WHAT *IS* WRONG WITH OSTEOPATHY? A RESPONSE TO THOMSON AND MACMILLAN

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Abstract

Thomson and MacMillan's paper *What's wrong with osteopathy?* has understandably caused some consternation within the profession. In this commentary I want to support the intent of their argument, but also suggest they do not go far enough. Western healthcare is entering a post-professional era which will profoundly affect every profession's identity and social purpose. The effects of late capitalism on the atomisation of the body, the unbundling of goodness and expertise, and the transformative effects of digital technologies are not commonly discussed issues in osteopathy, but they are becoming central concerns for any profession looking to adapt to future healthcare. In this essay, I briefly outline the challenges of post-professionalism and explore some of the reactions we have already seen in other professions like physiotherapy. Four response archetypes are identified: watching and waiting, a modern heritage approach, professional renaissance, and hybrid professionalism that, I argue, lies behind Thomson and MacMillan's proposition. All four of these approaches are shown to have significant limitations, so the paper ends with some suggestions for a direction that might be a better way forward for osteopathy.

'Declarations of interest: none'.

Keywords: biopsychosocial, healthcare reform, hybrid, physiotherapy, post-professionalism

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Introduction

Thomson and MacMillan's paper *What's wrong with osteopathy?* (Thomson & MacMillan, 2023) has understandably provoked a lot of discussion in the osteopathy community in recent months, in part, perhaps, because the profession is unused to this kind of critical scholarship. If it were more commonplace, it is possible that the authors would be seen to be doing a valuable service to the profession because all mature professions should be critically reflexive and responsive to the changing demands of society. Osteopathy in Mumbai today *should* be radically different to the osteopathy envisaged by Still in 1870s Missouri. The question, though, is what should persist; what should be carried forward from 19th century America to the 21st century sufficient to retain osteopathy's core identity? It is this tension between what must remain and what must change that many sociologists of the professions have contemplated over the last century, and to which Thomson and MacMillan turn.

Some have suggested that they go too far: that their critique is too destructive, and that their portrayal of osteopathy's core beliefs is misguided. In this paper, I want to suggest that their critique does not, in fact, go far enough. And that while I agree with much of their portrayal of osteopathy, I think their recommendations for change are too timid. Given what we know about the post-professional era healthcare is now entering, Thomson and MacMillan's solutions to osteopathy's professional self-interest and theoretical 'thinness' seem to suggest that a more overt commitment to humanism and holism will be sufficient to retain and grow osteopathy's social capital. But I believe this makes the fundamental mistake of thinking that osteopathy will be in control of its own professional destiny. Post-professionalism, if it is teaching us anything, is showing us that the long century of professional power and self-determination is coming to an end, and not only will orthodox professions be increasingly de-centred in the organisation of future healthcare, but that their ability to influence the process will also diminish.

Thomson and MacMillan suggest that greater humanism (through a greater focus on person-centred and critical/emancipatory osteopathy), and a more holistic approach to practice (by being more bio-psycho-social) offer solutions to the anxieties and frustrations a lot of health professionals, including osteopaths, are now feeling. But rather than seeing them as solutions, I want to suggest that they be seen as *symptoms*; as empirical evidence of a much more significant shift now taking place across the entire sphere of contemporary Western healthcare.

So, while Thomson and MacMillan's paper does a huge service to osteopathy in opening up a debate that could have enormous implications for the profession, I want to use their paper to push further, into the arguments now being made about post-professional healthcare and explore what might be left for osteopaths to do.

My bona fides

The first thing to acknowledge is that I am not an osteopath, so I have no deep sense for the history and culture of the profession. I have no place commenting on osteopathy's epistemological and ontological assumptions; osteopathic praxis and tacit knowledge; its beliefs and values. Equally, I have no dog in this fight; I have no side to

defend; no particular vested interest to promote. My professional background was as a public-sector respiratory physiotherapist, but for the last 30 years I have been an academic with a deep interest in the philosophy and sociology of the professions.

I was the founding Chair of the Critical Physiotherapy Network and the International Physiotherapy History Associations, and I have written extensively about the conditions that made physiotherapy historically and culturally possible, as well as books titled *The End of Physiotherapy* (Nicholls, 2017) and *Physiotherapy Otherwise* (Nicholls, 2022). I have always had an abiding interest in manual therapy and manipulative professional practice because evidence shows that these are the most innovative and creative arms of the physiotherapy profession. I have written histories of IFOMPT and interviewed many of the founders of modern musculoskeletal physiotherapy. I have drawn on the manual therapies as a source of empirical data for critical analyses of where physiotherapy came from, why it was facing its present problems, and where it might be going (Nicholls, 2021; Nicholls, 2023; Nicholls & Vieira, 2022; Nicholls & Nicholls, 2020). And I have taught osteopaths about the history of manual therapies and the challenges both musculoskeletal physiotherapists and osteopaths now face.

My experience has taught me that there are many differences between physiotherapists and osteopaths. Some of the differences are socio-political (physiotherapists, for instance, have traditionally held stronger ties to public health system and to orthodox Western biomedicine), others are theoretical (osteopaths, I believe, have a broader ontological framework and maintain a more open relationship with non-Western biomedical explanations for health and illness). But there are similarities, too. Both professions give primacy to 'physical' causes of illness, and have never engaged meaningfully in existential or phenomenological philosophies of health and illness. Neither profession has seen itself as an advocate for broader social questions, such as the reduction of poverty, prejudice, environmental degradation, and other significant determinants of health. And neither profession has a population-scale model of practice, preferring one-to-one care whenever possible.

