“Patient” and “Client”: A Study of Terminology in Health Professions, and the Case of Massage Therapy in Ontario

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Dedication

To Stephen, Callum, and Everett – thank you for everything

Abstract

This study examines how language used to describe recipients of care shapes power, professional identity, and healthcare relationships within Ontario's regulated health professions. It is guided by two research questions: (1) How do regulatory documents across Ontario's health professions use the terms "patient" and "client," and what do these uses reveal about power dynamics, professional identities, and healthcare relationships? and (2) How are "patient" and "client" used in documents from the College of Massage Therapists of Ontario, and in public college program descriptions of massage therapy, and what does this usage suggest about the professional identity and positioning of massage therapy within Ontario's healthcare system? Poststructuralist and feminist poststructuralist theory (Belsey, 1997, 2002a, 2002b; Foucault, 2003a, 2003b, 2004, 2008, 2013), as well as critical discourse analysis (Fairclough, 2010, 2013, 2014, 2023) were employed to frame the study and help interpret data.

Data was collected between May and July of 2025 and included regulatory documents from 26 colleges representing 27 regulated health professions, with one college counted twice because it governs two professions. Of these, 19 used "patient" exclusively, 4 used "client" exclusively, and 4 used both on their homepages. Massage therapy stood out: the regulatory college used "client" exclusively, while public-college program pages showed mixed usage.

Findings include "client" being utilized by health professions where the majority of practitioners are female, and health professions that do not generally receive public funding. The study considers the potential effects of everyday terminology choices within healthcare, care relationships, and how professions are seen within Ontario's healthcare system.

Keywords: patient; client; massage therapy; health professions education; poststructuralism; professional identity; terminology; Ontario healthcare; power dynamics; discourse analysis

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Chapter 1: Introduction and Research Problem

"Patient" is not a neutral word (Burnham, 2012; McLaughlin, 2009). It is a term with a range of meanings, roles, identities, labels, concepts, and contexts (Engel et al., 2019; Flores-Sandoval et al, 2021). "Patient" is also arguably the most common word seen across healthcare settings, but it can be interpreted in a vast number of ways (Costa et al., 2019; Deber et al., 2005). An exploration of the term "patient" in healthcare makes for a compelling study, not because it seeks a single all-encompassing term, but because it can uncover the various meanings, associations, and tensions inherent in a rather common word.

This thesis begins from the premise that language conveys power and is not neutral. However, it does not seek to simply restate that general claim. Instead, this study moves beyond them by examining how the specific terms "patient" and "client" are used within public-facing regulatory and educational discourses, and how such patterns of use may reproduce and interact with many aspects of healthcare in Ontario. By focusing on how these terms are distributed and mobilized across regulated health professions, the aim is to contribute a more context-specific analysis of language in practice, of how meaning is produced within particular provincial and institutional settings. Words such as "client" and "patient" do more than simply describe individuals receiving care; they play a role in shaping professional identities, understood here as a developing sense of self in relation to a profession, influence interprofessional collaboration (IPC), and may reflect underlying power dynamics (Brookes et al., 2023; Monrouxe, 2010). These terms also surface in health professions education (HPE), where they may affect how future healthcare professionals envisage their roles and relationships with those whom they serve.

In this thesis, the term "healthcare professional" is used in place of "provider" to avoid language that suggests care moves in only one direction, from professional to recipient. For clarity, throughout this study the term "health professions" encompasses both regulatory and educational contexts. It is used in an inclusive sense to refer to both the regulated practice of health professions and the educational environments in which future professionals are prepared for practice. This reflects the understanding that language used in each sphere - whether in

public-facing regulatory documents, or in health professions education (HPE) - plays a role in shaping professional identity, authority, and care relationships.

Historical definitions of "patient" emphasize passivity, suffering, and submission (Arneja & Gilardino, 2023; Lawrence, 2008). These definitions continue to affect current understandings of care, and the roles individuals hold within healthcare systems (Burnham, 2012; McLaughlin, 2009; Herxheimer & Goodare, 1999). However, despite its prevalence, "patient" is not universally accepted, with alternatives such as "client," "consumer," "user," and "participant" finding their way into various health professions, each with implications for identity, and power dynamics (Costa et al., 2019; Neuberger & Tallis, 1999; Towle et al., 2016). To help understand how these meanings are built and maintained, this thesis draws from poststructuralist theory and critical discourse analysis (CDA).

Poststructuralism and CDA are utilized to examine the power dynamics embedded and emerging in language, as well as how these may impact "patients", practitioners, and health professions education (HPE). Poststructuralism can provide insights into how language is implicated in the development of knowledge, identity, and authority (Foucault, 2008, 2013; Belsey, 2002b). Fairclough's three-dimensional model of critical discourse analysis (CDA) offers methods to analyze the ways that discourses such as those found in regulatory and educational documents establish and reinforce professional hierarchies and social norms (Fairclough, 2010, 2013; Wodak & Meyer, 2001).

This thesis tackles the many meanings of "patient" and its alternatives, in particular "client" in HPE and practice. These terms are defined, and their use within educational programs and regulatory institutions in Ontario is discussed, along with how these definitions influence relationships within healthcare. Massage therapy in Ontario serves as a further focus, to study the use of "patient" and "client"-related language in education, regulation, healthcare relations, and practice. It provides a useful case to examine how care-recipient terminology mingles with professional identity and institutional positioning (see Appendix A for "patient" and "client" terminology and Ontario's regulated health professions).

Massage therapy was included as a purposeful case within this study because existing scholarship and the Ontario healthcare regulatory context identify it as a regulated health profession with a distinctive and contested professional position Massage therapy is a formally regulated health profession in Ontario, yet the literature describes ongoing challenges related to

professional recognition, educational variability, limited interprofessional inclusion, and uneven public understanding of the profession (Baskwill et al., 2020a, 2020b, 2023a, 2023b; Fournier & Reeves, 2010). These features make massage therapy a useful case for examining how terminology, regulation, education, and professional identity interact within Ontario's health professions. Thus, the focus on massage therapy was not based solely on my personal connection to the profession, nor on findings generated after analysis began, but on its documented position as a regulated profession whose identity and place within healthcare remain actively negotiated.

1.1 Ontario's Healthcare Regulatory Context and the Positioning of Massage Therapy

Ontario's healthcare system is structured by the Regulated Health Professions Act, 1991 (RHPA), which provides the legislative foundation for regulating the province's twenty-seven health professions (Government of Ontario, n.d.; Regulated Health Professions Act, 1991, n.d.). The RHPA outlines scope-of-practice statements, establishes mechanisms intended to protect the public, and delegates authority to profession-specific regulatory colleges to set expectations for practice (Government of Ontario, n.d.; Regulated Health Professions Act, 1991, n.d.). These colleges outline standards, issue certificates of registration, respond to concerns about conduct, and offer the public information about what each profession does and what someone can reasonably expect when seeking care. The RHPA set the stage for the creation of the Massage Therapy Act, 1991, which includes the conditions for establishing the regulatory college for massage therapy and the College of Massage Therapists of Ontario (CMTO) (*Massage Therapy Act, 1991*, 1991). Through such activities, regulatory documents become a key place where the identity of a profession is communicated and understood.

Regulatory colleges also contribute to shaping how health professions are represented. Their websites and public-facing documents - especially homepages, and pages directed toward "patients" or "clients" - may be the first sources people consult when trying to make sense of a profession. These materials do more than provide information; they help form a picture of each profession and the kinds of relationships it seeks to build with the public. One element of this is the terminology used for those who receive care. Whether a college uses "patient," "client," or both hints at how it views the people its members work with, and the values that shape those interactions (Brookes et al., 2023; Engel et al., 2019). This point is more salient with changes to legislation specific to massage therapy. An amendment made in Ontario Regulation 228/24 to strike out the use of "patient" and substitute "client" under the Massage Therapy Act, 1991

published in 2024, also confirms how regulatory documents influence the profession, and how it may be seen by the public *(Amending O. Reg. 544/94, 2024)*.

Massage therapy is one of Ontario's regulated health professions, overseen by the College of Massage Therapists of Ontario (CMTO) (CMTO, n.d.). While the RHPA sets out a common regulatory framework, each college determines how it describes the individuals its members serve (Regulated Health Professions Act, 1991, n.d.). This makes the regulatory environment an important backdrop for understanding how the terms "patient" and "client" circulate across health professions, and how language choices may reflect or reinforce professional positioning.

To understand massage therapy's use of "client," it is useful to consider where the profession sits within Ontario's broader healthcare environment. Despite being formally regulated, massage therapy is sometimes viewed as peripheral or somewhat outside the centre of mainstream biomedical practice. This is echoed in both the literature and professional discourse, where massage therapists often describe feeling misunderstood, excluded from participating in interprofessional initiatives, or often positioned at the edges of healthcare (Baskwill et al., 2020b, 2023a; Fournier & Reeves, 2010). This sense of being "in" the regulatory system but not always recognized as part of the core health professions influences how massage therapy describes its work and the individuals it cares for.

Parts of this marginal positioning also appear in the materials encountered by prospective students. For example, on the centralized college application website, which is often the first point of contact for someone considering the profession, massage therapy programs appear with non-health and non-regulated fields such as hairstyling and esthetics (Massage, n.d.). While this website was not part of the formal data set, it illustrates how the profession is situated in public-facing contexts and may impact early impressions of massage therapy's place within Ontario's regulated health professions.

These early impressions are consequential. How massage therapy is presented may influence who chooses the profession, how future therapists interpret their roles, and how the field is perceived by the public (Baskwill et al., 2020b, 2023b). When considered alongside the language of the CMTO and its exclusive use of "client," these may contribute to a layered professional identity that is markedly different from those that use "patient". Also, by locating massage therapy within a wider regulatory and educational context, this thesis can more fully

explore how terminology, power, and identity intersect. This background helps set the stage for both the analysis that follows, and why examining the terms “patient” and “client” is meaningful and necessary.

1.2 Significance of the Study

The significance of this thesis resides in its potential to sift through the ways terminology may affect professional identities, interprofessional collaboration, and societal and institutional power structures. It also considers how language informs curriculum and how students understand healthcare relationships. With regard to regulatory bodies, attention is paid to the choice of “patient” or “client” and the ways this choice may influence public perception and professional legitimacy. For healthcare professionals (HCPs) it offers a critical look at the impact terminology may have on their inclusion, and authority within the healthcare system. Finally, for the “patient” or “client,” this work examines the labels used in healthcare that may mark their experiences, and agency (Bravo et al., 2015; Oben, 2020; Timmermans, 2020).

Language is not purely informational - it can represent relationships, authority, and identity (Belsey, 2002b; Foucault, 2003b). By extension, terms such as “patient” or “client” can serve as more than labels we append on individuals, they can help set expectations of care, influence how healthcare professions operate, and affect public trust (Foucault, 2008; Costa et al., 2019). Inconsistent use of these terms may potentially undermine interprofessional communication, thereby affecting collaboration and “patient” safety (Flores-Sandoval et al., 2021; Hunter et al., 2021). Furthermore, certain terminology tends to cluster within particular areas of the healthcare system such as “patient” appearing in professions tied to biomedical authority, whereas “client” may appear in professions positioned somewhat differently within healthcare (Christmas & Sweeney, 2016; Hoyt, 1979; Naseem et al., 2001). Terminology choices may impact how professions are perceived, their integration into healthcare, and possibly their access to resources (Powell, 2023; Baskwill et al., 2020b). These ideas provide further support to the notion that language is not a neutral tool but a site of negotiation and power, making its study important for understanding healthcare dynamics (Belsey, 2002b; Foucault, 2008, 2003b). While some may see “patient” involvement as empowering, others may interpret it as threatening professional authority, a tug-of-war over how power and language are understood (Rowland & Kumagai, 2018; Stewart, 2001; Vinson, 2016).

1.3 Research Questions

This divergence does raise a number of important questions: Does terminology matter with regards to how the regulated health professions are seen and positioned within healthcare systems? Could the choice of "client" – a term often linked to consumerism or service industries – potentially reinforce the marginalization of certain regulated health professions? Or might it indicate a deliberate effort to build more inclusive, collaborative models of care?

The review of the literature set the scene by sharing the current understanding of the historical, traditional, mainstream, and alternative definitions of the term "patient" in health professions education (HPE) and practice and by exposing the tensions or commonalities that exist among them. At times, peeling through the literature meant an exercise in reading about new and innovative imaginings of the "patient" and possibilities. However, at other times it proved a frustrating endeavor to find clear definitions, as much of the literature dances around defining "patient." The sheer range of terminology meant to define "patient" seems to indicate a lack of consensus, which begs the questions of who is the "patient", and does it matter? Could the choice of term affect how the "patient" is treated? Or if another term is used such as "client", is this a reflection of the person seeking healthcare, the person providing the care, or the norms within which both persons operate?

Two primary research questions guide this work: (1) How do regulatory documents across Ontario's health professions use the terms "patient" and "client," and what do these uses reveal about power dynamics, professional identities, and healthcare relationships? and (2) How are "patient" and "client" used in documents from the College of Massage Therapists of Ontario, and in public college program descriptions of massage therapy, and what does this usage suggest about the professional identity and positioning of massage therapy within Ontario's healthcare system?

1.4 Overview of the Thesis

To respond to these questions, this thesis begins with a review of the literature, scans definitions of "patient," documents alternatives, and introduces massage therapy's use of one the alternatives - "client", and its positioning among the regulated healthcare professions and health professions education (HPE) in Ontario. The theoretical framework component outlines concepts from poststructuralism and CDA that guide how the data is interpreted. The methodology and methods chapter describes the approaches taken, including NVivo-assisted coding. Data was collected from May to July of 2025. Details of the data collection, methods, and methodology are

further explained in the methodology and methods chapter. The findings section presents key results from the analysis, followed by a discussion chapter that then interprets the findings utilizing theory and existing scholarly works. The closing chapter seizes on the opportunity to reflect on limitations, proposes potential directions for future research, and includes concluding thoughts on the use of "patient" and "client" in healthcare.

1.5 Summary of Findings

Before turning to the literature review, a brief summary of the key findings is provided to give the reader a sense of the patterns that emerged from the analysis. The findings of this study show clear patterns in how terminology is used across Ontario's health professions. First, "patient" is the dominant term in regulatory documents, appearing in the majority of the twenty-seven regulated health professions (see Appendix A). Only a small number of professions, most of them female-majority, use "client," either exclusively or alongside "patient." Massage therapy is the only profession whose regulatory college uses "client" alone, with "patient" notably absent from all CMTO public-facing documents (see Appendix B, Table B2; Table 1).

Second, the educational materials analyzed for massage therapy did not mirror the regulatory approach as closely as expected. While "client" was the more common term, "patient" still appeared in several program descriptions and sometimes within the same page as "client," creating mixed messaging for students entering the profession (for the coded occurrences of "patient" and "client", please see Appendix B, Table B3). This contrast suggests that terminology is not standardized even within a single profession and that educational discourse may reflect different aspirations or pressures than regulatory discourse.

Third, the comparison between CMTO materials and massage-therapy-specific education documents revealed shared themes such as ethics, health, and hands-on practice, but also distinct emphases. CMTO documents emphasized professionalism, "client" rights, and protecting the public, whereas education documents shifted focus to skills, knowledge, and varied practice settings (Appendix B, Tables B2-B3; Chapter 5.2.3, Table 1). These thematic differences between the regulatory college and the public colleges that offer massage therapy programs hint at the multiple, sometimes competing, identities that massage therapists must navigate within its own profession.

Collectively, the findings demonstrate that terminology is unevenly distributed across Ontario's health professions, and that these choices carry implications for professional identity, relationships, and power. Massage therapy, as a case to study the impact of terminology in health professions, is positioned through language in ways that may affect its location within Ontario's healthcare system. Thus, the purpose here is not just to simply describe where "patient" and "client" did or did not appear, but also to situate them in context by looking at surrounding language, noting which documents house these terms and gaining insight into how these terms function within larger institutional patterns and positioning. These findings prepare for a deeper analysis presented in later chapters, where terminology, power, and identity are explored in greater depth.

Chapter 2: Review of the Literature

A review of the literature is generally meant to present all sides of an argument, and begins with selecting a topic, then progresses through surveying the literature, critiquing, and writing (Machi & McEvoy, 2016; O'Leary, 2021). This literature review aims to accomplish this by including a wide range of sources on the historical definitions of "patient," the emergence of alternatives such as "client," and implications of these terms for power and identity in healthcare. To keep this review comprehensive yet purposeful, I organize the chapter to move from history and definitions to terminology's links with power, identity, and relationships, to a focused case on massage therapy in Ontario, and finally to the implications for this study.

The literature review did expose several notable gaps - massage therapy is rarely included in discussions of healthcare terminology, and there is limited exploration of how healthcare institutions may shape professional identity through language (Baskwill et al., 2020a, 2023b; Fournier & Reeves, 2010). In addition, few studies seem to apply poststructuralist theory or CDA to examine terminology and power dynamics in healthcare (Catalano & Waugh, 2020; Fairclough, 2010; Foucault, 2008). Although issues with the use of "patient" and alternatives such as "client" appear to be well-documented, the absence of massage therapy and the underuse of CDA approaches suggest a need for deeper inquiry into how language may affect inclusion, and identity in health professions education and practice (Costa et al., 2019; McLaughlin, 2009). These gaps further justify the focus of this thesis on "patient" and "client" in Ontario's regulatory and educational discourse, with massage therapy serving as a case through which to examine how terminology travels across contexts**.**

To take stock of the current knowledge base and perspectives on "patient" and its alternatives, an extensive search of the literature was conducted. I first considered the use of the word "patient" from its historical roots to its multi-interpretations today, as well as evolving roles for "patients" and practitioners. I then unpacked the alternatives to "patient"; "client" emerged as a popular contender, particularly in non-medical healthcare settings and professions. As one of the regulated health professions in Ontario favouring "client", the current state of massage therapy in Ontario is briefly introduced, both to set the stage for the empirical research documented in this thesis, and because massage therapy is rarely included in health professions literature both within and outside of Ontario. Throughout, the focus is how terminology

intersects with power dynamics, professional identity, and healthcare relationships; these threads guide the analysis in later chapters.

2.1 The Terms "Patient" and "Client" in Healthcare

Terminology used to describe those receiving healthcare has long been tied to how care, authority, and professional relationships are understood (Costa et al., 2019; McLaughlin, 2009). Across Canadian contexts, "patient" and "client" consistently emerge as the two dominant labels, even though the wider international literature includes many other terms such as "service user", "consumer", or "care recipient" (Christmas & Sweeney, 2016; Simmons et al., 2010). In Ontario's regulated health professions, these alternatives appear infrequently. Because the regulatory and educational documents examined in this thesis use only "patient" or "client," these two terms form the central focus of the review that follows.

2.1.1 Historical and Contemporary Uses of "Patient"

The historical origins of the term "patient" are important to consider as much of how "patient" is still defined is a remnant of past definitions. Derived from the Latin "*patiens*" - to suffer or endure, "patient" has traditionally implied passivity and obedience within a paternalistic healthcare model (Arneja & Gilardino, 2023). This legacy continues to influence perceptions of "patients" as helpless, unable, or in need, often reinforcing power imbalances between healthcare providers and recipients (McLaughlin, 2009). These historical residues matter for this thesis because they surface in contemporary regulatory and educational discourse, shaping how care relationships are framed.

"Patient" first appeared in English as an adjective in the 14th-century expressing the idea of enduring hardship, then as a noun meaning a person bearing difficulties without complaint (Lawrence, 2008; McLaughlin, 2009). Later, its focus narrowed to medical contexts, signifying a person with an injury or disease, or one undergoing medical treatment. Over time, "patient" expanded to include populations - such as "inpatients" and "outpatients" - essentially a category within healthcare systems (Burnham, 2012; Lawrence, 2008). "Patient" went from being employed as an adjective, to becoming embodied by an individual, to removing individual identity and naming populations, to categorizing these populations, and may still cycle through all of these roles (Lawrence, 2008). The literature suggests these numerous interpretations contribute to the difficulty in arriving at a clear, accepted definition of "patient" (Costa et al.,

2019; McLaughlin, 2009). It follows that common understandings of "patient" remain elusive when one word evolved to take on so many potential meanings.

The term "patient" has also become something of an umbrella term that includes individuals with health conditions, the individual and their caregivers, and others with relevant lived experiences, such as community members or citizens, highlighting the difficulty of any single label to fully capture the complexity of these relationships (Towle et al., 2016). Despite this complexity, the term "patient" is often criticized for implying passivity**,** with turns of phrase such as "receiving care", "tests are performed on", as well as linking "patient" with a "sick role" that diminishes agency (Cahn, 2017; Herxheimer & Goodare, 1999; Kangasjarvi et al., 2023; Neuberger & Tallis, 1999). Perhaps one word – "patient" – is burdened with too many definitions, leaving it vulnerable to misinterpretation.

"Patient-centred" is one of the "patient"-hyphenated terms that appears most often in the literature, popular in healthcare policy and HPE (Christianson et al., 2007; Hansen et al., 2016; Hearn et al., 2019; Kumagai et al., 2009; Mead & Bower, 2000; Roberti di Sarsina & Tassinari, 2015; Robinson et al., 2008; Scholl et al., 2014). The term is commonly associated with values such as empathy, shared decision-making, a focus on the "patient" in HPE, and respect for the individual are treated as components of a "patient-centred" approach (Hansen et al., 2016; Mead & Bower, 2000). Despite its current popularity, several authors question whether "patient-centred" care has led to substantive changes in power relations or decision-making authority for those receiving care (Christianson et al., 2007; Scholl et al., 2014). Like "patient", a recurring concern in the literature seems to be the lack of consensus of what "patient-centred" means, with the term often used without any clear definition (Hearn et al., 2019; Robinson et al., 2008).

As mentioned, although "patient-centred" may be used to signal progressive, collaborative care, its implementation may be limited due to institutional constraints. Conventions and issues within healthcare and HPE such as time pressures; standardized protocols; long wait times for healthcare services; increasing demands on healthcare systems due to aging populations; possible financial barriers to HPE for students; and professional hierarchies may detract from a centred approach (Leidner et al., 2021; Spadafora & Tsotsos, 2016). The "patient-centred" ideal of care could get lost in the other demands on healthcare systems, such as the case for Ontario, where approximately one in five Ontarians do not have a family doctor, thus

even securing access to a family physician cannot be assumed (Ontario College of Family Physicians, 2023). This helps explain why some of the literature points out that “patient-centred” care may function more as an aspirational ideal than a consistently realized practice within strained healthcare systems (Leidner et al., 2021; Spadafora & Tsotsos, 2016).

Another factor that may undermine “patient-centred”-ness is it may be manipulated to justify decisions made by healthcare institutions and HCPs, rather than seeking input from “patients” (Belrhiti et al., 2021; Leidner et al., 2021). If the healthcare system is straining under the pressures of many competing needs, the ideals of partnership and collaboration found in “patient-centred” approaches may be limited (McIntyre et al., 2020; Officer & McBride-Henry, 2021; Rowland & Kumagai, 2018). It seems “patient-centred” care is widely invoked but inconsistently defined, and its practical limits often reflect institutional and professional constraints rather than the term itself.

Despite the widespread use of the term “patient,” there is no clear alternative that captures its complexity (McLaughlin, 2009; Neuberger & Tallis, 1999; Towle et al., 2010). Proponents of maintaining the status quo may argue that the established meanings of “patient” are sufficient. However, this perspective may overlook the potential for misinterpretation and the need for clarity, which could empower “patients” rather than leave them feeling marginalized.

The difficulties in defining “patient” are present in the literature and are compounded by historical definitions of the term that linger to this day. The debate surrounding the terminology used to describe individuals receiving healthcare services continues, with arguments for replacing “patient” with terms like “consumer,” “user,” or “client” (Christmas & Sweeney, 2016; Costa et al., 2019; Deber et al., 2005; Simmons et al., 2010). For the purposes of this thesis, the historical depth retained here will later be brought into conversation with current regulatory usage in Ontario, allowing a comparison between inherited meanings and present-day institutional language.

2.1.2 Historical and Contemporary Uses of “Client” and Alternatives to “Patient”

“Client” derives from the Latin *'dinare*' meaning "to lean," originally referring to a plebian under the patronage of a patrician in ancient Rome (Hoyt, 1979). In contrast to “patient”, “client,” rose to prominence more recently, and is often linked to shifts toward autonomy, and shared decision-making within health and social care (Arneja & Gilardino, 2023; McLaughlin, 2009). The term appears frequently in professions with a focus on counselling, rehabilitation,

education, or community-based practice, where care tends to be framed as collaborative and participatory rather than strictly hierarchical (Corring & Cook, 1999; McLaughlin, 2009; Petriwskyj et al., 2014). At the same time, “client” is often associated with consumerism and service industries, raising concerns that it may inadvertently frame care as a transaction rather than a therapeutic relationship (Reeder, 1972; Saito et al., 2013). Across the literature, “client” seems pulled between autonomy-oriented meanings and market-based associations.

