Between academization and good craftsmanship. The physiotherapists’ ambition to professionalize in the light of the conductive education challenge

Ove Mallander\textsuperscript{a} and Mårten Söder\textsuperscript{b,*}

\textsuperscript{a}Faculty of Health and Society, Malmö University, Malmö, Sweden; \textsuperscript{b}Department of Sociology, Uppsala University, Uppsala, Sweden

(Received 27 October 2008; accepted 5 October 2010)

During the 1990s, a debate took place in Sweden concerning Conductive Education. Proponents of this method focused their critique on the role and methods of physiotherapists but this profession was not active in the debate. Instead, the medical profession came out as defenders of habilitation services and methods. Departing from sociology of the professions, our objective in this article is to analyze the physiotherapists’ silence in relation to the profession’s position and its relation to the medical profession. The analysis is based on data from interviews with members of habilitation teams and other key persons, and on documents. The relative silence of physiotherapists is found to be related to both interprofessional factors (the subordination under the medical profession paired with a symbiotic relation based on common interests) and intraprofessional ones (the heterogeneity of the physiotherapist profession, their role in teamwork, and a change from a specialist to a generalist orientation).

Keywords: sociology of professions; physiotherapists; conductive education; youth habilitation; paradigmatic subordination

Introduction and purpose

During the 1990s a sometimes-infected debate took place in Sweden concerning Conductive Education (CE) or as it also is referred to, after its founder, the Petò method. The arguments in this debate were based mainly on the scientific controversy that previously and partly simultaneously had taken place on an international scale, the fundamental issue of which was whether the brain damage that ultimately characterizes cerebral palsy should be treated as an educational or medical issue. The medical perspective was held by the establishment within the Child and Youth Habilitation services (CYH), from the National Board of Health and Welfare to the spokesmen for local habilitation services. The educational perspective was represented by those who wanted to introduce the controversial Conductive Education in Sweden.

In this discussion the media played a prominent part. Television and newspapers broadcasted and published the sometimes-fierce contributions by both critics and proponents of CE. The critics focused on the physiotherapists’ role in the conventional treatment by local habilitation teams, but at the same time, the

\*Corresponding author. Email: marten.soder@soc.uu.se
representatives of this profession kept a low profile in the debate. Instead, mainly the medical profession (both habilitation physicians and representatives for the National Board of Health and Welfare) defended habilitation as well as the work of physiotherapists. In short: physicians participated in the discussion but were not the subject of it, while physiotherapists were the subject of discussion without participating in it.

Taking our point of departure in the sociological literature of professions, our main objective is to analyze the physiotherapists’ silence in the debate as reflecting fundamental traits in their professional status and its relation towards the medical profession in Sweden and to discuss the specific traits of this relation.

Subsequently, the research issue is: How are we to interpret that the physiotherapists did not defend their own profession and left almost their entire defence in the hands of representatives from the medical profession? This happened despite the fact that they, in the Swedish debate, were those criticized, and that their professionalization project may be considered a success and therefore ought to have reinforced their self-esteem.

Physiotherapy is a relatively young, female-dominated profession that has developed under the protection of and subordinated to the medical profession. In our analysis we will emphasize both interprofessional factors, mainly the relation between physicians and physiotherapists, and intraprofessional factors, i.e. we localize the principal possible reasons within the profession itself and its evolution. Since it is reasonable to presume that there exists no single discernible element that explains a professional group’s actions, this classification must primarily be considered as analytical in order to structure the discussion.

Based on data from interviews and the media debate our analysis identifies the relative heterogeneity of the physiotherapy profession, its ambivalent relation to the medical profession as well as the gendered composition of the two professions as possible explanations of their silence.

**Method**

Our analysis is theory driven, as we depart from a theoretical understanding of the nature of and relationship between the two professions. Data from interviews and the media debate are used to indicate the relevance and validity of different interpretations. The analysis is explorative in the sense that the results can be seen as hypotheses to be further explored in more systematically designed empirical studies.

The empirical material was collected in a larger project about team organization within the habilitation services and the implementation of innovative practices with CE as an illustrative case.