So, my hope here is that my parallel experiences of thinking critically about the future for physiotherapy will offer some insights that are useful to osteopaths. Not being an osteopath has its limitations in discussions like this, but I also hope I can bring a degree of objectivity to the discussion that might not otherwise be possible.

What is wrong with Thomson and MacMillan's osteopathy?

In brief, Thomson and MacMillan argue that:

- Osteopathy has an inherent biomedicalism and a practitioner-centric philosophy of practice that limits the profession's capacity for critical thought and practice;
- The profession has a weak theoretical basis, relying on persistent founding mythologies that it is reluctant to supplant;
- Osteopathy's focus on the biomechanics of the body and its emphasis on manual therapy undermines any claim the profession might make to holism or person-centredness.

Thomson and MacMillan's solution to this to argue that the profession should become more person-centred, phenomenological, inter-subjective, and enactive; 'incorporating new theories and methods to account for the complex psychosocial context of they individual patient' (Thomson & MacMillan, 2023, p. 3). They also suggest that osteopathy should become much more critically self-reflective and open to alternative ontological positions, creating new identities such as critical and phenomenological osteopathy. The problem with these recommendations, I would suggest, is that ultimately they will be inadequate to address the underlying tensions now facing osteopathy and many of the other healthcare professions.

Take, for example, Thomson and MacMillan's argument that osteopaths should embrace more psychosocial, experiential, and (inter)subjective approaches to healthcare. This sounds reasonable at first, because what profession could expect to prosper by ignoring the lived experiences and personal perspectives of its clients? But what this call fails to answer is why this is only being asked now? What has changed in the world to make this necessary when it wasn't necessary 10, 20, 50 or 100 years ago? Osteopathy isn't alone here. Most healthcare professions have followed Thomson and MacMillan's lead in recent years and staked a claim to the biopsychosocial model (BPSM) (Gentry et al., 2018; Erb & Schmid, 2021; De Groef et al., 2022; García-Martínez et al., 2022; Long et al., 2022; McLaren, 2022). And each has struggled to find a way to reconcile their desire to retain a distinctive professional identity whilst also being all things to all people (for what is holism if it is only partial?). None have successfully resolved the internal ontological inconsistencies of a holistic approach, which allow for reality to be constructed in wildly different, and necessarily incompatible ways. Some try to suspend the illusion that pain and illness, for instance, can be both a biological and non-biological phenomenon at the same time (in the current debate around the nature of chronic pain, for instance). Others simply ignore the fact that the adoption of an holistic model of practice like the BPSM demands that the profession gives up its professional identity. Because if osteopaths truly embraced the full implications of the bio-psycho-and-socio dimensions of health, they would have to embrace a panoply of new concepts and ideas (as well as supplanting many other professions who may have much stronger historical affinities with those positions). Many of these new concepts and ideas would be incompatible with each other, never mind the fundamental tenets of osteopathy. So, could osteopathy do what no profession has ever managed to do before and accommodate biological realism, phenomenology, and social constructionism and still claim to have a distinctive professional identity? It seems both unlikely and professionally undesirable.

It is understandable that osteopaths, like physiotherapists, nurses, psychologists, occupational therapists, and many others, are now looking at expanded models of practice. We have seen it in the moves towards specialisation and advanced practice, and in the move towards masters and doctoral entry university programmes. But, like the drive towards holism, these are *symptoms* of a much greater problem, not the solution. At best, they are ready-made suits that we don to feel smarter, more sophisticated and powerful. But they are illusions and empty calories if we use them inappropriately. They can be very useful, though, if we *do* see them as diagnostic markers; as the *effects* and indicators of the discourses now pressing down upon all of the healthcare professions.

To understand how they can be useful then, we need to invert our normal way of thinking about professional development. Rather than seeing osteopathy as the origin and instigator of professional reform, we need to think about osteopathy as an *effect*, the *achievement* or *response* to a set of social questions. Osteopathy, like all the healthcare professions, is a historical response to a particular cluster of issues that has retained its relevance for more than a century. But this does not mean that it is either the best or the only response; only that it is one amongst many contingent responses to a specific set of social issues. One interpretation of this is that osteopathy became historically important because it offered an effective response to the preponderance of pain and functional disability at a time when human productivity was a primary concern for economically ambitious nations. If those social problems remain, and osteopathy can argue that its response remains superior to other professional responses, then there is no reason to think osteopathy will go out of fashion. But, if the social problems change, then osteopathy also has to change, or it inevitably risks losing its status. And here lies the dilemma, because for it to *be* osteopathy, the profession has to retain a degree of internal consistency. But to hold on to an outdated identity in the face of widespread social change puts the future for the entire profession in jeopardy.

Hence why indicators of dissent in the profession are useful because they point to the ways in which osteopaths are now grappling with this problem. But, more significantly, may point to the realisation that things are indeed changing in the world of healthcare, and that osteopathy, like all the professions, is facing up to some threats and challenges that they have never had to face before. These can broadly be nested under the emerging concept of post-professionalism, and need to be considered carefully.