“Client” as a term is more often seen in parts of the world such as the Americas, while a few other regions favour alternative terms such as “user”, “consumer” or “service-user” by comparison (Christmas & Sweeney, 2016; Costa et al., 2019; Mcguire-Snieckus et al., 2003; McLaughlin, 2009; Naseem et al., 2001; Simmons et al., 2010; Sluzki, 2000). Some authors question whether “client” translates well in interprofessional collaborative care or medical settings, where shared terminology can support coordination and legitimacy (Costa et al., 2019).

Historically, “client” emerged in part as a deliberate alternative to “patient” (Reeder, 1972). “Client” was seen as an option for HCPs who wanted to focus on holistic and empowering care, expanding into the language used in certain healthcare education programs (Reeder, 1972). Carl Rogers’s introduction of “client-centred therapy” garners mention as an early move away from “patient” – infusing “client” with airs of autonomy, empathy, and partnership (Kramer, 1995; Shevell, 2009). Some of the literature from Canada similarly sees “client” as a term that supports shared decision-making and values the lived experience of the “client” (Corring & Cook, 1999; Mortenson & Dyck, 2006). Others caution that “client” may also be interpreted in a seemingly incompatible way, as implying a transactional relationship, thus potentially de-humanizing, and commodifying care (Herxheimer & Goodare, 1999; Petriwskyj et al., 2014; Reeder, 1972; Saito et al., 2013). “Client” with its market-based connotations may conflict with any notion of an inclusive, collaborative therapeutic spirit (Costa et al., 2019; Reeder, 1972). These critiques highlight ongoing debate regarding whether “client” sufficiently captures the relational and ethical dimensions of healthcare.

In Ontario, the use of “client” appears to be concentrated among a relatively small group of regulated health professions, several of which are predominantly female, such as massage therapy, midwifery, and occupational therapy (see Appendix A, Table A1 for profession distributions). This gendered pattern is consistent with scholarship suggesting that professions more strongly associated with relational or care-centred labour are often granted less authority

within healthcare hierarchies than those more closely aligned with biomedical or technical authority, a dynamic that may influence both terminology choice and how that terminology is interpreted (Cahn, 2017; Costa et al., 2019; Neuberger & Tallis, 1999).

"Client-centred" care expands on the meanings of "client" by prioritizing the autonomy, preferences, and active participation of individuals in their own healthcare journeys (Baskwill et al., 2020a; Corring & Cook, 1999). "Client-centred" care was first coined by Carl Rogers in 1939 and is defined by values such as respect, empathy, and the personalization of care (Corring & Cook, 1999). "Clients" are meant to be involved in the decision-making process, recognizing their expertise in their own health, and supporting them to take part in their own well-being (Corring & Cook, 1999). It is an approach that may be seen in sharp contrast to more traditional, paternalistic models of care where the healthcare provider is seen as the sole authority and the "patient" is docile and obedient (Hoyt, 1979; Vinson, 2016). However, the literature also notes challenges in "client-centred" care, as practitioners may be reluctant to cede power to their "client", and the "client" may be unwilling to take on engagement and autonomy over their own health (Mortenson & Dyck, 2006).

Although the international literature offers a range of alternatives such as "service user", "consumer", "participant", or "survivor", these terms vary considerably in meaning and each are shaped by the professional and cultural contexts in which they are used **(**Hebdon et al., 2015; Mcguire-Snieckus et al., 2003; Oben, 2020; Simmons et al., 2010)**.** While some alternatives emphasize agency or partnership, others draw on market-based language (Burnham, 2012; Cahn, 2017; Timmermans, 2020). The aforementioned alternatives, and others, highlight the difficulty of identifying a single replacement that is both meaningful and widely accepted.

In interprofessional settings, inconsistent use of the terms "patient" and "client" may lead to confusion or misalignment in care approaches, potentially affecting communication and collaboration (Flores-Sandoval et al., 2021; Hunter et al., 2021). These types of inconsistencies can influence how individuals are treated, how professionals relate to one another, and how healthcare is understood by the public.

Professional identity may also be impacted by the use of specific terminology within its profession. Health professions that favour "client" could be seen as less medical or scientific, potentially reinforcing their marginalization within healthcare (Baskwill et al., 2023b). Conversely, professions that use "patient" may be seen as more authoritative or central to

healthcare, even when the care provided is similar. These considerations further mark the importance of critically examining the language used in healthcare and HPE.

The alternatives to “patient” are terms that are not exclusive to Canada, though a few have gained traction through national initiatives such as the Canadian Institutes of Health Research’s Strategy for Patient-Oriented Research (SPOR), which promotes terms like “expert by experience” and “patient-partner” (Government of Canada, 2014; Towle et al., 2010). Such terms may be selected to reflect values of inclusion, and collaboration in HPE and “patient”-oriented research, although they also raise questions about compensation, tokenism, and the limits of participatory roles (Towle et al., 2010, 2014).

2.1.3 Rationale for a Focus on “Patient” and “Client”

The terms “patient” and “client” matter not only because they are the ones used in the Ontario documents analyzed in this thesis, but also because they carry distinct histories, assumptions, and relational expectations. “Patient” continues to be associated with biomedical authority, hierarchy, and longstanding ideas about vulnerability and dependence (Burnham, 2012; McLaughlin, 2009). “Client,” meanwhile, is frequently tied to more egalitarian models of care, though it also carries consumerist undertones (Arneja & Gilardino, 2023; Hoyt, 1979).

Across the literature, terminology is not treated as neutral. Word choice contributes to how power is distributed, how professions articulate their identity, and how healthcare relationships take shape (Costa et al., 2019). These terms act as more than simple labels - they interact between authority, agency, identity, and the roles individuals play in healthcare. For health professions seemingly situated at the margins of healthcare such as massage therapy, the use of “client” may reflect existing tensions or amplify perceptions of “fringe” status (Baskwill, et al., 2023b; Fournier & Reeves, 2010). By contrast, health professions aligned with “patient” may benefit from a more prominent placement within healthcare systems (Burnham, 2012). Because regulatory colleges set professional titles, standards, and public-facing language, examining their terminology choices helps assess how power, identity, and healthcare relationships are organized and communicated in Ontario’s healthcare system.

2.2 “Client” Considerations and the Identity of Massage Therapy in Ontario

The term "client" is often preferred over "patient" in health professions such as massage therapy, where the emphasis is placed in a more egalitarian and collaborative therapeutic relationship (Christmas & Sweeney, 2016; Hoyt, 1979; Petriwskyj et al., 2014). At the same

time, “client” has also been interpreted as transactional language drawn from consumer and service-industry contexts, raising concerns that it may commodify care or de-emphasize therapeutic relationships (Reeder, 1972; Saito et al., 2013). The literature therefore presents “client” as a term that is subject to many interpretations, depending on context and professional setting.

Massage therapy often advances “client” as part of a long-standing “culture of care” where the individual who chooses to see a massage therapist feels heard, attended to, respected in an environment of trust and interpersonal touch (Smith et al., 2009). Massage therapy has a long history in Ontario. It was first regulated under the Drugless Practitioners Act (1919), and later the Regulated Health Professions Act (1991) (Baskwill et al., 2020a, 2020b). However, this regulatory consistency is not shared across Canada. Massage therapy education in other provinces varies significantly in length and content and not every province has a regulatory institution such as the College of Massage Therapists of Ontario (CMTO) to oversee practice (Baskwill et al., 2020a). These inconsistencies in education and regulation across Canada may contribute to an uneven professional position for RMTs within healthcare, including their relationships with “clients” and the other regulated health professions (Baskwill et al., 2020a, 2022, 2023a).

The literature highlights initiatives such as standardizing educational programs to resolve quality issues in massage therapy education with the introduction of program accreditation by the Canadian Massage Therapy Council for Accreditation (CMTCA) in 2017 (Baskwill et al., 2020a). Alongside this approach is a need to develop higher education pathways for RMTs. The current diploma model limits their access to universities, and the lack of research on massage therapy in academia further compounds their underrepresentation when compared with other regulated health professions (Baskwill et al., 2020a). Despite the move toward program standardization, a lack of standardized training and credentialing processes for instructors further complicates the educational situation for massage therapy students (Baskwill et al., 2020a). There are ongoing challenges related to massage therapy education, including variability across provinces, differences in program length and content, and limited access to university-based pathways (Baskwill et al., 2020a). Accreditation through the Canadian Massage Therapy Council for Accreditation (CMTCA) is presented as one response to these concerns, although its

longer-term impact on professional identity and public positioning remains uncertain at this stage (Accreditation of Massage Therapy Education, n.d; Baskwill et al., 2020a).

The COVID-19 pandemic illuminated existing tensions surrounding massage therapy's professional identity and positioning (Baskwill et al., 2023a). During early lockdowns, massage therapists were frequently classified as non-essential, a designation that contributed to feelings of exclusion and moral distress among practitioners when unable to treat their "clients" (Baskwill et al., 2023a). Beyond the example of the COVID-19 pandemic, RMTs often work in isolation, with limited opportunities for interprofessional inclusion and collaboration (Baskwill et al., 2020a). The lack of involvement in IPE further impedes the inclusion of massage as part of interprofessional healthcare teams that serve the "client"/"patient" (Baskwill et al., 2020b).

The literature also notes limited opportunities for massage therapists to participate in interprofessional collaboration and interprofessional education, which may contribute to reduced visibility within publicly funded healthcare systems (Baskwill et al., 2020a, 2020b; Fournier & Reeves, 2010). Interprofessional initiatives may bring members of several of the other regulated health professions together, but massage therapists were not named as part of any of these teams in the literature – a further limit to its visibility or inclusion in the mainstream, publicly-funded, healthcare sphere (Hunter et al., 2021; Winfield et al., 2017). Important to consider in health professions such as massage therapy that opt for "client", is the potential divide between those who identify as healthcare providers and those who see themselves as service providers, as this can create confusion and weaken professional unity (Baskwill et al., 2023b). This division is further complicated by the varying perceptions of massage therapists held by the public, other health professionals, and the therapists themselves (Baskwill et al., 2023b).

The literature presents massage therapy in Ontario as a regulated health profession whose identity is shaped by terminology, education, regulation, and opportunities for inclusion within the healthcare system (Baskwill et al., 2020a, 2022, 2023b). Although the use of "client" for professions such as massage therapy is often framed as consistent with collaborative and relational values, the literature also highlights ongoing challenges related to integration, and professional recognition (Baskwill et al., 2022, 2023b; Fournier & Reeves, 2010). These tensions provide context for examining how regulatory and educational discourse may further impact professional identity.

2.3 Power Dynamics and Terminology

Power in healthcare is not limited to overt control, rather it may be subtle, embedded in language, and institutional norms. Drawing upon poststructuralism, power is not something that one group or individual holds, but something that shows up in everyday practices, language use, and in the ways institutions are set up and run (Belsey, 2002b; Foucault, 2008). Terminology such as “patient” and “client” participates in this process by influencing how authority and participation are negotiated within care relationships (Costa et al., 2019).

In healthcare practice and education, power dynamics manifest visibly through symbols of authority, such as the medic’s white coat, which can subtly establish healthcare professionals’ authority over “patients” and learners alike (Cohen Konrad et al., 2019; Henneman, 1995). These dynamics may extend beyond clinical interactions Finto regulatory and educational contexts. Although integrated and collaborative healthcare systems are increasingly advocated for, several scholars maintain that theories of power remain underutilized in interprofessional education, practice, and research (Cohen Konrad et al., 2019; D’amour & Oandasan, 2005).

Power dynamics are present in the “patient's” “sick role”, which frames illness as a deviation from societal norms that releases individuals from typical responsibilities (Burnham, 2012; Metersky et al., 2022b). Passive “patients” are expected to follow the authoritative provider's advice (Burnham, 2012). In healthcare models, power distribution varies – from a paternalistic physician-centred model, to a consumer-driven one where “patients” assert influence, to a partnership model that seeks power-sharing (Shutzberg, 2021). Along this continuum, “patient” advocacy serves as a distinct concept that is not necessarily rooted in consumerism. Literature that emphasizes advocacy stresses the importance of empowering “patients” to participate in decisions about their care, often through shared decision-making, education, as well as involvement in policy and research (Bravo et al., 2015; Rowland & Kumagai, 2018). Several authors caution that these models may oversimplify healthcare interactions, noting that power-sharing remains uneven and that collaborative ideals are not always realized in practice (Rowland & Kumagai, 2018; Shutzberg, 2021).

The literature documents increasing emphasis on integrating “patient voices” into healthcare practice, and education, including roles such as “patient-educators” or “patient-partners” (Burnham, 2012; Kangasjarvi et al., 2023; Towle et al., 2010, 2014). Participation as educators or "patient mentors", for example, sees "patients" who are often expected to volunteer without compensation, and additional ethical considerations may also be at

play such as “patient” confidentiality and the emotional toll of sharing personal health experiences (Kangasjarvi et al., 2023; Massé et al., 2024; Towle et al., 2010, 2014). The concerns raised here are about the sustainability and inclusivity of “patient” involvement in decision-making, and assurance that “patients” taking on these roles are respected and valued (Burnham, 2012). Additional issues reported in the literature include tensions produced from “patients” as instructors where HPE students may value the firsthand insights of "patient mentors" toward “patient-centred” learning yet also see “patient-led” sessions as less structured or credible than more standard, biomedical instruction (Henriksen & Ringsted, 2014). Such reactions demonstrate tensions in valuing experiential “patient” knowledge alongside the perceived authority of provider-led, evidence-based approaches (Henriksen & Ringsted, 2014).

More current frameworks such as Interprofessional Collaborative Care (IPCC) and Interprofessional Practice and Education (IPC) have helped promote teamwork across health professions and look to ease power dynamics in healthcare teams (Metersky et al., 2022b). However, the defined role of the “patient” in shaping and actively managing their own care is largely ignored, relegating them to secondary participant status (D’amour & Oandasan, 2005; Engel et al., 2019). Although there is the potential for "patient" as partner, as part of a team, it may require additional financial and time supports to evolve the “patient” role to a more active participant in healthcare (Metersky et al., 2022a). Despite growing emphasis on “patient-centred” care, “patients” may be portrayed as recipients rather than essential members of the care team. Practitioner-led decision-making may inadvertently reinforce hierarchies, limiting “patient” opportunities to contribute in any meaningful way (Metersky et al., 2022a).

2.4 Professional Identity in Healthcare Professions

Professional identity in healthcare can be understood as a developing sense of self in relation to a profession, shaped through the values, norms, roles, language, and expectations associated with belonging to a professional community (Cruess et al., 2019; Monrouxe, 2010; Sawatsky & Monrouxe, 2023). Rather than treating professional identity as a fixed personal attribute, this thesis approaches it as something formed and negotiated through education, regulation, institutional discourse, and everyday practice with those receiving care. Terminology contributes directly to this identity by signalling how professions understand the people they serve, and how they position themselves within healthcare systems (Cohen Konrad et al., 2019; Costa et al., 2019). The use of “patient,” for instance, is often tied to biomedical authority,

long-standing notions of expertise, and assumptions about the provider's interpretive power (Burnham, 2012; McLaughlin, 2009; Petriwskyj et al., 2014). Conversely, professions that use "client" may be associated with relational, community-based, or rehabilitative forms of practice, and these associations can influence how professions are perceived by the public and by other healthcare providers (McLaughlin, 2009).

These dynamics matter because professional identity is not built in isolation – rather, it is negotiated in relation to other professions, to regulatory standards, and to all parts of the healthcare system that oversee healthcare work **(**Petriwskyj et al., 2014; Powell, 2023). Health professions education (HPE) plays a role in this process by socializing learners into particular ways of thinking and communicating that align with their future professions (Hunter et al., 2021; Towle et al., 2016). To add to this, regulatory documents reinforce these identities by setting standards and expectations, and by embedding terms such as "patient" or "client" in professional competency frameworks, and public-facing descriptions (see Appendices A and B for coded examples of "patient" and "client" use). For the purposes of this thesis, professional identity is operationalized through the ways professions are described and positioned in regulatory and educational documents, including terminology choices, associated expectations, and patterns of inclusion or marginalization.

Massage therapy offers a compelling example of how terminology intersects with professional identity. As a "hands-on", relational profession that uses the term "client," it has historically occupied a less certain position within Ontario's healthcare system (Fournier & Reeves, 2010). This tentative position is compounded by regulation, educational inconsistencies, varying public perceptions, and the profession's marginal involvement in interprofessional collaboration (Baskwill et al., 2020a, 2023b). RMTs often navigate multiple, sometimes competing expectations - being positioned as healthcare providers in some contexts and as service-providers in others (Baskwill et al., 2023b). These tensions complicate how RMTs understand their own identity and how they are understood by other professions.

To summarize this section, it can be noted that terminology, regulation, and interprofessional interactions converge to influence professional identity. "Patient" and "client" carry with them different histories, relational expectations, and symbolic meanings, and these terms shape how professions articulate their scope, legitimacy, and place within Ontario's system of regulated health professions.

2.5 Healthcare Relationships and Roles

The literature also shows that the person receiving care is increasingly being described in ways that move beyond the historical connotations of “patient” as passive, dependent, or acted upon. Instead, a shift reframes the “patient” in active and participatory terms, emphasizing roles in decision-making, education, and research, refuting the traditional view of the “patient” as passive (Bravo et al., 2015; Hunter et al., 2021). Related concepts such as “person-centred” care further emphasize attention to individual needs and lived experience, sometimes prior to the application of the label “patient” itself (Santana et al., 2018). “Person-centred” healthcare aims to reduce health inequalities by empowering individuals and focusing on health generation rather than merely prevention (Roberti di Sarsina & Tassinari, 2015; Santana et al., 2018).

The evolving role of the “patient” includes "patient engagement" and being an "active partner" in "patient-oriented" research (Bird et al., 2020; Government of Canada, 2014). Within this literature, “patients” are seen as active partners in health research that will lead to improved health outcomes and an enhanced healthcare system (Government of Canada, 2014). Other researchers have echoed this, noting that “patient” involvement in research can improve relevance and trust in the findings (Bird et al., 2020; Rowland & Kumagai, 2018). **“**Patient” engagement here refers to meaningful and active collaboration in patient-oriented research where “patients” identify priorities (Government of Canada, 2014; Towle et al., 2016) However, the literature also raises questions about who is included in these participatory roles; how involvement is structured; if or how participants are compensated; and where decision-making authority ultimately resides (Massé et al., 2024; Towle et al., 2010, 2014).

The literature further documents increased emphasis on supporting individuals with long-term conditions in self-management and shared decision-making, framing “patients” as active participants in their care (Bravo et al., 2015; Cahn, 2017). These evolving roles of “patients” in healthcare are presented as a significant shift toward collaborative, “person-centred” models that prioritize “patient” autonomy and participation (Bravo et al., 2015; Timmermans, 2020).

Traditional notions of the "patient" as a passive recipient are contested in the literature**.** Authors argue that these connotations are being increasingly replaced by those encouraging active involvement, shared decision-making, and empowerment, thus challenging the established dynamics in healthcare interactions (Hunter et al., 2021; Roberti di Sarsina & Tassinari, 2015).

Several authors describe these developments as a shift toward more collaborative models of care, although the extent to which these shifts are realized in practice remains contested (Engel et al., 2019; Sheehan et al., 2007).

In health professions education (HPE), “patients” now contribute in varied capacities, including teaching, course development, and recruitment (Soon et al., 2020). This expanded involvement goes beyond anecdotal storytelling, offering opportunities for “patients” to serve as knowledgeable partners who enrich educational experiences with personal insights, thereby enhancing their own skills and sense of agency (Massé et al., 2024). Empowering “patients” in teaching roles promotes reciprocal learning and reflects some commitment to valuing diverse perspectives in HPE. Kangasjarvi et al. (2023) emphasize that incorporating “patient” perspectives in teaching shifts educational paradigms, offering personal benefits to “patient-educators”, such as self-insight and empowerment. However, “patient” involvement in education is not without its challenges. Students may value the experiences of “patient mentors” yet also see “patient”-led sessions as less credible than traditional biomedical instruction (Henriksen & Ringsted, 2014). This tension points to the ongoing difficulty of integrating experiential knowledge alongside institutional definitions of expertise (Henriksen & Ringsted, 2014; Kangasjarvi et al., 2023).

These models of a more "engaged patient" and "patient-partner" highlight the necessity of redefining “patient” roles as more dynamic and participatory (Bird et al., 2020; Shutzberg, 2021; Timmermans, 2020). For example, "patient-partners" in research settings contribute not only their lived experiences but also develop new skills, build relationships, and add the "patient voice" to research processes (Bird et al., 2020). These shifts point to an emergent model where “patients” are positioned as key stakeholders, co-designers, and advocates who influence healthcare priorities and practices (Metersky et al., 2022a). Interprofessional collaboration, therefore, must actively integrate these “patient” perspectives into a shared language and purpose to achieve true inclusivity and respect for “patient” contributions within the healthcare team (Cahn, 2017; Metersky et al., 2022a).

However, as promising as these models are, challenges remain. Despite aspirations for inclusive, “patient-centred” approaches, inconsistencies in the interpretation and implementation of these models continue to hinder fully collaborative relationships (Metersky et al., 2022a). The concept of "patient-centred communication" addresses this by advocating for clear, consistent

terminology that resonates across healthcare disciplines (Hunter et al., 2021). The literature on interprofessional collaboration emphasizes the importance of shared language and mutual understanding across professions yet notes that the role of the "patient" within interprofessional teams is often under-specified (Engel et al., 2019; Metersky et al., 2022a). While some frameworks advocate partnership, authors also suggest that "patients" may still be positioned as secondary participants rather than fully integrated team members (D'amour & Oandasan, 2005; Engel et al., 2019).

The literature presents a larger picture of healthcare relationships as moving toward greater participation and collaboration, while still documenting tensions in how roles, relationships, terminology, and power dynamics are negotiated (Engel et al., 2019; Timmermans, 2020). The terms used to describe those receiving care, such as "patient" or "client", are part of these ongoing negotiations and may influence clinical, educational, and research contexts in healthcare (Costa et al., 2019; McLaughlin, 2009).

2.6 Summary

The review of the literature traced the historical and contemporary meanings of "patient" and "client", and what these mean for healthcare. Despite ongoing attempts to move beyond some of the limitations of "patient" noted in the literature, no single alternative has gained universal acceptance. Across the literature, "patient" remains closely associated with biomedical authority, hierarchy, and long-standing assumptions about vulnerability and dependence, despite ongoing efforts to reframe the role as more active and participatory (Burnham, 2012; McLaughlin, 2009). As an alternative to "patient", "client" offers possibilities for collaboration and autonomy, yet it also carries consumerist undertones and is used by fewer health professions. By contrast, the literature also highlights tensions associated with "client," including consumerist connotations and uneven acceptance across professions and jurisdictions (Arneja & Gilardino, 2023; Hoyt, 1979).

Massage therapy's consistent use of "client" may contribute to its different positioning within healthcare systems. The literature suggests that professions characterized as relational, hands-on, or predominantly female often occupy more precarious positions within healthcare hierarchies, and terminology may both reflect and reinforce these dynamics (Baskwill et al., 2023b; Fournier & Reeves, 2010). The literature also indicates that healthcare language can

shape how professionals, and people receiving care understand their roles, and how authority is negotiated across health professions (Costa et al., 2019; McLaughlin, 2009).

Despite extensive discussion of terminology in the literature, gaps persist - particularly regarding massage therapy, and the application of poststructuralist and critical discourse analytic approaches to regulatory and educational language. These gaps demonstrate the need to examine how “patient” and “client” are used within Ontario’s regulatory and educational discourse, a focus taken up in the chapters that follow.

Chapter 3: Theoretical Framework

As presented in the preceding research problem and questions section, there are tensions that envelop the word "patient" – strongly enough that "patient"-hyphenated terms, and alternatives such as "client" have found their way into the healthcare lexicon, as noted in the previous chapter. Rather than avoid language-created inequalities, this thesis aims to expose them, to unearth how language can confine and constrain, and how it can also be changed, if there is a will to do so, as resistance (Belsey, 2002b). This resistance forges space for redefining the once passive "patient" and for investigating alternatives, such as the term "client". The theoretical framework was chosen to explore the tension-laden terms of "patient", "client", and the discourses they inhabit. The methodological approach guiding data collection and analysis is outlined in the chapters that follow.