Within the framework of the larger project we have carried out semi-structured interviews with 25 employees in five Child and Youth Habilitation Service Centres and 15 key persons (Bohlin, Mallander, and Söder 2001; Bohlin 2009). The employees at the Habilitation Service Centres work in teams that were selected as cases for studying work organization, relations between different professions, and the introduction of new treatment methods. The informants represent different professions and 7 of the 25 persons interviewed were physiotherapists. The interviewed key persons were identified through their participation in the CE debate in which they represented different points of view and different organizational affiliations. A majority of the key persons are medical doctors and only one is a physiotherapist.
The question of the relative silence of the physiotherapists in the CE debate was
not the primary focus in these interviews. In the staff interviews, the focus was on
their daily work, and addressed in different ways, directly as well as indirectly, issues
concerning different actors and their roles, as well as more general issues concerning
habilitation services. In this article, these interviews are mainly used to illustrate
professional and organizational issues in relation to the question at issue, which was
not a primary interest in the interviews. In the interviews with key persons, the focus
was more directly on the debate about CE, although direct questions about the
relative silence of physiotherapists were not posed. The interviews had the character
of retrospective reflections about the debate and only occasionally was the role of
physiotherapists in relation to the medical profession addressed by the informants.2

We thus use data that were primarily collected for other, although related,
purposes. This has its advantages as well as disadvantages. The advantage is that the
data we have collected concerning the relation between different professional groups
has not been influenced by the informant’s views on the physiotherapists’ non-
participation in the debate. We can therefore use what they say about, for example,
the debate, relations between professional groups, and the nature of their work, as
uninfluenced by possible interest of being in defence of their own professional group.
To establish a link between what they are saying and how that relates to the silence in
the debate is our analytical task and not a question that was posed to the informants.
On the other hand, it is a disadvantage that we have little information about how
they would have interpreted this fact. This underlines the theoretical point of
departure for our analysis. Our thesis is not the result of an inductive analysis of
qualitative interviews, but of a theoretical perspective informed by those interviews.
Our theoretically defined concepts have been used as searchlights for discovering
relevant utterances in the data.

Besides the interviews, we use the systematic summaries of the debate, which were
carried out within the framework of our project.

Conductive education and habilitation services

Conductive education is mainly directed at children and young persons with motor
difficulties, in particular those caused by cerebral palsy, and is a holistic learning
philosophy based on the idea that dysfunctions can be altered and controlled.
Emphasis in the method is on a fusion of sensorimotor, social, and cognitive fields.
The key idea is that the children learn through self-care, orthofunction. Continuous
and intensive training as well as active parental participation, are all essential
building blocks in this educational method. For more than four decades, the institute
in Budapest has offered a four-year education programme to become a ‘conductor’
and learn to lead and carry out training programmes.

Habilitation is the process through which comprehensive professional support is
given to youth and children with disabilities. The aim is to promote the best possible
development of the impaired function as well as achieving a good quality of life,
physically and mentally, for the individuals concerned (Bjerre et al. 2004, 123). This
professional support is carried out in the special Habilitation Centres (CYH), and is
offered by multidisciplinary teams consisting of occupational therapists, social
workers, psychologists, speech therapists, special need educators, and physiothera-
pists. Normally, nurses and part-time employed physicians are also included and
occasionally dieticians and recreation officers. The responsible authorities are the county councils, who also are the principals for almost all healthcare in Sweden.

The controversy
The Swedish debate started during late autumn in 1996, culminated round the turn of the year, and then slowly subsided without reaching a solution. The debate was initiated by filmmaker Lars Mullback, himself affected by CP, who in two articles severely criticized Swedish disability policy in general and CYH services in particular, which in his view passivated the patients:

The admirable integration idea has a counteractive effect because children are tied-down and turned into passive bystanders instead of active participants. They live in our society, but are constantly left outside, dependent on assistance. To survive this outsider ship you have to be mentally strong. (1996, 5, our translation)

In his self-produced TV-broadcasted film Jo du kan [You Can Do It] the stated procedure was contrasted with his experiences in Budapest where, during a three-month period, he participated in a CE programme and evolved from being dependent on assistance to being independently able to eat, dress, wash, drive a car, and kiss. A number of contributions followed and the debate culminated with a spectacular parents’ demonstration at the National Board of Health and Welfare in the beginning of January 1997, which as well-covered by the media. The protests concerned the self-same authorities that recently had announced that CE treatment fell under the Restricting Medical Quackery Act. The result was a revision of said interpretation and a gradually more liberal attitude towards the parents’ right to choose between CE and a conventional habilitation method even if this freedom of choice today varies from one county council to another.

Even if Mullback, in his summary of the debate (1997), seriously questioned the roles of the physicians, the physiotherapists, and not least the National Board of Health and Welfare, he gradually displaced the central point of his criticism. In the book Anklagelser [Accusations] he writes ‘The physiotherapy I received from my Swedish angels lacked both goal and method. If you are unqualified to treat people with CP you are unlikely to become a master in your professional field’ (1997, 78, our translation). The core of the criticism was thus the lack of competence to treat people with CP in particular, which according to Mullback, is an element that is next to nonexistent in the programme. While his tone of voice gradually becomes slightly more conciliatory towards the habilitation services, his questioning of the ‘angels’ still remains and furthermore it escalated. In a contribution to the debate almost four years later he maintains, together with his colleague Jesper Odelberg, that as disabled persons, they are dependent on assistance by the habilitation services and at the same time grateful for their existence but ‘the only thing we are dissatisfied with is the physiotherapy’ (Odelberg and Mullback 2000, our translation).

