements

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[72] Ibid 145.

[73] Wilhelmine G Wright, "Muscle Training in the Treatment of Infantile Paralysis," *The Boston Medical and Surgical Journal* 167(1912); "Crutch-Walking as an Art," *The American Journal of Surgery* 1(1926); Elsa Ramsden, "Physical Therapy in the United States of America," *Physiotherapy Theory and Practice* 3(1987). Cleather, *Head, Heart and Hands.*25-39. Murphy, *Healing the Generations*. 34-39, 123-130.

[74] Fussell, "Poliomyelitis and the Development of the Itinerant Physiotherapy Services in Victoria."

[75] Kelsall and McComas, *A Guide to Muscle Re-Education.* Webster, "Charles Hembrow's Lectures on Muscle Re-Education."

[76] Ibid. 25.

[77] Robert W Lovett, "Fatigue and Exercise in the Treatment of Infantile Paralysis: A Study of One Thousand Eight Hundred and Thirty-Six Cases," *Journal of the American Medical Association* 69(1917). Lovett established a system of testing and recording. In August 1921 Lovett, diagnosed Franklin D Roosevelt with polio.

observed. All muscles including tongue, face, palate and eyes required testing and grading. Two grading systems were noted, the nominal 'gone, trace, poor, fair, good, normal' and the favoured Children's Hospital numeric method of 0-6. Hembrow said. 'Treatment is simple in principle but complicated in detail'.[78] He invoked John Hunter regarding the importance of the patient's intellectual and physical commitment to exercise.[79] Restoring muscle power required daily treatment, individual muscle re-education using assisted through to active and resisted exercises, often initially with a powdered board, postural re-education and functional activities (Figure 7.7).

Hembrow stressed special risks such as scoliosis.[80] Patients rested in individually fitted double Thomas splints.[81] Corsets supported weak abdominal muscles and these people required daily breathing exercises. Other splints prevented or minimised deformities due to muscle imbalance, weakness, gravity and habitual postures, with additional warmth to minimise trophic changes and limb shortening (Figures 7.8 and 7.9).[82] Surgery was occasionally used but could make function worse.[83]

Physiotherapist Eunice Winter had polio as a child and Todd treated her. Winter considered Hembrow's teaching of posture and movement, the idea of a perfect body and the influence of muscle tone crucial to physiotherapy education.[84] Hembrow was viewed as a staunch advocate for physiotherapy and served on the AMassA and the MRB.[85] Cosh said he was 'well-respected at the

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[78] Webster, "Charles Hembrow's Lectures on Muscle Re-Education." 31.
[79] Ibid. 44. Hembrow quoting John Hunter 1728-1793.
[80] Ibid. 45-49.
[81] Jean Macnamara, "The Use of a Modified Double Thomas Frame in the Treatment of the Paralyses of Poliomyelitis," *The British Medical Journal* 2, no. 3754 (1932).
[82] Smith recalled sheepskins and her small electric blanket. Joan Smith Interview 6 June 2013.
[83] Joan Smith, 6 June 2013; *The Calliper Kids*. 4-5. Galbally and Cosh.
[84] Eunice Winter, "Oral History Record," (1987).
[85] Charles H Hembrow, "The Role of Physiotherapy in Orthopaedic Surgery," *Australian Journal of Physiotherapy* 3(1957). Member of the Board in 1940s and 1950s, see Public Record Office Victorian Archives Masseurs Registration Board VPRS 1684/P0002.

Alfred ... and at Austin. ... I think Charlie Hembrow had quite a big influence (on education) because he had a big influence on Vera'.[86]

Figure 7.7 Child in a tank respirator (left) where physiotherapy comprised passive and if possible active movements. Nancy Davies, physiotherapist, gaining active muscle contraction (right).[87]

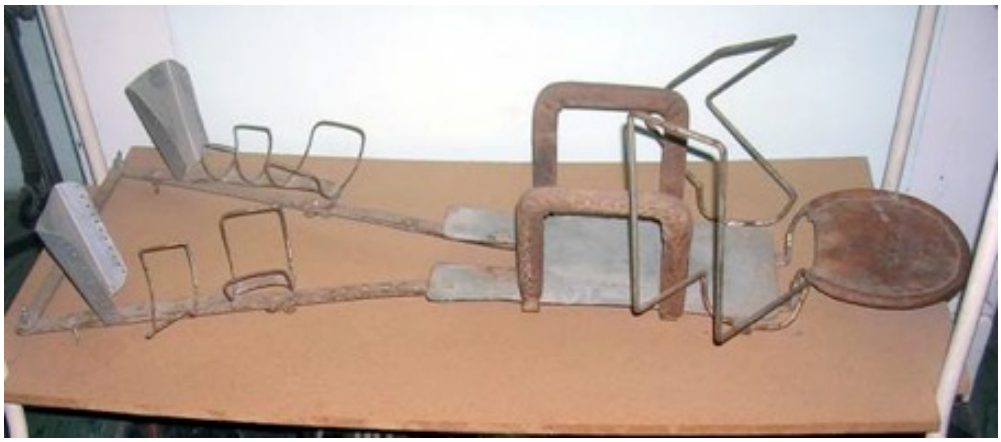

Figure 7.8 Upper body piece on a modified Double Thomas splint.[88]

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[86] Cosh. Elsa Spark, "Oral History Record," (Australian Physiotherapy Association, 1987). McLoughlin.
[87] Yule, The Royal Children's Hospital. 199, 202.
[88] "South Australian Medical Heritage Society Inc Website," http://samhs.org.au/Virtual%20Museum/hospital-andother-orgs/JamestownMuseum/Jamestown-Museum.html. Accessed 17 October 2012.

Figure 7.9 Standing in a mobile frame used for schoolwork and meals, wearing bilateral long leg callipers with square ferrules.[89]

Cosh, Head of Victoria's Physiotherapy School from 1960-1985, viewed her 1940s Victorian education superior to Britain as Vera Carter taught students how to grade and sequence exercises, critical for all patients but of paramount importance in physiotherapy for polio.[91] Many physiotherapists and medial practitioners considered Carter's teaching invaluable.[92] Hembrow wrote:

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[89] Australian Physiotherapy Association photograph.
[91] Cosh.
[92] Mildred Green, "Interview with Joyce Thompson," (Australian War Memorial1984). Bolwell (Kimpton), "Oral History Record."; Forster, "My Career as a Physiotherapist." Spark, "Oral History Record." McLoughlin.

> Her genius achieved ... the practical application of basic principles adapted to each case. ... Application of the knowledge required subtle qualities that escape definition - judgement, personality, common sense, great patience, power to inspire the patient with confidence in himself and in his physiotherapist, sympathy and understanding in his difficulties as well as imagination and ingenuity in translating and explaining the procedure in simple terms and in using measures applicable to each age, stage and type.[93]

Carter's approach encompassed many neuromuscular conditions, posture and physical fitness for people of all abilities including Olympic athletes. Carter also taught the University's physical education students.[94] In the USA, the highly influential Kendalls recognised Carter's work (Figure 7.10).[95] Elsa Spark summarised the general physiotherapy view of Hembrow and Carter. 'The whole subject was an inspiration. We did most practice on each other but had some on real patients ... with itinerant physios to the polios'.[96]

As polio could affect the diaphragm and intercostal muscles, physiotherapists required a sophisticated knowledge of breathing mechanisms. Carter pioneered physiotherapy research in exercise for asthma, immediately and dramatically improving patients' lives.[97] Thus Carter furthered professionalisation of physiotherapy through education and practice in cardiorespiratory physiotherapy, building on its unique knowledge base of muscle re-education. Later Beatrice Burke became the most knowledgeable physiotherapist in glossopharyngeal breathing enabling respirator-dependent people with polio to

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[93] Charles Hembrow's introduction in Kelsall and McComas, *A Guide to Muscle Re-Education.* viii.
[94] Carter a Lecturer, Department of Physical Education, University of Melbourne in 1953.
[95] See "Florence Kendall," http://www.hshsl.umaryland.edu/resources/historical/kendall/ Accessed 17 October 2012.
[96] Spark, "Oral History Record."
[97] Kelsall and McComas, *A Guide to Muscle Re-Education.* 104-113.

have periods without respiratory assistance.[98] In 1956, Helen Gordon recalled sessions with Carter, 'an eccentric elderly lady in the Alfred's hot little army huts still teaching'.[99]

Figure 7.10 Vera Carter.[100]

[98] Beatrice E Burke, "Glossopharyngeal Breathing and Its Use in the Treatment of Respiratory Poliomyelitis Patients, with Some Notes on Chest Respirators," *Australian Journal of Physiotherapy* 3(1957); "With the International Red Cross in Morocco," *Australian Jounal of Physiotherapy* 6(1960).
[99] Gordon, "Oral History Record."
[100] Photograph from Cynthia McLoughlin.

Jean Macnamara, another individualist, recruited many physiotherapists. In the following stories of the physiotherapists working with people with polio, chronological from the time of their graduation, Macnamara frequently features. This sample of physiotherapists is representative of those who provided professional and emotional commitment to their patients, undertaking work important to society and demonstrating laudable aspects of the modern physiotherapeutic professional as enunciated in Chapter 2.

Nancy Prentice began honorary work two afternoons a week at the Children's and in 1929, went to Austin Hospital when Macnamara secured a grant from the Whiting Fund Trust to pay Prentice to treat the Austin children. In her own time she treated children there on Sundays.[104] Margaret Robinson spent five years at the Austin with Macnamara and Carter assessing children with polio. In a pattern repeated by many, Robinson also worked at the Children's Hospital in Carlton, in Mount Eliza and the Children's IPS.[105] Gwen Stack worked in Melbourne's northern and western suburbs from 1931 to 1935.

With the huge polio epidemic from 1937 she managed physiotherapy at the After Care Clinic, in the commandeered Benevolent Homes and then in Tasmania.

> When we went to Launceston in 1938 ... there were 161 inpatients and 73 outpatients at the Public Hospital. ... Scarcely room to move between beds in the children's wards. ... To render splints effective, I sent requests simultaneously to all Ladies' Church Guilds asking the members to come to the hospital on a specific afternoon armed with stout needles and white thread and a pair of scissors. ... Under my instructions we had a giant "sewing bee" sewing slings on arm and leg pieces of the double Thomas splints. Others tore calico into strips and rolled them into bandages. ... Pleas had gone into the local

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[104] Prentice (Ashworth). Gault and Lucas, *A Century of Compassion a History of the Austin Hospital*. 180.
[105] Fussell, "Poliomyelitis." 4. Australian Physiotherapy Association, "Obituary Miss Helen Todd," *Australian Journal of Physiotherapy*. Yule, *The Royal Children's Hospital.* 193-205.

> newspaper for helpers to act as nursing aides. ... In addition to their muscle re-education work the six or seven physiotherapists ... were really busy, teaching all these new aides, and the nurses, the correct way to bandage patients into their splints.[106]

Whilst in Tasmania, Stack lectured on polio treatment to medical practitioners. Physiotherapists with extensive knowledge of polio were substantially more experienced than most general practitioners.[107] As with Teepoo Hall's teaching of medical students and Muriel Ross who later demonstrated at the Melbourne Hospital, this is another instance where physiotherapists were invited to provide their professional expertise to medical practitioners – a reversal of the generally assumed hierarchy of knowledge and skills (and in the twenty-first century with the explosion of physiotherapy research, a common occurrence). Ross's contributions to physiotherapy clinical practice, education and research are further elaborated below. Stack later conducted muscle re-education courses for physiotherapists returning from war service. In 1950 she established the Physiotherapy Department at the new Yooralla, where children with severe polio lived.[108]

Marjorie Farnbach too began honorary work at the Melbourne and Children's Hospitals commencing her career-long involvement with polio.[109] As the sole physiotherapist in Tasmania she established the first polio treatment programme from 1930 to 1934, then after four years in England, returned to the Children's Hospital IPS in 1938. After war service from 1940 until 1946, Farnbach managed the Children's IPS until mid 1950, then led the new Victorian State Health Department's IPS from 1950.[110] Despite Macnamara's vehement opposition to her appointment, probably as Macnamara wanted to

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[106] Stack (Nichols), "Oral History Record."
[107] Anne Killalea, *The Great Scourge: The Tasmanian Infantile Paralysis Epidemic 1937–1938* (Sandy Bay: Tasmanian Historical Research Association, 1995).
[108] Stack (Nichols), "Oral History Record."
[109] Farnbach, "Oral History Record."
[110] Health Act 1943, Regulation Number 4988 enabled establishment of consultative committees. One recommended a Poliomyelitis Division in the Department of Health.

keep the efficient Farnbach managing the Children's service, Farnbach ran the Health Department's IPS until 1968.[111] She identified the importance of physiotherapy enabling mobility and social interactions and the adverse psychological effects of prolonged immobilisation and absence from home.[112] Further recognising physiotherapy's professionalism, the State service exerted minimal control on the interaction between patient and physiotherapist. Macnamara too learned she could no longer have overarching control of the physiotherapists. Farnbach recruited staff pleased to work with a more respectful and congenial fellow-physiotherapist.[113] Perhaps Farnbach had gained additional knowledge, administrative capability, confidence and authority from her wartime service (Chapter 6).

Nancy Davies graduated in 1933 spending a year at the Melbourne Hospital.[114] Subsequently Davies worked with children with polio and chronic osteomyelitis at Mount Eliza.[115] Eunice Winter completed physiotherapy in 1934, and despite her polio-induced muscle weakness, worked half-time at Alfred Hospital and treating polio patients, at the Red Cross home *Stonnington*, travelling by public transport through lunchtime. Winter later treated polio patients at Caulfield Hospital where WW1 soldiers still resided. In the hot army huts physiotherapists wore masks and gowns whilst treating newly admitted, infectious patients. Carter, honorary consultant at Caulfield, demanded daily physiotherapy commence immediately after admission.[116] Carter let nothing stop treatment; even Winter's sister's death could not interrupt this regime. On Saturdays physiotherapists devoted their own time to report the week's progress to patients' families.

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[111] Marjorie Farnbach, "A Statewide Itinerant Physiotherapy Service," (Australian Physiotherapy Association Archives).
[112] "Physiotherapy for Poliomyelitis Patients in Victoria," *Australian Journal of Physiotherapy* 1(1953). Elma Casely, "Physiotherapy in South Australia," ibid.(1954).
[113] Many oral histories indicate Macnamara's controlling nature in contrast to Farnbach.
[114] Davies, "Oral History Record." Barry, *Orthopaedics in Australia.* 92-96.
[115] See Patricia Paterson, "Oral History Record," (Australian Physiotherapy Association, 1987). See also Yule, *The Royal Children's Hospital.* 183-184.
[116] Winter, "Oral History Record."*Stonnington*, original Government House, from 1938 was an after-care hospital for polio patients.

Lorraine O'Connor joined the IPS in 1938, treating patients in Carlton, Brunswick, Coburg and Campbellfield. Each morning, the almoner advised physiotherapists of patients newly discharged home they must see before children were removed from their splints.[117] In 1939, with war declared, many physiotherapists joined the army and O'Connor's patient-load expanded encompassing more Melbourne suburbs: Essendon, Pascoe Vale, Northcote and Preston. Marrying in 1940, O'Connor continued working. With the threat of enemy attack in 1942, she went with Yooralla's evacuated children to country Macedon. O'Connor continued there, leaving briefly only when her two children were born.[118] Freda Kimpton too joined the Children's IPS, delaying marrying until she established her career. She continued working, taking time out to have her three children, but returning to her polio patients each time. There was no maternity leave.[119] During the 1940s epidemics, Victorian kindergartens were closed and kindergarten teachers minded physiotherapists' children so their mothers could work.[120]

Society did not expect these middle-class women to work. Most were likely to marry men who would expect them to be mothers staying home whilst men worked.[121] The 1907 Harvester judgement, then a revolutionary workplace decision, decided men should be paid a minimum wage sufficient for an unskilled man and his family.[122] From the 1920s motherhood was a grave responsibility, a full-time occupation, incorporating the new knowledge of hygiene and nutrition. Mothers who undertook outside work, whether in the factories or as professionals, were challenged to live up to the expected

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[117] The first almoner appointed in 1931 was Isabel Hodge who graduated that year.
[118] Lorraine O'Connor, "Oral History Record," (1987).
[119] Maternity allowance introduced 1912, means tested from 1930-1943, cancelled 1978, reintroduced 1996. See Marjorie O'Neill and Robyn Johns, "The History of Welfare and Paid Maternity Leave in Australia" (paper presented at the IERA 2009 17th Annual Conference, Mahidol University, Bangkok, 2009).
[120] Bolwell (Kimpton), "Oral History Record." Freda married George Bolwell in 1939. See also Jean C Ross, "A History of Poliomyelitis in New Zealand" (University of Canterbury, 1993).
[121] See Marilyn Lake, "Feminist History as National History: Writing the Political History of Women," *AHS* 27(1996). McCalman, *Journeyings. Passim.*
[122] Macarthy, "The Harvester Judgement: An Historical Assessment."

standards, loving wife, nurturing mother, spotless housekeeper, perfect children.[123] Fortunate young women, like myself had role-models for professional futures.

Small numbers of women had studied medicine for several decades.[124] Women physiotherapists who would have liked to study medicine, generally found university fees made that career inaccessible. For women medical practitioners like Macnamara, working with women or children was acceptable in the eyes of their male colleagues. Women in medicine unsettled male authority, their status and prestige and the overall organisation of work.[125] Male physiotherapists challenged male medical practitioners, now female physiotherapists too demonstrated greater independence. My mother, who always wanted to practise physiotherapy, was desperately needed in the workforce and my father, unlike many men, encouraged his working wife by being proud of her professional contributions and sharing work at home. There was never criticism of Freda working and our home had severely disabled children to stay, providing their families some relief from their unremitting care commitments at a time of no respite care and limited State support.[126] Growing up, physiotherapy and people with polio were part of our lives.

The physical and emotional load on families with a disabled member could be extreme as they endeavored to fulfill society's expectations and that of their health professionals.[127] Beatrice Burke described the impact on her family, influencing her to study physiotherapy:

> My elder brother John contracted polio in January 1938. He was 27 ... just been accepted for the Royal Military College, Duntroon ...

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[123] Grimshaw et al., *Creating a Nation*. 225-247. Jean Macnamara, "Victorians on Their Mettle'," *UNA (Journal of the Victorian Trained Nurses' Association)*, no. 1 March (1938).
[124] Healy, *Strength of Mind: 125 Years of Women in Medicine Exhibition*.
[125] Pringle, *Sex and Medicine: Gender, Power and Authority in the Medical Profession*. 3-10. Also Merrilyn Murnane, *Honourable Healers: Pioneering Women Doctors* (Melbourne: Australian Scholarly Publishing, 2015).
[126] Bolwell (Kimpton), "Oral History Record."
[127] Grimshaw et al., *Creating a Nation* .225-247. Galbally and Cosh; Elizabeth Williams, Interview 5 November 2013.

> a terrible blow ... complete paralysis of his left leg, 50 per cent of his right leg, weak abdominal muscles and partial paralysis of left hand including the thenar eminence. After three weeks at Fairfield Hospital he was sent to *Stonnington*. ... For six months, ... with treatment twice per week.[128]
>
> My parents could see this as a life sentence, ... they contacted Dr Jean Macnamara and brought him home. Arrangements were made for ... Nell Lazarus ... I became aware of physiotherapy and its role in the treatment of patients. Miss Lazarus came 2-3 times per week and a regime of exercises with a powdered board etc, had to be carried out between visits - mostly done by my mother but we all played a part, particularly in putting my brother in and out of his double Thomas splint. He was 6'11" (2.11m) so it was quite a large splint. My parents also had to have a pram and trolley made ... and they paid for all the treatment. It was not until the advent of the Poliomyelitis Division ... and treatment and much equipment were provided free.[129]

After the Health Department created the Consultative Council in Respect of Treatment, After-Care and Rehabilitation of Persons Suffering from Poliomyelitis, many physiotherapists, including Freda transferred to the Poliomyelitis Division with Marjorie Farnbach. Freda treated people with polio in the orchard districts northeast of Melbourne.[130]

The largest 1937-38 epidemic needed every new graduate and Phyllis Frost, graduating in 1938, recalled issues during pregnancies and childbearing. A Children's itinerant physiotherapist, during the war Frost went to Yooralla at Macedon, working seven long days each week, with no paid overtime.[131] Frost married in 1941 and in 1944 took three weeks leave before her first child was

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[128] With insufficient physiotherapists, emphasis was on children: adults' families had to pay.
[129] Burke, "Oral History Record."
[130] Freda worked for the Health Department until aged sixty-five then as a private practitioner until seventy-eight.
[131] Evacuation was to avoid the threat of Japanese bombing. See Bassett, *Guns and Brooches.* 153-160.

born, returning to work six weeks afterwards. A nurse assisted with the breast-fed baby, travelling to Macedon with Frost.[132]

Polio ensured physiotherapists became increasingly skilled in making splints.[133] Frost taught physiotherapy students plaster-making at the Children's plaster clinic and worked with splint-makers repairing boots and splints. She designed metal and acrylic splints to hold the thumb opposed to the fingers. She 'used dental materials to make Bell's palsy mouth splints and devised other three point pressure contraptions'.[134] Splint-makers worked at the Children's, but physiotherapists fashioned plasters, a skill used extensively in WW2 (Chapter 8). Plaster kept joints in neutral positions and reduced the risk of strong muscles overacting and shortening. With foot dorsiflexors paralysed, a strong antagonistic muscle such as the calf would pull the foot into an equinus position, severely limiting walking or the potential for walking. A plaster half boot would be made and the foot bandaged in overnight. The careful positioning of limbs, moulding and holding of the plaster required at least two people. Additional splints were made, some later from fiberglass. Measuring and sewing corsets for patients with weak abdominal muscles was another challenge.[135] Splints made life difficult for patients, parents and physiotherapists. Aside from resting splints, people wore additional splints, full length or below knee callipers, crutches, trunk and neck braces and arm splints, to enable efficient walking and other functional activities. Physiotherapists

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[132] Grimshaw et al., *Creating a Nation*. 225-271.

[133] Medical practitioner John Murphy acknowledged physiotherapists' superior abilities. John Murphy, "Poliomyelitis and the Development of the Itinerant Physiotherapy Services in Victoria," (Australian Physiotherapy Association, 1994). Permanently in my mother's car were knives and scissors, tubs of Vaseline and tins of Gypsona plaster of Paris 4" 6" and 9" bandages.

[134] Phyllis Frost, "Oral History Record," (~1988). Dame Phyllis Frost became committed to unpopular causes, particularly women prisoners. She established *Keep Australia Beautiful*.

[135] As a physiotherapy assistant at Fairfield Hospital during summers 1958-1963, I put patients in and out of splints, Hubbard tanks, did muscle stretches made plaster bandages, patients' plasters, sewed canvas corsets for patients with weak abdominal muscles and went on 'plaster trips' to country patients. Paterson, "Oral History Record."; David Zuker, "Oral History Record," (Australian Physiotherapy Association, 1987).

took the measurements for such items, which the splint-makers manufactured.[136] Splints however caused a major controversy.

Jean Edwick assisted polio patients as a final year student volunteer at a local scouts' hall, continuing after graduation in 1938. In her first salaried position at Hampton Children's Convalescent Cottage, Edwick saw at first hand the challenge that Elizabeth Kenny presented to orthodox medicine and physiotherapy.[137] Kenny had no formal training. 'In 1911 she used hot cloth fomentations on the advice of Aeneas McDonnell, a Toowoomba surgeon, to treat symptomatically puzzling new cases, diagnosed by him telegraphically as infantile paralysis'.[138] Kenny opened a private hospital, later enlisting during WW1 before claiming to cure polio.[139] A controversial figure, bombastic and skillfully self-promoting, Kenny styled herself 'sister', claiming to know the pathology and how to cure polio without splinting. Hulett defined her a charismatic cult leader filling a special calling (Figure 7.11).[140]

Kenny did not conform to the traits expected of professionals. Flamboyant in dress, she advertised herself, made bold assertions and responded aggressively to criticism.[141] Her views on polio's pathology differed from extant scientific opinion.[142]

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[136] Yule, *The Royal Children's Hospital.* The splint-maker was the Children's highest paid tradesman 1925. 198.
[137] Ibid. 103-104, Ch. 12. Hampton opened in 1910 and in 1957 became a rehabilitation hospital for adults.
[138] Ross Patrick, "Kenny, Elizabeth (1880-1952)," Australian Dictionary of Biography, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/kenny-elizabeth-6934/text12031. Accessed 15 January 2013.
[139] Elizabeth Kenny, "Kenny Treatment of Poliomyelitis," *British Medical Journal* 1(1943). See also B Lee Ligon, "Biography: Sister Elizabeth Kenny: A Controversial Participant in the War against Polio," *Seminars in Pediatric Infectious Diseases* 11(2000).
[140] JE Hulett, "The Kenny Healing Cult: Preliminary Analysis of Leadership and Patterns of Interaction," *American Sociological Review* (1945).
[141] Sonda R Oppewal, "Sister Elizabeth Kenny, an Australian Nurse, and Treatment of Poliomyelitis Victims," *Journal of Nursing Scholarship* 29(1997); Johnson, *Professions and Power*. 23-29.
[142] Ralph K Ghormley et al., "Evaluation of the Kenny Treatment of Infantile Paralysis: Report of Committee," *Journal of the American Medical Association* 125(1944).

The Kenny saga interweaves public opinion, politics, professionalism, physiotherapy and medical practice.[143]

Figure 7.11 Elizabeth Kenny as miracle worker and feted self-promoter.[144]

Kenny did not respect medical practitioners and their knowledge. The rules of professional respectability are rarely fully articulated, they comprise tacit knowledge incorporated during professional education and are embodied within professional identities (Chapter 1).[148] Some explicable elements were within the AMassA's first ethics in 1906 and are frequently revised and elaborated.[149]

Kenny took her story to the public, subverting medical authority. Physiotherapists had achieved public recognition and respect as the legitimate practitioners to rehabilitate polio sufferers, now an uneducated, unprofessional woman denigrated their work, threatening their therapeutic techniques and

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[143] Naomi Rogers, "The Debate Considered," *AHS* 31(2000). "'Silence Has Its Own Stories': Elizabeth Kenny, Polio and the Culture of Medicine," *Social History of Medicine* 21(2008).
[144] Google images.
[148] Cynthia T Matthew and Robert J Sternberg, "Developing Experience-Based (Tacit) Knowledge through Reflection," *Learning and Individual Differences* 19(2009).
[149] Australian Physiotherapy Association, "Apa Code of Conduct," (2008).

professionalism. Members of the Victorian Poliomyelitis Consultative Committee strongly opposed Kenny. Nevertheless after considerable public pressure a Kenny clinic was established at Hampton Children's Convalescent Hospital in early 1939 in parallel with physiotherapy.[151] Edwick recalled:

> Kenny selected seven or eight nurses she trained to work on a one-to-one basis with a patient. (In the experiment) we were the control with a quarter of the staff and three times the number of patients. ... They fomented with saline foments several times a day and did full range passive movements for all joints, regardless of stronger muscle groups. The patients were not splinted but positioned with specially made sandbags.[152]

Kenny could not explain her methods and her treatments were extremely costly of staff time.

> The doctors ... were intimidated by her personality. The males waited for each other before taking a clinic, the females used the full-length windows and doors so they did not meet the guest ... but even on the spot we were limited in our knowledge of the Kenny clinic - and time did not permit.[153]

Kenny brazenly challenged the legitimacy of orthodox medicine and physiotherapy drawing heated debate between them and her champions.[154] Cleverly Kenny modified her stridency no longer claiming 'cure'. By 1940 she proposed that spasm tightened muscles causing tenderness and pain; spasm caused the patient to forget how to activate the muscle despite nerve pathways being intact. Using the wrong muscles because of spasm led to 'incoordination'.[155] As Bernard Roth, another son of Mathias proposed decades

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[151] Kenny incited controversy. For example see "Sister Kenny's Threat," *The Argus*, 6 January 1938. Accessed 12 January 2012. Zwar, *The Dame.* 82-90.
[152] Jean Edwick, "Oral History Record," (1987).
[153] Ibid.
[154] Macnamara, "Preventative Orthopaedics and the Physiotherapist."
[155] Oppewal, "Sister Elizabeth Kenny, an Australian Nurse, and Treatment of Poliomyelitis Victims."

earlier, Kenny advocated hot packs for pain relief.[156] Phillippa Martyr asserted the Kenny historiography ignored the role of the AMassA.[157] Martyr perceived Kenny as a threat to the medical support physiotherapists received compared to nurses. Splinting was the battleground.

> The rigorous routine of splinting and restraint in the name of preventing deformity aimed to serve a dual purpose: placing unruly young children under medical control, and keeping their limbs straight in order to prevent, at least in theory, crippling and disability.[158]

Orthodox treatment used splints for long periods, but these were removed for prolonged daily exercise. Even with Kenny's more intensive surveillance, Mrs Wilkinson, a 'Kenny' nurse at Hampton said 'the children were expected to lie quite still, but they didn't'.[159] They moved as much as possible, frustrating Kenny's staff. Splints designed to give people with polio the best chance of recovery without deformity could become a familiar comfort. Joan Smith slept in a double Thomas splint from aged three when she contracted polio, until she was sixteen and years later nostalgically remembered its comfort.[160]

Martyr proposed that medicine opposed Kenny because she was a nurse and decried physiotherapists' preparedness to defend their position using political and collegial alliances. I contend physiotherapists provided evidence of their professionalism.[161] Martyr stated polio benefited physiotherapists through 'a complete restructuring of existing after-care facilities to provide a more even

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[156] Roth, "The Surgical and Orthopædic Treatment of Infantile Paralysis." Rogers, "'Silence Has Its Own Stories': Elizabeth Kenny, Polio and the Culture of Medicine."
[157] Evan Willis, "Sister Elizabeth Kenny and the Evolution of the Occupational Division of Labour in Health Care," *Journal of Sociology* 15(1979); John R Wilson, *Through Kenny's Eyes: An Exploration of Sister Elizabeth Kenny's Views About Nursing* (Townsville, Qld: Townsville Regional Group, Royal College of Nursing Australia, 1995).
[158] Philippa Martyr, "A Small Price to Pay for Peace: The Elizabeth Kenny Controversy Re-Examined," *AHS* 28(1997).
[159] Quoted in Yule, The Royal Children's Hospital. 202.
[160] Smith. Regarding children's rapid adjustment to splints see Gordon, "Oral History Record."
[161] Margaret Denton, "Further Comments on the Elizabeth Kenny Controversy," *AHS* 31(2000). Denton cites Marie Hammond, former physiotherapist Head of South Australia's School of Physiotherapy who Denton interviewed March 1997.

distribution of resources and a standardised provision of treatment'.[162] The availability of paid positions for physiotherapy graduates after the polio epidemics certainly benefited physiotherapists. Furthermore the experience gained increased physiotherapists' confidence in their abilities to make clinical decisions as collaborative professionals with medicine.

The Queensland parliament in 1933/34 appointed Dr Ralph Cilento to investigate Kenny's approach and then in 1935 a Royal Commission - 'Investigation of Infantile Paralysis' into Kenny's methods.[163] It concluded. 'The Commission cannot recommend the application of the Kenny method to the treatment of cripples at any stage of paralysis, and especially not to the treatment of the very acute or early stage'.[164] The Commission stated that Kenny's treatment differed from the orthodox in allowing potentially damaging movement in the acute stage and not using splinting.[165] Kenny preferred early mobilisation, writing:

> Unparalysed muscles … are in orthodoxy supposed to be normal muscle contracting and pulling the skeleton into deformity. These muscles are in reality the sick muscles … they are the muscles that require careful nursing. The pain, spasm and shortening are centred in these muscles, and the alienation of the opponents is caused through this condition. ... Immobilisation had to be abandoned.[166]

Dr Harold Crawford, State President of the British Medical Association (BMA), strongly opposed Kenny's approach: he was the key protagonist in ensuring the commencement of physiotherapy at the University of Queensland

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[162] Martyr, "A Small Price to Pay for Peace."
[163] Ibid. Martyr cites Raphael Cilento, `Report on the Muscle Re-education Clinic, Townsville (Sister E. Kenny), and its Work, 24 August 1934', 1-2, VF 616.835 CIL C1. See Elizabeth Kenny and M Ostenso, *And They Shall Walk* (New York: Dodd, Mead and Co, 1943).118-121, 189. Patrick, "Kenny, Elizabeth (1880-1952)".
[164] "Sister Kenny's Threat."
[165] Denton, "Further Comments on the Elizabeth Kenny Controversy." Denton cites The Report of the Queensland Royal Commission. 212. Also see "Sister Kenny's Threat.".
[166] Kenny, "Kenny Treatment of Poliomyelitis."

in 1938.[167] The AMassA, Queensland branch jointly worked with medicine, testified at the Royal Commission and demonstrated a collective preparedness to use political influence.[168] Unlike Kenny, the Association's members were ethically prohibited from advertising, so their agenda had to be managed carefully through appropriate channels. By 1935 Kenny and Cilento, then Director General of Health in Queensland, became entangled in the Labour government's internal squabbles, and despite the Royal Commission's report, the government decided to support Kenny.[169]

Politicians, rarely averse to alternative health care, also funded a Kenny clinic at Sydney's Royal North Shore Hospital, where Martyr claimed physiotherapists chose to make little political fuss in case politicians, influenced by popular sentiment, registered her as a physiotherapist.[170] The media weighed into the controversy: the *Sydney Morning Herald* reported Kenny required medicine's cooperation and, 'if the best results are to be achieved, the co-operation of the Massage Association'.[171] The medical practitioners at the BMA's Canberra conference in 1936 hosted a scathing attack on Kenny through Lady Ella Latham, board chairman of Melbourne's Children's Hospital.[172] Macnamara, politically astute, well-prepared to champion her physiotherapists and approach to treatment, was highly influential in Victoria and determinedly opposed to Kenny.[173] Victorian physiotherapists had medical practitioners as their defenders and followed the

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[167] Geoffrey Kenny and Coralie Kenny, Interview 28 June 2012.
[168] Ibid. Harold Crawford promoted the University of Queensland's physiotherapy course that began 1938. Dean Wilkinson wrote a forward for Kenny's book, according to Geoffrey Kenny a significant factor in his demise.
[169] Willis, "Sister Elizabeth Kenny and the Evolution of the Occupational Division of Labour in Health Care."
[170] There was no physiotherapy registration in New South Wales then.
[171] "Sister Kenny," *The Sydney Morning Herald*, 20 January 1939. The *Sydney Morning Herald* up until 1954 had more than 6500 articles with Victorian newspapers 8,684 referencing Elizabeth Kenny.
[172] Australian Medical Association was formed as an independent body in 1962. Pensabene, *The Rise of the Medical Practitioner in Victoria*. 167-168. Ella Latham President of the Children's Hospital Board 1933-1954. Yule, *The Royal Children's Hospital.* 184.
[173] Martyr, "A Small Price to Pay for Peace." Willis, "Sister Elizabeth Kenny and the Evolution of the Occupational Division of Labour in Health Care."

same code of ethics. The bonds were strong. The Victorian AMassA office bearers were President, Major General Rupert Downes, Vice Presidents, Sir Stanley Argyle, Dr H Douglas Stephens, Mr John Colquohoun; Co-opted members, Dame Jean Macnamara, Mr Charles Hembrow, Dr Frank May, Dr Douglas Officer Brown, Mr Thomas King; Committee, Edith Pratt, Josephine Jennings, Nance Ashworth, Helen Todd, Ellis Finney, Honorary Secretaries E Campbell, John Eddy and Honorary Treasurer, Helen Murdoch.

When Kenny left Australia to promote herself in England in 1937, Vida Kirkcaldie, AMassA Federal Secretary advised the CSP that Kenny had no AMassA credentials. On Kenny's return she falsely claimed that several British hospitals supported her.[174] However the AMassA demonstrated this had not occurred and advised Cilento.[175] In the 1937-38 epidemic Victorian physiotherapists treated over 2000 cases: Kenny's team treated twenty-two.[176] Nevertheless, perhaps strengthened by the controversy, the Victorian government formalised its After-Care Committee, including the State Health Department's Dr HN Featonby, Fairfield Hospital medical superintendent Dr Frank Scholes, two Victorian Society for Crippled Children representatives and Drs John Colquhoun and Jean Macnamara.[177]

Despite no evidence, Martyr claimed 'definite indications that the Massage Registration Act would be amended, or abolished, and the work of treating poliomyelitis cases given to nurses, if there were active opposition to Miss

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[174] "Sister Kenny's Threat." Chris Knight, "The 1950s – Polio, a Different War," *Journal of Orthopaedic Nursing* 12(2008).
[175] Martyr, "A Small Price to Pay for Peace." Martyr cites letters 7 December 1937, Royal Council for the Care of Cripples; 18 December 1937, Guy's Hospital; 20 December 1937, Wingfield Morris Orthopaedic Hospital; 20 December 1937, Charing Cross Hospital; 21 December 1937, King's College Hospital; 22 December 1937, covering letter from CSMMG. Cilento returned them to the AMassA with a covering letter, 15 January 1938, AMAQ Polio, APA Qld.
[176] Edwick, "Oral History Record."
[177] Anne G Smith, "Macnamara, Dame Annie Jean (1899–1968," Australian National University, http://adb.anu.edu.au/biography/macnamara-dame-annie-jean-7427/text12927. Accessed 15 January 2013.

Kenny'.[178] There is no mention of Kenny in the MRB minutes of the period.[179] Similarly Martyr provides no evidence for 'the integration of the Kenny method into orthodox medical practice'.[180] She appears unaware of physiotherapist's knowledge of muscle re-education taught initially by Colin McKenzie from 1906. Aside from the local Australian political and professional stoush with Kenny, splinting created tensions in the USA. The Kendalls and Boynton wrote: 'if postural faults were simply an aesthetic problem, the concern about them might be limited to concern about appearance. ... Postural faults which persist may cause pain, discomfort or deformity'.[181] Kenny's approach nevertheless gained considerable traction with polio sufferer President Roosevelt's support in the USA, but also generated controversy.[182]

Polio's effects depended on the initial disease's severity. Historian physiotherapist Margaret Denton critically demolished many of Martyr's sources, which were frequently Kenny's own claims. Furthermore Denton demonstrated that Kenny modified her practices more towards the orthodox, although changing her treatment frequently. Denton reinforced polio's fickleness with enormous variation in anterior horn cell destruction. The resultant temporary or permanent paralysis presented difficulties in demonstrating one or other treatment as curable. Denton argued that 'Martyr is not only unaware of this but makes the unsubstantiated claim of clinical studies showing that orthodox treatment failed'.[183] Rebutting Martyr, Denton invoked

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[178] Martyr, "A Small Price to Pay for Peace."
[179] Victoria Masseurs Registration Board, "Minutes," (Melbourne, Victoria1923-1963). Only Victoria (1922) and Queensland (1928) had registration.
[180] Denton, "Further Comments on the Elizabeth Kenny Controversy."
[181] Henry Kendall, O, Florence Kendall, P, and Dorothy Boynton, *Posture and Pain* (Baltimore: Williams and Wilkins, 1952). 1.
[182] "Kenny Paralysis Treatment Approved by U.S. Medicine," *New York Times* 1941; "Sister Kenny Lectures," *New York Times* 1943; Kenny, "Kenny Treatment of Poliomyelitis." For a balanced retrospective view of the USA see Florence P Kendall, "John Stanley Coulter Lecture Sister Elizabeth Kenny Revisited," *Archives of Physical Medicine and Rehabilitation* 79(1998). Murphy, *Healing the Generations*. 98-160.
[183] Denton, "Further Comments on the Elizabeth Kenny Controversy." Denton cited HR McCarrol and CH Crego, "Evaluation of Physiotherapy in the Early Treatment of Anterior

her physiotherapy background, authors need a competent understanding of anatomy, physiology and pathology, and her historian credentials, and authors must understand the difference between documented evidence and anecdote.

In Victoria Macnamara and Carter emerged as far more influential than Kenny. Physiotherapy was legitimate practice and the outward signs of the most laudable aspects of professionalism in self-sacrifice, commitment and patient empowerment were clear. Nevertheless they also protected their professional 'patch'.[184] Reflection on the saga suggests that despite Kenny's public approbation, self-promotion and the support of politicians, the physiotherapists, aligned with their scientific and medical colleagues quietly demonstrated their professionalism and continued commitment to their patients.[185]

Furthermore, this period in Victoria exemplified the veracity of physiotherapy's educational curriculum in the rigorous teaching of muscle assessment and re-education and the strength of conviction of its importance in polio rehabilitation. Medicine was closely aligned: Mackenzie initiated the approach, Hembrow supported Carter in her detailed teaching of physiotherapy skills and Macnamara continued as a staunch advocate of its practice. Physiotherapy graduates always had detailed knowledge of the origins, insertions, actions and nerve supply of all skeletal muscles and, from the 1930s onwards, the execution of assisted, independent and resisted movement for every muscle. They were able to grade muscles for their strength, to exercise or re-educate as required and to retrain functional activities.[186]

Poliomyelitis," *Journal of Bone and Joint Sugery* 23(1941). See also WR Forster and Eric E Price, "Report on an Investigation of Twenty-Three Cases of Poliomyelitis in Which the 'Kenny System' of Treament Was Used," *Medical Journal of Australia*, no. 25 February (1939).

[184] Witz, "Patriarchy and Professions: The Gendered Politics of Occupational Closure."

[185] For example newspaper reports such as "The Paralysis Epidemic," *Camperdown Chronicle*, 13 November 1937.

[186] Personal documents, Webster, "Charles Hembrow's Lectures on Muscle Re-Education." Kelsall and McComas, *A Guide to Muscle Re-Education.* Florence P Kendall et al., *Muscles: Testing and Function* (Baltimore: Williams & Wilkins, 1983); Kendall, Kendall, and Boynton, *Posture and Pain*. JM Florence et al., "Intrarater Reliability of Manual Muscle Test (Medical Research Council Scale) Grades in Duchenne's Muscular Dystrophy," *Phys. Ther.* 72(1992).

Polio epidemics continued in Victoria for two further decades until vaccination eliminated the scourge. Elizabeth (Betty) Fussell succeeded Farnbach in charge of Health Department physiotherapists. Fussell ultimately was highly influential in Australian physiotherapists leading the world in rescinding physiotherapy's medical referral ethic at a time when medical dominance of health care began to decline.[187] The Presbyterian Ladies College, a middle-class, private school with university aspirations for all its students, educated Fussell.[188] She began working half-time at the Melbourne Hospital and in Drs Frank May and Leigh Wedlick's private physical medicine clinic before replacing McArthur Campbell as lecturer in Medical Gymnastics during wartime.[189] After working at Yooralla, Fussell moved to Farnbach's Health Department IPS as her Deputy in 1952, becoming Physiotherapist-in-Charge from 1968 to 1986. With previous Children's Hospital physiotherapists Fussell provided the blue print for the Health Department's 'Early Childhood Development Programme' introduced in 1974. Positioned to implement and reinforce a philosophy of community care, Fussell was the first non-medical professional to lead the service (Figure 7.12).

Treatment, based on the IPS, was incorporated in the home environment, supported with visiting services and specialist centres.[190] As the first contact practitioners detecting children with developmental problems, physiotherapists referred to medical practitioners, setting the scene for autonomous practice.[191] Triggered substantively by the IPS situation, after wide consultation, Australian physiotherapists took a further step in professional independence

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[187] Elizabeth Fussell, "Oral History Record," (Australian Physiotherapy Association, 1994). "Poliomyelitis." Cosh; Evan Willis, "Introduction: Taking Stock of Medical Dominance," *Health Sociology Review* 15(2006).
[188] Bassett, *Guns and Brooches.* Fussell's parents' experiences in WW1 are related here. 43, 51.
[189] May and Wedlick, members Physiotherapy Registration Board. Wedlick taught electrotherapy. See Leigh Wedlick, "Life's Odyssey."
[190] JB Best and BP McCloskey, "Early Childhood Development Programme-Early Detection," *Australian family physician* 7(1978). Fussell, "Poliomyelitis".
[191] Prue Galley, "Ethical Principles and Patient Referral," *Australian Journal of Physiotherapy* 21(1975); "Physiotherapists as First-Contact Practitioners – New Challenges and Responsibilities in Australia," *Physiotherapy* 63(1977).

and rescinded the medical referral ethic in 1976.[192] This contributed to stimulating significant advances in Victorian physiotherapy education in the 1970s and 1980s (Chapters 9 and 10).

Figure 7.12 Elizabeth Fussell.[193]

The IPS physiotherapists continued managing the 5-6000 Victorians with paralytic polio. As they required less attention the service expanded to encompass other long-term disabling conditions. Confident physiotherapists drew on their polio experience in strategic management and treatment for ameliorating disability and educating those involved with patient care. They worked in association with medical practitioners, occasionally with nurses, and as required, with social workers. No other health disciplines were involved. This chapter has concentrated on polio, but physiotherapists over this half-century were also treating other neurological conditions, musculoskeletal and

[192] Cosh.
[193] Author's copy.

cardiorespiratory disorders and increasingly obstetric and gynaecological problems.

The characteristics embodied by these physiotherapists included creativity, ingenuity and commitment often under trying conditions in crowded under-resourced hospitals or patients' homes. They ignored the risk of infection to themselves and frequently worked very long hours. Physiotherapists emerged from the polio epidemics with enhanced knowledge and skills through an extended and specialist education and enjoyed further political and bureaucratic recognition. Their increased autonomy and confidence and awareness of unique aspects of theory and practice different from medicine enabled eventual rescinding of the referral ethic. The era enabled women to begin to take significant leadership roles as exemplified by Marjorie Farnbach in physiotherapy and Jean Macnamara in medicine.

It led to geater emancipation for the many married women who changed their personal and professional expectations after their experience with polio patients. Most stopped work to have their children, before returning to practice. They established an expectation that all female physiotherapists would work, escaping from a female identity of domesticity following marriage. This was a new element in identity and reinforced the perspective that physiotherapy was a profession that behaved in similar ways to predominantly male professional groups.

The Second World War occurred midway through the most devastating epidemics drawing some of the already overworked physiotherapists to support the forces. In contrast to the first war physiotherapists were promptly sought. The next chapter addresses their involvement in the war with its further potential for the professionalisation of physiotherapists, their community recognition and the ensuing changes in education.

Chapter 8 From dust to mud: physiotherapy in wartime

Near the ditch about midway besides Nightingale Alley,
Is the tent where the "chesties" are each day asked to rally...
The handling of "chesties" is really no gamble
In the scheme of that trio King, Hayward and Campbell
They'll correct all our faults that soon we may be
Boarded out in our groups of A.B.C. or D.[1]

In this chapter I discuss how WW2 developed physiotherapy's professionalism through clinical innovation, the close collaboration with medical colleagues, the fostering of physiotherapy leaders and the shared experience, which strengthened the identity of physiotherapy. These Victorian physiotherapists gained in confidence, expertise and status, preparing many as leaders and effective academic and clinical educators and role models for the next generation of physiotherapists. Individuals had life changing experiences; physiotherapists who served worked in medical and surgical teams forging enduring clinical relationships with medical colleagues. Managing patients from all walks of life and making effective decisions under adverse conditions enhanced professional and personal knowledge and abilities. Physiotherapists demonstrated resourcefulness and a desire to 'get on with the job'. Despite frequent moves to unknown locations with challenging work and living conditions, many expressed a sense of adventure in working and visiting new places, overcoming or unfazed by the oft-experienced ineptitude of bureaucracy and sometimes life-threatening danger.

Physiotherapists worked to restore the physical condition of wounded and ill servicemen to enable them to return rapidly to their fighting units or to maximise their recovery for transport home. Gunshot wounds were the main source of injury causing often multiple orthopaedic and neurological problems. The results of chest wounds, burns, faciomaxillary, neurosurgery and plastic

[1] McArthur Campbell, "Oral History Record." Poem written by patient Sergeant J Doherty.

surgery introduced new or advanced existing techniques of assessment and treatment in physiotherapy.

As the only service with both men and women, as in WW1, again gender complicated status and pay requiring Australian Physiotherapy Association (APA) political intervention. Single women comprised 203 of the 226 physiotherapists who served.[2] Postwar a new wave of war-experienced mostly male service personnel became physiotherapists with many subsequently contributing to the profession. A third group of physiotherapists stayed home shouldering the additional burden relinquished by those in the services. For these married women, mentioned in the previous chapter, the return to work could be emancipating, setting them on a path of life-long practice.[3] The students of the 1950s to 1970s were the beneficiaries of the knowledge and enhanced sense of identity of all these groups of physiotherapists. They exemplified for us a physiotherapy identity and instilled in us their particular qualities of clinical confidence, common sense, pragmatism, for some political activism and probably their desire for travel.[4]

Alison McArthur Campbell volunteered in the first group of physiotherapists. Later appointed, Chief Physiotherapist, she led all Australian physiotherapists for the latter third of the war. A diarist, McArthur Campbell left personal diaries, photo albums and her oral history. The APA's oral historians include several of her Victorian colleagues in the services: Helen Todd MBE, Ellis Finney, Marjory Farnbach, Cynthia Duigan, Ruth McCarthy, Agatha Grey-Wilson MBE and Trevor Rice. Unfortunately detail about their war experiences

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[2] Bentley, The Path to Professionalism. 111.
[3] Indicated in oral histories and interviews. O'Connor, "Oral History Record."; Frost, "Oral History Record." Joan Gabb, Merle Gibson, and Jean Wilcox, Interview 26 March 2013.
[4] Carroll and McMeeken, "Establishing the Value of Rural Clinical Placements During Undergraduate Allied Health Education." Within five years of graduation eighty-five per cent of physiotherapists worked overseas.

is relatively sparse, however McArthur Campbell's photographs and those in the Australian War Memorial (AWM) depict physiotherapy practices.[5]

By the mid 1930s portents of war hung over Australia. Vida Kirkcaldie, an experienced WW1 physiotherapist chaired an Association meeting in 1935 proposing a Military Massage Unit to Major General Rupert Downes, Director General of Medical Services.[6] Downes, AMassA National President and Victorian MRB Chairman.[7] He knew many key physiotherapists including Helen Todd, course dux in 1928 and McArthur Campbell, a lecturer appointed by his Board.[8] Despite Downes' connections, the Army responded that it had reserves of male physiotherapists, but would consider women and the Association's suggestions. By December 1938 the war establishment decided that General Hospitals of 1200 beds required one male Warrant Officer physiotherapist and nine female physiotherapists and a 600-bed hospital one male Warrant Officer and five women.[9]

The proposed appointment of men as leaders reflected women's social position, but did not eventuate. However other issues of status became contentious for most of the war. Initially women were attached to the army, with male pay rates, accorded officer privileges, then commissioned in the Australian Army Medical Corps (AAMC) in early 1942.[10] Whilst supported by Downes, such recognition for women was highly irregular and in July 1943 the women physiotherapists were demoted in status and pay to the Australian Army

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[5] There are some errors in AWM photo descriptions, names, designations and activities depicted.

[6] Wilson, *Physiotherapists in War*. 13. "Masseurs Registration Board 2 August Minutes," (1934). Downes' appointment as Director General of Medical Services, last MRB meeting September 1939. "Masseurs Registration Board 9 March Minutes," (1939).

[7] Downes, 1907 Melbourne medical graduate, foundation member Australasian College of Surgeons, president BMA Victorian branch, 1935, University lecturer, MRB member from 1926, Chairman from 1928. "Masseurs Registration Board 3 May Minutes."; "Masseurs Registration Board 3 May Minutes."

[8] "Masseurs Registration Board 9 July Minutes."

[9] *Physiotherapists in War*. 14.

[10] Ibid. 14-15. McArthur Campbell, "Oral History Record." See Allan Seymour Walker, "Women Officers in the Aamc," in *Medical Services of the Royal Australian Navy and Royal Australian Air Force with a Section on Women in the Army Medical Services* (1961). 419.

Medical Women's Service (AAMWS).[11] The APA, which had lobbied for officer status and a Chief Physiotherapist to improve service efficiency, now sought reversal back to the AAMC. Army administration was deeply concerned that the anomaly for female physiotherapists earning male pay rates could lead to all the forces women, including nurses, expecting such pay. Eventually physiotherapists returned to the AAMC, but McArthur-Campbell recommended acceptance of female pay rates whilst ensuring Captain appointments for twenty-six senior physiotherapists.[12] Some colleagues though expressed concern at their reduced pay.[13] Status however appeared relatively unimportant to many physiotherapists working in the field. When reflecting on being promoted to Captain, Betty Cohn said 'No, it didn't give me any satisfaction. I was only a physiotherapist all the while. The army side didn't interest me'.[14]

The army in January 1940 advised volunteer physiotherapists they must be registered with their State authority, British, and if women, unmarried. Women initially reported to the hospital Matron, but worked under instruction from medical officers.[15] Men were subject to military law. Some eighty physiotherapists served abroad in the Middle East, Greece, Crete, Malaya, the Pacific Islands and New Guinea, working in hospitals, hospital ships, ambulances, transports, casualty clearing stations and convalescent centres. About 150 physiotherapists served within Australia.[16]

The first four physiotherapists, from NSW, joined the 2/1stAGH with thirty-nine nurses on January 2, 1940. They sailed for Gaza, Palestine, arriving mid

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[11] AAMWS included VADs and women scientists. See "Rehabilitation." Bassett, *Guns and Brooches.* 163. "Physiotherapists," in *Medical Services of the Royal Australian Navy and Royal Australian Air Force with a Section on Women in the Army Medical Services Part 3 Women in the Army Medical Services* (1961). 421-424.
[12] McArthur Campbell, "Oral History Record."
[13] Ibid.; Walker, "Physiotherapists." 421-424.
[14] Betty Rothstadt (Cohn), "The Keith Murdoch Sound Archive of Australia in the War of 1939-45, Interviewer Harry Martin," (AWM1990).
[15] Marie-Louise Franken, "Putting It All Back Together Again" (Honours, University of Melbourne, 1993).
[16] Walker, "Physiotherapists." 421-424.

February.[17] The second group, mainly Victorians, included Helen Todd, Senior Physiotherapist of the 2/2ndAGH with Marjory Farnbach, Jean Kelsall, Nell Lazarus, Cynthia Duigan, Margaret Mack, Honor Wilson, Roma Pengilly and Mary Colebatch.[18] These experienced physiotherapists, boarded the *Strathaird* on 15 April 1940, arriving at their tented accommodation at Gaza Ridge in mid May.[19] En route the physiotherapists ran physical training classes, continuing with these in Gaza.[20] Initially the physiotherapists worked in British hospitals and at times staff from both hospitals worked together.[21] Senior Physiotherapist Todd later served on the Atherton tableland before her final leadership posting at Heidelberg Military Hospital, Victoria.[22]

McArthur Campbell embarked with the 2/4thAGH comprising 600 beds staffed by Victorians - 176 officers and other ranks, fifty nurses and five physiotherapists (Figure 8.1).[23] Head of the medical and surgical sections were Lieutenant-Colonels E L Cooper, and Charles Littlejohn from the Melbourne Hospital.[24] As war began Littlejohn, then Bryan Keon-Cohen enlisted, leaving Eric Price and the Melbourne physiotherapists overloaded.[25] Intense workloads at home and abroad developed interprofessional camaraderie, often giving physiotherapists greater autonomy.