To support this objective, this chapter now brings together three interrelated theoretical and analytical components: (1) poststructuralist perspectives that address the many meanings, and tensions of "patient" and "client"; (2) feminist poststructuralist perspectives that deepen the analysis by drawing attention to gendered patterns within the professions that favour "client"; and (3) critical discourse analysis (CDA), which provides the analytic tools to examine how terminology circulates through regulatory and educational documents. These two theoretical perspectives, along with the analytical approach of CDA, help create a foundation for understanding the linguistic, institutional, and power-laden dynamics at play in the data presented in later chapters.

This study draws on poststructuralism as its overarching theoretical orientation, with feminist poststructuralist perspectives used to further interrogate the role of gender in professional identity and positioning, where such patterns emerged in the data. Critical discourse analysis (CDA), specifically Fairclough's three-dimensional model, was employed as the methodological approach guiding data collection, coding, and analysis. In this framework, theory and method operate in complementary ways: poststructuralism provides the conceptual basis for understanding language as constitutive of identity and power relations, while CDA offers a structured analytical method through which these relationships can be examined empirically in textual data. Feminist poststructuralism extends this framework by attending more explicitly to how discourse intersects with gendered patterns of authority, legitimacy, and professional status, particularly where these became visible across the datasets.

3.1 Theory

Poststructuralism fits well with this research because it offers ways of thinking about power and resistance that help make sense of how language operates in healthcare and health professions education. Critical discourse analysis (CDA) is included as an analytic approach for examining and organizing patterns in the documents analyzed for this thesis.

3.1.1 Poststructuralism

Poststructuralism and structuralism are two schools of thought that share premises of being concerned with the intersubjective and interpretive, as well as with language and the interconnectedness of vocabulary, but with a different focus (Davis & McMurtry, 2025). However, the insights of poststructuralism are most relevant for this study on terms used in healthcare because it shines a light on what is hidden or assumed, what remains unspoken or unnamed (Belsey, 2002a; Davis & McMurtry, 2025; Foucault, 2003a). These perspectives emphasize difference, and the power structures embedded in language which makes poststructuralism especially suited to examining terminology used in healthcare (Foucault, 2008). Poststructuralism takes a critical eye to taken-for-granted meanings and contexts which aligns with the purpose of this work to study the layers of meaning within, and embodied by, the words “patient” and “client” (Davis & McMurtry, 2025).

For theorists such as Catherine Belsey, poststructuralism emphasizes the mutability of meaning and the role of language in constructing social and institutional realities (Belsey, 2002b). Poststructuralism draws attention to language, discourse, truth, power, and resistance, which supports analysis of how terms such as “patient” and “client” are produced, stabilized, and challenged within healthcare contexts (Belsey, 2002b; McIntyre et al., 2020). Because language is not fixed, meanings of words can be altered if there is a culture or greater desire to do so (Belsey, 2002b). This stance helps account for the emergence of alternative terms and modifiers, such as “patient-centred”, without assuming that a change in labels necessarily alters underlying power relations.

Several of Foucault’s concepts have already made their way into healthcare research, and are pertinent to this study, including: *Power/knowledge,* where knowledge is not neutral but enmeshed in power relations; *surveillance* and *discipline,* where disciplinary power is asserted via the monitoring and regulation of bodies and behaviours, which could affect how “patients” see themselves and are seen; and *subjugated knowledges,* which encompasses forms of

knowledge that may carry less institutional authority, including those associated with “patients”, nurses, and other groups within healthcare (Foucault, 2008, 2013; McIntyre et al., 2020; Naidu et al., 2023; Petrovskaya, 2022; Powell, 2023; Suijker, 2023). While Foucault may not have placed emphasis on the specific terminology focused on in this thesis, his ideas nevertheless offer a useful rationale for poststructuralist analysis, given their value in critiquing healthcare hierarchies, and the discourses that sustain them.

The various components that form professional identities can be explored through poststructuralist views on language and power. Words such as “client” are not boxed into singular, universally accepted meanings. So too, professional identity is not fixed, it is constructed through discourse and influenced by dominant institutional authority and norms (Belsey, 2002b; Foucault, 2008, 2013, 2003b). Poststructuralism, therefore, provides a framework for examining how healthcare terminology becomes stabilized, yet can also shift and change, and how professional and institutional identities are negotiated through discourse, while keeping the analysis grounded in the documents studied.

3.1.2 Feminist Poststructuralist Perspectives

Feminist poststructuralism extends poststructuralist ideas by emphasizing how gender is woven through discourses on language, power relations, identity formation, and institutional structures. Drawing on theorists such as Belsey and Butler, feminist poststructuralism treats identities as discursively produced rather than fixed, or biologically determined (Belsey, 2002a; Butler, 2007). Meaning arises within cultural systems of difference, which then could impact how roles and authority are understood within healthcare (Belsey, 2002b). Feminist poststructuralist perspectives are particularly relevant in that they help explain how terminology use could be an expression of gendered roles and expectations (Belsey, 2002a; Butler, 2007). Although not the initial focus of this study, its significance emerged through patterns in terminology use across Ontario’s regulated health professions.

Scholars have long noted that professions more strongly associated with relational, supportive, or hands-on care work, rather than with biomedical diagnosis or technical intervention, are frequently positioned as less authoritative within healthcare hierarchies (Cahn, 2017; Costa et al., 2019). Hartsock’s (1990) feminist standpoint theory further critiques how dominant systems, including healthcare, may marginalize women’s experiences and the forms of

labour associated with them, a pattern that can also be seen in how certain health professions are positioned and valued.

Belsey draws on Julia Kristeva's account of "generations" of feminism; to illustrate how feminist thought has grappled with gender, identity, power, and language without assuming a single, stable position (Belsey & Drakakis, 2002). Although numbered, these "generations" are not meant to unfold in a specific chronological order, but as co-existing orientations (Belsey & Drakakis, 2002). Of these generations, a third one opens space to question fixed gender categories, and to examine identity as negotiated through discourse rather than treated as a stable essence, or fixed category (Aston, 2016; Belsey, 1997; Belsey & Drakakis, 2002; Butler, 2007; Demoor & Pieters, 2000; Maclaran & Stevens, 2019). This framing is useful here because instead of resolving questions of gender, this perspective highlights how identities are continuously negotiated through discourse. (Belsey & Drakakis, 2002; Butler, 2007; Demoor & Pieters, 2000).

While feminist scholars such as Hartsock (1990) have critiqued poststructuralism for failing to fully account for systemic gendered domination, others have built on poststructuralist approaches to interrogate binaries such as male/female, and examine multiple, or non-fixed identities (Butler, 2007; Maclaran & Stevens, 2019; Moulin de Souza & Parker, 2022). Feminist poststructuralism also brings attention to binary opposites and "other"-ing where one term holds privilege and power over another, such as strong/weak or authoritative/marginal (Belsey & Drakakis, 2002; Butler, 2007). These types of binaries move beyond being neutral linguistic structures, indeed they may produce power dynamics that impact professional identities and legitimacy.

Feminist poststructuralism thus adds an additional dimension to poststructuralist theory by looking at how terminology may intersect with gendered professional identity, and institutional power (Maclaran & Stevens, 2019). Within this thesis, feminist poststructuralism considers how healthcare language may reinforce, or challenge, gendered assumptions embedded in professional discourse, while avoiding the assumption that gender alone determines terminology use.

3.2 Key Concepts Derived from the Theoretical Framework

As presented in the preceding sections of this chapter, poststructuralism provides the theoretical tools for understanding how terminology functions within healthcare. This section

outlines key concepts which guide my interpretation of the regulatory and educational materials analyzed in this thesis.

Language and Power

Poststructuralist theory asserts that language is not merely a tool for communication, but a means through which power is exercised, negotiated, and sometimes resisted (Belsey, 2002b; Foucault, 2008, 2013). The terms "client" and "patient" are labels applied to people who engage with healthcare and may carry different connotations and implications for power dynamics in healthcare settings (Fage-Butler, 2021; Suijker, 2023). This may also be true of health professions that tend to favour alternatives to “patient,” such as “client,” and the regulatory bodies and other institutions that may, whether intentionally or unwittingly, continue to perpetuate power structures and professional hierarchies (Foucault, 2003a).

Foucault’s concept of *power/knowledge* is useful here, as it treats knowledge as produced within power relations (Foucault, 2008, 2013). In terms of regulatory terminology, labels do more than name (Belsey, 2002b). They can participate in defining what counts as legitimate expertise, and who is positioned to speak with authority (Foucault, 2008, 2013; Petrovskaya, 2022). The Sapir-Whorf hypothesis may also be mentioned, as it places an emphasis on how language can influence the ways in which people understand, and experience their social world (Davis & McMurtry, 2025).

Identity

The choice of “patient” speaks to identity in healthcare, and in educational settings (Brookes et al., 2023; Burnham, 2012; Engel et al., 2019; Flores-Sandoval et al., 2021; Herxheimer & Goodare, 1999; Nguyen et al., 2021). From a poststructuralist perspective, identity is not fixed or singular, and it continues to be negotiated through language (Belsey, 2002b; Foucault, 2008). In this thesis, identity is treated as an outcome of discourse instead of assuming it to be a pre-existing attribute.

Foucault’s clinical (medical) “gaze” names a dynamic in healthcare where the person receiving care may be understood primarily through professional observation and categories, rather than through their own account (Foucault, 2003b, Ristić et al., 2021). Through this gaze, the “patient” may come to be understood through the clinician’s acts of classification, and professional interpretation, positioning the person as an object of clinical (or medical) knowledge (Foucault 2003b, 2004; Molina-Mula, 2021). The notion is employed in this thesis to interpret

instances where regulatory language treats the "patient" as someone to be known and monitored, with authority residing in healthcare professions and institutions.

Subjugated knowledges refer to forms of knowledge that are treated as less credible because they do not align with dominant institutional, or scientific discourse (Foucault, 2008). Within healthcare, such knowledges may include experiential, or relational forms of understanding that can easily be sidelined (Foucault, 2004; Suijker, 2023). In this study, the concept is used to track how different forms of professional knowledge may present within regulatory, and educational, texts.

Poststructuralist, specifically feminist poststructuralist, approaches also attend to binary oppositions, where one term gains meaning by being set against an "other", and often in unequal ways (Belsey & Drakakis, 2002; Butler, 2007; Demoor & Pieters, 2000). In healthcare discourse, these binaries can be seen in pairings such as authoritative/marginal or scientific/experiential and can quietly organize legitimacy and inclusion (Butler, 2007). For this thesis, binaries and processes of other-ing provide points from which to consider how terminology can contribute to positioning some professions as central to healthcare, yet others as peripheral, even within regulated systems.

Institutional positioning and healthcare relationships

Because this thesis examines regulatory and educational documents, it is important to account for how institutions may impact healthcare relationships through discourse. Institutional language can sound collaborative, while still controlling the terms of participation, and where decision-making authority remains (Belsey, 2002a; Foucault, 2003a).

Governmentality describes how power works through ordinary, everyday systems, so that people come to govern themselves in line with institutional expectations (Foucault, 2003a; Lynch, 2016). In healthcare, this idea helps frame how roles and expectations are organized for regulated professionals, students in HPE, and care recipients (Foucault, 2003a; Powell, 2023; Ristić et al., 2021). In this thesis, governmentality supports examination of how regulatory discourse frames participation, responsibility, and public protection through institutionally sanctioned channels.

Biopower draws attention to how institutions regulate participation, legitimacy, and norms within healthcare systems (Foucault, 2003a). It does not operate solely through overt coercion; biopower also works more subtly through regulatory practices such as institutionally

established committees, and standards of practice, that may shape how professions, and individuals, are governed (Foucault, 2003a, 2003b; Suijker, 2023). For analytic purposes, this concept may help explain how professional legitimacy, and inclusion can be influenced by institutional decision-making, and risk management practices.

Although "patient" language may align with empowerment in some contexts, such as "patient-centred" promoting the authority of the "patient", it can simultaneously be involved in regulating and establishing norms for their behaviour, including advising on how to manage their health, or what medications to take (Foucault, 2003b; Suijker, 2023). Poststructuralist theory cautions that empowerment discourse does not necessarily redistribute authority, it may also operate within boundaries set by healthcare institutions (Foucault, 2003b, 2008; Rowland & Kumagai, 2018). For this thesis, "patient empowerment" and "patient-centred" language are treated as discursive constructions whose meanings and effects depend on how they are mobilized within institutional texts, rather than as self-evident indicators of power-sharing.

Before turning to critical discourse analysis as the methodological approach, it is important to note what I mean by discourse. Like "patient," there are many definitions of this word. Discourse in this thesis refers to all forms of symbolic interaction and communication between people, specifically written language (Bloor & Bloor, 2013). It also encompasses the ways language is used to construct social realities and identities, reflecting and shaping social norms, values, and power dynamics (Fairclough, 2013, 2023). This understanding of discourse links the theoretical concepts outlined above to the CDA-informed analytic approach described in the next section.

3.3 Critical Discourse Analysis (CDA)

Having outlined the concepts of language, power, discourse, and identity above, I now turn to critical discourse analysis (CDA), as the approach used to examine how these concepts function within institutional texts. CDA focuses on the relationship between power and language, ideologies, institutions, and social identities (Bloor & Bloor, 2013; Catalano & Waugh, 2020; Fairclough, 2010, 2013, 2014, 2023; Naidu et al., 2023; Wodak & Meyer, 2001; Yin, 2024). CDA helps reveal the importance of language in the social relations of power, and how contexts influence the formation of meaning and discourse (Bloor & Bloor, 2013). These emphases align well with a study concerned with terminology choices made by regulatory colleges and educational programs, particularly given the institutional authority such documents hold.

In this thesis, CDA is employed more specifically as a method to analyze documents. Poststructuralism informs how language, power, and identity are understood conceptually, while CDA provides a systematic approach to analyzing how these dynamics are produced and reproduced in regulatory and educational documents. Because CDA involves looking at the formal aspects of discourse, such as word choice, sentence structure, and the context in which language is used, it provides guidance on what to analyze within the regulatory websites in order to better understand how the terms "client" and "patient" influence power dynamics and relationships in healthcare (Fairclough, 2010; Naidu et al., 2023).

The perspectives outlined in this chapter provide the foundation for interpreting how terminology influences power, identity, and healthcare relationships. Chapter 4 outlines the methodological steps used to apply these perspectives to the documents examined in this study.

Chapter 4: Methodology and Methods

This chapter outlines the methodological and analytic approaches used in this thesis and explains how critical discourse analysis (CDA) was applied to examine terminology within regulatory and educational documents. The chapter also presents the epistemological assumptions underpinning the research, my positionality, the data collection process, and the analytical procedures used to interpret the documents examined.

4.1 Research Orientation and Epistemological Assumptions

This thesis employs a qualitative research approach that includes critical discourse analysis (CDA) as the primary method. It began with a review of the literature to assess the current understanding of both "patient" and "client", as well as massage therapy in Ontario, and continued with CDA-guided examination of the collected materials. The following are several of the epistemological assumptions that inform the research questions, and the ensuing research concerning "patient", and the alternative "client" within health professions, institutions, education, and relationships:

Language as a communicated form of knowledge may be constructed through social interactions and agreed-upon meanings

Language may be constructed through social interactions and agreed-upon meanings (Belsey, 2002a, 2002b; Bloor & Bloor, 2013; Catalano & Waugh, 2020; Davis & McMurtry, 2025; Fairclough, 2001, 2010, 2023). This notion is shared with structuralist, poststructuralist, and CDA views that our reality is shaped by language and discourse (Belsey, 2002b; Davis & McMurtry, 2025; Fairclough, 2010). However, poststructuralists are more concerned with "…the power structures at work – deliberate and accidental, explicit and tacit…" (Davis & McMurtry, 2025, p.139). For this thesis, this assumption underpins the idea that "patient"-related discourses are shaped by cultural and social contexts, and that meanings evolve through interactions between society, and more specifically via institutions, healthcare professionals (HCPs), and "patients". In this thesis, the term 'healthcare professional' is chosen rather than 'provider' to avoid language that frames care as flowing in a single direction from professional to recipient. While "professional" is not perfect, it allows for a "patient" that is not necessarily linked with passivity.

The meanings of words are not fixed

The meanings of words are not fixed (Belsey, 2002b; Fage-Butler, 2021). Words are not just snapshots of one moment in time. The history of a word can provide a starting point, such as with *patiens* (to suffer, bear, or endure hardship, associated with the virtues of tolerance and obedience) but it is not its final, unchangeable incarnation (Arneja & Gilardino, 2023; Belsey, 2002b). "…Poststructuralism rejects the structuralist conviction that enduring structures exist in discourse. Instead, discourses (systems of meaning and values) are in flux and are contestable" (Fage-Butler, 2021, p.164). This is important and is demonstrated in the review of the literature which raised issues concerning what "patient" means, as well as its alternatives in healthcare environments.

Language may create and perpetuate power dynamics and social inequalities

Language may create and perpetuate power dynamics and social inequalities (Belsey, 2002b; Bloor & Bloor, 2013; Fairclough, 2010, 2014; Foucault, 2008; Yin, 2024). This follows the previous two assumptions, and here is meant to connect CDA with my exploration of the power dynamics embedded in terms such as "patient," and the possible efforts to alter the effects of these with alternatives such as "client," and hyphenated terms such as "patient-centred."

At the core of CDA is the understanding that discourse plays a key role in shaping and maintaining power and control (Bloor & Bloor, 2013; Fairclough, 2010, 2014). According to Bloor and Bloor (2013), power is retained by both institutions and individuals, and any challenge to dominant language practices may also challenge those who hold power (p.4).

The importance of reflexivity in qualitative research

The importance of reflexivity in qualitative research is widely recognized (Alejandro & Zhao, 2024; Catalano & Waugh, 2020; Handford & Gee, 2023; Powell, 2023; Wodak & Meyer, 2001). Researchers must be self-critical and reflexive, and transparent about how their own assumptions may shape analysis (Catalano & Waugh, 2020; Mortenson & Dyck, 2006).

4.2 Critical Discourse Analysis (CDA) as Method

Central to discourse analysis is examining how language is used in communication, exploring patterns and structures within specific contexts (Gee, 2004; Gee & Handford, 2023). For HPE research, discourse analysis has been used to explore how students learn to participate in healthcare communities (Woodward-Kron, 2020). For example, Woodward-Kron (2020) applied genre-based discourse analysis to medical education to show how learners acquire the textual and conversational patterns found in clinical practice.

CDA, as an evolution of discourse analysis, shares many of the tenets of discourse analysis, yet goes further by analyzing how these language patterns reflect and reinforce power dynamics and social inequalities, aiming to uncover and challenge these influences (Bloor & Bloor, 2013; Fairclough, 2001, 2010, 2013, 2023; Naidu et al., 2023; Wodak & Meyer, 2001). With regards to HPE research, CDA has been used to examine how institutional documents and educational materials influence professional identity, and reinforce hierarchies (Naidu et al., 2023; Woodward-Kron, 2020). MacLeod et al., (2024) conducted a meta-study showing that CDA is frequently applied to analyze written texts in medical and nursing education, especially to understand how language influences perceptions of legitimacy and authority. Examples like this from HPE, with themes of language and legitimacy, align well with the work of this thesis.

CDA is employed to explore the implications of terminology in HPE and guide interpretation of the data collected. Gee (2004) offers a perspective of discourse analysis as the analysis of "language-in-use" which both creates and reflects the contexts in which it is used. In other words, Gee & Handford (2023) define discourse analysis as the study of the meanings we give language, and the actions we carry out when we use language in specific contexts. Specific to this thesis is analysis that considers the healthcare context and, by extension, HPE. In the context of healthcare, "health communication" fits under the umbrella of discourse analysis, examining all aspects of communication within medical contexts or related to health and illness (Brookes et al., 2023).

CDA is inherently multi-layered in its approach. The definition and positioning of CDA remains somewhat unsettled – with ongoing debates about whether it should be treated as a method, a methodology, or both (Fairclough, 2001). Perhaps this reflects a dual perspective for CDA, a bipartite view that also applies to how discourse can be interpreted in both macro and micro senses. What is meant by this is the macro sense considers the larger sociocultural implications of language and refers to "constrained ways of thinking and talking within a given sociocultural orbit" (Brookes et al., 2023, p.553). Bloor and Bloor (2013) emphasize that powerful, highly structured organizations use language to control daily life and shape societal thinking. For example, this device of control is made visible in the production of texts that regulate behaviours, and regularize institutional norms (Bloor & Bloor, 2013). It is here that CDA looks at the wide-ranging social, institutional, and societal contexts in which discourse is both produced and circulated (Catalano & Waugh, 2020). This provides a method to explore how

power, identity, and meaning are constructed through language, and connect to the power dynamics both in post-structuralism and in CDA.

The micro sense of CDA plunges more deeply still, not simply discussing language and how it constructs social realities, but also how it drills down into layers of power and meanings, exploring that which may initially be more hidden, or not obvious (Bloor & Bloor, 2013; Fairclough, 2010). Fairclough (2010) emphasizes the relationship between language, power, and ideology. These framing ideas help me further reflect on how such relationships may exist in the documents published by the regulatory colleges, and the educational texts analyzed for this study. Specific word choices in the documents analyzed may influence, or even coerce or control, the everyday language HCPs use in their work, education, or public interactions.

Fairclough (2001) further contributes to the use of CDA in this thesis by showing how terms can evolve, and gain significance over time. This aligns with Belsey's (2002b) emphasis on the fluid nature of language, and how it can shift and change. Also relevant to this thesis is the search for evidence in webpage content that may demonstrate ways language subtly influences professional identities, where even seemingly neutral terms can carry substantial ideological weight.

The macro-micro movement in CDA aligns with the analytic movement required in this study: From broad, public-facing institutional language to more detailed patterns within specific texts. A similar movement is often part of massage therapy practice, where an RMT may begin with more superficial techniques, and progress to deeper ones. In this thesis, the analogy is used only to highlight why CDA's movement between surface textual features, and deeper ideological implications is a good fit for interpreting healthcare terminology, and institutional discourse (Bloor & Bloor, 2013; Fairclough, 2001, 2010, 2013, 2023).

"Languaging" encompasses how language is used and understood in different contexts including material and non-material expressions (Davis & McMurtry, 2025). In healthcare, the physical and digital formats of documents, such as websites, can affect how this language is interpreted and used. This idea is enmeshed in CDA, particularly in Fairclough's take on discourse as both a product of social structures, and as a process that can actively reshape them (Fairclough, 2001, 2010).

Although justification in the choice of methodology has been presented, it is also important to consider potential drawbacks, specifically of those associated with CDA. The

paragraphs that follow respond to potential concerns that could impact the credibility and validity of this research. The analytical models in CDA may be vague and lack systematic and detailed analysis of texts, and there has been a call for more rigorous methodologies (Catalano & Waugh, 2020; Meyer, 2001). To address concerns about analytic rigour, I followed Fairclough's three-dimensional model and documented coding and analytic decisions in NVivo through code definitions, memos, and retrieval of coded excerpts (Araujo et al., 2019; Davidson, 2018; Fairclough, 2010).

CDA is criticized for being too subjective and given its critical stance and focus on power relations and social inequalities, there is a perceived risk that researchers may project their biases onto the data (Alejandro & Zhao, 2024; Catalano & Waugh, 2020; Handford & Gee, 2023; Powell, 2023; Wodak & Meyer, 2001). I have declared my positionality, and my insider status as an RMT, R.Ac. and educator. I have also maintained a written journal to create an ongoing process of reflection throughout the duration of researching and writing my thesis. Additionally, my committee has been granted access to these (should they prove of interest), and I have relied on their feedback to ensure academic rigour, and guard against any potential issues with my chosen research approach.

4.3 Positionality and Reflexivity

I identify as a Registered Massage Therapist (RMT), Registered Acupuncturist (R.Ac.), and educator. This positions me as an insider in relation to the professions, and educational contexts examined in this study. This insider position may allow me to notice discursive tensions that may be less visible to an external reader. However, my positionality also requires deliberate reflexive attention so that interpretation stays grounded in the documents, rather than creeping into personal preference, or professional advocacy.

Reflexivity is integral to qualitative and critical research, particularly in poststructuralist and CDA traditions where the researcher is understood to be situated within the discursive field under study (Catalano & Waugh, 2020; Wodak & Meyer, 2001). Throughout this thesis, I maintained a journal to document analytic decisions, emerging interpretations, and reflections on how my own professional background might affect the reading of the data. For example, when I noted my own tendency to read "client" language in massage therapy regulation as potentially empowering, I returned to the coded CMTO excerpts to examine whether that interpretation was supported consistently across documents, including where "client" appeared alongside

complaints, boundaries, and mandatory reporting language. My thesis committee has been granted access to these materials, and I have also relied on their feedback to ensure both academic rigour, and to guard against potential issues with subjectivity or bias in my chosen approach. Thesis committee feedback has provided an additional layer of accountability by identifying places where claims have needed clearer grounding in the dataset.