Interprofessional relations: subordination or symbiosis? 

Some concepts: jurisdiction and medicalization
According to Abbott (1988), every profession strives for full jurisdiction over the field of activities in which it is involved. This jurisdiction constitutes a connection
between a profession and its tasks and comprises a claim to classify problems (diagnosis), discuss them and to draw conclusions (inference), and an ambition to solve the problems (treatment).

Abbott argues there are ongoing jurisdictional conflicts within three arenas: the realm of public opinion, the legal system, and within the arena of the workplace. Regarding the first arena, exposure in the media and the public trustworthiness are of a central importance. By using technical terminology in public and thereby displaying their apparently exclusive and well-adapted knowledge about the field in question, the profession gains public sympathy and support for the tasks they claim to be qualified to execute.

Public sympathy for a profession precedes a jurisdictional claim in front of the legal system (state, legislative assemblies, and administrative structures). These authorities may accord the professions monopoly and control over the professional tasks. The workplace is a field where the complexity of professional life emerges clearly.

Abbott distinguishes several forms of settlements between professions: subordination (e.g. nurses in relation to physicians) or a division of labour (as within family counselling where different professional groups work independently side-by-side). In between division of labour and subordination, Abbott situates an agreement he calls intellectual jurisdiction. However, an intellectual jurisdiction may be compatible with elements of both symbiosis and subordination.

**Physicians and physiotherapists**

There is a tangible consensus among our informants regarding the existence of a hierarchy within habilitation services. One of the key informants, Ida, herself an educator with a great experience in this field, expresses this in the following way:

Doctors are top-notch in the hierarchy. And from time to time one can hear that this may cause problems especially since there seldom are enough doctors at the habilitation units to satisfy all teams. However, when a doctor is present on a team meeting he is always leading it. They are always in control. [...] Next to the doctors, the physiotherapists have a very influential role. Moreover, they are convinced to be way above everyone else in the hierarchy. They have a very strong professional identity of sorts.

Yet another key person, Oscar, a doctor professionally active at the National Board of Health and Welfare, expressed his point of view in the following way:

Well, yes, there is an inner hierarchy. No doubt. And, yes, physicians are generally at the top, making the decisions. At least they try to decide. Or else they avoid decisions and duck their responsibility. [...] I mean there is an ambiguity in today's leadership. [...] It happens that a strong nurse or a strong physiotherapist gets to take the initiatives and then makes a fantastic job of it... the individual personality is extremely important, you see. Someone with a strong personality who manifestedly knows the value of his 'personal contribution at work'... must be able to take over or to play a strong part in the team.

The key informants argue physicians have a higher status, but that the picture is more complex than this and cannot be expressed in terms of superiority and inferiority. For instance, when the latter informant talks about leadership ambiguity he refers to
the division of medical and administrative responsibilities. On a legal level, physicians can still have an administrative responsibility and be head of habilitation, although this is rare. Formally, however, they have a medical responsibility since all habilitation services are defined as medical and fall under the Health and Medical Services Act. In addition, clients are more often than not recruited via medical specialist referrals (paediatric and developmental clinics) which give them a paradigmatic superiority. Physicians make the diagnoses and inferences and are therefore, when participating, ‘always leading’ – although seldom formally conducting – the team meetings. However, the relatively few doctors within CYH services spend in general a major part of their working hours outside these organizations, which leaves room for other groups. Nearly all informants agreed that it is principally the physiotherapists who occupy this space. Furthermore, the physicians participate only exceptionally in person during the treatment. Instead, they let other professional groups handle this at their own discretion according to a joint assessment of the patient. Kristin, one of the physicians at a habilitation ward who works part-time described her role in relation to her professional colleagues in the following way:

I’m above all a medical specialist. [...] And my medical outlook on things influences all I do here. I work in a team and I let my team members do their part of the job [...] certainly, I poke my nose into matters I may have a personal view on, but absolutely not concerning specialist functions such as logopedics and physiotherapy which are out of my reach, however psychosocial and mental problems [...] at the same time in this field of work we get to keep our clients for 20 years. Most of them do not get well [...] . Apart from the medical side I enjoy the psychosocial angle to my job, I’ve always found it very stimulating. However, I can still miss the emergency unit a lot. I miss seeing my colleagues.

Kristin draws a picture where certain (specialist) professions (mainly physiotherapists) have a wide range of actions, while the physicians’ interest decides how she relates to the others. Globally in our interviews, the physicians’ position is described as strong mainly due to the medical responsibility; at the same time, the informants also stress the essential importance of personality traits. This concerns both the medical profession and the other professions.