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[17] McArthur Campbell, "Oral History Record." The prefix designation '2' denotes World War 2 followed by the individual hospital Unit Number. 80. Bassett, *Guns and Brooches.* 114.
[18] Wilson, *Physiotherapists in War*. Contains war material about Colebatch who met and married surgeon Donald Duffy.
[19] Ibid. 17-19. Bassett, *Guns and Brooches.* 116-117.
[20] Ibid. 19-27.
[21] Ibid. 116-119.
[22] "Obituary Miss Helen a Todd Mbe," *Australian Journal of Physiotherapy* 6(1984). 64.
[23] McArthur Campbell, "Oral History Record." McArthur Campbell's wartime dairies now at AWM, ID number: PR90/022.
[24] Ellis Finney, "Physiotherapy at War," (Australian Physiotherapy Association, 1958); John Isaac Hayward, "University of Melbourne Archives 2011.0099."; Walker, "Rehabilitation." Gregory, *The Ever Open Door.* 270-271.
[25] Chilvers (Wiseman), "Oral History Record."

Figure 8.1 Embarkation on the *Mauretania* of nurses and physiotherapists of 2/4thAGH. Back row nurse, then physiotherapists Bessie Pakes, Mary Bateman, Alison McArthur Campbell, Ivy Matheson and Betty Cohn.[27]

McArthur Campbell, Senior Physiotherapist in the 2/4thAGH was stationed initially at El Kantara in Egypt, then Tobruk and following the Australian withdrawal, in Palestine. She joined the 2/7thAGH, in 1941 during the Syrian Campaign. Posted to the 2/1stAGH from August 1941 to January 1942 in the Thoracic Unit in Gaza, a year with the 2/6thAGH followed. In 1943 McArthur Campbell returned to Australia, serving in Ballarat, Heidelberg and the Atherton Tableland (Figure 8.2).[28]

[27] AWM 004498.
[28] McArthur Campbell, "Oral History Record."

Figure 8.2 Gaza, Palestine September 1942 McArthur Campbell with wounded soldiers waiting for transport back to Australia. [29]

Having received their uniforms but no special training, Ivy Matheson and fellow 1933 graduate Bessie Pakes joined the 2/4thAGH with Betty Cohn, a South Australian working in Victoria's IPS. After completing physiotherapy Matheson treated polio patients at Bendigo Base Hospital.[30] Matheson and Cohn considered themselves fortunate to do war service.[31] Later there was some criticism of new graduate physiotherapists who did not enlist.[32] The women, honorary lieutenants, packed four to a two-berth cabin, shared the ship with 5000 troops ignoring the rules of not fraternising with other ranks.[33] The *Mauretania* stopped in Colombo, with the physiotherapists billeted on stretchers with a wealthy local family. St Peter's Church of England Boy's School became the hospital.[34] From Colombo they sailed to Suez, there

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[29] "Mcarthur Campbell Photograph Album."
[30] Gill, *The Lamp Still Burns*. 61.
[31] Rothstadt (Cohn), "The Keith Murdoch Sound Archive". Bassett, *Guns and Brooches.* 114.
[32] McLoughlin.
[33] Ivy Matheson, "The Keith Murdoch Sound Archive of Australia in the War of 1939-45, Interviewer Harry Martin," (AWM1990).
[34] Ibid.

meeting Todd and Farnbach.[35] With the considerable movement of physiotherapists during the war, they enjoyed meeting colleagues, sharing social experiences and new physiotherapy knowledge. When the 2/4th was stationed at El Kantara the communal living quarters bedded twelve to a sand-floored marquee. Awaiting their equipment, physiotherapists made plaster bandages, coped with dust storms and sheltered in air-raid trenches during intermittent air raids (Figure 8.3). In early March 1941 they miserably learned that the ship containing their equipment had been torpedoed and sunk.

Figure 8.3 Matheson, Pakes and McArthur Campbell in air raid trenches at El Kantara.[36]

In late March the physiotherapists and medical men left Kantara expecting to go to Barce, but instead established at Tobruk, vital for the Allies holding the Suez Canal. From April to August 1941 General Rommel, leading Germans and Italians besieged about 15000 Australian soldiers at Tobruk. Some twenty-

[35] McArthur Campbell, "Oral History Record." Diary February 2, 1941.
[36] "Mcarthur Campbell Photograph Album."

six ships were destroyed.[37] A harbour scene of utter desolation greeted the physiotherapists. Immediately they helped prepare and clean surgical wards, before finding a space for physiotherapy and scrounging furniture and equipment. They were prepared to do whatever was needed and make do as required.[38] In this period the 9th Division lost 832 killed and over 2000 wounded.[39] The troops streamed back to Tobruk, there were insufficient beds and bombing occurred. Every physiotherapist was needed. When Bill Amies took Cohn as a dental nurse, McArthur Campbell had 'a great battle to get her back'.[40]

In Tobruk their previous polio experience ensured expert treatment of a British soldier with polio: John West aged twenty-two, Royal Horse Artillery. 'We lengthened John's bed, (he was 1.94m) fixed up an arm board and put a munitions box tied on with rope at foot of bed to prevent foot drop. Muscle charted him'.[41] Polio presented a significant risk and British army neurosurgeon, Major Kenneth Eden died of bulbar poliomyelitis. [42] Whilst treating polio and nerve lesions was not new, the war provided experience treating many nerve lesions. Lucy Yapp's patients included several with polio and many ulnar, median, and radial nerve lesions. The latter had the best prognosis; median lesions were extremely painful, whilst ulnar results were poor. Germans and Italians shot upwards and soldier's arms were wounded as they protected their heads. Later casualties from New Guinea were mostly lower limb lesions as the Japanese shot downwards into the scrub.[43]

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[37] "Siege of Tobruk," https://www.awm.gov.au/encyclopedia/tobruk/. Accessed 14 February 2013.
[38] Peggy V Rosenhain, "Physiotherapist at War," (Unpublished: Wellcome Institute, ~1980). Rothstadt (Cohn), "The Keith Murdoch Sound Archive".
[39] "Siege of Tobruk".
[40] McArthur Campbell, "Oral History Record." Dairy April 1, 1941. Rothstadt (Cohn), "The Keith Murdoch Sound Archive".
[41] Matheson, "The Keith Murdoch Sound Archive."
[42] McArthur Campbell, "Oral History Record." Diary April 2, 1941. See Rosenhain, "Physiotherapist at War."; Peter H Schurr, "The Evolution of Field Neurosurgery in the British Army," *Joumal of the Royal Society of Medicine* 98(2005).
[43] Lucy Yapp, "Oral History Record," (Australian Physiotherapy Association, 1988).

In one of the most dangerous periods the fifty nurses and physiotherapists shared the eight-bed inn, the *Albergo Tobruk,* ten of them billeted in the cellar. Cohn and Bateman slept behind the reception desk. Matheson did not admit to being frightened: 'you just think you're impregnable'. [44] Aside from mostly orthopaedic injuries - eighty-seven major amputations were done in Tobruk - chest wounds and burns were common.[45] The surgeons took advantage of the physiotherapists' expert plastering, previously honed with their polio patients. The 'Tobruk plaster' was a full plaster cast incorporating a Thomas splint.[46] Although difficult to apply, plaster hip and shoulder spicas could be used (Figure 8.4). These immobilisation methods were necessary for difficult transportation conditions.[47] Compound fractures compromised by long ambulance journeys were a nightmare, but those with plaster over thick dressings were more comfortable.[48]

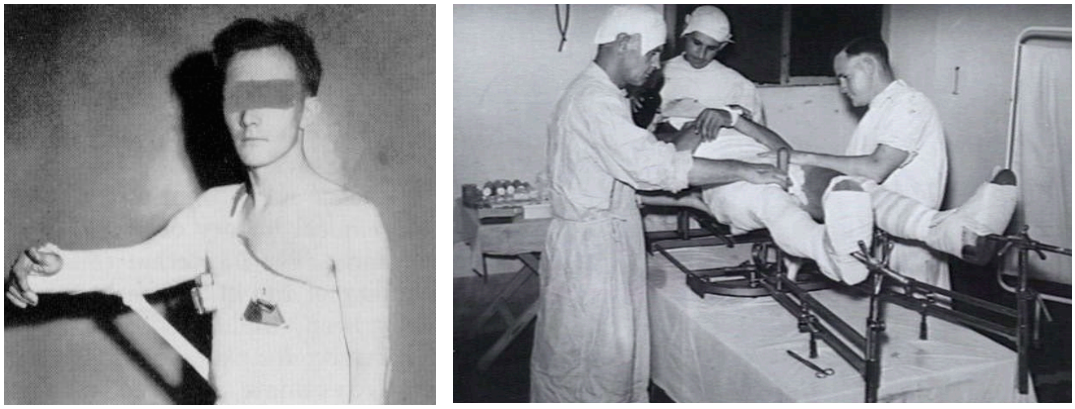

Figure 8.4 Shoulder spica (left), hip spica application (right).[49]

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[44] Matheson, "The Keith Murdoch Sound Archive."
[45] Allan Seymour Walker, *Australia in the War of 1939–1945. Series 5 – Medical Volume 2 – Middle East and Far East* (Sydney: Halsted Press, 1953). 221-222.
[46] Josep Trueta, "War Surgery of the Extremities in the Light of Recent Experience," *The Lancet* 243(1944).
[47] Walker, "Conditions in the Western Desert and Tobruk," in *Australia in the War of 1939–1945.* 222.
[48] Ibid. 220-221.
[49] William Colin Mackenzie, *The Action of Muscles: Including Muscle Rest and Muscle Re-Education* (London: Lewis, 1918). Figure 48 (left) AWM 020328 (right)

On 3 April McArthur Campbell noted 'since Benghazi and Bardi had fallen, nothing much between us and the Boche'. The next day there were '800 patients in the hospital and coming and going all day, and a wild rush of head and facial wounds'. Two days later as more men poured into the hospital with appalling wounds the women were told to pack a kit bag and be ready to leave.

> Did not sleep much - noise of battle, all night trucks and tanks and cars and troops moved up and down. Awoke at 6am, scrap breakfast, everything packed and in hall. Every man ... had a fresh story concerning the size and speed of the German army. They had grown from one to seven divisions and seemed to be within 40-50 miles and advancing rapidly. Except for one small minesweeper the harbour was empty. The hospital ship should have been in, in the night and loading. About 10.30am Charlie the orderly came in having spotted the ship. The relief was amazing. All round there were signs of intensive activity - ambulances and trucks coming up/down to the hospital. Tank traps were being prepared with old Ity trucks, one at our own gate. At 6pm the patients having all been loaded, ambulances came and we drove to the wharf.[50]

Matheson said there was bombing and insufficient beds with half the troops on mattresses on the floor. The physiotherapists were very resentful at not staying with the men.[51] Matheson said 'there were deliberate attacks upon the medical facilities and that was why they sent us away'.[52] The women and wounded sailed to Haifa, farwelled tearful John West, then the physiotherapists went to Gaza Ridge to join the 2/1stAGH, McArthur Campbell wrote the experience was unbelievable. They had arrived safe and well, while 'our men are fighting for their lives out there'.[53] The physiotherapists had supported their medical colleagues, honing their existing professional knowledge and clinical skills, but

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[50] McArthur Campbell, "Oral History Record." Diary April 3-7, 1941.
[51] Ibid. Diary April 3-7, 1941. Rothstadt (Cohn), "The Keith Murdoch Sound Archive".
[52] Matheson, "The Keith Murdoch Sound Archive." Bassett, *Guns and Brooches*. 120.
[53] McArthur Campbell, "Oral History Record." Diary April 10, 1941.

wartime strengthened alliances and provided opportunities to add to their clinical armamentarium.

New scientific, medical and physiotherapy knowledge would enhance both professions and benefit their patients. Farnbach had been in Palestine since April 1940 but late that year the 2/2nd physiotherapists came together again at Kantara. Major John Colquhoun from their polio clinics, made plans for a large orthopaedic physiotherapy establishment, introducing classes for those with injuries to the knees or feet.[54] Major Benjamin Rank, influenced by the work of Britain's leading plastic surgeon Archibald Macindoe, commenced a faciomaxillary and plastic surgery unit for burns and open wounds with new procedures replacing tannic acid and occlusion.[55]

> The most marvellous results are with the very bad burns. They give them an anaesthetic and then literally scrub the burnt surfaces to make them clean so that there will be no infection and sloughing. They are dressed under the anaesthetic and then go to the wards. Every morning they are lifted out of bed into a full sized bath filled with saline and the masseuse gets the patient to move his joints and muscles under water. It means we are often hanging head down in the bath for hours and get wet all over. At first it almost made me sick exercising a muscle with no skin over it, but the relief the patient feels on getting movement and the amazing way the skin grows and without being scarred and contracted makes it absolutely thrilling.[56]

Later lanoline was gently massaged into grafted areas. Staged tubed pedicle grafts replaced full thickness tissue often necessitating awkward and painful positions whilst the graft was transferred from its original site to the final position. Physiotherapy maximised pain free mobility and function. Hand

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[54] Wilson, *Physiotherapists in War*. 42-43, 81 indicates arrival with the 2/9th was secret.
[55] J Eastman Sheehan, "Burns as War Wounds," *The American Journal of Surgery* 61(1943); DM Jackson, "Mcindoe Lecture, 1978. Burns: Mcindoe's Contribution and Subsequent Advances," *Annals of the Royal College of Surgeons of England* 61(1979).
[56] McArthur Campbell, "Oral History Record."

injuries too required special attention with the multitude of small joints and the requirements of fine movement for full function. As orthopaedics and 'burns and plastics' consolidated for medicine, they became specialist areas for physiotherapists too who were embodying different identities within the wider profession (Figure 8.5).[57] Their already embodied knowledge of how far a joint could be moved in normal range, the feel of limitations to movement whether soft tissues or bone and just how far they could stretch tissue was especially critical in managing patients with burns or following plastic surgery.

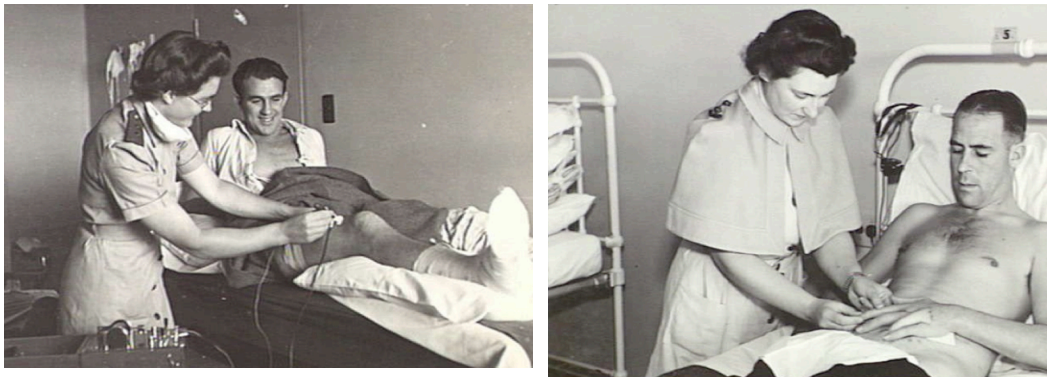

Figure 8.5 In the faciomaxillary and plastic surgery unit at Heidelberg. Physiotherapist Yule using electrical stimulation for neuromuscular testing (left), Honor Wilson treating a patient with a pedicle graft to the fourth finger of the left hand (right).[58]

McArthur Campbell advanced specialist thoracic physiotherapy with the 2/7thAGH in mid-1941, during the little-known Syrian Campaign, in which the Allies fought the Vichy French, took Damascus and agreed to an armistice just

[57] H Jackson Burrows, "Australian Orthopaedics in the Last Fifty Years," *The Journal of bone and joint surgery. British volume* 32(1950). Wilson, *Physiotherapists in War*. 40-42, 129-130. Rothstadt (Cohn), "The Keith Murdoch Sound Archive". I used these approaches in the Burns and Plastics Unit, Queen Mary's Hospital, Roehampton (1960s).

[58] AWM 084942. See also Benjamin K Rank, "Plastic Principles in Common Surgical Procedures. 1," *Australian and New Zealand Journal of Surgery* 14(1944). Benjamin Keith Rank, Alan Ross Wakefield, and John Turner Hueston, *Surgery of Repair as Applied to Hand Injuries* (Churchill Livingstone, 1968); Benjamin K Rank, *Heads and Hands: An Era of Plastic Surgery* (Sydney: London: Harper & Row, 1987); Christopher Lawrence, "Continuity in Crisis: Medicine, 1914-1945," in *The Western Medical Tradition 1800 to 2000*, ed. William F Bynum, et al. (New York: Cambridge University Press, 2006). 380-388.

outside Beirut.[59] She wrote at Rehovat, Palestine, 'Not wanted and not too well received by matron, but Bryan (Keon Cohen) and Tom (King) pleased to see me'.[60] Nurses far outnumbered physiotherapists and matrons could be officious and unreasonable in exerting authority. McArthur Campbell organised the physiotherapists into two shifts, including on-call at night, whilst she began working on chest wounds.[61]

> The work I am doing is absolutely fascinating 90% of my patients have no right to be alive ... bullets and bits of shell in their chests and lungs, windpipes, walls of heart, etc. and Edgar King ... has dug the metal out. All operations on the chest are pretty complicated ... If air gets in through the chest wall the lung collapses. Well, after he has dug the metal out it is my job to get the lung or lungs functioning again and it is marvellous the things one can do with exercises and position of arms and legs etc., and suction pumps.[62]

John Hayward had studied thoracic surgery at London's Brompton Chest Hospital. He showed the physiotherapists controlled breathing taught by English physiotherapists, which was applied to 'chest' patients.[63] When coping with many casualties, work was relentless: fourteen-hour days, each physiotherapist with forty-five to fifty patients.

After Christmas in 1941, news came that the Japanese had taken Burma and Malaya.[64] The physiotherapists returned to Australia, but few mention the hazardous journey in naval convoys.[65] McArthur Campbell, Matheson, Cohn

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[59] McArthur Campbell, "Oral History Record." See "Syrian Campaign," https://www.awm.gov.au/military-event/E295/ Accessed 12 May 2015.
[60] Keon Cohen, *Things - and Other Things.* Burrows, "Australian Orthopaedics in the Last Fifty Years."
[61] McArthur Campbell, "Oral History Record." Diary September 9, 1941.
[62] Ibid. Diary October 31, 1941. Major Edgar King, 2/2ndAGH led special thoracic surgical teams in Bardia and Tobruk, Libya, later with 2/7th Lae, New Guinea.
[63] Ibid. Diary October 22, 1941. John I Hayward, "Physiotherapy in Chest Surgery," *Australian & New Zealand Journal of Surgery* 13(1944). T Holmes Sellors, "The Evolution of Thoracic Surgery," *British Journal of Tuberculosis and Diseases of the Chest* 45(1951).
[64] Matheson, "The Keith Murdoch Sound Archive."
[65] Japan attacked USA Pearl Harbour, Hawaii, December 7, 1941.

and their colleagues left the Middle East in January 1943. Matheson and Cohn returned on troopships to work at Heidelberg Military Hospital before posting to Redbank in Queensland where the new antibiotic penicillin was introduced.[66] In 1943 young Victorian vet Val Bazeley returned from his regiment in New Guinea to learn penicillin production. By early 1944 Bazeley had the Commonwealth Serum Laboratory producing sufficient penicillin for use.[67] Matheson remembered an honorary saying 'We've just put the price of a Chevrolet car into that boy'.[68] Antibiotics such as penicillin would eventually revolutionise medical practice and influence physiotherapy too. Nevertheless the physiotherapy patients such as at Redbank, 'fractures and breathing troubles and injured backs and bad knees' would continue.[69] Medical men indicated the patients requiring treatment and unless learning new techniques, left the physiotherapists to decide the details. They appreciated what the physiotherapists achieved.[70] Cohn spent three years at Redbank, was promoted to Captain and went as Physiotherapist-in-Charge to Greenslopes in Brisbane.[71] After Redbank, Matheson went to Morotai, then Labuan in Borneo: in preparation receiving Atabrine as malarial prevention and target practice with handguns.[72] As the war ended physiotherapists treated Australian and Indian prisoners of war.

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[66] Rothstadt (Cohn), "The Keith Murdoch Sound Archive." Matheson, "The Keith Murdoch Sound Archive."
[67] Ian Gust, "Penicillin: World War 2 Infections and Howard Florey," *Microbiology Australia* 35(2014). Bazeley later worked with Salk on the polio vaccine.
[68] Matheson, "The Keith Murdoch Sound Archive." Ernst Chain, "The Early Years of the Penicillin Discovery," *Trends in Pharmacological Sciences* 1(1980); FW Diggins, "The True History of the Discovery of Penicillin, with Refutation of the Misinformation in the Literature," *British journal of biomedical science* 56(1998). Clinton K Murray et al., "Bacteriology of War Wounds at the Time of Injury," (DTIC Document, 2006).
[69] Matheson, "The Keith Murdoch Sound Archive."
[70] Burrows, "Australian Orthopaedics in the Last Fifty Years."; Frank May, "The Changing Face of Physical Medicine," *Australian Journal of Physiotherapy* 1(1954).
[71] Rothstadt (Cohn), "The Keith Murdoch Sound Archive."
[72] Matheson, "The Keith Murdoch Sound Archive." CW Hays, "The United States Army and Malaria Control in World War 2," *Parassitologia* 42(2000).

The war with Japan had brought physiotherapists home.[73] Nancy Davies embarked with the 2/7thAGH in February1941and worked in Palestine.[74] Returning to Australia at the end of February 1943 she worked at Heidelberg in the nerve injury ward, a WW2 initiative to aggregate particular injury types with appropriate clinical expertise.[75] These physiotherapists gained a more sophisticated knowledge with neurologist Sydney Sunderland and neurosurgeon Hugh Trumble.[76] Trumble invited physiotherapists to view his operations to understand the subsequent physiotherapy required.[77] Davies spent a year with the 2/7th in Lae, New Guinea, before going to Melbourne for *Grong Grong's* administrator's course, her cumulative experience leading to senior responsibilities at Royal Melbourne Hospital (RMH).

Davies, like Ruth McCarthy and many senior service women gained extensive clinical experience, but also undertook leadership roles fitting them for such positions later in physiotherapy. McCarthy served in the Middle East, Australia, and Madang, Aitape and Wewak in New Guinea, before joining St. Vincents Hospital and becoming Chief Physiotherapist from 1948-1978. Leadership ability such as McCarthy's was as important to physiotherapy's professionalisation and the development of physiotherapy's identity as the new and enhanced clinical skills. Her staff grew from six to twenty-three physiotherapists and four assistants working in the new clinical areas of intensive care, coronary care and heart surgery and the Bolte Rehabilitation

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[73] The 2/1, 2/2, 2/4, 2/5, 2/9 and 2/11AGHs left the Middle East in February/March 1942 when the 6th and 7th Divisions returned to defend Australia. See Bassett, *Guns and Brooches.* 130. Walker, *Australia in the War of 1939–1945. Series 5 – Medical Volume 2 – Middle East and Far East*.

[74] Davies, "Oral History Record."

[75] Lawrence, "Continuity in Crisis: Medicine, 1914-1945." 383-384.

[76] Sydney Sunderland and H Bruce Williams, "Nerve Injuries and Their Repair: A Critical Appraisal," *Plastic and Reconstructive Surgery* 89(1992). See JS Guest, "Trumble, Hugh Compson (1894–1962)," http://adb.anu.edu.au/biography/trumble-hugh-compson-11884/text21281. Accessed 17 November 2014.

[77] Davies, "Oral History Record."

unit she developed.[78] St Vincents became an important site for clinical education.[79]

Farnbach who had already led the Children's Hospital IPS would subsequently manage the Health Department service. She returned home in April 1942, went to Watten in Queensland, 258 miles west of Townsville. Watten was to manage potential casualties from Japanese air-raids on North Queensland. At Watten from May to December 1942, Farnbach in a typical physiotherapist's matter-of-fact words stated 'the tents were blown down' and they moved to Rocky Creek on the Atherton Tableland. [80] The event was elsewhere described: 'the hospital was devastated by a cyclonic storm and was abandoned after tents were blown down and the whole area flooded'.[81] In 1944 Farnbach was in Townsville for about twelve months before returning to Rocky Creek with Yapp, Todd, and Colebatch.[82]

Ellis Finney, Betty Bailey, Elinor Bishop, Lorna Meade and Rosslyn Murray were the physiotherapists allocated to the 500 bed 2/9thAGH firstly in Amiriya, then Nazareth followed by Adelaide and Morotai in the Pacific. Initially their patients were Australian and British soldiers from the Syrian campaign suffering chest conditions, pneumonia, asthma, and bronchitis. Jean Kelsall came from 2/2ndAGH to advise them, due to her previous experience volunteering in Vera Carter's asthma clinic.[83] Kelsall's five years wartime experience in the Middle East and New Guinea 'helped enormously in teaching how to assess patients and cope with difficulties. Working in the armed forces added up to experience in such a variety of fields' (Figure 8.6).[84]

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[78] Egan, Ways of a Hospital. 264.
[79] "Citation Ruth Elizabeth Mccarthy," (Australian Physiotherapy Association).
[80] Farnbach, "Oral History Record." Wilson, *Physiotherapists in War*. 81. See 2/2ndAGH http://www.ww2places.qld.gov.au/places/?id=1804 Accessed 10 November 2014.
[81] See "2/2nd Agh," http://www.ww2places.qld.gov.au/places/?id=1804. Accessed 10 November 2014.
[82] Farnbach, "Oral History Record."
[83] Finney, "Physiotherapy at War." Kelsall was Mentioned in Despatches.
[84] Kelsall (Blamey), "Oral History Record."

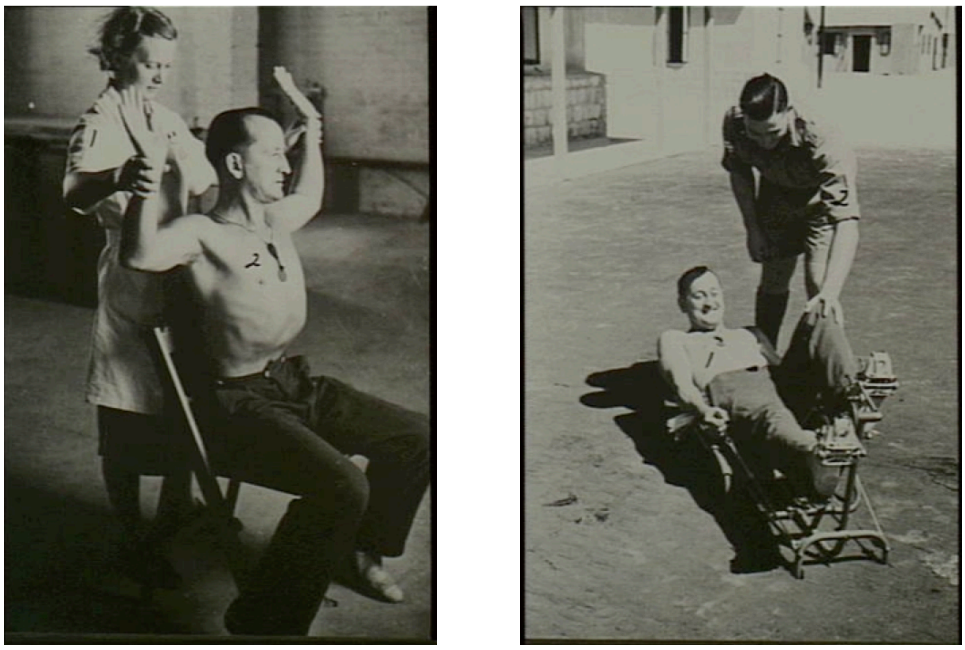

Figure 8.6 Kantara, Egypt. July 1941. Sergeant William Miller `Tickle' Whyte, a former Australian Olympic runner received a gunshot wound in the right shoulder in the Western Desert. Physiotherapists Jean Kelsall, (left) and Clive Peters, (right) assisted his rehabilitation.[85]

In Amiriya, Finney and her colleagues camped on sand; 'fine dust and fleas' penetrated everything.[86] After returning to Australia and eight months at Northfield, outside Adelaide, three physiotherapists of the 2/9thAGH embarked for New Guinea, where their hospital, inland from Port Moresby was at the foot of Roma Pass, leading into the mountains and the Kokoda Trail.[87] The Royal Australian Engineers built a physiotherapy department comprising two large open huts, with grass roofs and wooden floors (Figure 8.7). Many ward floors were earthen which became thick mud in the frequent tropical downpours. Finney recalled wondering if she would ever extract her embedded feet from heavy mud, after standing treating patients in the wards.

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[85] Photographs AWM 030042/02 and 030042/04.
[86] Finney, "Physiotherapy at War."
[87] Australian deaths were greatest in this campaign. See "Kokoda," https://www.awm.gov.au/encyclopedia/kokoda/. Accessed 10 November 2014.

Figure 8.7 Ellis Finney treating patients in her open hut.[88]

Busier in New Guinea than elsewhere, more physiotherapists arrived. The wounded troops from the Kokoda Trail sat on the ground waiting for their beds and tents while the hospital expanded rapidly to almost 2,000 beds. The ambulatory patients came to the department for group treatment. Each physiotherapist was responsible for 'her' wards, supervising bed patients individually twice daily and doing daily ward rounds to ensure that, in order to prevent chest complications following anaesthesia and unavoidable bed rest, pre-operative patients were taught appropriate breathing exercises and post-operatively practised them.[89]

The 2/9thAGH in New Guinea, the official hospital for thoracic surgery cared for soldiers with chest wounds with John Hayward in charge and his Melbourne University colleague, Ellis Finney, senior physiotherapist. Hayward reinforced extensive excision of foreign material, non-viable tissue and drainage of wounds, which must be irrigated with the 'best skin antiseptic in existence - soap and water'. He emphasised the importance of knowing

[88] AWM left 014560, right 014546.
[89] Finney, "Physiotherapy at War." Ellis S Finney, "Mitral Valvotomy for Physiotherapists," *Australian Journal of Physiotherapy* 3(1957).

anatomy and performing clinical tests of patency of main vessels and nerves.[90] Subsequently Finney specialised in cardiothoracic physiotherapy.[91] Whilst Hayward brought some aspects of thoracic physiotherapy from London, no other physiotherapy techniques apparently derived from Britain.

General activity was encouraged and specific exercises given, especially for the many orthopaedic cases, to prevent loss of movement of joints not immobilised.[92] In the late stages of rehabilitation physiotherapists required very energetic exercise (Figure 8.8). Postwar physiotherapists would continue to play a central role in Australia's rehabilitation services, although services would always be challenged to find sufficient physiotherapists.[93]

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[90] Hayward, "University of Melbourne Archives 2011.0099." Hayward's diary of WW2 sea voyage, London to Melbourne captures wartime travel risks, Finney's war manuscript in this archive. D G Macleish AO, "John Hayward Thoracic Surgeon 1910 - 1999," *Sydney Morning Herald*, August 7 1999. Brilliant student Hayward completed Royal College of Surgeons Fellowship first part in fourth year, completing the second at Brompton Hospital.
[91] Finney, "Mitral Valvotomy for Physiotherapists."
[92] Finney, "Physiotherapy at War."
[93] FH Rowe, "Rehabilitation in Australia," *International Labour Review* 78(1958).

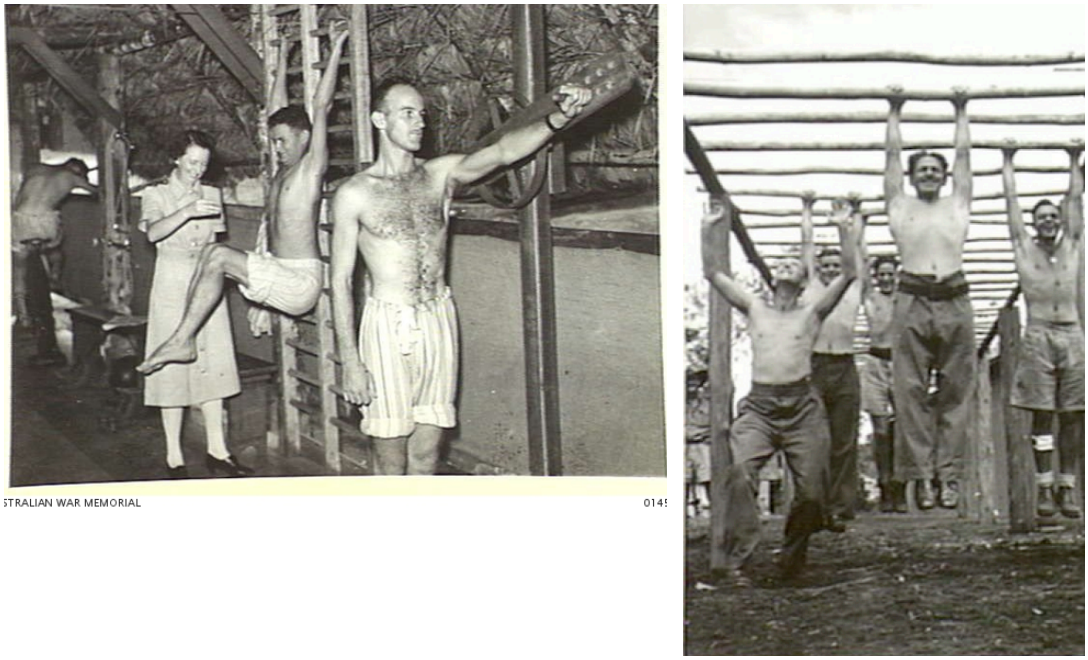

Figure 8.8 Ellis Finney instructing soldiers in New Guinea undertaking progressive strengthening exercises.[95]

Physiotherapists had much to do with plasters - from hand rolling plaster bandages, at times interminably, to carefully applying difficult plaster splints, often without medical assistance: back slabs for soft tissue wounds of limbs, shoulder spicas for fragmented humeral fractures and appropriate support for nerve lesions (Figure 8.9). After plasters were removed, they ensured restoration of joint movement and muscle power.[96] Physiotherapists' detailed and embodied knowledge of anatomy enabled them to use these especial skills to position damaged joints appropriately to maximise later recovery and rehabilitation. High levels of competency in plaster-making and splinting appear unique to Australian physiotherapists.[97]

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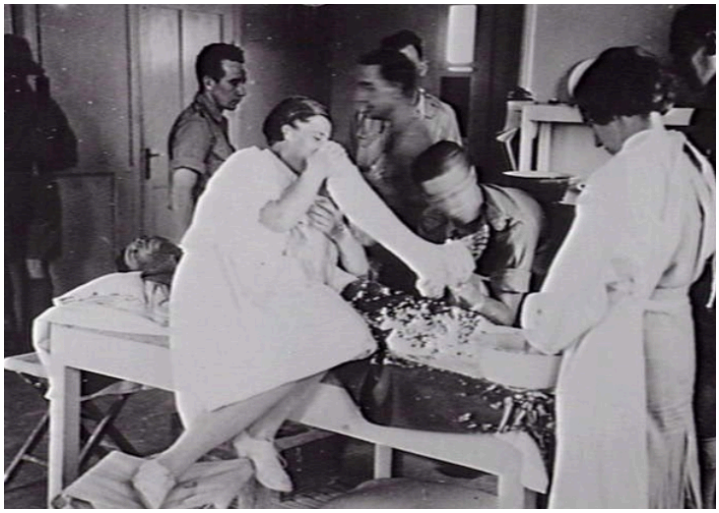
[95] AWM left 014559, right 015115.

[96] McArthur Campbell, "Oral History Record." Matheson, "The Keith Murdoch Sound Archive." Interviewer Martin has little appreciation of the expertise required in physiotherapy and the relationship with medicine.

[97] Farnbach, "Physiotherapy for Poliomyelitis Patients in Victoria." Barry Stillman, Interview 9 May 2013. At the Heidelberg Repatriation Hospital Agatha Grey-Wilson taught these skills to orthopaedic surgeons for five decades.



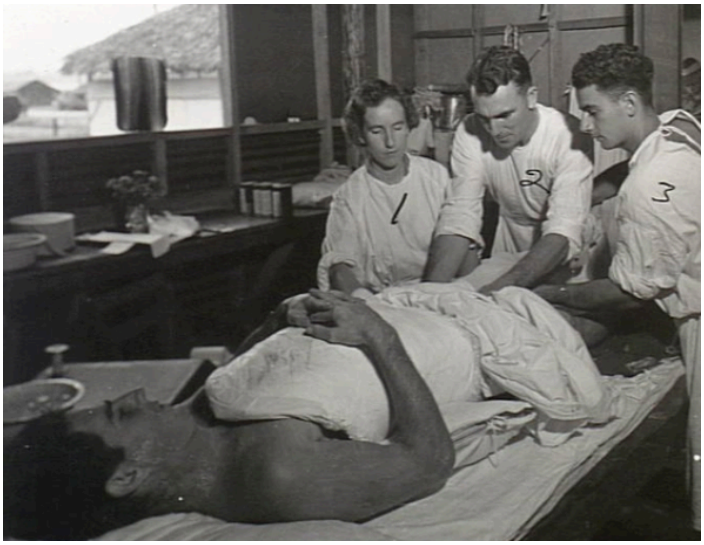


Figure 8.9 Jocelyn Growse and plasters, with orthopaedic surgeons (Palestine) (above), with medical officer and orderly (Lae, New Guinea) (below).[98]

Many wounded and plastered men travelled to Australia by hospital ship. Aura Forster posted to the 2/2 Hospital Ship *Wanganella,* with fellow physiotherapist Brenda Oldmeadow reported to the medical Colonel-in-Charge. Facilities included wards with single and double-decker berths, an operating theatre and

[98] McArthur Campbell, "Mcarthur Campbell Photograph Album." Right, AWM 100607.

plaster room. The well-equipped physiotherapy department had two wide couches, exercise equipment, diathermy, infrared and faradic machines. Here too physiotherapists did most of the plasterwork. Their first trip to Singapore retrieved many army patients just before fighting started. Runs to and from the Middle East and Australia and sometimes to New Zealand followed. Most patients had orthopaedic conditions requiring physiotherapy and often, new plasters. Forster's final trips were to Port Moresby, with the very last to Milne Bay to retrieve medical patients and ill Japanese prisoners-of-war.[99]

McArthur Campbell returned to Australia in 1943 working at Heidelberg Military Hospital and Ballarat before transferring to the 2/6thAGH on the Atherton Tablelands in December 1943. Lieutenant Colonel JB Douglas Galbraith was appointed to coordinate army medical rehabilitation in 1943 and early in 1944 McArthur Campbell became Chief Physiotherapist.[100]

> The first appointment to the position of chief physiotherapist on the staff of the Director General of Medical Services is Captain Alison McArthur Campbell ... A woman was appointed because women have made physiotherapy so largely their field. ... Physiotherapists have served in England, Libya, Palestine, Syria, Singapore, Malaya, New Guinea, hospital ships and sea ambulance transports. ... Captain Campbell's job will also include the inspection of the work of the physiotherapists employed in medical units and the keeping of a check on the adequacy and suitability of equipment used in Army physiotherapy departments.[101]

The report described her Army experiences, Melbourne University course, subsequent study and clinical experience in Australia and England. Appropriately for a woman, *The Argus* reported her appointment beside

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[99] Forster, "My Career as a Physiotherapist."
[100] Walker, "Rehabilitation." 525.
[101] "First Chief Physiotherapist," *The Sydney Morning Herald* 22 June 1944. 6. http://nla.gov.au/nla.news-article17911072 Accessed 7 November 2014.

engagements and cooking articles.[102] Despite their wartime contribution women's work still ranked well below that of men. Amongst the male physiotherapists was Trevor Rice, son of John Arthur Rice and contemporary of Farnbach, Finney and Todd. Rice served five years valuing the extensive work experience and the connections with surgeons such as Hayward for eighteen months in New Guinea. His posting to 102AGH at Tamworth preceded a steady tour of the convalescent centres, Burley Heads, Atherton Tableland, Bougainville, Lae, Ballarat and finally Heidelberg (Figure 8.10).[103]

Figure 8.10 At Bougainville April 1945, Trevor Rice treating Sergeant WJ Kinninmont who probably has an ulnar nerve lesion.[104]

At the 115thAGH, Heidelberg, 1920 graduate Maree Hancock, Physiotherapist-in-Charge, worked with Sydney Sunderland in his study of nerve injury

[102] "Given High Medical Post," *The Argus*, 20 June 1944. 9. http://nla.gov.au/nla.news-article11821475 "Woman's Realm," *The West Australian*, 22 June 1944. 3. http://nla.gov.au/nla.news-article44813455. Both accessed 7 November 2014.
[103] Rice, "Oral History Record."
[104] AWM 091285

recovery.[105] Honor Wilson extolled the privilege of working at Heidelberg with Bennie Rank.[106] As they related in their oral histories, many physiotherapists similarly considered their army experiences a privileged opportunity to learn and develop skills. Whilst at Ballarat Rice worked with orthopaedist John Jens who had been sent with Bryan Keon Cohen to the USA to investigate rehabilitation.[107] Orthopaedists continued firm advocates of physiotherapy.[108] Rice summarised, 'the war developed physiotherapy, introducing a new type of patient, gunshot wounds etc, new techniques and developed thoracic physiotherapy, postoperative orthopaedics and neurology'.[109] Together with medicine physiotherapists gained further knowledge and moved into additional clinical domains. Post-war Rice resumed private practice, becoming the first physiotherapist APA Victorian Branch President from 1967 to 1970, evidence of the increasing autonomy and independence from medical patronage to come.

Orthopaedic conditions affected the majority of convalescent centre patients where men were expected to actively contribute to their rehabilitation.[110] Australia modelled its rehabilitation on Reginald Watson-Jones's centres in Britain in which physiotherapists supervised hourly exercise, games and occupational activities.[111] They adopted Archibald Mcindoe's occupational rehabilitation which he had pioneered with severely burned aircrew in

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[105] Hancock (Maling), "Oral History Record." Sydney Sunderland, "Blood Supply of the Nerves of the Upper Limb in Man," *Archives of Neurology & Psychiatry* 53(1945); Sir Sydney Sunderland, *Nerves and Nerve Injuries* (Williams and Wilkins Co, 1968).

[106] Wilson, *Physiotherapists in War*. 129-130. See also R Goodman, *Our War Nurses* (Boolarong Publications, 1988); Benjamin K Rank, "Some Early History of Hand Surgery in Australia," *The Journal of Hand Surgery* 17(1992).

[107] Bryan Keon Cohen head orthopaedics 1947-1972, Royal Melbourne Hospital.

[108] Cosh; Frank Guymer, "Oral History Record," (Australian Physiotherapy Association, ~1988); Peter Wilcox, "Jens, John 1908-1981 Orthopaedic Surgeon," *Bayside Polio Group* 2013; Barry, *Orthopaedics in Australia: The History of the Australian Orthopaedic Association*. 92-96.

[109] Rice, "Oral History Record."

[110] Walker, "Rehabilitation." 527.

[111] William Humm, *Rehabilitation of the Lower Limb Amputee.* (London: Baiillere Tindall, 1965). Walker, "Rehabilitation." 528-529. Cooter, *Surgery and Society.* 199-233. Sir Reginald Watson-Jones, "A Brilliant Stu," *British Medical Journal*, no. 26 August (1972); Reginald Watson-Jones, *Fractures and Joint Injuries: Vol11* (London: Livingstone, 1960).

manufacturing aircraft precision instruments.[112] Watson-Jones and Mcindoe both developed rehabilitation as Britain's leading orthopaedic and plastic surgeons of the time. Japan's entry into the war required the Royal Australian Air Force (RAAF) to open its own convalescent depots, the first of four at Warburton, Victoria in 1942 (Figure 8.11).[113] Warburton accommodated 250 men.

Figure 8.11 Rehabilitation. Physiotherapists supervising exercise in New Guinea (left). Physiotherapist Jean Harley, right foreground taking men recovering from fractures hiking at 1st Medical Rehabilitation Unit, RAAF Warburton (right).

Necessity demanded additional convalescent depots in New Guinea. RAAF medical officer George Burniston spent a year investigating British rehabilitation thus influencing postwar development of more comprehensive Australian services, including for amputees.[114] Amputee rehabilitation in WW1

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[112] Walker, "Rehabilitation." 530. Menedimos Geomelas et al., "'The Maestro': A Pioneering Plastic Surgeon—Sir Archibald Mcindoe and His Innovating Work on Patients with Burn Injury During World War 2," *Journal of Burn Care & Research* 32(2011); E R Mayhew, *The Reconstruction of Warriors: Archibald Mcindoe, the Royal Air Force and the Guinea Pig Club* (London: Greenhill Books, 2004).

[113] Walker, "Rehabilitation." 531-532.

[114] GG Burniston, "Medical Rehabilitation; Its Organization in the Royal Air Force and the Royal Australian Air Force," *The Medical journal of Australia* 1(1946); "Rehabilitation Medicine in Australia," *Disability & Rehabilitation* 1(1979). See also Richard F Jones, "George Garrett Burniston, the Man, the Mission and the Memory," in *George Burniston Oration* (2010).

developed artificial limb-making and skilled physiotherapists in preparing the patients' limbs for prostheses and training patients in prosthetic use. The efficiency and durability of prostheses, especially for legs, had subsequently improved.[115] However most men with upper limb amputations preferred functional hook prostheses rather than a more natural-appearing hand. Returning prisoners-of-war comprised many of the WW2 amputees.[116]

Physiotherapy education continued during wartime with some new graduates joining the forces, however as a lecturer in a protected occupation Mary Robertson could not enlist.[117] Postwar Robertson undertook the British physiotherapy teachers' course returning to Melbourne to replace Pratt for a decade.[118] Robertson's new graduates however joined the Americans when they appropriated the new Melbourne Hospital as their Army Hospital.[119] American medical practitioners and nurses came from the Boston Medical School, but requested Australian physiotherapists under the Lend Lease scheme.[120] Muriel Ross, Jess Cobain, Shirley Vines, Margaret Ault and Joan Gabb worked with the Americans. The physiotherapists reflected they were shocked to discover the department completely segregated black and white Americans, the former

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[115] AWJ Craft, "Amputations and the Fitting of Artificial Limbs," *British Medical Journal* 2(1942); Humm, *Rehabilitation of the Lower Limb Amputee*; Dafydd S Edwards, Emily R Mayhew, and Andrew SC Rice, "'"Doomed to Go in Company with Miserable Pain": Surgical Recognition and Treatment of Amputation-Related Pain on the Western Front During World War 1," *The Lancet* 384(2014).

[116] Tony Gherardin, "Lt Col Albert Coates (Vx 503645) Medical Pow, Burma-Thailand Railway," http://www.pows-of-japan.net/articles/37.htm. Accessed 15 May 2015.

[117] MacInnes (Robertson), "Oral History Record." Gabb, Gibson, and Wilcox.

[118] Robertson replaced Pratt in 1950. "Masseurs Registration Board 26 May Minutes," (1949). See Gregory, *The Ever Open Door.* 298. Robertson was appointed annually. "Masseurs Registration Board 18 November Minutes," (1953). MacInnes (Robertson), "Oral History Record."

[119] Chilvers (Wiseman), "Oral History Record." Gregory, *The Ever Open Door.* 251-264.

[120] A 1942 reciprocal aid agreement between USA, UK, Australia, New Zealand, and the Free French. American forces overseas received goods, services, shipping, and military installations. "Australia at War," http://www.ozatwar.com/usarmy/lendlease.htm. Accessed 26 November 2014.

treated by young American orderlies with minimal training.[121] These young graduates from cocooned private girls schools were exposed to another world.

Ross, disappointed at not being posted overseas went as the sole physiotherapist, to another American hospital at Gatton, Queensland. She treated casualties who were expected to return to active duty: the more severely injured being repatriated to the USA. Ross returned to do officer training, then to Bonegilla army camp before being posted to Perth's 110thAGH Hollywood Repatriation Hospital as Physiotherapist-in-Charge, where she stayed until discharged in June 1947. Reflecting women's wage inequity, Ross earned 12/6 a day, men 19/-.[122] Postwar Ross returned to RMH, working with orthopaedists Keon Cohen and Price, 'forming a very satisfactory team'.[123] These relationships built in the life and death environments of the anatomy dissection room and the war were sustained as Ross, Keon Cohen and Price remained colleagues and became hospital leaders. The war thus strengthened the relationships, particularly with medical specialists, who recognised their physiotherapy colleagues' contribution to patients' recovery.[124]

Initially not all young WW2 graduates experienced appreciation. Joan Gabb, Merle Gibson, and Jean Wilcox indicated some medical practitioners sexualised physiotherapists. Figure 8.12 demonstrates physiotherapy's challenge to provide a non-sexual professional approach to some techniques. Gibson said in 1943 when she joined the air force,

> The chief surgeon at Heidelberg Hospital for the RAAF at that time said 'now I believe you're the something or other and tickle

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[121] Gabb, Gibson, and Wilcox.
[122] Muriel Floyd (Ross), "Oral History Record," (Australian Physiotherapy Association~1988). Bonegilla commenced September 1940 accommodating 5000 service personnel. "Bonegilla," http://www.bonegilla.org.au/history/whereitallbegan.asp. Accessed 26 November 2014. Earlier female pay was 9/2 compared to 16/-. Walker, "Physiotherapists." 422.
[123] Floyd (Ross), "Oral History Record." Keon Cohen, *Things - and Other Things.*
[124] Hugh C Trumble, "Some Aspects of the Diagnosis and Treatment of Prolapsed Intervertebral Discs," *Australian and New Zealand Journal of Surgery* 15(1946). Sydney Sunderland, "Observations on Injuries of the Radial Nerve Due to Gunshot Wounds and Other Causes," ibid.17(1948). Walker, "Physiotherapists."422-423."Rehabilitation." 525-531.

> merchant - what do you actually do'. I was furious when a doctor called me a - he did not know what we did. I had a couple of patients from him. In the finish I had a tremendous number from him. They gradually learned what we did do.[125]

Medical men like Charles Hembrow respected physiotherapists and many like Mary Miller had worked with him.[126] At Austin Hospital physiotherapists Marjorie Vahland and Betty Hooper enabled Miller to gain a sound grounding in treating

> polios of all ages, with respiratory and multiple muscle involvement and with plasters and splinting. Other complex conditions included tubercular spines and other joints, long-term bed patients, pulmonary and early pneumothorax, early rheumatoids, ankylosing arthritis, quadriplegias and spinal deformities.[127]

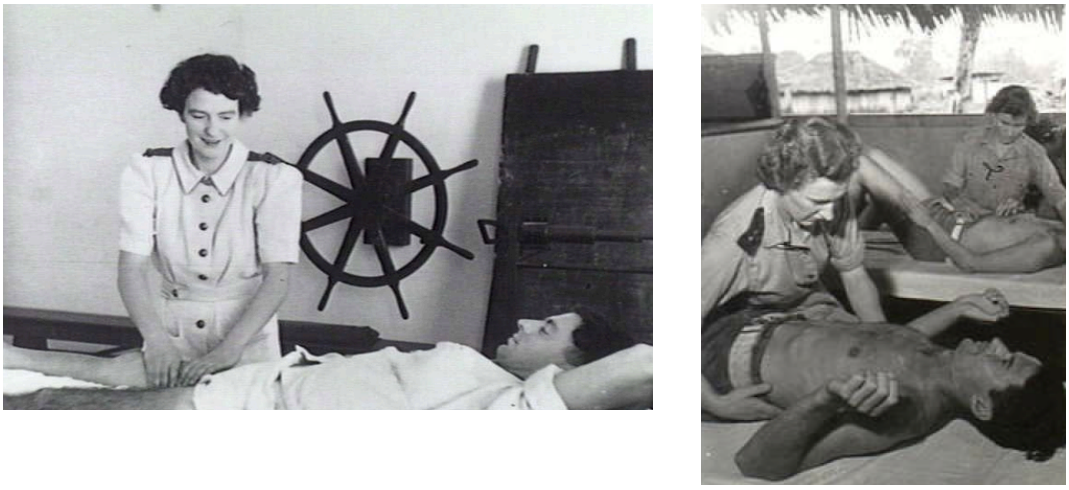

Figure 8.12 Joy Dickson (left), Nancy Davies and Diana Kay (right), treating patients.[128]

Elsa Spark and Merle Gilbert worked with Hembrow at the Alfred Hospital treated his private patients and at his request they and Miller joined the

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[125] Gabb, Gibson, and Wilcox.
[126] Hembrow was at Austin and Alfred Hospitals (1932-1956). Gault and Lucas, *A Century of Compassion.* 157, 180, 259. Mitchell, *The Hospital South of the Yarra.* 220, 224, 282.
[127] Mary Miller, "Oral History Record," (Australian Physiotherapy Association, 1987).
[128] AWM P01641.040 and 100606.

RAAF.[129] The experienced Spark found her five years in the RAAF very educative and interesting, and like many of her contemporaries with these exceptional wartime experiences, returned to lead: as the Alfred's Chief Physiotherapist.[130] Miller began at the commandeered Royal Agricultural Society Showgrounds, transferred to Heidelberg, then to NSW. Postwar Miller taught clinical physiotherapy and Medical Gymnastics with Margaret Mackie. Later she coordinated this subject with Murray Mitchell, Michael Craig, and Helen Coltman until it became Movement 2.[131] Miller was one of many war-experienced physiotherapists who brought their new ideas and practices to physiotherapy education. At Heidelberg, wartime graduate, Agatha Grey-Wilson MBE, organising her department with kindness mixed with military precision, was renowned for teaching orthopaedic practice, including plaster-making in the operating theatres to scores of orthopaedic registrars and physiotherapists.[132] A further example of physiotherapists' knowledge and skills being transferred to medicine as the Repatriation Commission became responsible for the health care of ex-service personnel and Heidelberg Repatriation Hospital (previously the Heidelberg Military Hospital) filled with veterans for decades.[133]

By war's end physiotherapy's knowledge domains in orthopaedics, burns, plastic surgery, nerve lesions, thoracic conditions and classes had evolved, with physiotherapists demonstrating increased professionalism in their capacity to take responsibility for many aspects of treatment. Official medical historian Alan Walker considered that plastic surgery and rehabilitation as practised in WW2 influenced subsequent treatment of all diseases and injuries as Linker described in the USA's rehabilitation programmes.[134] Hospitals such as

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[129] Gabb, Gibson, and Wilcox. Spark, "Oral History Record."
[130] "Oral History Record."
[131] Miller, "Oral History Record."; "Masseurs Registration Board 26 August Minutes," (1953).
[132] Elizabeth Crowe, "Agatha Grey-Wilson Oral History Record " (Australian Physiotherapy Association, 1981); Stillman.
[133] Walker, "Rehabilitation." 543.
[134] Linker, *War's Waste: Rehabilitation in World War I America*.