4.4 Data Collection Overview

Data collection for this thesis was designed to support critical discourse analysis (CDA), with NVivo used to organize, code, and interpret the materials. Following the review of the literature and development of the research questions, I conducted a systematic search of publicly accessible webpages belonging to regulatory colleges for Ontario's twenty-seven regulated health professions, as well as documents connected to massage therapy education. These documents represent pre-existing institutional texts produced independently of research activities.

The process began by identifying the relevant regulatory and educational documents. For each regulatory college, I first examined the homepage. If neither "patient" nor "client" appeared there, I then used the website's internal search function for these terms and selected the first relevant page returned. This approach was used to capture the primary public-facing discourse of each regulator, ensuring comparability across colleges even when terminology was not displayed on the homepage. To provide further depth specific to massage therapy, a targeted sub-sample of documents from the "RMT Clients" section of the College of Massage Therapists of Ontario (CMTO) website was examined, including all linked pages contained within that section. This additional sub-sample allowed for a more detailed analysis of the regulatory discourse unique to massage therapy.

A second group of documents consisted of massage-therapy-focused educational materials collected from publicly assisted Ontario colleges offering massage therapy programs. "*What to Expect from a Career as a Massage Therapist*" page on Ontariocolleges.ca was also included to reflect the messaging prospective students encounter at the point of application. These materials were selected to understand how terminology appears in the educational environment prior to students entering the profession.

For quick reference, the document sets used throughout Chapter 4 are:

- Regulatory college homepages (or first internal search result when terms absent)

- CMTO “RMT Clients” section (and all linked pages)
- Public-college massage therapy program descriptions + Ontariocolleges.ca page

Once documents were gathered, they were imported into NVivo. The software supported the organization of documents into folders, the creation of cases, and the development of both deductive and inductive codes. Deductive coding focused on the terms “patient” and “client,” while inductive coding identified additional themes relevant to language, power, professional identity, and healthcare context. NVivo’s tools, such as text search queries, word frequency visualizations, and memos, facilitated the iterative process of revisiting, refining, and documenting analytical insights.

Fairclough’s (2010) three-dimensional CDA model directed the analysis: First through textual analysis of word choices and structures, then through interpretation of discourse practices, and finally through explanation of sociocultural implications. This three-stage approach allowed for movement between surface, everyday terminology, and deeper exploration of how regulatory, educational, and professional contexts affect meaning. Data collection occurred between May and July 2025, during which all webpages were captured using NCapture, or alternative screenshot methods when needed. These reflect the content available at the time of collection and therefore represent a snapshot of publicly accessible discourse during this period.

4.5 Sample Definition and Inclusion/Exclusion Criteria

The sample for this thesis consists of publicly accessible documents gathered to examine how the terms “patient” and “client” appear across regulatory and educational contexts in Ontario. These documents include regulatory materials from the twenty-six regulatory colleges governing Ontario’s twenty-seven regulated health professions, a sub-sample of massage therapy-specific materials from the College of Massage Therapists of Ontario (CMTO), and public-facing program descriptions from Ontario’s publicly assisted colleges offering massage therapy diplomas. This combination of documents reflects both the provincial context, and the terminology specific to massage therapy as a regulated health profession.

The CMTO sub-sample was included because massage therapy was the focused case identified in the second research question. Its selection was informed by existing literature describing massage therapy’s contested professional identity, variable educational pathways, limited interprofessional inclusion, and ambiguous positioning within healthcare. This rationale preceded the analysis of the CMTO documents, and the specific terminology patterns noted in

those materials are reported in Chapter 5. The CMTO materials were then analyzed to examine the regulator's public-facing discourse for professional oversight and practitioner-care relationships.

The inclusion and exclusion criteria for each document group are outlined below.

A. Inclusion Criteria

1. Regulatory college documents

Documents were included if they met all of the following criteria:

- Published by a regulatory college established under the Regulated Health Professions Act, 1991.
- Freely accessible on the college's public website without login or membership.
- Located on the homepage; or, if neither term appeared, the first page returned by the internal search function for "patient" or "client."
- Contained at least one instance of either term.
- Current during the May to July 2025 data collection period.

Definition: Regulatory documents refer to the homepage or the first relevant public-facing landing page of a regulatory college's website, representing that college's primary institutional discourse directed at the public.

2. CMTO sub-sample - "RMT Clients" section

Documents were included if they met all of the following:

- Published by the College of Massage Therapists of Ontario.
- Located within the "RMT Clients" tab or linked from that section.
- Public-facing and accessible without login or password protection.
- Used the term "client" in regulatory, ethical, or protection of the public contexts.
- Current as of May to July 2025.

Definition: The "RMT Clients" section comprises CMTO materials related to "client" rights, professional boundaries, informed consent, the complaints process, and regulatory expectations of conduct. This subset was purposely included to draw out how massage therapy's regulator constructs "client", and to see how this compares to broader regulatory language.

3. Massage therapy educational program descriptions

Documents were included if they met all of the following:

- Published by a publicly assisted Ontario college offering a massage therapy program.

- Functioned as the primary program description page (i.e., the first page visible when selecting “Massage Therapy”).
- Contained at least one instance of “patient” or “client”.
- Current during May to July 2025.

Definition: Program descriptions refer to the public-facing overview pages outlining program scope, competencies, learning expectations, and descriptions of practice environments.

B. Exclusion Criteria

Documents were excluded if they:

- Originated from private career colleges, professional associations, advocacy groups, or commercial organizations.
- Required login, payment, or restricted access.
- Contained neither “patient” nor “client”.
- Appeared more than one click away from the homepage or primary program page.
- Were promotional materials not part of regulatory or educational discourse (e.g., advertisements, social media).
- Were unrelated to the study focus, with the exception of the massage therapy-specific “What to Expect from a Career as a Massage Therapist” page on Ontariocolleges.ca, included due to its potential impact on student perceptions of the profession.
- Were not primarily written in English to avoid any issues with quality of translation and trying to assess equivalence in terms in more than one language.

4.6 Data Sources – Documents

Data sources featured in this thesis consist of two predefined document groups: publicly available webpages from the regulatory colleges for Ontario’s regulated health professions, and education-focused documents from Ontariocolleges.ca and publicly assisted colleges in Ontario offering massage therapy programs. This combination supports comparison of terminology use across regulatory and educational institutional contexts.

1. Regulatory dataset

Scope: Twenty-six regulatory colleges representing Ontario’s twenty-seven regulated health professions.

Source pages:

- Homepage (primary).

- Where neither term appeared: first internal search result for “patient” and “client”.

Purpose: To establish terminology use across regulatory bodies and identify whether “patient” or “client” is used in public-facing documents.

Captured fields:

- College name
- Profession(s) governed
- Occurrence of “patient”
- Occurrence of “client”
- Presence of both terms (if applicable)
- URL and date accessed

2. CMTO regulatory sub-sample – “RMT Clients”

Scope: Documents contained within or linked from the “RMT Clients” section of the CMTO’s homepage.

Source pages include:

- Client rights
- Informed consent
- Professional boundaries and responsibilities
- Ethics
- Sexual abuse prevention materials
- Complaints

Purpose: To analyze the CMTO’s exclusive use of “client” and look at themes related to ethics, protection of the public, empowerment, and regulatory expectations specific to massage therapy that contribute to professional identity, and outline aspects of regulatory influence over the profession.

Captured fields:

- Number and context of “client” occurrences
- Absence of “patient”
- Themes related to ethics, boundaries, protecting the public, and “client” empowerment
- URL and date accessed

Webpages are dynamic and may be updated after capture. For this reason, the documents analyzed in this thesis are treated as a snapshot of public-facing discourse during the May through July 2025 collection period and are not retroactively replaced with later versions. After data collection was completed (May-July 2025), the CMTO updated portions of its public-facing navigation from “RMT Clients” to “RMT Patients”. This change falls outside the capture window and is not treated as part of the analyzed dataset, but it is noted as an indication that terminology may be shifting in massage therapy regulation.

3. Massage Therapy Educational Program Descriptions

Scope: Publicly assisted colleges in Ontario offering Massage Therapy programs (twelve English-language programs included). The profession-specific entry on Ontariocolleges.ca was also included.

Source pages:

- Primary program description pages
- “What to Expect from a Career as a Massage Therapist” (Ontariocolleges.ca)

Purpose: To assess whether terminology used in education aligns with or diverges from the CMTO’s regulatory language and to examine how massage therapy is positioned for prospective students.

Captured fields:

- College name
- Program title
- Terminology used - “patient”, “client”, or both
- Additional thematic language such as “healthcare”, “ethics”, “knowledge and skills”, “interprofessional”
- URL and date accessed

Including both regulatory and educational sources makes it possible to compare formal, institutional usage (regulators) with the language presented to prospective students (education). This comparison supports analysis of how terminology choices interact with professional identity, perceived legitimacy, and positioning of massage therapy within Ontario’s regulated health professions.

At the time of collection, thirteen of the twenty-four public colleges offer diplomas in massage therapy: twelve in English and one in French (Government of Ontario, n.d.; OCAS,

2025). Because this study focused on English-language terminology use, only the twelve English-language public college program pages were included in the educational dataset. The French-language program was noted as part of the broader Ontario context but was not analyzed to avoid any potential issues with translating words and meanings from French to English. Career/private colleges have been excluded based on sheer number as there are over 500 career and private colleges in Ontario, which would make for an impossible research task within a reasonable period of time as a solo researcher (Government of Ontario, n.d.).

All sources above were analyzed using CDA (see 4.8 for further details). When "patient" and "client" did not appear on a regulatory college homepage, that absence was itself noted as part of the public-facing presentation of terminology. In several of these cases, homepage language included "public" or "protecting the public" instead, which may suggest that the regulatory college's main landing page emphasized regulatory mandate rather than care-recipient terminology. Because this study was focused specifically on the terms "patient" and "client," the first internal search result for those terms was then captured so that a comparable public-facing document could still be included in the dataset. This occurred in nine instances (College of Chiropodists of Ontario; College of Chiropractors of Ontario; College of Denturists of Ontario; College of Dietitians of Ontario; College of Medical Radiation and Imaging Technologists of Ontario; College of Nurses of Ontario; College of Opticians of Ontario; College of Optometrists of Ontario; and College of Psychologists and Behaviour Analysts of Ontario) and was documented in NVivo memos and the reflexive journal to maintain an audit trail of selection decisions. Detailed NVivo procedures (NCapture/screenshots, coding steps) are described in 4.7 to avoid repetition here.

4.7 Document Preparation, NVivo Coding Procedures, and Development of Themes

NVivo (QSR International) was used to organize captured webpages, support coding, and document analytic decisions through code definitions and memos (Araujo et al., 2019; Davidson, 2018). A tool within NVivo, namely NCapture, was used to collect webpages as PDFs (QSR International, n.d.). Where capture was incomplete, screenshots were taken and imported to ensure that the same webpage content remained available for coding.

Documents were imported into NVivo and organized into folders and cases to support systematic coding across datasets (Davidson, 2018). Coding focused first on occurrences of "patient" and "client," and then expanded to additional themes identified inductively through

repeated patterns in the texts. NVivo queries (e.g., text search and word frequency) were used to support retrieval and checking of coded excerpts, while analytic memos were used to document coding decisions and emerging interpretations (Davidson, 2018; QSR International, n.d.). The CMTO, Ontariocolleges.ca, and public college massage therapy documents were coded in NVivo using the same two-phase strategy described below.

The coding process applied was a two-phase coding strategy which included deductive coding for specific terms, then inductive coding to identify and code emerging themes (Alejandro & Zhao, 2024; Saldana, 2009). This strategy embraces Fairclough's (2010) first stage of textual analysis, collecting the data to then critically interpret and explain it. To provide an example of the movement between deductive and inductive coding, I used deductive coding to create initial codes for "patient" and "client" as terms only, not interpreting the words beyond placing them within a theme, and the stage or dimension of textual analysis. Inductive coding was utilized to code additional excerpts and to identify recurring themes (e.g., public protection, consent, professionalism, healthcare positioning); this in turn created additional codes, which were reapplied iteratively across the CMTO and educational datasets. An audit trail was maintained throughout by documenting code definitions revisions and analytic decisions in NVivo memos to support transparency and traceability.

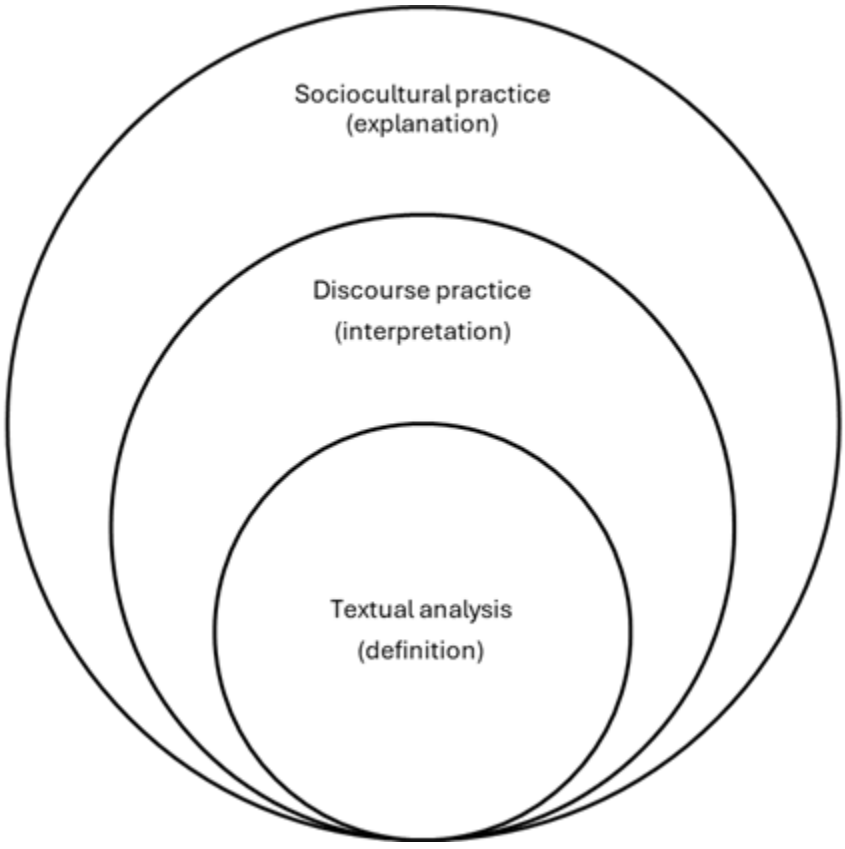
Sharing similarities with the phases of coding, the development of themes in this study was both deductively and inductively informed. The research questions provided a starting point for identifying prospective areas of interest, particularly in relation to terminology, professional identity, and healthcare relationships. At the same time, themes were identified and refined by looking for recurring language use across the datasets. These steps confirmed the four primary themes developed through the coding process: terminology and identity; power and ethics; professional practice; and educational positioning. In this way, the themes functioned as an organizational bridge between individual codes and wider patterns of meaning, supporting CDA analysis across the textual analysis, discourse practice, and sociocultural practice levels.
The four main themes are reflected across the datasets as follows: terminology and identity (how "patient" and "client" relate to professional identity); power and ethics as associated with consent, regulation, and accountability; professional practice to represent concepts such as care, skills, and roles; and educational positioning to note how massage therapy is framed within training contexts.

4.8 Analytical Process

Analysis followed Fairclough's CDA model of *three interrelated dimensions (stages)* with NVivo supporting this process by organizing coded excerpts and facilitating movement across the three stages of analysis (Araujo et al., 2019; Davidson, 2018; Fairclough, 2010, 2013). The three stages consist of 1) *description (textual analysis)* which includes the formal properties of the text; 2) *interpretation (discourse practice)* where there is a relationship between text and interaction and which Fairclough asserts is both an interactional process and a stage of an analysis; and 3) *explanation (sociocultural practice)* that then examines the relationships between the interactions and their social contexts, as well as their social effects (Fairclough, 2010, 2013). Figure 1 serves as a visual representation of the three dimensions used in the analysis.

Figure 1

Visual Depiction of Fairclough's Three Dimensional (Stages) Critical Discourse Analysis Model



Note: The figure is presented to show the nested, non-linear organization of the three dimensions, with textual analysis being at the base, but all dimensions, or stages, may interact with each other.

CDA has been used in HPE research to document the connections between institutional language, professional identity, and current educational norms. To illustrate by example, CDA has been used to analyze medical education documents and show how discourse contributes to the continuing influence of professional hierarchies and the marginalization of certain roles within healthcare (Macleod et al., 2024). It has also been utilized with health communication texts, noting the potential impact of terminology on perceptions of authority and legitimacy (Brookes et al., 2023). Studies such as these align well with my focus on “patient” and “client” terminology and how it may affect professional positioning within healthcare and HPE in Ontario.

Description (textual analysis) is the stage that involves analysis of texts, examining grammar, vocabulary, and structure (Fairclough, 2010). This stage documented occurrences of "patient" and "client" across the regulatory and educational datasets, producing coded excerpts, frequency counts, and summary tables reported in the appendices (Appendices A and B). The initial textual analysis focused first on the homepages of regulatory colleges, and then on the "RMT Clients" section of the CMTO’s website. In a small number of cases where website search results or date-stamped pages suggested a terminology shift over time, these traces were noted descriptively to provide limited historical context; however, the core dataset remained the May to July 2025 snapshot described earlier.

The homepages of twelve public colleges offering massage therapy programs in English were included, and coded for their use of “client”, a**s** well as any appearance or absence of “patient”, and for how massage therapy was positioned based on the research questions of this thesis (CMTO, n.d.; Government of Ontario, n.d.; OCAS, 2025). “*What to expect from a career as a Massage Therapist*” page from Ontariocolleges.ca was also added to the sample (OCAS, 2025). This document was included to extend analysis of how massage therapy is presented to prospective students, specifically during the college application process.

During the interpretation (discourse practice) stage, the focus shifted to how documents were positioned for their intended audiences, and how terminology functioned in context

(Fairclough, 2010). The intent here was to examine the ways in which language reflects and affects professional identities, power relations, and institutional norms (Fairclough, 2010). This stage included reviewing where “patient” and “client” appeared (e.g., public protection, consent, complaints, rights language, professional expectations, education, and employability descriptions) and identifying recurring groupings of terms that shaped how care relationships and professional roles were framed.

I used the term “clusters” to describe how related codes were grouped during analysis when similar patterns began to recur across documents. These groupings did not come from NVivo automatically. Instead, they developed gradually through repeated reading of coded excerpts and ongoing comparison across documents. When certain codes tended to appear together and seemed to be doing similar work in the texts, they were treated as part of the same cluster. Taking this step helped move the analysis away from individual coded instances and toward broader patterns that informed later interpretation (Saldana, 2009; Fairclough, 2010). Patterns were then organized using NVivo-assisted coding and memoing (see Appendices C and D), allowing movement beyond term frequency to interpret how institutional discourse organized professional identity, responsibility, and positioning. This part of the analysis also helped uncover other words beyond simply “client” and “patient” that could potentially provide additional insight specifically for massage therapy, and how the language in the documents may affect the way the profession is seen.

During the explanation (sociocultural practice) stage, focus turned to connecting patterns identified in the regulatory and educational texts with the broader institutional context of Ontario’s regulated health professions (Fairclough, 2010). This stage drew on the three defined datasets of regulatory college homepages/landing pages, the CMTO “RMT Clients” sub-sample, and public college program description pages, to interpret how terminology related to institutional authority, public protection mandates, and professional positioning. The aim was not to treat terminology as isolated word choice, but to situate “patient” and “client” within the regulatory and educational environments in which they circulate, and to consider how these environments may shape healthcare relationships and professional identity (Naidu et al., 2023).

Finally, findings from these stages were interpreted in relation to the literature review to offer a more complete picture of the impact language may have on professional identities and relationships in healthcare. Insights from this integration are presented within the discussion

chapter. Note these stages are not stringently linear; the critical aspect of CDA encourages reflection and returning to previous stages as findings emerge through the coding and analysis (Bloor & Bloor, 2013; Wodak & Meyer, 2001).

4.9 Ethical Considerations

Because this research involved publicly accessible documents, it did not require formal Research Ethics Board approval. However, ethical considerations still apply in relation to transparency, reflexivity, and accurate representation of institutional discourse. No private or identifiable personal information was used.

As part of the reflexive approach described above, I maintained a research journal and engaged regularly with my thesis committee to ensure rigour and ethical integrity throughout.

4.10 Chapter Summary

The methodology and methods sections have been drafted to align with the research questions and the theoretical framework. This chapter outlined the research orientation, data sources, sampling decisions, and analytic procedures used to apply Fairclough's three-dimensional CDA model to regulatory and educational documents. These methods provide a transparent basis for interpreting how "patient" and "client" are used across institutional contexts, and for tracing how analytic claims are grounded in the dataset.

Chapter 5: Findings

The findings included are ones that best respond to the questions and themes presented in the research problem and questions chapter. The research questions are: (1) How do regulatory documents across Ontario's health professions use the terms "patient" and "client," and what do these uses reveal about power dynamics, professional identities, and healthcare relationships? and (2) How are "patient" and "client" used in documents from the College of Massage Therapists of Ontario, and in public college program descriptions of massage therapy, and what does this usage suggest about the professional identity and positioning of massage therapy within Ontario's healthcare system? The purpose here is not merely to count or describe which terms appeared, but to demonstrate how specific language functions within broader institutional patterns of meaning and positioning.

5.1 Overview of Datasets

This chapter presents findings from a CDA-guided analysis of three distinct but interconnected datasets: (a) public-facing webpages from Ontario's regulatory colleges; (b) a focused sub-sample of "RMT Clients" materials produced by the College of Massage Therapists of Ontario (CMTO); and (c) public college massage therapy program descriptions, including the Ontariocolleges.ca overview page. Structuring the analysis around Fairclough's (2010) three dimensions of textual analysis (description), discourse practice (interpretation), and sociocultural practice (explanation) ensures a visible analytic trail from observable wording to broader institutional positioning. These dimensions intersect with four core themes developed through the coding process: terminology and identity; power and ethics; professional practice; and educational positioning. Rather than existing as rigid categories, these themes fluidly span across Fairclough's dimensions by connecting individual codes with deeper dynamics of identity, relationships, power, and positioning.

To support transparency, NVivo outputs are referenced throughout. Appendix C provides code definitions (codebook), with coded excerpts and code counts by dataset summarized in Appendix B (Tables B1–B3), and Appendix D provides an audit trail (NVivo file structure and selected coded excerpt outputs). A complete summary of the 27 regulatory colleges, their terminology use ("patient," "client," or both"), and most recent member counts are provided in Appendix A, Table A1.

5.2 Textual level (Description): Terminology Use in Public-Facing Texts

This section presents findings at the textual level, simply focusing on how the terms "patient" and "client" appear visibly in public-facing documents, without deeper interpretation (Fairclough, 2010). Attention is given to terminology as it is displayed within the documents, such as headings, navigation labels, and program descriptions, before later considering how these terms function in context. This is where the theme of "Terminology & Identity" seen in the codebook primarily resides (see Appendix C).