The relatively strong position held by physiotherapists in the team is, according to several informants, due to mainly two conditions, viz. that they by tradition have had a central role within habilitation services and its preceding form of treatment and that physiotherapists by the parents are the most demanded professional group within habilitation services. Bertil, a well-known professor, states:

I believe that physiotherapists in general are very... well, they’re dominant. We focus a lot on motor functions. Both historically and from the CP part, so to speak. So, it’s only normal that physiotherapists are central figures [...] . In many surveys, the parents demand almost unanimously more physiotherapy. People believe in the beginning that the more physiotherapy they get the better they get.

That physiotherapy is the most demanded service is a well-documented fact (The National Board of Health and Welfare 2003) and the reason for this is no doubt ‘because it is the physiotherapists who meet the parents first of all and most of all and who do the most practical services’. The only physiotherapist among the key persons – Ester – stresses specifically tradition and the connection to ‘medicine and remedy’ as an explanation to the physiotherapists’ position within the habilitation
field but also that they have adopted the evidence-based thinking that formerly belonged to the medical profession.

We may, in Abbott’s terms, describe the physicians’ jurisdiction over habilitation as an *intellectual jurisdiction*, based on *diagnosis* and *inference* more than on *treatment*. The arena where this jurisdiction is manifest is in the legal system, viz. the Health and Medical Services Act, fitting into the health care organization and the medical responsibility. The acceptance the medical profession and the medical thinking have in the eyes of the public opinion may be interpreted as a proof that the intellectual jurisdiction is strong also in this arena. In the workplace, the third arena according to Abbott, the picture is far from unequivocal. It may indeed be possible also to find a paradigmatic subordination on this arena; however, this is not tantamount to a formal subordination. Except from the fact that other professional groups are predominantly in leading positions today, the tasks and the team construction also leave a wide range for negotiation in the workplace. Here the physiotherapists have a strong position by tradition, popularity, and kinship to the medical profession. Thus, the care services are *institutionally medicalized*; the medical paradigm is predominant, physicians have the medical responsibility, but do not participate in the direct treatment (Conrad 1992).

The relation between physicians and physiotherapists within the habilitation field can also be seen as symbiotic in two aspects. Firstly, both groups confirm mutually each other’s position through the institutional medicalization of their care service and contribute in the reproduction of its characteristics. Secondly, they have a common interest that CE is not assimilated in the care service. The physiotherapists because their position and domain are at stake and the physicians because the whole habilitation service on a resource level otherwise is threatened when it is forced to renounce allocated means for transportation and treatment of their patients to CE services.6

Considering the paradigmatic intellectual predominance of physicians and medicine on the legal and medical arenas it may seem natural that this was the group that felt prompted to defend the system against the attack to which it was exposed by CE representatives. However, why the physiotherapists, which was the most affected group and which also had a strong position on the workplace arena, did not respond to the criticism cannot be explained in a satisfactory way through an interprofessional analysis alone.

**Intraprofessional factors**

In this section we will discuss explanations of the physiotherapists’ relative inactivity in the media that are related to their own profession. We will first examine the impact of the fact that physiotherapists form a rather heterogeneous profession, and, secondly, how the role of physiotherapists in habilitation put them in a rather ambiguous situation.

**A heterogeneous profession**

The physiotherapists employed by the habilitation services constitute about 6% of the approximately 12,000 physiotherapists that were active at the time of the debate about CE (The Swedish Agency for Higher Education 2004; Andersson 2006; Johansson 1997a). They belong to the majority of the physiotherapists employed by
municipalities and county councils (61%, Johansson 1997a). Other members of the profession are self- or privately employed.

A way of articulating the heterogeneity of the profession is to use the typology developed by Brante (1990) who differentiates between five various types of professions based on their respective material and cultural positions in a broader social context. The first one he calls free professions and includes those producing services as private practitioners working in smaller companies. The second type is the academic professions that produce teaching and research directed to the scientific community and whose material base is the traditional university. Professions of the state, the third type, are publicly employed, working in clinical medical services, rehabilitation, and habilitation. The fourth type is called professions of capital. They are characterized by production for trade and industry, indirectly directed to markets through big or highly specialized companies. The fifth type, finally, is political professions typified as full-time politicians and other politically elected groups with leadership and controlling tasks.

The majority of physiotherapists in Sweden (63%) belong to the professions of the state. However, physiotherapists can be found in all types of professions, even though they are quite few within the academic (3–4%) and political professions (less than 1%, mostly union representatives). But these minor groups are nevertheless quite influential in forming the policy of the professional organization.