Frankston's 1st Australian Orthopaedic Hospital and the convalescent depots were contemporary rehabilitation models.[135] Occupational therapy, initially taught and guided by physiotherapy, and vocational and educational guidance emerged.[136] Walker wrote of the importance of preparing service personnel returning to civilian life.[137] Some received much more assistance than others.

Returning physiotherapists received a small allowance to purchase books and a two-week course to orient them back into civilian work whereas medical officers were given extensive support. Those enlisting within two years of graduation received three months' fully paid leave. Refresher courses, scholarships, fellowships, local and overseas and research assistance were available.[138] The Australian government established the Commonwealth Reconstruction Training Scheme and some returned service personnel undertaking physiotherapy through the scheme had a sustained influence on physiotherapy's identity as a career for men and women, perhaps inadvertently overemphasising men's role in sports physiotherapy. Men contributed to education, physiotherapy equipment development and professionalisation of the APA as sketched briefly below.[139]

The new students' backgrounds contrasted from James Lamers who left school after form four and had to gain matriculation, to practising accountant, John Workman, ex-medical student, Frank Guymer and Basil Robinson who joined the army part-way through his University of Melbourne physical education course. As with the many women who came back to lead physiotherapy, several of these new physiotherapists became role models for male

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[135] Walker, "Rehabilitation." 524-525.
[136] Occupational Therapy began in NSW 1940 conducted by APA State branch. Betty Sutherland Cameron, *The Work of Our Hands* (Sale, Victoria: Gippsland Times, 1976). Occupational therapy was proposed to the MRB Victoria 1946, who declined. See "Masseurs Registration Board 14 August Minutes," (1946).
[137] Walker, "Rehabilitation." 540.
[138] Ibid. 541-542.
[139] "Commonwealth Reconstruction Training Scheme," http://www.naa.gov.au/collection/fact-sheets/fs179.aspx. Accessed 15 May 2015.

physiotherapy students inducing more men into physiotherapy.[140] Many made important contributions to physiotherapy.

Robinson's contributions were international. Posted to Malaya in the Field Ambulance, he volunteered for secret mission 204 to China, 'the longest British military overland expedition ever'.[141] Spending the remainder of the war in South East Asia he was awarded 'Mention in Despatches for exceptional service in the field'.[142] Robinson completed physical education then physiotherapy.[143] Perhaps influenced by his wartime experiences in China and South East Asia, Robinson initiated and developed the professionalisation of physiotherapists and rehabilitation in wartime Vietnam and Cambodia, and also in Taiwan, the West Indies, Guyana and remote indigenous Australia.[144]

Max Sandow, influenced as a wartime medical orderly to do physiotherapy, brought occupational physiotherapy, a new specialist area, to Victoria's rapidly developing industries in the La Trobe Valley.[145] In 1953 Sandow established physiotherapy at Yallourn Hospital, before becoming Chief Physiotherapist at Traralgon Hospital and later at Maryborough Hospital.[146] Adrian Wright used his skills differently. Politically active from student days with Beatrice Burke and Peg Gooden, Wright pressured the MRB to improve subject integration, examinations, facilities and request the University run the course.[147] On graduation, Wright commenced work in private practice and the Alfred Hospital encouraged by Hembrow in developing physiotherapy manipulation,

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[140] Harrow Morgan, "Oral History Record," (1987).
[141] William Noonan, *Lost Legion: Mission 204 and the Reluctant Dragon* (Sydney: Allen & Unwin, 1987). 214.
[142] London Gazette: 6 March 1947. 1095. Commonwealth of Australia Gazette. 754. "Gazette Basil Robinson," www.awm.gov.au/research/people/honours. Accessed 2 June 2013.
[143] Recently physical education/exercise physiology degrees have often preceded physiotherapy qualifications.
[144] Joan M McMeeken, "Mr Robinson: Physiotherapy in Taiwan," *The Formosan Journal of Physical Therapy 41* 41, no. 1 (2016). 1-6.
[145] La Trobe Valley http://en.wikipedia.org/wiki/Latrobe_Valley Accessed 1 December 2014.
[146] Maxwell Sandow, "Oral History Record," (Australian Physiotherapy Association, 1989).
[147] "Victorian Massage Association 2 July Minutes," in *Victorian Massage Association 1921-1953* (1947).

particularly for sporting injuries. Wright became a high profile sports physiotherapist to St. Kilda and Melbourne Football Clubs. He founded the St. Frances Xavier Cabrini Hospital Physiotherapy Department and contributed to the APA from new graduate representative in 1949 to its President (1970-1973).

Wright's Public Relations Committee campaigned vigorously but unsuccessfully, as did medicine, to protect medicine and physiotherapy's scientific knowledge, professional authority, position and power and prevent chiropractor registration.[148] This issue arose in 1938 when thirty-eight chiropractors formed the Australian Chiropractors' Association and began advocating for registration. Australian chiropractors had emerged in the 1920s with teaching beginning in small private colleges when several practitioners, principally from Britain established themselves. The Australian Chiropractors' Association's members practised the American Daniel David Palmer's form of chiropractic. Palmer commenced teaching in America in1898, maintaining that disease resulted from 'subluxations' or spinal misalignments which interfered with neural transmission, causing problems in internal organs. Spinal adjustment supposedly restored the normal 'nerve force', and health.[149] Biomedical science did not support this perspective, nevertheless Federal funding of chiropractic education began in 1982 at Phillip Institute of Technology and registration in the Australian states occurred between 1978 and 1985.[150]

Despite not succeeding in their attempts to prevent chiropractors' registration, Wright's Committee gained significant publicity for physiotherapy and further strengthened its alliance with medicine against unorthodox practitioners. His Committee worked to include physiotherapy within the National Health

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[148] Hans A Baer, "The Drive for Legitimation by Osteopathy and Chiropractic in Australia: Between Heterodoxy and Orthodoxy," *Complementary Health Practice Review* 11(2006).
[149] Ibid.
[150] Arthur O'Neill and Evan Willis, "Chiropractic and the Politics of Health Care," *Australian Journal of Public Health* 18(1994).

Scheme. Menzies Liberal/Country Party Government Minister of Health, Dr Earle Page, surgeon and BMA member, proposed a scheme based upon voluntary health insurance and fee for service. Implemented between 1950 and 1953 it gave preferential treatment to medical practitioners.[151] In this campaign medicine protected its own interests demonstrating the fickle nature of interprofessional loyalties. For Wright's dedicated Committee this was a learning exercise and its surviving members worked hard in the later campaign (Chapter 9).[152]

Former chartered accountant Major John Workman developed the Association's policies and stabilised and increased its finances. He had served with the 2/15th Field Regiment in Malaya before being incarcerated as a prisoner-of-war in Changi and Borneo. As a result of three-and-a-half years of privations, Workman was legally blind.[153] He worked at the Alfred Hospital whilst developing his private practice.[154] As they had always done, men generally entered full-time private practice to make money, despite earning more than the women when employed. Former RAAF Flight Lieutenant Frank Guymer opened his practice in Ballarat, working with orthopaedist John Jens. John Grace another airman, developed his private practice in country Warrnambool.[155] This first post-war intake mixed with school leavers: about twenty men with five years of wartime life experience and as many girls fresh from private schools.[156]

For three years the University urged the Registration Board to increase student numbers and to let ex-service personnel enter without the Leaving Certificate.

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[151] Theodore Fox, "The Antipodes: Private Practice Publicly Supported," *The Lancet* 281(1963). Pensabene, *The Rise of the Medical Practitioner in Victoria.* 170.
[152] Mary Wright, "Adrian Belloc Wright: Oral History Record " (Australian Physiotherapy Association, 1987); Christopher Wright, Interview 2014; McLoughlin.
[153] Australian Physiotherapy Association, "Citation John Skeete Workman," (Australian Physiotherapy Association); "Obituary John Skeete Workman," *Australian Physiotherapy Association Victorian Branch Newsletter* (1991).
[154] "Citation John Skeete Workman."; "Obituary John Skeete Workman."
[155] Guymer, "Oral History Record."
[156] Geoffrey Thomas Luke, "Oral History Record," (Australian Physiotherapy Association, 1987).

The Board refused, defending its hard-won boundaries and maintaining its educational standards. Physiotherapy's popularity ensured application of strict entry criteria and a ballot for scarce places.[157] Geoffrey Luke was amongst the twenty-five ex-servicemen with Leaving Certificates and sixty-nine others competing for places.[158] Luke had served in the Royal Australian Naval Reserve 'seeing the world'. Luke's first positions were half time at Austin Hospital and Repatriation Out Patients in St Kilda Road. 'We all worked for Trevor (Rice) ... at night after we knocked off'.[159] Jobs were plentiful but salaried positions were so poorly paid that additional work was essential for most physiotherapists. Luke, who became chief physiotherapist at Austin Hospital and Harrow Morgan were key drivers in establishing improved salaries for employed physiotherapists.[160]

Luke's successor at the Austin was Beatrice Burke. First introduced to physiotherapists treating her polio sufferer brother, as Lieutenant instructor at *Grong Grong*, the AAWS Officer's School, she met many physiotherapists.[161] Burke said.

> It was slightly mad because they were all flat out dealing with the injured in the hospitals from which they came, and left their units short-handed during their absence, and a lot of the knowledge gained would never have been utilised thereafter, it was really more suited to those doing administrative work.[162]

Ironically many very effectively used that administrative knowledge, amongst them the Victorians described above. Burke was posted as Officer Commanding to the 200-bed Townsville barracks for women where all Army

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[157] Over 40 students were planned for 1945. "Masseurs Registration Board 18 January Minutes," (1945).
[158] "Masseurs Registration Board 6 February Minutes," (1946).
[159] 16 May 2013.
[160] Gault and Lucas, *A Century of Compassion.* 143, 181-183.Morgan, "Oral History Record."
[161] Sioban Nelson and Jennifer Rabach, "Military Experience: The New Age of Australian Nursing & Other Failures," *Health and History* (2002).
[162] Burke, "Oral History Record."

women attached to Army hospitals, passed through. After closing the barracks Burke arrived home for her twenty-third birthday and was discharged in June 1946. In 1947 Burke commenced physiotherapy. She said, 'the school leavers were all ex-school captains or prefects. Never been with so many in my life! ... Mainly private schools, because the course had to be paid for'.[163]

The war had irrevocably changed physiotherapy - its scientific knowledge, clinical practice, relationships with medicine and professionalism. Whilst Cooter argued that WW2 did not realise its postwar opportunities for orthopaedics in Britain, physiotherapy was far more than orthopaedics and physiotherapists became essential team members in many aspects of acute medicine and surgery as well as in longer-term rehabilitation.[164] In Australia, physiotherapy became freely available for ex-service personnel from 1946 onwards. In 1948 the Government accepted the principle of providing a comprehensive rehabilitation service to all members of the community. Specially equipped rehabilitation centres such as Hampton Hospital included excellent physiotherapy facilities - a physiotherapy department, hydrotherapy pool and a gymnasium as well as outdoor remedial exercise areas.[165]

Under adverse wartime conditions physiotherapists had generally viewed the experience positively and just got on with the job, enjoying the camaraderie of working with their colleagues.[166] A small number like Lieutenant Ellis Finney and Captain Jean Kelsall received formal recognition.[167] Finney said, 'the effect of the war on physiotherapy was quite considerable; doctors were made aware

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[163] Burke went to private St Michael' s Church of England Girls Grammar School.
[164] Cooter, Surgery and Society. 218-233.
[165] "Rehabilitation in Australia the Commonwealth Rehabilitation Service," ed. Commonwealth department of Social Service (Melbourne 1955).
[166] Franken, "Putting It All Back Together Again."
[167] "Ellis Salisbury Finney, Mentioned in Despatches for Exceptional Services in the Field New Guinea," http://static.awm.gov.au/images/collection/items/ACCNUM_LARGE/RCDIG1068958/RCDIG1068958--146-.JPG. "Jean Boyd Kelsall, Mentioned in Despatches for Exceptional Service in the South West Pacific," http://static.awm.gov.au/images/collection/items/ACCNUM_LARGE/RCDIG1068960/RCDIG1068960--608-.JPG. Accessed 10 November 2014.

that physiotherapists existed and their worth and in postwar years physiotherapists were increasingly used as their value was realised'.[168] Many were proud ex-service people. Despite displaying acceptance of wartime conditions, for some home-coming proved difficult. Matheson felt lost. 'I was used to having all these people around and suddenly I was home with a mother and a father, that's all. And that was a sort of shock. ... You weren't part of a unit any more ... on your own.[169] Matheson had recalled her enjoyment of the army social life and behind those words we can only speculate the relationships that may have occurred amonst young men and women in stressful wartime environments. Peggy Rosenhain provides glimpses of some decadent times.[170] Marriages too, such as that of Betty Cohn were forged in wartime. Once home many women of the 2/4th continued to meet fortnightly. These meetings and the reunions, which included the men, became an important part of their lives.[171]

Links with wartime continued with returned physiotherapists on the teaching staff and in key roles in clinical education in the hospitals. Nell Lazarus and Elsa Sparks became the Chief Physiotherapists at the Alfred Hospital, Ruth McCarthy at St Vincent's, Ivy Matheson at Prince Henry's, Marjorie Farnbach at the Health Department, Agatha Grey-Wilson at Heidelberg Repatriation Hospital, Geoff Luke then Beatrice Burke at Austin and Joy Dickson and Dorothy Giderson at the Melbourne. Muriel Ross, Jocelyn Growse and Mary Miller became physiotherapy lecturers. The physiotherapy identity projected a capable, adaptable, hard-working practitioner, attracting the daughters of medical servicemen such as Major General Sir Kingsley Norris, Benjamin Rank and John Hayward. As key role models for me, many of these ex-service women taught in the early 1960s. Education benefitted from the introduction of the new knowledge and techniques learned in wartime and from the confidence

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[168] Finney, "Physiotherapy at War."
[169] Matheson, "The Keith Murdoch Sound Archive."
[170] Rosenhain, "Physiotherapist at War."
[171] Ibid. Rothstadt (Cohn), "The Keith Murdoch Sound Archive."

gained as physiotherapists and their medical colleagues realised they were indispensible to health care. Furthermore the injection of more mature students including men influenced physiotherapy education, clinical practice and the APA. The engagement of more worldly-wise veterans brought additional expertise to the Association in its management, political lobbying and the development of a salaried practitioners' group.[172]

Betty Cohn reflected:

> Army life taught me an awful lot. ... I gained because I learnt to mix with everybody. ... It didn't matter how much money ... And it's the only place I know where money didn't come into it or social status didn't come into it, and it does in civilian life. ... You were no better than anyone else and you had no right to be. ... They were good years.[173]

At the conclusion of the war the army's responsibilities for veterans' health were transferred to the Repatriation Department. Wartime rehabilitation presaged the introduction in 1955 of the Commonwealth Rehabilitation Service for severely disabled civilians who were considered capable of contributing economically to the community. Centres were developed in Victoria at Coonac, Maryport and Glen Waverley expanding rehabilitation and physiotherapy work opportunities.[174] I follow the prosperous postwar years in the next chapter when physiotherapy education eventually established a 'home', initially at Fairfield Hospital and later at Lincoln House.

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[172] Luke; Morgan, "Oral History Record."
[173] Rothstadt (Cohn), "The Keith Murdoch Sound Archive."
[174] Walker, "Rehabilitation." 544. Repatriation Department has continued through name changes: Repatriation Commission, Department of Veterans' Affairs and the Military Rehabilitation and Compensation Commission. Morgan, "Oral History Record."

Chapter 9 A home of our own

> *When I first started at the Melbourne we had to clock on. Furious at having to do this we always worked longer than hours. Would go down and clock off and then go back to the department and continue working. We were not recognised for doing anything extra. Even if no more money some appreciation and recognition would be appreciated even a line or two in the annual report would help.*[1]

As Australia enjoyed a prosperous three decades following WW2, physiotherapy emerged confident that it had made a worthwhile contribution to the war effort. Yet physiotherapy professionals should not be required to clock on and off, they gave of themselves beyond the call of duty and had developed an identity of volunteering and self-sacrifice.[2] Physiotherapists had contributed to developments in orthopaedics, thoracics, plastic surgery, neurology and neurosurgery and the physiotherapy treatment of patients with conditions in these specialities. There was a strong demand for physiotherapists to support the new medical and surgical endeavours.[3] People with polio still required physiotherapists and many who had served in wartime were drawn back into the polio services. Rehabilitation, with the needs of returning veterans had also grown.

New graduates had a choice of positions. The women had made a significant contribution during the war; they had worked beside their medical colleagues who more fully recognised physiotherapy's contribution restoring patients' physical abilities. Although being on salaries of only seventy-five per cent of the male basic wage, women now dominated as leaders. An influx of male war veterans into physiotherapy would ultimately influence particularly private practice, providing role models for the growing numbers of male graduates. However during the early postwar years some young male graduates felt they

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[1] Cosh.
[2] Ibid.
[3] Honor C Wilson, "Physical Therapy in a Plastic Surgery Unit," *Physiotherapy Review* 25(1945); Finney, "Physiotherapy at War."

had 'to do better to graduate'. ... The senior women regarded them as...'only interested in money'.[4] The public perceived physiotherapy's identity as predominantly female as during the war, yet men continued to join.

Education though had stagnated: with little change in the 1940s from the 1930s. It was not until the 1950s that education became effectively coordinated and in the 1960s the full implications of WW2 clinical advances filtered into the education programme. The challenge of finding a permanent home for physiotherapy education dragged on until in the 1970s Lincoln House became a reality. This chapter addresses the period when the governance and responsibility for physiotherapy transferred from the MRB to what became Lincoln Institute of Health Sciences (LIHS). Leadership and staffing changed during the period and the course's increasing popularity required considered selection of students. The APA and the students influenced the content and direction of the course, but throughout the university offerings changed little. As student numbers increased, their clinical experience diversified with additional hospitals and clinicians sharing their physiotherapy practice knowledge and skills. New graduates took these attributes into the workforce. Yet physiotherapy remained beholden to medicine, struggling to convincingly demonstrate ownership of its knowledge and advance that knowledge through scholarly endeavour and research. In this chapter I demonstrate that physiotherapists' efforts to take greater responsibility for their education were important milestones in the continuing professionalisation of physiotherapy and in moulding the identity of physiotherapists

The MRB's responsibility for physiotherapy education continued for fifty years. The Board decided curriculum, appointed lecturers and their assistants, controlled examinations and endeavoured to maintain high educational standards and financial viability. In 1946, the University wanted the MRB to take still more students and to consider teaching occupational therapy.[5] The

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[4] Peter Rice, "Oral History Record," (Australian Physiotherapy Association, 1988).
[5] "Masseurs Registration Board 13 February Minutes," (1946).

Board maintaining its standards resisted both, and also Sydney Sunderland's suggestion to reduce anatomy to a single year as the Faculty of Medicine struggled to find teaching staff.[6] They did pay for anatomy's additional demonstrator at a further £100 per annum.[7] The influx of postwar students also required additional physiotherapy staff. McArthur Campbell, restored to her position, sought two assistants in addition to second year students assisting in teaching first year students. To ensure intellectual capability and again encourage the University to run the course, the Board made matriculation an entry requirement from 1948.[8] In the meantime a rare conference of lecturers discussed the course and sharpened procedures.[9]

With Hembrow in the chair, Elizabeth McComas, Eric Price, Leigh Wedlick, Edith Pratt, Ellis Finney, Mary Robertson, Alison McArthur Campbell, Diana Kay, Margaret Mackie, Nan Ashworth, Vera Carter and Margaret Hutchinson considered each subject. Anatomy required a definitive syllabus, more demonstrations and attention to surface anatomy. Bandaging would add cardiopulmonary resuscitation. Pathology required microscope slides and ward demonstrations by orthopaedists, Medical Gymnastics must emphasise treatment through movements and Muscle Re-education reconsider splinting and plaster work. Wedlick proposed hydrology lectures. Lecturers agreed to eliminate unsuitable students early in the course, but to allow adequate time for revision between annual and supplementary examinations.[10] Price suggested combining physiotherapy and occupational therapy: 'both treatments should be undertaken by physiotherapists'.[11]

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[6] "Masseurs Registration Board 17 July Minutes," (1946). "Masseurs Registration Board 25 September Minutes," (1946). Jones, *Humanity's Mirror.* 199-203.
[7] "Masseurs Registration Board 25 September Minutes."
[8] "Masseurs Registration Board 8 May Minutes," (1946); "Masseurs Registration Board 20 November Minutes," (1946).
[9] Conferences were held in these years. "Masseurs Registration Board 10 November Minutes," (1938); "Masseurs Registration Board 6 March Minutes," (1941); "Masseurs Registration Board 7 March Minutes," (1951).
[10] "Masseurs Registration Board 27 November Minutes," (1946).
[11] Occupational therapy was not yet established in Victoria.

In May of 1947 the students, empowered by the mature veterans, specified improvements they considered necessary.[12] They asked for other hospitals, such as St Vincent's to contribute to clinical training. Pratt, perhaps jealous of protecting her own position, did not think it possible to have 'lecturers of equal status' to those at the RMH.[13] The APA too applied pressure. A deputation comprising ex-servicewomen Muriel Ross, Brenda Oldmeadow and Diana Kay sought a preselection committee to interview applicants and an honour's standard.[14] As the Board and Association debated education the Board considered appointing a director of training. Furthermore to improve graduates' standards the Board arranged more hospital work between students' final exams and first appointment, imposing additional supervision on APA members.[15] Students were furious. 'The MRB dropped a dirty one on us halfway through final term, ... all the newly qualified had to do two months honorary work before passing ... really to keep outpatients going at RMH'.[16]

Cynthia McLoughlin, an eighteen-year-old matriculant applied to commence physiotherapy in 1946, but balloted out by the Board's selection process, could not begin until 1947. She loved anatomy with AG Matheson, Kenneth Russell, Gordon Keys Smith and Les Ray who engaged the physiotherapy students indicating they had to know their anatomy ‘better than the medical students’.[17] Margaret Hutchinson taught physiology with Ding Dyason 'funny and a good teacher'. Educational Gymnastics at the Melbourne Teachers College on Saturdays taught ‘students how to teach’. Physiotherapy students felt part of the University: it was 'a carefree existence ... a wonderful time, especially the social side. Physios knew a lot of the medical students and common room dances were

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[12] "Masseurs Registration Board 25 May Minutes," (1947); "Masseurs Registration Board 2 July Minutes," (1947); "Masseurs Registration Board 12 August Minutes," (1947).
[13] "Masseurs Registration Board 4 February Minutes," (1948).
[14] The Board had already decided to require matriculation that is Leaving Honours, so the honours standard probably applies to graduation standards.
[15] "Masseurs Registration Board 24 November Minutes," (1948).
[16] Burke, "Oral History Record."
[17] Cynthia McLoughlin, "Oral History Record," (Australian Physiotherapy Association, 1987). Jones, *Humanity’s Mirror.* 206-207. Les Ray became head of the department. Russell, *The Melbourne Medical School.* 177-201.

attended at Trinity and the other colleges'.[18] Australia was prosperous, with new settlers arriving to influence food, art and literature. A new Australian identity was developing. McLoughlin attended many Union Theatre events, including watching young comedian Barry Humphries and Ray Lawler's play the *Summer of the Seventeenth Doll.* The play reflected an Australia separate from Britain.[19] The graduates however, especially the young women, still regarded experience in England and travel in Europe part of their education and physiotherapy's identity.

McLoughlin considered her course prepared her well for treating patients with musculoskeletal and orthopaedic conditions and adequately for neurological and cardiothoracic problems. Students only observed paediatric patients and pre- and postnatal exercises. Despite no community health or private practice experience, within months many new graduates treated private patients. Postgraduate education comprised learning from more experienced physiotherapists at work, short continuing education courses offered by the APA, attending conferences and working overseas.[20]

Undergraduate education became more costly. In the 1947 academic year the University Extension Board required £240 for physiology and £1100 for anatomy with an additional £150 for three anatomy demonstrators.[21] In 1950 the students paid first year fees of £50, £70 second year and £50 third year. Supplementary examinations attracted extra fees. In 1951 the MRB agreed to Sunderland's request that examination fees be paid directly to him and not to the University.[22] Helen Gordon who worked for a year before commencing the course in 1953 'now had enough money in my bank account to pay my first

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[18] McLoughlin, "Oral History Record,"
[19] "Summer of the Doll," http://www.hat-archive.com/summerofthe17thdoll.htm. Accessed 17 November 2012.
[20] McLoughlin.
[21] "Masseurs Registration Board 5 March Minutes," (1947). See Registrar's Office Correspondence, "University of Melbourne Archives No. 296 Extension Board Course for Outside Bodies," (University of Melbourne Archives, 1941). The University's Extension Board assumed responsibility for dealing with the MRB.
[22] "Masseurs Registration Board 19 December Minutes," (1951).

years fees. I never thought that my parents ought to pay for my course in physiotherapy'.[23] Each student's fees were £224 in 1954.[24] That year £3434/11/- covered the University charges.[25] Despite physiotherapy's unusual educational arrangements, from the 1950s the government recognised physiotherapy students for Commonwealth scholarships.[26] In 1955 the Extension Board endeavoured unsuccessfully to require the MRB to pay its physiotherapy lecturers at the same rate as University lecturers.[27] The MRB was protective of its role as the controller of the course and its rate of pay to physiotherapy lecturers was dismally low. In 1957 Patricia Cosh and Peg Gooden challenged the salaries offered and were told, that 'lecture work offered other advantages which compensate for a possible monetary loss'.[28] They did not provide an explanation of the 'other advantages'. An expectation of giving of expertise was a hallmark of professionals.[29]

Selection of suitable students to become physiotherapists was a prerogative of the Board's medical president, who received the students' consultation fees for his physical examination. The Registrar briefly interviewed applicants.[30] Board physiotherapists appear to have played no role. Perhaps the medical president preferred students like Pratt who deferred to medical practitioners. After forty-one years, in 1949 Pratt resigned from teaching but remained on the Board until

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[23] Gordon, "Oral History Record."
[24] "Masseurs Registration Board 29 July Minutes," (1953).
[25] "Masseurs Registration Board 20 October Minutes," (1954).
[26] Barbara Duncan, "Oral History Record," (Australian Physiotherapy Association, 1988).
[27] "Masseurs Registration Board 23 November Minutes," (1955). The University Extension Board endeavoured unsuccessfully to require the MRB to issue a prospectus.
[28] "Masseurs Registration Board 4 April Minutes," (1957).
[29] Warren O Hagstrom, "Gift Giving as an Organising Principle in Science," in *Science in Context Readings in the Sociology of Science*, ed. Barry Barnes and David Edge (Cambridge, Mass.: MIT Press, 1982). Freidson, "Theory and the Professions."; Burnham, "How the Idea of Profession Changed the Writing of Medical History."; Aafke E Komter, "Introduction," in *The Gift: An Interdisciplinary Perspective*, ed. Aafke E Komter (Amsterdam: Amsterdam University Press, 1996).
[30] Mabel Cooper, "Oral History Record," (Australian Physiotherapy Association, 1989). "Masseurs Registration Board 23 January Minutes," (1956).

1954, continuing to influence the course's overall management.[31] Pratt had given her life to physiotherapy. Many physiotherapists cited her gentle hands and kindly nature, but Cosh said

> She is so often depicted as an angel - ... she was very nice and very sweet to people, looked after us like a mother and clucked over us like a clucky hen, but she was ... content to be an ancillary. The doctor was ... God virtually, and she tried to imbue us with the fact - these perfect people, we did what they wanted us to do. That was part of her image. It was those of us who came after that objected to that.[32]

As I demonstrate in the following chapters, Pratt's successors like Cosh would seek autonomous control of physiotherapy education and practice. In the 1950s change was afoot. With growing numbers of students and increasing management responsibilities, the MRB discussed a Director of Training to implement the Board's instructions, arrange timetables, interview and advise students, observe students' progress and report curriculum or timetable defects to the Board.[33] Naively Pratt asked 'whether it would be possible ... to do this work on Saturday mornings'![34]

Muriel Ross contributed to the changes in education and research, participating in student selection in 1948.[35] In March 1950 Ross became the first part-time Director, eventually offered an annual fee of £120, when a full time physiotherapy position was about £1000 annually.[36] Whilst undertaking the administrative tasks associated with managing students, Ross promoted physiotherapy, but only invited students from girl's private schools to visit the RMH's physiotherapy department. These girls would fit comfortably with their

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[31] "Masseurs Registration Board 3 July Minutes," (1923); "Masseurs Registration Board 20 October Minutes."
[32] Cosh.
[33] "Masseurs Registration Board 8 February Minutes," (1950).
[34] "Masseurs Registration Board 1 March Minutes," (1950).
[35] "Masseurs Registration Board 24 November Minutes."
[36] "Masseurs Registration Board 22 March Minutes," (1950); "Masseurs Registration Board 20 December Minutes," (1950). Physiotherapy salaries in Burke, "Oral History Record."

predecessors and their parents could afford the fees. Nevertheless Ross was a trailblazer undertaking research in thoracic physiotherapy.[37] As she commenced as the first Director, McArthur Campbell resigned and Margaret Mackie replaced her, Jocelyn Growse replacing Ellis Finney. Other far-reaching changes occurred in the Board: Frank May resigned as Chairman, Mabel Cooper became Registrar and Leigh Wedlick joined the Board.[38] Cooper and Wedlick would remain for many years.[39]

The APA, not for the first time concerned about the 1950s' curriculum, met with the Board to discuss more study in first year and additional practical work. This resulted in some very minor modifications.[40] It appears that the major body representing practising physiotherapists had little influence on the course, however they persisted. Board member Marjorie Farnbach, supporting the APA's recommendations, indicated that it required at least another three months full time to train a recently qualified physiotherapist to treat people with polio. She considered a compulsory intern year should be instituted before graduates were permitted to undertake private work. Furthermore this would help Hospital staffing. The APA's concern was that there would be insufficient hospitals with adequate physiotherapy staff for an intern year with essential physiotherapy supervision.[41] The matter continued to be discussed until the Board left the decision in the medical hands of Hembrow and Wedlick who decided against an intern year.[42] Perhaps physiotherapists lost a valuable opportunity to consolidate

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[37] "Masseurs Registration Board 12 November Minutes," (1952); JH Bolton, Bryan Gandevia, and Muriel Ross, "The Rationale and Results of Breathing Exercises for Asthma," *Medical Journal of Australia* 2(1956); Muriel Ross, Bryan Gandevia, and JH Bolton, "The Rationale, Methods and Results of Physiotherapy for Asthma," *Australian Journal of Physiotherapy* 4(1958).
[38] "Masseurs Registration Board 2 August Minutes," (1950); "Masseurs Registration Board 13 September Minutes," (1950); "Masseurs Registration Board 4 October Minutes," (1950).
[39] Mabel Cooper, Registrar 1950-1964. Cooper, "Oral History Record."
[40] "Masseurs Registration Board 23 July Minutes," (1952); "Masseurs Registration Board 10 December Minutes," (1952).
[41] "Masseurs Registration Board 11 February Minutes," (1953).
[42] "Masseurs Registration Board 26 August Minutes."

education in a period when the Board was responsible and could have made an independent decision.

Despite MRB physiotherapists permitting the medical men to decide such an important educational decision, again the APA recommended that all physiotherapy lecturing positions be advertised for a three-year term and be subject to review and another conference of lecturers be held in 1954. Lecturers had not met together since 1951.[43] The profession represented by the APA pushed the Board to make changes to advance education. In 1957 Ross, now also on the Board, proposed a further lecturers' meeting to minimise overlap and finalise the syllabus. However the MRB registrar still dealt with matters relating to examinations and communicating with lecturers and students.[44] From 1951 Ross as Chief Physiotherapist at the RMH where students completed most of their clinical experience, her responsibilities included the physiotherapists treating patients and teaching third year students.[45] The latter attended the hospital each afternoon for Physiotherapy Practice and Medical Electricity and treated outpatients. Junior graduates worked in the mornings under staff supervision. The hospital physiotherapists and the Board, with its small addition to Ross' income, contributed to the cost of supervision of students and new staff.

Ross, a member of the MRB and the Branch Council of the APA, provided the pivotal link between the staff, students, Board and Association. Her physiotherapy teacher training in London facilitated her responsibilities to set standards and advance the profession. Ross described herself as a stirrer always battling to raise standards and the status of physiotherapy. She ensured medical students spent time in the physiotherapy department attending lectures and demonstrations to increase their understanding and appropriate use of physiotherapy. Ross started weekend rostered work for physiotherapy staff,

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[43] "Masseurs Registration Board 15 October Minutes," (1953).
[44] "Masseurs Registration Board 13 June Minutes," (1957).
[45] Floyd (Ross), "Oral History Record."

believing that sickness was 'not just for week days'.[46] Staff received some time off *in lieu* for this work. Unusual in physiotherapy at the time Ross participated in thoracic physiotherapy research, publishing with Bryan Gandevia, thoracic physician, medical historian and then editor of the Association's journal.[47] Ross also reportedly published with Wedlick on electrical stimulation for peripheral nerve lesions.[48] As was common with many married physiotherapists and increasingly an identifying characteristic, Ross brought up two children while working in a more than full time job.[49] Not until 1958 did the MRB increase her allowance to £156 per annum.[50]

Medical influence remained strong as the Board confirmed or changed educational procedures. The Board 'formally approved of the principle that there should be a medical practitioner, either examiner or co-examiner, in every subject of the physiotherapy course'.[51] Medical practitioner fathers were several times reported as attempting to influence the Board to pass their offspring who had failed subjects. To surgeon Robert Southby the Board responded that 'it would be more effective if his daughter was able to discuss her failures ... with the lecturers concerned'.[52] This may have motivated a tightening of examination procedures to permit supplementary examinations only if a student had failed in one or two subjects, but not in more. The Board also confirmed that students repeating a year must complete all subjects. It reiterated that Jewish students, for whom the course was relatively popular, were not exempted from attendance after sundown on Fridays.[53] The RMH was no longer able to accommodate all third year students for their clinical experience, which may have contributed to

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[46] Ibid.
[47] "Masseurs Registration Board 12 November Minutes."; Bolton, Gandevia, and Ross, "The Rationale and Results of Breathing Exercises for Asthma."; Ross, Gandevia, and Bolton, "The Rationale, Methods and Results of Physiotherapy for Asthma."
[48] "Masseurs Registration Board 19 December Minutes."
[49] Floyd (Ross), "Oral History Record."
[50] "Masseurs Registration Board 17 July Minutes," (1958).
[51] "Masseurs Registration Board 20 October Minutes."
[52] "Masseurs Registration Board 26 January Minutes," (1955).
[53] "Masseurs Registration Board 16 May Minutes," (1957).

only half of the students passing Practice of Massage in 1957.[54] Board minutes and the oral histories of physiotherapists indicate high failure rates. A similar pattern occurred in the medical faculty.[55] In an era of less stringent entry criteria, if tertiary applicants had passed matriculation and could pay fees they were usually accepted. High failure rates were a common mechanism for maintaining standards.[56]

Supplementary exams and repeat years did not deter 1950s students. The course and graduates were in high demand, although ultimate financial returns remained modest. Students though expressed frustration with the course's organisation. Melbourne Physiotherapy Students' Society President Michael Craig and Secretary Alison Holt visited the Registrar to discuss concerns. Students requested earlier advice regarding term dates, not organising their own ante- and post-natal exams, having insurance cover and a student's handbook. Furthermore the course needed a more evenly-balanced workload redistribution.[57] Lack of course advice continued to raise students' ire.[58]

A special meeting of the MRB in 1956 discussed the Hospitals and Charities Commission's concern that twenty-two Victorian public hospital physiotherapy positions remained unfilled possibly reflecting a more lucrative private practice environment. Furthermore new hospitals at Footscray, Box Hill, Brighton and Northcote would soon require graduates. Facilities for physiotherapy education were inadequate and Victoria needed a Physiotherapy School where lectures and practical work could take place. Detailed discussion regarding the needs for a future School ensued.[59] It took two years though before the Board, through the auspice of Ross, Farnbach and Cooper sought the Hospitals and Charities

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[54] "Masseurs Registration Board 17 October Minutes," (1957); "Masseurs Registration Board 14 November Minutes," (1957).
[55] Catherine Nall, "Oral History Record," (Australian Physiotherapy Association, 1987). Quotas on entry into medicine were imposed in the 1950s see Rice, "Oral History Record."
[56] Nall, "Oral History Record."
[57] "Masseurs Registration Board 6 July Minutes," (1955).
[58] "Masseurs Registration Board 8 August Minutes," (1956).
[59] "Masseurs Registration Board 15 August Minutes," (1956).

Commission's support for a Physiotherapy School.[60] No tangible results appear to have eventuated, but other changes were occurring. The Board accepted medical practitioner Les Koadlow to do the physiotherapy subjects, thus obtaining all the information, much of which he incorporated into his physical medicine practice.[61] This practice, reminiscent of the medical practitioners who studied in Sweden, did not occur formally again, although medical practitioners would continue to appropriate physiotherapy knowledge into their practices and not share their own specialist knowledge in return. Physiotherapists used therapeutic diathermy from the early twentieth century and ultrasound after WW2, the only practitioners receiving education in the use of electrotherapy. The Act's exemption allowing medical practitioners to perform physiotherapy themselves or their unqualified staff giving potentially dangerous electrotherapy treatments. Some other health practitioners also inappropriately used electrotherapy. (Figure 9.1).

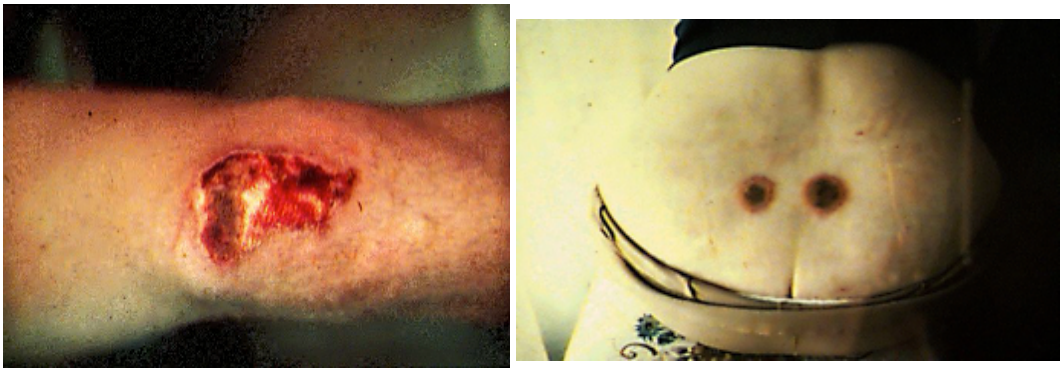

Figure 9.1 Third degree electrotherapy burns caused by non-physiotherapists. Shortwave, (left), two ultrasound burns (right).[62]

Victorian physiotherapy education benefitted from the MRB's 1957 appointment of two key, hardworking and committed women, Marjorie Farnbach and Patricia

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[60] "Masseurs Registration Board 18 September Minutes," (1958).
[61] "Masseurs Registration Board 14 November Minutes." Koadlow founded Arthritis Victoria. http://www.arthritisvic.org.au/Useful-Information/About-Us Accessed 11 January 2015.
[62] Author's photographs. See May, "The Changing Face of Physical Medicine." Margaret C Fyfe and Margaret I Bullock, "Therapeutic Ultrasound: Some Historical Background and Development in Knowledge of Its Effect on Healing," ibid.31(1985).

Cosh, to teach muscle re-education. Although Cosh soon challenged the inadequate fees for lecturers, Farnbach returned her fees and offered to hold classes at Fairfield Hospital, her location as Chief Physiotherapist for the State Health Department's IPS and for Fairfield Hospital's physiotherapy service.[63] Farnbach prepared for teaching muscle re-education collecting the necessary equipment and purchasing material for students to make pillowcases.[64] The next year students completed examinations in this subject at Fairfield.[65] When Farnbach resigned from teaching she recommended Cosh as the senior lecturer.[66]

Commencing in 1958 Cosh began her considerable influence in physiotherapy education, immediately proposing additional lectures in muscle re-education and pathology.[67] The following year the APA advised the Board that it was 'exploring the possibility of associating the course with the University, with the ultimate object of making it a degree course'. [68] Ross's plans for a new curriculum incorporated the material agreed from a National Conference of Directors. Then she and Farnbach recommended a full time Director, suggesting Cosh.[69] Two additional events accelerated change. Vera Carter died and Charles Hembrow, her staunch advocate, retired from the Board after eighteen years. The new Board comprised Wedlick in the Chair, Bryan Keon-Cohen, Marjorie Farnbach, Muriel Ross, Austin Peters, (Alfred's son) and Trevor Rice. The responsibility for prospective students' medical examination passed to Wedlick at a guinea a time.

Wedlick exerted further control on physiotherapy's own knowledge stating that James Cyriax's new book on orthopaedic medicine 'was not required for the

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[63] "Masseurs Registration Board 15 November Minutes," (1956); "Masseurs Registration Board 22 February Minutes," (1956); Farnbach, "Oral History Record."
[64] "Masseurs Registration Board 21 February Minutes," (1957).
[65] "Masseurs Registration Board 9 September Minutes," (1957).
[66] "Masseurs Registration Board 14 November Minutes."
[67] "Masseurs Registration Board 21 January Minutes," (1958).
[68] "Masseurs Registration Board 18 September Minutes."
[69] "Masseurs Registration Board 20 November Minutes," (1958).

students' library' - the Cyriax family who had appropriated Ling's physiotherapy teachings - and *Kinesiology of the human body* was beyond the scope of physiotherapists' studies.[70] Wedlick, who lectured in electrotherapy, did recommend purchase of electrotherapy texts for the Board's small library accessible to students at RMH.[71] However now physiotherapists began to take greater control of their own educational destiny, moving away from medicine. As Ross tendered her resignation on moving to Sydney, the Board asked Cosh to become Director.[72] By May she agreed and Farnbach had already organised for Fairfield Hospital to provide *pro bono* two decommissioned pavilion wards for the Physiotherapy School - a gift of immeasurable value.[73]

Fairfield Hospital became the site of the Physiotherapy School of Victoria from 1959 to 1966. I studied physiotherapy from 1961 to 1963 and well-remember Fairfield. The staff resided in the previous nursing sister's station. Chairs were moved to the front of the wards for lectures and we practised our physiotherapy techniques on one another on the high old iron beds. Electrotherapy required wooden physiotherapy couches and wooden chairs, as metal would have been heated dangerously with the ancient longwave and more modern shortwave diathermy machines. The classic pavilion wards were long and large providing plenty of space (Figure 9.2). In first and second year we travelled between the University of Melbourne and Fairfield every day frequently overloading the very few cars that students had at their disposal.

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[70] "Masseurs Registration Board 15 August Minutes," (1957). For details of this appropriation see Ottosson, "When the Orthopedist Was a Physical Therapist," "The Manipulated History of Manipulations."
[71] "Masseurs Registration Board 19 December Minutes."
[72] "Masseurs Registration Board 1 January Minutes," (1959).
[73] "Masseurs Registration Board 18 December Minutes," (1958). Fairfield provided linen and cleaning.

Figure 9.2 Fairfield Hospital as the ward blocks were in the 1950s and 1960s.[75]

Cosh reflected.

> First I said to Mabel Cooper I wanted a meeting of all the lecturers. ... It took nearly 12 months to get that meeting and all ... agreed for the need. ... I'd never worked so hard. ... I realised I needed to do a degree myself and investigated an arts degree but when this all started I just didn't have time to think of anything else but physio.[76]

At the start of the 1959 the Board appointed Margaret Nayler, LF 'Dick' Lloyd and Yvonne Burns.[77] Both women would later complete their PhDs. These events would occur much later, but the beginning of the sixties heralded significant change for physiotherapy education. Nayler, who had considerable Victorian metropolitan, rural and overseas experience, was looking for a change. With the encouragement of Farnbach she joined the RMH staff and began

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[75] Fairfield http://www.wikinorthia.net.au/the-queens-memorial-infectious-diseases-hospital/. Accessed 7 January 2013.
[76] Cosh; Margaret Nayler, Interview 10 August 2012.
[77] "Masseurs Registration Board 26 February Minutes," (1959).

teaching students as a clinical demonstrator (Figure 9.3).[78] Until Cosh and Nayler eventually organised the School at Fairfield, the haphazard nature of teaching, appointments and student supervision emerged from Nayler's interview. Cosh, in trying to reorganise the course, held a large meeting with many 'people offering opinions'.[79] In addition to course planning Cosh sought funds for the School from the APA and the VMPA, and the University of Melbourne was seriously considering physiotherapy.

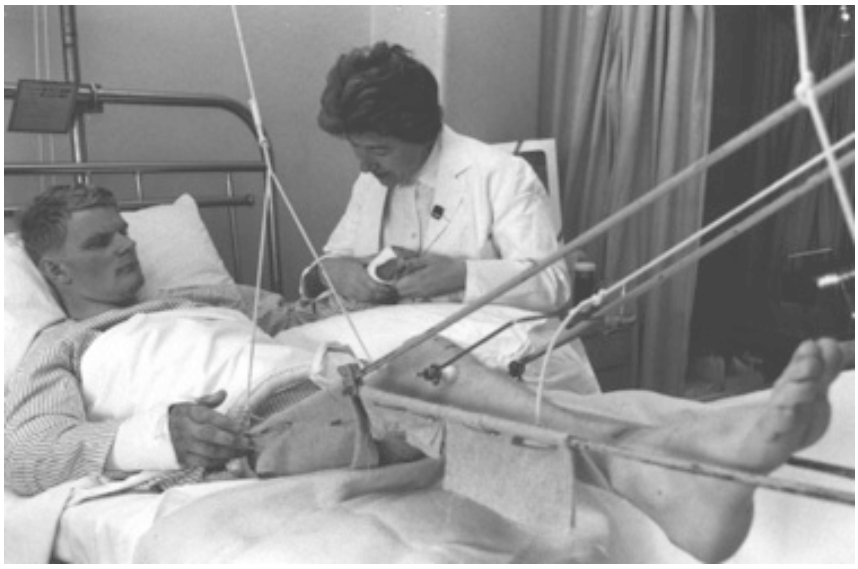

Figure 9.3 Margaret Nayler at the RMH treating a patient with multiple injuries. Both arms are in plaster and his right leg is in traction due to a fractured femur.[80]

In a letter from the University registrar to the MRB dated 3 March 1960 'the Committee of Council had considered that there was a strong case for considering the Board's proposals in greater detail'.[81] The Faculty of Medicine's Dean, Sydney Sunderland viewed a degree was unnecessary: Cosh therefore

[78] Ibid.
[79] Ibid.
[80] Author's photograph.
[81] "Masseurs Registration Board 24 March Minutes," (1960).

prepared a diploma course outline for discussion.[82] She expected meeting with the Vice Chancellor, Sir George Paton.[83]

A Committee chaired by Paton comprising Professors Edwin Hills, Sydney Sunderland, Sir Arthur Amies, Maurice Ewing and Hembrow, Wedlick and Cosh, met in the Vice Chancellor's room on 10 October 1961 to consider the physiotherapy proposal.[85] The Committee discussed details of curriculum, staff, buildings, finance and a Board of Studies. They decided that 'the proposed course was worthy of acceptance by the University'. The matter would be 'referred to the Professorial Board for consideration and advice and the Faculty of Medicine for comment'.[86]

The APA strongly supported the Board approaching the University, but the Victorian Massage and Physiotherapy Association (VMPA), now with a membership only a fraction of the APA, maintained its 1920s' stance that the University should not offer physiotherapy.[87] Despite this irritation Sunderland approved the proposed diploma course supported by Professor of Anatomy Les Ray and Dr Graeme Gardner from psychology, who taught physiotherapy students.[88] Despite Sunderland's support, the Faculty of Medicine inexplicably advised the Professorial Board that the University not accept physiotherapy at

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[82] "Masseurs Registration Board 30 June Minutes," (1960).
[83] "Masseurs Registration Board 24 August Minutes," (1961).
[85] "Minute Book Professorial Board No. 36," (University of Melbourne, 1961). 14 November. 393-395. Registrar FA Johnston and RB Osborn attended.
[86] "Minute Book Professorial Board No. 38," (University of Melbourne, 1963). Professorial Board paper.
[87] "Masseurs Registration Board 24 November Minutes," (1960). The last Minute book record of the VMA identifies 27 members in 1950. See "Victorian Massage Association 21 June Minutes," in *Victorian Massage Association 1921-1953* (1951).
[88] Re Sunderland see Russell, *The Melbourne Medical School.* 217. "Masseurs Registration Board 24 August Minutes." Following unsuccessful attempts to have the University take full responsibility for physiotherapy in 1907, 1923/24, 1938-40, 1946, 1958/59 this was the most promising.

diploma level.[89] The Professorial Board agreed.[90] Cosh considered that the Martin report was to blame for the non-acceptance by the University.[91]

At the end 1961, acting on advice from the Australian Universities Commission, the Prime Minister, Robert Menzies, established a committee to advise on the future of tertiary education in Australia. Allowing two months for submissions the committee invited the University and the MRB to respond.[92] Leslie Martin, Chair of the Commission and the University's previous professor of physics, had an Oxbridge view of universities and recommended that vocationally oriented courses like physiotherapy, (ironically not medicine, dentistry or engineering), be located in colleges. Whilst providing high-level training, colleges of advanced education would focus on teaching, not research. Martin's fully accepted report established the pattern for Australia's rapidly growing higher education sector until John Dawkins radical changes of the 1980s.[93]

Another avenue opened for physiotherapy. Demonstrating physiotherapy's identity trait of persistence, Cosh began discussions with the occupational therapy association regarding the potential of physiotherapy, occupational and speech therapies collaborating on a combined school and seeking Government assistance. Although this all seemed unlikely, representatives continued communicating.[94] Government authorities advised Cosh to develop a comprehensive paper describing the background of physiotherapy education, architectural drawings indicating all facility requirements and ongoing maintenance and recurrent charges.[95] Whilst such important proposals received attention, Cosh addressed upgrading the course. She now appeared to have full

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[89] "Faculty of Medicine 16 November Minutes," (University of Melbourne, 1961). 408.
[90] "Minute Book Professorial Board No. 36." 12 December. 438.
[91] Cosh.
[92] "Minute Book Professorial Board No. 36." Letter from L Martin dated 23 October 1961. "Masseurs Registration Board 23 November Minutes," (1961).
[93] RW Home, "Martin, Sir Leslie Harold (1900–1983)," Australian Dictionary of Biography, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/martin-sir-leslie-harold-14939/text26128. Accessed 15 January 2015.
[94] "Masseurs Registration Board 1 March Minutes," (1962).
[95] "Masseurs Registration Board 8 April Minutes," (1962).

control of education, appointing enthusiastic young physiotherapists as tutor/demonstrators. Helen Craig recalled that 'by this time Med Gym had become Movement 2, with Murray Mitchell as lecturer, and Michael Craig, me and Elizabeth Delany as tutors'. Mitchell and the tutors developed the new subject. 'We worked hard and long in trying to come to terms with the basics of the subject: many a time working into the early hours of the morning discussing and evaluating the programme and the students'. [96] Cosh advised the Chief Physiotherapists at major city hospitals to prepare for students in a forty-two-week revamped third year.[97] Selection of examiners also embraced new requirements.

The Board's policy to have medical examiners for all subjects had continued to give medicine authority over physiotherapy, assuming that medical practitioners knew what physiotherapy entailed. In 1962 Cosh asserting physiotherapy's knowledge of its own discipline, argued that for third year

> she doubted whether members of the medical profession, with respect, could help very much with the final year examinations, as quite often a doctor himself was not fully conversant with the work of a physiotherapist.[98]

The Board supported her decision and in giving Cosh approval to choose final year examiners (WW2 veterans MacArthur Campbell, Finney, Miller, Lazarus, Luke, Grey Wilson, with Val Irwin, Nan Main and Dr David Cheshire) gave her full control of the graduating standards for Victorian physiotherapists (Figure 9.4).[99]

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[96] Helen Craig, "Oral History Record," (Australian Physiotherapy Association, 1989).
[97] "Masseurs Registration Board 30 July Minutes," (1959); "Masseurs Registration Board 3 September Minutes," (1959).
[98] "Masseurs Registration Board 26 July Minutes," (1962).
[99] "Masseurs Registration Board 8 November Minutes," (1962). Irwin Chief Physiotherapist, Children's, Main Chief Physiotherapist RMH, Cheshire, Head of the Spinal Unit Austin Hospital.

Figure 9.4 Patricia Cosh second from left with several 1963 physiotherapy graduates.[100]

Nayler had now returned from another period working overseas and became the next full-time staff member doing everything from secretarial work to supervising students and teaching. She said, 'I don't think anybody ever taught me how to teach ... I did enjoy it. ... That's when I started my arts degree as well. ... There was absolutely nothing (for physiotherapists) postgraduate'.[101] Nayler contributed to building the Victorian Physiotherapy School's positive reputation through her diligence to all academic matters, her demonstrable personal academic ability as she achieved her BA, MA and PhD and her editorship of the *Australian Journal of Physiotherapy*.

In 1963 Dr Eric Glasgow wrote from the University of Western Australia where he taught physiotherapists anatomy, asking if he could visit Cosh to discuss training.[102] He later moved to Monash University, becoming a valued friend of physiotherapy, and during the 1980s a mentor to me. In 1963, still pursuing

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[100] Author's photograph.
[101] Nayler.
[102] "Masseurs Registration Board 24 January Minutes," (1963). "Masseurs Registration Board 2 February Minutes," (1963).

appropriate accommodation, Cosh sought MRB approval to seek further meetings with Government ministers. Amongst the Board members only the far-sighted Farnbach supported her.[103] With widespread concern at the dire shortage of physiotherapists, from individual hospitals, the Hospitals and Charities Commission and the Australian Universities Commission asked, why were there so few men. Low salaries in public hospitals mitigated against breadwinners being attracted. In an era when women earned less than men, new male graduates earned more than McLoughlin did as the Alfred's Chief Physiotherapist.[104] This opportune time to seek government funding lapsed and although there was little in common between physiotherapy, occupational and speech therapies, the joint therapy proposal now took precedence. Cosh considered Government more likely to support a permanent site if the three groups acted in concert.[105] Meanwhile students still perceived the University as where they belonged (Figure 9.5).

Figure 9.5 The 1960s. The victorious physiotherapy football team on the University oval, after defeating the women medical students, (left). Students working on their splint books at Fairfield, Gillian Webb (right).