5.2.1 Regulatory College Terminology Distribution

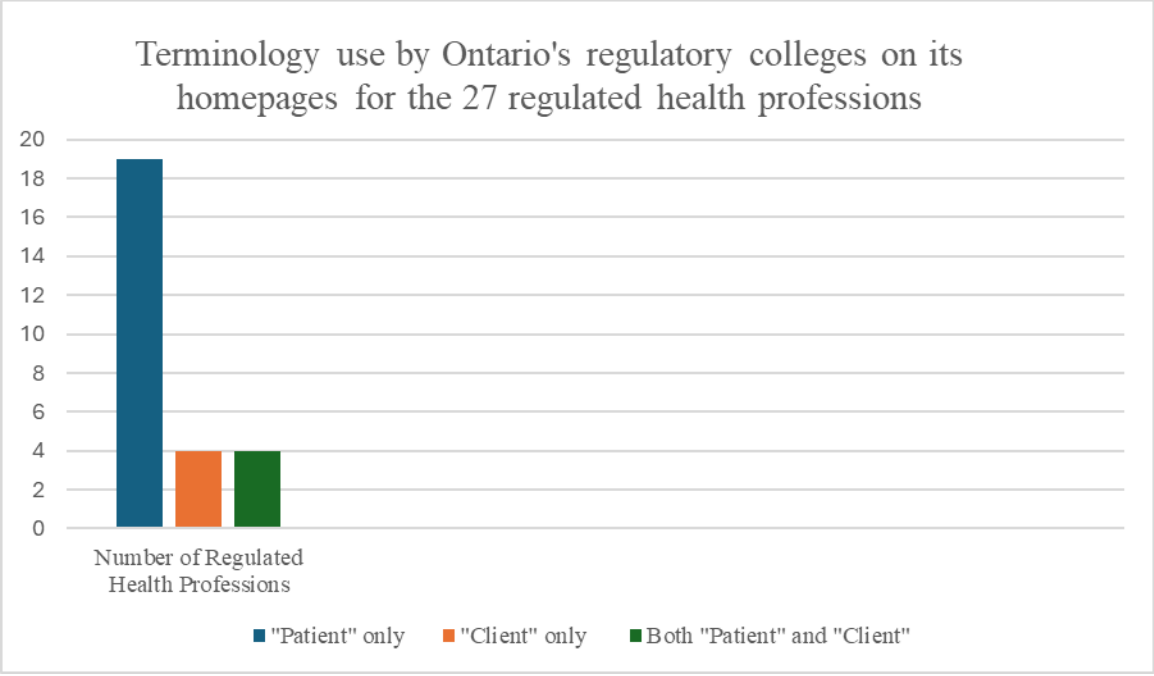
Analysis of the homepages of Ontario's 27 regulatory colleges available to the public showed a clear preference for "patient" over "client."

- 19 colleges use "patient" exclusively
- 4 colleges use "client" exclusively (midwives, psychotherapists, massage therapists, dental hygienists)
- 4 colleges use both terms (psychologists, applied behaviour analysts, respiratory therapists, occupational therapists)

These counts correspond to the distributions presented in Appendix A, Table A2, with profession-specific terminology details available in Appendix A, Table A1.

Figure 2

Regulatory College Terminology Distribution across Ontario's Regulated Health Professions



Note. The figure summarizes terminology used on the homepages for Ontario's 27 regulated health professions. Nineteen health professions use "patient" exclusively, four use "client," and four use both.

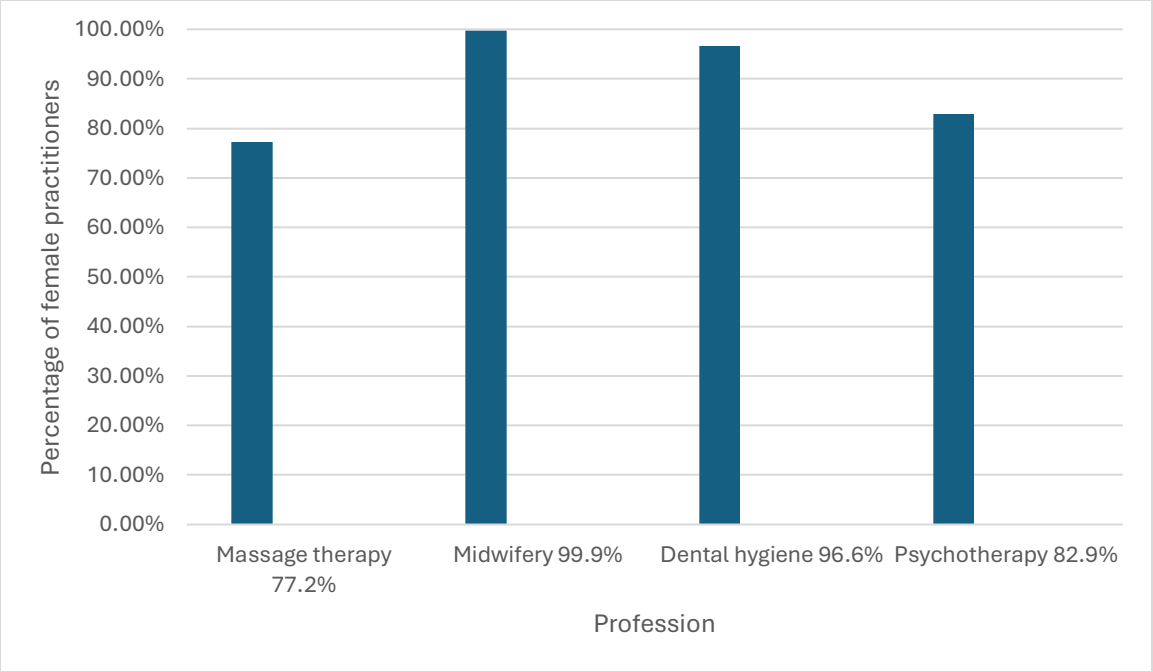
Notable observations:

- An additional historical observation was visible in the College of Nurses of Ontario (CNO) website search results: although CNO now uses "patient" exclusively in its public-facing materials, archived date stamps associated with "client" search results suggest that this terminology largely disappeared prior to 2010 (*Welcome to CNO*, n.d.).
- Some colleges display dual-term labels, such as the College of Occupational Therapists of Ontario, which includes a "Patient/Client" heading under its public navigation menu (*College of Occupational Therapists of Ontario (COTO)*, n.d.).
- These patterns reflect not only word preference but also the ways regulatory colleges position their professions through language. NVivo coding of these regulatory webpages further confirmed this terminology pattern, with aggregated code counts presented in Appendix B, Table B1.
- In several cases, the appearance of both terms on the same regulatory site suggests either deliberate inclusivity or unresolved internal decisions about preferred terminology.

These findings confirm that "patient" dominates regulatory discourse for the healthcare professions in Ontario, while "client" appears in a minority of cases. As shown in Figure 3 and detailed in Appendix A, the professions whose regulatory colleges use "client" as a primary public-facing term are predominantly female-majority professions.

Figure 3

Female-Majority Practitioner Pattern Among Professions Whose Regulatory Colleges Use "Client" Exclusively



Note. Figure shows the professions in Ontario whose regulatory colleges use "client" exclusively and the available practitioner gender distributions associated with those professions. Data are derived from Appendix A, Table A1.

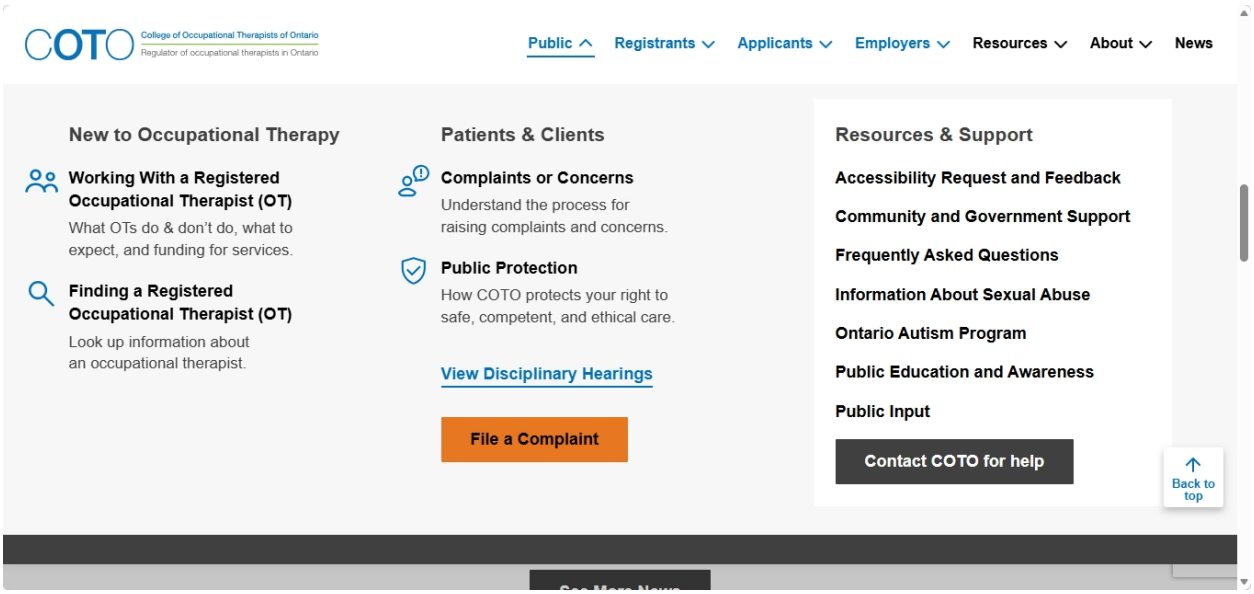
5.2.2 Public-Facing Labels and Headings

Public-facing terminology differences were also visible in how labels appeared on regulatory and institutional webpages. In the regulatory dataset, some colleges displayed combined labels rather than selecting a single term. Figure 4 shows COTO using "Patients & Clients" as a public-facing label in the same navigation space as items related to public protection and complaints.

In the CMTO dataset, terminology was consistent across the "RMT Clients" sub-sample: "patient" did not appear, while "client" appeared repeatedly in headings and in statements of rights and consent. Figure 5 shows a coded excerpt from CMTO's "What to Expect When You See an RMT" page, where "Your Rights as a Client" illustrates how "client" is discursively paired with rights-based language in CMTO public-facing regulatory texts, including consent, information-seeking, and record access.

Figure 4

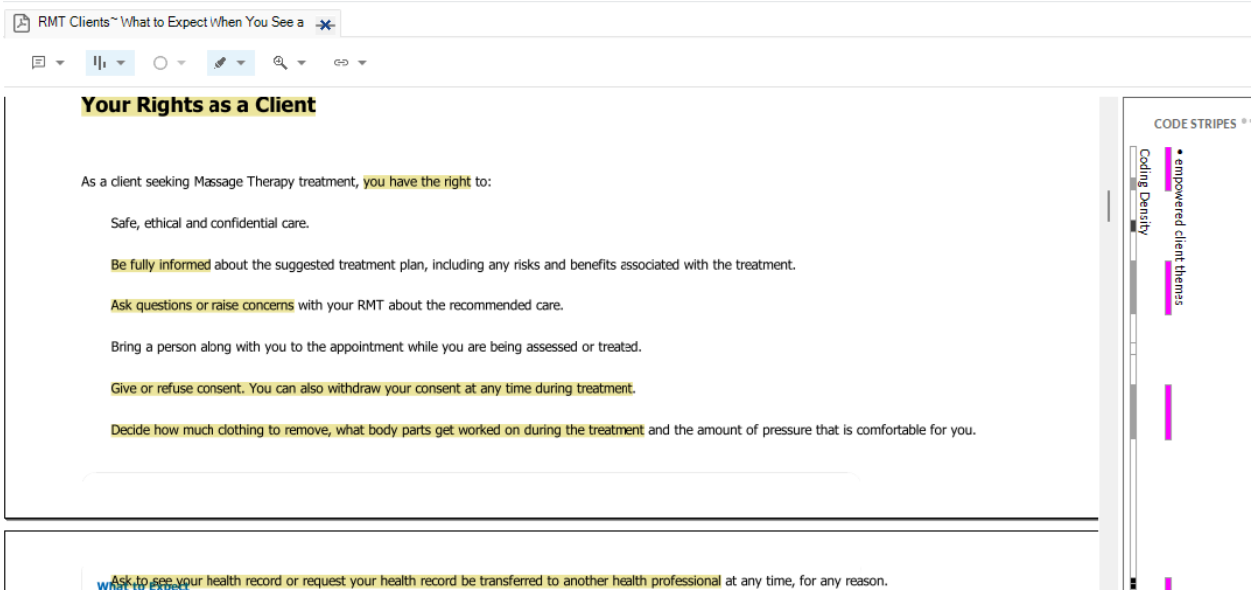
College of Occupational Therapists of Ontario Public Navigation



Note. Captured May 13, 2025: *"Patients & Clients"* displayed as a public-facing category. (URL: https://www.coto.org/)

Figure 5

"Client" Framed Through Rights and Consent in CMTO Public-Facing Regulatory Discourse



Note. Screenshot from the College of Massage Therapists of Ontario "RMT Clients" webpage (captured July 20, 2025) showing "client" language paired with explicit rights and consent statements. Only the coding stripe for "empowered client themes" is displayed to highlight "client" and rights-based framing in this regulatory context.

5.2.3 Cross-Dataset Code Patterns

Using NVivo, I generated coding-reference counts for the CMTO regulatory sub-sample, and the education datasets based on the codes I applied during analysis. These counts are drawn from the summaries reported in Appendix B (Tables B2 and B3). Words such as “massage”, “therapy”, and “Ontario” were excluded from these counts to keep attention on terms and clusters relevant to terminology, positioning, and institutional framing. The full codebook used to guide this process, including definitions, interpretive notes, and thematic groupings, is presented in Appendix C. The codes applied reflect both deductive codes (“patient,” “client”) and inductively generated thematic codes developed through repeated engagement with the documents.

Across the CMTO dataset, the most frequent coded clusters were “client”; “professional”; “health”; “ethical”; and “sexual misconduct or abuse.” (see Appendix B, Table B2). For the education dataset, the most frequent coded clusters were “knowledge and skills”; “client”; “health care or healthcare”; “people and public themes”; with “ethics” and “patient” appearing at similar levels (see Appendix B, Table B3). While “health/healthcare” was common to both sets, the surrounding language in the education documents tended to describe practice environments or learning outcomes, as opposed to regulatory expectations. Table 1 presents a side-by-side comparison of the most frequent coded clusters across the CMTO and education datasets.

Table 1

Comparison of Top Coded Terms and Clusters across CMTO and Education Datasets

Top codes: CMTO (regulatory sub-sample)	**Coding References**	**Top codes: Education (public colleges + Ontariocolleges.ca)**	**Coding References**
Client	79	Knowledge and skills	22
Professional	60	Client	19
Health	39	Health care or healthcare	17
Ethical	33	People and public themes	16
Sexual misconduct or abuse	30	Patient	10
-	-	Ethics	10

Note. Counts reflect NVivo coding references within each dataset. Full code lists and definitions appear in Appendix C, and dataset summaries appear in Appendix B.

These code-frequency patterns are used here as a descriptive entry point. Counts indicate what terms and clusters are prominent, but they do not show how "patient" and "client" were used in context, or how meaning was produced. Accordingly, the next section (discourse practice) turns to coded excerpts and document context.

5.3 Discourse Practice (Interpretation): How "Patient" and "Client" Function in Context

The discourse practice stage moves beyond the level of simply labelling terms to examine how "patient" and "client" operate in context within the documents. This involves analyzing how surrounding language in texts, and the purpose of the documents may impact professional relationships and institutional expectations (Fairclough, 2010). This section anchors the terms within their immediate contexts of use, providing a necessary bridge toward much wider critical interpretation. By doing so, it sets the stage for Section 5.4, which takes up a more extensive evaluation of the sociocultural implications surrounding professional positioning, gender dynamics, and institutional legitimacy.

5.3.1 CMTO (RMT Clients): "Client" Paired with Rights, Consent, and Oversight

Across the CMTO "RMT Clients" sub-sample, "patient" did not appear, while "client" occurred 79 times across 16 documents (Appendix B, Table B2). Within this dataset, "client" was consistently used in proximity to rights, consent, boundaries, and public protection language. This aligns with the theme of *Power & Ethics*, showing how "client" care terminology is tied to regulatory accountability and oversight. These groupings of words together as clusters provide a means for the regulatory college to prioritize what is communicated to practitioners, and by extension, what is important for the public to see.

Within the CMTO "RMT Clients" dataset, the term "client" often appeared along with language concerning rights, informed consent, professional accountability, and regulatory obligations. During the coding process, these concepts were initially identified as separate codes, including "empowered client themes", "ethical", and "duties and obligations". However, their repeated co-occurrence across multiple documents implied that they were functioning together, rather than independently. As analysis progressed, these related codes were interpreted as forming a broader cluster centred on "client" rights, consent, and regulatory oversight.

This progression can be illustrated through several examples. Public-facing documents include headings such as “Your Rights as a Client” together with statements that individuals may “give or refuse consent”, “withdraw your consent at any time”, “be fully informed”, “ask questions or raise concerns”, and “ask to see your health record” (CMTO, n.d.). These excerpts were coded as reflecting client empowerment because they placed the individual receiving care as an active participant with recognized rights and access to information. In the same documents, however, this rights-based language appeared along with expectations directed toward practitioners, including references to informed consent, mandatory reporting, professional conduct, accountability, and regulatory responsibilities. These excerpts were coded under “ethical” and “duties and obligations”.

Examining these coded excerpts together revealed more meaning than any individual code could alone. At the textual analysis level, “client” was repeatedly associated with consent, rights, professional responsibilities, and public protection. At the stage of discourse practice, these recurring associations hint at a practitioner-“client” relationship that is forged through a regulatory framework in which participation, ethical practice, accountability, and oversight are closely interconnected. Rather than portraying the therapeutic relationship solely as an interpersonal interaction, the documents consistently locate it within the responsibilities of professional regulation. The larger implications of this pattern for professional identity and the positioning of massage therapy within healthcare are considered further in the sociocultural analysis (Section 5.4).

Another example specific to the CMTO dataset was the presence of “client” alongside language concerning misconduct, including references to sexual abuse, professional boundaries, mandatory reporting, and disciplinary obligations. Unlike the rights-based pattern described above, these excerpts situated “client” within documents addressing public protection and professional misconduct. References such as “Prevention of Sexual Abuse”, “client abuse, particularly sexual abuse”, and “support a client working through the trauma resulting from an incident of sexual abuse by an RMT” illustrate how client terminology frequently appeared in conjunction with “client” protection, regulatory obligations and professional accountability (CMTO, n.d.).

For the dimension of discourse practice, this example implies that discussions of the RMT-“client” relationship extend beyond therapeutic interaction to encompass institutional

responsibilities for concepts included in the language of the documents, such as public protection, professional boundaries, and ethical practice. Rather than interpreting the significance of these recurring associations at this stage, the analysis identifies them as a notable feature of the CMTO discourse. Further implications for professional identity, public trust, and the sociocultural positioning of massage therapy are explored later in this chapter.

To provide a transparent audit trail, coding summaries are presented in Appendix B, together with the codebook definitions (Appendix C) and screen captures from NVivo to show evidence of the analytic process used (Appendix D).

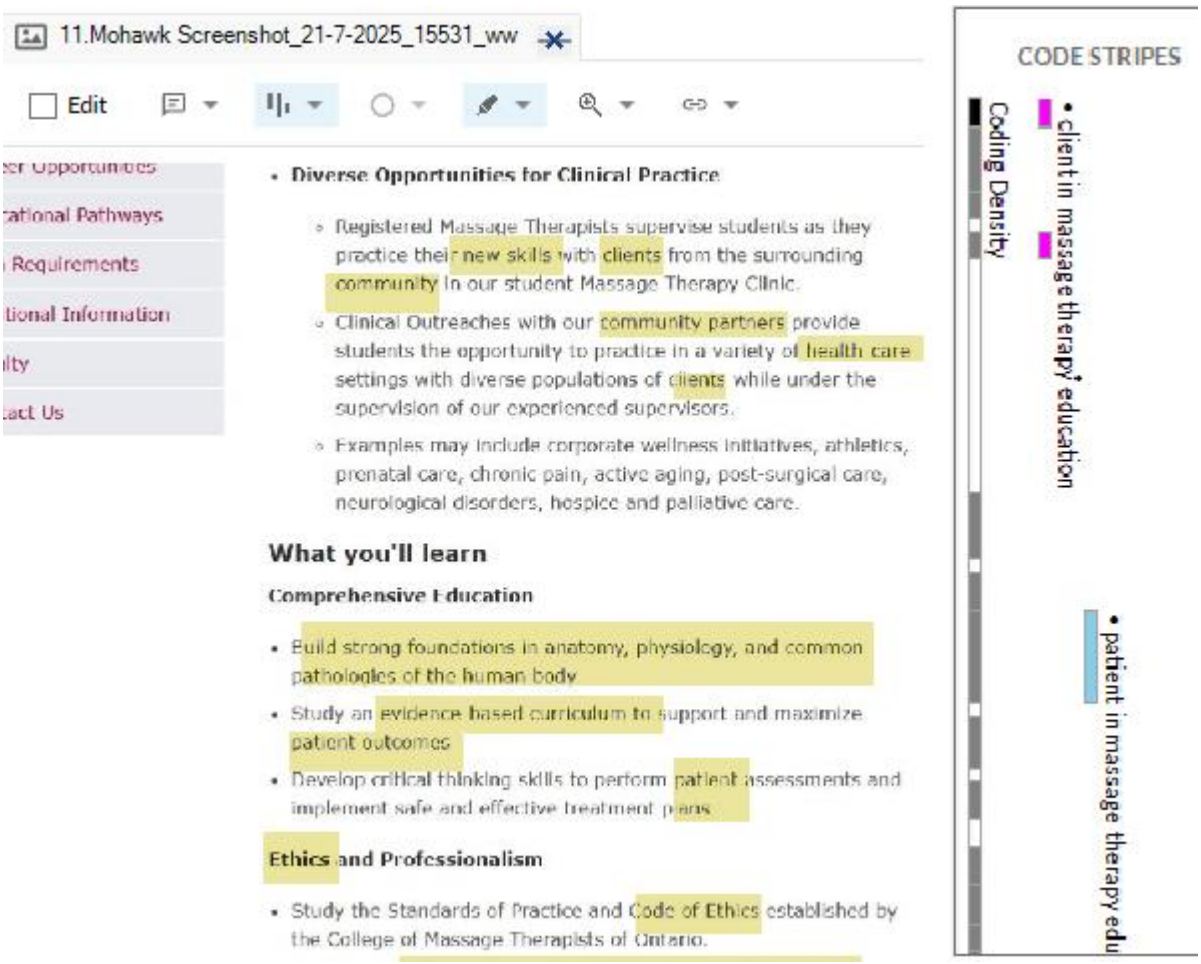
5.3.2 Education Dataset: Mixed Terminology and Contexts of Use

This section aligns with the themes of "educational positioning" and "professional practice", highlighting how massage therapy is framed within the educational documents. In the education dataset, "client" and "patient" appeared together more often than in the regulatory dataset, often within the same document, but are associated with different types of language. (Appendix B, Table B3). For example, a Mohawk College program description refers to "practice in a variety of health-care settings with diverse populations of clients," while also stating that students will "perform patient assessments" (Mohawk College, n.d.). Similarly, Durham College materials describe a student clinic as offering services for "clients and students," while the same page frames the program in terms of becoming a "healthcare professional" who can "assess and treat physical dysfunction and pain" (Durham College, n.d.). These excerpts were coded under both "client" and "patient", as well as "healthcare" and "knowledge and skills" codes (Appendix B; Appendix C).

At the level of discourse practice, this mixed use hints that "client" and "patient" are not used interchangeably but are associated with different aspects of the program. "Client" tends to appear in descriptions of learning environments, practice settings, and program structure, while "patient" is more closely aligned with assessment, treatment, and clinically oriented activities. This indicates that educational discourse organizes terminology in ways that differentiate between training contexts and clinical practice, at times within the same documents.

Figure 6

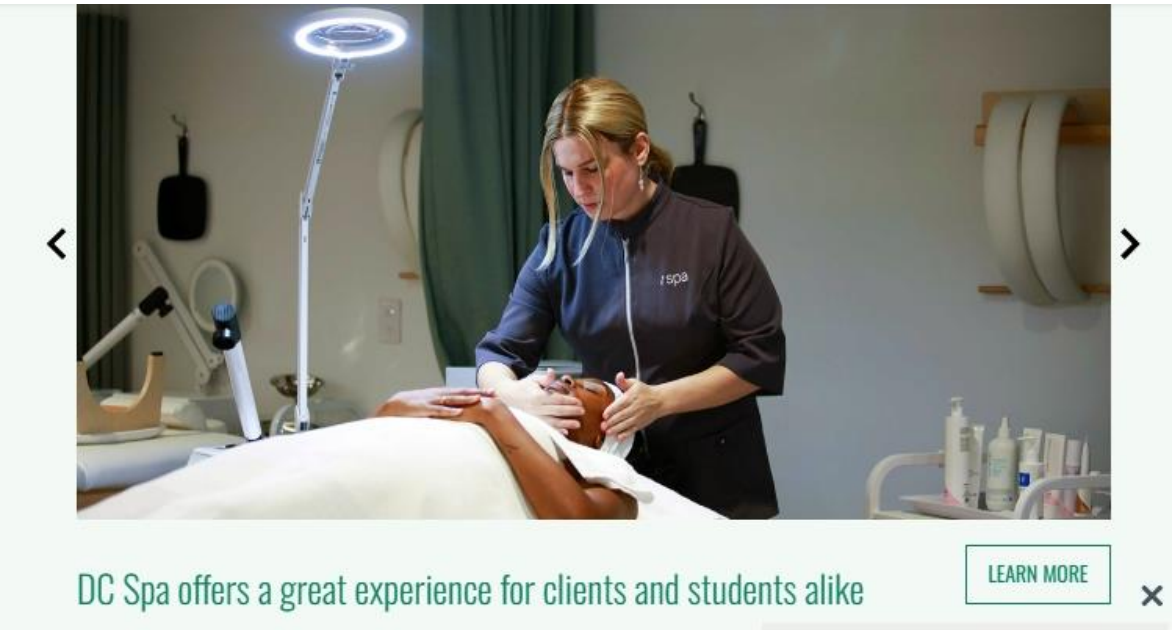
Mixed Use of "Client" and "Patient" Within a Single Massage Therapy Program Description



Note. Mohawk College Massage Therapy program page captured July 21, 2025 (URL: https://www.mohawkcollege.ca/programs/health/massage-therapy-469) showing both “client” and “patient” terminology within the same document. Only parent-level coding stripes related to terminology use are displayed to highlight how different terms are attached to different aspects of educational framing.

