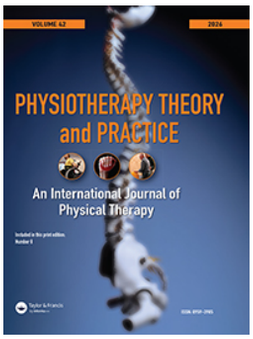

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When algorithms don't care: physiotherapy and the post-professional turn

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ABSTRACT

Physiotherapy has long resisted the forces that restructured manufacturing, journalism, and finance. This resistance is ending. Drawing on Gilles Deleuze's prescient analysis of societies of control, this paper argues that physiotherapy – along with the orthodox health professions more broadly – is entering a post-professional era characterized by the progressive marginalization of practitioners in the coordination and delivery of care. Three concurrent forces drive this transformation: the atomization of bodies and health into commodifiable fragments under late-stage capitalism; the systematic unbundling of professional claims to goodness and expertise from both political left and right; and digitally mediated technological disruption that promises efficiency gains while hollowing out professional jurisdiction. Yet Deleuze's framework, written before the internet and artificial intelligence, requires updating. The paper proposes that we are now witnessing the emergence of a "society of indifference" – a post-neoliberal formation in which predictive algorithms replace individual choice altogether, offering consumers the benefits of personalization without the burden of decision-making. Using the case of Flok Health, the UK's first AI physiotherapy clinic, the paper demonstrates how this shift threatens not merely physiotherapy tasks but physiotherapists' agency itself. When artificial intelligence can autonomously assess, diagnose, treat, and discharge patients with musculoskeletal conditions, what remains for human practitioners? More troublingly, if the disciplinary infrastructure that sustained professional physiotherapy is progressively dismantled, how will populations' rehabilitation needs be met when algorithms and personal choice prove insufficient? The paper concludes by considering how physiotherapy might respond – not by defending professional territory, but by identifying and sharing the "intensities" that have sustained physical therapy practices for millennia.

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INTRODUCTION

In 2022, Nicholls argued that physiotherapy was now entering a post-professional era in which all of the traditional orthodox, regulated, and state-sponsored health professions would be increasingly marginalized in healthcare coordination and delivery (Nicholls, 2022). Nicholls argued that three powerful discourses were driving this process: the atomization of the body in the late-stage capitalism, the unbundling of professional claims to goodness and expertise, and digitally mediated technological disruption.

In this paper, I want to extend this analysis to incorporate the rapid global impact of artificial intelligence and predictive algorithms. I want to suggest that this latest revolutionary technology promises to transform healthcare from the kind of "society of discipline" (Foucault, 1977) that physiotherapy prospered under during much of the twentieth century, through the "society of control" (Deleuze, 1992) that physiotherapy has embraced in recent decades, and into an emergent "Society of Indifference," in which specialist clinical expertise and individual subjective experience becomes redundant, replaced by a new form of objectivity designed around frictionless consumption of goods and services.

WHAT IS POST-PROFESSIONALISM?

Post-professionalism does not mean the sudden death of any one professional group or the end of all professionals, per se. Rather, it refers to the slow decline of professional power; the centrifugal drift of the professional groups to the margins where they become less important in the delivery and organization of some particular social function; the substitution of the knowledge and expertise of professionals for viable alternatives; an involuntary obsolescence.[1] There have been many examples of post-professionalism particularly within high-income countries over the last half century or more. Manufacturing, journalism, banking and

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finance, the music and film industries, transportation, retail, and telecommunications are all sectors that have undergone dramatic restructuring over recent decades with deskilling, labor arbitrage, para-professionalization, task delegation, robotics and automation, disintermediation, and routinization all downgrading the status of professionals in these sectors.

Post-professionalism itself has been studied extensively since the 1970s, with major contributions from authors like Ivan Illich, Terry Johnson, Eliot Freidson and Magali Larson (Freidson, 2001; Illich, 1977; Johnson, 1993; Larson, 2005). But during this time, healthcare has been somewhat immune to widespread cultural disruption, and still relies heavily on a hierarchical, medical, professionally strong work environment. Nicholls argues though that this period of stability is coming to an end with the cause being the confluence of three powerful discourses. Each of these will be recapped below.

ATOMIZATION IN LATE-STAGE CAPITALISM

The first discourse that Nicholls identifies refers to the way in which the body, health and illness, and healthcare itself, have been atomised – or split apart – to create thousands of new market opportunities for goods and services that previously didn't exist.

For much of the twentieth century, people understood health as a binary state: one was healthy for most of the time, occasionally suffering injury or lapsing into illness. Susan Sontag described it as being like holding two passports; one for the land of the healthy and the other for the land of the sick. Other binaries dominated healthcare too: people were classified as able-bodied or disabled, mad or sane, fit or unfit for work, normal or abnormal. And health professions existed largely to address the needs of the disabled, mad, unfit and abnormal and return them to the land of the healthy.

For physiotherapy, the focus was on the ill or injured body, and for much of the twentieth century the profession dominated orthodox physical rehabilitation bolstered by its association with the state and the medical profession.

The emergence of late-stage capitalism in the 1970s created the conditions for much of this to change. People were encouraged to exercise greater freedom of choice, patients were rebranded as clients and consumers, regulations were relaxed, and new globalized markets were opened up in an attempt to revive flagging western economies.

The atomization of the body and health did not really take hold, though, until the new millennium, perhaps because of the iron grip that medicine, nursing, and other high-prestige health professions held over society. But once it was realized that the body in health and illness could be the site of newfound wealth, an explosion of healthcare consumerism took place. Think of how the growth in areas like self-care, health promotion, digital health and precision medicine, integrative care, consumer quality assurance, appearance medicine, retail medicine, online advice, wearables and healthcare tracking technologies, healthcare adverts, podcasts, and social media, personal fitness, gymnasiums and wellness spas, direct to consumer laboratory testing, and medical tourism. The growth of the personal fitness industry, the availability of social media influencer advice on everything from how to manage tensor fasciaelatae pain to the proper use of a Theragun, and the growth of wearable fitness technologies like Apple and Garmin biometric watches are just some of the ways forms of atomization are affecting physiotherapy today.