The various material conditions of the five types interact with different interests as well as cognitive maps. A self-employed lawyer may thus have more in common with self-employed physiotherapists than the latter have with physiotherapists in habilitation services, which is why they have different views on political measures and conceptions of their professional tasks etc. Furthermore, work priorities may vary between different professional types. Bergman (1989) has shown, for example, that while self-employed physiotherapists spend almost half their time on direct patient contact, physiotherapists employed by the public welfare services spend a third of their time on said contacts. This heterogeneity within the profession risks to disunite the whole professional group (Larkin 1983; Witz 1992; Hellberg 1999).

The heterogeneity also co-varies with gender. Gender conflicts had corroded the profession prior to the Second World War (Ottosson 2004). The number of men within the profession has steadily increased. Between 1970 and 2000, their share doubled from 10–20% (Statistisk Årsbok 2003). Johansson (1997a, 1f) has shown that within the profession there exists a gender-based horizontal work distribution where male domains are private clinics, consulting services, occupational health care, sports medicine, and general health care, while female domains are somatic institutional and non-institutional health care and habilitation services. In terms of Brante’s professional types, males are overrepresented in the profession of capital and free professions, while the females are overrepresented in welfare state professions and academic professions (Johansson 1997b). These professions differ not only in work conditions but also in compensation.

One reason why physiotherapists as a profession did not actively participate in the CE debate may be due to this heterogeneity. The criticism focused on the welfare profession within CYH services, which is dominated by women. Other physiotherapy groups were probably indifferent to the issue or shared perhaps the critical views on their colleagues. At stake was the unity within the professional group, which was an important part of the trade union strategy. In a situation like this, to strain profession solidarity by taking an active public part in the media and thereby
running the risk of sundering or of fomenting profession type and gender-oriented inner antagonisms seems clearly an unsuitable strategy.

**Teamwork in the habilitation services**

While the heterogeneity within the profession can contribute to our understanding of the passivity of the union and professional organization, another question is why the physiotherapists within habilitation services, those who were directly in focus of the criticism, were so passive in the debate. To highlight that question we want to draw attention to some specific characteristics of work and organization of the habilitation services.

In physiotherapy, as in a majority of the professional education programmes, the gap between theory and practice has long been under discussion. Newly-fledged physiotherapists are known to be badly prepared for the concrete work tasks in their professional field of practice. Due to a diminishing amount of practice during the programme, they have to rely on the workplace where they are first employed to learn certain practical elements. In this respect, habilitation is probably particularly exposed. During the education programme, the students get a limited knowledge on the key target groups in habilitation. One of our key informants, Henrik, a long-time chairman in the paediatric section for habilitation services, argues that although physiotherapists that start off within CYH services directly after their education programme train their skills, ‘In the beginning I don’t think they have what it takes. I believe a graduate conductor knows much more about CP treatment in practice’.

This is also a theme, which in various ways reappears in the workplace interviews. Petter describes his debut on a habilitation ward as ‘being in deep waters’, and another relatively fresh graduate of physiotherapy expressed his view on work methods in the following way:

> I have no model. So far anyway. I wonder if there is any. [...] I don’t think I want to hold on to a model in any case. I usually say that I experiment with the children I find it difficult to treat. There is both good and bad in this word, to ‘experiment’. However, from the good side, I pick whatever suits the child and myself best. Still, there is no model that fits all children, no, I simply adapt myself to the child at hand all the time.

The individual physiotherapist’s work process becomes particularly complex due to her/his double role as ‘general practitioner’ and ‘specialist’. While all physiotherapists by virtue of their education are qualified to execute some of the tasks (‘specialist’), the joint habilitation knowledge (‘generalist’) is learnt in the workplace. The model with joint teams emphasizes the generalist aspect of the work, articulating what all the participating professions have in common. The physiotherapists have an almost daily contact with many of their collaboration partners from other professional groups within CYH. The forms of collaboration are here similar to what Waks (2003, 146) calls complementary. The objective is to add the physiotherapists’ knowledge to that of the rest of the team; however, they do not share the actual tasks that the physiotherapists often carry out single-handedly. This has a strong uniting impact on the CYH team. The feeling of being part of a collective is stronger than in other physiotherapeutic practices and entails a demand for shared points of view and solidarity with other professional groups. Consensus is the predominant value and form of making decisions.
The team organization also creates another problem as it tends to give priority to cases that are possible to help and 'cure' according to the dominating medical paradigm, discarding problems when the hard-to-treat illnesses, mainly CP and physically disabled, are discarded. Molly, a long time practitioner in the occupation expresses this:

The disadvantages as I can see it when we are in a team meeting is that it is hard – and [...] everyone is aware of this – to take time for the seriously disabled children whose situation we cannot change all that much but which is there. It is easier to make room for the team that specializes on Autism Spectrum Disorders, which are much more turbulent. The team spends a lot of time on them. The seriously disabled that we continue to treat on the quiet and who need frequent assistance and who often raise medical questions are usually not brought up for discussion.