Nevertheless, Cosh rallied students to political action; Deidre Inkster's mother brought Mrs Bolte, wife of the Victorian Premier, to see the staff and student

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[103] "Masseurs Registration Board 13 June Minutes," (1963).
[104] McLoughlin.
[105] "Masseurs Registration Board 26 July Minutes."

conditions in the old wards at Fairfield. Mrs Bolte was suitably horrified. Barbara Griffith's father, a doctor practising in the Western District, took the opportunity when driving back with the Minister for Health, Dr RW Mack to lobby him to work for the Davies Coop Building to be made available to the therapies. Both these incidents may have influenced physiotherapy's future.[106]

In August 1963 after protracted negotiations, GW Rogan, Secretary of the Department of Health convened a meeting, which agreed that each therapy School retain its academic autonomy and Council/Board and a combined House Committee be appointed. In October the Government purchased the Davies Coop building at 625 Swanston Street, five minutes walk from the University.[107] My father, in his role as Director of Administration in the Public Works Department was instrumental in its allocation to the Schools at a peppercorn rent. The building could accommodate all the current needs for 500 students. After significant refurbishment, students and staff relocated in May 1966.[108] The Premier Henry Bolte MHR officially opened Lincoln House on 28 September 1966 (Figure 9.6).[109]

Lincoln House became the location for the School of Physiotherapy from 1966 to 1973. The details of the now Physiotherapists Registration Board's (PRB) ruminations over these years cannot be discerned as the Board minutes from mid-1963 onwards are still embargoed and the detail of its continuing management of the course by the Board is unobtainable.[110] Nevertheless there are many other sources, although my personal knowledge is scant having lived overseas for nearly all this period.

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[106] Deidre McLean (Inkster), "Oral History Record," (Australian Physiotherapy Association, 1988).
[107] Cameron, *The Work of Our Hands*. 80-81.
[108] Ibid. 83-87.
[109] Ibid. 86-87.
[110] Multiple contacts over two years have been made with the Public Record Office, Australian Health Practitioners Registration Agency, and members the current Physiotherapy Registration Board to no avail.

Figure 9.6 The Davies Coop building, which became Lincoln House.[111]

Students of the three disciplines still attended the University for foundation sciences. The University later stopped teaching speech and occupational therapy students with Alison McArthur Campbell teaching applied anatomy and kinesiology to the latter. Physiotherapy students though, continued studying biomedical sciences at the nearby University. Students remembered the excitement of moving from Fairfield to Lincoln House, but the University still made the most sustained impression on many such as Elizabeth Williams. She said 'It didn't ever occur to me that I hadn't gone to Uni ... and that was why the thought of that dislocation in the late 1980s was anathema to all of us' (Chapter 9).[112] Margaret Sherburn, like I had been in 1962, was the physiotherapy representative on the University of Melbourne Students Representative Council. The Council had embraced physiotherapy, yet Sherburn remembered that at Lincoln 'we had a really good set up where we were in physio ... we had a brand new building, good teachers'.[113]

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[111] Museum Victoria http://museumvictoria.com.au/collections/itemimages/148/174/148174_large.jpg Accessed 10 July 2015.
[112] Williams.
[113] Margaret Sherburn, Interview 14 June 2013.

Lincoln House established a Board of Management, became affiliated with the Victorian Institute of Colleges (VIC) and offered a rapidly growing library. A more congenial environment for staff enabled ideas, information and equipment to be shared. Betty Sutherland Cameron quoted *The National Times* highlighting changes in students as a result of scholarships and bursaries. Not only 'the fashionable young daughters of the socially well-to-do pretty well dominated entrants', but a wider group of students entered Lincoln.[114]

Cosh and her Deputy Director Nayler have shared their stories of the School. They remember the unremitting workload of the time.[115] Cosh unstintingly campaigned and committed herself to physiotherapy as a member of the MRB, the executive of the APA and on many of its committees. Nayler taught for some thirty-seven years: initially when I was a student she demonstrated in Medical Electricity and after I joined Lincoln in 1977 we were colleagues. Intellectually brilliant, wickedly and quietly humorous and endlessly supportive to Cosh, Nayler contributed to and edited the *Australian Journal of Physiotherapy*, spent her last few academic years as Head of the School of Physiotherapy after Lincoln amalgamated with La Trobe University and continues collecting physiotherapists' histories for the APA. Another dedicated devotee to physiotherapy, Nayler supported Cosh through the worst and the best of times: arguably the best were the Whitlam years.

Gough Whitlam, leader of the Labor party, came to power as Australia's Prime Minister in December 1972 and was notoriously dismissed by Governor-General John Kerr on 11 November 1975. For many of us the 'It's Time' campaign, successful after twenty-three years of Coalition Government, and stopping conscription of young men to fight in Vietnam, were defining moments in our lives. Whitlam recognised indigenous land rights, introduced universal

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[114] Cameron, *The Work of Our Hands*. 96-97.
[115] Cosh; Nayler.

health care and free university education.[116] The funds for physiotherapy education enabled a full academic staff, but there was no opportunity for research and the considerable real cost of clinical education was not factored into funding. Clinical physiotherapists, responsible for most of the clinical education of students, still freely gave their time and knowledge as a gift to the next generation - the continuing identity of self-sacrifice. Whitlam's health reforms provided free physiotherapy in public hospitals but private patients still paid full fees, albeit supported by partial reimbursement if patients had private health insurance.[117]

For the forty years that the MRB had responsibility for the physiotherapy course many of its members too gave unstintingly of their time and expertise.[118] With an understanding of education often limited to their own experience, they nevertheless ensured the course continued. Throughout these years medical men chaired the Board. With the exception of the supremely confident Alfred Peters, none of the physiotherapists until Farnbach and Cosh challenged the medical practitioners' authority. As most physiotherapists deferred to medicine for patient referrals, medical patronage remained their lifeblood. In the 1970s, chairing the Board moved into Cosh's hands. She was President from 1974 until 1995, remaining on the Board until 1998. Cosh thus played a pivotal role on the Board, in the APA and in education. With the passing of the Physiotherapists Act 1978, the Board at last was called the Physiotherapists Registration Board. This terminology was retained in the new Physiotherapists Registration Act 1998.[120] However in 1972, Lincoln Institute was Cosh 's educational focus.

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[116] For summary information see "Whitlam Institute," http://www.whitlam.org/gough_whitlam/achievements. Accessed 15 January 2015.
[117] Jenny Hocking, *Gough Whitlam: His Time* (Carlton: Miegunyah Press, 2012). 117 for an overview.
[118] Cooper, "Oral History Record." Mabel Cooper reinforced how members' time and expertise was all given in an honorary capacity.
[120] "Physiotherapists Registration Board of Victoria," http://ands-uat.anu.edu.au/physiotherapists-registration-board-1923-19. Accessed 15 May 2015.

Lincoln Institute, a College of Advanced Education was established under an Order in Council on 19 December 1972.[121] The first meeting of the incorporated body of the Lincoln Institute Council occurred in February 1973. Dr Phillip Law chaired the Council comprising Professor Keith Bradley, Mr G Crowther, Miss JM Guest, Mrs Freda Hooper, Messrs Trevor Rice and EW (Ted) Wall-Smith, physiotherapists, Dr WS Rickards, Mrs T Taft, Miss NH Tweeddale and Institute members Mr JPG Claridge, Miss Patricia Cosh and Mr RN Harrison.[122] The three schools now a single institute, resought affiliation with the VIC and in August two VIC nominees Ian Langlands and Bernard Rechter joined the Council.

During the year discussion ensued regarding appointment and funding of a director of the new Institute and by April 1974 Council appointed Bernard Rechter. Professor Alan Day replaced Bradley (an avowed supporter of physiotherapy) on the Council. [123] Plans to expand the disciplines offered by the Institute brought chiropody, prosthetics and orthotics and orthoptics under consideration.[124] Despite Council planning to increase the length of these diploma courses, physiotherapists' aspirations were already being blocked. Physiotherapy staff, through Cosh, were accustomed to making their own educational decisions. Now oversight was the responsibility of a Council who reported to the VIC and an increasing number of Institute Committees who scrutinised physiotherapy plans. Most committee members knew little about physiotherapy and even less about its educational requirements.

Ever mindful of the cramped course, where teaching years extended from late January to early December, physiotherapy wanted to introduce a four-year

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[121] *Lincoln Institute a College of Advanced Education Offering Courses in Applied Behavioural and Medical Sciences*, (Carlton: Lincoln Institute, 1974).
[122] "Lincoln Institute Council 21 February Minutes," (1973). An Act of Parliament established the Victorian Institute of Colleges 1965. Dr Phillip Law was first Vice President.
[123] "Lincoln Institute Council 23 April Minutes," (1974). Professor of Anatomy Melbourne 1966-1976.
[124] "Lincoln Institute Council 25 June Minutes," (1974).

degree. The new Council and the VIC denied the entreaties of deputations.[125] More expansion into nursing and potentially radiography took priority, with nursing approved within a month. The Council made decisions too about new staff, Dr Robert Kirkby to lead behavioural sciences and Hugh Batten educational resources. The first intimations of the plans of Bernard Rechter and others for a generic health worker were mooted.[126] The loss of physiotherapy autonomy that Cosh had led since 1958 may have been part of a compromise for accommodation and facilities close to the University of Melbourne. Cosh, a strong personality used to achieving her educational goals for physiotherapy, had led the School for more than a decade. She had almost achieved physiotherapy's transfer to the University of Melbourne, had gained Lincoln House but was now subject to the VIC, the LIHS Council and a growing bureaucracy. Although medicine was not fully conversant with physiotherapy it had greater awareness than the new gatekeepers.

Lincoln Council approved physiotherapy's three-and-a-half year degree proposal by the middle of 1975. Physiotherapy planned their first postgraduate Diploma in manipulative therapy, with ideas for further such diplomas in community health, and remedial exercise and recreation therapy.[127] With an old educational programme to teach out, new programmes to develop, including a conversion course for diplomates wishing to convert to the new degree, plus new postgraduate courses, academic staff were stretched. Characteristically most physiotherapists through this period focused on their students and teaching the curriculum well, or upon their patients and treating them well - they were politically naive and showed little interest outside these major foci.[128] They

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[125] "Lincoln Institute Council 26 March Minutes," (1974); "Lincoln Institute Council 23 July Minutes," (1974).
[126] "Lincoln Institute Council 22 October Minutes," (1974); "Lincoln Institute Council 26 November Minutes," (1974).
[127] "Lincoln Institute Council 20 May Minutes," (1975); "Lincoln Institute Council 22 July Minutes," (1975).
[128] I became increasingly conscious of this characteristic as I observed colleagues: as a student, at Lincoln, the Royal Melbourne Hospital and the University of Melbourne. Most

fulfilled Thornquist's view that physiotherapists 'confirm their professional identities by doing something for the patient' or the surrogate patient, the student.[129]

The physiotherapy students clearly wanted all their subjects to be demonstrably relevant to physiotherapy. Their anatomy and physiology continued at the University of Melbourne, but when the Institute established its own biological sciences department led by Phyllis Fry in 1976, it recruited nearly its entire staff from the University's physiology department.[130] The Institute's departments of biological and behavioural sciences taught subjects in these disciplines. But for physiotherapy students, anatomy with its requirements for greater detail and dissection continued at the University. Barry Stillman, a physiotherapy Senior Lecturer, having been influenced by research, especially from Margaret Rood, and completing studies in physiology at the University, introduced Applied Physiology explicating its relevance to physiotherapy.[131] Cosh was more revolutionary.

Conscious of turf wars between physiotherapists treating patients with manipulative techniques and chiropractors, Cosh proposed a programme which would bring chiropractic into Lincoln with a joint foundation with physiotherapy.[132] Discussions with the Royal Melbourne Institute of Technology (RMIT) who were considering a chiropractic course too resulted in a joint

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physiotherapists took their primary responsibilities very seriously and would not stand back to seek a longer-term gain by using different strategies. Few had the 'political' upbringing I had,

[129] Eline Thornquist, "Profession and Life: Separated Worlds," *Social science & medicine* 39(1994).

[130] "Lincoln Institute Council 6 April Minutes," (1976). For physiology's history see Flesch, *Life's Logic*.

[131] Stillman. See Barry C Stillman, "A Discussion on the Use of Muscle Stretch in Re-Education," *Australian Journal of Physiotherapy* 12(1966); "Some Aspects of the Theory, Performance, and Interpretation of the Strength Duration Test," *Australian Journal of Physiotherapy* 13(1967); "The Activation or De-Activation of Receptors for the Purpose of Developing Somatic, Autonomic, and Mental Functions: Introduction. Part I—Philosophy," *Australian Journal of Physiotherapy* 14(1968); "Physiology of Pregnancy," *Australian Journal of Physiotherapy* 15(1969); "Vibratory Motor Stimulation: A Preliminary Report," *Australian Journal of Physiotherapy* 16(1970).

[132] Cosh.

proposal, which the Lincoln Council approved to be forwarded to the VIC.[133] Although physiotherapists, particularly those treating patients with musculoskeletal disorders, had practised manipulation for decades and were firmly supported in that practice by Charles Hembrow, the APA and the medical associations were totally opposed to any links with chiropractic.[134] Most medical practitioners and physiotherapists opposed chiropractic because of its unscientific Palmer foundations, its use of forceful manipulations, its preparedness to advertise and, regardless of the condition, its often unrealistic promise to cure.[135] But it was also a boundary dispute and the medical and physiotherapy practitioners were strengthening their professional boundaries, in part by arguing the case that only they had the knowledge and skills for scientific manipulation.[136] Furthermore the relationships between medical practitioners and physiotherapists remained strong with a shared sense of professionalism and scientific knowledge base.

The clinical chiropractors opposed joint coursework too and in 1978 Phillip Institute of Technology (PIT) submitted its chiropractic course to the VIC, although normal procedures for course accreditation may not have been followed. Lincoln Council requested its President to write to the VIC President 'expressing concern at the unusual channels being employed to reach a decision in the matter'.[137] Although the VIC's academic committee recommended the undergraduate course in manipulative therapy for Lincoln, a VIC Vice President's committee was established to review this decision. Lincoln had continuing concerns about the way decisions were being made and intimated

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[133] "Lincoln Institute Council 4 May Minutes," (1976); "Lincoln Institute Council 6 December Minutes," (1977).
[134] James Mennell promoted manipulation for physiotherapists. Mennell, The Treatment of Fractures by Mobilisation and Massage; Massage, Its Principles and Practice; The Science and Art of Joint Manipulation, vol. 1 (London: J & A Churchill, 1949). As did James Cyriax who visited Australia at physiotherapists' invitation. Cyriax, Textbook of Orthopaedic Medicine. Wright, "Adrian Belloc Wright: Oral History Record "; Wright. Cosh.
[135] Samuel Homola, "Chiropractic: History and Overview of Theories and Methods," *Clin. Orthop. Relat. Res.* 444(2006).
[136] Burnham, "How the Idea of Profession Changed the Writing of Medical History." 25-26.
[137] "Lincoln Institute Council 2 May Minutes," (1978).

political interference.[138] The then new Vice Principal of Lincoln, Arthur O'Neill, later researched these tensions between physiotherapists and chiropractors.[139]

As O'Neill joined Lincoln, Dr Peter Robinson from the Anatomy Department at the University became a member of the Council.[140] When Cosh retired in 1985 Lincoln would appoint Robinson Head of the School of Physiotherapy. Physiotherapists respected Robinson as an academic, but many considered appointing a non-physiotherapist a seriously retrograde step.[141]

However in 1979, another problem was the protracted delay in approval for physiotherapy's postgraduate course in manipulative therapy. Members of Council presumed to know what was needed for physiotherapy, suggesting that some of the behavioural sciences were irrelevant.[142] Physiotherapy had established the College of Physiotherapy, enabling formal recognition of specialisation in 1971, chosen its first physiotherapist President of the APA in 1972, Margaret Peel, and made the decision to rescind the medical referral ethic in 1976. We did not want an administrative body deciding our educational paths.[143] We considered ourselves autonomous professionals fulfilling the key criteria identified by Johnson in the 1970s as delivering a unique product in society's division of labour and performing a special role.[144] Furthermore physiotherapists exhibited important professional values of accountability, altruism, compassion, ethics and social responsibility.[145]

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[138] "Lincoln Institute Council 5 September Minutes," (1978).
[139] Arthur O'Neill, "Enemies within and Without" (New England, 1991).
[140] "Lincoln Institute Council 1 March Minutes," (1977); "Lincoln Institute Council 6 June Minutes," (1978).
[141] As a member of the physiotherapy academic staff at Lincoln, I was part of contemporary discussions amongst physiotherapy academics and clinicians. We had observed an unsatisfactory similar arrangement occur in Sydney.
[142] "Lincoln Institute Council 6 March Minutes," (1979).
[143] Bentley, *The Path to Professionalism*. 192-193, 202-205. Rescinding created disagreement Grant and Trott.
[144] Johnson, *Professions and Power*. 10.
[145] American Physical Therapy Association, "Professionalism in Physical Therapy: Core Values," American Physical Therapy Association, http://www.apta.org. Accessed 15 January 2013.

In August 1979 Deidre Jones, a physiotherapy Senior Lecturer developed a Manipulative Therapy conference. Lincoln provided a generous fellowship to Professor Edwin Korr of Texas College of Osteopathy to attend.[146] Whilst this conference drew all manipulative therapists together, its underlying purpose was not explicit. Perhaps Cosh orchestrated it to bring chiropractic, osteopathy and physiotherapy together, or to demonstrate aspects of physiotherapy's growing science. However tensions remained.[147]

As 1979 progressed, the physiotherapy postgraduate proposal continued to be delayed as the LIHS Committee on Academic Development sought proposals from other disciplines.[148] In the meantime Council proposed a planned manpower study on physiotherapy.[149] Intellectually bright students clamoured to do physiotherapy with over 1000 applicants for sixty places and a severe shortage of physiotherapists making the discipline highly attractive to an Institute endeavouring to grow its student numbers. The School of Physiotherapy's position was paradoxical. Whilst privately recognised as the 'jewel in the crown' publically they were being 'cut down to size'.[150] The latter was pointedly obvious in the Master Plan submission to Council in May 1980 for an undergraduate generic health science degree. 'Some members expressed doubt as to whether a course of the kind proposed was feasible or desirable' but it would be further explored.[151]

At the August meeting the Council received submissions from the Executive of the School of Physiotherapy, the President of the APA and the Chairman of the Physiotherapy Staff Meeting regarding Council's decision not to begin the postgraduate course in 1981. As a result Council asked the Institute's Board of Studies to reconsider, but expressed concerns that it would 'place great demands

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[146] "Lincoln Institute Council 7 February Minutes," (1979).
[147] Susan A Nancarrow and Alan M Borthwick, "Dynamic Professional Boundaries in the Healthcare Workforce," *Sociology of Health & Illness* 27(2005).
[148] "Lincoln Institute Council 5 May Minutes," (1979).
[149] "Lincoln Institute Council 2 October Minutes," (1979).
[150] Author's knowledge.Guy Zito, Interview 14 November 2013.
[151] "Lincoln Institute Council 6 May Minutes," (1980).

on the Institute's resources', student contact hours were high and they may receive few applications despite the profession's support.[152] Tension increased throughout the year with the Institute's Board of Studies reaffirming that physiotherapy's postgraduate diploma not be introduced in 1981. I perceived the other disciplines did not want physiotherapy advancing. They wanted all Lincoln's disciplines to be recognised as equivalent. The Standing Committee on Academic Developments supported physiotherapy. Finally the Council, now under new Chairman Professor Ross Day, proposed that some postgraduate diploma subjects could be introduced in 1981 to provide advanced standing in 1982.[153]

The LIHS Director, Bernard Rechter, wanted more students in physiotherapy, occupational and speech therapy despite the Heads of the Schools advising that clinical education placement availability was a barrier. Furthermore in budgeting for staff 'no allowance had been made for possible charges for clinical placements in hospitals'.[154] The lack of recognition given by the Institute to the clinical education contribution by clinical therapists was a growing concern for physiotherapists. It exacerbated with the expectation that clinicians would accept more and more students.[155] The clinicians taught a significant proportion, some twenty-five to thirty per cent of the course without any financial recompense or reduction in their clinical work.

The simmering tensions regarding control of physiotherapy's undergraduate and postgraduate education, the lack of understanding of clinical education and recognition of the substantial contribution which clinicians gave, combined with the eventual appointment of a non-physiotherapist to head the School boiled over in the late 1980s. These concerns contributed to the campaign that would

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[152] "Lincoln Institute Council 5 August Minutes," (1980).
[153] These discussions continued over several Council meetings, for example, "Lincoln Institute Council 7 October Minutes," (1980); "Lincoln Institute Council 11 November Minutes," (1980); "Lincoln Institute Council 2 February Minutes," (1981).
[154] "Lincoln Institute Council 5 August Minutes."
[155] Nall, "Oral History Record."

arise to endeavour to divorce physiotherapy from LIHS in the late 1980s (Chapter 10).

The early 1980s saw the reintroduction of tuition fees for students.[156] Physiotherapy offered a re-entry course to physiotherapists who had been out of the profession. As lecturer responsible for Electrotherapy, I participated in the course's planning and delivery, which was additional to our already heavy commitments.[157] On average academic staff had about twenty-five direct contact hours with students each week - additional if they participated in clinical supervision and delivered Continuing Education courses, such as that in Pharmacology in 1983 and the Pain Management courses that Barry Stillman and I ran.[158] The School's joint postgraduate programme of remedial exercise with Footscray Institute of Technology received approval despite the APA's concerns regarding protection of its areas of practice with the dissemination of physiotherapy knowledge and clinical skills to other disciplines.[159] The Institute Council however keenly sought such collaborations. [160]

The VIC and the Council of Adult Education approved LIHS's expansion onto a larger old convent site at Abbottsford, in April 1975.[161] Throughout this period accommodation concerns, intermittently linked with potential amalgamations continued. Physiotherapy staff urged the Council 'the Institute should take a stronger line in its negotiations with the Victorian Post Secondary Education Commission, even to the extent of publicising the Institute's case via the media'.[162] Physiotherapists were beginning to demonstrate a greater political awareness.

Postwar physiotherapy had struggled to furthered its professionalisation but by 1961 it had consolidated undergraduate education although not in its prerrefed

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[156] "Lincoln Institute Council 10 November Minutes," (1981).
[157] "Lincoln Institute Council 2 February Minutes," (1982).
[158] "Lincoln Institute Council 5 July Minutes," (1983).
[159] "Lincoln Institute Council 4 March Minutes," (1982).
[160] "Lincoln Institute Council 6 July Minutes," (1982).
[161] "Lincoln Institute Council 26 November Minutes."
[162] "Lincoln Institute Council 5 August Minutes."

University location. It had established a stronger professional identity and eventually secured the beginnings of its own specialist knowledge in postgraduate education. Medical colleagues had stymied some physiotherapy-proposed educational development on the Board. Now other medical practitioners joined in protecting ccupational boundaries and recognised epistemology. There were still battles to be won against a concerted drive for a generic health practitioner and the internal pressure to align physiotherapy more closely with the other disciplines now in Lincoln. Furthermore, those of us who were interested in research had to make our own way. Nevertheless, young physiotherapists had observed a forceful physiotherapist in Patricia Cosh in taking control of physiotherapy's destiny. Although we were unaware at the time, this confidence was being forged into our embodied physiotherapy identities and would come to the fore in the next decade.

Chapter 10 Campaign for Melbourne - fight for professional identity and educational autonomy

The identification of an event and of its meaning is, however, usually based on the network of sequential and simultaneous events to which it is linked by means of the narrative and memory mode.[1]

Whoever controls the way physiotherapists are educated, controls the way they practice.[2]

I think its a crunch point in the history of the profession a very pivotal one.[3]

We felt we were part of the fabric at Melbourne.[4]

In the previous chapters I identified my mother, Freda Bolwell (Kimpton) as a physiotherapist and my studies in the early 1960s and a Lincoln staff member from 1977. This chapter brings me as a player in the story as a participant-observer-historian. Contemporary documents support the recollections of my colleagues and I in the two following chapters. As physiotherapists we had a strong sense of identity in 1980. We had achieved the professional aspirations of higher education, state registration, self-regulation and ethical codes, defined areas of work and primary contact practice. Although recognition of physiotherapy's specific epistemology and research were still emerging, we were in high demand in the workforce and distinct specialist areas of clinical practice continued to evolve. The fortunes of physiotherapy education were transformed by its move into Lincoln House in 1973 and the golden Whitlam years of Australian education with sustained strong competition to enter the course.[5] Progressively though, the School of Physiotherapy's autonomy eroded, as layers of administration and additional disciplines turned Lincoln into an Institute of Health Sciences. By the 1980s, only anatomy remained taught at

[1] Portelli, "The Death of Luigi Trastulli: Memory and the Event." 1-26.
[2] Margaret Kraehe National Physiotherapy Bulletin March 1988.
[3] Jennifer Lake, Interview 8 November 2013.
[4] Anne McCoy, Interview 10 May 2013.
[5] "Lincoln Institute Council 21 February Minutes."

the University of Melbourne as debate regarding amalgamation of tertiary institutions began.[6] In an era when women had been 'assigned by birth to activities which ... carried no economic reward, little public status, and very limited access to public power', as I describe in this chapter, Victorian physiotherapists determined to establish our own destiny.[7]

The prospect of an amalgamation with La Trobe University further threatened physiotherapy's independence. Many of us had grown disgruntled by Lincoln administration endeavouring to remove any distinction between its different health professionals. Australian labor governments, in power federally and in Victoria, were committed to 'silencing differences and voices from the margins'.[8] Arguably they were 'dumbing down' higher education.[9] As I will demonstrate, physiotherapists firmly believed they were different in breadth and depth of knowledge and clinical skills. We sought recognition for physiotherapy science's foundation and long association with medicine and physiotherapy's distinct identity from other health professionals including the 'alternative' chiropractors. Our campaign for educational autonomy demonstrated difference, as physiotherapists were the only professional group to make a public stand. The campaign was a gender struggle too where men sought to impose their decisions on a group that comprised predominantly women, but male medical practitioners acted as allies for physiotherapists. The campaign reinforced our persistence, cynicism, the importance of political allies and the need to orchestrate a compromise to reach agreement.[10]

This chapter traces the proposals for Lincoln to merge with La Trobe University. At the centre is a protracted campaign to locate physiotherapy

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[6] Initial discussions regarding LIHS/university amalgamation began 1981 predating Dawkins.
[7] "Girls, School and Society; Report of a Study Group to the Schools Commission," (Canberra1975).
[8] Lyn Yates, "Feminism and Australian State Policy: Some Questions for the 1990s," in *Feminism and Social Justice in Education: International Perspectives*, ed. Kathleen Weiler (London: Falmer Press, 1993). 167.
[9] Alan D Gilbert, "The Idea of a University Beyond 2000," *Policy Anal.* 16(2000).
[10] Catherine Nall and Patricia Baker, Interview 1 September 2012; Gillian Webb, 22 April 2013; Zito.

education at the University of Melbourne, necessitating opposition to colleagues in other health sciences, Lincoln and La Trobe's leaders, and Federal and State governments.[11] The reasons why we, mostly middle-aged, middle-class 'ladies' fought for so long in a hostile institutional and public environment included several issues which long-frustrated some of us. These issues included a lack of research opportunities or career advancement through postgraduate coursework and our desire for educational and clinical excellence. History, gender, power, and status emerge in this chapter as we struggled to retain the educational hallmark of professionalisation. Here are many powerful personal memories, but I am aware that to give stories true meanings and to make sense of particular events memory can disrupt realities as Portelli demonstrated.[12] Extensive contemporary archival material supports my recollections.

After graduating in 1963 with a Diploma of Physiotherapy, I worked as a clinical physiotherapist in England and Australia and had three children. From 1971 I completed a BSc (Hons) whilst working part-time as a tutor/demonstrator in zoology, as a private practice clinical physiotherapist in La Trobe University Health Service and a physiotherapy tutor at Lincoln. My full-time academic career began with a physiotherapy lectureship at Lincoln in 1978. Yet physiotherapy had merged into the growing conglomerate of Lincoln, where men monopolised senior administrative positions. Gillian Webb, one of the women with young families who comprised our nearly all female staff, reflected 'it was men brought in to lead: Batten, Rechter, O'Neill, Massaro, and women had established Lincoln'.[13]

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[11] John S Dawkins, "Higher Education: A Policy Discussion Paper (Green Paper)," ed. Department Education Employment and Training (Canberra: Australian Government Printing Service, 1987); "Higher Education: A Policy Discussion Paper (White Paper)," ed. Department Education Employment Training (Canberra: Australian Government Printing Service, 1988). "The Challenge for Higher Education in Australia," (Canberra, Australian Capital Territory: Department of Employment, Education and Training (DEET), 1987).

[12] Portelli, "The Death of Luigi Trastulli: Memory and the Event."

[13] Webb. Bernard Rechter, Director succeeded by Hugh Batten, Arthur O'Neill, Vice Principal, Vin Massaro Registrar succeeded by Peter Baillie.

Physiotherapists embodied the application of anatomy, physiology, behavioural and physiotherapy sciences to physical dysfunction: treatment techniques learned in the embodied experience of practical sessions and preparation for the core specialist areas of neurological, orthopaedic and cardiorespiratory physiotherapy.[14] My academic work comprised lectures, tutorials, anatomy demonstrations, practical laboratory and clinical sessions. Like many colleagues, I initially had responsibility for students in each clinical block, mine at the Heidelberg Repatriation Hospital. Students considered that real physiotherapy began in clinics, employing their previously learned academic and practical skills, and importantly absorbing the tacit knowledge of practice through conversation, observation, role modeling and treating patients.[15] Lecturer planning responsibilities included undergraduate and postgraduate programmes. We prepared subject manuals, orientated and supervised tutors and liaised with clinicians. We delivered continuing education courses and provided professional consultation. This broad spectrum of responsibilities and workloads comprising more than twenty-five weekly contact hours from mid-January to mid-December, mitigated against developing research. Nevertheless, supervising student projects and research with biological science colleagues initially satisfied my research inclinations.[16] In 1984, still working full-time, I commenced a part-time MSc with Christopher Bell in the Department of Physiology at the University of Melbourne.[17]

Lincoln then comprised eight Schools: Physiotherapy; Occupational Therapy; Communication Disorders; Medical Record Administration; Orthoptics;

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[14] Polanyi, *The Tacit Dimension*; Anna Aalten, "Listening to the Dancer's Body," *The sociological review* 55, no. s1 (2007); Chris Shilling and Philip A Mellor, "Cultures of Embodied Experience: Technology, Religion and Body Pedagogics," ibid.

[15] Robyn Ewing et al., "Doing, Knowing, Being and Becoming: The Nature of Professional Practice," *Professional practice in health, education and the creative arts* (2001); McMeeken et al., "Learning Outcomes and Curriculum Development in Australian Physiotherapy Education "; Joy Higgs and Mark A Jones, "Clinical Decision Making and Multiple Problem Spaces," *Clinical reasoning in the health professions* 3(2008).

[16] Research with physicist Alex Ward led to changes in electrical stimulation equipment adopted worldwide.

[17] See YS Bakhle and V Campbell, "Christopher Bell," 2008. "Phyllis Fry," *WISENET* 65(2004). Flesch, *Life's Logic.*

Nursing; Prosthetics and Orthotics; and Podiatry. Three departments, Biological Sciences, Behavioural Sciences and Educational Resources provided service teaching. Lincoln's administrators were ambitious for growth, but accommodation was limiting, despite the recently acquired Abbotsford Convent.[18]

In 1981 Malcolm Fraser's Federal Government established a 'Razor' gang, which determined that institutions of fewer than 2000 students should amalgamate, close or revert to State funding.[19] When State Minister for Education Alan Hunt advised the Legislative Council that Lincoln and Melbourne State College would amalgamate, it forced Lincoln's Council to address the matter. Seeking professional associations' political support, Council opposed this amalgamation and sought alliances with other institutions.[20] The State Government launched an 'Inquiry into the Location and Institutional arrangements for Education in the Health Sciences'. Rechter and Cosh prepared Lincoln's submission.[21] Staff discussed their draft, which contended that Lincoln, Victoria's centre of excellence for health science education, should remain a separate entity whilst improving its links with Victoria's three universities. Lincoln required accommodation and resources for development. The submission identified physiotherapy's anatomy teaching at Melbourne, citing the excellent academic calibre of physiotherapy students whose attrition rates were low and graduates rapidly employed.[22]

Chair of the Council Professor Ross Day, Rechter, O'Neill and Dr John Bench (Head of Communication Disorders), spoke to the submission. Day believed that moving into a medical faculty would subsume the disciplines to medicine.

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[18] "Lincoln Institute Council 26 August Minutes," (1980).
[19] Grant Harman, "Restructuring Higher Education Systems through Institutional Mergers: Australian Experience, 1981–1983," *Higher Education* 15(1986).
[20] "Lincoln Institute Council 5 May Minutes," (1981). "Lincoln Institute Council 2 June Minutes," (1981).
[21] "Lincoln Institute Council 6 October Minutes," (1981).
[22] Cosh's amalgamation involvement appears limited to this period. Patricia Cosh, "Seventy Years of the Development of Physiotherapy in Victoria. As Experienced by Patricia Cosh 1940 to 2010," (Melbourne: Australian Physiotherapy Association, 2013). 6.

Rechter strongly advocated growth incorporating pharmacy, optometry, chiropractic and radiography.[23] Bench, the singular clinical professional, more aware of interprofessional tensions, proposed Lincoln develop a broader academic perspective, more postgraduate courses, improved research and interdisciplinary work. He preferred amalgamation into a university with a medical school to enable clinical research.

O'Neill's lucid discussion paper, argued for full amalgamation with a university.[24] He proposed common health sciences foundation courses with later discipline specialisation. O'Neill believed that the professional associations controlled Lincoln's schools and despite a common purpose, the schools had separate identities. He counseled the importance of convincing governments of amalgamation's desirability.[25] Staff members supported amalgamation with a university whilst retaining autonomy. Lincoln Council reported discussions with Melbourne and Monash Universities, but received no commitments.[26]

A School of Physiotherapy Working Party canvassed staff and student views regarding Lincoln's submission. Our document focussed on maintaining the rigour of physiotherapy's academic and clinical standards, concluding we preferred affiliation with a university including a medical school.[27] The latter would offer appropriate biomedical sciences, enable staff to upgrade qualifications, provide postgraduate study opportunities, interaction with a wider range of disciplines and better facilities. I annotated prophetically, 'Monash University appeared to want Lincoln', 'clinical placements cost money' and 'country must preserve universities, colleges appear dispensable'. I

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[23] Author's documents.
[24] Arthur O'Neill, "A University Connection?," (Lincoln Institute, 1982).
[25] Arthur O'Neill, Interview 9 October 2013.
[26] "Lincoln Institute Council 7 July Minutes," (1981).
[27] School of Physiotherapy – Working Party on Affiliation 1982

presaged developments in sports medicine, geriatrics, rehabilitation and community health.[28]

Professor John Scott, Vice Chancellor of La Trobe University sent a letter to Lincoln Council in December 1983 'concerning possible avenues for collaboration'.[29] Council agreed to Rechter commencing informal discussions.[30] La Trobe wanted physiotherapy for its public profile, high entry scores to lift community perceptions of La Trobe and an argument for instituting medicine.[31] Eighteen months later Lincoln Council considered a report from a Lincoln Institute/La Trobe University 'Working Party on Liaison'.[32] Council appointed Hugh Batten to Chair a Steering Committee including John Bench, Judith Parker (Nursing), Peter Foreman and Felicity Allen (Behavioural Science), administrators O'Neill and Peter Bailie, but no-one from physiotherapy, Lincoln's founder and largest discipline. Batten's memorandum implied amalgamation would occur; therefore staff could not discuss academic rationale, only matters such as timetabling, student affairs, facilities, finances and external relationships. Comments were required by September, with drafting of jointly agreed documents for negotiation by November/December 1985.[33]

Rechter and Scott's next Liaison report agreed that 'Lincoln Institute becomes a School of Health Sciences within La Trobe University'.[34] These men in power had decided to demote our School even though physiotherapy had more undergraduate degree students than Schools of Agriculture or Behavioural Sciences at La Trobe. The Lincoln School would become the university's largest. *The Age* reported that La Trobe and Lincoln would merge, pending

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[28] Author's 1981 documents.
[29] "Lincoln Institute Council 22 December Minutes," (1983).
[30] "Lincoln Institute Council 6 March Minutes," (1984).
[31] Author's discussions with John Scott, confirmed by O'Neill.
[32] Hugh Batten, "La Trobe University-Lincoln Institute Working Party on Liaison Report 24 May," (La Trobe University - Lincoln Institute, 1985).
[33] Batten memorandum 7 May 1985.
[34] Author's documents.

approval of a joint working party proposal. Lincoln planned to upgrade its undergraduate diplomas to degrees thus further reducing physiotherapy's distinction. La Trobe wished to increase student numbers. Current proposals expected all of Lincoln to go to Abbotsford, and Rechter said moving to La Trobe's Bundoora campus 'was not an option'.[35]

Physiotherapy's Working Party comprised Professor Eric Glasgow, Patricia Cosh, Mary Fielding and me to respond to the Liaison report.[36] Cosh wrote that physiotherapy required a separate, sophisticated Anatomy Department, specialist medical lecturers and clinical staff, unrestricted hospital affiliations for clinical education, and collaboration with La Trobe academics. Although my notes do not confirm, Cosh's memo indicated that physiotherapy supported amalgamation.[37] Cosh, as Head of School, Registration Board Chair and a senior APA member, might consider she could speak for all physiotherapists.[38] Cosh retired early in 1986. Lincoln Council's Minute of Appreciation noted her 'political lobbying and planning'. Cosh achieved physiotherapy degrees, doubled staff and trebled annual applicants.[39] More fulsome approbation credited Cosh with making the major contributions to physiotherapy education for thirty years.[40]

I favoured a university with a medical school, despite great affection for La Trobe where staff and students had been lecturers, colleagues and/or patients.[41] My La Trobe experiences were positive; contemporaries included academic

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[35] Geoff Maslen and Peter Lowe, "La Trobe and Lincoln May Start Merging Next Year," *The Age*, 3 June 1985.
[36] School of Physiotherapy, "Working Party on Affiliation 11 June," (Lincoln Institute of Health Sciences, 1985).
[37] Physiotherapy School, "Physiotherapy School Response to the Paper on Discussion with Latrobe University," (1985). Author's documents meeting 11 June 1985.
[38] Cosh; "Seventy Years of the Development of Physiotherapy."
[39] "Lincoln Institute Council 8 April Minutes," (1986).
[40] Elspeth Brinsmead, "Oral History Record," (Australian Physiotherapy Association, 1987). Diana Elton, "Oral History Record," (Australian Physiotherapy Association, 1988); Gordon, "Oral History Record."
[41] Howard Toyne and I conducted free students/staff clinics weekly. "Howard Toyne," http://www.sahof.org.au/hall-of-fame/member-profile/?memberID=542&memberType=athlete. Accessed 7 February 2014.

staff in the School of Biological Sciences, Professor Alan Thornton, Drs Alan Marshall, my BSc(Hons) supervisor, and Alan Wright. Young lecturers included Drs Jenny Graves and John McKenzie. In the physiotherapy practice I treated staff and students from across the university including Dr David Myers, Vice Chancellor. Nevertheless La Trobe did not offer the human anatomy, physiology and pathology necessary for physiotherapy education, or the association with medicine, the crux of physiotherapy's professional relationships and practice and integral to our professional identity.

Batten's Steering Committee now included Dr Owen Evans from Biological Sciences.[42] However, La Trobe's Academic Board expressed uncertainties regarding Lincoln's research capacity, requesting more detail before making amalgamation decisions, and established working groups to address specific issues.[43] In 1986 the first Bulletin from the Joint Working Party, Batten, Bench, Foreman, Parker and La Trobe's Professors Kit Carson, Greg O'Brien and Ray Over, acknowledged 'some unfavourable comment ... concerning the proposal'.[44] Dr Vin Massaro, now coordinating administrative functions arranged reciprocal campus visits.[45] Anticipating a midyear final report Rechter confirmed Lincoln still planned relocating to Abbotsford.

The June Bulletin proposed just days for comment on the 'First Draft Report'.[46] The institutions' governing bodies would consider the final report in August. Physiotherapy academics expressed concern regarding funding and threats to physiotherapy's educational standards.[47] We wished to retain our very high entrance scores and responsibility for student selection. A common first year could add an additional year to physiotherapy degrees. Proposals for a

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[42] Hugh Batten, "La Trobe University-Lincoln Institute Working Party on Liaison Report 21 August," (1985).
[43] La Trobe University, "Academic Board 25 September Minutes," (1985). 2-3. "Academic Board 26 November Minutes," (1985). 14.
[44] Author's documents.
[45] La Trobe University, "Academic Board 21 May Minutes," (1986). 6.
[46] "Steering Committees on the La Trobe/Lincoln Merger Proposal First Draft Report for Discussion and Comment ", (1986).
[47] School of Physiotherapy, "Lincoln Institute of Health Sciences," (1986).

generalist health sciences degree trivialised clinical education and relationships.[48] The Report recognised 'some members of the professions and some staff of the Institute' preferred association with a medical school'. Physiotherapy's proposal for its coursework masters programme was highjacked to a 'general coursework Masters degree in the Health Sciences'.[49]

Further limiting discussion, the next Report was delayed possibly due to Ray Over's dissenting Minority Report.[50] Nevertheless the Joint Working Party endorsed 'a decision in principle to merge on 1 January 1988'. Bulletins implied that decision was already made.[51] I noted 'political power in the service departments'.[52] Lincoln's prime movers, physiotherapy and occupational therapy, were still not on any committees.

The School of Physiotherapy's Academic Committee met on 8 July 1986. We considered the amalgamation had little academic rationale: the quality of physiotherapy students and graduates could be degraded with selection changes and a common first year. We stressed the importance of anatomy, adequate staff-student ratios for academic and clinical education, geographic access to La Trobe and to clinical sites and our loss of identity as 'physiotherapy'. Although we did not enunciate it at the time, these were critical aspects of our embodiment as physiotherapists. After discussing the proposal, we voted: for amalgamation strongly in favour five, in favour with reservations seven, against with major reservations 12, and three abstentions. We did not vote again. Eventually only two physiotherapy academics publically support amalgamation.

At the invitation of Biological Sciences I attended their Academic Committee meeting. I believed La Trobe's genetics and zoology could complement

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[48] Ibid.
[49] La Trobe University-Lincoln Institute, "Draft Report," (1986).
[50] Hugh Batten, "La Trobe University-Lincoln Institute Working Party on Liaison Report 17 June," (1986). "La Trobe University-Lincoln Institute Working Party on Liaison Report 7 July," (1986).
[51] Bulletin, "La Trobe University-Lincoln Institute Bulletin 5 July," (1986).
[52] Author's contemporary notes.

Lincoln's human biosciences. The University of Melbourne had always provided dissection and access to comprehensive anatomy and pathology museums, integral to physiotherapy knowledge and neuromusculoskeletal anatomy, which exceeded that required for medical graduates. Surgical registrars and expert physiotherapists tutored anatomy. Neither Lincoln nor La Trobe had expertise or suitable facilities. Biological Sciences staff considered the potential for higher degrees provided the only academic amalgamation rationale. Research required reduced teaching or increased funding with major laboratory developments; a common first year presented difficulties; students needed co-location to gain wider university benefits and smaller Lincoln units were vulnerable. In Bob Naughton's view amalgamation depended

> on such slippery words as can, may, should … staff are voting 'yes with reservation' in the good faith that money will come, small Schools will stay, common first year won't be enforced…They really want to vote NO, because of these major concerns.[53]

Biological Science wished to stay within Health Sciences, voting marginally in favour of amalgamation. Again physiotherapy was the only School without official representation on the Biological Sciences Academic Committee. Physiotherapy had six senior lecturers, who could have represented us. I think the reason was a mix of complacency, political naiveté, physiotherapists' tendency to focus on students, an Acting Head who was unwell and overworked and perhaps because Cosh had made decisions for physiotherapy for too long.

In July Rechter urged La Trobe's Academic Board to make a decision-in-principle, offering $0.5 million and top-level students. Rechter perceived amalgamation would reduce Lincoln's 'concentration on vocational aspects' and 'inflexible courses'. He advocated a common first year. Furthermore, as Lincoln's 'students spent substantial time in hospitals' they required less space,

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[53] Author's meeting notes.

disregarding large practical facilities or research spaces.[54] Rechter's plans could potentially reduce physiotherapy's identity, downgrade its educational and research aspirations and break or damage the important professional nexus with the clinicians, the APA, the University and medical colleagues.

La Trobe's Academic Board decided against professorial positions in each health discipline. Thornton sought 'a clear plan for academic structure of courses ... and disposition of Lincoln units' before any decision.[55] Carson, Chair of the now Amalgamation Committee, supported amalgamation, arguing benefits to La Trobe in research, student mix and strengthening the sciences. Over dissented, as no academic rationale for amalgamation had been demonstrated.[56] Although mixed views prevailed in discussion, the merger proposal carried twenty-four to seven. The institutions' Councils appointed an Implementation Committee.[57] The Academic Board authorised Scott to sign the agreement.[58]

The Victorian Post-Secondary Education Commission (VPSEC) now urged merger discussion with Phillip Institute of Technology (PIT).[59] With chiropractic at PIT this proposal triggered further concerns for physiotherapy. A decade earlier, physiotherapists and medical practitioners fought a tense battle against chiropractors' registration.[60] Co-located with PIT, chiropractic had privately developed its own course.[61] A merger would challenge

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[54] La Trobe University, "Academic Board 23 July Minutes," (1986); "Academic Board 30 July Minutes," (1986). 2-8. Human movement laboratories require at least $100m^2$
[55] "Academic Board 23 July Minutes." 8.
[56] DT Gamage, "La Trobe and Lincoln Merger: The Process and Outcome," *Journal of Educational Administration* 30(1992).
[57] La Trobe University, "Academic Board 27 August Minutes," (1986). 16-17.
[58] "Academic Board 24 September Minutes," (1986). 8-9.
[59] "Academic Board 22 October Minutes," (1986). Details of this proposal are the basis of O'Neill, "Enemies within and Without."
[60] Lance Twomey and Joan Cole, "The Changing Face of Australian Physiotherapy," *Physiotherapy Practice* 1(1985); Arthur O'Neill, "Keeping Independent: The Physiotherapy Session," (1988); "Enemies within and Without."
[61] "Enemies within and Without."; Cosh.

physiotherapist's professional identity as orthodox, biomedical science-based practitioners.

Scott as chair of the Amalgamation Implementation Committee planned upgrading Lincoln's diplomas to degrees. But the amalgamation was under-costed, without funding for anatomy or student services. Scott anticipated savings in laboratories, considering Lincoln required fewer technical staff and hospitals would supervise most postgraduates.[62] Scott's perspective demonstrated manifest misunderstanding of physiotherapy's requirements: large practical laboratories, low staff-student ratios and expensive equipment. Our research occurs in laboratories and clinically, where supervisors require time and recognition for supervision. Furthermore no-one considered clinical education costs.

Physiotherapy education was in limbo. After unsuccessfully advertising for a new Head, Lincoln Council blamed Government, not itself, for the lack of opportunities for physiotherapy postgraduate education.[63] Acting Head Nayler focused on maintaining physiotherapy's programmes.[64] In December Lincoln Council offered the Headship to its member, Dr Peter Robinson.[65] Physiotherapists had concerns about a non-physiotherapist as Head. Losing authority over education would further damage physiotherapy's reputation and sense of identity as an autonomous profession. As women still comprised the majority of physiotherapists, many considered a woman should lead.[66] Robinson, a respected scientist, had no professional knowledge of physiotherapy or departmental head experience. He sought to support

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[62] La Trobe University, "Academic Board 24 November Minutes," (1986). 3-5.
[63] "Lincoln Institute Council 11 November Minutes," (1986).
[64] Nayler.
[65] "Lincoln Institute Council 2 December Minutes," (1986).
[66] Informal discussion between academic and clinical women.

physiotherapy, initially championing amalgamation, later aligning with the physiotherapists.[67]

Meanwhile Lincoln Council realised it should mollify the clinicians providing many hours of unfunded clinical education. Council proposed awarding them honorary positions, including unspecified access to Lincoln and a handbook listing.[68] La Trobe floundered considering clinical academics: would they be 'appointed on the basis of professional and/or clinical competency and not necessarily as research leaders ... not ... automatically converted to chairs'?[69] Pragmatically, all proposals for professorships would depend on savings.[70] Whilst La Trobe's Research Committee worried about Lincoln's research and its biomedical science's legitimacy, the Implementation Committee focussed on governance, staffing conditions and administration. Thornton's agitation led eventually to a Masters Degrees Committee, although there was no funding for Lincoln research.[71] In parallel Lincoln approved regulations for a research Master of Applied Sciences.[72]

Tensions increased. O'Neill said some Lincoln administrators realised that physiotherapists should not be ignored and others 'were disillusioned with stances adopted by the University'.[73] Scott was under pressure as Vice Chancellor, Chair of the Amalgamation Implementation Committee and the Academic Board.[74] Furthermore, Professor McNicol, Chair of La Trobe 's Advisory Committee pessimistically predicted that, under-enrolled, the university would lose $1million without amalgamation. It desperately needed a professional school like Lincoln to upgrade its image. Additionally a

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[67] Robinson participated in earlier discussions with Melbourne, Monash universities. "Lincoln Institute Council 7 July Minutes."
[68] "Lincoln Institute Council 5 May Minutes," (1987). Lincoln's 1989 Handbook has no honorary listing.
[69] La Trobe University, "Academic Board 27 July Minutes," (1987). 2-7.
[70] "Academic Board 19 August Minutes," (1987). 6-9.
[71] "Academic Board 22 April Minutes," (1987). 9-11. "Academic Board 27 May Minutes," (1987). 10-12. "Academic Board 21 October Minutes," (1987). 2-4.
[72] "Lincoln Institute Council 6 October Minutes," (1987).
[73] O'Neill.
[74] La Trobe University, "Academic Board 24 June Minutes," (1987).

sympathetic Government would offer new buildings. Furthermore McNicol threatened, both Monash and Melbourne had approached Lincoln.[75] No evidence supports a Melbourne approach where medicine preferred 'links' with institutions training health-care professionals, having declined the Health Department's request to consider postgraduate nursing.[76] As the agreement deadline approached, O'Neill said Monash offered all Lincoln's needs including accepting all staff. Although supported by many Lincoln administrators, VPSEC was vehemently opposed and Rechter declined.[77]

Newly appointed a Senior Lecturer, I focused on physiotherapy's research opportunities. Physiotherapy staff, mostly women some part-time with young families and juggling multiple demands, had responded to reports but played little part in the amalgamation. The APA Victorian Branch, concerned at Lincoln's lack of consultation with physiotherapists who provided a significant unfunded contribution in clinical education, and the APA's recent knowledge of inadequate funding for physiotherapy education, expressed its amalgamation concerns to Lincoln's Council. The Council decried this late submission's tone, which seemingly wished to 'direct the independent actions of the Institute'.[78]

The APA prepared 'The Future Direction of Physiotherapy Education and Practice' explaining physiotherapy's foundation in the biomedical sciences in which eight Victorian physiotherapists were now undertaking research degrees: seven in anatomy and me in physiology.[80] Emphasising anatomy, the APA argued for physiotherapy education within a university teaching medicine. Lobbying began. Lincoln's Council members received letters from physiotherapists and students proposing their School be relocated to a

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[75] "Academic Board 27 July Minutes."
[76] "Faculty of Medicine Minutes," (University of Melbourne, 1987). 146-152.
[77] O'Neill.
[78] Letter APA Branch Executive Officer Beverly Jenkin reported "Lincoln Institute Council 4 August Minutes," (1987).
[80] Australian Physiotherapy Association, "The Future Direction of Physiotherapy Education and Practice " (Melbourne1987). 12 August. Melbourne hosted seven, Monash one. There were only five Australian PhD-holding physiotherapists.

university with a medical school.[81] Parliamentarians received letters before the second reading of the amalgamation Bill on 16 September 1987. The Minister for Education, Ian Cathie presented the Bill as though supported unanimously at Lincoln. To disabuse this perception, the APA sought meetings with incumbent Labor Ministers and Shadow Ministers. Physiotherapists continued writing letters and met politicians.

Physiotherapists emphasised their eighty-year association with medicine at the University of Melbourne, potentially strengthened when a newly-created Chair in Rehabilitation commenced.[82] Academically able physiotherapy students, we argued, needed biomedical sciences within a university with recognised standards and expertise. Fiscal considerations also supported relocation to Melbourne, which had teaching resources and a potential physiotherapy building.

'RED ALERT Quality Physiotherapy Education is endangered by the proposed Lincoln-La Trobe amalgamation', headlined the Victorian APA's branch newsletter.[83] The article advised the APA had unsuccessfully requested a meeting with the Amalgamation Implementation Committee and physiotherapists should prepare for more intensive political lobbying.

> Physiotherapy is attracting the highest calibre of secondary students. The profession is recognised by legislation as a medical science. It has a valuable contribution to make to health. Only a high quality training with **appropriate** undergraduate education, research and postgraduate opportunities will ensure the future development of the profession. ... (The issue was) potentially the most seriously damaging the profession has faced in a number of years.[84]

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[81] "Lincoln Institute Council 1 September Minutes," (1987).
[82] "Hugh Burry," http://en.wikipedia.org/wiki/Hugh_Burry. Accessed 7 February 2013.
[83] Australian Physiotherapy Association Victorian Branch, "Red Alert," *Australian Physiotherapy Association Victorian Branch Newsletter*, September 1987.
[84] Ibid.