Physiotherapy had been especially immune to some of these disruptions, particularly in the public sector, where the work was often hands-on, one-to-one, analytical, and intensive. Physiotherapy lacked the kinds of opportunities for commercialization that could be found in areas like medical technology, radiography, sports and exercise science, podiatry, and dentistry. Private practice physiotherapy was different, however, and we have seen the impact of consumerism especially here. In the latter half of the twentieth century, private practice physiotherapy had become dominated by the highly technical, hands-on mobilization and manipulation of musculoskeletal injuries, and a professional culture led by practice "gurus" who promoted their own specific diagnostic and treatment regimes, had taken hold. But a lack of strong supporting evidence, greater marketplace competition, and a stronger consumer-driven desire to be more active in the rehabilitation process has seen private practitioners shift to new, more holistic, (inter)active, humanistic, and collaborative approaches to practice.

What atomization has done to healthcare, and specifically the body, has been to create a thousand new markets for goods and services in places that physiotherapists do not and cannot control. Where once people's options were strictly limited, there are now myriad practitioners offering in-person or online therapeutic services that were once unavailable to anyone outside of a few large urban centers: chiropractors, osteopaths, myofascial release therapists, exercise physiologists, personal trainers, sports performance coaches, vestibular therapists, Pilates instructors, yoga therapists and Feldenkrais practitioners, acupuncturists, shiatsu practitioners, Bowen therapists, and the like are

all competing to offer alternatives to conventional physiotherapy and, in many cases, using their alternative status to implicitly argue that physiotherapy remains a hallmark of old-world healthcare.[2]

UNBUNDLING OF GOODNESS AND EXPERTISE

The healthcare professions owe much of their social capital to the long-held belief that they are altruistic, diligent, fair-minded, self-sacrificing, empathetic, trustworthy, knowledgeable, dependable, and principled. Healthcare work is often thought of as a special calling that demands a particularly caring disposition, because so much of the work is perceived to be complex, physically grueling, and emotionally harrowing.

But as the stock of all professionals has fallen in recent decades, so has that of the health professionals, with assaults coming from the political left and right (Friedman, 1962; Illich, 1975; McKinlay and Arches, 1985; Nichols, 2017). From the right have come accusations that the professions are expensive, inefficient, state-sponsored monopolies (Kleiner and Vorotnikov, 2018). Right-wing politicians like British MP Michael Gove have argued that "people in this country have had enough of experts" (Katz, 2017), while Donald Trump in the US, Victor Orbán in Hungary, and Jair Bolsanaro in Brazil have all worked hard to undermine people's confidence in expert opinion.

But left-wing sociologists have also leveled sustained criticism at professionals' claims to goodness and expertise – a criticism that begin in the 1950s and continues to the present day. Health professionals have been accused of a range "professogenic effects" (Burns, 2019),[3] including inverse care failures (harming when they should be healing) (Hart, 1971); of being self-serving, overly protective of their professional territories (Freidson, 1983; Johnson, 1982; Macdonald, 1995), resistant to change (Petersen, 1994), and relying on particular form of abstract knowledge to further their status claims (Henwood, Wyatt, Hart, and Smith, 2003; Robertson et al, 2011); of taking advantage of the stigma level of people with physical disabilities and mental health problems (Abbott, 2005; Davies, 1996; Illich, 1977), of promoting a blame culture around self-care and personal responsibility (Galvin, 2002), and making "specious claims" to being ethical and caring (Witz, 1994). Others have gone even further, accusing the health professionals of being exploitative, elitist, exclusive, patriarchal, discriminatory, and promoting a 'gentlemanly' Victorian form of group morality (Abbott and Meerabeau, 1998; Pillay and Kathard, 2015; Svensson, 2010).

These criticisms have led to some significant changes to the way healthcare is organized, and each of these has had an effect on the traditional primacy of the healthcare professions. Governments around the world have tried to control spending on healthcare by introducing discourses of risk and accountability drawn directly from accountancy (Armstrong, 2023). They have introduced quality assurance schemes and new public management systems from the business world (Evetts, 2009). They have loosened statutory regulations that once protected professional titles, and relaxed scopes of practice (Jacobsson, Wallinder, and Seing, 2020).[4] They have nurtured inter-, multi-, and trans-professional practice (Hald et al, 2024), encouraged the shift from tertiary care to healthcare at home and care in the community (Landers et al, 2016), and have encouraged the democratization of knowledge that was once the sole domain of elite professions by seeding investment in internet widespread access (Caputo and Cervino, 2025).

Physiotherapy internationally has been in an interesting position here. On the one hand evidence from the profession's academic literature suggests that physiotherapists have shown little interest in studying their profession sociologically, preferring to concentrate on improving their technical knowledge and the evidence needed to support or refute it (Nicholls, 2022). At the same time, sociologists have taken almost no interest in physiotherapy as a profession, concentrating almost all of their attention on medicine and, to some extent, nursing. Consequently, physiotherapists have felt the effects of this unbundling but have very little sociological understanding of why it is taking place.

Thus, we have seen significant work done already to move the locus of physical therapy knowledge and expertise away from the physiotherapist and into the hands of other "actors" (be they clients and consumers, communities, competitor professionals, administrators, or support workers), without a deep appreciation for the sociological forces that are driving this change (Jensen et al, 2022; Rowe, Nicholls, and Shaw, 2021; Sanders, Ong, Sowden, and Foster, 2014).

We have seen calls for more holistic, biopsychosocial approaches to practice, allied with more self-care and personal responsibility on the part of the client, to replace the expert-led, passive approaches to practice that dominated physiotherapy in the past; there have been calls for greater recognition of the client's subjective expertise and more patient choice in the language of therapeutic alliance, person-centered care, and a growing interest in qualitative research; a larger focus on external monitoring of the profession through quality audits, evidence-based practice, cost reduction programs, and revenue enhancement programs; as well

as calls for more inter-professional collaborative practice, knowledge translation, and accessible health information on social media (Cholewicki et al, 2026; Kandal, Østerås, and Söderström, 2025; van Dijk et al, 2023).

All of these in one way or another challenge the status of physiotherapy as *the* principal provider of physical health and rehabilitation in orthodox healthcare and, in doing so, increase the sense that physiotherapy is losing its hard-won prestige or social value.

Professions like physiotherapy have faced challenges like this before, though, and always won through. So why should now be different? To answer this question, we first need to understand why atomization, late-stage capitalism, and the unbundling of goodness and expertise hadn't been sufficient in themselves in deconstructing healthcare, and physiotherapy specifically, when these had been such powerful forces of change in other sectors of society. To do this, we need to turn to the social philosophy that helped to explain the enduring power of orthodox healthcare.