Figure 7

Durham College Massage Therapy Program Page Positioning



Note. Durham College Massage Therapy Program Page was captured July 19, 2025, including the phrasing "clients and students alike." (URL: https://durhamcollege.ca/programs/massage-therapy)

5.4 Sociocultural Practice (Explanation): Positioning Across Datasets

Building on the patterns identified in sections 5.2 and 5.3, this third dimension moves to sociocultural practice. Here, the focus shifts from how terminology functions within texts to how these patterns relate to societal-level views of professional identity, institutional positioning, gender, and legitimacy within Ontario's healthcare system. Sociocultural practice situates the documented patterns within wider sociocultural, and institutional contexts (Fairclough, 2010). The findings presented here focus on observable positioning signals such as workforce demographics and public-facing educational placement. Interpretive discussion is reserved for Chapter 6.

5.4.1 CMTO Professional Positioning and Sociocultural Practice

The discourse practice dimension helped in identifying the recurring association of "client" with rights, informed consent, ethical responsibilities, public protection, and regulatory oversight. These findings can be extended with Fairclough's (2010) third dimension of sociocultural practice. At this stage of analysis, the focus shifts to how the recurring patterns involving "client" participate in influencing professional legitimacy, identity, and institutional authority.

Throughout the CMTO's "RMT Clients" documents, "client" rarely appears as a neutral descriptor of the recipient of care. Instead, it is embedded within language emphasizing informed consent, professional obligations, accountability, and public protection. Document titles such as "Your Rights as a Client", coupled with references to being fully informed, asking questions, accessing health records, and providing or withdrawing consent, position the care recipient as an active participant within a regulated healthcare relationship (CMTO, n.d.). At the same time, accompanying references to mandatory reporting, ethical conduct, and professional responsibilities intimate a profession whose legitimacy depends upon adherence to clearly defined regulatory expectations.

This dual emphasis reflects the intersection of the themes of "power and ethics" and "terminology and identity" (Appendix C). What is meant here is the discourse constructs professional relationships through both therapeutic interaction and institutional expectations concerning accountability, transparency, and public trust. In applying sociocultural practice, the term "client" participates in a much larger regulatory discourse where professional identity is constantly negotiated through demonstrations of ethical practice rather than assumed through professional status alone.

This is reinforced by repeated references to the College's responsibility to protect the public interest, coded in the "RMT Clients" documents as "community and public". Extracts including "public can have confidence", "Regulatory excellence, promoting public trust", and "CMTO exists to protect the public interest" move beyond individual practitioner behaviour to the profession's collective relationship with society (CMTO, n.d.). The emphasis on public confidence reveals a regulatory discourse that functions both to govern practitioners and to establish and maintain the legitimacy of massage therapy as a regulated health profession.

The other example presented earlier involves the prominence of the code "sexual misconduct or abuse" which further illustrates how terminology and regulation intersect within the CMTO's "RMT Clients" documents. References to "Prevention of Sexual Abuse" and the "College's longstanding support for the sexual abuse provisions of the Regulated Health Professions Act, 1991", as well as statements that "a client can never give true consent to a sexual or romantic activity or relationship", continually situate the RMT-"client" relationship within a legal and ethical framework extending beyond clinical practice itself (CMTO, n.d.).

These texts help frame not just how an RMT is expected to behave, but how the regulator presents the profession publicly.

Viewed from a sociocultural dimension, the repeated association of "client" with sexual abuse prevention and public protection suggests that regulatory discourse serves multiple purposes. It aims to protect members of the public, establishes expectations for practitioner conduct, and demonstrates the profession's commitment to accountability within Ontario's regulated healthcare system. In this way, discussions of sexual abuse function not only as regulatory requirements but also as mechanisms through which the regulatory college perpetuates its version of massage therapy's legitimacy, trustworthiness, and healthcare relationships at a societal level.

5.4.2 Gender Connections with Terminology

The sociocultural patterns identified in this study extend to the distribution of terminology across professions, particularly in relation to gender. "Client" appears in professions with predominantly female practitioner populations, which was confirmed in the regulatory dataset. The membership numbers used to identify these demographic patterns come directly from Appendix A, Table A1, which compiles the most recent publicly available counts for each profession. For massage therapy, the CMTO's most recent annual report lists 12,495 RMTs self-identifying as female, or 77.2% (CMTO, 2024). Annual reports for other professions confirm similar patterns, with exceptions noted for midwives and occupational therapists. For midwives in Ontario, a search of the midwifery groups in the Ottawa area and surrounding regions did not list any self-identifying male midwives (*Find a Midwife | AOM*, n.d.). Statistics for occupational therapists in Ontario were not available; however, national ones for 2023 reported 90.3% of occupational therapists in Canada were female (*Occupational Therapists | CIHI*, n.d.-b).

For the four professions whose regulatory colleges use "client" exclusively (massage therapy, midwifery, psychotherapy, dental hygiene), the most recent membership data show women comprise the substantial majority of practitioners. Among the four professions whose regulatory colleges use both terms, three (occupational therapy, respiratory therapy, applied behaviour analysis) also have practitioner populations that lean strongly female, based on available national or provincial data. No male-majority regulated profession in Ontario used "client" as its primary terminology in this dataset.

These findings uncover a gendered pattern in the dataset for professions that opt for "client". The heavy concentration of "client" language within predominantly female healthcare professions suggests that vocabulary is closely bound to sociocultural processes of identity, positioning, and gendered value. This pattern reveals that "client" is not a neutral choice but helps dictate how specific professions are valued and understood within healthcare in Ontario. This analysis connects with the themes of "terminology and identity" and "power and ethics", laying the groundwork for the extended discussion in Chapter 6.

5.4.3 Public-Facing Educational Positioning of Massage Therapy

The educational materials also reveal how massage therapy is institutionally positioned for prospective students. Ontariocolleges.ca functions as the application portal for Ontario's publicly assisted colleges (*The Application Service for Ontario's Public Colleges*, n.d.). Among the thirteen colleges offering massage therapy programs (twelve English-language programs included), terminology use was mixed. "Client" and "patient" appeared across the program description pages, and the "What to Expect from a Career as a Massage Therapist" page (*Massage*, n.d.; Appendix B, Table B3). This deviation from the CMTO's language suggests that educational discourse does not present a single, unified understanding of massage therapy, but instead reflects multiple institutional perspectives on the profession.

Positioning was not limited to terminology alone. The Ontariocolleges.ca document included references to "patient care strategies" and "future clients" on the same public-facing page (Massage, n.d.). The same page also listed massage therapy alongside unrelated programs such as esthetics and hairstyling, which places it among non-health or non-regulated categories (Massage, n.d.). These classification patterns correspond to codes captured under the "Non-massage therapy education - Ontariocolleges.ca" category (Appendix B, Table B3). Similarly, institutional placement varied across colleges. For example, At Algonquin College, massage therapy appeared under "Wellness/Public Safety/Community Studies", grouping it with programs like early childhood education and police foundations, rather than "Health Studies" (Algonquin College, n.d.). This indicates different public-facing positioning within the same institution. Although these classifications may reflect administrative decisions rather than explicit statements about professional identity, they nevertheless contribute to the public-facing context through which prospective students encounter massage therapy.

Explained through Fairclough's (2010) sociocultural dimension, these differences indicate that educational institutions may participate in forming multiple understandings of massage therapy. The profession is presented as a regulated healthcare occupation while also being located within wellness, community, or service-oriented educational contexts. These findings align most closely with the themes of "educational positioning" and "terminology and identity". These present in the documents analyzed as how institutional classification and language together contribute to the public representation of massage therapy.

5.5 Summary of Key Findings in Relation to the Research Questions

This summary highlights several key findings from this chapter, and how they map onto each research question. To further respond to the research questions, a number of the findings are then taken up, and interpreted in the discussion chapter.

Research Question 1 (regulatory colleges): ***How do regulatory documents across Ontario's health professions use the terms "patient" and "client," and what do these uses reveal about power dynamics, professional identities, and healthcare relationships?***

The findings demonstrated that terminology use across Ontario's regulatory colleges extends beyond differences in word choice. Public-facing regulatory discourse across Ontario's regulated health professions was predominantly organized through the term "patient", often within clusters related to public protection, complaints, and regulatory authority. Of the 27 regulated health professions, 19 use "patient" exclusively, four use "client" exclusively (midwives, psychotherapists, massage therapists, dental hygienists), and four use both terms (see Appendix A, Table A2). Beyond the numbers that reflect a majority use of "patient" by the regulatory colleges, the prominence of the term is further explored in the chapter that follows. "Client" appeared in fewer professions, was used in female-majority health professions, and was commonly associated with rights, informed consent, accountability, and relational care. Rather than functioning as interchangeable terms, "patient" and "client" appear embedded within distinct discourses that put forth different understandings of care relationships, professional identity, and power dynamics that are more fully addressed in the discussion chapter.

Research Question 2 (case of massage therapy): ***How are "patient" and "client" used in documents from the College of Massage Therapists of Ontario, and in public college program descriptions of massage therapy, and what does this usage suggest about the professional identity and positioning of massage therapy within Ontario's healthcare system?***

For massage therapy, the findings suggest that terminology reflects an ongoing negotiation of professional identity within Ontario's healthcare system. Throughout the CMTO documents, client was consistently associated with rights, informed consent, ethical practice, and regulatory accountability (Appendix B, Table B2). “Patient” did not appear in the CMTO “RMT Clients” dataset at all. By contrast, public college program descriptions used both “client” and “patient”, often within the same document (Appendix B, Table B3). Where “patient” was more commonly associated with assessment and clinically oriented language, “client” was frequently seen in descriptions of learning environments and practice settings. These differing patterns suggest that massage therapy occupies multiple institutional contexts, with terminology reflecting distinct regulatory, educational, and healthcare discourses.

Chapter 6: Discussion

Chapter 5 presented findings on terminology use, professional positioning, and institutional discourse across regulatory and educational documents. These findings are expanded on in this chapter by engaging with poststructuralist concepts of language, power, authority, and knowledge. Following this approach allows the discussion to remain grounded in the data while also situating the findings within larger debates in healthcare practice, and HPE. Of note, the themes of gendered language and perceived professional prestige were findings that surfaced during coding, and therefore further explored in greater depth through additional contextual sources, including annual reports from regulatory colleges. These findings are treated cautiously as descriptive patterns in Chapter 5 and are interpreted more fully in this discussion chapter. Overall, this chapter makes visible the tensions embedded in the terms "patient" and "client" by examining how these discursive patterns function at the level of sociocultural practice, and considers how these terms may impact healthcare relationships, professional identities, and institutional positioning in Ontario.

Although the use of terminology could potentially vary between regulatory colleges and professional practice, unless otherwise noted, the term utilized by a regulatory college is assumed to align with the health profession it oversees. Massage therapy is a notable exception. The discussion shows that instances of "patient" do present in educational and professional contexts despite the overwhelmingly "client"-oriented language of the College of Massage Therapists of Ontario (CMTO).

6.1 Why "Patient" Remains the Dominant Term Used by Regulatory Colleges in Ontario

Chapter 5 showed that "patient" is the dominant public-facing term used by regulatory colleges across Ontario's health professions. Attention now turns more specifically to why that dominance persists, despite longstanding critiques of the term in healthcare literature and the availability of alternatives such as "client" (Arneja & Gilardino, 2023; McLaughlin, 2009). Drawing on poststructuralist perspectives, "patient" is explored as a term having accumulated layers of historical meanings and assumptions over time. Rather than resolving debates surrounding the term, the discussion focuses on how regulatory institutions continue to reproduce "patient" as a stable and recognizable label, and how that stability may serve institutional and professional interests.

6.1.1 Historical Meanings and Issues Defining "Patient"

As outlined in Chapter 2, historical connotations of "patient" related to suffering, passivity, and waiting persist and continue to influence contemporary interpretations (Arneja & Gilardino, 2023; Lawrence, 2008; McLaughlin, 2009). In the regulatory college documents analyzed for this study, "patient" appeared frequently but without definition, suggesting that its meaning was assumed, rather than articulated. The absence of explicit definition is noteworthy given the dominance of "patient" across Ontario's regulatory colleges. As presented in Chapter 5, "patient" is the primary term used: Nineteen of Ontario's regulated health professions are governed by colleges that opt for "patient", and a further four of the twenty-seven currently use both "patient" and "client" (see Appendix A, Table A2). Despite its use, none of the documents analyzed from these regulatory colleges explained what the term was intended to convey.

The persistence of "patient" raises questions about whether historical meanings continue to operate implicitly. In much of the healthcare literature, a "patient" may still be understood as someone waiting for the practitioner – patiently waiting, submissive, passive (Burnham, 2012; Cahn, 2017; Costa et al., 2019; Herxheimer & Goodare, 1999; Lawrence, 2008; McLaughlin, 2009). This view implies a seemingly unequal relationship between the user of healthcare services and the provider. The healthcare professional has a title with clearly delineated professional authority, whereas the "patient's" title is one of suffering, of being in pain, and positioned as acted upon rather than acting.

As outlined in Chapter 3, this dynamic can be understood through Foucault's analysis of the medical or clinical "gaze" (*regard* in its original French which also hints at a sense of esteem, not just seeing) which situates the "patient" as an object of medical knowledge and surveillance within modern healthcare institutions (Foucault, 2003b). An additional perspective from poststructuralism that is relevant here is one where historically situated meanings continue to infuse contemporary language with cultural values that are often internalized, rather than questioned (Belsey, 2002b). Collectively, these perspectives help explain how "patient" can continue to function as a stable regulatory term while carrying assumptions about authority, dependence, and expertise that are rarely made explicit.

These inherited meanings form an important backdrop for understanding the continued regulatory preference for "patient" observed in Chapter 5. Rather than being a neutral descriptor, "patient" operates within a much larger historical and institutional context that influences how

care relationships are imagined and regulated, even when such assumptions are not directly stated.

6.1.2 Institutional Authority, Empowerment, and the Limits of Participation

Though not specifically acknowledged in the regulatory college documents analyzed, the literature does point to a wide span of issues of what it means to be a "patient" The continued use of "patient" by most regulatory colleges may function as a marker of legitimacy, reinforcing alignment with established healthcare institutions (Foucault, 2003b; Powell, 2023). The persistence of "patient" may also stem from a perceived neutrality and universality, with its historical baggage seemingly an afterthought, if thought of at all (Scholl et al., 2014).

Why, then, do historical definitions of a passive, sickly, weak, lacking knowledge, and waiting "patient" persist? The inconsistencies in current definitions speak to perhaps an unwillingness, or lack of impetus, to shift the meaning of "patient". Despite critique in the literature, "patient" continues to be reproduced without clarification, possibly because it continues to serve existing healthcare power relations (Foucault, 2003b). From a poststructuralist perspective, "patient" is not some neutral descriptor, but a culturally produced term enmeshed within systems of power and knowledge (Foucault, 2004, 2008). Read through Foucault's concept of power/knowledge (Chapter 3), the regulatory stability of "patient" can be treated as part of how institutional discourse organizes what counts as legitimate expertise, and who is positioned to speak with authority (Foucault, 2008, 2013; Petrovskaya, 2022). While poststructuralism emphasizes that meaning is not fixed, the regulatory discourse examined here does not appear to engage with this instability, instead, they rely on "patient" as a taken-for-granted label that stabilizes regulatory communication (Belsey, 2002b; Foucault, 2003b).

One way that regulatory discourse appears to address concerns about power and vulnerability is through the language of empowerment. Empowerment discourse appears in the literature as ways for the "patient" to reduce risk, or exercise greater autonomy (Bravo et al., 2015; Engel et al., 2019; Metersky et al., 2022b; Scholl et al., 2014; Shutzberg, 2021). Within Ontario's regulatory framework, however, empowerment is expressed primarily through mechanisms such as complaints processes, public registers, and limited public participation on regulatory committees (Regulated Health Professions | Ontario.Ca, n.d.; Vinson, 2016). While these processes align the public interest with the interests of the "patient", they do not involve

“patients” directly in decision-making about professional standards or disciplinary outcomes Vinson, 2016). Authority remains firmly located within regulatory institutions established under the Regulated Health Professions Act (Regulated Health Professions | Ontario.Ca, n.d.). Approached through the concept of governmentality, these "empowerment" tactics invite participation only through approved channels, ensuring that final authority stays within the institution's control (Foucault, 2003a; Lynch, 2016; Powell, 2023).

The regulatory documents analyzed for this study reflect this constrained form of participation. Public-facing language emphasizes protection of vulnerable individuals and the control exercised over healthcare professionals, as seen in disciplinary and complaints-related statements such as “Prohibition of a sexual relationship with a patient” (CCO, n.d.), or “Patients and their family members can make a complaint” (CNO, n.d.). This corresponds with the Regulated Health Professions Act (RHPA), which outlines the rules and regulations for health professions in Ontario and contains provisions for public participation on committees such as Registration, Inquiries, Complaints and Reports, Discipline, and Fitness to Practise (Regulated Health Professions | Ontario.Ca, n.d.). However, these texts frame "empowerment" as access to reporting and oversight rather than shared authority. As discussed in Chapter 3, biopower explains how these standards and "risk" language govern conduct to define who is protected, and how the institution maintains its legitimacy (Foucault, 2003a, 2003b; Suijker, 2023).

The regulatory version of empowerment contrasts with the literature where empowerment is often associated with the “patient” as “expert by experience”, or within “patient-centred” approaches, particularly in HPE and IPE contexts (Cheng & Towle, 2017; Kangasjarvi et al., 2023; McLaughlin, 2009; Towle et al., 2014). This form of empowerment was not evident in the regulatory documents analyzed for this study, nor in Ontario’s publicly available massage therapy education materials. Instead, empowerment discourse appears most strongly in areas such as chronic disease management and shared decision-making, which differs from the narrower version of empowerment found in regulatory materials (Aujoulat et al., 2007; Rowland & Kumagai, 2018).

The literature further complicates the assumption that “patients” always desire empowerment. Some studies describe “patients” who prefer to remain dependent on healthcare professionals and defer decision-making to them (Acuña Mora et al., 2022; Devillers et al., 2023). Rather than supporting a simple narrative in which the “patient” endeavors to move from

passivity to empowerment, these studies may suggest that the notion of empowerment is far more complex. Empowerment may also be in question in another way, as the literature exposed a "patient" that did not necessarily want to be empowered, that wanted to remain ill/taken care of (Acuña Mora et al., 2022; Devillers et al., 2023; Dowling et al., 2011).

From a poststructuralist standpoint, this limited empowerment may itself function as a form of disciplinary power. Language such as "patient-centred" gestures toward ethical and collaborative care while leaving underlying power relations largely unchanged (Belsey, 2002a; Foucault, 2003b). "Patient-centred" (and less frequently, "client-centred") is a prominent, hyphenated term that appears both in the literature and in a few of the documents (Christianson et al., 2007; Hansen et al., 2016; Hearn et al., 2019; Mead & Bower, 2000; Roberti di Sarsina & Tassinari, 2015; Robinson et al., 2008). Although "patient-centred" appeared in several documents analyzed, it was rarely defined. The assumption seems to be made that "patient-centred" is simply understood, without explanation. Yet if it cannot be explained, then a "patient-centred" model of care could be challenging to implement. Given that the documents analyzed are all public-facing in nature, it may be confusing for anyone visiting the regulatory college websites to search for simply introductory information about approach to care, when its "patient-centred" one is not clear.

When pieced together, these patterns help explain why "patient" remains so stable within regulatory discourse. "Patient" is consistently included in the language of medical education, and most healthcare professions in Ontario, adding to the sense of authority of this term over any other alternatives such as "client" (see Appendix A, Table A1). It remains a socially recognizable term, garnering public trust without requiring explicit definition (Costa et al., 2019)**.** Indeed, regulated health professions in Ontario that choose "client" may struggle to gain equivalent recognition, even when their contributions to care are substantial (Baskwill et al., 2020b). Within this context, alternatives such as "client" emerge as marked departures from the dominant regulatory norm - a point that becomes especially salient in the case of massage therapy.

6.1.3 Communication, Standardization, and Professional Prestige

If institutional authority explains why "patient" persists in regulatory discourse, communication and professional prestige help explain how that dominance is maintained and reinforced across the healthcare system. As shown in Chapter 5, "patient" functions as the default public-facing term for most regulatory colleges in Ontario, while alternatives such as "client"

remain limited to a small subset of professions. This seems to suggest that "patient" carries communicative and symbolic weight beyond its descriptive function.

An example of this dynamic is the College of Nurses of Ontario's (CNO) drift away from "client" toward exclusive use of "patient" (CNO, n.d). As noted in the findings, archival evidence from the CNO website indicates that "client" usage largely disappeared prior to 2010, leaving "patient" as the sole term used in public-facing materials (Welcome to CNO, n.d.). This shift aligns with the wider regulatory pattern identified in this study of "patient" as possibly the more authoritative and professionally acceptable term within Ontario's healthcare context. As a follow-up to the example of the CNO, this differs from nurses in some other parts of the world where "client" seems to be preferred (Saito et al., 2013).

Communication may also help explain why "patient" remains the dominant regulatory term in Ontario. When most regulatory colleges use "patient", that term becomes the most recognizable and standardized label across professions, institutions, and public-facing documents and interactions (Engel et al., 2019; Flores-Sandoval et al., 2021; Hull, 2016; Hunter et al., 2021; Martin et al., 2022; Metersky et al., 2022a; Nguyen et al., 2021; Sheehan et al., 2007). From this perspective, "patient" functions as a shared communicative norm that supports clarity and consistency, even in the absence of explicit definition (Fairclough, 2010). As discussed in Chapter 5, regulatory documents rarely define "patient", yet its repeated use across jurisdictions gives it the appearance of neutrality and universality.

The case of regulatory colleges that use both "patient" and "client" further illustrates this point. As stated in the Chapter 5, the majority of the regulatory college websites for the regulated health professions in Ontario exclusively use "patient", but four include both "patient" and "client" as a single public-facing category, without clarifying how or when each term should be applied (see Appendix A, Table A2). This coupling of terms may reflect deliberate inclusivity or perhaps indicate unresolved terminological tension. Of the four that use both "patient" and "client", the regulatory colleges for respiratory therapists, and occupational therapists in Ontario have a "Patient Relations Committee", not a "Client Relations Committee" (College of Occupational Therapists of Ontario (COTO), n.d.; Home - CRTO, n.d.). This may speak to "patient" being the more entrenched, and accepted term for the public. It may also reflect a move to align with other regulated health professions in Ontario by including "patient". Not doing so could create confusion for the "patient" or "client" themselves, as well as for other healthcare

providers collaborating with occupational therapists in interprofessional teams (Hunter et al., 2021; Martin et al., 2022; Ripat et al., 2014; Sumsion, 2000). This example is useful because it shows that "patient" may be seen as the more suitable term, even when alternatives to it appear in regulatory discourse.

Professional prestige also appears to operate relationally. A shared terminology may both facilitate interprofessional collaboration, yet also simultaneously maintain professional hierarchies (Susilo et al., 2022). In terms of interprofessional use, professions favouring "patient" may be more readily recognized as central to healthcare, while those choosing "client" may be perceived as peripheral or less scientific (Bennett-Weston et al., 2023; Costa et al., 2019; Leidner et al., 2021; Spadafora & Tsotsos, 2016; Zhou & Grant-Kels, 2023). The literature repeatedly links those professions that opt for "patient" with professional status, public trust, and biomedical authority (Nguyen et al., 2021; Wing, 1997). For example, "patient" has been used to reinforce the physician's role as the leader of a medical team, even as a sense of ownership - my "patient" – so that "patient" may in part symbolize the dominance of one health profession over another (Selway, 2009; Skyberg & Jenssen, 2024; Zhou & Grant-Kels, 2023). In these instances, terminology is not simply a tool to describe relationships, it participates in positioning which professions appear central, and which remain peripheral.