The general uncertainty these conditions create in physiotherapists within CYH services are unlikely to encourage a debate in medias about the target group’s problems and CE, which moreover is a method about which they have an insufficient knowledge (Lind 2003). The high degree of interaction, solidarity, and institutional medicalization all contribute to consolidate a feeling of insecurity toward the surrounding world. Generally, this makes it difficult for a part of the collective – the physiotherapists – when they are being attacked as in the controversy.

Habilitation physiotherapy has a lower status than both other public physiotherapy groups and the minority that work in private practice or as self-employed therapists. This is also the case for a majority of the professions within CYH services in relation to their colleagues in other services. One of our key persons answers the question whether it is considered as low prestige being a physician within habilitation services positively: ‘there exists an internal pecking order within the medical profession as well. I know that among orthopaedists they just don’t rate surgery in CP patients very highly’. This is also a common way of thinking among the habilitation staff we interviewed; for example Bess, a late-in-life educated physiotherapist, claims that the CYH services, just like elderly care and psychiatry, have a low status. Maybe the speech-language therapist Olga best illustrates this situation in her description of the attraction this field had on her and her fellow students:

It wasn’t that I definitely not wanted to work with habilitation, this was not the case. However, several among my fellow students were like that. That’s how it is with status, you know. They are no high-status choices, that’s for sure.

There is reason to presume that this point of view contributed to the low profile the physiotherapists kept in the debate. They were not only in a subordinate position in relation to the physicians, they also had a low status within their own profession, which had an influence on their propensity to take a defensive stand regarding a field (CE) of which they had relatively limited knowledge.

Finally, the passivity of physiotherapists probably has something to do with the fact that the debate occurred at a time when physiotherapists were just about to change their professional strategy and aims. At the time, the physiotherapists were still doing ‘hands-on’ treatment. A majority among them are practically oriented and genuinely uninterested in research (Bellner 1997) and only a small ambitious group are apologists for ‘evidence-based thinking’. Almost all professional practitioners
were trained in programmes where the connection to research was weak and practical elements extensive. Many of our older informants still express, almost a decade later, a sceptical view of research-based thinking and the consultative work model. At the time of the controversy, the physiotherapists had not yet moved from an emphasis on practice, experience, and direct treatment work to consulting work and research-oriented, evidence-based thinking. However, the relevance of evidence-based physiotherapy is disputed ground. Norma, professor in medicine and governmental expert on evidence-based methods within human services, raises doubts that there is a sufficiently high degree of scientific awareness:

There are not people enough scientifically trained. It is so to say not a natural part of the everyday work. I can also imagine that there in this group exist some amount of contempt for research saying that we only take interest in sick rats.

A contributory cause as to why physiotherapists kept a low profile in the debate may thus have been that they were not ready to take to the field and defend themselves. They had an ambivalent position within the habilitation teams. They were to a large extent working with low status patients in a low status branch of their field and they had not at the time established themselves as scientifically-oriented consultants but were still very much a ‘hands on profession’. Consequently, they acted as passive witnesses as the physicians defended both habilitation services in general and physiotherapists and their work in particular.

Discussion

The debate on CE was sometimes fierce and attracted attention in the media. Mullback’s accusations were directed towards Swedish disability policy in general and the CYH in particular. The most criticized professional group were the physiotherapists who – next to the National Board of Health and Welfare’s intent of banning this method through the Restricting Medical Quackery Act with their lack of knowledge about CP impairments and their defective methods – were the biggest obstacles to access to CE for children and youths with CP.

However, in the debate the physiotherapists kept quiet – it was the physicians who replied to the charge. It is this silence from a relatively well-established profession that we have tried to understand using some concepts from the sociology of professions.

The physiotherapists’ successful professionalization strategy meant among other things that they subordinated themselves to medical science and accepted the medical profession’s intellectual jurisdiction. The physicians handled diagnosis and inference while the physiotherapists mainly carried out the treatment, an almost general paradigm also evident within CYH services. The physicians also had legal jurisdiction through CYH’s legal and organizational position in the health care system. The other professions within the teams, however, principally handle direct contact with the patients. Through their popularity with users and their place within the medical paradigm, the physiotherapists have a strong position in the workplace arena.

This subordination to the medical profession may therefore primarily be said to be a paradigmatic subordination. In the direct organization and execution of
treatments, physiotherapists have a relatively independent role in relation to physicians but are instead limited by teamwork demands.