FOUCAULT AND SOCIETIES OF DISCIPLINE

Michel Foucault (1926–1984) was one of the most important philosophers of the twentieth century and he remains one of the most popular and widely cited authors in history (O'Farrell, 2025). Physiotherapists have turned increasingly to Foucault's working in recent years to help them understand the conditions that made the professional of physiotherapy historically and socially possible, and to make sense of some of the challenges now facing the profession (Eisenberg, 2012; Nicholls, 2012; Owen, 2014; Pezdek, 2023; Praestegaard, Gard, and Glasdam, 2015; Rasoulivalajoozi, Cucuzzella, Farhoudi, and Dyer, 2025; Wilson, Pope, Roberts, and Crouch, 2014).

Foucault popularized a form of postmodern critical scholarship that transformed philosophy and political social theory in the late twentieth century. He disliked phenomenology and thought subjective accounts of events were like confessionals, he disputed the idea that history was progressive, and he thought that critical theory accounts of power as oppressive were too simplistic. His concepts of biopower, discipline, discourse, the gaze, genealogy, governmentality, pastoral power, the panopticon, power and resistance are ubiquitous now in social theory, but we will concentrate here on another of his key constructs: societies of control.

Over the course of four major books (Foucault, 1970, 1972, 1973, 1977), Foucault showed how modern society had become 'disciplinary' and that we had replaced the spectacular, punitive power of kings and queens in feudal mediaeval societies with systematic, orderly, bureaucratic, more humane and democratic forms of power, that operated quietly through institutions whose role was to shape the way we thought and behaved. Difficult though it might be to see, physiotherapy represents one of the archetypal institutions Foucault was talking about.

In Foucault's analysis, modern societies operated by passing people through a series of institutions: families, schools, barracks and prisoners, factories, healthcare clinics including physiotherapy clinics, workhouses, monasteries and universities, hospitals and professions, and these all served to train us to be docile and productive citizens through constant observation, examination, and normalization. Think of the way physiotherapy students are observed and examined and how they learn to apply the same skills to patient diagnosis and monitoring. Or of how physiotherapists are regulated and how their professional scopes and conditions of employment are defined. More than this even, think of how important normalization is in defining who a physiotherapist treats and how the idea of returning a patient to "normal" shapes almost every aspect of our practice.

What Foucault showed was that these disciplinary "technologies," built up incrementally over time, shaping our actions, understandings, and even our "selves" as patients and practitioners, without us ever realizing the power that these discourses exerted over us. We take these things for granted because we believed that being watched, judged, measured, and coerced into proper conduct was the trade-off for social progress. And so modern forms of government became the science of everyday, incremental improvements in getting people to do what was needed *without* force. People need to be lawful without the threat of punitive state violence; to be good moral citizens without the threat of eternal damnation; to be healthy seemingly of their own free will and self-determination. Modern government in this sense then is not a form of top down, oppressive power forced onto people by harsh laws and public acts of punishment, but an enormous, living network of minor systems and operations – a "microphysics of power" that constantly shapes how society works and defines who and what we are.

Almost the entire early history of the physiotherapy profession can be seen as an attempt to align itself with these new forms of government. From the profession's early success showing that it could produce therapists who were above suspicion, and its adoption of a biomedical approach to the body-as-machine, to its work restoring men injured in war and work to useful occupation and reducing the burden of infantile paralysis, to its focus on government health priorities and

being a loyal servant to public healthcare, physiotherapy has been a paradigm case of a disciplinary institution. Most crucially of all though, it has done this without dissent or an overly political focus. In return it has been favored with protective legislation and protection of title, exclusive access to ill and injured patients within the public health system of many countries, subsidized training and practice, and enormous prestige and social capital (for an extended analysis of physiotherapy's role as a disciplinary institution, see Nicholls, 2017).

Much of this prestige endured even in the last quarter of the twentieth century with the emergence of atomization and late-stage capitalism, in part because of the profession's long-standing association with medicine, which retained much of its prestige and privilege in the public imagination while other disciplines were going to the wall. But also because of the central importance of touch and hands-on care in people's minds, and the belief that physiotherapy, like many other health professions, held an empathic connection with patients that could not, and should not, be disturbed. What then might cause this to have changed in recent years? What might be now threatening physiotherapy as a paradigm example of a disciplinary institution?

DIGITALLY MEDIATED TECHNOLOGICAL DISRUPTION

Some sectors of society have been almost entirely restructured by neoliberal economic reforms over the last half century (agriculture and food production, banking and finance, business and trade, defense, energy supply, and transportation, for instance). Others have been unbundled, with growing doubts cast about their probity, objectivity and relevance (education, environment, justice, and news media). Others still have been transformed by digital innovation (culture, national security, foreign affairs, research and development, sport). It has taken the combined power of all three, however, to bring the post-professional era to healthcare's door.

Digitally mediated technological disruption (DMTD) is now seen by many as the next paradigm shift in medicine; an "inevitable and promising future of healthcare" (Carboni, Wehrens, van der Veen, and de Bont, 2022; Lottonen et al, 2024). Emerging as a force in the early 2000s, interest has surged in the last few years with the rapid atomization of the body and health post-COVID. AI chatbots, automated surgery, clinical decision support, electronic health records, genomics, health information systems, machine learning, point-of-care diagnostic testing, remote monitoring, robotics, sensors, smartphone apps, social media feeds, telemedicine, virtual and augmented reality clinical simulation, and wearable monitoring devices are now commonly discussed as essential adjuncts to future healthcare (Petrakaki, Chamakiotis, and Russell, 2025; SteinyWellsjo et al, 2025). But DMTD is not only confined to digital technology, other forms of technologically mediated disruption need to be considered as well, including labor arbitrage, disintermediation, routinization, and mass customization (Susskind and Susskind, 2015).

DMTD promises increased efficiency, greater accuracy, simplified workflows, reduced error rates, assisted independence, new insights, better access and immediacy; a necessity, some claim, "if healthcare systems are to achieve economies of scale" (Petrakaki, Chamakiotis, and Russell, 2025). Proponents of DMTD claim it will remove the drudgery and make healthcare work more meaningful; freeing up time for clinicians to spend in the kinds of work that machines and low-cost labor cannot do (even though these claims remain largely untested) (Carboni, Wehrens, van der Veen, and de Bont, 2022).

Many people have expressed concerns about the "datafication" of health (Heyen and Salloch, 2021), as well as raising questions about data privacy and security (Simonsen et al, 2025). Some clinicians have naturally expressed fears that DMTD will erode their professional judgment, disrupt the traditional hierarchies between doctors and patients (Ziebland, Hyde, and Powell, 2021), accelerate the "risk of skill obsolescence and automation" (Arora and Garg, 2024), and deplete an already jaded sense of professional worth among health professionals (Van Zoonen and Sivunen, 2022).