Challenges facing the profession(s)

Osteopaths, like all health professionals, are facing some profound social challenges. Be it the increasing demands for holistic healthcare for ageing populations of increasingly complex, comorbid, chronically ill people; digital technologies and the rapid rise of AI and digital data; peoples' appetite for personalised healthcare demanding more choice, greater flexibility, and more control over the services they receive; demands for ever increasing levels of professional expertise and specialisation, married to the publics' progressive loss of faith in once powerful — often professional — authorities; the pressure to remain up-to-date with the latest evidence-based findings; the loss of control of knowledge that was once 'ours' (with most of the information contained within a health curricula now openly available online); threats of encroachment from other professions looking for competitive advantage and greater social prestige; the rising cost of healthcare matched with the desire by governments to cut and contain healthcare expenditure; the rapid privatisation and atomisation of health and the growing social gradient between those who can afford professional care and those who cannot; the downstream costs of unhealthy lifestyles; and the growing critique of the regulated professions for their intransigence, stubbornness and resistance in the face of change.

And we can add to these *general* healthcare challenges with problems inherent in being a comparatively small healthcare workforce. Susan Nancarrow (co-author of the excellent 2021 *The allied health professions: a*

sociological perspective (Nancarrow & Borthwick, 2021)), wrote recently that small allied health workforces often suffer from:

- a lack of knowledge and awareness of the profession, which in turn leads to fewer referrals for the service and a smaller pipeline of prospective workers;
- a lack of visibility at policy and service levels;
- being under-represented in large organisations, therefore lacking a voice within institutional structures;
- under-representation in leadership roles;
- not be captured in national census data, which further diminishes the visibility of the professional group (Nancarrow, 2022).

If this weren't enough, we can add to this very 'local' anxieties that osteopaths, physiotherapists, and others are now openly expressing online: that the profession is spread too thin; that our professional status is in decline, and that there doesn't appear to be a clear plan for how to get it back; that we lack the skills to be creative and innovative; that evidence-based research repeatedly undermines what we know to be good about our work; that our professions are engineered for curative approaches towards acute, episodic illness and injury, in a world that needs sustained, long-term care where no ready fix is possible; that our remuneration is not keeping pace with rising student debt, making our professions less-and-less attractive to new graduates; and that our care model was always individualistic, meaning we have no scalable, population-level approach to healthcare.

We would undoubtedly be better equipped to handle these challenges and possibilities if we had a solid training in anthropology, cultural studies, economics, the humanities, philosophy and politics, the social sciences. But our training only rarely, if ever, included even the merest mention of these things. Instead, we learned anatomy and physiology, pathology and biomechanics, diagnostic and treatment techniques: approaches that worked well in yesterday's healthcare, but are looking increasingly rigid, removed, and perhaps even redundant today. Even the skills of evidence-based medicine and the design of clinical trials that many in our professions have turned to in recent years, will be of limited value to our professions because so many of the challenges we now face are fundamentally sociological.

The sociology of the professions

Fortunately, osteopathy and the other professions are not operating in a vacuum. There has been an enormous body of sociological work analysing the past, present and future for the professions over the last 100 years, and there is even a long history of sociology dedicated to healthcare. But this work has mostly concentrated on medicine and nursing, and the professions *allied* to medicine have been given little attention (Cheek, 1997; Nettleton, 2013; Jones & Bradbury, 2018; Nancarrow & Borthwick, 2021). The sociological focus on healthcare has become much more intense in the last decade, however, because healthcare is now seen as *the* place where broader social questions about the role of expertise, digitisation, labour restructuring, educational innovation, and nation-wide economic restructuring are taking place.

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Healthcare, and healthcare education, has lagged behind other professional reforms. Where areas like agriculture, banking, construction, entertainment, journalism and media, manufacturing, the primary industries, retail, sport, telecommunications, tourism, and transportation had been radically restructured over the last 40 years, healthcare and education have eluded transformative change (Susskind & Susskind, 2015; Austin et al., 2016). This was due to what Edgar Burns described as their special claims to goodness and expertise (Burns, 2019), combined with the monopoly power of medicine and enormous social capital. This has all changed in recent years, however, as healthcare (and education) are now increasingly seen as vast, new, untapped territories, somewhat akin to a New World, holding enormous unexplored potential for market exploitation, commodification, and enterprise. Consequently, over the last two decades, we have seen the rapid, diffuse proliferation of new experts, new knowledges, and new markets across the entire healthcare and education sectors [1].

This seismic shift is already fundamentally altering what societies ask of their experts and healthcare providers. And such a shift will inevitably demand professions like osteopathy respond and change accordingly, or risk becoming obsolete. From a sociological perspective, there are perhaps two conditions that seem to hold the most significance for the contemporary moment in the evolution of all the healthcare professions: the atomisation of the body in late capitalism, and the critique of the professions' claims to goodness and expertise.