Margaret Kraehe, APA Branch President invited me to share information about the amalgamation and how it pertained to the School.[85] Branch Council swiftly established a Campaign Committee comprising Margaret Kraehe, Travers Stow, Patricia Baker, Cathy Nall and me, to 'coordinate lobbying activities'.[86] In parliament, members raised questions to which Cathie gave an assurance that physiotherapists' concerns would be reviewed.[87] Subsequently Jan Williamson, VPSEC Executive Director, sent the APA proposed terms of reference for the 'Review Committee of Provision of Physiotherapy Programs'.[88] Our first Campaign Committee meeting reviewed the terms of reference and considered membership.[89] Pointedly the terms of reference omitted physiotherapy's location. We wanted physiotherapist Professor Lance Twomey as a Review member.[90] We considered organisations to submit to the review and our probable supporters; professors of medicine and surgery; specialist medical and dental colleges; APA special interest groups; medical and physiotherapy clinical leaders. We discussed lobbying, assessing the positions of opposition Members of Parliament (MPs) and activating a Submission Committee to develop academic and curriculum arguments.[91] MP Vin Heffernan wrote indicating the Liberal party would support physiotherapy.[92] Key media personalities agreed to assist in publicising our cause.[93]

By October the Campaign progressed with productive meetings with Ministers for Education and Health (David White).[94] We had supporters from both sides

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[85] Letter Beverly Jenkin to Joan McMeeken 23 September 1987.
[86] "Australian Physiotherapy Association Victorian Branch Council October Meeting," (1987).
[87] Transcript parliament Legislative Assembly 7 October 1987.
[88] Letter Jan Williamson, Executive Director VPSEC 8 October 1987.
[89] "Australian Physiotherapy Association Victorian Branch Council October Meeting."
[90] Then Vice Chancellor at Curtin University. Twomey was a corresponding member. Lance Twomey, Interview 24 May 2013.
[91] "Australian Physiotherapy Association Victorian Branch Council October Meeting."
[92] Letter Vin Heffernan.
[93] Such as Schildberger, John Hounslow and Bob Kearsley, "A Man of Many Journalistic Coups Michael Julius Schildberger 4-4-1938-2-6-2010," *The Age*, 9 June 2010.
[94] Letter Beverly Jenkin 7 October 1987.

of politics; my most sympathetic correspondence came from David White and Shadow Minister for Education, Haddon Storey.[95] Fred Grimwade, previous Liberal National Party Leader in the Legislative Council, whose daughter had completed physiotherapy, provided advice on influential MPs to lobby.[96] At Lincoln we presented the false economies in duplicating anatomy and biomedical research at La Trobe, whilst highlighting the association of clinical physiotherapists with medical colleagues and stating plans for common degrees might subjugate academic and clinical excellence. The 'Campaign Special Edition' Branch Newsletter brought members up-to-date with current activities.[97]

Open verbal stoushing reached the media with Lincoln/La Trobe defending their position. An advertorial in *The Age* emblazoned 'Lincoln, La Trobe Unite to Improve the Education of Victoria's Health Professionals' - the first voluntary amalgamation. *Access Age* published many pieces indicating it was vital any merger reflected physiotherapists' medical science requirements. La Trobe advertised Postgraduate Studies and Scholarships in its new School of Health Sciences.[98]

Despite physiotherapy students comprising a quarter of Lincoln, it was 12 October 1987 before physiotherapy staff had their only meeting with Rechter.[99] Having already seen physiotherapy's autonomy eroded at Lincoln, our concerns remained a further reduction in our identity, autonomy and influence. Significant uncertainty about anatomy teaching pertained and the longstanding arrangement with Melbourne was not assured. Rechter advocated submerging independent disciplines into a multidisciplinary health professional.[100] We

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[95] Letters from MPs. September 1987.
[96] Mark Birrell (Shadow Minister for Health), Haddon Storey (Shadow Minister for Education), Bob Lawson, Geoff Conrad, Bill Baxter and John Dawkins Federally. Supportive State MPs included Milton Whiting, Marie Tehan, Bill McGrath and Prue Sibree.
[97] 'Action at Last' Victorian Branch Newsletter October 1987.
[98] Cuttings *The Age* 9, 10 October 1987.
[99] In author's possession, separate meeting notes of seven academic staff.
[100] Multidisciplinary health professionals deny individual disciplinary practice complexity.

knew that Canada's McGill University had abandoned a joint physiotherapy/occupational therapy degree as most graduates wanted to practice as physiotherapists. Whilst psychology had been part of physiotherapy education since the 1930s, progressively through the 1970s and 1980s physiotherapy teaching embraced the new 'biopsychosocial' paradigm.[101] Influenced by colleagues in the behavioural sciences too, to recognise psychological, cultural and sociological components of health, yet Lincoln's mass teaching in behavioural science did not intellectually challenge physiotherapy students.[102] We worried about educational standards, a common first year and additional electives which would require a fifth year for physiotherapy students. Clinical education was a particular concern, as Lincoln did not even acknowledge, let alone fund physiotherapists' clinical teaching contributions in more than seventy metropolitan and seventeen rural hospitals.[103]

Other longer-standing issues resurfaced: minimal staff development or study leave, high workloads due to our practical classes, little incentive or mentorship for research or postgraduate studies. Lincoln Council delayed our planned postgraduate coursework.[104] Despite a reputation for good teaching, we had no research culture and had recently asked the APA to assist in improving physiotherapists' confidence to undertake research.[105] Funding within Lincoln appeared to be distributed disproportionately to the 'service schools' whose staff took study leave and did research.[106]. I noted, 'service departments are no

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[101] George L Engel, "The Biopsychosocial Model and the Education of Health Professionals," *Annals of the New York Academy of Sciences* 310(1978). Thomas S Kuhn, *The Structure of Scientific Revolutions* (Chicago: Chicago University Press, 1962); Anne Parry, "New Paradigms for Old: Musings on the Shape of Clouds," *Physiotherapy* 83(1997).
[102] Academic staff discussions Lincoln Institute.
[103] Peter Robinson 24 September 1987 memo to Michael Kellock, Amalgamation Implementation Committee secretariat.
[104] "Lincoln Institute Council 6 March Minutes." Physiotherapy application, delayed until 1982 "Lincoln Institute Council 2 June Minutes."
[105] Research Fund Committee meeting 15 September 1987. Reported APA Victorian Branch Council meeting 11 February1988. Item BC/8802/3.7.
[106] I later learned each school whose students attended combined lectures separately paid service schools.

longer service but schools in their own right and competing for students'. We had no insights into funding arrangements within Lincoln and no confidence that amalgamation would improve our position.

Overall the lack of representation, consultation and recognition of physiotherapy's concerns contributed to our view that a La Trobe amalgamation was problematic. Late reports from working groups and committees precluded sufficient time to address issues whilst running teaching programmes. Physiotherapy staff overwhelmingly preferred a medical faculty. We objected to being told what to do and to trust that the merger would solve all problems.[107] The meeting did not promote congenial relations and Rechter's attitude was perceived as 'let us - who know best - look after all matters pertaining to the physiotherapy school and profession'.[108] This meeting may have been the turning point for Robinson who subsequently cooperated with the APA.

During October correspondence regarding the Review's terms of reference flowed between the APA and VPSEC.[109] The APA expected the Review to respond to its concerns regarding amalgamation, recommending the university and anatomy teaching locations for physiotherapy and identifying our programme's capacity to meet workforce needs.[110] The one dissenting view from the Campaign's activities came from academic physiotherapist, Patricia Bate, criticising the APA for giving insufficient credence to behavioural science which taught about twenty per cent of undergraduate physiotherapy.[111] We acknowledged behavioural science's contribution in broadening physiotherapists' views and capabilities but all universities could offer these courses.

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[107] Elizabeth Kerr and Pearl Stock's notes of Rechter meeting.
[108] Ibid.
[109] Correspondence 20, 23 October 1987 Beverley Jenkin, Jan Williamson.
[110] Letter Jan Williamson.
[111] Correspondence from Patricia Bate, Margaret Kraehe 17 September 1987.

Additional Lincoln staff now expressed concern. The Lincoln Branch of the Victorian Colleges Staff Association held a stop-work meeting on 5 November seeking deferral on administrative grounds. Another meeting authorised by Dr Marcelle Schwartz, President of the Lincoln Institute Professional Staff Association stated 'More problems with the merger'.[112] These concerns had a familiar ring: outstanding researchers would teach less, have more opportunity for promotion and be the only academics entitled to study leave. La Trobe would not appoint Lincoln staff to Professorial positions, devalued teaching and professional and clinical education.[113]

Their concerns were too late. With Federal and Victorian State Labor governments in power, some conservative Coalition MPs had indicated support for physiotherapy. However in the Legislative Assembly debate, conservatives Milton Whiting and David Lea, members of La Trobe University Council, argued legal urgency required the Bill to ensure funding for Lincoln's Health Sciences at La Trobe. Whiting stated physiotherapy students, about 500 of Lincoln's 2200 students, were vital to the amalgamation. Lea indicated amalgamation would strengthen La Trobe and provide opportunities for disadvantaged students.[114] Ian Cathie emphasised that Victoria's legislation should complement John Dawkins's Federal Government plans. The Assembly passed the Bill. Minster for Education, Evan Walker moved the first reading in the Legislative Council.[115] Walker stated the amalgamation was voluntary, provided opportunities for northern region students, capacity for lateral transfers between courses and proposed linkages with PIT.[116] Haddon Storey quipped 'if this is typical of a voluntary merger, with the amount of problems ... I do not want to be involved in too many involuntary mergers'. Perhaps the

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[112] Announcements Staff Association's meetings November 1987.
[113] O'Neill.
[114] Hansard, "Legislative Assembly 13 November," (Melbourne: Jean Gordon Government Printer, 1987). 49-51.
[115] "Legislative Council 13 November " (Melbourne: Jean Gordon Government Printer, 1987). 56, 74-78. Walker became Professor of Architecture at Melbourne.
[116] O'Neill, "Enemies within and Without."

issue surfaced at home, as Storey's wife was Deputy Chancellor of La Trobe. Storey, citing numerous letters, stressed physiotherapy's sustained relationships with the University of Melbourne and that physiotherapy's closest associations were with the medical sciences rather than Lincoln's health sciences. Storey raised Lincoln staff 's concerns regarding senior positions and financial viability. Nevertheless, the opposition supported the Bill subject to attention to physiotherapy matters.

The University of Melbourne and its medical faculty transmitted their message through MP Geoffrey Connard. As Chairman of Fairfield Hospital, Connard met the Chancellor, eminent medical scientist, Emeritus Professor Sir Douglas Wright, the professors of medicine and surgery and two additional university professors at Fairfield.[117] Connard said:

> The Faculty of Medicine ... professors asked me to indicate ... the transfer of the physiotherapists' school to La Trobe University was totally inappropriate when it has historically used the facilities of the Anatomy School at the University of Melbourne. ... The most distinguished people in medicine in this State strongly support the view, ... that the physiotherapy school should be located at the University of Melbourne. [118]

Storey and others pressed ministers to state that passing the Bill would not prejudice any review outcome. Government members skirted the major concern of location in all exchanges. La Trobe University (Amendment) Bill to 'provide for the incorporation of Lincoln Institute of Health Sciences as a School of La Trobe University' passed the Legislative Assembly on 1

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[117] Peter McPhee, *Pansy: A Life of Roy Douglas Wright* (Carlton: Melbourne University Press, 1999).
[118] Hansard, "Legislative Council 13 November ". 56, 74-78.

December 1987.[119] That month Dawkins released his green paper spurring further tertiary amalgamations.[120]

Dr Isobel Bear of VPSEC chaired the February 1988 Review Committee. Its specific tasks were to: review the Bachelor of Applied Science (Physiotherapy) at Lincoln; provide advice on its capacity to meet Victoria's future needs; advise the appropriate university and anatomy requirements; and investigate the APA's wider concerns. The Committee received many submissions. In summary those from individuals and groups of physiotherapists urged the Committee to resolve which university physiotherapy should be located at; where anatomy should be taught; how research might be fostered and supported; the possible funding arrangements for clinical education; as well as a more general demand for the restoration of physiotherapy's educational autonomy. Submissions endorsed the University of Melbourne for postgraduate study and research and its leadership in biomedical and clinical sciences. Further advantages included its excellent library and geographic location. The APA demonstrated physiotherapy's significantly greater congruence with medicine in education and practice. The justification for maintaining gross anatomy with dissection was extensively argued.[121]

The APA felt entitled to question La Trobe's capacity to offer physiotherapy in part because members freely provided clinical education.[122] Consultations between educational institutions and members of the profession were essential to determine curriculum requirements for Victoria's future physiotherapy workforce.[123] The lack of consultation countered Dawkins's explicit directives,

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[119] "La Trobe University (Amendment) Bill 1987 Including Explanatory Memorandum," (Victoria1987).
[120] Dawkins, "The Challenge for Higher Education in Australia."
[121] Author's possession. Letter, fifteen researchers. Australian Physiotherapy Association, "Submission to Review Committee on Provision of Physiotherapy Programs," (Fitzroy: Australian Physiotherapy Association, 1988). 11, 44-63.
[122] Ibid. 67-73. "Australian Physiotherapy Association Victorian Branch Council March Meeting," (1988). Document BC/8803/5.10 new Lincoln Institute clinical education subcommittee.
[123] "Submission to Review Committee on Provision of Physiotherapy Programs." 64-65, 83-84.

which sought to make higher education institutions more responsive to industry needs.[124] The Amalgamation Implementation Committee had not undertaken 'wide ranging consultation', with physiotherapy.[125] Furthermore, with its high standards, allegiance to science, patient safety and orthodox practice, the APA again reiterated it would not support chiropractors and osteopaths being trained in the same university as physiotherapists, nor with homoeopathists and acupuncturists as previously proposed.[126] Defending its profession, the APA affirmed a distinctive, physiotherapy-specific programme requiring specialist postgraduate education and research, which either Melbourne or Monash universities could provide.[127] However Melbourne was the 'most economic and efficient location for the School of Physiotherapy'. Any second physiotherapy school should be at Monash.[128]

The 'Physiotherapists in Management' paper concentrated on education's role in providing physiotherapists for Victoria's community. It advocated clinical research, citing local physiotherapy research following hip fracture, which saved $2800 per patient in bed costs (a potential annual national saving of $60 million).[129] Margaret Kraehe and Patricia Baker, both departmental heads, met the Review Committee in April confident physiotherapy 'had won the anatomy argument'.[130] National APA President, Joan Cole advised that the 'National Executive was most supportive of the Victorian Branch initiatives'.[131]

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[124] Dawkins, "The Challenge for Higher Education in Australia." 4. Cited in Association, "Submission to Review Committee on Provision of Physiotherapy Programs." 13.
[125] "Submission to Review Committee on Provision of Physiotherapy Programs." 14.
[126] Ibid. 92-93. The Medical Benefits Review Committee of June 1986. Discussed in O'Neill, "Enemies within and Without."; Edzard Ernst, "Adverse Effects of Spinal Manipulation: A Systematic Review," *Journal of the Royal Society of Medicine* 100(2007).
[127] Association, "Submission to Review Committee on Provision of Physiotherapy Programs." 74-78.
[128] Ibid. vii.
[129] Patricia Baker, Owen Evans, and C Lee, "Treadmill Gait Re-Training Following Fractured Neck of Femur," *Archives of Physical Medicine and Rehabilitation* 72(1991).
[130] "Australian Physiotherapy Association Victorian Branch Council May Meeting," (1988). Executive Committee meeting 3 May 1988. BC/8805/5.
[131] "Australian Physiotherapy Association Victorian Branch Council June Meeting," (1988). Item 5.2.

Monash University argued its case on the basis of education, location, buildings and funding. It emphasised its small group, integrated teaching, and a postgraduate study environment fertile for physiotherapy. Monash guaranteed medical connections, suitable buildings and the adjacent Medical Centre.[132] The University of Melbourne's submission outlined physiotherapy's history with the University, the excellence of physiotherapy students and graduates, the Faculty's clinical connections and its cost efficiency. Having had discussions with Vice Chancellor David Penington and Dean Graeme Ryan, my suggestions regarding research, naming the degree a Bachelor of Physiotherapy, the potential for lateral entry into second year and the implementation of postgraduate coursework were incorporated. Melbourne proposed a Professor of Physiotherapy, an independent Department, support for research and strong medical liaisons.[133]

Three Vice Chancellors now competed for physiotherapy, although Monash was not in the media's purview (Figure 10.1). The Faculty of Medicine Executive at Melbourne confidentially discussed the Faculty's submission and the possibilities offered by incorporating physiotherapy.[134] The Review Committee visited, inspecting Melbourne's facilities.[135] Faculty awaited the outcome 'with interest'.[136] Penington informed the University Council of his discussions with State ministers and physiotherapists.[137] The Review Committee, unwisely consisting of four individuals made a split decision, half for La Trobe and half for Melbourne. The cause of physiotherapy education had not, it seemed, made any advances.

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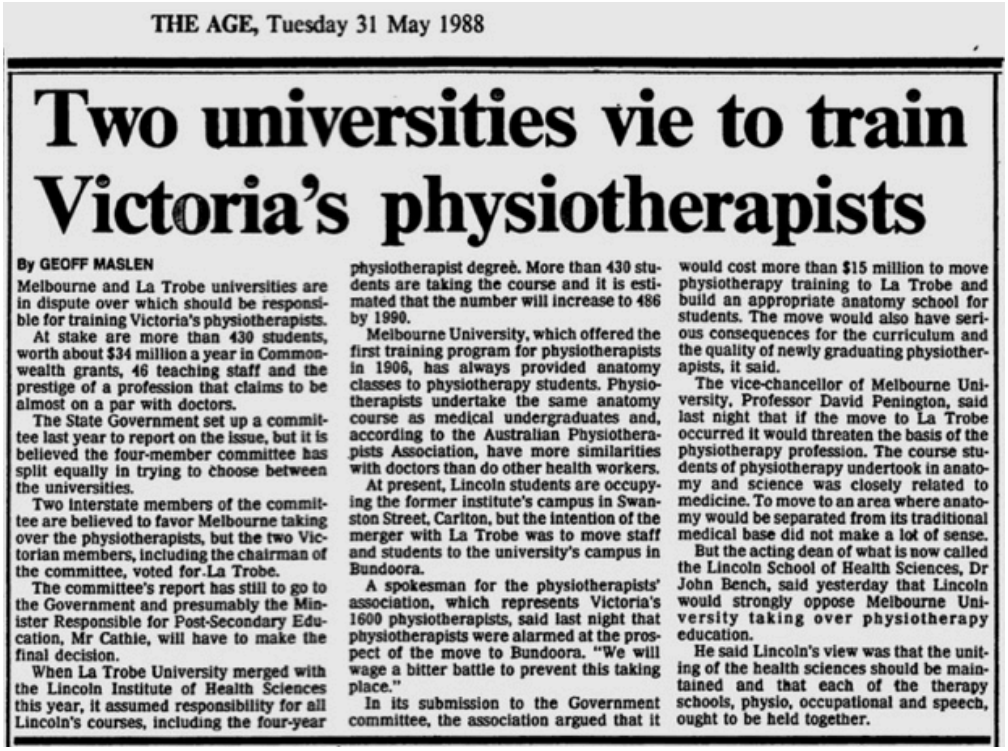
[132] "Monash University Submission to the Review Committee on Provision of Physiotherapy Programs, February," (1988).
[133] "University of Melbourne Submission to the Review Committee on Provision of Physiotherapy Programs, February," (1988).
[134] "Faculty of Medicine Minutes," (University of Melbourne, 1988). February. 452, 513-523.
[135] Ibid. 19 May. 612.
[136] Ibid. 14 July. 662.
[137] David Penington, Interview 8 November 2013.



THE AGE, Tuesday 31 May 1988

Two universities vie to train Victoria's physiotherapists

By GEOFF MASLEN

Melbourne and La Trobe universities are in dispute over which should be responsible for training Victoria's physiotherapists.

At stake are more than 430 students, worth about $34 million a year in Commonwealth grants, 46 teaching staff and the prestige of a profession that claims to be almost on a par with doctors.

The State Government set up a committee last year to report on the issue, but it is believed the four-member committee has split equally in trying to choose between the universities.

Two interstate members of the committee are believed to favor Melbourne taking over the physiotherapists, but the two Victorian members, including the chairman of the committee, voted for La Trobe.

The committee's report has still to go to the Government and presumably the Minister Responsible for Post-Secondary Education, Mr Cathie, will have to make the final decision.

When La Trobe University merged with the Lincoln Institute of Health Sciences this year, it assumed responsibility for all Lincoln's courses, including the four-year physiotherapist degree. More than 430 students are taking the course and it is estimated that the number will increase to 486 by 1990.

Melbourne University, which offered the first training program for physiotherapists in 1906, has always provided anatomy classes to physiotherapy students. Physiotherapists undertake the same anatomy course as medical undergraduates and, according to the Australian Physiotherapists Association, have more similarities with doctors than do other health workers.

At present, Lincoln students are occupying the former institute's campus in Swanston Street, Carlton, but the intention of the merger with La Trobe was to move staff and students to the university's campus in Bundoora.

A spokesman for the physiotherapists' association, which represents Victoria's 1600 physiotherapists, said last night that physiotherapists were alarmed at the prospect of the move to Bundoora. "We will wage a bitter battle to prevent this taking place."

In its submission to the Government committee, the association argued that it would cost more than $15 million to move physiotherapy training to La Trobe and build an appropriate anatomy school for students. The move would also have serious consequences for the curriculum and the quality of newly graduating physiotherapists, it said.

The vice-chancellor of Melbourne University, Professor David Penington, said last night that if the move to La Trobe occurred it would threaten the basis of the physiotherapy profession. The course students of physiotherapy undertook in anatomy and science was closely related to medicine. To move to an area where anatomy would be separated from its traditional medical base did not make a lot of sense.

But the acting dean of what is now called the Lincoln School of Health Sciences, Dr John Bench, said yesterday that Lincoln would strongly oppose Melbourne University taking over physiotherapy education.

He said Lincoln's view was that the uniting of the health sciences should be maintained and that each of the therapy schools, physio, occupational and speech, ought to be held together.

Figure 10.1 Contemporary newspaper report.[138]

Dramatic events then changed my career. Peter Robinson suffered a massive heart attack in June 1988. Margaret Nayler was on sick leave. Despite several staff more senior to me, I was the only senior lecturer prepared to act as Head of Physiotherapy. Changes affecting the Campaign occurred when Jennifer Lake replaced Beverly Jenkin at the APA and Hayden Cock, a parliamentary lobbyist, became Campaign advisor. They attended Campaign meetings and provided valuable strategies. We targeted MPs and high profile people. Students and patients used the media. Private practices provided handbills with a suggested letter to Ministers. Margaret Kraehe advised Branch Council that both Melbourne and Monash universities expressed interest in offering a second physiotherapy programme, but our public position maintained moving physiotherapy from La Trobe to Melbourne.[139]

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[138] In author's possession.

[139] "Australian Physiotherapy Association Victorian Branch Council August Meeting," (1988).

La Trobe's Academic Board asserted that physiotherapy education had developed successfully within Lincoln, removing physiotherapy was 'unwarranted and would be severely detrimental to the development of all the health science professions currently educated within the Lincoln School'. The Board condemned the APA's self-interested campaign, but was not averse to the prospect of fleecing physiotherapists.[140] Lincoln had previously only reluctantly permitted physiotherapy's Postgraduate Diploma in Manipulative Therapy, without acknowledging any clinical education costs (Chapter 8). Ironically La Trobe now proposed charging $3000 for the Diploma because of its 'heavier clinical requirements peculiar to physiotherapy'.[141] To further fuel the Campaign, Government pressured La Trobe to include PIT.[142]

The Campaign Committee met weekly and we discussed the situation with the three Vice Chancellors. The Physiotherapists in Management group contemplated withdrawing clinical education.[143] We perceived another proposed Governmental health sciences' review as a stalling tactic.[144] Television, radio and print journalists interviewed Rick Clingan, President of the Physiotherapy Students Association. Students worried about housing, but transport between Carlton and Bundoora was paramount, as it affected clinical access and library facilities.[145] To highlight this issue, students raced between Lincoln and La Trobe, pitting various forms of transport against each other. Margaret Kraehe, Guy Zito, Rick Clingan and I addressed the students at a pre-race rally (Figure 10.2).

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[140] La Trobe University, "Academic Board 12 October Minutes," (1988). Attachment to Minutes.
[141] "Academic Board 14 September Minutes," (1988). 7-8.
[142] "Academic Board 10 August Minutes," (1988); O'Neill, "Enemies within and Without."
[143] The Physiotherapists in Management Group comprised physiotherapy department heads and me.
[144] "Australian Physiotherapy Association Victorian Branch Council September Meeting," (1988). Item 5.3.
[145] Stephen Martin, Interview 22 October 2013.

Steve Martin said.

> Moving to Bundoora was not at all popular ... We had a rally ... in Lincoln Square and ended at La Trobe. I was marathon running at the time, and I ran, people on bicycles, taking trams. I headed off, Channel 9 ... were driving along beside me as I ran - it was on the news.[146]

Figure 10.2 Steve Martin, (left), a student car in the Lincoln to La Trobe race, (right).

Student Campaign members Adrian Schwarz and David Berlowitz assured students' commitment. Physiotherapy academics and head physiotherapists from the major metropolitan hospitals withdrew education for the day, joining the rally. This heralded unprecedented action.

Our September Campaign meeting threatened that unless State Government was prepared to address our concerns by 23 September 1988:

> On Monday 26 September rolling industrial action by academic staff will commence. This includes withdrawal of lectures without notice. ... On Wednesday 28 September 1988, Clinical Education will be withdrawn indefinitely in the metropolitan area. On Friday 30 September 1988 Clinical Education will be withdrawn

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[146] Ibid.

indefinitely from country placements.[147]

On 27 September Minister Cathie responded: the VPSEC Review 'may not be the appropriate mechanism to deal with the concerns of the Physiotherapy professional community', instituting another review.[148] I had discussions with Penington and Ryan whilst other Campaign members met Scott. These briefings to Vice Chancellors ensured they knew our views before Penington and Scott met with Minsters Cathie and White on 30 September. Here Penington advised that Melbourne could take physiotherapy if Scott agreed.[149] Compounding matters, a State Election occurred on 1 October. We sought meetings with the new State Minister for Education, Caroline Hogg and federally with Dawkins.[150]

Inflaming the situation, chiropractic at La Trobe had resurfaced. Travis Stowe, now APA Branch President told an angry rally of 300 physiotherapists, students and parents that physiotherapy would not be co-located with chiropractic. The Australian Medical Association (AMA) supported us. Brian Davie, chairman of Orthopaedic Surgeons Victorian branch wrote to architect Evan Walker that to associate physiotherapists with chiropractors was 'like associating architectural professionals with builders labourers'.[151] Chiropractors vacillated in preferring La Trobe or RMIT. Ultimately negotiations with La Trobe collapsed and PIT amalgamated with RMIT. [152]

Medical men used their influence on physiotherapy's behalf. Penington, as advisor to Health Minister David White, ensured that White and Dawkins were aware of physiotherapy's issues.[153] Dr William McCubbery, AMA Victorian

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[147] "Campaign Committee 20 September Minutes," (1988).
[148] "Australian Physiotherapy Association Victorian Branch Council October Meeting," (1988). BC/9910/5.1 minutes of the Campaign Committee meetings. "Faculty of Medicine Minutes." 13 October Executive 17 November Faculty meeting. 831-832.
[149] Penington.
[150] "Australian Physiotherapy Association Victorian Branch Council October Meeting." BC/9910/5.1 minutes of the Campaign Committee meetings.
[151] O'Neill, "Enemies within and Without." 209.
[152] Ibid. 212-229.
[153] Penington.

Branch President, offered his Association's continuing support as we contemplated another stop work meeting and withdrawing clinical education in 1989.[154] Whilst we renewed our efforts, Hugh Batten, now Dean of Health Sciences, sought support from other professional organisations. New physiotherapists like Michael Farrell thought physiotherapy was 'being a bit over the top'.[155] Farrell and Keith Hill had enjoyed student life at Lincoln in an era of generous funding.[156] Older physiotherapists for whom Melbourne was 'their University' indefatigably supported the Campaign.[157]

In October La Trobe sought appeasement. Its Council, Academic Board and Batten invited students for discussions. Campaign member students agreed for their views to be acknowledged, but not to negotiate.[158] Students castigated Hogg following her misleading statements in parliament.[159] The media publicised the implications of no clinical education for 1989 and when La Trobe suggested physiotherapy students could graduate with a diploma rather than the degree students, their parents and physiotherapists expressed outrage. Peter Worland, David White's advisor sought a meeting with the APA. All Victorian MPs again received letters, indicating consensus would be impossible. At the 23 November Campaign meeting I reported that I had appraised Peter Worland and Keith Cole, Dean of Physical Sciences at La Trobe about the situation. As La Trobe now wanted to engage, we attended meetings to reiterate our position.[160] La Trobe Academic Board, reporting the

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[154] "Australian Physiotherapy Association Victorian Branch Council November Meeting," (1988).
[155] Michael Farrell, Interview 8 August 2013.
[156] Keith Hill, Interview 23 May 2013.
[157] McLoughlin; Luke.
[158] "Australian Physiotherapy Association Victorian Branch Council November Meeting." BC/8811/5.1
[159] Hansard, "Legislative Council 6 December," (Melbourne: Jean Gordon Government Printer, 1988). 616.
[160] "Australian Physiotherapy Association Victorian Branch Council December Meeting," (1988). BC/8812/5.1.

students' position, anticipated that state and federal governments would decide physiotherapy's future before Christmas.[161]

Hansard reported JG Miles and Haddon Storey's questioning of Hogg. If physiotherapists did not graduate due to the withdrawal of clinical education, Victoria's already dire shortage of physiotherapists would be compounded.[162] State Government letters to students on 21 December advised that physiotherapy would stay at La Trobe. Fiona McKinnon, Physiotherapists in Management Chair, indicated that no clinical education arrangements would be renewed for 1989. Margaret Kraehe and I met with Penington on 22 December, discussed current Government thinking and the possibility of a second school at Melbourne, thus flagging a potential solution.[163]

Into another year the Campaign continued.[164] Physiotherapy academics felt acutely dissatisfied with the Government decision for physiotherapy to stay institutionally with La Trobe but physically at a Carlton campus.[165] Meeting with Scott I discussed physiotherapy's critical funding shortfall jeopardising academic components of the course. In a conciliatory gesture, Scott suggested that La Trobe and the APA should approach VPSEC together, presenting a united front. Scott finally appeared to accept that Lincoln's leaders had misrepresented physiotherapy's views. The APA declined Scott's offer and planned a further barrage of correspondence.[166]

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[161] La Trobe University, "Academic Board 23 November Minutes," (1988). 5.
[162] Hansard, "Legislative Council 24 November," (Melbourne: Jean Gordon Government Printer, 1988). 590. "Legislative Council 7 December," (Melbourne: Jean Gordon Government Printer, 1988). 751.
[163] "Australian Physiotherapy Association Victorian Branch Council Executive February Meeting," (1989). BC/8901/5.1. Penington; "Campaign Committee 10 January Minutes," (1989).
[164] My 1989 diary records Campaign Committee meetings attendance: 10, 24 January, 15 February, 7, 15 March, 2, 16, 25 May, 8, 14, 21 June, 18, 25 July, 3, 10, 15 August, 3, 26 September. 6, 10 October, 8, 20, 28 November and 5 December.
[165] La Trobe University, "Academic Board 15 February Minutes," (1989). 9-11.
[166] "Australian Physiotherapy Association Victorian Branch Council June Meeting." BC/8901/5.1. "Campaign Committee 24 January Minutes," (1989).

The APA Executive Committee with Jennifer Lake and Hayden Cock, reconsidered campaign strategies and options for 1989. Physiotherapists committed to withdrawing clinical education would not resile. Neil Cole, a Labor Party MP and Penington indicated that it was unlikely that the Commonwealth Government would change its funding decisions. Penington also thought a second school at Melbourne was unlikely with Lincoln geographically close. We needed to consider a compromise with La Trobe. For me compromise was untenable: although seeing merit in both Melbourne and La Trobe, my public position remained firmly for Melbourne.

Our Campaign Committee resolved to continue lobbying, drawing attention to clinical education, the long-term effects on Victoria's physiotherapy shortage and emphasising that bans would remain until physiotherapy's location was resolved.[167] Clinical placements were withdrawn from 13 February. Students were understandably anxious. President of Lincoln's student union, Rebecca Fagan, who strongly supported La Trobe's position, issued a press statement blaming the APA for wrecking students' courses. Physiotherapy academic/clinician Guy Zito urged students to direct their anger at the government instead. Students continued supporting the Campaign and furthermore rallied on 3 March with speakers at Lincoln Square and marched to the Education Department.[168]

Physiotherapy academics supported students with a one-day strike, but it was the withdrawal of clinical education that sharpened the Government's attention. With my fellow physiotherapy staff I met with VPSEC, including Chairman Dr Ron Cullen, regarding our discipline weighting and Lincoln's lack of funding transparency. The APA represented by Kraehe, Nall, Baker, Zito and Jill Nosworthy separately met with VPSEC to elaborate physiotherapy's position and reinforce the need for autonomy, adequate funding, clinical education and research and postgraduate programmes. Physiotherapy's location received little

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[167] Minutes of the Campaign Committee meetings 7, 15 and 22 February 1989.
[168] Zito.

attention, although with a critical shortage of physiotherapists, APA representatives raised the possibility of a second school. Cullen assured funding for anatomy at Melbourne, but clinical education would need to come from physiotherapy's budget.[169] If physiotherapy had succeeded in gaining clinical education funding, the other health sciences would argue for funding too.

During 1989 tertiary amalgamations proceeded apace. PIT successfully negotiated with RMIT.[170] The University of Melbourne amalgamated with the Melbourne College of Advanced Education and the Victorian College of the Arts.[171] As Dawkins used one per cent of General Research Funds to push amalgamations, La Trobe enviously noted Melbourne's progress.[172] The Campaign meeting in March 1989 reported the student march. My inclination was that physiotherapy academics would not strike unless La Trobe forced students to accept a diploma.[173] At Kraehe and Baker's meeting and my separate one with Scott, he could not understand why physiotherapy perceived itself as different, and why we wanted autonomy.[174] However following these meetings Scott established a task force to consider physiotherapy's autonomy at La Trobe and advertised for a Professor of Physiotherapy.[175]

As some resolution of internal difficulties for physiotherapy within La Trobe appeared, we learned that Batten and VPSEC considered incorporating natural therapies into Lincoln, again without consultation with the professional schools. The APA wrote to Scott, relevant Ministers, Shadow Ministers and VPSEC indicating that not only would the proposal 'seriously compromise the academic standing of La Trobe University', but also Batten had acted

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[169] "Australian Physiotherapy Association Victorian Branch Council March Meeting," (1989). BC/8903/5.1 contains February Campaign Committee meetings minutes.
[170] O'Neill, "Enemies within and Without."
[171] La Trobe University, "Academic Board 15 March Minutes," (1989).12-14.
[172] Ibid. 14.
[173] "Australian Physiotherapy Association Victorian Branch Council March Meeting."
[174] Nall and Baker.
[175] Letter John Scott to Travis Stow 18 April 1989. EX/8904/1.1. La Trobe University, "Academic Board 2 February Minutes," (1989). 9-11.

independently.[176] Scott sheeted all responsibility to Batten who did not progress the matter.

Keeping alert to the views of the other health sciences, Jill Nosworthy attended the Combined Health Professionals Associations meetings. Their members now grumbled about relationships with La Trobe despite Dawkins's planned spending of $11million on La Trobe buildings. [177] All expressed concern about the possible inclusion of natural therapies, but they had not been prepared to make a public stand.[178] John Bench later told me the physiotherapists were right; others should have been braver and followed. School Heads Alison Pitt, Orthoptics, and Judith Parker, Nursing echoed Bench.[179]

My political stance had been maintained within and outside the academy and I could not continue working for La Trobe when being so outspoken about the need for physiotherapy to be elsewhere. When an advertisement for Manager of Physiotherapy at the Amalgamated Royal Melbourne and Essendon Hospitals appeared, I applied and was appointed, leaving Lincoln in June 1989. I continued on the Campaign Committee and Valmai Robertson, now Acting Head of Physiotherapy also attended meetings.[180] At Lincoln Gillian Webb was outspoken. 'When there's a cause that people believe in it's perfectly appropriate to protest. Student ... voices will change things'. La Trobe issued a writ against Webb to stop her talking.[181] Louisa Remedios reflected,

> I was as keen as everyone else to go. There was talk of shutting down the School. I was very distressed that students may not have been able to finish their programme. Very traumatising ... I was

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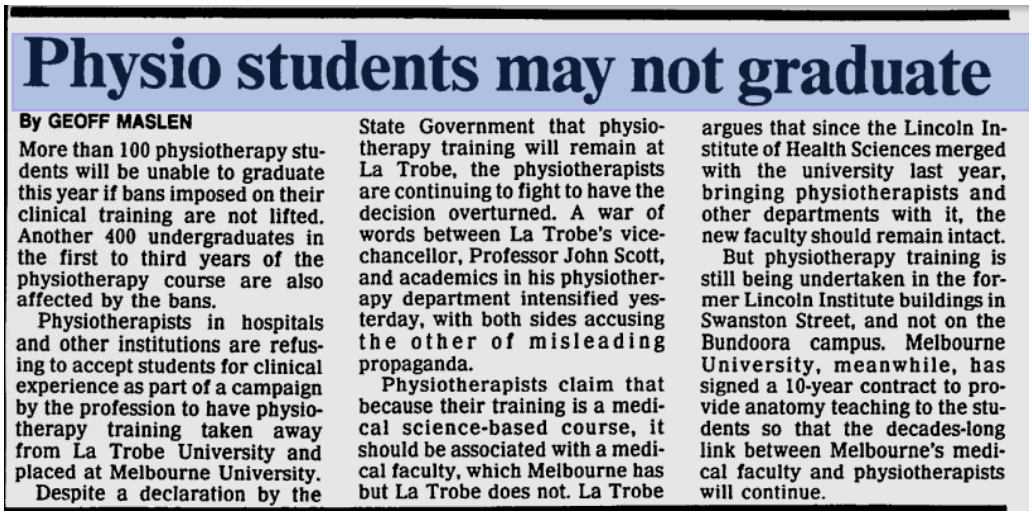
[176] "Australian Physiotherapy Association Victorian Branch Council Executive April Meeting," (1989). Letter 28 April 1989 EX/8904.2.1.
[177] "Australian Physiotherapy Association Victorian Branch Council April Meeting," (1988). BC/8804/5.3 "Australian Physiotherapy Association Victorian Branch Council Executive July Meeting," (1989). Item 1.
[178] O'Neill, "Enemies within and Without."
[179] Conversations with author 1990s.
[180] Robertson and I did not seek leadership, but agreed it provided unexpected opportunities. Robertson, President Academic Senate, Newcastle University.
[181] Webb.

> involved with the marches. ... A defining part of my career in ways I'd never anticipated.[182]

Barry Stillman left Lincoln on principle. 'Gillian Webb said we're all going to resign ... Barry did and no one else did'.[183] Stillman's action permanently affected his long academic career and the issue continued to be stressful for students and staff (Figure 10.3).[184]



Physio students may not graduate

By GEOFF MASLEN

More than 100 physiotherapy students will be unable to graduate this year if bans imposed on their clinical training are not lifted. Another 400 undergraduates in the first to third years of the physiotherapy course are also affected by the bans.

Physiotherapists in hospitals and other institutions are refusing to accept students for clinical experience as part of a campaign by the profession to have physiotherapy training taken away from La Trobe University and placed at Melbourne University.

Despite a declaration by the State Government that physiotherapy training will remain at La Trobe, the physiotherapists are continuing to fight to have the decision overturned. A war of words between La Trobe's vice-chancellor, Professor John Scott, and academics in his physiotherapy department intensified yesterday, with both sides accusing the other of misleading propaganda.

Physiotherapists claim that because their training is a medical science-based course, it should be associated with a medical faculty, which Melbourne has but La Trobe does not. La Trobe argues that since the Lincoln Institute of Health Sciences merged with the university last year, bringing physiotherapists and other departments with it, the new faculty should remain intact.

But physiotherapy training is still being undertaken in the former Lincoln Institute buildings in Swanston Street, and not on the Bundoora campus. Melbourne University, meanwhile, has signed a 10-year contract to provide anatomy teaching to the students so that the decades-long link between Melbourne's medical faculty and physiotherapists will continue.

Figure 10.3 *The Age* 29 August 1989. 16.

Our meetings continued with Penington and Evan Walker, again conveying to Walker the preferred location of Melbourne and the ongoing problems at La Trobe. The university became more conciliatory probably with advice from their newly employed public relations professionals.[185] Trying to engage with the APA, La Trobe sought representatives for its Undergraduate Course Advisory Committee and Professor of Physiotherapy selection panel.[186] Whilst APA Branch President, Travis Stow advised Walker that negotiations with La

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[182] Louisa Remedios, Interview 6 May 2015.
[183] Elizabeth Tully, Interview 14 May 2013.
[184] Stillman.
[185] La Trobe University, "Academic Board 16 August Minutes," (1989). 12-13.
[186] "Australian Physiotherapy Association Victorian Branch Council July Meeting," (1989). Item 5.

Trobe were inappropriate, the Association trod a fine line.[187] If a second programme began at Melbourne with one retained at La Trobe, the APA would have to consider how it would support physiotherapists in two universities. At an Extraordinary General Meeting on 15 August the APA resolved it would support Lincoln physiotherapy academics and students and authorised our Campaign Committee to continue working to achieve relocation to Melbourne.[188]

A pivotal event in our Campaign occurred on 14 September 1989. Several hundred physiotherapists and students marched through Melbourne to Parliament House with banners held high and speeches on the steps.

> Politicians realised that physios were not going to go away if well bred young women, the majority, were willing to take to the streets ... they feel so passionate about their profession and prepared to be photographed and probably by ASIO ... leading physios, leading academics were prepared to join the march.[189]

All television stations showed the event on the evening news (Figure 10.4). It became increasingly difficult for students. David Kelly said 'towards the end of my third year, we went on a march through the city and to the steps of parliament. ... The threat that our clinical placements might not go through was unsettling and you weren't sure what was going to happen'.[190]

Walker referred our 'dispute' to the Industrial Relations Commission because of the withdrawal of clinical education. As a gift clinicians made to education, it fell outside the jurisdiction of physiotherapy's industrial award.[191] Nevertheless Deputy Commissioner RJ Garlick requested the Department of Labour

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[187] "Australian Physiotherapy Association Victorian Branch Council August Meeting," (1989). Item 4.5. Nosworthy participated.
[188] "Australian Physiotherapy Association Victorian Branch Council September Meeting," (1989). Item 5.2.
[189] Lake.
[190] David Kelly, Interview 27 August 2013.
[191] "Australian Physiotherapy Association Victorian Branch Council September Meeting." Item 5.1.

organise a conference involving Melbourne and La Trobe universities, the APA and the Victorian Allied Health Professionals Association, to develop an agreed position.[192] Following this meeting, formal bans were lifted but individual clinicians still refused students.[193] Peter Taylor, a physiotherapy student's parent, now on the Campaign Committee, met Walker to reinforce our collective view.[194]

Figure 10.4 14 September 1989.

At the end of another year physiotherapists, our students and many parents continued to support the Campaign. Physiotherapy had raised its profile and several of us, now more cynical, had learned much about the games of politics and academia. Zito encapsulated our perspective regarding the political and academic chicanery displayed. 'Not being treated respectfully was very

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[192] "Australian Physiotherapy Association Victorian Branch Council October Meeting," (1989). Item 5.1. Supplementary information Executive Meeting 26 September BC/8910/4.
[193] Only some physiotherapists belonged to Victorian Allied Health Professionals Association. The award did not include educating students.
[194] "Australian Physiotherapy Association Victorian Branch Council Executive October Meeting," (1989).

annoying'.[195] We had engaged with Vice Chancellors and politicians directly involved with education and health in Victoria. Our resolve had not wavered. Now physiotherapy academics voted not to send any representatives to Lincoln's Board of Examiners meetings.[196]

John Scott retired at the end of 1989 replaced by Michael Osborne from the University of Melbourne. Medical administrator Gad Trevaks received a brief from the State Government to achieve resolution. Skilled negotiator Patricia Baker now convened the Campaign Committee, representing the APA on Trevaks' Working Party with Penington, Osborne and a VPSEC representative. Baker reported in February that the Working Party agreed that students would enrol at La Trobe in 1990 and a Melbourne programme would commence in 1991. Students would be distributed between both programmes and no academic staff would become redundant. Once the State Government and VPSEC supported these proposals they would go to Canberra.[197]

Despite this agreement, necessary to ensure both universities' funding, La Trobe proposed major amendments to the Working Party Statement, displeasing both the APA and VPSEC.[198] La Trobe began lobbying against student transfer rights.[199] Vice Chancellor Osborne provided a copy of the agreement to the La Trobe community. Pleased that Health Sciences would now be at Bundoora, Osborne disagreed with student transfer, which would disrupt the extant Department of Employment Education and Training

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[195] Zito.
[196] "Australian Physiotherapy Association Victorian Branch Council December Meeting," (1989). Item 5.1.
[197] "Australian Physiotherapy Association Victorian Branch Council February Meeting," (1990). Item 5.1. "Minutes, Faculty of Medicine and Dentistry, University of Melbourne," (Melbourne: University of Melbourne, 1990). Graeme Ryan reported 15 March 1990 both universities would offer physiotherapy. 4-5.
[198] "Australian Physiotherapy Association Victorian Branch Council March Meeting," (1990). Working Party Statement, BC/9003/5.1.
[199] "Australian Physiotherapy Association Victorian Branch Council Executive March Meeting," (1990).

profiling.[200] Another change occurred in State Government. Joan Kirner assumed responsibility for Walker's portfolio.[201] Kirner, passionate about education, community action, women and support for the disadvantaged was sympathetic to our concerns, perhaps particularly the gendered and powered nature of our struggle.

Monash University contested for physiotherapy, but now the focus was almost entirely on Melbourne. Several of us had worked with Monash's anatomy Professors Eric Glasgow and David de Kretzer on a graduate entry programme.[202] Monash made academic changes to facilitate such a programme and together we kept the Monash proposal active. Vice Chancellor Mal Logan expressed enthusiasm for physiotherapy. The Monash proposal, the first potential graduate entry programme in physiotherapy in Australia, generated significant debate. APA members, strongly lobbied by the University of Queensland, voted down the proposal. Two ironic outcomes ensued: the University of Queensland offered physiotherapy's first graduate entry programme and Monash commenced a bachelor programme after Melbourne's erstwhile Dean, Professor Richard Larkins, became Vice Chancellor in 2003.[203]

Our Campaign Committee continued engaging with politicians and Penington.[204] In May it became apparent that students would not transfer or La Trobe release any funds. When we met with Kirner she sought physiotherapists' guarantees on clinical education and bridging finance for a programme at Melbourne.[205] Victoria's new Shadow Minister for Health, Marie

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[200] Michael Osborne 'Message from the Vice-Chancellor La Trobe University, Physiotherapy Education' 29 March 1990.
[201] "Joan Kirner," http://www.parliament.vic.gov.au/re-member/bioregfull.cfm?mid=1212. Accessed 21 June 2015.
[202] De Kretzer became Governor of Victoria.
[203] Larkins advised me he planned physiotherapy at Monash, influenced by our programme's success.
[204] "Australian Physiotherapy Association Victorian Branch Council Executive May Meeting," (1990). BC/9005/4.1. Penington.
[205] "Australian Physiotherapy Association Victorian Branch Council June Meeting," (1990). BC/9006/2 and BC/9006/4.1. Nall and Baker.

Tehan, sympatheticly wrote to the Association assuring her ready access.[206] Although many men are physiotherapists, we were still perceived as predominantly female and the Campaign leaders were women. Perhaps the women politicians felt a particular empathy as Kirner was treated disrespectfully during her premiership.

Broader issues relating to education surfaced. The Higher Education Council considered length, nomenclature and credit transfer in undergraduate and postgraduate programmes. The APA strongly resisted embracing physiotherapy within a Bachelor of Health Sciences. A further concern was a move to transfer clinical education to the workplace.[207] I was aware of and specifically confronted these issues in developing national educational accreditation standards for physiotherapy.[208] These standards would influence Melbourne's programmes and my long future involvement in accreditation.

Joan Kirner formally announced a physiotherapy programme at the University of Melbourne on 25 July 1990. The State Government agreed to forty physiotherapy students commencing in 1991 and VPSEC approved a four-year Bachelor of Physiotherapy. Postgraduate programmes would follow. Ryan planned a working party with wide consultative powers to develop the education programmes.[209] Faculty proposed restructuring and renaming the Faculty of Medicine, Dentistry and Health Sciences to include a School of Physiotherapy. The Head and Deputy Head of the School, nominees of the PRB, the APA Victorian Branch and physiotherapy student representatives would become Faculty members and the Head and Deputy Head of the School

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[206] "Australian Physiotherapy Association Victorian Branch Council July Meeting," (1990). BC/9008/2, letter BC/9007.8.4.
[207] Education and Training National Board of Employment, (paper presented at the Seminar on Credit Transfer, Course Length and Nomenclature and Postgraduate Studies, Canberra, 5-6 March 1990). "Australian Physiotherapy Association Victorian Branch Council July Meeting." Australian Physiotherapy Association Submission BC/9007/8.3.
[208] "Australian Standards for Physiotherapy."
[209] "Minutes, Faculty of Medicine and Dentistry, University of Melbourne."176-178. Report of Curriculum Review Committee 29 June 1990. 195.

of Physiotherapy join the Faculty Executive Committee.[210] The University prepared its advertisement for a Foundation Chair of Physiotherapy. The Campaign Committee invited Penington and Ryan to a celebratory lunch where I was asked to assist the university in planning for the new programme. Over the ensuing months I consulted with colleagues regarding the curriculum and with the University's Department of Property and Buildings in the building development of 200 Berkeley Street.

The prolonged and intense campaign epitomised physiotherapists' struggle for educational autonomy that had been steadily eroded. Physiotherapy perceived the proposed amalgamation as an opportunity to finally return to the University of Melbourne - the place where education had begun and where generations of physiotherapists felt they belonged. As in the beginning in 1906, the profession would be restored to its traditional association with medicine, a restoration of professional identity and status, but now with the confidence and autonomy to make our own decisions. Unexpectedly the decades long gift of clinical education provided a powerful tool for the Campaign.

In a culture of hegemonic masculinity as perceived as the holding of power and the organisation of the institution, the Lincoln/La Trobe men had perceived physiotherapists as compliant women. Rechter, Scott, Batten, Walker, could not understand us; we should do as we were told. Our years of struggle to regain our educational autonomy succeeded. Did medicine again assert dominance over physiotherapy in the guise of assistance; because there was a potential prize they wanted too, especially the high entrance scores of students, equivalent to medical entrants. As Willis appreciated, the relationship between health occupations is predominantly through the exercise of modes of power and control by medicine.[211] And medical men, Penington and Ryan demonstrated dominance over La Trobe's leaders. We watched with some

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[210] Ibid. 209-210.
[211] Willis, *Medical Dominance: The Division of Labour in Australian Health Care*; "Introduction: Taking Stock of Medical Dominance."

amusement as the men battled for supremacy. In our Campaign years we learned some of the games played, not to trust those in power, and to persist against the odds. We had not been brought up to behave like this in our homes, schools and churches.

As an added distraction to our focus the rivalry with other health professionals arose. Within Lincoln there was little overt disagreement and ultimately recognition from some that physiotherapy had made the right choice. The Campaign Committee did not become distracted with chiropractic and other potential players, but pursued its aim for Melbourne. The realisation of the School of Physiotherapy at the University of Melbourne, a vision so long held and so often sought by Victorian physiotherapists, is the subject of the next chapter.

Chapter 11 A vision realised - Science in our Hands

> *I have a sense of the rocket taking off from year one and the rocket didn't sort of get into orbit ... and get into level flight for 6 or 7 years ... the numbers kept on going up.*[1]

The Campaign for Melbourne ended with great excitement with a physiotherapy programme approved at the University of Melbourne. I agreed to develop physiotherapy's academic programme, ensure buildings and equipment were ready and establish necessary clinical relationships so that physiotherapy could commence in 1991. This chapter integrates the context of education and health in Victoria, Australia in the following two decades as the School of Physiotherapy developed. Having been an academic, a clinical physiotherapist working overseas and in Australia, observed physiotherapy in a number of countries and discussed possibilities with local colleagues, I had a clear vision for a new school. Planning and delivery occurred at a hectic pace. Challenges included establishing clinical education and introducing a research culture.

The University's Academic Board required physiotherapy's undergraduate programme in six weeks. It would incorporate my key philosophical perspectives: that clinical education played a pivotal role and senior clinicians must participate in planning, delivering and reviewing the curriculum; graduates needed a comprehensive understanding of physiotherapy in health promotion, acute and chronic conditions across the lifespan and in a global context; research must be central. Students required current theoretical knowledge, metropolitan and rural clinical practice in primary, secondary and tertiary healthcare. Living in a world of different societies and health systems, we would promote international experience, particularly in less well-developed countries of our region. Students would develop an understanding of research and the School offer postgraduate study in research and advanced clinical

[1] Ian Story, Interview 13 June 2013.

practice in physiotherapy's specialist areas. Aligned with the University's mission as a university of excellence and international standing, the School aimed to:

- Preserve, refine and advance knowledge in physiotherapy sciences relevant to the promotion and maintenance of health and understanding, preventing and alleviating human disease;
- Achieve excellence in undergraduate, postgraduate and continuing education in physiotherapy; and
- Contribute to leadership in the development of the local and international community by effective interaction with the physiotherapy profession and other appropriate groups outside the University.[2]

The generous assistance of physiotherapy colleagues enabled speedy preparation of the critical educational requirements: the undergraduate degree and a proposed Master of Physiotherapy (MPhysio) gained Academic Board's approval in November.[3] The Bachelor of Physiotherapy (BPhysio) received provisional accreditation from the PRB.[4] In December Graeme Ryan advised the APA Victorian Branch Council of the University's approval. Honours graduates could progress to higher degrees, as research and postgraduate study were a high priority. The building and equipment plans were on target with $1.7million allocated.[5]

Clinical education, a fraught issue in the Campaign, received especial attention. Ryan, who provided me with educational and financial autonomy in planning, supported developing a close, collegial and mutually supportive relationship with the physiotherapists who would provide clinical education for our students. In an innovative model for physiotherapy, but building on that offered

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[2] David Penington, *Making Waves* (Carlton: The Miegunyah Press MUP, 2010). 224-240.
[3] "Minutes, Academic Committee of Academic Board," (University of Melbourne, 1990). Item 5.2. 3356, 3408-3481.
[4] PRB granted full accreditation November 1993.
[5] "Australian Physiotherapy Association Victorian Branch Council December Meeting," (1990).

in the Medical School, students would belong to one of three Clinical Schools: Austin Hospital/Repatriation Medical Centre; the Royal Melbourne/Western Hospitals; or the St. Vincent's/Geelong Hospitals. Within their Clinical School, students could develop strong professional affiliations in a stable learning environment and contribute to patient care. With consistent physiotherapy role models and mentors, their professional identities would develop as they embodied physiotherapy.[6] In fourth year, students would also attend specialist Clinical Schools: the Royal Children's Hospital for paediatrics and Mount Royal for aged care.[7]

The University allocated 200 Berkeley Street for the School. Consulting the University's Property and Buildings Department, I worked closely in the extensive refurbishing and equipping the building with Doug Pattenden, architect, Noel McInnes, project manager, and builders. Pattenden's drawings captured my specifications: semicircular lecture theatre with ramped floor; large research space; tutorial and practical rooms divisible by expandable doors; student computer laboratory; central reception area with adjacent administrative and staff offices, staff room, capacious storage areas, student lockers and socialising room. In later years further refurbishment occurred, including an adjacent building for research.

The Faculty approved a Chair in Physiotherapy and two academic positions.[8] With Ryan, I prepared the first triennial budget. Darryl Mead, Faculty General Manager, and Cyril Yardin, Finance Manager, provided advice and Tina Adams became School Manager. Acknowledging that introducing physiotherapy increased the workload of Faculty departments, Anatomy and Physiology each received senior lecturer funding. With my intention to increase students' understanding of exercise physiology, we appointed Dr Mark

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[6] McCoy.
[7] Letter Ryan to Chief Executive Officers of University's Clinical Schools seeking agreement to have physiotherapy students, 1990. This 'gentlemen's agreement' the only formal document between the University and Clinical Schools for 17 years.
[8] "Minutes, Faculty of Medicine and Dentistry, University of Melbourne." 222. 1993 intake eighty students, growing to 120.

Hargreaves.[9] In anatomy, Dr Christopher Briggs continued teaching physiotherapy students and appointed additional tutors.[10] The first physiotherapy academics, with which I had taught at Lincoln, met our requirements for enthusiasm, commitment and experience in developing curriculum and teaching. Elizabeth Tully with physiotherapy and tertiary teaching qualifications would teach Applied Anatomy and Kinesiology. Gillian Webb began with responsibility for Physiotherapy Principles and Practice and the first-year clinical programme. Webb believed 'ninety-nine per cent of physio is about teaching and education ... I've loved being with students and seeing them develop and grow'.[11] Both continued in the School for more than two decades.