Others have shown, however, that DMTD is becoming increasingly "domesticated" in healthcare since the pandemic (Ghis Malfilatre and Louvel, 2025) and that its disruptive influence is blowing across "multiple fields including skills, workflow, workload, roles, autonomy, relationships, policies, practices, actions, expectations, and cultural and social aspects" (Lottonen et al, 2024).

Calculating which health professions will be most affected by DMTD is complicated. To date, most of the research has focused on medicine, but it is possible that the most destabilizing effects of DMTD will be felt among the professions allied to medicine – nurses, physiotherapists, paramedics, midwives, pathologists, occupational therapists, and healthcare assistants – who depend on medicine but possess much less social and economic capital. As a consequence, these professions experience many more existential threats of obsolescence, and much greater pressure to adapt to DMTD's sociotechnical imaginary and its "promissory

discourses" (Carboni, Wehrens, van der Veen, and de Bont, 2023).

In physiotherapy, we have seen a strong desire to turn away from the profession's historical focus on treating the body-as-machine and an openness to new more holistic, biopsychosocial understandings of health and illness (for a critical summary of this, see Breedt, Tichenor, and Barlott, 2025; Hebron, Ekornsaeter, and Mescouto, 2025; Mescouto, Olson, and Setchell, 2023). This has prompted some to ask whether we still need a detailed and comprehensive understanding of human anatomy, for instance, if the "tissues are no longer the issues?" Do we need to focus so heavily on diagnostic testing if we are now concentrating on helping people to live with long-term illness rather than curing them of acute disorders and dysfunctions? Should we privilege psychology over physiology? Given that these were once the cornerstones of physiotherapy education and practice, such talk is forcing some within the profession to reevaluate what it even means to *be* a physiotherapist (Breedt, Tichenor, and Barlott, 2025; Nicholls, 2022).

Physiotherapists are encouraged to focus now only on high-value care and those interventions that carry the greatest benefit for the least cost. Older, more labor-intensive, "passive" forms of mechanotherapy (therapeutic touch, mobilization and manipulation) are increasingly seen as passé. Patients – now clients, or healthcare consumers – are encouraged to take more personal responsibility for their own care and to be active in the rehabilitation process, rather than the passive recipients of treatment as in the past. And healthcare and therapy assistants are being used much more for the routine rehabilitation work in part because they are cheaper to train and employ than highly skilled therapists. All of these changes carry with them the implicit assumption that physiotherapy work will become increasingly rare, specialized and, in all likelihood, luxurious, as people's appetite for DMTD grows.

Case study – FlokHealth

In May 2024, the UK's Chartered Society of Physiotherapy (CSP) claimed that the growing number of people waiting for physiotherapy treatment (324,000 as of March 2024) was "causing problems in other parts of the NHS and harming the UK's economy" (Tapper, 2024). Waiting lists for musculoskeletal treatments had grown by 27% in just over a year and the CSP argued that a 7% year-on-year increase in the number of NHS physiotherapy positions was needed to keep pace with the growing demand (ibid).

Around the same time, "The world's first AI physiotherapy clinic" (https://www.flok.health/) was launched in the UK, offering to replace the need for "a human clinician to assess a patient" (Stevenson, 2024) with an "entire care pathway – from initial assessment and diagnosis, through to treatment delivery and discharge … carried out autonomously by the AI physiotherapist without human-in-loop supervision" (Johnson, 2025).[5]

Based in Cambridge, UK, Flok Health – an mobile device app "Created by former medic and athlete, Finn Stevenson, technologist Ric da Silva, and their team of physiotherapy and AI experts" (https://businesscloud.co.uk/news/flok-health-raises-9-5m-to-scale-the-worlds-first-ai-clinician/) – offers a "the digital clinic [that] manipulates real footage of a human physiotherapist to simulate the experience of a live video call appointment that responds in real-time to what a patient is saying and doing" (ibid). The app-based "clinic" ran its first trials of the AI tool in the treatment of 2,500 healthcare workers reporting symptoms of back pain. The reported trial results showed that non-human AI physiotherapy "more than halved the waiting list and reduced waiting times for all MSK conditions by 44% in less than ten weeks, treating over 2,500 back pain referrals" (Johnson, 2025). Added to this, "More than four in five participants reported that their symptoms had improved during treatment with the platform" and "57% of patients said they thought the AI experience was better" than traditional face-to-face physiotherapy (Thomas, 2025).[6]

The problems that Flok Health app sought to answer were already well known: "The healthcare needs of our population are rapidly outgrowing what is possible for a traditional clinical workforce to manage," Flok Health CEO, Finn Stevenson (Johnson, 2025). "30 million working days are lost to MSK conditions every year in the UK and they account for up to 30% of GP consultations in England" (Stevenson, 2024). At the same time, "The NHS remains a chronically understaffed and underfunded public service, leading to increased wait times," particularly for the very musculoskeletal issues that the CSP and Flok Health were so eager to resolve (Better Society Capital, 2024).

Crucially, Flok Health is now "The only MSK platform with Class IIa medical device certification" from the Care Quality Commission (CQC), which means that the app is now approved not only for the delivery of MSK triage and treatment, but for diagnostic decision-making and discharge planning too. And with the approval, the app can now be expanded to include "the management of hip, knee, shoulder, and pelvic health conditions" (Johnson, 2025).

And the app's founders' ambitions do not end here, with Stevenson suggesting in 2024 that the company's

intention was always "to build the world's best community healthcare provider" and to "scale clinicians by automating high volume treatment pathways, and free up capacity in existing services" (Stevenson, 2024). As Professor Mick Thacker argued recently:

> We simply cannot train 12,000 extra physios overnight. Faced with a national MSK pain pandemic, we have to widen the front door to care and make the best use of AI and technology . . . Digital approaches naturally support effective self-management, empowering the person to take control of their own condition. (Johnson, 2025)

This seems to offer something for everyone: consumers get immediate access to AI physiotherapy, waiting times are dramatically reduced, and a physiotherapy workforce can be freed up to concentrate on "other" work. But does everyone win in this new image of healthcare practice? If we look only from the perspective of the physiotherapy profession, then the future looks much less clear.