The atomisation of the body in late capitalism

Early capitalism refers to the period broadly from the 17th to the 20th centuries synonymous with the Industrial Revolution. During this period capitalism emerged as a belief in the possibility for unlimited economic growth. As long as raw materials could be found and manufactured, the demand for goods and services would always create

[1] Evidence of this is everywhere across the media today, and it seems every aspect of human health and wellbeing is now the subject of new experts with new advice to give and new things to sell. From food to exercise, relationships to work, better sleep to focused energy, optimal health is just one gym memberships, one new diet, one new app away. There was a great example of this recently with an article in the British newspaper The Guardian titled ''I'm not just faster, but taller': how I learned to walk properly – and changed my pace, posture and perspective' (https://tinyurl.com/2jubmd2r, accessed 20 June 2023). The article focuses on the work of 'fitness expert' Joanna Hall, who pioneered a 'WalkActive system' (including personal coaching, an app, and an follow-along four week program), to teach people that they have been walking wrongly for years and how, by walking 'correctly' they can change their life. Comments on the article suggest some people love this approach, others think it is an example of a world gone mad. What is telling though, is that someone without any formal training can today become an expert of something as mundane and quotidian as walking, and seemingly make a handsome living doing so. Just as it's now possible for someone to learn how to perform a high-velocity thrust manoeuvre on the cervical spine from a YouTube video, it seems a far cry from the kind of healthcare our grandparents once knew.

surplus value, which could then fuel economic prosperity. As resources 'at home' because exhausted, developing nations turned to global expansion to drive growth.

'First world' countries argued that they needed to colonise other lands and peoples in order to fuel growth at home, and this was achieved by 'hard' colonisation (war, brutal repression, enslavement, treaties designed to acquire land, etc.) and 'soft' colonisation (including governance over new territories, the imposition of Western education systems, religious missionary work, new citizenship rights, organised healthcare, etc.) (Lester & Dussart, 2014; Connell, 2011). All of these measures helped supply the 'cheap' natural resources as well as the fit, able, and cheap workers to fuel the machinery of capital, whilst also giving the colonist the sense that their work was a form of charitable, enlightened and 'ruthless benevolence' (Fitzpatrick & Protschky, 2009).

Clearly, politicians and captains of industry could not do all of the work of building hospitals, teaching schoolchildren, maintaining the roads, and running the farms all by themselves, so an 'enabling class' of trusted and specifically trained workers was created to do the groundwork of capital expansion. This new professional class willingly took up the work of governing at arm's length: administrators, doctors, lawyers, ministers, and teachers became the front line of early capitalist expansion, in return for protective legislation, subsidised training and practice, and a newly created 'closed' market — known now as 'healthcare' — in which to operate. This has been variously called the 'grand bargain' or the professions' social contract (Cruess, 2006; Relkin, 2016; Razavi et al., 2020).

Because of the power of this system to feed prosperity at least for some, early capitalism remained the main economic driver in most high-income countries until the latter part of the 20th century. But since then Gross Domestic Product (GDP), productivity, and countries' balance of payments have continued to decline, in large part because it is harder to find new land to colonise and cheap labour to exploit. In its place, new forms of capitalism — known as late or 'advanced' capitalism — began to emerge in the mid-1970s with a raft of neoliberal economic reforms, new forms of global economic market speculation, and the automation and restructuring of commodity supply chains. Crucially, though, late capitalism turned the idea of unlimited growth and expansion *inwards*. Instead of looking overseas for new lands and people to exploit, late capitalism has turned towards individual people: people's bodies, people's lifestyles and habits, people's relationships, people's work… In fact, every possible facet of human existence has been turned into its own specialised field, replete with commodities and consumer goods, as well as a raft of dedicated experts, counsellors, coaches, and advisors. In effect, every single aspect of human life has been atomised: turned into its own market and the possibilities for unlimited growth — and the future for a new form of capitalist exploitation — appears restored (Giddens, 2013; Kennedy, 2015; Gough & Eisenschitz, 2022).

This has obvious implications for all health professionals because, on the one hand, we have seen a vast new field emerge in which the knowledge and skills we once commanded have taken on new relevance. But, on the other hand, this newly 'atomised' human being has been opened up as a market for any and all who can find an as yet un-tapped market opportunity. Late capitalism is forcing the complete reorganisation of the orthodox health professions, but it is only one of the two main drivers of change we need to consider, though. The second comes from the growing critique of the professions' claims to historic goodness and expertise.

The critique of the professions' claims to goodness and expertise

The second shift shaping post-professionalism comes from the branch of sociology specifically dedicated to the study of the professions. Sociologists have been studying the professions for over 100 years, since, in fact, the first elite professions consolidated their power and became apex social actors (Lupton, 2012). Before 1900, 'professions' largely took the form of trade guilds for the working classes, and small gentlemanly occupations for those who worked for pleasure rather than financial necessity. Few organised professional bodies existed. The development of the professions we know today only really occurred between 1870 and 1920 as Western economies grew and a new rising middle class sought avenues for educational expression, meaningful work, guarantees of a liveable wage and, crucially, social prestige. Professions like medicine, osteopathy, physiotherapy, psychology and nursing were born in this era. This led to an extraordinary growth in social capital for those professions that could demonstrate their legitimacy.[2]

From the 1920s onwards, sociologists began studying how it had been possible for this new incredibly powerful professional class to emerge. In the case of medicine — perhaps the most studied of all of the elite professions — the invention of anaesthesia and antisepsis, along with the discovery of 'germs', X-rays, the ECG, blood transfusions, vitamin deficiencies, penicillin, and the synthesis of insulin, penicillin and vaccines enchanted the population. But it was the ability to couple this sense of the profession's newfound expertise with the 'goodness' that came from its claim to be altruistic and public-spirited that really consolidated its power and prestige.