When the University advertised for a Foundation Professor of Physiotherapy and Head of the new School I received strong encouragement from Ryan, Penington and physiotherapy colleagues to apply. In unprecedented recognition for Victoria's physiotherapists, I was appointed in 1991, the eighth woman professor in the University's history and, following Professor Priscilla Kincaid-Smith, the second in the Faculty. Tully said 'what a big change we had made, women coming into the Sanderson room: the boys club'.[12] Reminiscent of the AMassA and the MRB men occupied all the senior roles; women were in minor administrative positions. Despite modest leadership experience at Lincoln/La Trobe, Melbourne, a much more complex institution provided more opportunities to develop. Participating in the inaugural live-in leadership programme at the Melbourne Business School, I learned more about leadership, the University and forged friendships.[13] School commitments allowed little time for university socialising and this experience and committees proved invaluable for meeting people outside the Faculty. As one

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[9] Hargreaves previous Head of Physiology: since 2011 ProVice Chancellor (Research Partnerships), 2015/16 Dean of the Faculty.
[10] Christopher Briggs, Interview 22 August 2012.
[11] Webb.
[12] Tully.
[13] Penington, *Making Waves*. 222-224.

of few professorial women, I sat on many committees. Fittingly another woman, the Hon. Maureen Lyster, State Minister of Health, formally opened the School of Physiotherapy on 3 July 1991, cementing the long-held vision of Victorian physiotherapists to locate physiotherapy education at the University of Melbourne and fulfil a significant professionalisation aim of our forebears - a university education, the ultimate attainment in professional recognition.[14] We had 'sought to be part of the legitimate highest status educational institution, to be recognised alongside medicine with the trapping of a profession'.[15]

In 1991 physiotherapy had little educational research and we had no theoretical educational framework: pragmatism prevailed.[16] We valued small group learning with part-time physiotherapy tutors leading some fourteen students in tutorials and practical sessions.[17] We advertised that Melbourne's programme

> prepares graduates to work in health care settings such as hospitals, outpatients clinics, community centres, private practice, rehabilitation centres, patients' homes, schools, extended care facilities, sports venues, aged care centres, industrial and commercial premises, nursing homes, psychiatric centres and educational institutions. Students may qualify for the degree with Honours.[18]

The first student selection committee comprised Ryan, his Deputy Professor Gordon Clunie, Briggs, Tully, Webb and myself.[19] Student selection followed La Trobe's criteria in 1991. Subsequently we aligned with medicine and

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[14] Andrew Norton, "Mapping Australian Higher Education," *Carlton, Victoria, Australia: Grattan Institute* 12(2012).
[15] Celina McEwan and Franziska Trede, "The Academisation of Emerging Professions: Implications for Universities, Academics and Students," *Power and Education* 6(2014).
[16] Anne Parry, "Physiotherapy and Methods of Inquiry: Conflict and Reconciliation," *Physiotherapy* 77(1991); "Talking to Ourselves," *Physiotherapy* 78(1992). Early physiotherapy educational research Joy Higgs and Angela Titchen, "The Nature, Generation and Verification of Knowledge," ibid.81(1995).
[17] Webb.
[18] First marketing brochure 1990.
[19] "Minutes, Faculty of Medicine and Dentistry, University of Melbourne." 278.

dentistry, requiring English, chemistry, mathematics and one of physics or biology, as all students would share some biomedical science subjects. Consistently overwhelmed with more than ten applicants for every place, selection required tight criteria. Within budget and on time for commencement in 1991, the final weekend before students arrived, with husbands, the architect, project manager and builder we unpacked and allocated furniture and equipment. Forty undergraduate students, twenty-two women and eighteen men with the State's third highest university entrance scores began.[20]

Compared to decades earlier, applicants knew about physiotherapy. Rana Hinman began science before transferring into physiotherapy. Unlike many fellow students educated at private schools, Hinman came from a State high school. She enjoyed our small student cohort and a fixed course in contrast to science where

> you may only see a fellow student for one hour a week. Physio did build ... your friendships ... you have a home. ... Everybody wanted to be there ... to learn, took it seriously and also it was fun and a sense of collegiality. ... The staff knew who you were and cared about you. ... I liked anatomy and the practical subjects the core physio discipline subjects because they were about physio.[21]

The full programme and collegiality reflects the hours of tutorials and hands-on practice necessary for skill acquisition. Embodiment as physiotherapists began immediately, they perceived themselves as different from those who in medicine and dentistry shared the biomedical sciences: however they forged future professional relationships.[22] Initial trepidation soon disappeared.

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[20] Overwhelming demand continued.
[21] Rana Hinman, Interview 2 July 2013.
[22] Catherine Granger, Interview 3 December 2013.

> Rumours about physio: you'd have to cut up bodies and you'd have to undress. ... but it was the best opportunity. I remember particularly the forearm and thinking how many muscles are packed into that forearm and without having the chance to really look at it I don't know whether I would ever have grasped what's in there in such a small area. The opportunity to explore a bit and people would find anomalies ... Anatomy was fantastic.[23]

As they learned about the body, many agreed that physiology and neuroscience were the most difficult subjects. Kate Lawler remembered her physiotherapy cohort achieved better results in the neuroscience examination than medical students, debunking the common and insulting stereotype that people become physiotherapists because they cannot do medicine.[24]

Unlike medicine, physiotherapy education simultaneously engages the student's physical body and the mind. Theory is intimately linked with practical skills, thus we advised prospective students they would learn about their own and one another's bodies and would practice therapeutic techniques on one another. Physiotherapy Principles and Practice introduced students to the ethical behaviour expected of them with one another and the patients they would see in the first of their fortnightly visits to their Clinical Schools. The APA Ethical Principles provided a foundation for student discussion of the profession's expectations, contributing to construction of their physiotherapy identities and their future positions as health professionals.

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[23] Lawler.
[24] Ibid. Every physiotherapy student could have entered an Australian medical programme.

> Respect the right and dignity of all individuals.
>
> Help all those who seek their professional services, without discrimination, fear or favour.
>
> Give an honest, competent and accountable professional service.
>
> Recognise the extent and limitations of their professional expertise and undertake only those activities that are within their professional competence.
>
> Hold in confidence all personal information entrusted to them, except where disclosure is in the best interests of the patient/client/colleague.
>
> Maintain at all times the highest standard of professional competence and continually update and extend their professional knowledge and skill.
>
> Contribute to the planning and development of services, which enable individuals within the community to achieve optimum health.[25]

Students swiftly became comfortable interacting and handling one another's bodies whilst dressed in underwear. In embodiment characteristic of physiotherapy and in contrast to medical students, physiotherapy students agreed they could not learn or empathise with patients without practising techniques on each other.[26] Students were listening to their own and fellow students' bodies, appreciation which involves bodily transformation.[27] 'We started hands-on doing things ... in your underwear ... you practice on each

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[25] "Australian Physiotherapy Association Ethical Principles," (1990). 2. Current principles "Apa Code of Conduct," http://www.physiotherapy.asn.au/DocumentsFolder/APAWCM/The%20APA/Governance/Code_of_Conduct_V2013.pdf. Accessed 10 February2014.

[26] Granger; Lawler.

[27] Chris Shilling, "Sociology and the Body: Classical Traditions and New Agendas," *The Sociological Review* (2007).

other and then you also go to the clinic ... that's when the course really started for me'.[28]

Clinical education, a source of contention at Lincoln/La Trobe, required a reliable, integrated, collaborative academic and clinical programme at Melbourne. The Clinical Education Committee (CEC) oversaw clinical education. Physiotherapists in the Clinical Schools and the affiliated country hospitals, rehabilitation and community centres and physiotherapy practices would, together with academics, undertake responsibility for developing clinical knowledge and skills for students. The members of the first CEC were Austin Hospital, Cathy Nall; Repatriation Hospital, Helen McCausland; RMH, Fiona MacKinnon; Western Hospital, Bridget Shaw; St Vincent's Hospital, Jill Nosworthy, Geelong Hospital, Dorothy Trezise; Royal Children's Hospital, Anne McCoy; Mount Royal, Lee Pope, Gillian Webb and me.

Anne McCoy viewed the CEC:

> A new beginning, a revelation, collaboration, a mutual respect. ... Talking about other issues, what was going on in the hospitals, the sharing of politics. ... We learned from each other ... it was sharing. When you put the proposal up I don't think we could grasp, could believe it was so good, it was such a change.[29]

Our new physiotherapy clinical education approach took some five years to embed and become the 'norm'.[30] The CEC monthly meetings enabled strategic planning and sharing developments in health and education.[31] Together we weathered the storms of a succession of reduced funding to public health facilities by Jeffrey Kennett's State Liberal Government from 1994. Public hospitals suffered from wasted resources and overspending. Previously treated

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[28] Uyen Phan, Interview 4 June 2013.
[29] McCoy.
[30] Joan M McMeeken, "Melbourne's Clinical School Model for Physiotherapy" (paper presented at the Proceedings of the Sixth International Physiotherapy Congress, Canberra, 2000); "Physiotherapy Education in Australia," *Physical Therapy Reviews* 12(2007).
[31] For example School of Physiotherapy, "Clinical Education Committee 20 December," (1995); "Clinical Education Committee 21 February," (2006).

leniently, Kennett's government tightened the purse strings. Patients discharged 'quicker and sicker' could paradoxically lead to more costly readmissions, but community facilities and teaching hospitals lost staff. New graduates and students who required the ongoing support of experienced clinical colleagues were challenged and some rural sites could no longer take students.[32]

Health budgets tightened although workforce projections indicated a growth in employment for physiotherapists of 47.3 per cent between 1991 and 2001.[33] Physiotherapists, without medicine's political power or nursing's union power, could be treated as discretionary employees. Despite these fiscal pressures, physiotherapy departments developed creative approaches to maintain or increase staff, including physiotherapists in emergency departments replacing aspects of medical practice.[34] Pressure also arose from competition for student placements and Bendigo, Ballarat and Goulbourn Valley Health linked with our Clinical Schools. Our integrated, collaborative clinical education programme was new, effective and appealed to others. The University of Sydney followed our model, as did La Trobe.[35] Our Clinical Schools had committed to us, but the previous head of the State and Federal health departments, Stephen Duckett, when Dean of Health Sciences at La Trobe used his influence to demand student placements. Cathy Nall at the Austin resisted this call, but the Royal Children's Hospital could not. La Trobe strategically offered a physiotherapy programme at its Bendigo campus and Bendigo Health

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[32] McMeeken, "Melbourne's Clinical School Model for Physiotherapy."
[33] Department of Employment Education and Training, "Physiotherapy in New South Wales. A Labour Market Report Prepared by Occupational Research and Information Section of the Department of Employment, Education and Training," (Canberra1990).
[34] Val J Robertson et al., "Taking Charge of Change: A New Career Structure in Physiotherapy," *Australian Journal of Physiotherapy* 49(2003). Catherine Nall, "Looking Back, Looking Forward: Achievements and Future Directions of Physiotherapy in Australia," ibid.52(2006); Leonie B Oldmeadow et al., "Experienced Physiotherapists as Gatekeepers to Hospital Orthopaedic Outpatient Care," *Medical Journal of Australia* 186(2007).
[35] Sylvia Rodger et al., "Clinical Education and Practice Placements in the Allied Health Professions: An International Perspective," *Journal of Allied Health* 37, no. 1 (2008). Catherine M Dean et al., "A Profile of Physiotherapy Clinical Education," *Australian Health Review* 33, no. 1 (2009).

no longer participated with us. Rivalry between physiotherapy schools at La Trobe, Melbourne and later Monash universities probably drove us all to improve our educational offerings.

Despite the challenges of their clinical loads and our full fees, clinicians undertook postgraduate studies, filling a previous demand. International student numbers grew and enabled our funding shortfalls generally to be retrieved as universities also suffered funding cuts and the School's budget tightened.[36] The solidarity gained through the Campaign helped the CEC to collectively consider our responses to these matters. We felt a shared responsibility in ensuring effective clinical practice and supporting students' learning.[37]

In another innovative approach, physiotherapy academic staff engaged with the senior specialist physiotherapists from each clinical facility.[38] Working groups, meeting regularly, planned, developed and reviewed undergraduate and postgraduate programmes for cardiothoracic, musculoskeletal, neurological, paediatric and aged care. In-service sessions across Clinical Schools used videoed examinations to standardise assessment, shared academic and clinical expertise and co-developed the changes required as research-based approaches to learning, clinical reasoning theory and reflective practice, gained ascendance.[39] Influencing Australian physiotherapy more broadly we encouraged similar collaborative educational approaches through the Australian Physiotherapy Council's accreditation mechanisms as the number of Australian physiotherapy entry-level programmes grew from six to twenty-

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[36] For example School of Physiotherapy, "Planning and Budgets Committee 12 August," (2004).
[37] McCoy; Nall and Baker; Webb.
[38] Joan M McMeeken, "Physiotherapy Entry Level Education in Australia," in *Australian Physiotherapy Association Congress* (Perth Australia2008). Linda Denehy, Interview 24 October 2013.
[39] Donald A Schön, *The Reflective Practitioner How Professionals Think in Action* (Ashgate: Arena, 1983); Mark Jones, "Clinical Reasoning in Manual Therapy," *Phys. Ther.* 72(1992); Gillian Webb, "Clinical Education in Physiotherapy: A Discursive Model" (D Ed, University of Melbourne, 2004); Rola Ajjawi and Joy Higgs, "Learning to Reason: A Journey of Professional Socialisation," *Advances in Health Sciences Education* 13, no. 2 (2008).

eight from 1991-2011.[40] Our consultative processes reflected much of the background of Gillian Webb, Cathy Nall and myself: of Methodist youth groups, planning activities, being at camps where vibrant participatory discussion and discursive thinking engaged us. Webb's later doctoral studies in clinical education confirmed this approach: we were 'way out in front ... in clinical education'.[41] Comprising about one third of the undergraduate programme, we facilitated our clinical arrangements with modest funding to Clinical Schools and programmes to assist clinicians in educating students.[42] The financial recognition did not go to individuals nor cover the full costs; much of clinical education remained a gift from clinician to student in a still-sustained component of physiotherapy's identity.

A new component of identity emerged as physiotherapy research established in Australia, Canada and Britain. The USA with its 1920s beginnings in universities had more experienced researchers, but its reputation for clinical practice did not match the other countries.[43] In 1992 two outstanding contributors began, Sara Carroll and Ian Story. Carroll previously held the only Victorian clinical/research physiotherapist position at the Austin Hospital.[44] Carroll and Story embedded research in our programmes. Tully said, 'Sara supervising many different things ... gave much of herself. Ian was particularly helpful to all, ... I would have been lost with the computer without Ian'.[45] With an abiding interest in information and computer technology (ICT), the student

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[40] Webb. See http://www.physiocouncil.com.au/accreditation. Accessed 9 March 2015. Joan McMeeken Chaired the Accreditation Committee, the Australian Physiotherapy Council and participated in developing the Australian Standards for Physiotherapy.
[41] Dr Rod Fawns, from University's Education Faculty, which subsequently introduced 'clinical' education.
[42] Elizabeth Katherine Molloy, "Insights into the Formal Feedback Culture in Physiotherapy Clinical Education" (PhD, University of Melbourne, 2006); Clare Delany and Elizabeth Molloy, *Clinical Education in the Health Professions* (Sydney, NSW: Churchill Livingston Elsevier, 2009).
[43] Cosh; Di Newham, Interview 10 September 2013; Patricia Wrightson and Sue Kelly, Interview 7 September 2013; Grant and Trott.
[44] Carroll, Caltex Woman Graduate Scholar of the Year in Western Australia, completed a research Masters in Canada.
[45] Tully.

computer laboratory, established to promote multimedia technology in teaching and research suited Story. The first staff member with a PhD, psychologist Story provided guidance on behavioural science subjects.[46] He came into an unfamiliar environment.

> The thing that struck me ... was just how dynamic the people were ... a consequence I think of the enormity of the task ... Levels of dynamism a feature of people who do physio...'do' is a verb that would describe physio not 'procrastinate', 'prevaricate'. ... I come from a more traditional half psych half sociology ... I got to this little intense knot of people and frankly it was like joining the SAS. ... It's rewarding. Exhausting. ... Talking about the procedures for the research ... a lot of very early planning for the units and subjects ... tremendous work but also tremendous freedom to plan how the curriculum should go and we were doing it year by year.[47]

Relatively unconstrained in programme development, we used an extended academic year to accommodate clinical, elective and teaching blocks. Educational policies developed progressively, but evaluation began immediately. Aiming for excellence in our programmes we ensured a sustained cycle of planning, delivering and reviewing every subject each semester. These activities generated intense discussion. Students provided feedback through anonymous questionnaires and informal discussion. Webb claimed in developing and implementing effective curricula, 'we were miles ahead of our medical colleagues ... we were used to small group teaching, talking to each other'.[48] Students began teaching one another in practical classes and communicating with and teaching patients in their Clinical Schools.

From 1992 we offered a 'Lateral Entry' programme to a small number of students with the appropriate first year non-physiotherapy subjects.[49] During

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[46] The School of Behavioural Science taught these subjects.
[47] Story.
[48] Webb.
[49] Entrants required H1/H2a results. Some had Masters and PhDs.

January and February these students undertook an intensive foundation physiotherapy-bridging programme, to enable their second year entry. More theory, practical skill development and modest clinical exposure filled second year. Third year included academic teaching blocks and eighteen weeks fulltime in the Clinical Schools. For Jason Smith clinic fulltime felt like 'a huge gulf between what we were doing at the Uni and what was required of us out there ... I can remember at the time thinking it's like two courses'.[50] The realities of a strict time schedule, exposure to death and disability, communicating with patients in pain or who may not share a language and additionally reviewing theory after clinic, were enlightening (Figure 11.1 and 11.2).

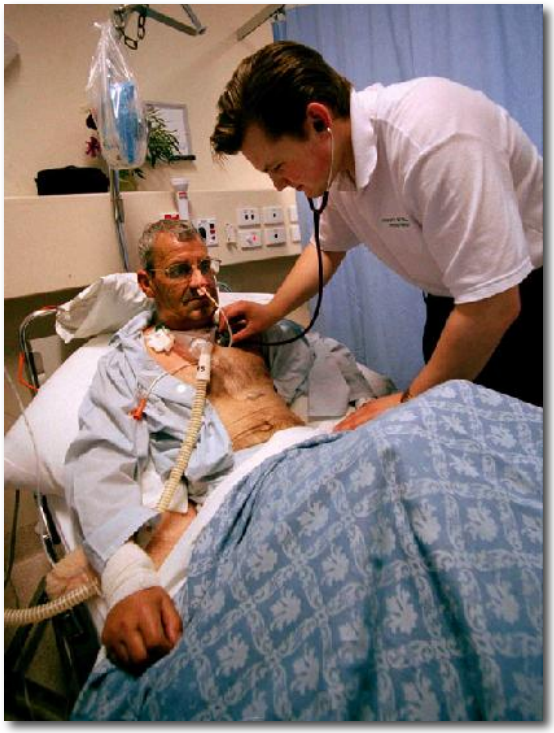

Figure 11.1 Student with a patient with a cardiorespiratory condition.

[50] Smith.

Figure 11.2 Students in Outpatients with their clinical educator.

The Global Elective provided a further eye-opener at the end of third year. The Global Elective was one of three electives. Students completed the Professional and Clinical Electives towards the end of fourth year. The electives were:

> To broaden students' experience, increase their self-confidence and provide an opportunity to explore different areas of physiotherapy and related professional practice ... develop an understanding of the social, cultural and political context of health care management, the role of the physiotherapist, and the application of physiotherapy within the elective placement.[51]

We encouraged students to undertake international and remote Australian options. Colleagues in the Asia-Pacific region, agreed to take Melbourne students. The cultural and professional contrasts and similarities could provide valuable learning experiences and, through sharing knowledge, enable us to assist physiotherapy's development. Students would live within and experience another culture and make future professional contacts. Prepared with ethics and our expectations, students departed for a minimum four weeks full-time.

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[51] My letter to prospective elective placements.

Students within Australia worked in Aboriginal and rural communities and those overseas in placements from the highlands of Papua New Guinea, throughout the Asia-Pacific region to Eastern Europe.

Glenn Bilby spent three months in Indonesia. The volcanic explosion of Gunung Merapi near the residential rehabilitation hospital delayed Glenn in Bali. He began familiarising himself with Indonesia before going to Yogyakarta where, 'I had a bedroom with bars on it, ate rice and fish for breakfast with my fingers'. He worked with children aged eight-sixteen years with spinal injuries, leprosy, polio, and spina bifida. 'The families couldn't afford to have them. They were on the street'. Unaware of the importance of 'saving face' Glenn learned cultural sensitivity the hard way by embarrassing the local physiotherapist. Through careful assessment and facilitation he enabled a little girl to walk.

> She was crying, cheering, the whole room of forty kids was clapping and poor Guru (the physiotherapist) standing in the corner was ashamed and he didn't talk to me for a whole week and I'd shown him up, ... it was a good lesson for me, ... a lifetime lesson.[52]

Glenn learned basic Indonesian. He brought back a greater understanding of himself and meditation, *kekuatan mental.* 'I exposed myself to things I would never have known being a boy from Bundoora'.[53]

Kate Lawler and Jason Smith went to Cambodia, working within a non-government hospital artificial limb project with an English prosthetist and two Cambodian physiotherapists. Kate worked in the hospital, appalled by the bloodstained floor, the tiny birthing cell and untreated talipes. She enjoyed the mutual sharing of language and learning how much physiotherapy could contribute.[54] Jason was 'besotted by the whole opportunity and went back afterwards ... Life changing and I don't say that glibly, that's not a cliché,

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[52] Glen Bilby, Interview 13 December 2013.
[53] Ibid. *Kekuatan mental* = mental power.
[54] Lawler.

absolutely life changing'.[55] Jason claimed it seeded the programme he instigated through his charitable 'SOS Foundation', which provides *pro bono* physiotherapy services on Palm Island, in Arnhem Land, Melbourne and Brisbane. Jason indicated a characteristic, embodied in physiotherapists: 'they are pleased to assist people'.[56]

Catherine Granger said of her most memorable clinical placement, the university hospital in Chiang Mai, Thailand. 'I've never seen anything like it ... open windows, people sitting on the ground, a different world'. [57] Due to the School's ongoing connections, Dr Granger, now a Melbourne academic and clinician/researcher in cardiorespiratory physiotherapy went in 2014 to teach Fijian physiotherapy students. Although a small number of students saw it as an extended holiday, the Global Elective generally realised our aims for broadening experiences that would foster maturity and increase cultural knowledge. A young Monash University graduate physiotherapist said, 'I would have given anything to have done your Global Elective'.[58] Physiotherapy was the only programme at the University providing this opportunity to all students. One goal of this elective for me, was for students to learn more about themselves and further develop their sense of professionalism as physiotherapists. On reflection, perhaps the international elective provided some students with an accelerated learning period that earlier generations experienced during wartime or the polio epidemics.

The non-clinical professional elective occurred in administration, health bureaucracies and voluntary organisations. Jennifer Lake at the APA, initially wondered about the suitability of their work, but was pleased with students' contributions, citing one student completing the literature review for the revised physiotherapy standards. Students learnt work-related skills of timeliness, looking and being professional, interacting with colleagues and

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[55] Smith.
[56] Ibid. "Sos Foundation," http://soshealth.org.au. Accessed 3 March 2014.
[57] Granger.
[58] Webb. The elective continues in the DPhysio.

baking the Thursday cake. 'We always had morning tea and the boys baked it'.[59] The Clinical Elective occurred in more specialised practice areas such as burns or amputee management.

In 1993 the first graduation ceremony occurred of the first cohort of Postgraduate Diplomates in Physiotherapy, the culmination of a two-year part-time Postgraduate Diploma in Physiotherapy in clinical or research streams. Penington, Ryan, families and friends attended. The latter enabled practising physiotherapists to undertake the equivalent of an Honours degree part-time with several later progressing to PhD.

As the School grew, staff numbers increased. Glenda Nicol appointed as School Executive Officer, guided physiotherapy's administrative and technical staff. Gavin Walsh as Technical Officer performed the latter functions, eventually leading a team of five. Interdependent, professional and academic staff enjoyed harmonious relationships Walsh recalled, and knew and cared for the students.[60] By 1993 Linda Denehey in cardiothoracic, Paul Lew, Henry Wajswelner and Philip Hart in musculoskeletal and Jackie Reznik in neurological physiotherapy had joined.[61] These specialist staff, essential for theory and practical skills in core areas of physiotherapy, collaborated with clinical educators. In contrast to her experiences in several other universities, Reznick remembered close relationships with clinicians, 'Everybody was listened to and everybody's opinion was taken on board and any decisions that were made we all felt a part of'.[62]

Kim Bennell commenced just before completing her PhD.[63] Although physiotherapists with doctorates were still few nationally and internationally, with Kim and physiotherapist/neuroscientist Mary Galea, we increased

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[59] Lake.
[60] Michelle King, Gavin Walsh, and Kate Taylor, Interview 17 October 2013; Webb; Story; Sherburn.
[61] Henry Wajswelner et al., "Muscle Action and Stress on the Ribs in Rowing," *Physical Therapy in Sport* 1(2000). Professor Linda Denehey, Head of Physiotherapy 2015.
[62] Jackie Reznick, Interview 4 October 2013.
[63] Kim Bennell, Interview 19 November 2013.

opportunities for research higher degrees. We established Galea's histology and microscopy laboratory. Wajswelner, after leaving Canberra's Australian Institute of Sport began investigating rib stress fracture in élite rowers. In the research laboratory, the 'Oarsome Foursome', Olympic and World Gold medal rowers attracted much attention. Sport interested several of us who contributed to *Sports Physiotherapy: Applied Science and Practice*.[64] Guy Zito replaced Paul Lew in 1996 when a coursework Master of Physiotherapy (musculoskeletal, neurological, cardiothoracic, hand and upper limb rehabilitation, or paediatric) superseded the Postgraduate Diploma.

Elizabeth Williams, an experienced paediatric physiotherapist, participated in the increasingly important part ICT played in educational delivery. Steve Martin with his physiotherapy and ICT expertise contributed to producing multimedia promotional programmes. *Electro Alive* featured simulated electrotherapy equipment enabling students to practice on simulators before subjecting their peers to electrical stimulation or ultrasound.[65] Other ICT programmes supported clinical reasoning and assessment. Elizabeth Tully's *Kinemyo* combined anatomy, biomechanics and kinesiology.[66]

Martin took pleasure in blending computer programming with 'a clean slate to work out ways of doing things'.

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[64] Maria Zuluaga et al., *Sports Physiotherapy. Applied Science and Practice* (Edinburgh: Churchill Livingstone, 1995).
[65] Joan M McMeeken, Sara Carroll, and Stephen Martin, "Electro Alive," (School of Physiotherapy The University of Melbourne, 1998).
[66] Kinemyo: Understanding the Biomedical Principles and the Structure and Function of Muscle.

He recollected:

> When Henry was working with the 'Oarsome Foursome' ... we synchronised the video, the Amlab and the rowing machine to work out the stroke rate. ... The derivatives of that, acceleration and deceleration ... able to work out the timing without referring to the video ... nobody else was thinking about that sort of thing ... trying to synchronise the rubbery rulers - well before there was much going on with video analysis.[67]

Staff, available and responsive to students' needs, role-modelled the professional behaviours patients should expect from their physiotherapists, thus influencing identity development and embodying physiotherapy. We sought to embed our collegial approach to education for new staff through team teaching, clinical education seminars and visits to our designated Clinical Schools. Several experienced physiotherapists commenced as part-time tutors, remaining and increasing in seniority whilst completing doctoral degrees. These included Drs Margaret Sherburn, David Kelly, Guy Zito, Marilyn Webster, Associate Professors Louisa Remedios and Clare Delany and Professor Linda Denehy. As an example, Sherburn started teaching five years after graduating, maintained her expertise in anatomy and kinesiology, developed exercise especially for women and obtained our first PhD in women's health physiotherapy. Perhaps because she was already an excellent teacher, Sherburn appreciated the University's teaching and learning seminars, which introduced current ideas in pedagogy.[68] Her research too has changed clinical practice.[69]

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[67] Martin. University of Melbourne Physics Department developed rubbery rulers.

[68] Formal and informal feedback and national and international developments based on her teaching, Lois Woodward Award Royal Women's Hospital. Sherburn. Part-time academic, Head Physiotherapist, Royal Women's Hospital.

[69] Sherburn's papers include. "Pelvic Floor Muscle Training During Pregnancy Facilitates Labour," *Australian Journal of Physiotherapy* 50(2004); Helena C Frawley et al., "Reliability of Pelvic Floor Muscle Strength Assessment Using Different Test Positions and Tools," *Neurourology and urodynamics* 25(2006); Margaret Sherburn et al., "Incontinence Improves in

Our most challenging goal was developing physiotherapy research. Initially only Story had a doctorate, Carroll and I had research Masters degrees and had received competitive grant funding. My University grant equipped a movement laboratory and research initiatives began in conjunction with clinical physiotherapists at the RMH, Royal Children's, Austin, Alfred and Repatriation Hospitals. Initially my research naivety made us too ambitious. We asked undergraduate students to undertake single-case research. Carroll remembered sending examples to clinicians.

> One said, 'This was all poppy cock they didn't do any of this' and I remember thinking oh dear. ... I now know students a lot better ... I know all the shortcuts they'll try and take and ... if they can see a way of doing something without very much effort they will.[70]

Tully too remembered me suggesting she apply for a grant. She forwarded an application for hip measurement. 'Some ortho said "I don't care how you measure it I'm not going to change what I do". Typical of how the orthopods were'.[71] The lack of specific opportunities for physiotherapy research elsewhere was a key driver in our desire to embed physiotherapy at Melbourne. Committed to fulfilling the strong demand for postgraduate studies, in 1992, the MPhysio (by research) and PhD began. Each candidate had a Research Committee: initially Carroll, Story or myself: later Bennell and Galea with cosupervisors. Professor Robert Helme, for example, cosupervised several early PhDs, Keith Hill, Michael Farrell and Zhen Zheng. Our research candidates completed training in research methodology, literature review, research and grant proposal writing, research proposal defence and seminar presentation.[72] By 2010 all staff had doctorates. The rapid growth of

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Older Women after Intensive Pelvic Floor Muscle Training: An Assessor‐Blinded Randomized Controlled Trial," ibid.30(2011).

[70] Sara Carroll, Interview 23 May 2013.

[71] Tully.

[72] For example School of Physiotherapy, "Research Committee 19 May," (2005). This incorporated the School's Human Research Ethics Committee.

physiotherapy research has changed physiotherapists' identities into 'evidence-based' practitioners.[73]

However as we commenced the School, I considered it vital to maintain connections with the physiotherapists who had campaigned for Melbourne. In early 1992 we established the Friends of Physiotherapy to promote such links. Margaret Kraehe became the first chairman.[74] When our graduates emerged, the Friends became the University of Melbourne Physiotherapy Alumni Society (UMPAS) contributing to student mentoring and multicultural communication programmes. Some staff members addressed such challenges in research. Gillian Webb completed a Masters and Doctorate in Education focusing on clinical education. Louisa Remedios turned her PhD attention to communication and learning for students of non-English speaking backgrounds and Clare Delaney, completing postgraduate studies in law, researched physiotherapists' ethics.[75]

As Mostrom later demonstrated education's importance in identity formation, professional ethics played a pervasive component of education, integrated into all subjects and beginning from the first day.[76] Elements of ethics and professional behaviour are self-evident in treating survivors of torture, but such topics do not fit neatly into the key specialities: Seminars in Physiotherapy addressed them. Seminars provided an opportunity to invite inspirational speakers such as Tony Moore. In a car accident he sustained over twenty fractures and a ruptured lung and spent a week in Intensive Care, three months in RMH and nine months at Hampton Rehabilitation Hospital with intensive

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[73] Steven J Kamper et al., "15 Years of Tracking Physiotherapy Evidence on Pedro, Where Are We Now?," *British journal of sports medicine* (2015).
[74] Letter to Professor David Penington, 24 February 1992. Brochure for *Friends of Physiotherapy*.
[75] Gillian Webb, "Clinical Education in Physiotherapy : A Discursive Model" (2004); Louisa Remedios, "Experiences and Responses of Overseas-Educated Students to Problem-Based Learning and Its Classroom Culture in an Australian Physiotherapy Context," (2005); Clare Maree Delany, "Informed Consent: Ethical Theory, Legal Obligations and the Physiotherapy Clinical Encounter" (University of Melbourne, 2006).
[76] Elizabeth Mostrom, "Professionalism in Physical Therapy: A Reflection on Ways of Being in Physical Therapy Education," *Journal Physical Therapy Education* 18(2004).

physiotherapy facilitating his physical recovery. Ex-surgeon and now rehabilitation physician, Moore learned much about humanity, the importance of pain management, rest and accepting a changed life. Long-remembered, his story provided students with additional insights into their professional futures and patients' issues.[77] Seminars became the vehicle for the Faculty's first annual student-led conference.[78]

Students learned together. Glen recalled 'we had groups of people at my house studying during swot vac and reading research papers that weren't on the curriculum'.[79] Students lived by the maxim 'work hard, play hard'. They formed the Melbourne University Physiotherapy Society (MUPS) in 1991, organising activities, acting as student advocates and participating in each of the Discovery/Open Days for prospective students who eagerly sought them out for credible advice. The students formed cohesive cohorts.[80] Catherine, a MUPS President, represented students at Faculty and School meetings. MUPS presidents joined the APA National Student Group broadening their knowledge of the profession, gaining further exposure to leadership opportunities and reinforcing their physiotherapy identities.[81]

Students experienced their final undergraduate year as very full, longer than the traditional university year with theory blocks, twenty-eight clinical weeks and capstone assessments. Timetabling the students in clinics required juggling as third and fourth year students could not be accommodated together. Uyen Phan recognised: 'we were the envy of the other physiotherapy courses ... it did prepare us really well ... three clinics in third year and then seven clinics in the fourth ... so much time to really develop your skills'. He admitted though on graduating, 'I still was nervous and needed to learn more'.[82] Wanting graduates

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[77] Tony Moore, Cry of the Damaged Man (Sydney: Picador, 1991); Echoes of the Early Tides (Sydney: Harper Collins, 1994).
[78] Williams.
[79] Bilby.
[80] Kelly; Hinman; Phan.
[81] Granger.
[82] Phan.

to be exposed to job opportunities, towards the end of 1994 we inaugurated the 'Job Show', inviting final year La Trobe students, the APA and PRB to present, and potential employers to promote their opportunities.[83] It was a buyers' market for new graduates as we celebrated the first Graduation Ceremony for the BPhysio Pass and Honours degrees in December 1994. Julie Nitschke received our first PhD.[84] The new tradition of a celebratory lunch with awarding of prizes followed graduation (Figure 11.3). Graduates soon commenced working.

Figure 11.3 Freda Bolwell, Richard Ainley, dux BPhysio (Hons) 1998, Joan McMeeken.

Our graduates began their careers in the mid-1990s when the World Health Organisation estimated only ten per cent of the 450 million disabled people in developing nations received trained help.[85] In Australia despite one physiotherapist to 2500 people, physiotherapists were one of three employment groups in shortest supply.[86] Indonesia had less than 1000 physiotherapists for

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[83] Melbourne hosted the 'Job Show' for fifteen years, subsequently shared with other universities.
[84] Hugh Burry and I supervised Nitschke.
[85] Elizabeth Key, C Kilonzo, and MJ Harris, "Improving Rehabilitation Services in Developing Nations: The Proposed Role of the Physiotherapists," *Physiotherapy* 80(1994).
[86] Australia's workforce in the year 2001 (1991) Department of Employment Education and Training Australian Government Publishing Service, Canberra.

187.8 million people.[87] African ratios were worse still.[88] Inadequate transport, limited funds, poor awareness of services and conflicts compounded service delivery. International efforts focused on primary care, although failure to rehabilitate increased medical and custodial costs. We urged graduates to become highly motivated professional physiotherapists, prepared for leadership and participation in political persuasion and public action as their predecessors had demonstrated.[89] Furthermore, with the staff sharing the ethos of 'for those to whom much is given, much will be required', and our students generally from privileged backgrounds, we chose to develop *noblesse oblige*.[90]

We also sought to access public opinion by engaging the broader community in the School Expert Advisory Committee, which considered 'big picture' strategic and political issues and opportunities. Fiona McKinnon chaired the Committee and representatives from Workcare, the Transport Accident Commission, the APA and Department of Human Services participated.[91] Graduate Uyen Phan considered his membership a privilege as 'a young physio in this high-powered committee with really influential, motivated people'.[92] On this committee Uyen became part of community engagement a characteristic of the physiotherapy academics in patient advocacy groups and the APA. School staff and postgraduate students also provided physiotherapy at reduced rates for University students and staff in a clinic.[93] Located in the Sports Centre, fifteen years on their rental charges eventually made this initiative unviable.

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[87] John Hardjourno, 1993.
[88] Key, Kilonzo, and Harris, "Improving Rehabilitation Services in Developing Nations: The Proposed Role of the Physiotherapists."
[89] Joan M McMeeken, "Physiotherapy: Past Present and Future (Lessons from the Past)," in *National Physiotherapy Students Annual Symposium* (University of Melbourne1995). Including community organisations, advocacy, leadership, financial and practical support in specific disability groups, national and international volunteering.
[90] The mantra of Dr Harold Wood, Principal of my secondary school, the Methodist Ladies College. Thompson Zainu'ddin, *They Dreamt of a School a Centenary History of Methodist Ladies' College Kew 1882-1992*. 276-314. For example see K Bradley, *Poverty, Philanthropy and the State: Charities and the Working Classes in London, 1918–79.* (Manchester: Manchester University Press., 2009).
[91] School of Physiotherapy, "Expert Advisory Committee 27 November," (2002). Lake.
[92] Phan.
[93] Kelly.

Furthermore, several University people considered that physiotherapy would provide free services: from individual requests, to departments wanting the School to provide occupational health and safety advice. Whilst I contributed to the University's WorkCover Policy Advisory Committee, the Risk Management Committee and the Sport and Recreation Policy Committee, free physiotherapy was not an option. Perhaps the expectation that middle-class professional women viewed giving as its own reward was alive and well.

During the first decade the School instituted educational programmes to fulfil our aspirations. But these programmes developed in a constantly changing University environment. Penington made excellence in research, teaching and community service central at Melbourne.[94] By 1997 Penington and Ryan, crucial supporters of physiotherapy, had retired. Professor Alan Gilbert became Vice-Chancellor and Professor Gordon Clunie, Dean of our Faculty. Clunie brought postgraduate nursing into the Faculty and instigated an education review in the professional schools. Professor Richard Larkins implemented these educational changes when he became Dean from 1999 to 2003. Professor James Angus, pharmacologist, then became the first non-medical Dean of the Faculty. However the loss of medical dominance was brief.[95]

Gilbert's significant architectural legacy extended the university precinct around the School, whose offices ultimately moved into the 'Alan Gilbert' building. Nationwide in the late 1990s Australian universities simultaneously experienced reduced public funding, growth of educational ICT and increasing globalisation. Gilbert foresaw an international university, all students enjoying international experiences with more fee-paying students providing operational funds. Gilbert founded Universitas 21, a group of like-minded universities.[96] Bringing the Universitas 21 physiotherapy schools together enabled shared research, staff and student exchanges, study leave and postdoctoral

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[94] Penington. 281-283.
[95] Professor Stephen Smith appointed 2013-2015.
[96] "Universitas 21," http://www.universitas21.com/about. Accessed 25 February 2015.

fellowships.[97] Gilbert's agenda demanded physiotherapy recruit unrealistic numbers of fee-paying students as government funding decreased and Melbourne embarked on ambitious building projects.[98] Simultaneous pressures challenged the School: developing more extensive strategic and operational plans with goals, targets, strategies and 'key performance indicators', targets for international students, demands of a new curriculum, increased staff workloads and ironically, our cultural change towards more research leading to some staff members' desire to teach less.[99] Professor Kwong Lee Dow became Melbourne's Vice-Chancellor in 2004 until Professor Glynn Davis commencing in 2005 introduced his triple-helix of research, education and community engagement and the 'Melbourne Model' of graduate entry professional education.[100]

The chronicle of the School of Physiotherapy demonstrates it maintained its collegial identity and core initiatives through political, institutional and staff changes. Kate Lawler related neurological physiotherapist Reznick's influence on her future career. Reznick intuitively knew patients' therapeutic needs and was passionate about her work.[101] Her intuition reflected her own embodiment, which in skilled physiotherapists appears to include an intuitive understanding of the patient's body and the positioning and facilitation required by the physiotherapist. Perhaps this represents a Bourdieun physiotherapy 'habitus'

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[97] "Eva Nordmark," http://www.lunduniversity.lu.se/lucat/user/efa82882fcf84c3ecd9baa8a7d214bbf. Accessed 18 January 2014.

[98] Bob Bessant, A Climate of Fear': From Collegiality to Corporatisation in the Subversion of Australian Universities, (Woollongong: Fund for Intellectual Dissent, 2002), http://www.uow.edu.au/arts/sts/bmartin/dissent/documents/sau/. 77. Accessed 18 January 2014.

[99] Example School of Physiotherapy, "Operational Plan 1999," (1998). "Planning and Budgets Committee 12 August."

[100] Glyn Davis, "Mind the Gap: How Should We Fund Public Universities?," in *"Making the Boom Pay", a conference hosted by the Melbourne Institute and The Australian* (2006); "Esteem-Powered Learning," *Australian Universities' Review* 49(2007); Glyn Davis, Linda O'Brien, and Pat McLean, "Growing in Esteem: Positioning the University of Melbourne in the Global Knowledge Economy," in *The Tower and the Cloud*, ed. Richard N Katz (USA: Educause, 2008); Glyn Davis, *Willing to Try: The Introduction of the Melbourne Model* (University of Melbourne, 2010).

[101] Lawler.

analogous to Renee Fox's recognition of this in medicine.[102] When Reznick returned to Israel, Canadian Kim Miller joined the School. Miller, an experienced academic, stayed fifteen years, completing her PhD and patenting a new tool for measuring sensation, before returning home.[103] Dr Bev Phillips from the Australian Neuromuscular Research Institute in Western Australia, brought expertise in neuromuscular disorders and research methods. As Phillips arrived Carroll returned to Western Australia. We all missed her contributions. Gavin Walsh became ICT Manager as Story moved to Deakin University as did Lorri Cahill, School Manager after supporting our accreditation requirements. Kay Faunce replaced her.

Tully who enlivened the staff room as 'a fantastic story teller and good for a laugh at her expense', completed her PhD in 2002.[104] In 2001 Webb became Deputy Head then Education Coordinator and Head of the School in 2006/2007. Innovative educator Williams's Paediatric Educational Network ensured all students had paediatric clinical experience.[105] With her family home 250km from Melbourne, Williams moved to the Faculty's Centre for Rural Health. From our School's beginning every student experienced at least one rural clinical placement and Williams continued developing rural educational opportunities for health professionals and students, instituting the Rural Health Academic Network (Figure 11.4).[106]

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[102] Renee C Fox, *The Sociology of Medicine: A Participant Observer's View* (New Jersey: Prentice Hall, 1989).
[103] Miller, University of British Colombia http://emglab.rehab.med.ubc.ca/people/ Accessed 25 February 2015.
[104] Story. Elizabeth Ann Tully, "A New Model for Image Based Analysis of Hip, Knee and Thoracolumbar Spinal Movement in the Sagittal Plane" (University of Melbourne, 2002).
[105] Williams.
[106] Elizabeth Williams and Joan M McMeeken, "Relations and Rewards Are Key Strategies in Recruitment and Retention of Rural Physiotherapists," (Victoria: Department of Human Services, 2005); Elizabeth Williams, Wendy D'Amore, and Joan McMeeken, "Physiotherapy in Rural and Regional Australia," *Australian Journal of Rural Health* 15(2007); Elizabeth N Williams and Joan M McMeeken, "Building Capacity in the Rural Physiotherapy Workforce: A Paediatric Training Partnership," *Rural and remote health* 14, no. 2475 (2014).

Figure 11.4 Physiotherapy students at the Centre for Rural Health, Shepparton.

Student numbers grew with pressure to accept more local and international students. Students entered physiotherapy based on academic results, choosing physiotherapy, in Catherine's words, because they had been 'treated by a physiotherapist, often for sporting injuries and work experience/observation'. With very competitive entry she 'dedicated my high school studies to getting into Melbourne Uni ... It's the best choice I've ever made'.[107] For most it was first choice, for some it was second choice to medicine at Melbourne and several graduates subsequently completed medicine.

[107] Granger.

Jason Smith considered medicine, instead he

> landed where I was meant to be. ... Physiotherapy had the dual attraction of being incredibly stimulating ... hard work I loved learning about the body, - academically challenging, at every level ... but incredibly rewarding. ... Engaging. It was really like the cool version of medicine ... I felt like it was the right combination for me. ... Awesome.[108]

Students recognised the contributions of tutors David Kelly, Louisa Remedios, Marilyn Webster, Margaret Sherburn, Barry Stillman and Jon Ford then doing his PhD.[109] Uyen noted, 'from talking to him you learnt the importance of research'. [110] The clinical supervisors were influential too.

> One day in fourth year early on I was getting quite stressed working out, am I good enough and there was one supervisor ... we just had a tute ... he just broke it down making it really logical, simple things, made it no nonsense ... I knew where I was going and I felt more at ease from that time.[111]

Physiotherapy's small community appealed to many students: knowing everyone in a year level and many in other years. Echoing Uyen's recollections, Catherine 'enjoyed the physio (subjects) when you're doing pracs and tutes and things like that'.[112] She lived in a residential college. 'I enjoyed being part of the physio school more than college. ... So many things happening with MUPS and the entire social events and being involved with the APA'.[113] Students rapidly embodied a physiotherapy identity arguably influenced by the social world, the

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[108] Smith.
[109] These then tutors all earned their doctorates whilst teaching in the School.
[110] Phan.
[111] Ibid. Phan received the Austin Clinical School students' award for the best clinical educator for five years. Now Senior Clinician at Royal Melbourne Hospital.
[112] Granger.
[113] Ibid.

collegiality of physiotherapists and the preparedness of academic, clinical staff and the Association to embrace students within their small community.[114]

By 2000 physiotherapy, medicine and dentistry had introduced new selection requirements and hybrid problem based learning (PBL) programmes. Applicants undertook the Undergraduate Medicine and Health Sciences Admission Test (UMAT), designed to enhance selection of students appropriate for health practitioner careers. The UMAT caused considerable angst and public sanction when academically excellent applicants were rejected on the basis of UMAT results. Although medicine received most public criticism, physiotherapy also rejected some students.[115] We could not tell if the UMAT made a difference as we introduced PBL curricula simultaneously. 'Hybrid' signified lectures delivered on key principles and topics, but most academic work occurred collaboratively in small tutorial groups with initially a staff member facilitating. Students had increased responsibility for their learning, a strategy to encourage life-long learning - a professional strategy introduced by the AMassA in 1906. PBL suited self-driven physiotherapy students:

> PBLs were good fun. Everybody used to bring in breakfast food to share, it was a good environment and a tutor who would just facilitate ... very quiet really. Over the week you'd get a question or a case come up with learning outcomes, brainstorm the diagnoses. Liz Molloy and Pete Bragge were tutors doing their PhDs.[116]

Using a clinical problem in a structured manner across two weeks of PBL, tutorial groups were collectively responsible for determining what they needed to know to solve the problem, finding the resources and elaborating the solution and sharing their knowledge with their tutorial group (Figure 11.5).

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[114] Bryan S Turner, *The Body and Society*, vol. 24 (Oxford Univ Press, 1984) Lake.
[115] UMAT's multiple-choice tests assess logical reasoning, problem solving, critical thinking.
[116] Granger.

In preparation for PBL tutorial rooms required refurbishing: Walsh ensured their completion with square metres of white boarding, suitable furniture, a web-accessible computer and multimedia learning packages.[117] Tully and Webb attended a workshop on PBL and curriculum design in Atlanta, USA. Tully returned expecting clinician-developed clinical problems focusing on content whilst she conveyed difficult concepts and theory.[118] Bilby viewed Tully's applied anatomy and kinesiology superior to anatomy; she integrated biomechanics, muscle physiology and their clinical relevance. And she was 'great fun'.[119]

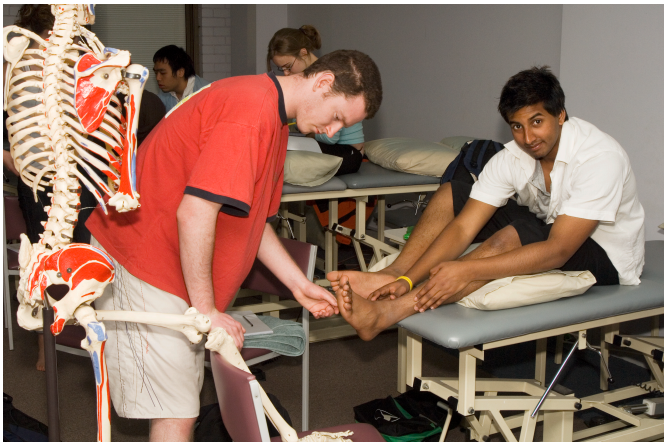

Figure 11.5 PBL tutorial session, (above), a practical class, (below).

[117] King, Walsh, and Taylor.
[118] Tully.
[119] Bilby.

Webb considered PBL a sound framework for clinical reasoning. The reiteration of process 'what information do you need to seek, why do you need to seek it. ... Using prior knowledge ... (having) faith that you will construct new knowledge'. Initially students received more facilitation but, 'they're better without a facilitator there in the end because they really challenge each other'.[120] Arguably the most difficult element of the new programme was restraining academic staff from providing answers or pontificating.[121] As clinical cases were always an integral part of our subjects, we asked clinicians if PBL affected the outcome. Clinical educators reported first year students already speaking the language of physiotherapy with greater awareness of physiotherapy practice. But some detailed academic knowledge suffered. PBL enhanced communication - a critical skill especially in Australia's multicultural environment. Most students adapted well to the communication challenges when they first entered their Clinical Schools with Webb providing strong support to clinical educators and students, recognised by the University's Inaugural Academic Cultural Diversity Award.[122] Louisa Remedios and Clare Delaney's research-based teaching made additional contributions and clinical educators and academic staff intermingled as clinicians and academics undertook research and completed higher degrees, taught students at undergraduate and postgraduate levels and communicated together.[123] The School and Clinical Schools were vibrant environments.

Melbourne's BPhysio received the first national seven-year accreditation in 2003. The Accreditation Report suggested reducing staff workloads and further

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[120] Webb.
[121] Stillman.
[122] Webb, "Clinical Education in Physiotherapy: A Discursive Model."
[123] Remedios, "Experiences and Responses of Overseas-Educated Students to Problem-Based Learning and Its Classroom Culture in an Australian Physiotherapy Context."; Delany, "Informed Consent: Ethical Theory, Legal Obligations and the Physiotherapy Clinical Encounter."

supporting research with strategic funds.[124] It noted that some biomedical sciences lecturers still taught as though the class only comprised medical students and 'forgot' physiotherapy and dental students. Multidisciplinary PBLs could be beneficial, as we had encouraged. However growing numbers of international physiotherapy students enriched multicultural learning. Staff too enjoyed international visits to present at conferences and provide courses. In addition to courses in Malaysia, Singapore, Indonesia, Thailand, Fiji and India, Zito's fluent Italian ensured annual courses in musculoskeletal physiotherapy in Italy.[125]

Sherburn coordinated the Postgraduate Certificate in Physiotherapy (Continence and Pelvic Floor Rehabilitation). First delivered in 1998, grounded in research, the Certificate is offered annually. Graduates have developed similar courses in the Netherlands, Canada, Norway, the Middle East and Western Australia. Students are limited to twenty-four by the availability of private cubicles for practical work.[126] This course exemplifies physiotherapy's embodied learning. Physiotherapists practise the necessary pelvic examinations on one another. They gift to each other practical knowledge and incorporate within themselves an understanding of the emotional and physical effects of the process, thus embodying both patient and professional experience. Perhaps no other health professionals are as deeply engaged in the intimate physical embodiment characteristic of physiotherapy.[127]

Numbers of local postgraduate students commencing specialist coursework MPhysio had fallen by 2000 - an Australia-wide trend. The University-demanded fees made recruitment difficult and unlike nursing and medicine, governments, still perceiving physiotherapy as less essential, did not support

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[124] Australian Council of Physiotherapy Regulating Authorities, "The University of Melbourne Bachelor of Physiotherapy Accreditation Report," (Canberra: Australian Council of Physiotherapy Regulating Authorities, 2003).
[125] Zito.
[126] Sherburn.
[127] Ibid.

fees or clinical places.[128] Nevertheless Uyen acknowledged, despite his MPhysio (Musculoskeletal) costing $14,000, with opportunity cost about $40,000, he regained costs through career advancement and job satisfaction.[129] Our clinical doctorate offered further specialisation but costs again limited applicants. A new Postgraduate Diploma began in 2001 attracted international physiotherapists seeking to migrate and gain Australian registration. Whilst being a significant challenge to academic and clinical staff, this assisted international colleagues to pass Australian examinations.[130]

Research grew exponentially: experienced physiotherapists became research candidates and many, like Inge-Lise Bygott the first MPhysio graduate, tutored during study years.[131] Bygott received the Sports Medicine Australia Young Investigator Award. (Professor) Kay Crossley, another recipient completed her PhD. Becoming enthused by research, Professor Crossley continued at Melbourne in physiotherapy and bioengineering for fifteen years.[132] Some graduates returned as PhD candidates, such as Ilana Ackerman, Peter Bragge and Liz Molloy. They completed PhDs, combining research careers with families.[133] Amongst some 100 research higher degree graduates are Professor Keith Hill, Professor of Physiotherapy at Curtin University and Professor Linda Denehy, head at Melbourne.[134] Associate Professor Stuart Warden graduated in 1997 completed his PhD and is Associate Dean for Research at Indiana University.[135] Professor Rana Hinman's favourite subjects included anatomy and the practical physiotherapy subjects. Ironically the subjects she

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[128] Faculty of Medicine Dentistry and Health Sciences, "Submission to the 2005 Planning Review," (2005).
[129] Phan.
[130] Tully and Kelly gave /give considerable long-term support to these graduates. Tully; Kelly.
[131] Inge-Lise J. Bygott, "Investigation of Gravity Correction in Electro-Mechanical Trunk Dynamometry" (1996).
[132] Kay Margaret Crossley, "Physiotherapy Treatment of Patellofemoral Pain" (2001).
[133] Ilana Naomi Ackerman, "The Pre-Operative Status of People Undergoing Primary Total Hip and Knee Replacement Surgery" (2006). Molloy, "Insights into the Formal Feedback Culture in Physiotherapy Clinical Education."
[134] Carroll was PhD co-supervisor for Tully, Denehy and Hill.
[135] Stuart James Warden, "The Skeletal Effects of Low-Intensity Pulsed Ultrasound" (2001).

disliked she now teaches: research methods and evidence based practice, focusing on graduates being consumers of research.[136]

Professors Mary Galea and Kim Bennell, active researchers, gained plaudits, prestigious grants and students. Participating in an international health care delegation to Vietnam, with Dr Chris Brooks, Director of Clinical Services in the Victorian Department of Health, I proposed the Department fund a chair in Clinical Physiotherapy. Galea occupied this first Australian chair, creating the Rehabilitation Sciences Research Centre.[137] The Department also funded Elizabeth Williams's position in Shepparton. Unfortunately further professorial proposals were unsuccessful. More satisfactorily we established the Centre for Health, Exercise and Sports Medicine (CHESM) led by Bennell.[138] Both centres necessitated significant funds to develop sophisticated human movement analysis laboratories, run by Dr Noel Lythgo and Tim Wrigley. CHESM offered Masters degrees in sports physiotherapy and sports medicine: the latter recognised by the Australasian College of Sports Physicians as sports physicians' postgraduate qualifications. Appointing Associate Professors Peter Brukner, Paul McCrory and Adam Bryant ensured CHESM's research multidisciplinarity. In 2013 CHESM had forty research higher degree candidates and ten staff employed on grant funds.[139] Professor Meg Morris, renowned for her research in Parkinson's disease, joined the school in 2006 for five years. Morris led a large clinical research team and contributed to the School's doctoral research. As I relinquished leadership, the School had four professors, three associate professors and two research centres. My professorial colleagues, Galea, Bennell and Morris were all internationally recognised as research leaders. In parallel with physiotherapy schools around Australia, physiotherapy had established the long-desired research to develop new

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[136] Hinman.
[137] Located at Austin Hospital. Mary Galea, Interview 3 November 2013.
[138] "Chesm," http://chesm.unimelb.edu.au. Accessed 25 February 2015.
[139] Hinman; Bennell.

knowledge and validate and inform physiotherapy practice. Physiotherapy now embodied a research culture.