For instance, when Stevenson talks of AI freeing up capacity in existing services, what kind of work would this entail for the newly liberated physiotherapist? If the Flok Health app, and other AI physiotherapy apps now being implemented, offer everything from MSK patient identification, triage and diagnosis through to treatment, monitoring and discharge, what other work will be left for human physiotherapists to do? Some might suggest that human physiotherapists will still be needed for the patient with complex comorbidities and, presumably, this work will demand particular forms of expertise and skill. But how does one become an expert in fields like this in the future when most of the rungs on the ladder that once led to expertise are now occupied by AI apps, therapy robots, and YouTube do-it-yourself videos?

How should the profession respond to innovation like this, then? It cannot oppose it outright because to do so would only confirm Johnson's claim from the 1980s that the professions were really "apex social actors primarily concerned with securing monopolies over professional territories" (Johnson, 1982). Neither can it wholeheartedly embrace it when it knows that it is supporting a technology that strikes at the heart of physiotherapy clinical practice and the very essence of what it means to *be* a physiotherapist.

It is notable that MSK physiotherapy has been the area chosen for the first AI apps.[7] The treatment of back pain through self-directed exercise has become one of the most methodical, mechanistic, and algorithmic approaches in contemporary physiotherapy. Much of the hands-on manual therapy work has been replaced by behavioral interventions and hands-off advice. The prevalence of back pain also makes it an ideal source of scalable profit, far more, perhaps, than might be possible with other areas of physiotherapy practice like respiratory care, neurological rehabilitation, women's health, pediatrics, and chronic pain management, which are notoriously multi-factorial and inter-subjective.

AI physiotherapy is proving an effective way of cutting the cost of healthcare. It is obviously much less costly to refer people to a mobile phone app than it is to train and employ a conventional physiotherapist. But reducing the number of working physiotherapists has other "benefits" for those who want to rationalize twenty-first-century healthcare. By reducing the number of human professional therapists, you slowly degrade their collective power as well as undercutting the status of the physiotherapy profession as *the* recognized provider of physical therapy services to the public. All three steps accelerate the unbundling of traditional healthcare in the post-professional era.

Understood in this way, AI physiotherapy represents a break with the kind of institutionalized healthcare Foucault described with his notion of a society of discipline. We are moving inexorably into a post-professional world in healthcare, a world that Foucault anticipated but could not fully articulate. That task fell to his longtime colleague, Gilles Deleuze, whose *Postscript On The Societies Of Control* we will turn to next.

DELEUZE AND SOCIETIES OF CONTROL

> Today's society is no longer Foucault's disciplinary world of hospitals, madhouses, prisons, barracks, and factories. It has long been replaced by another regime, namely a society of fitness studios, office towers, banks, airports, shopping malls, and genetic laboratories. Twenty-first-century society is no longer a disciplinary society, but rather an achievement society [Leistungsgesellschaft]. Also, its inhabitants are no longer "obedience-subjects" but "achievement-subjects." They are entrepreneurs of themselves. (Han, 2021)

Foucault's concept of societies of discipline provided one of the most comprehensive and cohesive analyses of the conditions that made the physiotherapy profession historically and socially possible. Societies of discipline dominated western social structures for much of the nineteenth and twentieth centuries, giving birth to institutions like the expert and the professional. Professional experts, in turn, stabilized their power through the construction of buildings like asylum, the prison, the hospital and clinic, the school room, and the university. They used their power to define how people

should think and talk about health and illness (as biomedical or patho-anatomical, for instance). They designed curricula to ensure students were socialized into these way of thinking, and regulated practitioners to keep them ordered. They determined the nature of therapeutic relationships (passive patient, active therapist) and took control over the way people engaged in healthcare (with the therapist in some form of clinical center being "visited" by the in- or out-patient).

Societies of discipline gave enormous power and prestige to enabling professionals with their protective occupational enclosures, and they replaced the oppression and brute force of earlier "sovereign" forms of power with the science of coercion, encouragement, examination, inducement, normalization, and surveillance. But "the disciplinary model of enclosure ultimately proved too inflexible, unable to adapt itself to the demands of a changing economy for modulated controls over production" (Bogard, 2014, p. 32).

Published in 1992, Gilles Deleuze's *Postscript on the Societies of Control* (Deleuze, 1992) updated Foucault's ideas for the late twentieth century. Echoing the unbundling critique that appeared in the sociology literature after 1950, Deleuze argued that the institutions that had been so important for earlier generations had become cumbersome, inflexible and expensive. The professions were struggling to adapt to the increasingly atomized, global and diffuse flow of human and material resources (Nadesan, 2010). What Deleuze's *Postscript* showed was that new forms of "biopower" were emerging that were more malleable, fluid, adaptive, persuasive, continuous, unbounded, and ubiquitous, with the professions as centralized and hierarchical forms of power pushed increasingly to the margins.

After the 1970s, the neoliberal entrepreneurial mantra that personal choice was at "the core of humanity and individuality" (Schwarz, 2025) began to replace disciplinary technologies, first in high-income countries, then increasingly, through globalization, throughout the world. Individualism, liberty, authenticity, and free choice were increasingly promoted as ways of resisting the "massification and uniformity" (ibid) of past generations, "since only through free choice could individuals be true to their unique selves in their consumption and conduct" (ibid).

True freedom, though, came with significant risks for government in all developed economies who still demanded strong economic growth, a degree of social cohesion, conformity with the law, productive citizens, and so on. What Deleuze showed, then, was the way in which neoliberal societies learned to govern *through* the actions of individual entrepreneurial rational individuals, without the need for a defined center or institutional superstructure (Gane, 2021; Lemke, 2001; McIntyre, Burton, and Holmes, 2020). The decisive judgments and evaluations that the professional expert class had claimed to offer – and had been so systematically unbundled – were slowly replaced by strategies designed to navigate uncertainty in increasingly complex global situations (Davies, 2015). Truth was derived less and less from expert evidence and replaced with a "plurality of competing perspectives" (ibid) that challenge the validity of any one claim to absolute knowledge or truth.

The nation state – once the axis around which disciplinary societies, and professions like physiotherapy turned – was slowly replaced by the corporation. And the person who was once the more-or-less passive subject of institutional attention – the student, the patient, the criminal, the worker, the mother, and so on – were replaced by the active consumer, prosumer, client, influencer and service user.

The creation of consumer culture shifted responsibility for the health, wealth, and happiness of the public away from public institutions, and made every individual responsible for their own well-being. In effect, we moved from a society of discipline in which the professions and their institutions formed the bridge between the nation state and the individual, to a society of control in which the needs and desires of the individual free-choosing consumer became the principle around which all healthcare was planned, organized and delivered.