Given the well-established role of the medical profession in society, and its intellectual and legal seniority over physiotherapists, it may seem natural that it was the medical profession that defended CYH services and physiotherapists. In addition, the relationship between these two groups has its symbiotic features. They share the medical paradigm and are within the framework of this relationship mutually dependent on one another. In the same way that physiotherapists depend on the physicians’ diagnoses and referrals, the physicians depend on the physiotherapists’ treatment competence. They also have a common interest in counteracting treatment methods, which like CE, are based on another professional competence and indirectly threaten the balance in CYH team organization. This feature of symbiosis could have had as a result a joining of forces in the debate by, for instance, coordinating their media contributions systematically, by making joint statements, or by appearing alternately in the debate, dividing the media appearances, and thus attacking on different media fronts. That this never happened has probably to do with inherent characteristics in the physiotherapist profession.

One reason behind this muteness may be that at the time of the debate physiotherapists were in the middle of a reorganization of their professional orientation that put more emphasis on science and evidence-based thinking, simultaneously as they profiled themselves as consultants for other professions that carry out direct treatment.

That the physiotherapists, as a professional group, did not participate in the debate probably also has to do with the heterogeneity of the group. The professional types we have identified among physiotherapists seem to have different interests within separate fields. To back the issue on CE may have had a disuniting effect on the profession. However, the CE issue most probably did not even interest a majority of the members, notably among occupational healthcare and self-employed physiotherapists but also among large numbers of physiotherapists employed in clinically organized services, since the domain claims of CE only challenged habilitation and possibly paediatrics and child neurology.

Several of our informants have testified to the difficulty of balancing professionspecific specialist knowledge with the role of a generalist that is integrated into a team organization. The heterogeneous clientele also create an uncertainty since they seldom ‘fit’ a specific treatment method without difficulty. In addition, our informants have given us ample testimonies about the low status that habilitation services have within different professional groups, which, in its turn, has to do with the fact that the clients they meet demand long-term contacts and that, in the short-term, ‘success’ in the form of rehabilitation results are hard to determine.

Obviously, one cannot disregard the gender aspect and that the behaviour of the here-studied professional groups can be seen as parts of the gender system and gendered power structures (Hirdman 1998).

The physiotherapists within CYH as well as in the physiotherapists union are predominantly women. It is also mainly women who show an interest in the issues – research – that the vocational strategy primarily is based upon, while the interests of male practitioners point in a completely different direction. On the other hand, all the physicians that expressed their critical views on CE in the debate were men.

From this point of view, the different strategies taken in the controversy could be interpreted as a reflection of an unconscious and deeply rooted gendered pattern of
dominance and subordination. But physiotherapists were not forced to be silent: they adopted that position apparently without any hesitation or major internal discussion. In that way, their silence in the debate mirrors their ambivalent position in relation to the medical profession, being subordinated and symbiotic at the same time. This position has been one of the mechanisms behind their largely successful professionalization project. In a paradoxical way, they never hesitated to use this mechanism to reach their ultimate goal: emancipation from the same subordinated role.

Notes
1. Judging by the way this debate was reflected in the profession’s trade union journal *Sjukgymnasten* [The physiotherapist] they balanced between a probing curiosity and occasionally a disconcerted and incoherent attitude as to which position they should take towards the CE challenge (see the special issue (1/97) on CE).
2. Although many of our key persons are well-known to the relevant strata of the Swedish public, we have allotted them pseudonyms, in accordance with the mode of procedure for all other interviewees.
3. By subordination, we mean that one professional group has a long-lasting hierarchical dominance over another. Symbiosis refers to a more than temporary and important coexistence between different groups *from which both parties profit*.
4. Abbott points out, as an example of intellectual jurisdiction, psychiatry in the post-second world war in the USA, which despite that different professions such as psychologists, priests and psychotherapists work there was influenced by psychiatric knowledge.
5. Today there are only three cases where physicians still hold this double function, but before the legal amendment in 1997 – i.e. at the time of the controversy – this was relatively usual.
6. CE does not challenge diagnosis or inference primarily but the treatment claim. Instead, CE backs the medical interpretation of the significance of CP disabilities but argues that the treatment must be *educational* and that the effects of a CP disability occasionally may be cured. This is probably one reason why some physicians express themselves in a relatively conciliatory manner on the subject of CE.
7. Brante’s classification into professional types can be considered as one among many contributions within profession sociology where differences as well as similarities within a specific professional group are stressed and connect the same profession to separate professional fields and different material conditions (see Dæhlen and Svensson 2009, 123 ff. for a short survey). Thereby the analysis is liberated from the idealistic description based on joint education programmes and registered qualifications as decisive factors in understanding the specificity of professional groups.
8. The professionalization ambitions in itself may, as Waks (2003, 173) has noticed, have an opposite effect.
9. Ottosson seeks an explanation of the professional development ‘from a male high-status occupation associated with *scientificity* and *autonomy*, to a female occupation in the backyard of medical science’ in the early conflict between the Swedish Medical University Karolinska Institutet and GCI (Stockholm University College of Physical Education and Sports), a power struggle between different male interests. Women entered the scene at a point of time when this conflict was not yet settled on the one hand and on the other hand ‘their entry did not entail any strike actions’ (2004, 83–92).
10. Today, circa 10–20% compared to the 5-term education programme which according to the 1977 higher education reform stipulated 25–30% (Öman 2001, 15; Andersson 2006).
11. The equivalent of a half-term – at a high estimate – of the six-term education programme.
12. See Johansson 1997a, 238, Table 23.