Early functionalist sociologists of the professions thought that medicine had achieved its remarkable levels of social advantage because it brought balance and order to society. The calculus was straightforward: for every illness there would be a cure, and doctors would be given enormous social license in return for their unstinting work to rid the world of disease and illness. These early sociologists gave us the traits that we still use today when we try to distinguish a true profession from someone that is merely *semi*-professional; they connected health to Darwinism and Henry Ford's production lines; like medicine, they saw the body as a machine, and the 'sick role' as a contract between the individual, the state, and the doctor (Saks, 2010; Varul, 2010). These early 'functionalist' sociologists re-shaped medical training (see The Flexnor Report, for example Duffy, 2011), and explained the necessity of organising the clinic, the hospital, and the healthcare system entirely in medicine's image.

[2] It is perhaps worth remembering how medicine was viewed by the public prior to the discovery of germ theory in the 1880s and the placebo effect in the early 20th century. Prior to this, doctors were often characterised as alienists, butchers, and charlatans. So it is perhaps unsurprising that their transformation into an elite social class after WWI should draw the attention of sociologists.

But this sociological view really only held sway in the 1930s and 40s. Since the 1950s, the vast swathe of sociology of the professions has been critical.[3] Rather than lauding medicine's remarkable achievements, sociologists have been raising concerns about the power medicine acquired for itself; a power that increasingly seemed to be:

- Perpetuating a Western, Enlightenment, rational, mechanistic, instrumental, pathology-centred view of bodies and illness, undermining the contribution people's cultures and histories, subjective beliefs and values, relationships and communities, and social circumstances make to health and illness ;
- Using its power to define what is considered normal and abnormal, mad and sane, health and sick and, in so doing, stigmatising people whilst furthering its own interests;
- Promulgating a gendered division of labour that pushed women into low-paid, abject, low-prestige work (the work of caring for the sick and injured, for instance, which was seen as a woman's natural tendency — and unworthy of high pay and prestige, compared to the skilled technical work demanding high pay and social status for men);
- Insisting on the necessity of governing itself as a way of hiding its faults and failures, ethical misdemeanours and malpractices.[4]

These were not isolated critiques, but represent decades of sustained scrutiny of medicine's much vaunted goodness and expertise. Without this critique, it is unlikely that we would have as much choice in healthcare providers as we do today. Questions of professional power and lay-professional relationships might not have come under such intense scrutiny, paving the way for person-centred care, qualitative health research, more robust ethical review and professional accountability. We might not have seen the development of the social model of disability, the ICF framework, or the bio-psycho-social model. We might not be challenging the gendered division of healthcare labour, or taking overt measures to address the social gradient that sees indigenous peoples consistently experiencing the worst health and the worst health care.

Episodes of appalling abuses of power have not helped medicine's cause. Events like the Thalidomide scandal, the Tuskegee Alabama study, the conviction of Dr Harold Shipman, the Paulo Macchiarini scandal, the Bristol Royal Infirmary Inquiry, and the opioid crisis have all progressively undermined medicine's claim to ethical goodness.

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[3] 'Critical' here refers to 'social and philosophical theories that challenge taken-for-granted assumptions and considerations of power… including examining whose knowledge is considered legitimate and why. These considerations of power can be at a macro level (e.g., health care structures, funding) or a micro level (e.g., interactions between clients and health care professionals)' (Setchell et al., 2018).

[4] For a detailed exploration of these arguments and the various critical positions taken towards medicine and healthcare over the last half century, see (Nicholls, 2022). The book was written to guide physiotherapists through the evidence for these claims, but most of the arguments may be equally applicable to osteopathy.

And the rapid expansion of a global digital infrastructure has made almost everything that was once available only in restrictive medical libraries available to everyone.

Added to this, medicine's power to control healthcare spending and organisation has been gradually curtailed since the 1980s, with the rise of new public management. At the same time, neoliberal economic and legislative reforms have eroded medicine's monopoly over healthcare, opening health up be one of the largest new global marketplaces on the planet. The focus has shifted from 'the doctor knows best' and the patient's deference to medical expertise, to 'the client will see you now', health promotion, and a much greater emphasis on self-care and personal responsibility (Topol, 2016). 'Optimal health' — with its personal responsibility that can never be achieved but demands constant healthcare consumption — has replaced medicine's earlier promise of complete physical, psychological and social health (Baum, 2016).

The focus of national health priorities have shifted from those things that biomedicine was designed for — short, episodic injuries and diseases that respond to a largely binary, passive, heroic treatments — to complex, co-morbid, lifestyle disorders that require long-term care and support (Nettleton, 2013). And as healthcare budgets continue to grow, governments are increasingly trying to find ways to contain costs without appearing to be 'against' healthcare. (Making people feel 'culpable in the face of known risk' — as Rose Galvin put it — has been one of the most effective methods (Galvin, 2002).) And, of course, where medicine has gone, the professions allied to medicine have followed.