Physiotherapist and doctoral candidate Eduan Breedt, along with Erin Tichenor and Tim Barlott recently drew on Deleuze's *Society of Control*to mount a searing critique of the way in which musculoskeletal (MSK) physiotherapy has evolved over recent years (Breedt, Tichenor, and Barlott, 2025). They show how important the shift from a society of discipline to one of control has been in driving physiotherapy's turn away from the body-as-machine; the resulting pernicious growth of biopsychosocial holism, psychologically informed practice, and the language of therapeutic alliance; the influence of cybernetics and neurobiology influencing everything from motor control to pain management; and the turn to subjective lived experience having failed to demonstrate the value of physiotherapy quantitatively (ibid). Their thesis is that the physiotherapy profession has exchanged the body-as-machine for a Deleuzian body-as-modulation. "The old enclosures that enabled power to normalize bodies according to a rigid ideal," they suggest, "are being broken open and replaced by constantly deforming and porous boundaries that automatically modulate and control bodies" (ibid).

However, I want to suggest here that Breedt, Tichenor and Barlott'sargument has already been overtaken by events, and that if we want to understand some of the very particular conditions being faced by the profession today, following the COVID pandemic and the revolutionary effects of the sudden appearance of AI and Large Language Models, we need to move beyond Deleuze's *Society of Control*. Deleuze diagnosed very accurately the social conditions that have shaped the professions over the last 30 years, but some authors now believe that we have moved from a society of control into something else. It has no name at the moment – scholars are still struggling to come to terms with the seismic change – so, for the purposes of this argument, I will call it the emergence of a Society of Indifference and set out its parameters below.

A NEW SOCIETY OF INDIFFERENCE

Given that Deleuze's *Postscript* was written before the internet, neoliberal biopolitics, social media, and surveillance capitalism had become as pervasive as they are today (never mind the accelerating effects of rapid climate collapse, the global finance collapse of 2008, COVID-19, and the rise of totalitarianism around the globe), Deleuze's short paper has proven to be a powerful and oddly prophetic text. A recent 30-year retrospective, however, suggested that *Postscript* needed updating, as a raft of new social forces were at play. Weeks and Lyons suggested, for instance, that "political economies throughout the world are moving away from neoliberalism," and that we are experiencing another "'mutation of capitalism' (Deleuze, 1992, p. 6), similar to the 1980s displacement of Keynesianism by neoliberalism that [Deleuze] so presciently analyze[d]" (Weeks and Lyons, 2024).

The issue, for Weeks, Lyons and others, hinges on the degree to which global Big Tech firms like Alphabet (formerly Google), Amazon, Apple, Meta, and Microsoft have become influential architects of social infrastructure, far exceeding their role as commercial service providers (Davies and Gane, 2021). After the COVID-19 pandemic, Big Tech firms realized that the neoliberal ideal of individual freedom of choice and personal entrepreneurship was, in fact, reducing consumption and driving down profits (Brubaker, 2022). So, while the neoliberal fantasy of individual freedom of choice had proven useful as a way to break stagnant social welfare monopolies in the 1970s, 1980s and 1990s, people were becoming increasingly overwhelmed by "choice overload" (Schwarz, 2025). Some choice is good, Barry Schwartz argued in 2004, but this "doesn't necessarily mean that more choice is better" (Schwartz, 2004, p. 3).

This realization led to some important changes to the ways social network sites (SNS) operated from 2000 onwards. In his recent paper, Ori Schwarz offers a brief potted history:

(1) SNSs began as "interconnected personal profile pages containing friend lists".
(2) From 2006, people's news feeds began to privilege those people you had actively chosen to follow, with new posts ordered chronologically: a "networked individualistic" model (Wellman, 2002).
(3) This chronological ordering was then slowly replaced by "personalized and dynamic" algorithms that recommended feeds based on "maximiz[ing] usage time and user engagement (sharing, liking and commenting)" (Schwarz, 2025).

All three of these stages retained broad fidelity with the neoliberal idea of self-actualization – and Deleuze's notion of a society of control. But this changed in 2017 with the rise of TikTok.

(4) TikTok's full algorithmic curation replaced the news feeds populated by people one had chosen to follow with a feed dominated by an algorithm that "estimate[d] the interest of users in videos posted by those [you] have never chosen to befriend or follow" (ibid).

There is a powerful illustration of this process already at work in healthcare in Armstrong's (2023) paper on the social life of risk probabilities in medicine (Armstrong, 2023). In the paper, Armstrong shows how risk culture became a dominant discourse in Western medicine after WWII. Briefly, although medicine had drawn on the epidemiological language of "rates" (rates of mortality, rates of illness, etc.) for decades, it only began to adopt the language of "risk" in the latter half of the twentieth century under the influence of neoliberalism, social concern for a greater patient voice, and as medicine itself began to undertake more large randomized clinical trials. Focus shifted from the incidence of illness to the probability of future illness in a background population, particularly for those populations with longstanding, complex co-morbidities. This produced data with few black and white answers. Clinical decision making became much more complex and uncertain, which led to the proliferation of expert-panels with their practice guidelines and protocols. Behavioral psychology and

a growing consumer health movement pushed for greater patient input, seen in Sackett's call for a new evidence-based approach to healthcare that encouraged non-expert opinion and new statistical measures such as the Number Needed to Treat for one patient to benefit. Clinical decision making shifted from the sovereign responsibility of the medical expert to shared decision-making, and the patient, now a client/consumer, was presented with options and relative risks and "allowed" to make an informed choice. But now, we have arrived at the point where risk probabilities are so complex, and the factors the clinician-patient dyad must weigh are often so complex, that everyone is paralyzed by indecision. Perhaps unsurprisingly then, we are seeing the increasing use of game theory, behavior economics and predictive algorithms as clinical decision-making tools to churn through the welter of data and arrive at recommendations in an economic and timely way.