One hundred years after Eliza McAuley began studying anatomy at Melbourne we held a *Centenary Conference* inviting speakers from Melbourne and La Trobe universities and our Clinical Schools. Beginning with Victoria's physiotherapy history, following speakers identified changed clinical practice through physiotherapy research. A historical display provided opportunities for reminiscing and a celebratory dinner attended by 100 physiotherapists, including Australasian Heads of Schools. Freda Bolwell, Patricia Cosh, Nan Main, Margaret Nayler, David Lawrence and Fiona McKinnon related their educational experiences. Melbourne graduate, UMPAS President Carl Byers was Master of Ceremonies.[140] Our annual Honoured Guest dinners celebrated key contributors to physiotherapy. The first, Margaret Kraehe, preceded many others including Basil Robinson, Betty Hooper and Beatrice Burke. Jennifer Lake regaled her pleasure at receiving this acknowledgement.[141]

How would the new graduates be celebrated? The undergraduate programme consistently rated in the top ten per cent of Australian university programmes in the national Course Experience Questionnaire.[142] Evaluation by graduates' employers provided more detailed information enabling programme refinement (Appendix 4). Despite their clinical education experience, new graduates could feel unprepared in terms of skill and confidence to take full responsibility, such as in intensive care units on weekends. A new graduate year in a supportive environment, effectively as an intern, and originally suggested by Marjorie Farnbach, is not mandated for physiotherapists. Whilst generally available in public hospitals from the 1940s to 1980s this enabled learning consolidation with increased responsibility under experienced guidance. Jason Smith and

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[140] Speaker programme Centenary Conference 13 March 1998.
[141] Lake.
[142] Graduate Careers Australia Course Experience Questionnaire overview http://www.graduatecareers.com.au/research/start/agsoverview/ctags/ceqo/ Accessed 3 October 2013.

others have formalised supportive internship in private practice to alleviate contemporary challenges for recent graduates and provide management skills we could not fit into the packed curriculum.[143]

Generic skills, however, particularly in communication and problem solving, enable physiotherapists to move into other careers, although a shortage of physiotherapists remains.[144] Public health systems include insufficient senior positions limiting career paths. A lack of respect, recognition and tangible rewards for the knowledge and skills of graduates can prevail.[145] Increasing competition from general medical practitioners to alternative therapists, make establishing and maintaining private practice challenging.[146] Jason Smith observes physiotherapy students as 'down to earth, fun-loving ... charisma, energy, passion and raw talent'. He perceives many physiotherapists need 'a sense of accomplishment, achievement and acknowledgement ... a sense of emotional connection' with more opportunity to express the breadth of their knowledge and skills.[147] Glenn Bilby also advocates new ideas being pursued with research, now that physiotherapists demonstrate research success with the most prestigious grants and fellowships 'that legitimises the profession'.[148]

As Foundation Head my goals included developing excellent physiotherapy education and research, fulfilling community needs and the personal aspirations of students and colleagues. The Faculty Deans consistently gave encouragement and support and importantly, autonomy to make the School decisions. Still until the second decade it was a Faculty leadership of exclusively medical men who often ignored my suggestions until one of them picked up the proposal. Nevertheless, participation in the planning and delivery

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[143] Smith. See also PhD graduate "Jon Ford," https://www.kalsi.com.au/consultant.php?id_consultant=1. Accessed 10 March 2015.
[144] Recent data still indicates "Skills Shortage," http://docs.employment.gov.au/node/30587. Accessed 23 January 2014.
[145] McMeeken and Phillips, "Drivers of Attrition from the Physiotherapy Workforce in Victoria. A Qualitative Research Project."
[146] Peter Duras, "Oral History Record," (1987); Kelly.
[147] Smith.
[148] Bilby.

of strategic Faculty activities was rewarding. A truly integrated Faculty giving all students a broader perspective beyond their own disciplines remained elusive.

A significant part of our physiotherapy education occurred in the clinical environment - forty weeks in Melbourne's B Physio. Without government support for clinical education, unlike medicine's funding for public facilities and general practitioners and nursing's practice educators, physiotherapy has relied on the gift of clinicians.[149] In the early 1990s I urged Heads of Physiotherapy Schools in Australia and New Zealand to bring the matter to political attention, triggering a succession of reviews by finance and accountancy firms considering the costs of clinical education. Influenced particularly by medicine, which feared redistribution of current funds, the reviews made no substantive decision.[150] Some of us participated in calculating the true costs of clinical education; others argued clinical education did not cost them. They expected clinicians to teach their students, not recognising that for ninety years clinicians had given their contribution to physiotherapy education. It was not the first time that national unity was disrupted, although a rarity in a supportive collegiate group. The Heads completed a national benchmarking exercise to drive us all to achieve best practice in physiotherapy education.[151] Now the Council of Physiotherapy Deans Australia and New Zealand perpetuates the aims of the Australasian pioneers.[152] And I sought assistance from Vice Chancellor Glynn Davis who actively supported physiotherapy's political lobbying for funding for clinical education.

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[149] Penington, *Making Waves*; .

[150] Peter Phelan, 1995. Firms included Coopers and Lybrand, KPMG, influenced by Coopers and Lybrand, "Unbundling the Costs & Benefits of Clinical Training a Report to the Ministry of Health," (New Zealand1993).

[151] Joy Higgs and Joan M McMeeken, "Benchmarking in Physiotherapy Education: A Collaborative Project," *Australian Journal of Physiotherapy* 43(1997); "Achieving Quality in Physiotherapy Programs through Benchmarking," *New Zealand Journal of Physiotherapy* 25(1997); "Peer Review and Development of Educational Programs through Benchmarking," *ANZAME Bulletin* 24(1997).

[152] McMeeken, "Competition or Cooperation." "Celebrating a Shared Past, Planning a Shared Future: Physiotherapy in Australia and New Zealand ".

> The original RFM (Relative Funding Model) classification for physiotherapy, ... failed to recognise the required clinical load. This has triggered a crisis for the discipline, with some institutions unable to afford the clinical placement necessary for graduates to receive accreditation. At a time of workforce shortage in physiotherapy, universities have been discouraged from seeking further Commonwealth-supported places by the financial penalty involved.[153]

Consulting over letters and tactics we contributed to the Productivity Commission's Australia's Health Workforce review advocating educational and workforce requirements for physiotherapy.[154] I sought funding for physiotherapy equivalent to that for science.[155] Editorials to physiotherapy journals emphasised funding needs for physiotherapy education.[156] Perhaps these activities contributed to the decisions of the Council of Australian Governments through Health Workforce Australia (HWA), to temporarily fund new programmes' clinical education, but not existing programmes.[157] Prior to HWA's closure in August 2014, they acknowledged the requirement for nationally consistent clinical education funding, but had not determined an appropriate pricing mechanism.[158] Jennifer Lake reflected that a concerted campaign by all APA members would have exerted much greater political pressure.[159] In contrast to medicine's feminisation, there is increasing masculinisation of physiotherapy, but we have yet to benefit as occurs in

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[153] Davis, "Mind the Gap: How Should We Fund Public Universities?."
[154] Productivity Commission, "Australia's Health Workforce, Research Report," (Canberra: Australian Government Productivity Commission, 2005); Joan M McMeeken, 14 August 2006.
[155] 5 July 2005; "Response to the Productivity Commission Study in Relation to the Health Workforce Study," (Productivity Commission website2005).
[156] "Funding for Clinical Education," *Physiotherapy in Motion*, no. June (2006); "Physiotherapy Education - What Are the Costs?," *Australian Journal of Physiotherapy* 54(2008).
[157] See "Clinical Training Funding," http://www.hwa.gov.au/work-programs/clinical-training-reform/clinical-training-funding. Accessed 20 January 2014.
[158] "Hwa Clinical Training Funding Programme," http://www.hwa.gov.au/our-work/build-capacity/clinical-training-funding-program. Accessed 26 February 2015.
[159] Lake.

professions where males predominate.[160] Whilst physiotherapy education continues on a shoestring budget, academics and clinicians strive to deliver a high quality education. Linda Denehy bemoaned 'HWA - a juggernaut wasting millions. You've got to be able to manage with what you've got'.[161] 'Making do' is embodied within physiotherapists.

If Australia requires registerable, practice-ready physiotherapists at graduation, Kate Lawler's perspective warrants attention. 'How grateful I was to get so much clinical time ... lucky to go through with six weeks plus four weeks and electives, paeds and gerries. Just needed the time ... I was always very grateful for that'.[162] Educational consistency is a further issue. Several universities offered entry-level Masters programmes for physiotherapy by 2000. Although arguing for uniform graduate professional entry in Australia, I did not succeed in obtaining universal support.[163]

In March 2006 I relinquished the headship of the School to Gillian Webb and formally retired from the University at the end of December 2007. Meg Morris became head in 2008. In the new Melbourne Model of graduate entry for professional programmes physiotherapy commenced an entry level Doctor of Physiotherapy programme in 2011 and the first graduation from this new programme was in December 2013. Professor Linda Denehey, in 2015 is responsible for physiotherapy.

From my perspective physiotherapy had already achieved many of the professional goals enunciated in Chapter 1 by the 1980s. Melbourne provided the School of Physiotherapy educational autonomy and fostered research. It

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[160] Deborah J Schofield and Susan L Fletcher, "The Physiotherapy Workforce Is Ageing, Becoming More Masculinised, and Is Working Longer Hours: A Demographic Study," *Australian Journal of Physiotherapy* 53(2007); Toni Schofield, "Gendered Organizational Dynamics the Elephant in the Room for Australian Allied Health Workforce Policy and Planning?," *Journal of Sociology* 45(2009); Willis, *Medical Dominance: The Division of Labour in Australian Health Care*.

[161] Denehy.

[162] Lawler. Students had six weeks in third year and four weeks in fourth year in each of musculoskeletal, cardiorespiratory and neurological physiotherapy.

[163] McMeeken, "Physiotherapy Entry Level Education in Australia." I preferred a graduate-entry Doctoral programme. Melbourne's D Physio began in 2011.

enabled us to contribute to the growth of physiotherapy's body of knowledge and the opportunity to realise an embodied professional physiotherapy identity in our students.

Chapter 12 Conclusion

> *A serious life, by definition, is a life one reflects on, a life one tries to make sense of and bear witness to.*[1]

In 1960 towards the end of my final year in secondary school I contemplated the next stage in my life. My school matriculation results opened a world of tertiary opportunities. I chose my mother's career, having seen her engagement and enjoyment of her work. Working as a physiotherapy assistant in summer vacations I appreciated the exchanges with patients and this world of work primarily at Fairfield Hospital under the firm, kindly and quiet leadership of Marjorie Farnbach. I would become a physiotherapist.

By 1989 when I marched with fellow physiotherapists in support of physiotherapy's campaign for educational autonomy and our biomedical science foundation I espoused a strong commitment to my profession. As a contributor to the sustained political campaign to secure physiotherapy education in the University of Melbourne, I had not contemplated leading the new School of Physiotherapy. After seventeen years in that role I now reflect on my years in physiotherapy and cannot overstate the privilege I feel at having been a participant-observer in this engaging, reflective, analytical and interpretive journey. Although there remain many more stories to be told, I trust that this work will contribute to the story of physiotherapy. As I analysed the data and wrote I recognised there that more could be investigated and said, as such processes 'are always ongoing, emergent, unpredictable and unfinished'.[4]

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[1] Vivian Gornick, *The Situation and the Story: The Art of Personal Narrative* (New York Farrar, Straus, and Giroux, 2002). 91.

[4] Norman K Denzin and Yvonna S Lincoln, *The Sage Handbook of Qualitative Research*, 4th ed. (Thousand Oaks California: Sage Publications Inc, 2011). 563. David L Altheide and John M Johnson, "Reflections on Interpretive Adequacy in Qualitative Research," in *The Sage Handbook of Qualitative Research*, ed. Norman K Denzin and Yvonna S Lincoln (Thousand Oaks California: Sage Publications Inc, 2011). 581-582.

In fulfilling my objective, this narrative history provides the first detailed account of important local events in the development of physiotherapy: the third largest clinical discipline in healthcare.[5] In addition to addressing the theoretical aspects of, in particular, professionalisation, embodiment and identity, the history has further considerd elements of gender and the gift. In this conlusion I refer in addition to how these questions are being addressed by scholars in congruent professions. In briefly surveying physical education and chiropractic, I allude to furthr health care professions. Researchers in these disciplines have all been profoundly influenced by the theorists discussed in this thesis.

In considering the theoretical frameworks of professionalisation, embodiment identity and gender, I have identified the roles of individuals and organisations in physiotherapy's professional, educational and institutional journey through engaging with the archive, with the texts of meeting minutes, ephemeral scraps, photographs, the APA oral histories and people. I enjoyed detailed conversations with physiotherapists. As part of the process I reflected on my privileged position in this research as a physiotherapy student, a clinical physiotherapist and an academic in physiotherapy education. In analysing the development of physiotherapy education and physiotherapists, it became clear that education profoundly influenced the professionalisation process, the development of professional identities and embodiment as women and men became physiotherapists.

The history also demonstrates the relationship that evolved between physiotherapists and their medical colleagues who physiotherapy emulated in its own professionalisation project. The voluminous historiography of medical professionalisation can be accessed in John Burnham’s detailed work. Burnham wrote that nineteenth century writers perceived themselves as

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[5] Anders Ottosson, "One History or Many Herstories? Gender Politics and the History of Physiotherapy's Origins in the Nineteenth and Early Twentieth Century," *Women's History Review* (2015).

reformers trying 'to improve the status of scientific medicine and the practitioners who embodied it'.[6] This had the effect by the mid nineteenth century, of protecting the well-educated orthodox practitioners in a strategy of exclusion.[7] An occupational hierarchy and medical regulation established education requirements. As the new century began local and national medical history narratives appeared. Through the twentieth century sociologists became intensely interested in medicine. At the turn of the new millennium Burnham perceived that social forces limited the position of medicine.

Medical historians and sociologists had theorised medicine's social history from many aspects. Despite referring to postmodern, poststructuralist (influenced by Foucault), and 'the literary turn', Burnham wrote 'it is striking that when new historiographical trends came along, they extended but did not particularly change the usual concept of profession' which he based on the extended work of Freidson.[8] The four decades of Freidson's theoretical work concentrated on medicine and as I further discuss below, I have employed his theoretical lens of the 'ideal' to analyse the professionalisation of physiotherapy in Victoria.

An understanding of the context of local physiotherapy professionalisation is garnered from a brief review of the medical profession in Tony Pensabene's historical narrative. A poor reputation prevailed until the beginning of the twentieth century, when advances in medical science, changed community perceptions, a growth in demand for medical services, increasing specialisation, and the emergence of the BMA as a powerful medical union. Medical education increased from three to five years and medical associations protected and promoted members' interests. Political connections, the

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[6] John C Burnham, "How the Idea of Profession Changed the Writing of Medical History," *Medical History Supplement* 18(1998). 25.
[7] Roy Porter, *Quacks Fakers and Charlatans in English Medicine* (Stroud, Gloucestershire: Tempus, 2001); "The Historiography of Medicine in the United Kingdom," in *Locating Medical History: The Stories and Their Meanings*, ed. F.; Warner Huisman, J. (Baltimore, London: Johns Hopkins University Press, 2004).
[8] Burnham, "How the Idea of Profession Changed the Writing of Medical History." 182.

associations and registration achieved occupational closure. The high professional status and power of the medical profession were firmly established by 1930.[9]

Physiotherapy aligned itself with medicine from its shared biomedical sciences foundation to its professional aspirations. Medical practitioners referred patients and acted as patrons, colleagues and sometimes as rivals. Nurses also worked under medicine's direction and successfully sought registration. But they differed significantly from physiotherapy with their large numbers and increasingly secure public employment. Once nurses' education moved from hospitals to tertiary institutes in the 1970s, eventually moving from diplomas to three-year degrees in the 1980s and universities by 1990s Then Australian nursing research accelerated. Nurses sought to identify their philosophical perspectives elaborating a rhetoric of care. They frequently chose sociological theorisation and qualitative research approaches with gender a common topic.[10] In considering the research questions outside physiotherapy I will concentrate on the groups of scholars those addressing physical education and chiropractic as I consider them most directly comparable with physiotherapy.

The thesis is framed by the contemporary debates in historiography and in particular informed by the perspective of Evans, Cronon, Munslow and Leavitt that there is no single historical reality yet a narrative history can provide an interpretation of the past. History is written from the perspective of the historian in a complex relationship with her past, just as events and experiences are interpreted from the perspectives of those involved. As a participant-observer, throughout this narrative I have been conscious of subjectivity, self-reflexivity, emotionality and the complexities of dialogue.[11] I have been

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[9] Tony S Pensabene, *The Rise of the Medical Practitioner in Victoria* (Canberra: Australian National University Press, 1980). 159.
[10] As an example see *Nursing Inquiry*.
[11] Carolyn Ellis, Tony E Adams, and Arthur P Bochner, "Autoethnograpy: An Overview," *Historical Social Research* 36(2011).

committed to the 'autobiographical pact' to write truthfully.[12] A collection of oral histories, further recent conversations and the textual and photographic archive supported by my archive and memories enabled crystallisation of my ideas through a reflective and iterative consideration of all the data.

The qualitative methodology encompassed a bricolage of descriptive narrative including biography and autobiography, phenomenology, grounded theory and participatory, cooperative and interpretive inquiry as elaborated in Chapter 1. Such diversity of approaches is appropriate to accommodate a time period greater than a century. Phenomenology addressed the breadth of experiences, whilst its methodological offspring, grounded theory, enabled saturation of data. Participatory, cooperative and interpretive inquiry encapsulated the former and respected practical knowing, which is of particular importance to understanding the theoretical constructs of embodiment.[13]

I demonstrate that the physiotherapists who began their association and a formal education programme had started on a pathway to ultimately embrace Eliot Freidson's theoretical perspective of the 'ideal' professionals as did include physical education and chiropractic.[14] Martha Verbrugge's historical narrative of physical education's North American journey contains many similarities to that of Victoria's physiotherapists.

Both disciplines emerged from Ling's RCBI.[15] Women physical educationists in the USA with additional training, became the rehabilitation aides of WW1, and later become physiotherapists as Linker has demonstrated.[16] Whilst the

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[12] Philippe Lejeune, "The Genetic Study of Autobiographical Texts," *Biography* 14, no. 1 (1991). See also Mary Jo Maynes, Jennifer L Pierce, and Barbara Laslett, *Telling Stories: The Use of Personal Narratives in the Social Sciences and History* (Ithica: Cornell University Press, 2012).

[13] John Heron and Peter Reason, "A Participatory Inquiry Paradigm," *Qualitative inquiry* 3(1997).

[14] Eliot Freidson, *Professionalism: The Third Logic* (Cambridge: Polity Press, 2001).

[15] Martha H Verbrugge, "Recreating the Body: Women's Physical Education and the Science of Sex Differences in America, 1900-1940," *Bulletin of the History of Medicine* 71, no. 2 (1997).

[16] Beth Linker, "The Business of Ethics: Gender, Medicine, and the Professional Codification of the American Physiotherapy Association, 1918-1935," *Journal of the History of Medicine*

men and women in AMassA adopted their first ethical principles in 1906, their struggles for respect and recognition were mirrored in the USA. In 1935 the predominantly female American physiotherapists firmly aligned their professional aspirations with the American Medical Association, appointed medical men to their advisory board and defined themselves as part of the medical establishment. Linker interpreted professionalism as that of Flexner's concept of a physician, and physiotherapists would work 'in conjunction with' their medical colleagues. They adopted the masculinised rhetoric of medical professionalism, reflecting this approach in their increasingly objective reports in the members' journal.[17] Physiotherapists' professional image too, unlike other women such as nurses working in health, challenged perceptions of women as nurturers. Their professional identity comprised athleticism and physical strength.[18]

The women that continued as physical educators Verbrugge considered through the theoretical lenses of accommodationism and radicalism. She determined they sought both equality with men and autonomy of decision-making and action, agreeing with Linker that few women of the time projected such contradictory ideas.[19] Both researchers focussed on the women. Melbourne's physiotherapists were both men and women and they too adopted a perspective of professionalism in the prevailing male view early in the twentieth century. Their embodied learning and practical experience constructed a distinctive physiotherapy identity, although this was often incorrectly perceived as all female.

Physiotherapy men were amongst Melbourne's graduates. The closest comparison is the professionalisation process and embodiment of

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and Allied Sciences 60(2005); "Strength and Science: Gender, Physiotherapy, and Medicine in Early-Twentieth-Century America," *Journal of Women's History* 17(2005).

[17] "The Business of Ethics: Gender, Medicine, and the Professional Codification of the American Physiotherapy Association, 1918-1935."

[18] "Strength and Science: Gender, Physiotherapy, and Medicine in Early-Twentieth-Century America."

[19] Verbrugge, "Recreating the Body: Women's Physical Education and the Science of Sex Differences in America, 1900-1940."

predominantly male chiropractors. Ann Cobb wrote a narrative history of chiropractic in the USA with its first state licensing in Kansas in 1913. Citing Freidson, she considered chiropractic a consulting profession, eventually licence-controlled throughout the USA states and in receipt of third party payments including from Federal Medicare. Chiropractic professionalism emphasised traits and functionalist perspectives.[20] Although Freidson did not acknowledge chiropractic as part of medical work, nevertheless chiropractic became increasingly legitimised by public and political support.[21] In describing the professionalisation of chiropractic in Canada, David Coburn and Lesley Biggs employed Freidson's theory of occupational dominance.[22] As Willis had argued medicine subordinated, excluded or limited rivals such as chiropractic but did not eliminate them.[23]

Researchers considering comparable disciplines to physiotherapy have employed historical narrative with sociological theory to consider a professions' development. In considering the development of physiotherapists as individuals, professionalisation is intricately bound up with their embodiment and divorcing the two in narrative is problematic. Successive educational programmes however, provide a frame for reconsidering my analytical research objectives.

The frame comprises three time periods related to the qualification. The first is from 1906 to 1932 when a two-year diploma was offered, the second from 1933 until 1976 with a three-year diploma and the third from 1966 to 2010 when a four-year bachelor degree provided the initial physiotherapy qualification. The analytical theories are those of professionalisation and

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[20] Ann Kuckelman Cobb, "Part One: Pluralistic Legitimation of an Alternative Therapy System: The Case of Chiropractic," *Medical anthropology* 1, no. 4 (1977).
[21] Eliot Freidson, *Profession of Medicine* (New York: Dodd Mead, 1970).
[22] David Coburn and C Lesley Biggs, "Limits to Medical Dominance: The Case of Chiropractic," *Social Science & Medicine* 22, no. 10 (1986); Freidson, *Profession of Medicine*; *Professional Dominance: The Social Structure of Medical Care* (Transaction Publishers, 1970).
[23] Evan Willis, *Medical Dominance: The Division of Labour in Australian Health Care*, Studies in Society (Sydney: Allen & Unwin, 1989).

embodiment/identity with some additional reflections on the influence of gender and the enduring strength of the clinical gift.

When physiotherapy began its educational journey in Australia the concept of professionalism included offering honorary service to the charity hospitals, attaining privileged knowledge and skills, and exclusionary regulation.[24] By forming the AMassA and commencing a two-year full time educational programme in conjunction with the University members began achieving these aims. Initial successes gave the practitioners status in Victoria's society, enhancing that already attained as honorary practitioners. Here as in education they emulated their medical colleagues. However the diversity of physiotherapy teachers' educational backgrounds introduced a specific physiotherapy applied science epistemology, beginning with theoretically informed Swedish remedial gymnastics, electrotherapy and Eliza McAuley's dissection-related applied anatomy. By the 1920s, learning would be informed by physiotherapy graduate Margaret Hutchinson's physiology teaching. This specialist knowledge, which would continue growing over the century, is recognised as an important component of professionalisation by theorists such as Parsons and Freidson. In addition they had achieved some control over the physiotherapy components of education including the application of biomedical sciences.

Reflecting the importance of Bourdieu's habitus and Merleau-Pony's experiential learning students incorporated their theoretical knowledge as they developed their clinical techniques by practising their skills on one another. Such hands-on learning provided unique sensory opportunities to learn about their bodies/themselves whilst learning about others' bodies. With their new knowledge and practical experiences students began embodying a distinctive physiotherapy identity, which blurred the distinctions between mind and body. No other health practitioners learned in this unique manner. Clinical practice,

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[24] Eliot Freidson, "The Changing Nature of Professional Control," *Annual Review of Sociology* 10(1984). Citing Herbert Spencer, *Principles of Sociology*, vol. 3 (New York: Appleton, 1896).

the other major physiotherapy educational accomplishment occurred in the University's teaching hospital: the same location for medical students.

Medicine was recognised as the professional model for aspirational occupations and in attempting physiotherapy's professionalisation benefitted from medical patronage and close clinical associations. Medicine though swiftly exerted its power over the AMassA whose initial code of conduct required all patients to be medically referred and ensured advertising was discreet. The new physiotherapy practitioners remained relatively unknown, being initially ignored in the medical and nursing plans for WW1. It was public agitation and recognition of their value, in addition to political entreaties by the AMassA and the more socially connected practitioners such as Alfred Peters that ensured physiotherapy's contribution to the rehabilitation of the war wounded. Physiotherapy's achievements and setbacks characterise progression towards professionalisation.[25] At this stage Freidson's analytical lens characterised physiotherapists as somewhere between technician and professional.[26]

The war delayed consideration of the significant professionalisation aim of state licensure through registration. Although implemented in 1923, physiotherapy was again thwarted by medical practitioners having the right to practise physiotherapy despite being unaware of the detail of physiotherapy knowledge. Medicine retained its dominant position on the MRB for fifty years. The registration Act however gave the board licence to prosecute and exclude untrained practitioners granting, with medicine's exception, the occupational closure Freidson, Johnson and others agreed was a component of professionalisation.[27] As the MRB became responsible for physiotherapy education, the University relationship continued. Persistent attempts to gain

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[25] Terence James Johnson, *Professions and Power* (London: Macmillan, 1972).
[26] Freidson, *Professionalism: The Third Logic*. 90-93.
[27] Terry Johnson, "Governmentality and the Institutionalization of Expertise," in *Health Professions and the State in Europe*, ed. Terry Johnson, G V Larkin, and Mike Saks (London: Rooutledge, 1995). Freidson, *Professionalism: The Third Logic*.

full university control and status for physiotherapy education, a key professionalisation agenda, were unsuccessful perhaps because medical faculty sought to marginalise physiotherapy. Medicine's power in Australia had been wielded largely through political influence.[28] Furthermore as Freidson proposed, power also depended on dominance over other health occupations such as the physiotherapists.[29]

The second educational period commenced during the most financially difficult times, of the depression in the early 1930s. Aligning with Freidson's view of increasing specialisation the physiotherapy-specific knowledge and skill requirements increased, such that the diploma was extended to three years full time. The three-year diploma would remain the education qualification for physiotherapy until 1976. As polio epidemics ravaged Victoria the major additional specialist physiotherapy knowledge included the theory and practise of muscle assessment, re-education and splinting. Contemporaneously, physiotherapy's biomedical view was changing to recognise some aspects of psychological, cultural and sociological components of health. Ideological models of health, illness and rehabilitation were differing from that of medicine, thus furthering independence and professionalisation.[30]

Medicine's wartime expansion in for example burns, orthopaedic and thoracic conditions also expanded physiotherapists' interventions and opportunities. Their specialist epistemology led to increasing autonomy in clinical decisions, although still dependent on medical referrals. Reliance on physiotherapy treatment for a wide range of acute and chronic conditions meant referral was frequently tokenistic. Physiotherapists working with servicemen and polio sufferers embodied the additional professional attributes within Shilling's conception of their 'body schema' and projected a more confident professional

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[28] Evan Willis, "Introduction: Taking Stock of Medical Dominance," *Health Sociology Review* 15, no. 5 (2006).
[29] Freidson, *Profession of Medicine*; *Professional Dominance: The Social Structure of Medical Care*.
[30] John A Øvretveit, "Medical Dominance and the Development of Professional Autonomy in Physiotherapy," *Sociology of Health & Illness* 7(1985).

identity.[31] Furthermore, as Rose indicted they reflected their care through empowerment, enabling and meeting their patients' needs.[32] The additional knowledge, skills and identity characteristics were translated into education's academic and clinical programme and presented through cultural role modelling by the educators.

By the mid 1960s education consolidated, competition for entry increased and entry requirements and standards were similar to medicine. Physiotherapy achieved the status of being within a highly desirable, culturally appropriate Bourdieusian field. Whilst remaining connected to the University for biomedical science teaching, a School of Physiotherapy with strong female leadership was established independent of the MRB and within the tertiary system. Capable women, many with wartime experience also reigned in hospital physiotherapy departments. The site of clinical education, students embodied Polanyi's concept of tacit knowledge of physiotherapy values and behaviours through observation and role modelling and absorbing the transmission of the gift of clinical teaching.[33]

Tacit and formal learning occurred as social sciences, formally introduced into education, explicated psychology and sociology. However the beginning physiotherapy researchers predominantly sought their biomedical science colleagues as supervisors in positivistic, quantitative research. Academic nurses chose sociologists, establishing patterns that would persist for several decades. Nursing, almost exclusively female, joined LIHS in the 1970s where its three-year diploma became then remained a three-year degree.

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[31] Chris Shilling, *The Body and Social Theory* (London: Sage, 2012). 233-241.
[32] Nicholas J Fox, *Beyond Health Postmodernism and Embodiment* (London: Free Association Books, 1999).
[33] Ingrid Lindquist et al., "Physiotherapy Students' Professional Identity on the Edge of Working Life," *Medical teacher* 28(2006); Michael Polanyi, *The Tacit Dimension* (Chicago: University of Chicago Press, 2011); Marcel Mauss, *The Gift: Forms and Functions of Exchange in Archaic Societies*, trans. Ian Cunnison (Mansfield Centre CT: Martino Publishing, 1925 trans 1954).

This period has been termed the 'golden age' of medical dominance due to state support and patronage. Health matters resided in the hands of a relatively small and homogenous group of upper middle class white men.[34] Physiotherapists benefitted too from being in very high demand from the late 1930s onwards with little competition from other practitioners. The APA had further elaborated codes of conduct and ethical standards. These reflected more than a professionalisation strategy, it included professionals' important role in maintaining trust in society. Educational socialisation into an appropriate moral code fostered adherence to appropriate conduct.[35] Freidson's 'ideal' professional behaves ethically whilst deciding and implementing the most appropriate skills.[36] As the expectations of physiotherapists' professional role in society became more clearly enunciated, physiotherapy continued as a career for both men and women. The gender distribution generally saw men opting for the more lucrative private practice. However the physiotherapy requirements for polio and wartime reinforced an expectation of married women physiotherapists of all economic situations working, contrasting with many of their contemporaries.

Could phyiotherapy then be compared with other disciplines? Amitai Etzioni viewed teachers, nurses and social workers examples of the female semi-professions with shorter education, a smaller body of knowledge, less legitimated status and power, and work control than 'true' male professions. Etzioni gendered the professions perceiving women amenable to administrative control and less conscious of status.[37] Armstrong indicated that physiotherapy

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[34] Willis, "Introduction: Taking Stock of Medical Dominance."
[35] Robert Dingwall and Paul Fenn, ""A Respectable Profession"? Sociological and Economic Perspectives on the Regulation of Professional Services," *International review of law and economics* 7(1987).
[36] Freidson, *Professionalism: The Third Logic*.
[37] Amitai Etzioni, *The Semi-Professions and Their Organization* (New York: Free Press, 1969).

in Britain was categorised in this way when medicine had more direct control of physiotherapist's work.[38]

Then a physiotherapist working in Britain I consider this perspective reflected an 'outsider' view. Blanket referral of patients occurred in my workplaces, physiotherapists used their professional judgement on which patients to treat and how to treat them. Medical dominance related to managerial status. Julius Sim argued that physiotherapists' work fitted between the archetypical male medical practitioner who cures and the female nurse who cares. He viewed physiotherapy an occupational niche combining rigorous science with a humanistic orientation.[39] I argue that this occupational niche also reflected an unusual gender distribution that was increasingly male in the next period.

By the third education period Patricia Cosh had revitalised physiotherapy teaching, established the School and influenced the APA and the registration Board. Physiotherapists became presidents of the Registration Board, the State branch and the Federal APA, further advancing towards Freidson's 'ideal'. Cosh instituted the four-year degree and the time was ripe for Elizabeth Fussell to initiate the drive for clinical autonomy. As physiotherapy formally rescinded the ethic requiring medical referral, relationships with medical colleagues remained remarkably congenial. The world body for physiotherapy the WCPT initially reacted with consternation, but the Australians initiated a worldwide change in physiotherapy and a further fulfilment of the 'ideal'.[40] In this third education phase however, the relationships within LIHS gradually changed.

Physiotherapy continued to be aspirational and several of us had commenced physiotherapy-relevant research. Under growing managerial control we were increasingly frustrated in educational advancements, particularly in developing

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[38] David Armstrong, "Medicine as a Profession: Times of Change," *British Medical Journal* 301(1990).
[39] Julius Sim, "Physiotherapy: A Professional Profile," *Physiotherapy Theory and Practice* 1(1985).
[40] Øvretveit, "Medical Dominance and the Development of Professional Autonomy in Physiotherapy."; W P Wong, "Historical Development of Physiotherapy in Singapore," *Physiotherapy Singapore* 11(2008).

research and further postgraduate studies, and maintaining physiotherapy's profile. By the time LIHS proposed amalgamation of the Institute with La Trobe University, physiotherapists demonstrated a sustained political will to return, now fully incorporated to the University of Melbourne.

Previous political activities of physiotherapy had rarely reached the press. Its actions during the Kenny controversy and the issues regarding chiropractic registration had been hidden behind medicine. The Campaign brought physiotherapy to the forefront and its legacy and further APA activism contributed to a more sustained influential political voice. On a personal level our activism and my later position probably contributed to my participation on government committees, hospital boards and in accreditation bodies. Other colleagues contributed in similar ways and we have been able to foster continuing engagement for younger colleagues. Theorists including Freidson, Johnson and others had reflected the importance of political astuteness and connections in the development of professional organisation and individual professionals.

Over the historical period reflected in this thesis, I have considered how physiotherapists perceived themselves and embodied a physiotherapy identity. Physiotherapists participating in the conversations recognised they possess privileged scientific knowledge about the body and share the legacy of the embodied physicality and of physiotherapy. Education provided, in a measure greater and quite different to medicine, an applied epistemology and the shared sensual understanding of human bodies in their Bourdieusian 'field'.[41] The embodiment of physiotherapists I attest contributed to engendering a strong sense of camaraderie and collegiality that may contribute to their enthusiasm for continued learning and their participation in the gift obligations as initially identified by Mauss.[42] As students throughout the century they received the gift

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[41] Linker, "Strength and Science: Gender, Physiotherapy, and Medicine in Early-Twentieth-Century America."
[42] Mauss, *The Gift: Forms and Functions of Exchange in Archaic Societies*.

of the bodies of the dead, the licence to learn on one another, from their educators and patients. The gifts of knowledge and experience have been handed on with a sense of obligation and responsibility to the next generation.[43]

The professional physiotherapy identity embodies much of the early physiotherapists in its continuing integration of intellect, emotion and physicality, in its academic and clinical learning and ongoing postgraduate education. For a century physiotherapists came from an educationally and culturally privileged, largely middle-class habitus that Bourdieu may have recognised. Through education in the biomedical and social sciences and clinical experience with patients, Polanyi's tacit knowledge becomes embodied in parallel with the more explicit physicality of hands-on practice with one another through Merleau-Ponty's 'world of perception'.[44] Graduate physiotherapists recognise much remains to learn, continuing in the process Shilling describes as 'becoming'.[45]

In the twenty first century physiotherapy's professionalisation project, according to Freidson's criteria, is also incomplete. Freidson's model has been amenable to a narrative history and enables the use of multiple sources of data, however whilst a useful tool for the consideration of professionalisation over a long period, does not include the influence of the public, the patients or the other members of the growing number of health care providers. Today's graduate physiotherapists, about sixty per cent as private practitioners and the

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[43] For example as expressed by Matheson, "The Keith Murdoch Sound Archive." Rothstadt (Cohn), Ibid; Joan Gabb, Merle Gibson, and Jean Wilcox, Interview 26 March 2013; Kate Lawler, Interview 13 August 2013; Uyen Phan, Interview 4 June 2013; Jason Smith, Interview 11 July 2013. Rana Hinman, Interview 2 July 2013; Smith; Beatrice E Burke, "Oral History Record," (1990).

[44] Michael Polanyi, *The Tacit Dimension* (New York: Ancor, 1967). Maurice Merleau-Ponty, *The World of Perception*, trans. O Davis (London and New York: Routledge, 2004 original 1948). 39. *The Visible and the Invisible*, trans. Alphonso Lingis (Evanston, Illinois: Northwestern University Press, 1969). Erving Goffman, *The Presentation of Self in Everyday Life* (London: Allen Lane, 1969). Merleau-Ponty, *The World of Perception*. 39. Also *The Visible and the Invisible*. Goffman, *The Presentation of Self in Everyday Life*.

[45] Sara Carroll and Joan M McMeeken, "Establishing the Value of Rural Clinical Placements During Undergraduate Allied Health Education," (Melbourne: Coordinating unit for rural health education in Victoria, 2000); Shilling, *The Body and Social Theory*.

remainder in public facilities, work in a health environment amongst a plethora of diverse practitioners, including those from alternative health care. As Armstrong has indicated, contemporary access to the Internet, increased information regarding health issues and strong advocacy groups provide the potential for increased 'consumer' control of health, shifting indeterminacy back at least part, in favour of the patient and influencing health professional and government decisions and actions. Health care professions are employing a revised rhetoric promoting quality, safety, expertise and a public orientation in order to persuade governments that they are worthy of continuing 'exclusive occupational roles'.[46]

The exclusivity of roles is also shifting with occupational borders increasingly permeable. Continuing demand has meant physiotherapists have relinquished some previous roles enabling other groups to enter what was traditionally physiotherapy territory. Local boundary skirmishes sometimes occur.[47] As Armstrong, Willis and others have elaborated, more recently challenges have arisen through neoliberal governmental approaches that arguably are deprofessionalising. Many occupations that enjoyed professional status are facing severe criticism, investigation, and potentially deprofessionalisation. This has contributed to the professions relationship with society deteriorating, fuelled by the media and the revelations of professional misdeeds. In Britain, the USA and Australia, neo-liberal governments have undermined the capacity of professional organisations to govern themselves and have increased requirements for compliance and audit.[48] Neo-liberalism has challenged health

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[46] Sharon C Bolton, Daniel Muzio, and Carol Boyd-Quinn, "Making Sense of Modern Medical Careers: The Case of the Uk's National Health Service," *Sociology* 45(2011). Stephen Pattison and Roisin Pill, *Values in Professional Practice: Lessons for Health, Social Care, and Other Professionals* (Oxford: Radcliffe Medical Press, 2004).

[47] An ongoing element of boundary issues in professionalisation, rarely researched, occurs between physiotherapy and occupational therapy, podiatrists, exercise physiologists and others.

[48] Armstrong, "Medicine as a Profession: Times of Change."; "Professionalism, Indeterminacy and the Ebm Project," *BioSocieties* 2(2007). Willis, "Introduction: Taking Stock of Medical Dominance."

professionals' status and autonomy.[49] Thus professional identities, boundaries and professional organisations have been under pressure.[50] The dynamic process of professionalisation including for physiotherapists, continues.

In this concluding chapter I have summarised and reflected on my findings of physiotherapy's journey of professionalisation and the development of professional identities through embodiment of physiotherapy.

The history of physiotherapy reflects a dynamic profession and future historians and sociologists will have much to ponder and write about with an increasing porosity of occupational borders aligned with pressure for interprofessional education and clinical teamwork. The healing power of physiotherapy touch remains to be explored.[51] This thesis has not undertaken a desirable in-depth critical analysis of gender. Gender ratios in the student population fluctuated, but at the University of Melbourne from 1991 the gender ratio reflected that of the wider university with up to fifty per cent male. As masculinisation of the physiotherapy profession increases worldwide, several authors have indicated that being female may become a barrier to leadership, as with society's continuing gender bias, male leaders tend to be preferred, and the driver of social opinion, the media usually portrays physiotherapists as men.[52]

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[49] KE Shaw, "Skills, Control, and the Mass Professions," *The Sociological Review* 35(1987). Armstrong, "Professionalism, Indeterminacy and the Ebm Project." Bolton, Muzio, and Boyd-Quinn, "Making Sense of Modern Medical Careers: The Case of the Uk's National Health Service." Armstrong, "Professionalism, Indeterminacy and the Ebm Project." Kirsten Harley et al., "Constructing Health Consumers: Australian and Uk Private Health Insurance Discourses," *Health Sociology Review* 20, no. 3 (2011).

[50] Freidson, *Professionalism: The Third Logic*.

[51] Nicola Kay Gale, "From Body-Talk to Body-Stories: Body Work in Complementary and Alternative Medicine," *Sociology of Health & Illness* 33, no. 2 (2011).

[52] Birgitta Bergman and Staffan Marklund, "Masculinisation and Professionalisation of the Physiotherapy Profession: A Study of Swedish Physiotherapists," *Physiotherapy Theory and Practice* 5(1989). Richard Hugman, *Power in Caring Professions* (Macmillan, 1991). Jennifer Bresnick, "Women in Physical Therapy: Can We #Sol- Vept without a Strong Enough Voice? The Pt Student," www.theptstudent.com/2014/03/24/women_in_pt/?utm_con-tent5buffer7c38c&utm_medium5social&utm_source5twit- ter.com&utm_campaign5buffer Accessed 11 June 2015. Emer McGowan and Emma Stokes, "Leadership in the Profession of Physical Therapy," *Physical Therapy Reviews* 20(2015). Deborah J Schofield and Susan L

Research in to the professional histories and work styles of male and female physiotherapists in private practice found few differences.[53] Recent authors perceive physiotherapists as reflecting male values and behaviour with a focus on curing patients through a biomedical/biomechanical perspective, in contrast to the traditional role of women to care.[54] The research for this thesis rejects the emphasis on this dichotomous gendered approach and indicates that from the inception of physiotherapy two centuries ago, physiotherapy practitioners have long had a capacity to both cure and care. There are additional complexities in physiotherapy.

Ehrenreich and English considered examples of predominatly female becoming predominantly male occupations were rare requiring redefiniton as 'masculine' before men joined.[55] With recognition that identites are fluid, men in occupations dominated by women strive to preserve a male identity, whereas women in established male work environments often compromise to the demands of male work and are often admired or respected. Their adoption of 'male' behaviours, Lupton noted, does not compromise their core identites. By

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Fletcher, "The Physiotherapy Workforce Is Ageing, Becoming More Masculinised, and Is Working Longer Hours: A Demographic Study," *Australian Journal of Physiotherapy* 53(2007).

[53] Lesley McLoghlin and Mary Westbrook, "Private Physiotherapy: Characteristics of a Sample of Practitioners and Their Practices," ibid.30(1984). The Australian Health Practitioner Regulation Agency Annual Report 2010-11.

[54] Bergman and Marklund, "Masculinisation and Professionalisation of the Physiotherapy Profession: A Study of Swedish Physiotherapists."; Tobba Therkildsen Sudmann, "(En) Gendering Body Politics. Physiotherapy as a Window on Health and Illness" (University of Bergen, 2009); Tone Dahl-Michelsen, "Sportiness and Masculinities among Female and Male Physiotherapy Students," *Physiotherapy theory and practice* (2014); "Curing and Caring Competences in the Skills Training of Physiotherapy Students," *Physiotherapy theory and practice* (2014); Tone Dahl-Michelsen and Kari Nyheim Solbrække, "When Bodies Matter: Significance of the Body in Gender Constructions in Physiotherapy Education," *Gender and Education*, no. ahead-of-print (2014). Jeanette Praestegaard, Gunvor Gard, and Stinne Glasdam, "Physiotherapy as a Disciplinary Institution in Modern Society-a Foucauldian Perspective on Physiotherapy in Danish Private Practice," *Physiotherapy theory and practice* 31(2014).

[55] Barbara Ehrenreich and Deirdre English, *For Her Own Good: 100 Years of Expert Advice to Women* (Garden City, New York: Anchor Press, 1978).

constrast men in 'female' occupations either reconstruct the occupation to fit their notions of masculinity or realign themselves into different masculinities.[56]

Physiotherapy included women like Pratt who played Stein's 'game', to Cosh who challenged male authority behind the scenes, to the Campaign, which brought the challenge into the open. Physiotherapy does not demonstrate a simple classification but has elements of both female and male occupations. There is ambiguity in its public image, due to media portrayal, which is almost always male. In 2007, in the UK men comprised eighteen per cent of physiotherapists, thirty per cent in the USA and twenty seven per cent, in Australia.[57] Physiotherapists are not discussed in the wider literature perhaps reinforcing our ambiguous position. Physiotherapy therefore represents one of the professions where the proportion of men and women is approaching equality. It is a natural experiment in process and warrants further research.

Physiotherapists know little of their history. Education and the profession generally could benefit from knowledge of past experience. Awareness of the IPS for example, could have assisted the development of domiciliary treatment, (re)discovered in Australia during the 1990s.[58] Promoted as a new socially desirable, patient-centred approach with patients potentially regaining control, by the end of the twentieth century Jewson's 'sick man' and woman were returning.[59] Thus, the patient-centred attention with deliberate empowerment of family members to contribute, previously exemplified by the physiotherapists in the IPS, is giving some control back to the patient.[60]

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[56] Ben Lupton, "Maintaining Masculinity: Men Who Do 'Women's Work'," *Br J Manage* 11, no. s1 (2000).
[57] Schofield and Fletcher, "The Physiotherapy Workforce Is Ageing, Becoming More Masculinised, and Is Working Longer Hours: A Demographic Study."
[58] "Hospital in the Home," www.hithsociety.org.au/about. Accessed 23 September 2012.
[59] Malcolm Nicolson, "Commentary: Nicholas Jewson and the Disappearance of the Sick Man from Medical Cosmology, 1770–1870," *International Journal of Epidemiology* 38(2009).
[60] Mary Vaughan, "Oral History Record," (Australian Physiotherapy Association, 1987). Stucki, G., Cieza, A., & Melvin, J. (2007). The international classification of functioning, disability and health: A unifying model for the conceptual description of the rehabilitation strategy. *Journal of Rehabilitation Medicine*, 39, 279-285. Naomi R Eisenberg, "Post-

In 1997, Anne Parry asserted that ‘physiotherapy is multi-paradigmatic' and encouraged physiotherapists to explore a diversity of research options. Her perspective illuminates the connection between history and the theories of professionalism, identity, embodiment, gender and giving.[61]

In this thesis I have demonstrated that physiotherapists in Victoria embodied an evolving professionalism throughout the twentieth century. The path has not been smooth and further challenges are inevitable. The dedication, resilience and resourcefulness of earlier physiotherapists challenged powerful men in medicine, the army, administration and governments who attempted to thwart physiotherapists' goals. Today the dominant perspective of a market economy seeks efficiency without valuing the invisible processes of professional work.[62] Physiotherapists initially embracing EBP are realising that practice guidelines ignore professional artistry and the invisible skills of thinking, reasoning, intuition, reflection and creativity.[63]

Structural Conceptualizations of Power Relationships in Physiotherapy," *Physiotherapy Theory and Practice,* 28(2012). David A Nicholls, "Foucault and Physiotherapy," *Physiotherapy Theory and Practice* 28(2012).

[61] Anne Parry, "New Paradigms for Old: Musings on the Shape of Clouds," *Physiotherapy* 83(1997). James A Shaw and Ryan T DeForge, "Physiotherapy as Bricolage: Theorizing Expert Practice," *Physiotherapy Theory and Practice* 28(2012).

[62] Jane Broadbent and Richard Laughlin, "Public Service Professionals and the New Public Management," *New public management: Current trends and future prospects* (2002). See also Jane Broadbent, Michael Dietrich, and Jennifer Roberts, *End of the Professions?: The Restructuring of Professional Work* (Routledge, 2005).

[63] D Fish and C Coles, "Seeing Anew: Understanding Professional Practice as Artistry," *Developing professional judgement in health care: Learning through the critical appreciation of practice* (1998). See also Joy Higgs, Barbara Richardson, and Madeleine Abrandt Dahlgren, "Developing Practice Knowledge for Health Professionals," (2004); Barbara Richardson, Joy Higgs, and Madeleine Abrandt Dahlgren, "Recognising Practice Epistemology in the Health Professions," (2004).

We are well reminded of Freidson's words

> Professionalism ... is not just any kind of work ... (but) is esoteric, complex and discretionary in character: It requires theoretical knowledge, skill, and judgement that ordinary people do not possess, may not wholly comprehend and cannot readily evaluate ... The work (professionals) do is believed to be especially important for the well-being of individuals or society at large, having a value so special that money cannot serve as its sole measure ... It is the capacity to perform that special kind of work which distinguishes those who are professional from most other workers.[64]

[64] Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (London: Policy Press, 1994). 100.

Bibliography

Primary Sources

The fifty-six interviewees

Name	Position Summary	Interview Date
Coralie and Geoffrey Kenny	Physiotherapist, medical practitioner neuroanatomist, both taught anatomy	29.6.2012
Margaret Nayler	Physiotherapist, Deputy Head then Head, Physiotherapy Lincoln, La Trobe University	10.8.2012
Christopher Briggs	Anatomist, taught anatomy to physiotherapy students 20+ years	22.8.2012
Patricia Baker and Cathy Nall	Head Physiotherapists Caulfield and Austin Hospitals clinicians researchers educators APA leaders	1.9.2012
Rhonda Galbally and Patricia Cosh	Polio sufferer, social and disability advocate, and her physiotherapist	2.11.2012
Cynthia McLoughlin	Head Physiotherapist Alfred Hospital, taught students, private practitioner	14.11.2012
Patricia Cosh	Director of School of Physiotherapy, Fairfield and Lincoln 1960-1985	22.2.2013
Joan Gabb, Jean Wilcox, Merle Gibson	Physiotherapists, aged 90+ years at interview, WW2 graduates	26.3.2013
Gillian Webb 1	Physiotherapist, Clinical Coordinator, Deputy Head Physiotherapy University of Melbourne, D Ed	22.4.2013
Barry Stillman	Physiotherapist academic, Lincoln, University of Melbourne for 40+ years. PhD physiotherapy, University of Melbourne	9.5.2013
Anne McCoy	Head Physiotherapist Royal Children's Hospital	10.5.2013
Elizabeth Tully	Physiotherapist academic kinesiology and applied anatomy PhD physiotherapy, University of Melbourne	14.5.2013
Geoffrey Luke	Head Physiotherapist Austin Hospital, private practitioner 90+ years	16.5.2013
Keith Hill	Professor of Physiotherapy Curtin University, UG Lincoln, PhD physiotherapy, University of Melbourne	23.5.2013
Sara Carroll	Physiotherapist academic now Curtin University, previously University of Melbourne	23.5.2013

Lance Twomey	Physiotherapist previously Vice Chancellor Curtin University, reviewer during Campaign	24.5.2013
Joan Smith	Polio sufferer, social and disability advocate	30.5.2013
Uyen Phan	Physiotherapist UG, Masters physiotherapy, University of Melbourne Senior Clinician Royal Melbourne Hospital	4.6.2013
Ian Story	Behavioural scientist academic staff member physiotherapy, University of Melbourne	13.6.2013
Margaret Sherburn	Physiotherapist Clinician academic, Lincoln Melbourne PhD physiotherapy, University of Melbourne, part-time staff member University of Melbourne, Physiotherapy manager Royal Women's Hospital	14.6.2013
Rana Hinman	Physiotherapist academic UG physiotherapy, PhD physiotherapy, University of Melbourne	2.7.2013
Jason Smith	Physiotherapist entrepreneur philanthropist UG physiotherapy, University of Melbourne	11.7.2013
Anne and Charles Robinson	Daughter and son of Basil Robinson physiotherapist, international educator	18.7.2013
Michael Farrell	Physiotherapist researcher UG Lincoln, PhD physiotherapy, University of Melbourne	8.8.2013
Kate Lawler	Physiotherapist PhD candidate UG physiotherapy, University of Melbourne	13.8.2013
David Kelly	Physiotherapist Clinician academic UG Lincoln DPhysio physiotherapy, University of Melbourne	27.8.2013
Patricia Wrightson	Professor of Physiotherapy University of Birmingham	7.9.2013
Grahame Pope	Professor of Physiotherapy University of Nottingham	9.9.2013
Di Newham	Professor of Physiotherapy Kings College London	10.9.2013
Sally Ouston	Physiotherapist clinician UK Australia UK	15.9.2013
Eleanor Kinnear	Physiotherapist clinician UK international philanthropist	19.9.2013
Jackie Reznick	Physiotherapist Clinician academic, many locations including Lincoln Melbourne	4.10.2013
Arthur O'Neill	Administrator Lincoln, amalgamation experience writer, PhD on chiropractic re amalgamation	9.10.2013
Mary Galea	Professor Clinical Physiotherapy physiotherapist neuroscientist academic Melbourne	3.11.2013

Professional Staff: Michelle King, Gavin Walsh, Kate Taylor	Administration, ICT, School of Physiotherapy Melbourne	17.10.2013
Stephen Martin	Physiotherapist ICT professional Melbourne UG Lincoln	22.10.2013
Linda Denehy	Professor, current Head of Physiotherapy Melbourne Clinician academic Lincoln Melbourne PhD physiotherapy, University of Melbourne	24.10.2013
Jennifer Lake	Previous Chief Executive Officer, APA Victorian Branch	8.11.2013
David Penington	Previous Vice Chancellor University of Melbourne	8.11.2013
Guy Zito	Physiotherapist Clinician academic UG Lincoln DPhysio physiotherapy, University of Melbourne	14.11.2013
Elisabeth Williams	Physiotherapist academic UG Lincoln, University of Melbourne PhD candidate University of Melbourne	5.11.2013
Kim Bennell	Professor of Physiotherapy UG Lincoln PhD LaTrobe academic Melbourne	19.11.2013
Catherine Granger	Physiotherapist academic UG PhD physiotherapy, University of Melbourne	3.12.2013
Glen Bilby	Physiotherapist entrepreneur UG physiotherapy, University of Melbourne works internationally	13.12.2013
Fay Marles	First female Chancellor Melbourne	30.12.2013
Gillian Webb 2	Physiotherapist, Clinical Coordinator, Deputy Head Physiotherapy Melbourne	15.7.2014
Ruth Grant and Patricia Trott	Professors of Physiotherapy University South Australia experienced clinicians academics	4.8.2014
Louisa Remedios	Physiotherapist Clinician academic Lincoln University of Melbourne PhD physiotherapy, University of Melbourne	5.5.2015

Personal papers and materials:

Freda Bolwell (Kimpton), Cynthia McLoughlin, Patricia Cosh, Rosemary Aitken, Basil Robinson, Joan McMeeken provided personal papers. The materials of Bolwell and McMeeken extend from 1929 to 2015 and include personal diaries, photographs and correspondence, physiotherapy subject notes and laboratory manuals, teaching material from Lincoln Institute and the University of Melbourne, correspondence, reports, annotated meeting minutes, photographs and the like.