At a 'meta' level, the social contract that was established between Western medicine and 'the state' in the early years of the 20th century has eroded to the point where the 'grand bargain' no longer remains. And this erosion only accelerated with the COVID pandemic and the emergence of generative AI. What the post-professional era codifies, then, is both what is happening, and what might follow. Daniel and Richard Susskind have suggested that '[w]e are on the brink of a period of fundamental and irreversible change in the ways that the expertise of the specialists is made available in society' (Susskind & Susskind, 2015), a sentiment echoed by Edgar Burns who has argued that;

> "While post-professionalism does not deny that society needs the service of articulate, clever, society-oriented actors and professionals, who can be a human beacon in a world of juridified, formalised, corporatised correctness, it does assume that professionals will be less important than they used to be' (Burns, 2019).

The problem has expressed repeatedly throughout the sociology literature in recent years, summed up here by Susskind and Susskind;

> 'Professionals play such a central role in our lives that we can barely imagine different ways of tackling the problems that they sort out for us. But the professions are not immutable… To pick out a few of their shortcomings — we cannot afford them, they are often antiquated, the expertise of the best is enjoyed only by a few, and their workings are not transparent. For these and other reasons, we believe today's professions should and will be displaced by feasible alternatives' (Susskind & Susskind, 2015).

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In physiotherapy, medicine, nursing, and other Western health professions, we are seeing reactions to this fundamental change in the business and organisation of healthcare that, I suspect, are being mirrored in osteopathy as the profession adapts to the post-professional era. These reactions can be broadly grouped into four archetypes.

Four responses to post-professionalism

The first response we are seeing from the health professions might be broadly described as *doing nothing*: watching and waiting to see what emerges from this period of unprecedented disruption; trusting in the profession's heritage, resilience, and long history; not being reactive or risking making a mis-step as a result of naivety or over-eagerness. This is understandable given that these are indeed unprecedented times, and most osteopaths are not trained to think economically, philosophically, politically, or sociologically about healthcare reform. But the danger with this approach is in deliberating and obfuscating over a response to the threats of post-professionalism, osteopaths allow others to steal a march on the profession's legacy territory. The profession may get left behind and become marginalised, or even obsolete; replaced by more agile alternatives. (There are many examples of this happening in across other disciplines and professions in recent years; from journalism to manufacturing, banking to telecommunications.). So, given its inherent risks, this would not seem to be the best way forward.

The second archetype involves a conscious revival of the profession's heritage. We see this with calls from some within the profession for osteopathy to return to its roots and restate its long fought-for professional identity. This 'modern heritage' approach rejects contemporary trends and discourses that are seen as ill winds blowing the profession off course. What is recommended, instead, is that osteopathy consolidates back into an image of the profession that is familiar. The appeal of this approach lies in its nostalgia — not in the negative sense of the word, but in the sense of a revival of something tried and tested. Such an image would be easy to teach and promote because it is engrained in the profession's 'soul', and it offers a strong rallying point for a nervous profession. We are seeing this approach manifest in moves made to specialise and advance the profession into higher qualifications, higher professional entry standards, tighter professional regulations, claims to advanced practice, and other actions that re-assert where osteopathy ends and others begin. This act of delineation is designed to strengthen the professions historical 'enclosure' and make it less open, less permeable, more resistance to capsize and overwhelm. The appeal is obvious for a beleaguered profession, but the danger with this approach is that it relies on the continued relevance of an historic image of the profession being adequate to the social questions of the 21st century. There is a real risk that the profession becomes marginalised because its claim to expertise is no longer seen to be relevant. It can be seen as elitist and self-serving; focused too much on those problems that further the professions' interests and saying too little about the social health problems of today. Psychotherapy is an example of profession struggling with this tension at the moment. By holding to a model that emphasises one-to-one, highly intensive, lengthy and, thereby, expensive training and practice, the profession has few answers to the tsunami of mental health problems now being experienced in society. Psychotherapists believe passionately in their person-centred approach to practice, but the approach can come

across as self-serving elitism in the face of so much un-met suffering and need. So this would also seem to be a flawed strategy if society no longer wants the image of osteopathy that some in the profession would want to restore.

The third archetype might be called the renaissance professional. This is the osteopath who wants to throw the baby out with the bathwater and begin again, with a new model of osteopathy designed specifically for the 21st century. To my knowledge, this image has not appeared yet in the osteopathy literature, but it has certainly appeared in nursing, midwifery, occupational therapy, physiotherapy, psychology, and elsewhere in recent years. The renaissance proposal respects, but ultimately rejects, the profession's heritage, and an entirely new definition of the profession emerges. The advantage of this is that it shows the world that the profession is listening: that it is responsive to the changing social world, and is both agile and adaptive; two highly valued traits in today's postmodern times. By actively listening to the needs of the state, the public at large, the market, and its collaborators and competitors, the profession uses a design-led process to reinvent itself to meet today's needs (in some ways using the same process the profession's founders did in the late 19th century when the profession was founded). Perhaps the archetypal example of this in healthcare is occupational therapy which, in an act designed to shift the profession from the public perception of it as 'applied common sense', has redefined occupation to apply to *any* meaningful activity, giving birth to a plethora of new practice models, occupational performance indicators, occupational justice frameworks, and the whole new field of occupational science. In many ways, occupational therapy has been revived; moving out from the safe but constricting blanket of biomedicine, into a new territory of its own making. The danger of this approach is that in rejecting one's history, one loses one's anchors. All of the ties one nurtured for a century or more have to be severed and new networks and axes of connection built. Coherent frameworks of meaning have to be defined anew. Stable concepts like pain, dysfunction, mobility, and flexibility have to be re-imagined (where, for instance, would pain reside if osteopathy rejected the Western biomedicinal view in favour of phenomenology or critical theory?) The approach might be deeply unappealing to current osteopaths causing a schism in the profession and confusion about the nature of 'real' osteopathy. And the new approach could be decidedly unappealing to others (ministries, funders, regulators, collaborators, etc.). Worse still, by the time all of the conceptual work had been completed, scopes and curricula rewritten, it would be too late to revert back to the 'old way' if the new way fails. These are profound risks that also probably make this approach unfeasible.