The communicative dominance of "patient" is further reinforced by its widespread use in medical education and health professions education more broadly. As a result, "patient" becomes the standard against which alternatives are judged. Even though the term lacks a consistent definition, its familiarity and institutional saturation give it practical communicative value (Engel et al., 2019; Flores-Sandoval et al., 2021; Hull, 2015; Oben, 2020). Regulatory institutions may continue to reproduce "patient" not because it is conceptually clearer, but because it stabilizes communication, and aligns with established professional expectations (Costa et al., 2019; Foucault, 2008).

To further this point, attempts to define "patient" may be confusing, or lead to further ambiguity. For example, resources such as SNOMED (Systematized Medical Nomenclature for Medicine), which may be used in healthcare communications, define "patient" in general terms as "person in the healthcare environment," with the majority of the 1252 "patient"-related terms in a search describing actions being done to the "patient", rather than requests coming from the "patient" themselves (West Coast Informatics SNOMED CT Browser, n.d.). This reinforces a

view of the "patient" as an object of action, defined by professional intervention rather than agency (Foucault, 2004). Additionally, although some literature expands the term to include a community, population, or those involved in care such as family or caregivers, these expanding definitions have also been criticized for introducing further ambiguity (Bird et al., 2020; Bravo et al., 2015; Martin et al., 2022; Santana et al., 2018; Sheehan et al., 2007; Shutzberg, 2021; Timmermans, 2020; Towle et al., 2016).

The way "patient" is communicated may also contribute to forms of de-personalization, particularly when individuals are framed primarily as cases rather than as people. I mention this deliberately from my own experience, as both a practitioner and an educator, where the "patient" or "client" may be presented as a case, or case study in HPE. Frequently, the "patient" completely loses their identity and is rendered as a collection of signs and symptoms (Foucault, 2003b). This seems to match the clinical gaze, privileging professional expertise over the "patient's" lived experience (Foucault, 2003b; McIntyre et al., 2020).

These patterns help explain why challenges to "patient" have not resulted in widespread terminological change within Ontario's healthcare system. "Patient" supports institutional authority, professional prestige, and interprofessional communication. Within this context, "client" emerges as a marked alternative, it signals difference and departure from dominant healthcare norms. These conditions set the stage for the more detailed examination of massage therapy that follows.

6.2 Discourse from the CMTO's Consistent Use of "Client"

While the previous section inspected the dominance of "patient" across Ontario's regulated health professions, attention now turns to massage therapy as a profession that consistently departs from that pattern through its regulatory use of "client." As noted in Chapter 5, massage therapy is one of four regulated health professions in Ontario, along with midwifery, psychotherapy, and dental hygiene, whose regulatory college favours "client" instead of "patient" in the public-facing documents analyzed (see Appendix A). Registered massage therapists comprise the largest group within this subset, making massage therapy a particularly compelling case for examining the regulatory use of "client". Providing some context is important here: The number of HCPs under the purview of the four regulatory colleges opting for "client" alone is approximately 41,800, or just over 10% of the more than 397,000 regulated health professionals in Ontario (see Appendix A, Table A1). Taking these numbers into account,

"client" occupies a clear minority position within Ontario's regulated health professions. Only a small proportion of regulated health professionals fall under colleges that use "client" exclusively, while the vast majority are governed by colleges that rely on "patient". This imbalance makes it difficult to treat "client" as an equivalent alternative within regulatory discourse. Instead, "client" functions as a marked choice - one that departs from the dominant language used to organize regulatory authority and public-facing healthcare communication. This minority positioning is significant because as discussed earlier, regulatory language does not simply describe professional practice – it can also contribute to how professions are seen by the public, and within healthcare. The CMTO's consistent use of "client" therefore warrants closer examination, not as a neutral terminological preference, but as a distinct choice with potential implications for massage therapy as a profession.

The literature did at times present "client" as a progressive alternative to "patient," linking it to autonomy, collaboration, and resistance to more paternalistic models of healthcare (Reeder, 1972; Kramer, 1995; Shevell, 2009). From this perspective, "client" aligns with relational and person-centred approaches to care that emphasize shared decision-making and respect for lived experience (Corring & Cook, 1999; Mortenson & Dyck, 2006). At the same time, the literature also noted some hesitation over use of the term. "Client" carries market-based associations that may imply a transactional relationship which risks commodifying care and reframing healthcare interactions as consumerist (Herxheimer & Goodare, 1999; Petriwskyj et al., 2014).

This tension provides important context for interpreting the CMTO findings. Despite its favourable portrayal in parts of the literature, "client" remains marginal within Ontario's regulatory discourse. As discussed in Section 6.2.3, "patient" remains the preferred choice for the vast majority of Ontario's regulated health professions. Thus, the significance of CMTO's consistent and exclusive use of "client" lies not in the novelty of the term, but in its departure from the dominant regulatory norm. This regulatory divergence becomes especially visible when considered alongside massage therapy's educational and public-facing representations, where "client" and "patient" appear together in more variable and sometimes contradictory ways. As shown in Chapter 5, massage therapy education materials simultaneously reflect CMTO's regulatory language and respond to broader healthcare conventions that continue to privilege "patient" terminology.

It is also worth noting that regulatory terminology is not static. After the data collection period for this study, CMTO updated its public-facing navigation from “RMT Clients” to “RMT Patients.” This post capture change is not treated as part of the analyzed dataset, but it serves as a reminder that institutional terminology is not fixed, and that changes in naming can occur even within a single regulator’s public discourse over time. The emergence of “patient” within CMTO’s public interface, even in limited form, highlights the ongoing negotiation of terminology and professional positioning that this study documents.

These findings suggest that massage therapy’s regulatory use of “client” is not merely a matter of word choice. Rather, it reflects a broader negotiation of professional identity and legitimacy within a healthcare system whose dominant regulatory language continues to be organized around “patient”.

6.3 Discursive Tensions in Massage Therapy Education

Building on the regulatory and professional discourses examined in the previous sections, this section turns to massage therapy education as a key site where competing terminologies are negotiated. Massage therapy education in Ontario appears to occupy an unsettled position within healthcare and HPE, which presents through the language used in public-facing educational texts (see Appendix C for the codebook, and Appendix D for the NVivo audit trail). Programs must remain aligned with the regulatory expectations of the College of Massage Therapists of Ontario (CMTO), which consistently used the term “client” in the captured dataset, while simultaneously preparing graduates to enter a healthcare system in which “patient” remains the dominant, widely recognized term (CMTO, n.d.).

From a poststructuralist perspective, education can be understood as more than simply the transmission of technical skills or professional competencies. It is also a site where professional norms, values, and identities are formed and maintained through language (Belsey, 2002b). In this context, the terminology used in massage therapy education contributes to how future practitioners may come to understand their role within healthcare, as well as how people receiving care are positioned linguistically and relationally.

The findings suggest that this tension is not explicitly named, nor critically examined within massage therapy education materials. Instead, it appears to be managed through alternating language choices. References to “client” tend to align massage therapy education with CMTO regulatory discourse, while the inclusion of terms such as “patient,” “healthcare,”

and interprofessional language gestures toward legitimacy within the wider, "patient"-oriented healthcare system (see Appendix C; Baskwill et al., 2020a, 2022). Such patterns do not necessarily reflect confusion or inconsistency. Instead, they may offer insight into the pressures facing massage therapy education as it seeks to maintain regulatory compliance, while also asserting credibility within a healthcare system that continues to privilege "patient" terminology (Baskwill et al., 2022).

This played out in the documents analyzed. A notable observation from coding was the appearance of "patient" in several of the documents for the public colleges in Ontario that offer programs in massage therapy despite the CMTO's consistent commitment to "client" (Appendix B, Table B3). The ratio of "client" over "patient" was nearly two to one, but the appearance of "patient" at all deviated from the CMTO's commitment to "client" (Appendix B, Table B2). Although "client" appeared more frequently overall, the presence of "patient" at all represents a meaningful divergence in educational discourse. For example, Mohawk College's massage therapy program webpage uses both terms within the same document: "Registered Massage Therapists supervise students as they practice their new skills with clients…", and "…perform patient assessments and implement safe and effective treatment plans" (Mohawk College, n.d.). This juxtaposition occurs without explanation, positioning "client" and "patient" as functionally interchangeable within a single educational text. Instead of reading this as accidental, as an error of some sort, this mixed usage may indicate an effort to align student learning with regulatory language on the one hand, and with the more dominant healthcare norms on the other.

The educational positioning of massage therapy in Ontario is in flux due to several legislative and regulatory changes, with the most impactful being the introduction of a stringent accreditation process for massage therapy programs (Accreditation of Massage Therapy Education, n.d.; Our Accreditation Process, n.d.). This may partly explain the prominence of *knowledge and skills* language in the education dataset to validate academic and competency-based aspects of training (see Appendix B, Table B3). The challenges of massage therapy education do persist as educational programs vary widely in length and content, and not every province and territory in Canada is overseen by a regulatory institution such as the CMTO (Baskwill et al., 2020a).

Additionally, although thirteen of the twenty-four publicly assisted colleges in Ontario offer massage therapy programs, there are estimated to be hundreds of private colleges across

Ontario that do so as well (Ontario Colleges | Ontario.Ca, n.d.). There are those who see this as a contributor to inconsistencies in massage therapy education, as much of it is taught by instructors working with for-profit businesses (Baskwill, et al., 2020a). A further contention is that most educators in massage therapy are RMTs who may not possess the educational background and training to teach; there is a lack of standardized training and credentialing processes for massage therapy instructors which could negatively affect perceptions of the quality of massage therapy (Baskwill et al., 2020a, 2020b).

However, substantial efforts have been made to standardize massage therapy education, as the profession seeks to assure and assert its place in HPE. This perhaps also ties into several of the language themes that presented in the documents analyzed such as the aforementioned *knowledge and skills*, to emphasize academic aspects in public-facing materials (see Appendix B, Table B3). The introduction of program accreditation by the Canadian Massage Therapy Council for Accreditation (CMTCA) in 2017 requires that all massage therapy programs meet a stringent set of standards, to ensure that all massage therapy students will receive an education that matches the entrance competencies to practice put forth by the CMTO (Baskwill et al., 2020a). It remains too soon to fully assess whether this measure will change how massage therapy is perceived both within and outside of the profession, though attending an accredited massage therapy program will be mandatory for registration as an RMT beginning in 2027 (Accreditation of Massage Therapy Education, n.d.; Our Accreditation Process, n.d.).

Another factor that comes into focus in the efforts to gain greater acceptance within healthcare is a perceived need to develop higher education pathways for RMTs (Baskwill et al., 2020a). The current educational ceiling is a diploma, which limits their access to universities, and the lack of research on massage therapy in academia further compounds the profession's underrepresentation compared with other regulated health professions (Baskwill, 2018). I have firsthand experience with this, as my acceptance into a graduate degree program at the University of Ottawa was predicated on having already earned an honours undergraduate degree, not on my college diploma in massage therapy. Also of note, is there are no graduate level degrees in massage therapy in Ontario, further limiting opportunities for advanced academic engagement within the profession.

Not seen and not heard, it is unsurprising then that although RMTs overwhelmingly enjoy what they do, there is the lingering self-perception of being relegated to the bottom of the

healthcare hierarchy (Baskwill et al., 2020a, 2023b). The combined absence of university-level education, and lack of visibility in research, may contribute to massage therapy's limited authority in healthcare discourse, where "client" language further separates massage therapy from the more dominant, "patient"-concentrated paradigm (Baskwill et al., 2020a, 2022, 2023b). When viewed together, these conditions shape not only educational opportunities, but also whose knowledge is recognized. This aligns with Foucault's notion of subjugated knowledges (Chapter 3), drawing attention to how relational, embodied, or practice-based forms of expertise may be valued differently than biomedical knowledge within institutional discourse (Foucault, 2008). Within the scope of this thesis, these observations are not intended to evaluate the quality of massage therapy education, but to illustrate how educational pathways intersect with language, visibility, and professional authority, further impacting how "client" and "patient" are understood and valued within Ontario's healthcare.

Institutional placement decisions reinforce these dynamics. At Algonquin College, massage therapy is the only program in the "School of Wellness, Public Safety, and Community Studies" that prepares students for entry into one of Ontario's regulated health professions (Algonquin College, n.d.). Similarly, the Ontariocolleges.ca website, specifically the "What to Expect From a Career as a Massage Therapist" page, group massage therapy program options with unregulated health professions and non-health professions options (OCAS, n.d.). Given this is the website where all students apply for public college programs in Ontario and may function as an early point of contact for prospective students, these categorizations may contribute to how massage therapy is initially understood and publicly positioned. When grouped with non-health programs or placed outside health studies, massage therapy risks being viewed as peripheral rather than integral to healthcare.

When the factors outlined above are brought together, massage therapy education presents as a site of ongoing discursive negotiation. One of the larger themes that connects with other findings discussed in this chapter is this tension within massage therapy of reflecting both a desire to align with established healthcare norms, and an effort to preserve its own distinct professional discourse (Foucault, 2008, 2003a, 2003b).

6.4 Gendered Patterns and Terminology Use

This section considers gender as an additional analytic lens through which to interpret the patterns in terminology, prestige, and professional positioning identified earlier, rather than as a

standalone explanation. As shown in Chapter 5, the regulatory colleges that used “client” exclusively, or did so alongside “patient”, govern professions whose practitioner populations are predominantly female (CDHO, 2025; CMTO, 2025; CPBAO, 2025; CRPO, 2025; CRTO, 2025). While this pattern does not imply causation, it raises important questions about how gendered norms of care may intersect with terminology choice.

The findings from the regulatory dataset showed women as the majority of practitioners in every profession whose college used “client”, including those that used both “client” and “patient”. As mentioned in the literature, “client” may be associated with models of care that emphasize relationality, empathy, collaboration, and ethical attentiveness - qualities that have historically been feminized within healthcare discourse (Aston, 2016; Henneman, 1995; McIntyre et al., 2020; Petrovskaya, 2022). Several of these qualities were also coded in the documents analyzed such as *empowered client themes* and *serve, care, compassion* (Appendix B, Table B2) Read cautiously, this notion of feminized healthcare aligns with scholarship that links relational and care-oriented practices to professions with limited institutional authority relative to more medicalized fields (Leonard, 2003; Willett & Etowa, 2023).

Notably, gender-focused analyses are unevenly distributed across the health professions literature. One clear exception is nursing, where a substantial body of scholarship examines the profession’s gendered history, including persistent stereotypes of nurses as compassionate, care-oriented, and subservient to physicians within patriarchal medical hierarchies (Bruyneel et al., 2019; Henneman, 1995; Leonard, 2003; McIntyre et al., 2020; Petrovskaya, 2022; Reeves et al., 2008; Rowen, 2010). Importantly, feminist theory and analyses of feminization are explicitly taken up within this literature, rather than avoided (Aston, 2016; Rowen, 2010; Willett & Etowa, 2023). By contrast, similar analyses are largely absent from the literature on other female-majority health professions, including massage therapy, where gender appears as a statistical afterthought, rather than as an analytic category shaping professional identity or authority (Baskwill et al., 2022, 2023b; The College of Massage Therapists of Ontario - Annual Report 2024, n.d.).

The relative absence of gender-based analysis is significant given the health professions that are mostly female are generally not the powerholders within current healthcare hierarchies (Carducci et al., 2022). One possible implication of this is that when gender is treated as incidental, gender-based inequities become easier to overlook (Aston, 2016; Belsey, 1997).

Another is that professions associated with feminized forms of care may struggle to gain recognition as sites of legitimate knowledge and authority, particularly within systems organized around biomedical norms (Brookes et al., 2023; Hartsock, 1990; Leonard, 2003). Gender itself may even function as a site of tension or suspicion. For example, RMTs who self-identify as male have reported experiencing bias against them, as members of a health profession that generally favours female RMTs by those who choose massage therapy as part of their healthcare regime (Baskwill et al, 2018). While a full examination of gender-based inequities lies beyond the scope of this thesis, these dynamics may intersect with massage therapy, gender, the use of "client", and positioning within healthcare.

The case of nursing provides an instructive contrast. As mentioned in Chapter 5, the College of Nurses of Ontario, representing a predominantly female practitioner population, appears to have shifted from "client" to "patient" over time. The timing of "client" disappearing and its replacement with "patient" in Ontario seems to coincide with shifts documented in literature that emphasize progress in the rights and professional autonomy of nurses; the growing prominence of nurse practitioners; increased educational pathways; and expanded scopes of practice that were previously associated exclusively with physicians (Kelly et al., 2023; Government of Ontario, 2024.; Oudshoorn, 2005; Reeves et al., 2008; Rowen, 2010; Selway, 2009). In this context, the discontinuation of "client" appears to accompany, rather than precede, enhanced professional authority. This contrast is useful because the abandonment by Ontario nurses of "client" may inadvertently reinforce marginalization of professions that continue to retain it.

Using poststructuralist approaches to language and power (Chapter 3), these findings suggest that the terms "patient" and "client" may function as a gendered binary that creates a sense of other-ing within healthcare (Belsey & Drakakis, 2002; Butler, 2007). As established in the theoretical framework, this perspective of binaries and other-ing helps frame "patient/client" as a relational pairing through which authority and legitimacy are unevenly distributed in healthcare discourse (Belsey & Drakakis, 2002; Butler, 2007; Demoor & Pieters, 2000). In this binary, "patient" aligns with institutional authority and biomedical legitimacy, while "client" aligns with care-oriented models that have historically been feminized (Aston, 2016; Belsey, 1997; Belsey & Drakakis, 2002; Butler, 2007; Mortenson & Dyck, 2006). These terms do not have fixed meanings; instead, they show how language constantly renegotiates identity (Belsey,

2002b). In the case of massage therapy, the coexistence of "client" in regulatory discourse, and intermittent appearances of "patient" in educational contexts reflects not a resolved shift, but a continuing tension involving gendered valuations of care (McLaughlin, 2009; Mortenson & Dyck, 2006).

6.5 Massage Therapy, Professional Identity, and Public Positioning

This section of the discussion brings together the regulatory, educational, gendered, and professional patterns discussed earlier to examine how terminology contributes to massage therapy's current identity, and public positioning within Ontario's healthcare system. Across the documents analyzed, massage therapy is consistently attached to "client-centred" language. Within the CMTO dataset, this language is entrenched in a strong regulatory discourse of consent, public protection, ethical obligation, and professional accountability. As mentioned in Chapter 5, "client" does not function as a dominant term within regulatory discourse such that its use within massage therapy may position it differently from professions whose discourse matches more consistently with "patient"-centred language. The associations with "client" are not necessarily presented here as deficiencies, but as different discursive choices to the more popular "patient".

It appears that professional inclusion, and public perception are at least partly shaped by these discursive differences. For example, some members of the public may not view massage therapy as part of healthcare, but rather as providing relaxation, or associating it more with wellness or service than with regulated healthcare (Baskwill et al., 2023a; Fournier & Reeves, 2010; Powell, 2023). Additionally, the literature spoke to how massage therapists often feel misunderstood or excluded from the larger healthcare discourse and are rarely included in IPC or IPE (Baskwill et al., 2022, 2023a). Within this context, the choice of "client" may function in seemingly conflicting ways, serving as both a marker of empowerment, and as a source of exclusion (Austin et al., 2021; Baskwill et al., 2020b).

The coexistence of empowerment and exclusion is important here: In one sense, "client" can highlight values such as compassion, partnership, and agency (Corring & Cook, 1999; Costa et al., 2019; Petriwskyj et al., 2014). Conversely, it lacks the institutional familiarity and legitimacy that "patient" continues to hold within mainstream healthcare discourse (Corring & Cook, 1999; Costa et al., 2019). Massage therapy provides a useful example of how this tension may operate in practice. Noted in the literature is how massage therapy is often excluded from

interprofessional education, public funding, and essential health service classifications (Baskwill, 2011; Baskwill et al., 2023a; Fox, 2016; Kania-Richmond et al., 2015). As a result, the use of "client" may support certain models of care, while simultaneously constraining how the profession is perceived within more medicalized settings.

Massage therapy in Ontario appears to face ongoing tensions related to terminology inclusion or exclusion, as well as to its professional positioning and identity. The documents analyzed revealed some commonalities and a few marked differences as detailed in Chapter 5. Beyond the top five ranked themes coded for each set of analyzed documents are others that convey a sense of the values and notions that contribute to identity in massage therapy. The analyzed documents suggest overlap in themes such as "client", "health and healthcare", and "ethics and being ethical" while also revealing uneven emphasis on terms associated with professionalism and interprofessional positioning. Read together, these patterns point to a profession negotiating how it wishes to be understood within healthcare.

The literature is helpful here as far as it supports the interpretation that massage therapy's identity within Ontario's healthcare sphere remains somewhat unsettled and unevenly recognized (Baskwill et al., 2020a, 2022, 2023a, 2023b; Fournier & Reeves, 2010). An example of this from the literature is what occurred during the COVID-19 pandemic. One article describes a similar experience between RMTs in Canada and those in Australia, confirming the tenuous status of massage therapy within the healthcare system (Baskwill et al., 2023a). During the beginning, lockdown-ed days of the pandemic, RMTs were classified by government authorities as non-essential, lumped in with tattoo artists and hairstylists – not recognized as HCPs at all (Baskwill et al., 2023a). This example is useful because it illustrates how massage therapy's already precarious position became more evident under crisis conditions (Baskwill et al., 2023a). The pandemic did not create these tensions, but it did make them more visible. This episode is not presented as evidence that terminology determines policy decisions, but as an instance where existing professional hierarchies became more visible under strain.

Like other regulated health professions in Ontario, massage therapy is regulated under the Regulated Health Professions Act (RHPA) (Regulated Health Professions Act, 1991, S.O. 1991, c. 18, Ontario.Ca, n.d.). Despite this, being formally regulated does not automatically secure equal recognition within the healthcare system as seen in the COVID-19 example. This indicates that regulation alone does not determine professional standing, and that perhaps language

operates alongside education, funding, public perception, and institutional recognition. Together, these factors may shape how massage therapists enter healthcare conversations, advocate for their work, and are regarded within interprofessional settings (Baskwill et al., 2020a; Fournier & Reeves, 2010).

Amanda Baskwill is one of the few researchers (and former RMT) who consistently focuses on massage therapy in Ontario and tends to document "patient" instead of "client" in her work (Baskwill, 2011; Baskwill et al., 2023b). The CMTO uses "client" only, not limited to the documents analyzed, but permeating all areas such as the "STRiVE" program which is a professional development program RMTs are required to complete on an ongoing basis (Strive, n.d.). The volleying between "patient" and "client" is certainly not limited to massage therapy in Ontario and is more apparent still in the documents analyzed for the four regulated health professions with regulatory colleges that include both "patient" and "client". This contrast is important because it indicates that regulatory discourse and scholarly discourse do not always align, even within the same profession.

The contention between "client" and "patient" in massage therapy may reflect competing discourses that run deeper than simply word preference. The CMTO's commitment to "client" aligns with its sense of compassionate care that serves the public, and partnership with the "client" also may imply that the healthcare model is different from health professions that use "patient" (Baskwill et al., 2022; Client-Centred Care (Standard), n.d.). Some educators and practitioners, however, appear to use "patient" in ways that suggest closer alignment with dominant healthcare norms (Baskwill et al., 2022; Powell, 2023). When these patterns are read together, it becomes clear that terminology is part of how massage therapy defines itself and how it is perceived by others.

From a poststructuralist perspective, the concurrent use of "patient" and "client" may point to a professional and educational identity that is not singular, but divided or unsettled (Belsey, 2002b). Here, massage therapy appears to be sifting through competing claims to legitimacy, belonging, and self-definition. Terminology may then be doing more than describing care relationships, becoming part of the ongoing production of professional identity (Belsey, 2002b; Foucault, 2008, 2003a, 2003b). These considerations are of value in terms of massage therapy - it is not as an outlier to be explained away, but instead is a revealing case of how

language, and the professional identity and positioning of a healthcare profession may be deeply entwined.