The principal attraction of this approach was that it made choice *frictionless*, meaning that SNS users were no longer overwhelmed by the "tyranny of choice" (ibid), rather, one was offered all of the seeming benefits of choice "without its costs in time and effort" (ibid). The behavioralist's justification for this approach was that it was not what people *said* they wanted but the evidence of their actions that should govern the choices they were fed (Stephens-Davidowitz, 2017). This shift is not about a different kind of individual personhood then, but the rejection of self-reflective subjectivication altogether (Fisher, 2022). Schwarz suggests that predictive analytics have seen us relinquish the "consumerist form of autonomy and freedom" Deleuze anticipated so presciently in *Postscript*, so that we can be spared 'the trouble of choice,' thereby increasing efficiency and convenience for users and profits for [SNS] firms' (Schwarz, 2025; see also Brubaker, 2022). More than this though, Davies has suggested that "Ubiquitous surveillance and Big Data [now allows] techniques of corporate power to flood spaces that were previously beyond rationalisation, even by markets. While all of this may be suffocating, it is also potentially more politicising than a society dominated by discipline" (Davies, 2015).

Perhaps the greatest paradox here though is how easily the tools needed to make this transition a reality have been so easily acquired and so freely given. Echoing Spinoza's adage that we will fight for our servitude as if it were our salvation, we have all been entranced by digital immediacy in the form of mobile device apps, SMS notifications, curated images, music or video selections, news updates, digital map prompts, on-demand entertainment, any myriad other forms of "socio-technical entanglements" (Lindner, 2020). Gioia called this the "most shallow and flattened digital fluff" (Gioia, 2025), designed to extract market value from the data that we provide through our seemingly ceaseless dopamine micro-dosing (Gioia, 2025; Robins et al, 2025). Our social relations have become "private goods to be priced and consumed" (Davies, 2015).

But this often free easy access is a double-edged sword;

> If you wanted to see Lippi's Madonna and Child when it was first painted in 1490, you would have to go to Florence and convince Lorenzo de Medici to let you in his house. Now you can see a dozen Lippi paintings in a sitting by typing their names into Wikipedia . . . An ordinary latte might blend beans from Ethiopia, Ghana, and Suriname with sugar from Brazil and vanilla from a rare orchid found only in Madagascar; by now, it's so unbearably boring that you can find dozens of Reddit threads asking how to spruce it up, make it feel new again . . . It's all amazing, and we're bored to death of all of it. (Alexander, 2025)

All of the real (social) processing power is now in the hands of the Big Tech firms who can parcel us into "ever-more segmented markets for goods and services" (Weeks and Lyons, 2024). And these firms are taking every opportunity to turn the atomization of the body in health and illness – as well as myriad other atomistic possibilities – into lucrative markets for new goods and services. Taking minor liberties with Joseph Grima's pithy line, we might say that "If data is the new oil, the body is the next Texas" (Grima, 2014). Illness is no longer something to be eliminated. Illness is now an opportunity for growth; a boon to flagging profits. For a precious few at least.

DISCUSSION

> 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 and Susskind, 2015)

Daniel and Richard Susskind's statement written a decade ago reminds us how much the stock of the professional class has fallen in recent decades. Neoliberal atomization, unbundling, and digitally mediated technological disruption have seriously depleted the prestige and social capital of the

professions generally, and this effect is increasingly being felt by the healthcare professions.

But in thinking about what the future holds for physiotherapists, doctors, nurses, paramedics and others – as well as the broader implications for the delivery of healthcare generally – we need to be cautious about making broad generalizations from the particular. Almost all the healthcare research on societies of discipline and control, for instance, has focused only on the medical profession in high-income countries. The effects of post-professionalization will be patchy and highly variable among different professions, different geographical locations, and different healthcare systems.

It is difficult to see which professions will be affected most by post-professionalism. Perhapsmedicine is more vulnerable to sociotechnical disruption, for instance, because its work is more prestigious, it commands significantly more economic capital and offers potentially much greater financial return on investment. As a consequence, it may be the victim of aggressive predatory speculation of Big Tech firms, eager to make money from high-value care. But equally, perhaps professions like physiotherapy, midwifery, occupational therapy and counseling are more vulnerable because they offer much less of these things?

The problem is made more complex still because the very idea of what it means to be a profession has become much more fluid and mobile in recent years (Castells, 2010; Esmonde et al, 2024; Golden and Bencherki, 2024; Harper, 2020; Noordegraaf, 2020), and healthcare has proven to be fertile ground for hybrid, connective forms of professionalism (in new public management and healthcare quality improvement, for instance).

Some professions have clearly embraced more hybrid professional identities as a way to remain culturally relevant, and increase their "capacity to act and strengthen their position as key actors in the continuity of care and at the forefront of the health system" (Ghis Malfilatre and Louvel, 2025). Ghis Malfilatre and Louvel have shown, for instance, that doctors are now engaged in "cognitive job crafting" in order to change the "meaning they give to their work," and "redefine their professional activity" (Ghis Malfilatre and Louvel, 2025), and there is a widespread acceptance that "[w]ork tasks may disappear, move between professionals or merge, while new tasks may arise that will affect the job descriptions and roles of professionals" (Lottonen et al, 2024). Both this paper and Breedt et al. are suggesting that this process of professional definition is now very much at work in physiotherapy.

But if the goal of this professional restructuring is to maintain the profession's prestige and social capital, what likelihood is there that it will be successful? A key feature of the post-professional era is the way it slowly depletes the ability of the professions themselves to determine their own future. Post-professionalism is not just about marginalizing healthcare *practice*, but also health professional agency and self-determination. So, while the goal of *being* a healthcare professional may remain the same into the future – to find a role that offers meaningful work and fair pay, and a means to protect oneself and one's profession from "precarious employment, social isolation, work-life imbalances, and skill obsolescence" (Arora and Garg, 2024) – the means by which this can be achieved is likely to slip inexorably through the professions' fingers.

If many of the high-prestige aspects of physiotherapy clinical work are lost to new digital technologies, robots and AI, then; if funding continues to be squeezed and job pressures increase; if the work becomes so mundane to the point where lengthy training becomes a pointless expense; if the profession feels it no longer commands the trust of the public and has lost all meaningful political support; if routinization hollows out every day work making specialization unachievable; and if physiotherapy practice is stripped of its cachet and mystique, will not the brightest minds in practice go elsewhere and the pipeline of students coming into the profession dry up? So, even if orthodox, discipline-led healthcare persists for a while longer, post-professionalism may denature healthcare practice to the point where the health professionals themselves elect to leave (exacerbating further the already debilitating problem of professional attrition). What we would then have to consider is how the healthcare needs of the population might be met if there was no longer any working institutional, disciplinary infrastructure; no backup when personal choice and predictive algorithms fail.