Based on what has emerged to date, the fourth archetype — what might be broadly termed a 'hybrid' approach — appears to be the most attractive option. This approach seeks to take the best of the old and blend it with the best of the new. It attempts to retain the profession's historical ideologies and alliances, and combine them with modern-day sensibilities. Reductive Western science and objectivity are blended with a new subjectivity. An interest in the biological body is allied to an interest in the mind and social determinants. Quantitative, experimental approaches are mixed with those drawn from qualitative, (inter)subjective methods. New so-called holistic models of practice are embraced and the profession's 'reach' expands into new territories. Some suggest this is only expressing more formally what has always been within the profession, others claim it represents a profound break. As with the modern heritage approach, the appeal perhaps is easier to see than the problems, but these are no less present.

Not least of these is the philosophical question of what ontological foundations underpin the new hybrid osteopathy. Ontology here refers to the basic beliefs one has about the nature of reality. Is illness a mind independent biological truth, for instance? Or is it the product of conscious thought or phenomenological intentionality? Or is it neither of these things and a purely social construct? We might have our own views about these questions, but other radically different and, in some cases, mutually exclusive alternatives exist nonetheless. We should be careful here, though, because the internal contradictions between these different ontologies cannot simply be resolved by creating a convenient new model or composing them as overlapping spheres in a crude Venn diagram. Having said that, their fundamental differences need not be seen as entirely negative, though, evidenced by the fact that a number of health practitioners have been keen to exploit these alternative ontologies for some time now.

Consider the current debate in manual therapy about the nature of pain, for instance. Some are now arguing that the 'tissues are not the issues'; that we should not look for pain in the intervertebral discs or the facet joints. Some enactivists, psychologically-informed practitioners, and advocates of cognitive functional therapy are suggesting that pain actually lies within a person's cognitions, thoughts, and mental projections, all underpinned by certain patterns of behaviour. Besides the possibilities this brings for new forms of practice, the turn towards the subjectification of pain is advancing a radically anti-biomedical notion of where pain now actually *resides*: no longer in the tissues, but in the mind, in emotions, in (inter)subjective relationships, in actions. Some are even claiming that this hybrid practice constitutes a new form of bio-psycho-social 'holistic' practice (Solli & Barbosa da Silva, 2012; Holopainen, 2021; Pomarensky et al., 2022).

There are four fundamental problems with this assertion, though: Firstly, no profession nor practitioner can ever be wholly holistic. One cannot accept all ontologies unless one only operates in superficialities. One cannot accept the biological basis of illness in one moment and deny it with phenomenology of critical theory the next. The only way to claim to be holistic is to either take the singular position of denying the existence of any other ontology beyond the one one supports, or to perform some kind of ontological *slurring* that accepts all philosophical positions as equally valid and, by doing so, accepting nothing. Secondly, to be holistic *means* to lose one's professional identity; to give up taking the particular view in favour of the view from everywhere and nowhere. Thirdly, holism implies the ultimate form of hostile professional encroachment, as one discipline claims everything that was once offered by others. Fourthly, holism is a philosophy of expansion with no contraction. Nothing can be given away or allowed to sit 'outside' the new framework, because to do so acknowledges that the profession is not, in fact, holistic, but only *different* to before. No profession claiming to be holistic has so far been prepared to state what it will be giving away in order to hybridise into a holistic, bio-psycho-social profession. Concepts and content are only ever added. Physiotherapists who have taken to psychologically-informed physiotherapy, enactivism, and cognitive functional therapy, for instance, have been happy to advocate for the mind as a seat of pain, but have not yet suggested that physiotherapists should stop learning anatomy, physiology, pathology, biomechanics, kinesiology, or the other bastions of the 'old' biomedical body-as-machine.

So, although the hybrid approach appears superficially appealing, its ultimate goal appears unclear and riven with dangers. This hybrid position is, to my view, the view recommended by Thomson and MacMillan and it is, in some

ways, the most dangerous because it carries the allure of being the ideal solution to osteopathy's desire to retain its past whilst embracing the post-professional future. But it is an illusion and is as deeply flawed as the other three approaches outlined before it. So, is there a solution to the problem now being posed by a society that no longer seems to want the healthcare professions that it leant on so heavily in the past.