References
Abbott, A. 1988. *The system of professions*. London: University of Chicago Press.
Andersson, T. 2006. Personal communication with Administrative Director Tonnie Andersson, LSR 20060510.
Bellner, A-L. 1997. Professionalization and rehabilitation. The case of Swedish occupational and physical therapists. Diss., Department of Health and Society, Linköping University.

Bergman, B. 1989. Being a physiotherapist – Professional role, utilization of time and vocational strategies. Diss., Department of Physical Medicine and Rehabilitation Umeå University.

Bohlin, U. 2009. Habiliteringen i focus. En människobehandelnde organisation och dess utmaningar [The habilitation services. A human service organization and its challenges]. Lund, Sweden: Lund Dissertations In Social Work.

Bohlin, U., O. Mallander, and M. Söder. 2001. Habiliteringen ifrågasatt – Den konduktiva pedagogiken som organisatorisk, professionell och kunskapsteoretisk utmaning [The habilitation services questioned – Conductive Education as an organizational, professional and epistemological challenge]. Forskningsrådet för arbetsliv och socialvetenskap. Ansökan Dnr 2001-2106.

Brante, T. 1990. Professional types as a strategy of analysis. In Professions in theory and history. Rethinking the study of professions, ed. M. Burrage and R. Thorstendahl, 75–93. London: Sage Publications.

Conrad, P. 1992. Medicalization and social control. Annual Review of Sociology 18: 209–31.

Dahlen, M., and L. Svensson. 2009. Profesjon, classe og kjønn [Professions, class and gender]. In Profesjonsstudier, ed. A. Molander and L.-I. Terum, 119–29. Oslo: Universitetsforlaget.

Hellberg, I. 1999. Altruism and utility: Two logics of professional action. In Professional Identities in Transition, ed. I. Hellberg, M. Saks, and C. Benoit, 27–42. Göteborg, Sweden: Department of Sociology.

Johansson, S. 1997a. Sjukgymnasters arbete [The physiotherapists work]. Stockholm: Arbetsmiljörådet.

Johansson, S. 1997b. Hälsoprofessioner i välfärdsstatens omvandling [Health professions in the transformation of the welfare state]. In Om makt och kön – i spåren av den offentliga sektorns omvandling [On power and gender – On the heels of the transformation of the public sector], ed. E. Sundin, 69–102. SOU 1997:8. Stockholm: Fritzes.

Larkin, G. 1983. Occupational monopoly and modern medicine. London: Tavistock.

Lind, Lena. 2003. One more time: Habilitation teams' conceptions of conductive education and support to children with motor disabilities. Diss., Inst. of Education Press, Stockholm.

Mullback, L. 1996. PETO-metoden och svensk Cp-behandling [The Petö-method and Swedish Treatment of people with CP]. Folket i Bild/Kulturfront 11/96. http://www.fib.se/mullback.html

Mullback, L. 1997. Anklagelser [Accusations]. Stockholm: Hägglunds förlag.

Odelberg, J. and L. Mullback. 2000. CP-skadades rätt åsidosättts [The rights for people with CP are disregarded]. GP 2000-09-29.

Öman, A. 2001. Profession on the move. Changing conditions and gendered development in physiotherapy. Diss., Department of Public Health and Clinical Medicine, Umeå.

Ottosson, A. 2004. Avmaskulinisering. Ett alternativ till omkodning av kön? [Demasculinization. An alternative to decoding gender?]. Kvinnovetenskaplig Tidskrift 1–2: 81–98. Statistik Arsbok. 2003. [Statistics of Sweden]. Stockholm: SCB.

Waks, C. 2003. Arbetsorganisering och professionella gränssnittningar. Sjukgymnasters samarbete och arbetets mångfald [Organization of work and professional Boundaries – The co-operation of physiotherapists and the diversity of work]. Diss., Department of Business Studies, Uppsala.

Witz, A. 1992. Professions and patriarchy. London: Routledge and Kegan Paul.