In some ways, the Big Tech firms have been right to say that many of us have been paralyzed by so much consumer choice, by the corruption and deliberate degradation of social discourse, and the sheer enormity of the hyperobjects now facing us as a civilization (Morton, 2013; see also World Economic Forum, 2023). They are right to say that people are looking for help to make choices about themselves, their families and their communities. But are they also correct in thinking that *they* should now be trusted to provide us with the answers? Are we really going to trust a handful of global technological superpowers with decisions about how we want to organize and experience healthcare into the future? Are the problems we now face really too messy, too complex, and too diffuse for us to grapple with individually or collectively? Can we really do without the

orthodox health professions and the institutions that they established and maintained?

Some might argue that a society of indifference is only a new layer of sediment on top of the existing strata laid down over hundreds of years by sovereign rule, disciplinary technologies and biopolitical systems of control. However, and this is the crucial point, this assumes that the sub-strata will remain broadly intact. Post-professionalism, however, suggests that over the last 75 years the disciplinary, institutional layer of society has been eviscerated by neoliberalism, unbundling, and DMTD. It suggests that the technologies of discipline that gave birth to the professions; to the public health system; to centralized, regulated, legitimated healthcare; to the hospital and healthcare infrastructure; to public health measures; political systems of universal access, professional regulation, and state sponsorship, have been pushed so far to the margins that they are becoming unsustainable for funders, regulators, taxpayers, and the professions alike.

More than anything then, post-professionalism says that a society of indifference is not simply the development of a new layer of social governance, but an expression of a radical departure from forms of social ordering that have gone before. The very same forces that made the society of indifference possible – neoliberalism, unbundling, and DMTD – are the same systems that have been degrading the infrastructure that we have always believed was the backbone of orthodox healthcare. Predictive algorithms will certainly, and should, have a place in future health professional practice. As will individual choice. But people will almost certainly also want to defer to the expertise of well-trained, well-supported professionals in the future. If the post-professional turn makes their work untenable though, it is difficult to see how organized healthcare will function effectively in the years to come.

In Chapter 9 of *Physiotherapy Otherwise* (Nicholls, 2022), I attempted to show how physiotherapy might respond to these changes. And although the book was completed before the widespread emergence of AI, it anticipated many of the acts of professional "hollowing out" that we are now seeing at work. The book argues that critical thinkers in physiotherapy need to find the "intensities" lying at the heart of the physical therapies (the powers and forces that have sustained touch, movement, thermodynamic energy, rest, and so on, for thousands of years). Clinicians, educators and professional leaders need to anticipate what will be lost from physiotherapy over the months and years to come (that which is easy to describe, repeat, and deliver, especially), and redesign curricula, regulatory frameworks, day-to-day practice … the entire profession in effect, around these intensities. Perhaps most radically, I argue that we should now abandon our long project to secure the profession's power and prestige and look instead to sharing our expertise as widely as possible. In effect, giving physiotherapy away.

We know the world around physiotherapy is changing fast, and the signposts are clear. The post-professional era will be as disruptive as any event in physiotherapy's history, but what is clear is that the profession will not return to "normal" when all of this disruption is over. Having a firm understanding for the conditions that will shape the profession's future is vital, then, if we are going to make wise choices in a new society of indifference.

CONCLUSION

As Deleuze and Foucault both argued, new emergent forms of power only ever supplant older forms, so sovereign powers, disciplinary technologies, and societies of control will endure even as new societies of indifference emerge. That being said, I would argue, along with many others, that the sociotechnical acceleration of the last decade (Rosa, 2010, 2013) represents an "epistemic crisis" (Simonsen et al, 2025); a moral re-ordering of healthcare work (McLoughlin, Garrety, and Wilson, 2017); a transformation that has "implications for the ways care is provided, the clinical learning environment is organised, and what it means to be a competent professional" (Rowland, Brydges, and Kulasegaram, 2024). Societies of indifference represent a fundamental shift in what it means "to be a health professional in contemporary healthcare" (Simonsen et al, 2025).

In this article I have asked whether physiotherapy, and the orthodox health professions alike, have *any* role to play in the future of healthcare. Post-professionalism names a number of concurrent phenomena that are shaping the way physiotherapy will increasingly experience health care practice into the future. It argues that: orthodox health professions like physiotherapy will have a decreasing role in the organization and delivery of health care in the future; its ability to shape healthcare in their own interests will also progressively decline; and the golden age of the orthodox health professions is over. Post-professionalism has been brought about by a combination of factors, most especially neoliberal atomization, the unbundling of goodness and expertise, and digitally mediated technological disruption. Given the evisceration of institutional and disciplinary forms of knowledge and expertise, it is hard to envisage how the healthcare needs of the population will be met in the future.

Notes

1. In some jurisdications, a post-professional degree refers to "postprofessional DPT degree is conferred upon completion of a structured postprofessional educational experience that results in the augmentation of knowledge, skills, and behaviors to a level consistent with current professional (entry-level) DPT standards" (https://www.apta.org/your-career/career-advancement/postprofessional-degree). This is a different interpretation of the concept of post-professional to the one used in this paper.
2. For more comprehensive explanation and analysis of atomization and late-stage capitalism, as well as the unbundling of goodness and expertise and digitally mediated technological disruption that follow, see (Nicholls, 2022).
3. Just as iatrogenic effects are harms caused by medical treatment itself, professogenic effects are the negative consequences that arise when health professions control or dictate how people's health and wellbeing are organized and governed.
4. In December 2025, US Department of Education announced that physical therapy, nursing, occupational therapy, audiology and social work would no longer be considered professions, whilst recognizing the professional status of chiropractic, osteopathy, podiatry, pharmacy and clinical psychology (Nicholls, 2025).
5. At the time of writing, Flok Health announced that it had just raised £9.5 million in a venrure capital funding, describing their app as a "pioneering clinic [that] is the first and only AI platform in Europe to deliver entire healthcare pathways autonomously without requiring human oversight. The tech is currently available to millions of NHS patients across the UK, offering on-demand appointments for back pain with zero waitlist, via a simple mobile app" (https://businesscloud.co.uk/news/flok-health-raises-9-5m-to-scale-the-worlds-first-ai-clinician/).
6. It should be noted that these are reported results provided to the media by the company. To date, no raw data have been made available for public scrutiny.
7. At the time of writing, other apps like DocHQ (https://dochq.co.uk/business/physio), Exakthealth (https://www.exakthealth.com/en), Exer (https://www.exer.ai/), Kaia Health (https://kaiahealth.com/), Phio (https://www.eql.ai/phio, and others are also targeting AI MSK exercise-based therapy ahead of the many other kinds of physiotherapy practice.

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