A viable alternative

If there appears no viable alternative, it is sometimes useful to examine the premise of the problem and ask if the premise itself is flawed. And, in this case, I would suggest the problem lies in the assumption that our goal here is to preserve osteopathy as a profession. Post-professionalism is first and foremost a reminder that:

1. All professions — osteopathy included — are relatively recent responses to problems that have existed since the dawn of humanity;
2. They are neither necessarily the best or the only solution to these problems;
3. The professions were never really altruistic and public-spirited, in the functionalist sense of the word, but were always primarily concerned with furthering their own professionalisation projects;
4. Many viable alternatives emerge when professional monopolies are eroded, because the professions themselves are often the greatest obstacles to radical reform.

In talking with colleagues about these questions I sometimes ask them whether they would consider disbanding their profession entirely if it were in the public's interest. More often than not, people have to think about their answer, which seems remarkable to me given that they would be doing it *in the public's interest*. It is a theoretical exercise, of course, but what conditions could exists to sustain a profession when it was no longer working in the public's interest? So the critical question to ask is not how can we save, protect, preserve or promote osteopathy, but what is it that people need today to be healthy?

Once we rid ourselves of the need to preserve osteopathy at all costs, everything changes. Especially when we recognise that the skills osteopaths possess are some of the skills that people will always want and need, regardless of generative AI, robotics, late capitalism, or professional disintermediation. The challenge then becomes how to isolate the *intensities* at the heart of osteopathy that hold most meaning for people, and those things that can now be hollowed out.

In my work on physiotherapy, I have argued that the profession needs to put the physical therapies back into the public's hands: to find ways to equip as many people as possible with the skills that the profession colonised nearly 130 years ago. I have argued that we need plurality not holism: a thousand different physical therapies, not just one uniform model. I have argued for 'vernacular' therapy: forms of physical therapy that look inherently different in Melbourne as they do in Manchester, because each physical therapy is an expression of the local beliefs and culture, environment, history and resources. I have argued that biomedical physiotherapy is fine, but so is phenomenological and social activist therapy. Each can exist in its own ontological domain without needing to make claims to holism, and still retain the essence of the physical therapies.

And so, to my mind, the most important task for us to undertake right now is to identify those 'intensities' that lie at the heart of our practice. In recent years, a swathe of new philosophical approaches have emerged that allow us to radically reimagine what things like mobilisation, touch, therapy, and movement mean in a 21st century context. We have seen this in the emergence of new philosophies and theories like actor network theory, object oriented ontology, new materialism, and speculative realism, and these are beginning to be applied to bodies in a way that does not so much sit alongside conventional ways of thinking, but rather sets these entirely aside and comes at questions of knowledge and reality in entirely new ways.

Conclusion

In this article I have wanted to follow Thomson and MacMillan's lead and raise the question of the future for osteopathy. As someone outside the profession, I could understand it if those within osteopathy rejected the argument I have put forward here because I am not an osteopath. But I hope I have offered enough evidence of a widespread shift in the nature of healthcare practice beyond the narrow confines of professional affiliations to convince the reader that many of the same issues affecting the other healthcare professions also affect osteopathy.

While I wholeheartedly support Thomson and MacMillan's argument that osteopathy needs reform, I would suggest they don't go far enough. And in trying to appease members of the profession into thinking that it can adapt to the changing landscape of healthcare by adopting more phenomenological or critical social positions, they weaken the case that there is actually a far more profound shift taking place.

Having resisted the post-professional era for 40 years, Western healthcare is now entering a period of rapid change that will see all the health professionals displaced from the centre of healthcare thinking and practice. Late capitalism and its neoliberal economic and legislative reforms, coupled with the atomisation of bodies, and the growing social critique of the professions as largely Victorian, patriarchal, gentlemanly, middle-class social projects, are ushering in a new era in which viable alternatives will be pursued.

The instinctive response from those within the professions is always to circle the wagons; shore up their hard-won prestige, and seek security in consolidation, specialisation, and territorial expansion. But such actions will only serve to embolden those who argue that the professions were always more concerned with self-protection and their own professionalisation projects.

The answer I propose follows the old adage that the goal of any expert is to make themselves redundant: that our goal should not be self-preservation but equipping the greatest number of people with the skills needed so that we no longer need to exist. In essence, I am suggesting that osteopaths join the post-professional project and look to find new ways to secure our own obsolescence.

To those worried about their careers, I would say that the skills we possess will always be in demand. They simply do not need to be enclosed within a professional body in order to find their expression. Unlike pharmacy, radiography, and perhaps even large swathes of medicine, surgery and nursing, people will likely always want

someone they can trust to use their hands to heal, or understand why a movement pattern might be causing pain in a distal part of the body. The question we have to ask ourselves is whether our project is preserving the good name of a profession that has served some well for a century or more, but is now being de-centred, or whether we want everyone to be their own osteopath. All evidence now suggests that one of these options has a future in healthcare, and the other does not.

Acknowledgements

I would like to acknowledge the two blinded reviewers who not only offered constructive comments on the paper, but also personal insights that supported many of the arguments made here. Their reflections on their recent experiences in osteopathy ran to over 1000 words. I attempted to incorporate them into the text as a postscript, but this would have turned an already large paper into a disquisition. I hope their thoughts and comments find their way into the debate in some form in the future, and thank them again for their insightful reflections.

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