Archives

Australian Physiotherapy Association Oral Histories and archives

The Australian Physiotherapy Association (APA) archive contains summarised oral histories collected from physiotherapists and occasionally other people associated with the development of physiotherapy in Victoria. All available 128 oral histories were read. Beatrice Burke, Elizabeth Fussell and Margaret Nayler ensured this information was collected during the late 1980s. All participants in the Oral History signed the ethics form on the following page.

Jonathon Kruger, then General Manager - Advocacy and International Relations Division Australian Physiotherapy Association during email exchanges during 2012 approved access to the Australian Physiotherapy Association archives held in Malvern and Cris Massis Chief Executive Officer extended approval to the University of Melbourne archive holdings. The latter is a much smaller archive, which I had previously accessed in 1991/2.

See email below.

Sent 10 February 2012

Dear Joan

On behalf of the APA, I am happy to approve your request to access and copy material from the University archives for research purposes.

If you require further information, please feel free to contact me directly.

Kind regards

Cris Massis *Chief Executive Officer* Level 1,1175 Toorak Road, Camberwell, VIC 3124 Australia
PO Box 437 Hawthorn BC VIC 3122 Australia
e: cris.massis@physiotherapy.asn.au
p: +61 3 9092 0801 | m: +61 (0) 411 745 074
www.physiotherapy.asn.au

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION ORAL HISTORY PROGRAMME RELEASE FORM

For and in consideration of the participation by the Australian Physiotherapy Association in any programmes involving the dissemination of and oral history material for publication, copyright, and other uses, I hereby release all right, title, or interest in and to all my tape recorded memoirs to the Australian Physiotherapy Association and declare they may be used without any restriction whatsoever and may be copyrighted and published by the Australian Physiotherapy Association, which may also assign said copyright and publication rights to serious research scholars.

In addition to the rights and authority given the Australian Physiotherapy Association under the preceding paragraph, I hereby authorize the Australian Physiotherapy Association to edit, publish, sell and/or license the use of my oral history memoir in any manner, which the Australian Physiotherapy Association considers desirable, and I waive any claim to any payments which may be received as a consequence thereof by the Australian Physiotherapy Association.

Place: Date:

(Interviewee) (Interviewer)

For Australian Physiotherapy Association

JUNE 1987

(Oral histories; some of these record the date of interview but others do not. Collection of those used for this thesis occurred predominantly in the late 1980s.)

JMcM Code	Surname	First Name	Student years
BOH2	McAuley	Eliza	~1895-1896
BOH4	McAuley	Eliza	~1895-1896
BOH2	Pratt	Edith	1906-1907
BOH3	Rooke	Lucy (Johnson)	1912-1913
BOH1	Horwood	Vair E	Wartime + completion
BOH1	Adair	Edith (Garrard]	1917-1918
BOH1	Hancock	Maree (Maling]	1918-1919
BOH3	Wiseman	Floris (Chilvers)	1919-1920
BOH3	Stone	Laura	1920-1921
BOH3	Waitt	Hilda	1920-1921
BOH3	Trounson	Vair	1920-1922
BOH2	McArthur Campbell	Alison ll	1922-1924
BOH4	McArthur Campbell	Alison	1924-1925
BOH4	Duigan	Cynthia	1926-1927
BOH1	Farnbach	Marjorie	1927-1928
BOH3	Todd OBE	Helen	1927-1928
BOH1	Finney	Ellis	1928-1929
BOH2	Rice	Trevor	1928-1929
BOH3	Robinson	Margaret	1928-1929
BOH3	Shaw	Isabel	1928-1929
BOH2	Powers	Clare	1928-1930
BOH3	Stack (Nichols)	Gwen	1929-1930
BOH2	Huon (Longmore)	Gwen	1929-1931
BOH1	Davies	Nancy Winifred	1930-1933
IPS	Forster	Aura	1931-1933
BOH2	MacInnes (Robertson)	Mary	1931-1933
BOH2	Rakuzinas	Norma	1931-1933
IPS	Gordon	Molly	1932-1934
BOH3	Spark	Elsa	1932-1934
BOH3	Winter	Eunice	1932-1934
BOH4	Blamey (Kelsall)	Jean	1933-1935
BOH4	O'Connor	Lorraine	1933-1935

BOH3	Vorrath	Frances	1934-1935
BOH4	Bolwell (Kimpton)	Freda	1935-1937
IPS	Bone	Betty	IPS
BOH4	Edwick	Jean	1935-1937
BOH3	Yapp	Lucy	1936-1937
BOH4	Frost	Dame Phyllis	1936-1938
BOH4	McCarthy	Ruth	1934-1938
BOH2	Miller	Josephine	1935-1938
BOH4	Giderson	Dorothy	1937-1939
BOH1	Bell	Joan	1939-1941
BOH4	McComas (Waddell)	Meredith	1939-1941
BOH2	Poulton	Margaret	1938-1941
BOH1	Ross (Floyd)	Muriel	1939-1941
BOH1	Fussell OAM	Elizabeth	1940-1942
BOH2	McKenzie	Betty	1940-1942
BOH2	Miller	Mary	1940-1942
BOH1/4	Grey-Wilson MBE	Agatha	1941-1943
BOH1	Cosh MBE	Patricia	1942-1944
BOH4	Barraclough	Barbara	1943-1945
BOH2	Robinson	Basil	1944-1946
BOH3	Truscott	Betty	1944-1946
BOH4	Main	Nancy	1945-1947
BOH2	Maplestone	Wendy	1945-1947
BOH3	Wister (Fussell)	Shirley	1945-1947
BOH1	Breheny	Lesley	1945-1948
BOH1	Guymer	Frank	1946-1948
BOH2	Luke	Geoffrey	1946-1948
BOH3	Workman	John	1946-1948
BOH3	Wright	Adrian	1946-1948
BOH1	Burke	Beatrice	1947-1949
BOH4	Liddicut	Norman	1947-1949
BOH2	McLoughlin	Cynthia	1947-1949
IPS	Towns	Jocelyn	1947-1949
BOH2	Lamers	W James	1948-1950
BOH3	Sandow	Max	1947-1949
BOH1	Ellis	Rosemary	1950-1952

BOH4	Margetts	Dorothy	1950-1952
BOH2	Nayler	Margaret	1950-1952
BOH1	Craig	Helen	1951-1953
BOH1	Baker	Annette Elizabeth	1951-1954
BOH2	Morgan	Harrow	1952-1954
BOH1	Craig	Michael	1953-1956
BOH1	Gordon	Helen	1953-1956
IPS	Kopp	Audrey	1954-1956
BOH2	Paterson	Patricia	1954-1956
BOH1	Brinsmead (McColl)	Elsbeth	1954-1957
BOH1	Burns	Yvonne	1954-1957
BOH1	Hirschfield	Margaret	1954-1957
BOH2	Jones	Deidre	1955-1957
BOH3	San Miguel	Jillian	1955-1957
BOH2	McKenzie	Peta	1956-1958
BOH2	Rice	Peter	1957-1959
BOH3	Tippett	Elizabeth	1957-1959
BOH1	Kraehe	Margaret	1958-1960
BOH1	Duncan	Barbara	1959-1961
BOH3	Zuker OAM	David	1958-1961
BOH1	Grant	Ann	1960-1962
BOH3	Vaughan	Mary	1960-1962
BOH1	Bauer	Doreen	NSW-1963
BOH1	Best	Margaret Olive	1961-1963
BOH1	Elton	Diana	1961-1963
BOH2	McMeeken (Bolwell)	Joan	1961-1963
BOH3	Worth	David Worth	1960-1963
BOH2	McLean (Inkster)	Deidre	1962-1964
BOH3	Walker	Barbara	1962-1964
BOH2	Kerr	Elizabeth	1959-1965
BOH3	Vowells	Lindsay	1963-1965
BOH2	McCoy	Anne	1964-1966
BOH3	Taylor	Terrell	1964-1966
BOH1	Farr	Rod	1965-1967
BOH2	Richardson	Barry	1965-1967
BOH1	Duras	Peter	1966-1968

BOH1	Duras	Susan	1966-1968
BOH1	Baker	Patricia	1967-1969
BOH4	Nall	Catherine	1969-1971
BOH1	Fitch	Susan	1969-1972
IPS	Delany	Elizabeth	1950-1952
IPS	Murphy	John	IPS
IPS	Gardiner	Alexander	IPS
IPS	RCH physiotherapists	Summary	IPS
IPS	McCloskey	Bertram	IPS
IPS	Spurr	Margaret	IPS
IPS	Spurr	Noel	IPS
IPS	Colville	Peter	IPS
BOH1	Cooper	Mabel	MRB Registrar
BOH4	Finney	Ellis	ms
BOH2	Jennings	Josephine	South Australia
BOH4	Kirkcaldie	Katherine Vida	NSW
BOH2	Leschen	Hugo Leschen	South Australia
BOH2	Peters	Alfred & Austin Peters	Niece

Australian Physiotherapy Association Archive

This archive is stored at Wilson Self Storage, 272 Wattletree Road, Malvern East VIC 3145 272 Wattletree Road, Malvern Eand then all located at room 116.

In this archive I sought additional information that related particularly to physiotherapy education.

The large uncatalogued collection of Association materials includes the Oral Histories Collections in three boxes and a small collection of oral histories from the Itinerant Poliomyelitis Service transcribed by Elizabeth Fussell.

Meeting minutes Victorian Branch Committee, Victorian Branch Executive Committee, Victorian Branch Campaign Committee 1986-1991.

Victorian Massage Association Minute books.

Additional materials include photographs found serendipitously.

The Association also provided access to some materials such as recent photographs still stored at the APA Headquarters in Toorak Road, Camberwell.

Royal Australian Nursing Federation, Victorian Branch Library

The extant Australasian Massage Association meeting minutes and lecture transcripts were recorded in UNA the Journal of the Victorian Trained Nurses' Association, 1903; Royal Victorian Trained Nurses' Association, 1904-February 1932 held at the Royal Australian Nursing Federation, Victorian Branch, Elizabeth Street Melbourne. A search was done of all UNA journals commencing 1903 to 1927 when reporting in the journal ceased.

University of Melbourne Archives

All material encoded as physiotherapy or massage was explored.

Australian Physiotherapy Association University of Melbourne Archive Collection 'History', - alphabetical series 'O'/1-8, G, Numbered Series 9, 17/3-20/7, 22, boxes, 37, 40, 42, and 46

Individuals

University of Melbourne 1990.0101 Rooke, Lucy Adelaide (1912-1920)

Folder containing Australasian Massage Association Rules and Register of Members 1913-14 (showing LA Rooke to be a second student) and Register of Members 1920, testimonials, papers relating to enlistment, photographs taken during war-service and during employment in Australia, some labeled but undated. Photographs are placed in plastic covers with photocopies (some appear only in photocopy, the originals to be forwarded to Archives in due course. Diploma in Massage from Association in metal container; medals.

University of Melbourne 2011.0099 Papers of Hayward, John Isaac (1910-1998

Correspondence inwards from his family (1937-1939); correspondence outwards (1937-1339); reports on physiotherapy, surgery and typhoid during war (1943-1944); papers relating to scholarships and appointments (1922-1949). Memoir of the voyage 'London to Melbourne in Ninety-One Days' (nd). Personal papers including passport, medical certificates, reprints, certificates and miscellenea.

University of Melbourne 1998.0100 Patterson, Susan E A

Student notebook of Mabel Dowling Woods, student of massage, early 1930s (notes entered at either end); framed diploma of the Massage Association of Australasia, Vic. Branch, awarded to Mabel D Woods in May 1935; tennis trophies won by Woods 1929, 1934; photograph of Geoffrey E A Taylor and friend Colin McKenzie Henry, pilot, later Air Commodore, late 1930s or early wartime.

Physiotherapy education

Additional materials related to physiotherapy or massage education were sourced from the following:

The University of Melbourne

Council, Professorial Board and Faculty of Medicine minutes, Council box no.5 on microfilm.

University calendar 1906 included subjects. For example:

> Anatomy subject for physiotherapy and medical students 1906.
>
> ANATOMY—Descriptive, Topographical, Regional, and Applied. A competent knowledge of embryology will be required.
>
> Dissections. —Each student must dissect all parts of the body twice. The distribution of dissecting work between the second and third years will be determined by the Professor of Anatomy.
>
> Books recommended: — Gray—Anatomy (particularly for bones, joints, and muscles). Quain—Anatomy, particularly Vol. III, Part IV, and the Appendix. Cunningham—Text the second and third years will be determined by the Professor of Anatomy. Treves—Surgical Applied Anatomy. And as a Dissecting Manual—Cunningham—Manual of Practical Anatomy.

When I began physiotherapy 60 years later Grays and Cunningham were still the main text sources of information.

Dr John Springthorpe taught medical students the subject Therapeutics, Dietetics and Hygiene, which had particularly pertinent elements relating to physiotherapy.

> Therapeutics—General rules of treatment. Therapeutic requirements of the different functions and organs. Drugs, their mode of action and uses. Selected prescriptions. The therapeutics of air, climate, baths, mineral waters, massage, electricity, suggestion, hypnotism, etc.
>
> In the Third Term, practical instruction is arranged in prescription writing, electro-therapeutics, massage, Swedish movements, hydrotherapy, public hygiene, etc.

Registrar's office correspondence

Year	Number	Title
1906	38	Massage students
1906	40	Medical school
1907	30	Massage students
1907	32	Medical school
1923	38	Massage students
1940	420	Masseurs Registration Board
1941	448	Massage Course (See extension board)
1941	449	Masseurs Registration Board
1941	296	Extension board Course for outside bodies
1959	1196h	Physiotherapy: Administration of Course (See 1960)
1960	1208	Physiotherapy: Administration of Course See 1963)
1963	1026	Physiotherapy: Administration of Course. Not found

Letter no. 290 1923 'request for establishment of diploma'

Faculty of Medicine and of the Academic Committee 1989-1991 minutes

Accessed through the University Secretary's Department.

Speculum

Speculum the journal of the Melbourne Medical Students' Society, the digital repository, speculum site

https://digitised-collections.unimelb.edu.au/handle/11343/144.

Freda Bolwell's copies 1935-1937.

Schools of Physiotherapy

Leigh Wedlick's manuscript 'Life's Odyssey'. Wedlick a medical member of the MRB examined potential students and taught electrotherapy theory for at least two decades.

Lincoln Institute of Health Sciences/La Trobe University

Extensive personal collection from 1978-1990. In particular I kept records relating to the amalgamation issues from the early 1980s through all Campaign Committee meetings. Copies of the University of Melbourne and Monash University's and the Australian Physiotherapy Association's submissions to the Physiotherapy Reviews

University of Melbourne

Extensive personal collection from 1991-2015 including annotated Committee Minutes of University, Faculty and School meetings, correspondence, Academic Committee papers, student manuals, graduation lists, photographs.

Australian Council of Physiotherapy Regulating Authorities. 'The University of Melbourne Bachelor of Physiotherapy Accreditation Report'. Canberra: Australian Council of Physiotherapy Regulating Authorities, 2003.

Victorian Public Record Office

Masseurs Registration Board

Victorian Public Record Office, Series VPRS 16484 Board Minutes, Physiotherapists Registration Board of Victoria (I) (previously known as Masseurs Registration Board of Victoria 1923-1978).

Minutes of meetings VPRS 1684/P0001/2/3. 19 February 1923- 20 December 1928, January 1929 - June 1950 and July 1950 - June 1963.

The remainder July 1963 - 2010 are embargoed unless redacted which was quoted at more than $12,000 by Deborah Brown, Senior Research Fellow - Strategy and Research unit, Strategy and Policy Directorate, Australian Health Practitioner Regulation Agency.

Lincoln Institute Council

La Trobe University Archives

Archives at La Trobe University. Over a period of more than six months I was advised to seek the information through FOI. Finally I asked Professor Keith Nugent; previously a colleague as Professor of Physics at the University of Melbourne, now PVC Research at La Trobe, who facilitated access to the Academic Board Minutes from La Trobe in July 2014 - a year after the initial inquiry.

Minutes of the La Trobe University Academic Board meetings from 1985 to 1995.

Chartered Society of Physiotherapy

Chartered Society of Physiotherapy Library

Archival materials, the History of the Physiotherapy Profession and the Chartered Society of Physiotherapy bibliography, books, journals located at 14 Bedford Row London.

The Wellcome Library

A large collection of the Chartered Society of Physiotherapy's main repository for meeting minutes, photographs, and newspaper cuttings located at 183 Euston Road London.

State Library Victoria

Hard copy newspapers, *Weekly Times, Victorian Massage Monthly*, Volumes 1-8, Cyclopedia of Victoria, Hansard Spring Session 51 LC V392 Oct-Dec1988 and on line materials located at Swanston Street, Melbourne.

Trove

Trove newspapers on line at http://trove.nla.gov.au and Google news on line at ws.google.com.au. This included specific searches for many named individuals in addition to 'Swedish exercise', 'Swedish gymnastics', 'massage' and 'physiotherapy'. *The Argus* and *Table Talk* especially provided rich materials.

Australian Physiotherapy Association

Australian Physiotherapy Association archive oral histories, photographs, diaries.

Australian War Memorial

Australian War Memorial many on line searches for general history, individuals, diaries, photographs through https://www.awm.gov.au.

Medical History Museum, Brownless Biomedical Library

Captain Wilfrid Leeming MHM04327, MHM04477 massage notes, WWI, MHM04482 Autograph book, 1913-17 MHM04487 photographs.

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Appendices

The appendices contain the following information

Appendix 1. ***Historical timeline of the thesis***

Significant events	Year	Physiotherapy education in Melbourne	International physiotherapy
'Marvellous Melbourne' built with proceeds of the gold rushes	1880s	Practitioners with Swedish approaches and English 'rubbers' from Europe, United Kingdom & India train women and men as apprentices	Swedish physiotherapy approaches disseminated to Europe, United Kingdom, Australia, North America 1888 Dutch physiotherapy association
Depression	1890s	Eliza McAuley undertakes anatomy studies including dissection at the University of Melbourne, clinical practice at the Melbourne Hospital McAuley's 9 months course at the University of Melbourne, clinical practice at the Melbourne Hospital Honorary physiotherapists at charity hospitals	1894 United Kingdom Society of Trained Masseuses (STM) Massage only examined Women only admitted
1901 Australia becomes a federation. 1902 Franchise Act guarantees women's right to vote in federal elections	1906	Australasian Massage Association Diploma of Massage 2 years University of Melbourne, clinical practice at the Melbourne Hospital. Biomedical sciences with remedial exercise, electrotherapy, massage specialist areas of practice. Men and women admitted	United Kingdom 1910 examination in Swedish remedial exercises 1913 Diploma in the University of Otago New Zealand

First World War	1914-1918	Diploma of Massage 2 years continues. Temporary wartime 1 year course added comprising biomedical sciences with one of remedial exercise, electrotherapy, massage.	United Kingdom 1915 Almeric Paget Military Massage Corps, examination in medical electricity Canadian massage course begins Toronto 1917 USA reconstruction aides: physical education graduates begin training
1929-1939 Depression 1937-38 Largest polio epidemics - high demand for physiotherapists continued henceforth	1920s-1930s	1923 State Registration. Victorian MRB responsible for the Diploma of Massage 2 years University of Melbourne, clinical practice at the Melbourne Hospital 1933 Diploma of Massage 3 years, increasing independence in practice 1938 Designation change to 'physiotherapy', Australian Physiotherapy Association Diploma of Physiotherapy	United Kingdom 1920 men admitted to STM 1929 remedial exercise, electrotherapy, massage required for membership
Second World War 1944 penicillin becomes available 1947 first transistor	1939-1945	Significant expansion in physiotherapy practice Increased proportion in men as students post-war Commonwealth scholarships become available post-war	1943 STM name changed to the Chartered Society of Physiotherapy (CSP), 4/25 training schools admit men NHS Act 1946 leading to the formation of the National Health Service (NHS) on 7 July 1948
Menzies government introduces publicly subsidised, private health insurance 1953 DNA double helix	1950s	Muriel Ross becomes part-time education coordinator Patricia Cosh begins teaching, intake 75% female 1954 Australian Journal of Physiotherapy begins	
Vietnam War Feminism Contraceptive pill Thalidomide Organ transplants 1969 moon walk	1960s	1960 Patricia Cosh appointed full-time Director Elizabeth Tully, Joan McMeeken, Gillian Webb complete Diploma of Physiotherapy 1965 Lincoln House education for physiotherapy, occupational therapy speech therapy. Victorian	United Kingdom introduces registration, mandatory 1964 16/38 training schools admit men

		Institute of Colleges approves staffing, courses confers degrees Biomedical and behavioural sciences University of Melbourne	
1972 "It's Time" Gough Whitlam's Labour Government education reform Feminism 1975 Medibank introduced Ethical issues and patients' rights	1970s	1971 Australian College of Physiotherapy specialisation Biomedical and behavioural sciences continue University of Melbourne 1976 Lincoln Institute of Health Sciences begins Bachelor of Applied Science (Physiotherapy) initially 3.5 then 4 years Anatomy University of Melbourne 1976 Australian Physiotherapy Association rescinds medical referral ethic biopsychosocial approach challenging biomedical mode All Australian programmes 4 year bachelor degrees	1976 First 3 year degree course in Northern Ireland 1978 UK physiotherapists permitted to treat without medical referral
1980 WHO International Classification of Impairments, Disability & Handicaps 1981 United Nations International Year of Disabled Persons 1984 Labour governments Medicare, for medical services HIV-Aids, human genome project, stem cells	1980s	1988 Lincoln/La Trobe University amalgamation Bachelor of Applied Science (Physiotherapy) continues 1987-1990 Campaign for Melbourne 1989-1990 Joan McMeeken acting Head of School Lincoln/La Trobe	
1990 Nelson Mandela freed 1991 www launched, Laser eye surgery, Prosthetic joints, Avian flu	1990s	1991 University of Melbourne Bachelor of Physiotherapy Bachelor of Physiotherapy (Hons), 4 years, Doctor of Philosophy in physiotherapy Integrated academic and clinical programme within Clinical Schools	1992 UK all graduates with degrees, 1993 national exams cease

1993 Howard Government incentives for private health insurance		Professor Joan McMeeken appointed 1992 Lateral entry programme of graduates into year 2 of Bachelor of Physiotherapy Postgraduate Diploma of Physiotherapy in Research and 4 clinical streams Masters of Physiotherapy by research Joan McMeeken convenes first biannual meeting of Heads of Schools of Physiotherapy in Australia and New Zealand 1994 First graduates Bachelor of Physiotherapy, Bachelor of Physiotherapy (Hons) Doctor of Philosophy in physiotherapy Australian Standards for Physiotherapy developed Christine Ewan and Joan McMeeken convene the first annual meeting of the Deans of Schools of Health Science in Australia 1996 Masters of Physiotherapy by coursework in 6 streams Postgraduate Certificate in Physiotherapy 1997 National accreditation of physiotherapy education programmes, rapid growth in numbers of programmes	1996, 31 University departments offering BSc (Hons) Physiotherapy 1998 Extended Scope Practitioner and clinical specialists in National Health Service
9/11 MRSA Emergent 'new' viruses SARS Obesity cosmetic surgery 2004 Medicare Enhanced Primary Care Scheme patient rebates	2000s	2001 Appointment of the first Professor of Clinical Physiotherapy – Mary Galea Joan McMeeken convenes the first annual meeting of Universitas 21 Rehabilitation Sciences academics 2005 Appointment of Professors of Physiotherapy Meg Morris, Kim Bennell 2006 Postgraduate Doctor of Clinical Physiotherapy 3 years commences 2007 Professor Joan McMeeken retires, Associate Professor Gillian	

		Webb becomes Head of School 2008 National Registration of physiotherapists Professor Meg Morris Head of School, (moves to La Trobe 2012)	
Global terrorism	2010s	2011 Students enter postgraduate Doctor of Physiotherapy 3 years following a 3/4 year undergraduate degree Professor Linda Denehy Head of Physiotherapy	2010 UK physiotherapists recognised as first contact practitioners within the NHS

Appendix 2. ***Ethics information***

The Human Research Ethics Committee of the University of Melbourne approval for this project is No. 1137163.1.

All interviewees for the oral history component of the project received the following documents and agreed to participate in the project. No one approached for the project declined. All persons named in the thesis agreed to be named.

The documents are:

A sample letter sent to potential participants

The Plain Language Statement

The consent form

A questionnaire

Minor modifications were made to documents such as the letter and the questionnaire to suit the particular participant.

Furthermore as the project evolved so did the discussion in the context of a grounded theory approach of achieving saturation of the data, as I received confirmation of particular events or interpretations. Additional questions arose as a result of transcription, analysis and my reflexion on the information.

THE UNIVERSITY OF MELBOURNE

School of Historical and Philosophical Studies

Date

Dear

As physiotherapy colleagues, I would like to invite you to participate in my project.

I am undertaking research to document the history of physiotherapy education at the University of Melbourne from its beginnings more than a century ago to 2010. Why do I want to do this research? Lyn Richards suggests that researchers should document their qualifications and indicate why they wish to undertake their research.[1]

As a second-generation physiotherapist who graduated in 1963 I have been involved with the profession of physiotherapy all my life. My mother Freda Kimpton graduated in 1937 and practised as a physiotherapist for 54 years. Although I only managed 44 years, so far I have continued to be closely involved with physiotherapy for a further seven!

However I also have a BSc (Hons) and a Research Master of Science. These degrees were focused on physiology and genetics with the research degree investigating some aspects of physiotherapy's physiological effects. I worked as a clinical physiotherapist from graduation in 1963 until 1991, but have had a full time academic career since 1978. Initially this was at Lincoln Institute of Health Sciences in the School of Physiotherapy where in 1988/89 I was acting as Head of School. After two years as Manager of the Physiotherapy Department at the Royal Melbourne and Essendon Hospitals and an Associate of the Department of Medicine, I was appointed the Foundation Professor and Head of the new School of Physiotherapy at the University of Melbourne in 1991. The responsibilities of this position included developing the first new physiotherapy undergraduate and postgraduate programmes in Australia since 1950. I held that position for 15 years and am now a Professorial Fellow of the University.

[1] Lyn Richards, *Handling Qualitative Data*, Second ed. (London: Sage, 2009).

I come to this research project with considerable enthusiasm to document the educational story of physiotherapy and its connections to the University of Melbourne. I am also aware that I come with my own perspectives, experiences and assumptions. I plan to use archival material and undertake interviews with those physiotherapists and other significant people who have been involved with physiotherapy at Melbourne. Whilst I have selected the names of people suitable to interview initially, you may suggest other names. Amongst the initial people to interview all will have a different perspective to me and amongst them are those who I anticipate will have very contrary views to my own on some topics.

Enclosed is the Ethics Application 'Plain Language Statement' that provides further information about the project such as the procedure, any risks, your rights and how data will be managed. My full contact details, those of Dr James Bradley and the Executive Officer of Human Research Ethics at the University of Melbourne are included.

Your participation would be most welcome. If you wish to be involved, or if you would like any further information about the project, please contact me by return email or by telephone. I am available to hold our conversation at a time and place that is convenient to you.

Yours sincerely

Joan M McMeeken

THE UNIVERSITY OF MELBOURNE

School of Historical and Philosophical Studies

PLAIN LANGUAGE STATEMENT

Research project:	**The history of physiotherapy education at the University of Melbourne 1895 - 2010**
Responsible Researcher:	Dr James Bradley (Supervisor)
	Email: jbradley@unimelb.edu.au
	Phone: 03 8344 3851
Student Researcher:	Professor Joan McMeeken AM (PhD candidate)
	Email: j.mcmeeken@unimelb.edu.au
	Phone:03 8344 5631
	History and Philosophy of Science School of Historical and Philosophical Studies Faculty of Arts University of Melbourne Parkville Victoria 3010 Australia

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Introduction

You are invited to participate in the history of physiotherapy at Melbourne, which is being conducted, by Professor Joan McMeeken (PhD candidate) and Dr James Bradley (Supervisor) of the School of Historical and Philosophical Studies at the University of Melbourne. This project will form part of Joan McMeeken's PhD thesis, and has been approved by the Human Research Ethics Committee (HREC). Joan McMeeken has sought your participation as an individual who has had significant involvement with physiotherapy education at the University of Melbourne.

Background information

Physiotherapy education began at the University of Melbourne in the 1890s and was formally begun as a course under the auspices of the Australasian Massage Association in 1906. Anatomy has been taught at the University to physiotherapy students since then. Although the University taught the biomedical sciences, it was not until 1991 that the University had full responsibility for a new School of Physiotherapy. As the Foundation Professor since 1991

and Head of the School of Physiotherapy until 2007, Joan McMeeken is writing a thesis describing the development and implementation of the School of Physiotherapy at the University of Melbourne. The stories provided by people interviewed will enrich the information sought from published and archival materials.

Procedure

Physiotherapy graduates of the programme, physiotherapy educators and other influential people have been identified as potential participants in the project. Participants will be asked to discuss their experiences in relation to physiotherapy education at Melbourne. The researchers will ask you to complete a short questionnaire and then use a pre-formulated interview guide as an aide memoire (Appendices). The interview will be tape-recorded to ensure an accurate record of the conversation. Participants will be provided with a copy of the transcript in order to verify that the information is correct and/or request deletions. It is anticipated that the time commitment required of participants will not exceed 2 hours.

As these conversations have the capacity to contribute to a wider oral history of physiotherapy Joan McMeeken will ask participants if they are prepared for their audiotapes and transcripts to be retained as archival material for future researchers.

Risks

As the number of people to be interviewed is small there may be some implications for the protection of your identity should that be your wish.

Participants may choose to be identified, be referred to by pseudonym or be anonymous and have their (unquoted) experiences more generally described in the thesis (and any subsequent publications that may arise from it). Participants' preference for their identification will be sought in writing and at the commencement of the interview. Participants will be able to provide some information off-the-record – participants can identify those responses to be included and those not during the interview, or during their reviews of the transcript of the interview. If participants' preference is to be referred to by pseudonym any contextual details that might reveal their identity will be omitted. Those participants who request complete anonymity will not be directly quoted.

It is not anticipated that participants will be subject to any mental or emotional risk in the course of responding to the interview questions, however in the event that participants

become distressed during the interview, the interview will be terminated immediately and participants will be advised to seek counselling. Should this occur Joan McMeeken would discuss the matter with the Responsible Researcher before undertaking any further interviews.

Rights

Participation in this study is entirely voluntary. Should participants wish to withdraw at any stage, or to withdraw any unprocessed data supplied, they are free to do so without prejudice.

The completed PhD thesis, in addition to any other publications arising from the research, will be made available to participants upon application to the School of Historical and Philosophical Studies.

Confidentiality & data storage

All data will be kept in locked filing cabinets and all electronic data will be password-protected and accessible to the named researcher(s) only. All data are to be maintained for the minimum retention period of five years after publication or public release (in the form of the thesis and presentation of results and/or the publication of journal articles or conference papers) of the research as required by the University of Melbourne Code of Conduct for Research, *and* for as long as they are of continuing value to the researcher, *and* as long as recordkeeping requirements, legislative and other regulatory requirements exist.

At the conclusion of this period the decisions of the participants in relation to their audiotapes and transcripts will be respected. For those that have requested that they are not identified either by pseudonym or complete anonymity all printed materials will be shredded, electronic materials will be permanently deleted, and audiotapes will be permanently deleted. Participants are advised that ultimately confidentiality is subject to legal limitations.

Further information and assistance

If you agree to participate in this research project, please indicate that you have read and understood this information by signing the accompanying consent form and returning it in the envelope provided. Joan McMeeken will then contact you to arrange a mutually convenient time to conduct the interview.

Should participants require any additional information concerning this research project they should contact Joan McMeeken (03 8344 5631) or Dr Bradley (03 8344 3851). Should participants have any concerns about the conduct of this research project they can contact the Executive Officer, Human Research Ethics, University of Melbourne, phone 03 8344 2073 or fax 03 9347 6739.

THE UNIVERSITY OF MELBOURNE

School of Historical and Philosophical Studies

CONSENT FORM

Research project: **The history of physiotherapy education at the University of Melbourne 1895 - 2010**

Responsible Researcher: Dr James Bradley

Student Researcher: Professor Joan McMeeken AM (PhD candidate)

Name of participant _____

I consent to participate in the above-named project and acknowledge and accept the following:

a) that the project is for research purposes
b) that involvement in the project is voluntary and that I am free to withdraw at any time, and that I am free to withdraw any unprocessed identifiable data previously supplied
c) that I will be asked to provide my responses to a list of pre-prepared questions, that Joan McMeeken will take notes during the interview, and will ask for consent for the interview to be audio-taped

I consent to my interview being audio-taped: Yes ☐ No ☐

That I am prepared to participate in a further conversation Yes ☐ No ☐

d) that the following arrangements have been made to protect the confidentiality of data:
   i. Joan McMeeken will be responsible for security of data collected
   ii. data is to be stored in locked facilities in a University office and locked filing cabinet at 766 Elizabeth Street
   iii. data and codes and all identifying information is to be kept in separate locked filing cabinets
   iv. data stored electronically is to be password-protected and accessible to the named researchers only
   v. data are to be maintained for the minimum retention period of five years after publication, or public release, of the work of the research, *and* for as long as they are of *continuing value* to the researcher, *and* as long as recordkeeping requirements such as patent requirements, legislative and other regulatory requirements exist

vi. at the conclusion of the period outlined in the previous point, your audiotape and all printed materials will be archived if you request same or permanently destroyed

e) that there are legal limitations to data confidentiality and that it is possible for data to be subject to subpoena, freedom of information request or mandated reporting by some professions

f) that the small numbers of the participants may have implications for the protection of your identity

g) that I am offered the option of either being identified or being referred to by pseudonym or be completely anonymous in the research results (and any subsequent publications that may arise) **(please indicate one only of these choices)**

vii. the information I provide can be used in further research projects which have ethics approval Yes ☐ No ☐

OR

viii. the information I provide can be used in further research projects which have ethics approval as long as my name and contact information is removed

Yes ☐ No ☐

OR

ix. the information that I provide cannot be used by other researchers without asking me first Yes ☐ No ☐

OR

x. the information I provide cannot be used, except for this project

Yes ☐ No ☐

h) that the purpose of the research project and requests made of me have been adequately explained, that a copy of the Plain Language Statement and Consent Form have been provided, and that the signed and returned Consent Form will be retained by the researcher

i) I wish to receive a copy of the summary project report Yes ☐ No ☐

Signature: _____ **Date:**_____

THE UNIVERSITY OF MELBOURNE

School of Historical and Philosophical Studies

The history of physiotherapy education at the University of Melbourne 1895 - 2010

Questionnaire

These questions are for the physiotherapy participants in the research. They collect background information for our conversation. Thank you for completing them.

Coded identification: ……

(*With the exception of those who specifically agree to be identified in quotations or photographs only the researchers will know the names of participants.)*

Your Name	As a physiotherapy student: Now:
Date and place of birth	
Gender	Female Male
Contact information	Phone Email
Father's Occupation	
Mother's Occupation	

Education prior to undertaking physiotherapy	*Please circle the appropriate answer or provide an explanation regarding your school education:* Year 11 Leaving Honours Year 12 or matriculation Tertiary transfer Other *(please explain)*
Why did you choose to study physiotherapy?	*Please circle the appropriate answer:* Relative a physiotherapist Treated by a physiotherapist Work experience/ observation School counsellor suggestion Other *(please explain)*
Years as a physiotherapy student	From To Location/s, college, university, country
Years as a practising physiotherapist	From To Location/s city, country
Physiotherapy course details	3 year Diploma 4 year Degree Other *(please explain)* How many students in your year? Number of men, women [or %]
Who was the leader of the course?	
Where did you undertake your theoretical studies?	Location(s)
What subjects did you study at the University of Melbourne?	

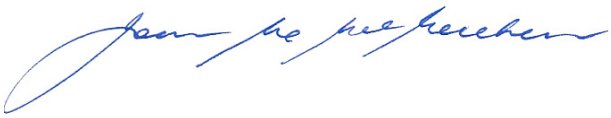
Did you study anatomy with dissection? {Please circle the answer)	No Yes - If yes please comment on the value or otherwise to dissection for physiotherapy education and practice
Where did you undertake your clinical studies?	Location(s)
What types of patient conditions did you see during your clinical studies?	
How were you taught at the time?	*Please circle all that are appropriate:* Largely didactic – students take notes dictated by teacher Mainly a problem solving approach Required sourcing and discussing research literature to justify assessment and treatment options Other *(please explain)*
How well did your course prepare you for commencing clinical practice?	
Musculoskeletal / orthopaedic	*Please circle the most appropriate answer:* Not at all Barely Adequately Well prepared
Neurological	*Please circle the most appropriate answer:* Not at all Barely Adequately Well prepared

Cardiorespiratory	*Please circle the most appropriate answer:* Not at all Barely Adequately Well prepared
Paediatrics	*Please circle the most appropriate answer:* Not at all Barely Adequately Well prepared
Gerontology	*Please circle the most appropriate answer:* Not at all Barely Adequately Well prepared
Women's Health	*Please circle the most appropriate answer:* Not at all Barely Adequately Well prepared
Community practice	*Please circle the most appropriate answer:* Not at all Barely Adequately Well prepared

Private practice	*Please circle the most appropriate answer:* Not at all Barely Adequately Well prepared
Postgraduate Education	*Please circle all that are appropriate and add the hospital/college/university name/s location/s* Learning 'on the job' Short CE courses PG Diploma Masters Clinical Research Clinical Doctorate PhD Teaching qualification
If you are no longer practising physiotherapy	*What are you doing now?* *What prompted the change?* *What would have encouraged you to continue practising physiotherapy?*
Influence of undertaking physiotherapy	*Please reflect on how studying physiotherapy has influenced you as an individual and on your professional career*
Influence of undertaking postgraduate studies in physiotherapy	*Please reflect on how your postgraduate study has influenced you as an individual and on your professional career*
What do you consider are the defining characteristics of physiotherapists?	*Please elaborate* *Do you think these characteristics are universal? If so please*

	elaborate
By what mechanisms do the physiotherapy educational processes facilitate the development of these characteristics?	*Please elaborate*

Thank you for taking the time to complete this preliminary questionnaire.



Professor Joan M McMeeken AM

Appendix 3. ***Evolving curriculum objectives/aims of BPhysio programmes***

1991

- Preserve, refine and advance knowledge in physiotherapy sciences relevant to the promotion and maintenance of health and understanding, preventing and alleviating human disease
- Achieve excellence in undergraduate, postgraduate and continuing education in physiotherapy
- Contribute to leadership in the development of the local and international community by effective interaction with the physiotherapy profession and other appropriate groups outside the University

1997

- To produce graduates whose qualification is registerable by the Physiotherapists' Registration Boards.
- To provide graduates with a strong basis of knowledge of physical, biological, medical and behavioural sciences.
- To provide graduates with the clinical knowledge, skills and attitudes necessary for the competent assessment, prevention, treatment and rehabilitation of patients with physical disorders and disabilities.
- To provide graduates with a capacity and motivation for continuing independent learning.
- To provide graduates with a capacity to communicate effectively with patients, colleagues and members of other health professions.
- To provide graduates with an understanding of professional responsibility and ethical principles in relation to individuals and the community.

Subjects 1991-1999

Year 1, Anatomy 1, Applied Anatomy and Kinesiology 1, Behavioural Science, Growth, Development and Ageing, Medical Biology, Physics, Physiology 1, and Physiotherapy Principles and Practice 1.

Year 2. Anatomy 2, Applied Anatomy and Kinesiology 2, Communication Skills, Electrotherapy, Exercise and Integrated Physiology, Human Movement Development, Neuroscience, Pathology, Physiology 2, Physiotherapy Principles and Practice 2 and Research Methods 1.

Year 3. Cardiothoracic Physiotherapy 1, Kinesiology and Measurement, Musculoskeletal Physiotherapy 1, Neurological Physiotherapy 1, Pharmacology for Physiotherapy, Research Methods 2 and Seminars in Physiotherapy.

Year 4. Cardiothoracic Physiotherapy 2, Clinical Neuroscience, Clinical Physiotherapy, Elective Studies, Exercise Prescription, Gerontology, Musculoskeletal Physiotherapy 2, Neurological Physiotherapy 2, Paediatrics, Sports and Manipulative Physiotherapy, Seminars in Physiotherapy 2 and Research Methods 3.

Subjects 1999-2011 with the hybrid PBL pedagogy

The School of Physiotherapy transitioned all BPhysio and BPhysio (Hons) subjects into new format of hybrid PBL.

Year 1

Physiotherapy 1, Principles of Biomedical Science, Physiotherapy 2, Musculoskeletal Systems

Year 2

Physiotherapy 3, Cardiorespiratory Systems, Physiotherapy 4, Sensorimotor Control Systems

Year 3

Musculoskeletal Physiotherapy 1, Neurological Physiotherapy 1, Cardiothoracic Physiotherapy 1, Physiotherapy Practice 1, Clinical Research Methods 1

Global Elective between years 3 and 4

Year 4

Cardiothoracic Physiotherapy 2, Gerontology, Musculoskeletal Physiotherapy 2, Neurological Physiotherapy 2, Paediatrics, Exercise Prescription, Sports and Elective Physiotherapy, Clinical Research Methods 2, Physiotherapy Practice 2.

The revised course for Physiotherapy had the following key features:

- Integration of basic and clinical sciences throughout the course ensuring continuation of clinical contact from the beginning of the course and integration of basic sciences into all four years
- Further emphasis on the learning and understanding of principles and concepts
- Extensive vertical and horizontal integration of subjects
- Organisation of learning from first year around body systems rather than by traditional subject boundaries. This will take place in the year 2000
- Development of attitudes and skills characteristic of physiotherapy best practice
- Emphasis on the evaluation and application of research evidence in physiotherapy
- Change in teaching-learning methods, in particular the use of problem -based learning methods; interactive computer-based learning activities and a greater emphasis on self directed learning and data-seeking skills

- Inclusion of an evaluation process at all levels of the undergraduate programme and of the graduates and employers to enable ongoing review
- Appropriate formative and summative student assessment, which reflects the evolution in learning and teaching methods.

Appendix 4. ***New Graduate Survey***

This annual survey collected information from employers of new graduates approximately nine months following completion of the course. A similar survey collected information from the graduates.

The University of Melbourne

School of Physiotherapy

NEW GRADUATE SURVEY

November 2004

Name of Organisation:……

Contact Name & Phone Number……

The School of Physiotherapy at The University of Melbourne commenced in 1991 with the first graduates from the undergraduate programme completing in December 1994. The academic staff of the School and its associated clinical staff in the Clinical Schools of the University developed an integrated clinical education programme to complement the physiotherapy, medical and behavioural sciences undertaken at the University. In our model of education, a significantly greater amount of pathophysiology and clinical theory is undertaken in the Clinical Schools. Graduates also complete 12 weeks of electives from a wide choice including overseas electives.

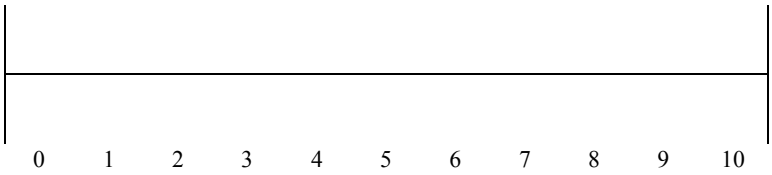
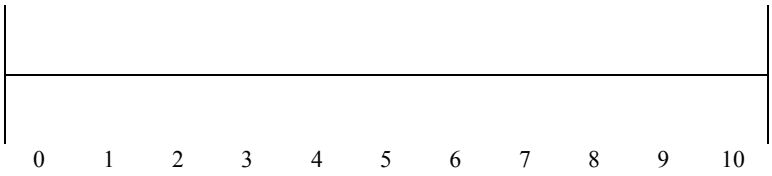
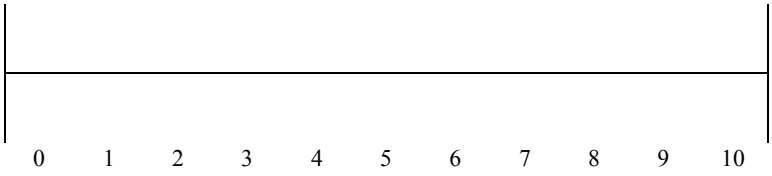
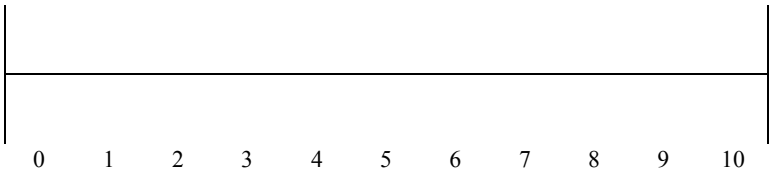
The advice of employers of the graduating classes of 1994 to 2002 has assisted the School in its ongoing course review. I now seek your opinion with respect to the performance of The University of Melbourne physiotherapy graduates from 2003 in the work environment. The following questionnaire is in two parts. The first section identifies the attributes of University of Melbourne graduates. The second is based on the work undertaken by many members of the Australian Physiotherapy Association on the requirements of a newly graduated physiotherapist (Australian Physiotherapy Competency Standards 1994, 2002, appendix 1.

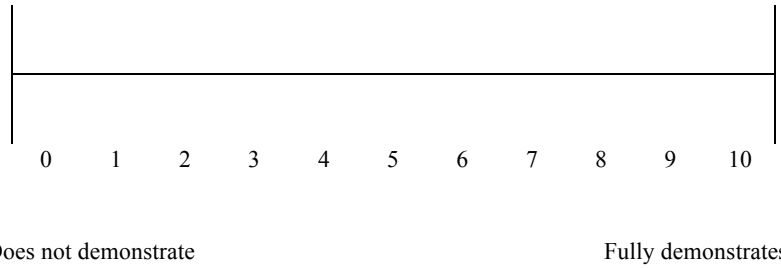
Attributes of the Graduates of the University of Melbourne

The University of Melbourne is a research-intensive university that attaches the very highest priority to undergraduate education and seeks to stimulate, nurture and develop graduates of the finest international calibre.

The University expects its graduates to be educated and well-informed, able to contribute effectively to their communities wherever in the world they choose to live and work. It expects Melbourne graduates to have the following qualities and skills. Please circle the number that best represents how well you consider your graduate fills these qualities and skills on the visual analogue scale beside each attribute. At the left hand end of the line is "does NOT demonstrate" and at the right hand end is "fully demonstrates".

Profound respect for truth and intellectual integrity, and for the ethics of scholarship;	
Highly developed cognitive, analytic and problem-solving skills;	
Capacity for independent critical thought, rational inquiry and self-directed learning;	

Intellectual curiosity and creativity, including understanding of the philosophical and methodological bases of research activity;	 Does not demonstrate Fully demonstrates
Openness to new ideas and unconventional critiques of received wisdom;	 Does not demonstrate Fully demonstrates
Extensive knowledge of professional areas, relevant professional knowledge and skills, and informed respect for principles, disciplines, values and ethics of physiotherapy;	 Does not demonstrate Fully demonstrates
Ability and self-confidence to comprehend complex concepts, to express them lucidly, whether orally or in writing, and to confront unfamiliar problems;	 Does not demonstrate Fully demonstrates

Awareness of advanced communications technologies and modalities, sound working skills in the application of computer systems and software, and receptiveness to the expanding opportunities of the 'information revolution';	
International awareness and openness to the world, based on understanding and appreciation of social and cultural diversity and respect for human individual human rights and dignity;	
Leadership capacity, including a willingness to engage in constructive public discourse, to accept social and civic responsibilities and to speak out against prejudice, injustice and the abuse of power;	

Ability and confidence to participate effectively in collaborative learning as a team-member, while respecting individual differences; and	
Ability to plan work and to use time effectively.	

Professional Competencies of Newly Graduated Physiotherapists

The new graduate is expected to have acquired a minimum level of theoretical knowledge, achieved a minimum level of clinical skills and to behave in an appropriately professional manner. These attainments have been categorised under the following eight headings:

1. **Assessment:** Assesses the client's abilities, problems and needs
2. **Interpretation and diagnosis:** Interprets and analyses assessment findings for the diagnosis of the client's problems and the definition of client needs
3. **Planning:** Develops a physiotherapy intervention and management plan to meet defined goals
4. **Implementation:** Implements physiotherapy strategies
5. **Evaluation:** Evaluates the effectiveness of physiotherapy
6. **Professional Behaviour:** Demonstrates professional behaviour appropriate to a physiotherapist
7. **Health Care:** Operates effectively within the health care system
8. **Management:** Applies management skills in physiotherapy practice

Performance Criteria

Performance Criteria describe the standards of workplace performance expected of the entry level physiotherapist and provide the basis on which a physiotherapy assessor may judge whether the performance reaches the standard acceptable for entry level physiotherapy professional practice.

For each of the Performance Criteria you are requested to categorise your new graduate on a 4-point rating scale:

1 below acceptable level performance

2 acceptable level performance

3 good performance

4 excellent performance

Please circle the number that best represents your new graduate's performance on the criteria listed below:

If you have been unable to assess a particular criterion, please do not encircle any number.

If you consider any criterion is not applicable, please indicate with a NA to the left of the criterion.

1.	**Assesses the client's abilities, problems and needs.**	
a.	Demonstrates an understanding of the theoretical bases for the assessment of the client's abilities, problems and needs	1 2 3 4
b.	Communicates effectively with clients, caregivers and professional colleagues.	1 2 3 4
c.	Obtains information relevant to physiotherapy from the client and/or caregiver.	1 2 3 4
d.	Collects supplementary information relevant to physiotherapy relating to the client's health status, history of the problem and current management.	1 2 3 4
e.	Collects from the client in an appropriate manner, quantitative and qualitative data relevant to the perceived problem and	1 2 3 4

	physiotherapy.	
f.	Documents physiotherapy assessment findings accurately.	1 2 3 4
g.	Recognises the scope of physiotherapy assessment.	1 2 3 4
2.	**Interprets and analyses assessment findings for the diagnosis of the client's problems and the definition of client needs.**	
a.	Analyses physiotherapy assessment findings effectively as a basis for defining the client's abilities, problems and potential for change.	1 2 3 4
b.	Makes justifiable decisions regarding a diagnosis, reflecting scientific knowledge and argument.	1 2 3 4
3.	**Develops a physiotherapy intervention plan to meet defined goals.**	
a.	Develops logical rationale for physiotherapy intervention.	1 2 3 4
b.	Establishes appropriate short and long term goals relevant to physiotherapy, in consultation with client and/or caregivers and colleagues.	1 2 3 4
c.	Selects appropriate forms of intervention, based on theoretical knowledge and physiotherapy practice.	1 2 3 4

d.	Incorporates relevant evaluation procedures within the physiotherapy plan.	1 2 3 4
4.	**Implements physiotherapy intervention strategies.**	
a.	Communicates with clients, caregivers and colleagues in an effective manner in relation to implementation of physiotherapy intervention.	1 2 3 4
b.	Ensures the safe and effective implementation of appropriate physiotherapy intervention.	1 2 3 4
c.	Documents and reports on the physiotherapy intervention programme appropriately.	1 2 3 4
5.	**Evaluates the effectiveness of physiotherapy intervention.**	
a.	Monitors effectively the results of physiotherapy intervention.	1 2 3 4
b.	Makes sound judgements on the effectiveness of physiotherapy intervention.	1 2 3 4
c.	Modifies appropriately the physiotherapy intervention programme, in accordance with evaluation results.	1 2 3 4
d.	Uses evidence based practice as a grounding for clinical practice.	1 2 3 4

e.	Where appropriate, carries out evaluative research relevant to physiotherapy practice, at the level of a beginning researcher.	1 2 3 4
6.	**Demonstrates professional behaviour appropriate to physiotherapy.**	
a.	Is committed to ethical practice for the physiotherapist and acts in accordance with legal requirements.	1 2 3 4
b.	Has a commitment to excellence in physiotherapy practice.	1 2 3 4
7.	**Operates effectively within the health care system.**	
a.	Demonstrates awareness of the current health and related systems relevant to physiotherapy and the services provided within them.	1 2 3 4

8.	**Applies management skills in physiotherapy practice.**	
a.	Recognises conditions relevant to physiotherapy employment.	1 2 3 4
b.	Contributes effectively to the planning of physiotherapy services and resources.	1 2 3 4
c.	Where relevant, assists in the development of appropriate physiotherapy strategies to promote health within the community.	1 2 3 4
d.	Manages time and resources effectively to ensure efficient physiotherapy practice.	1 2 3 4
e.	Supervises other staff as appropriate to ensure maintenance of physiotherapy standards.	1 2 3 4
9.	**Ability to access and effectively use information technology**	1 2 3 4

In your opinion, what are the **two main strengths** of the new graduate?

1. .....

2. .....

In your opinion, what are the **two main weaknesses** of the new graduate?

1. .....

2. .....

Any additional comments:

.....