6.6 Chapter Summary

This chapter interpreted the findings from Chapter 5 using a poststructuralist framework. It focused on how the terms “patient” and “client” relate to questions of power, identity, and professional standing in Ontario healthcare. The discussion began with the more consistent regulatory pattern, where “patient” is used by most regulated health professions in Ontario. It then turned to massage therapy, where “client” remains dominant in regulatory language, even though “patient” also appears in some educational and professional contexts. This difference places massage therapy somewhat outside the more usual pattern seen in most other regulated health professions. The chapter also highlighted education as a key site where competing regulatory and healthcare discourses are negotiated and considered how gender further inflects terminology use and professional positioning.

Language plays a role in how care relationships and professions take shape. For massage therapy, using both “client” and “patient” speaks of a profession still working out how it fits within healthcare. Language is only one influence among many. Regulation, education, institutional recognition, and the healthcare system overall also affect professional standing.

Chapter 7: Conclusion

This final chapter concludes the thesis by briefly considering its methodological limits, the implications of the findings, and possible directions for future research, before returning to the research questions and the potential significance of the study.

7.1 Methodological Reflections and Limitations

This thesis is limited by both the scope of the study design, and the nature of the dataset. As a solo researcher, I was constrained by time, by my positionality and potential biases as an RMT and educator, and by the use of publicly available webpages captured between May and July 2025. Those webpages may not reflect changes made after the period of data collection. The study was also limited to document and webpage analysis and did not include interviews, observations, or other forms of data that may have provided further insight into how "patient" and "client" are understood and used in practice.

For these reasons, this thesis cannot fully account for the full range of meanings attached to these terms, nor can it fully capture the power relations and professional identities at work across Ontario's healthcare system. These limitations are important to acknowledge, particularly where the discussion chapter interprets broader implications from a defined set of texts.

7.2 Implications and Future Directions

Several avenues for future research emerged from this study. These are noted briefly below, as they may help clarify or extend the findings presented here:

- Investigate how gender may intersect with terminology choice in regulated health professions, particularly in professions where females comprise the majority.
- The prevalence of references to sexual abuse within the "RMT Clients" documents of the College of Massage Therapists of Ontario warrants further study. Answering whether the large number of coding occurrences related to sexual misconduct or abuse potentially perpetuate views of massage therapy as having a sexual abuse problem is beyond the scope of this study. This aspect of massage therapy in Ontario was absent in the literature.
- Consider intersectionality and the ways it may present in healthcare language with gender, race, age, and the perspectives of practitioners and educators in health professions education and interprofessional education.

- Examine how people receiving care understand and prefer the terms “patient” and “client,” including the contexts in which those identities may shift.
- Interview RMTs and students about their preferences for “patient” or “client”; how they understand their professional role; how they believe they are perceived by others; and how terminology may relate to identity, legitimacy, and inclusion within healthcare.
- Expand the document set to include a larger sample of regulatory, educational, and professional texts in order to better trace how these terms circulate across contexts.
- Research the experiences of other HCPs that opt for “client” instead of “patient”, or those that seem to be phasing out use of “client” or “patient” or using other alternatives to “patient” and potentially compare with other healthcare jurisdictions in various parts of the world.
- Explore how shifts in healthcare language relate to changing professional roles, and authority within healthcare settings.

Conclusion

This thesis has centred on the meanings of one of the most common words in healthcare – “patient” – and then “client” as one of its potential word-alternatives. It examined how terminology circulates through public-facing institutional documents and how word choice can shape professional identity, perceived legitimacy, and healthcare relationships. A particular focus was placed on massage therapy in Ontario, both as a regulated health profession and as an educational program of study in which “client” remains prominent.

It has endeavoured to respond to the research questions: (1) How do regulatory documents across Ontario’s health professions use the terms “patient” and “client,” and what do these uses reveal about power dynamics, professional identities, and healthcare relationships? and (2) How are “patient” and “client” used in documents from the College of Massage Therapists of Ontario, and in public college program descriptions of massage therapy, and what does this usage suggest about the professional identity and positioning of massage therapy within Ontario’s healthcare system?

In response to Research Question 1, the findings showed that Ontario’s regulatory colleges overwhelmingly rely on “patient” as the dominant public-facing term, with “client” appearing in a clearly bounded minority of professions. Where both terms appeared together (e.g., “Patients & Clients”), terminology was presented as institutionally interchangeable rather

than explicitly defined, reinforcing the sense that meaning is often assumed rather than articulated in regulatory discourse.

In response to Research Question 2, massage therapy presented a more internally differentiated pattern. Within the CMTO public-facing dataset captured for this study, “client” was used consistently and was paired with rights, consent, boundaries, and public protection language. In contrast, publicly available massage therapy education materials and application-facing platforms displayed more mixed usage, including instances where “client” and “patient” appeared within the same page. This variability hints at massage therapy as a profession that is publicly positioned through overlapping vocabularies that draw simultaneously on regulatory “client” discourse, and broader healthcare “patient” norms.

These findings support the central claim of this thesis: terminology is not merely descriptive. In institutional settings, terms such as “patient” and “client” participate in how professions are positioned, how authority is signalled, and how care relationships are framed for the public and for future practitioners. While this thesis does not resolve the “patient/client” debate, it makes visible the discursive tensions through which these terms continue to operate in Ontario’s regulated health professions, and in massage therapy in particular. This study also demonstrates how CDA plus an NVivo audit trail can make document analysis transparent.

As with any qualitative document analysis, the findings are bounded by the captured dataset and by the limits of publicly available texts. The dataset is a fixed snapshot in time, collected May to July 2025. As such, this thesis is unable to address any shifts within healthcare discourse thereafter. Future research could extend this work through interviews with regulators, educators, practitioners, and people receiving care, as well as through analysis of a more extensive range of institutional documents over time. Nevertheless, this study contributes a detailed, data-grounded account of how “patient” and “client” intermingle across regulation and education, and why those choices matter.

References

Accreditation of Massage Therapy Education. (n.d.). Retrieved July 19, 2025, from https://www.cmto.com/wp-content/uploads/2024/09/Accreditation-of-Massage-Therapy-Education-Final.pdf

Acuña Mora, M., Sparud-Lundin, C., Moons, P., & Bratt, E.-L. (2022). Definitions, instruments and correlates of patient empowerment: A descriptive review. *Patient Education and Counseling*, *105*(2), 346–355. https://doi.org/10.1016/j.pec.2021.06.014

Alejandro, A., & Zhao, L. (2024). Multi-method qualitative text and discourse analysis: A methodological framework. *Qualitative Inquiry*, *30*(6), 461–473. https://doi.org/10.1177/10778004231184421

Algonquin College of Applied Arts and. (n.d.). Massage Therapy. *School of Wellness, Public Safety & Community Studies*. Retrieved August 24, 2025, from https://www.algonquincollege.com/wellness-safety-community/program/massage-therapy/

Algonquin College of Applied Arts and, T. (n.d.). *School of Health Studies*. Retrieved August 24, 2025, from https://www.algonquincollege.com/health-studies/

Amending O. Reg. 544/94 (General), O Reg 228/24. https://www.ontario.ca/laws/regulation/r24228

Araujo, C. L., do Carmo, E. A., & Fraga, R. G. (2019). Describing the experience of young researchers in interdisciplinary qualitative research based on critical discourse analysis (CDA) using NVivo®. *Computer Supported Qualitative Research*, 1–11. https://doi.org/10.1007/978-3-030-01406-3_1

Arneja, J. S., & Gilardino, M. S. (2023). What nomenclature should plastic surgeons use for those we treat? *Plastic Surgery*, *31*(2), 113–114. https://doi.org/10.1177/22925503231162007

Aston, M. (2016). Teaching feminist poststructuralism: Founding scholars still relevant today. *Creative Education*, *7*(15), 2251–2267. https://doi.org/10.4236/ce.2016.715220

Aujoulat, I., d'Hoore, W., & Deccache, A. (2007). Patient empowerment in theory and practice: Polysemy or cacophony? *Patient Education and Counseling*, *66*(1), 13–20. https://doi.org/10.1016/j.pec.2006.09.008

Austin, R. R., Lu, S.-C., Geiger-Simpson, E., Ringdahl, D., Pruinelli, L., Lindquist, R., Koithan, M., Monsen, K. A., Kreitzer, M. J., & Delaney, C. W. (2021). Evaluating systemized nomenclature of medicine clinical terms coverage of complementary and integrative health therapy approaches used within integrative nursing, health, and medicine. *CIN: Computers, Informatics, Nursing*, *39*(12), 1000. https://doi.org/10.1097/CIN.0000000000000764

Baskwill, A. (2011). Changing the culture of clinical education in massage therapy. *International Journal of Therapeutic Massage & Bodywork*, *4*(4), 33–36. https://doi.org/10.3822/ijtmb.v4i4.140

Baskwill, A. (2018). Developing capability: Transforming massage therapy education through inquiry-based learning. *International Journal of Therapeutic Massage & Bodywork*, *11*(3), 10–14. https://doi.org/10.3822/ijtmb.v11i3.409

Baskwill, A., Hay, P., Calleri, F., Fiddes, L., Barnett, R., & Fogarty, S. (2023a). The paradox of the impact of the COVID-19 pandemic on massage therapists in Australia and Canada: The reporting of a qualitative strand of a mixed methods study. *Journal of Bodywork and Movement Therapies*, *35*, 371–377. https://doi.org/10.1016/j.jbmt.2023.04.086

Baskwill, A., Sumpton, B., Shipwright, S., Atack, L., & Maher, J. (2020a). A Canadian massage therapy education environmental scan. *International Journal of Therapeutic Massage & Bodywork*, *13*(4), 12. https://pmc.ncbi.nlm.nih.gov/articles/PMC7704042/

Baskwill, A., & Vanstone, M. (2018). "Just don't be creepy": A phenomenological study of the experiences of men in massage therapy. *Journal of Complementary and Integrative Medicine*, *15*(1). https://doi.org/10.1515/jcim-2017-0075

Baskwill, A., Vanstone, M., Harnish, D., & Dore, K. (2020b). "I am a healthcare practitioner": A qualitative exploration of massage therapists' professional identity. *Journal of Complementary & Integrative Medicine*, *17*(2), 21-. https://doi.org/10.1515/jcim-2019-0067

Baskwill, A., Vanstone, M., Harnish, D., & Dore, K. (2022). Identification of common features within massage therapists' professional identity. *Journal of Complementary and Integrative Medicine*, *19*(1), 91–99. https://doi.org/10.1515/jcim-2020-0368

Baskwill, A., Vanstone, M., Harnish, D., & Dore, K. (2023b). Variation determinants within massage therapists' professional identity. *Journal of Complementary and Integrative Medicine*, *20*(2), 464–470. https://doi.org/10.1515/jcim-2021-0255

Belrhiti, Z., Van Belle, S., & Criel, B. (2021). How medical dominance and interprofessional conflicts undermine patient-centred care in hospitals: Historical analysis and multiple embedded case study in Morocco. *BMJ Global Health*, *6*(7), e006140-. https://doi.org/10.1136/bmjgh-2021-006140

Belsey, C. (1997). Feminism and beyond. *Shakespeare Studies*, *25*, 32–41. https://www.proquest.com/docview/222399659/abstract/DBF79E4067AD4893PQ/1

Belsey, C. (2002a). *Critical Practice*. Taylor & Francis Group. http://ebookcentral.proquest.com/lib/ottawa/detail.action?docID=181634

Belsey, C. (2002b). *Poststructuralism: A very short introduction*. Oxford University Press.

Belsey, C., & Drakakis, J. (2002). Chapter 8: Disrupting sexual difference. In *Alternative Shakespeares* (pp. 170–194). Taylor & Francis Ltd / Books. https://login.proxy.bib.uottawa.ca/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ibh&AN=17443224&site=ehost-live

Bennett-Weston, A., Gay, S., & Anderson, E. S. (2023). A theoretical systematic review of patient involvement in health and social care education. *Advances in Health Sciences Education*, *28*(1), 279–304. https://doi.org/10.1007/s10459-022-10137-3

Bird, M., Ouellette, C., Whitmore, C., Li, L., Nair, K., McGillion, M. H., Yost, J., Banfield, L., Campbell, E., & Carroll, S. L. (2020). Preparing for patient partnership: A scoping review of patient partner engagement and evaluation in research. *Health Expectations*, *23*(3), 523–539. https://doi.org/10.1111/hex.13040

Bloor, M. (with Bloor, T.). (2013). *The practice of critical discourse analysis: An introduction*. Routledge, Taylor & Francis Group. https://doi.org/10.4324/9780203775660

Bloor, M., & Wood, F. (2006). *Keywords in qualitative methods: A vocabulary of research concepts*. SAGE Publications, Limited. http://ebookcentral.proquest.com/lib/ottawa/detail.action?docID=334442

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal*, *9*(2), 27–40. https://doi.org/10.3316/QRJ0902027

Bravo, P., Edwards, A., Barr, P. J., Scholl, I., Elwyn, G., McAllister, M., & the Cochrane Healthcare Quality Research Group, C. U. (2015). Conceptualising patient empowerment: A mixed methods study. *BMC Health Services Research*, *15*(1), 252. https://doi.org/10.1186/s12913-015-0907-z

Brookes, G., Harvey, K., & Adolphs, S. (2023). Discourse and health(care). In *The Routledge Handbook of Discourse Analysis* (2nd ed.). Routledge.

Bruyneel, L., Lesaffre, E., Meuleman, B., & Sermeus, W. (2019). Power distance and physician–nurse collegial relations across 14 European countries: National culture is not merely a nuisance factor in international comparative research. *Journal of Nursing Scholarship*, *51*(6), 708–716. https://doi.org/10.1111/jnu.12514

Burnham, J. C. (2012). The death of the sick role. *Social History of Medicine : The Journal of the Society for the Social History of Medicine*, *25*(4), 761–776. https://doi.org/10.1093/shm/hks018

Butler, J. (2007). Subjects of sex/gender/desire. In *Gender Trouble* (1st ed., pp. 1–46). Routledge. https://doi.org/10.4324/9780203824979-3

Cahn, P. S. (2017). Seven dirty words: Hot button language that undermines interprofessional education and practice. *Academic Medicine*, *92*(8), 1086–1090. https://doi.org/10.1097/ACM.0000000000001469

Carducci, B., Keats, E. C., Amri, M., Plamondon, K. M., Shoveller, J., Ako, O., Osler, F. G., Henry, C., Pai, N. P., & Ruggiero, E. D. (2022). Prioritizing gender equity and intersectionality in Canadian global health institutions and partnerships. *PLOS Global Public Health*, *2*(10), e0001105. https://doi.org/10.1371/journal.pgph.0001105

Caslpo—College of audiologists and speech-language pathologists of Ontario. (n.d.). Retrieved May 15, 2025, from https://www.caslpo.com/

Catalano, T., & Waugh, L. R. (2020). *Critical Discourse Analysis, Critical Discourse Studies and Beyond* (Vol. 26). Springer International Publishing. https://doi.org/10.1007/978-3-030-49379-0

CDHO – College of Dental Hygienists of Ontario. (n.d.). Retrieved May 13, 2025, from https://cdho.org/

Centennial College—Massage Therapy. (n.d.). Retrieved July 20, 2025, from http://www.centennialcollege.ca

Cheng, P. T. M., & Towle, A. (2017). How patient educators help students to learn: An exploratory study. *Medical Teacher*, *39*(3), 308–314. https://doi.org/10.1080/0142159X.2017.1270426

Christianson, C. E., McBride, R. B., Vari, R. C., Olson, L., & Wilson, H. D. (2007). From traditional to patient-centered learning: Curriculum change as an intervention for changing institutional culture and promoting professionalism in undergraduate medical education: *Academic Medicine*, *82*(11), 1079–1088. https://doi.org/10.1097/ACM.0b013e3181574a62

Christmas, D. M. B., & Sweeney, A. (2016). Service user, patient, survivor or client … has the time come to return to 'patient'? *British Journal of Psychiatry*, *209*(1), 9–13. https://doi.org/10.1192/bjp.bp.115.167221

Client-centred Care (Standard). (n.d.). Retrieved July 20, 2025, from https://www.cmto.com/rules/client-centred-care/

CMLTO. (n.d.). Retrieved May 13, 2025, from https://www.cmlto.com/

CMRITO Portal. (n.d.). Retrieved November 17, 2024, from https://www.cmrito.org/

Cohen Konrad, S., Fletcher, S., Hood, R., & Patel, K. (2019). Theories of power in interprofessional research—Developing the field. *Journal of Interprofessional Care*, *33*(5), 401–405. https://doi.org/10.1080/13561820.2019.1669544

College of Chiropractors of Ontario. (n.d.). Retrieved November 17, 2024, from https://cco.on.ca/

College of Dental Technologists of Ontario. (n.d.). Retrieved May 13, 2025, from https://cdto.ca/

College of Denturists of Ontario. (n.d.). Retrieved November 17, 2024, from https://denturists-cdo.com/

College of Homeopaths of Ontario. (n.d.). Retrieved July 2, 2025, from http://collegeofhomeopaths.com/

College of Kinesiologists of Ontario. (n.d.). Retrieved November 17, 2024, from https://www.coko.ca/

College of Midwives of Ontario. (n.d.). Retrieved May 24, 2025, from https://cmo.on.ca/

College of Naturopaths Of Ontario (n.d.). Retrieved November 17, 2024, from https://www.collegeofnaturopaths.on.ca/

College of Occupational Therapists of Ontario (COTO). (n.d.). College of Occupational Therapists of Ontario (COTO). Retrieved May 13, 2025, from https://www.coto.org/

College of Optometrists of Ontario. Retrieved November 17, 2024, from https://collegeoptom.on.ca

College of Physiotherapists of Ontario, Physiotherapy Ontario. (n.d.). College of Physiotherapists of Ontario. Retrieved May 17, 2025, from https://www.collegept.org/

Corring, D., & Cook, J. (1999). Client-centred care means that I am a valued human being. *Canadian Journal of Occupational Therapy (1939)*, *66*(2), 71–82. https://doi.org/10.1177/000841749906600203

Costa, D. S. J., Mercieca-Bebber, R., Tesson, S., Seidler, Z., & Lopez, A.-L. (2019). Patient, client, consumer, survivor or other alternatives? A scoping review of preferred terms for labelling individuals who access healthcare across settings. *BMJ Open*, *9*(3), e025166. https://doi.org/10.1136/bmjopen-2018-025166

CPBAO Public – Regulating Psychology and Applied Behaviour Analysis in Ontario. (n.d.). Retrieved July 24, 2025, from https://cpbao.ca/

CPSO - Home. (n.d.). Retrieved July 2, 2025, from https://www.cpso.on.ca/

CRPO - Home Page. (n.d.). *College of Registered Psychotherapists of Ontario*. Retrieved November 17, 2024, from https://crpo.ca/

CRTO. (n.d.). Retrieved May 24, 2025, from https://www.crto.on.ca/

CTCMPAO Website. (n.d.). Retrieved December 17, 2024, from https://www.ctcmpao.on.ca/

D'amour, D., & Oandasan, I. (2005). Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept. *Journal of Interprofessional Care*, *19*(S1), 8–20. https://doi.org/10.1080/13561820500081604

Davidson, J. (n.d.). *Sage Research Methods—The SAGE Encyclopedia of Educational Research, Measurement, and Evaluation—NVivo*. Retrieved April 13, 2025, from https://methods.sagepub.com/ency/edvol/sage-encyclopedia-of-educational-research-measurement-evaluation/chpt/nvivo

Davis, B. & McMurtry, A. (2025). *Inventions of teaching: A genealogy* (Second edition.). Routledge. https://doi.org/10.4324/9781003493440

Deber, R. B., Kraetschmer, N., Urowitz, S., & Sharpe, N. (2005). Patient, consumer, client, or customer: What do people want to be called? *Health Expectations*, *8*(4), 345–351. https://doi.org/10.1111/j.1369-7625.2005.00352.x

Demoor, M., & Pieters, J. (2000). Discursive Desire: Catherine Belsey's feminism. *Feminist Review*, *66*(1), 25–45. https://doi.org/10.1080/014177800440220

Devillers, L., Subts, A., De Bandt, D., Druais, P.-L., & Gilles de la Londe, J. (2023). Patients' experiences of being touched by their general practitioner: A qualitative study. *BMJ Open*, *13*(7), e071701–e071701. https://doi.org/10.1136/bmjopen-2023-071701

Documents and Publications · CTCMPAO Website. (n.d.). Retrieved September 16, 2023, from https://www.ctcmpao.on.ca/resources/forms-and-documents/

Dowling, M., Murphy, K., Cooney, A., & Casey, D. (2011). A concept analysis of empowerment in chronic illness from the perspective of the nurse and the client living with chronic obstructive pulmonary disease. *Journal of Nursing and Healthcare of Chronic Illness*, *3*(4), 476–487. https://doi.org/10.1111/j.1752-9824.2011.01123.x

Engel, J., Prentice, D., & Hicks, R. (2019). Where does the patient fit? An analysis of word use within the context of interprofessional collaborative care. *Global Qualitative Nursing Research*, *6*, 2333393619889353. https://doi.org/10.1177/2333393619889353

Fage-Butler, A. (2021). Poststructuralist discourse analysis: Investigating representations of knowledge and knowledge-related subjectivities in an online forum on HPV vaccination. In G. Brookes & D. Hunt (Eds.), *Analysing Health Communication* (pp. 161–188). Springer International Publishing. https://doi.org/10.1007/978-3-030-68184-5_7

Fairclough, N. (2010). Language and discourse*. In *Language in Use*. Routledge.

Fairclough, N. (2013). Critical discourse analysis and critical policy studies. *Critical Policy Studies*, *7*(2), 177–197. https://doi.org/10.1080/19460171.2013.798239

Fairclough, N. (2014). *Critical Language Awareness*. Routledge. https://doi.org/10.4324/9781315845661

Fairclough, N. (2023). Critical discourse analysis. In *The Routledge Handbook of Discourse Analysis* (2nd ed.). Routledge.

Find a Midwife | AOM. (n.d.). Retrieved August 24, 2025, from https://www.ontariomidwives.ca/find-midwife

Flores-Sandoval, C., Sibbald, S., Ryan, B. L., & Orange, J. B. (2021). Healthcare teams and patient-related terminology: A review of concepts and uses. *Scandinavian Journal of Caring Sciences*, *35*(1), 55–66. https://doi.org/10.1111/scs.12843

Foucault, M. (2004). The crisis of medicine or the crisis of antimedicine? *Foucault Studies*, *1*, 5–19. https://doi.org/10.22439/fs.v0i1.562

Foucault, M. (2008). Power/knowledge. In *The New Social Theory Reader* (2nd ed.). Routledge.

Foucault, M. (2013). *Archaeology of Knowledge* (2nd ed.). Routledge. https://doi.org/10.4324/9780203604168

Foucault, M. (with Bertani, M., Fontana, A., & Macey, D.). (2003a). *"Society must be defended": Lectures at the Collège de France, 1975-76* (1st Picador pbk. ed.). Picador.

Foucault, M. (with Sheridan, A.). (2003b). *The birth of the clinic: An archaeology of medical perception*. Routledge. https://doi.org/10.4324/9780203715109

Fournier, C., & Reeves, S. (2010). The nature of collaboration and professional status within an interprofessional context: A view of massage therapy. *European Journal of Integrative Medicine*, *2*, 263–263. https://doi.org/10.1016/j.eujim.2010.09.193

Fox, N. J. (2016). Health sociology from post-structuralism to the new materialisms. *Health*, *20*(1), 62–74. https://doi.org/10.1177/1363459315615393

Gee, J. P. (2004). *An introduction to discourse analysis: Theory and method* (2nd ed.). Routledge. https://doi.org/10.4324/9780203005675

Gee, J. P., & Handford, M. (2023). Introduction. In *The Routledge handbook of discourse analysis* (2nd ed.). Routledge.

Georgian College. (n.d.). Retrieved July 20, 2025, from https://www.georgiancollege.ca/academics/programs/massage-therapy/

Government of Canada, C. I. of H. R. (2014, July 2). *Strategy for patient-oriented research—patient engagement framework—CIHR*. https://cihr-irsc.gc.ca/e/48413.html#a4

Government of Ontario, M. of H. and L.-T. C. (n.d.). *Regulated health professions—Health Workforce Planning Branch—Health Care Professionals—MOHLTC*. Government of Ontario, Ministry of Health and Long-Term Care. Retrieved September 16, 2023, from https://www.health.gov.on.ca/en/pro/programs/hhrsd/about/regulated_professions.aspx

Hall, K. & Nel, D. (2007). Attention to language: An interview with Catherine Belsey. *Limina: A Journal of Historical and Cultural Studies*, *13*(1), 1–9. https://doaj.org/article/40442d9f152a45e2a7474d876fc6a7e6

Handford, M., & Gee, J. P. (2023). *The Routledge handbook of discourse analysis* (2nd ed.). Routledge.

Hansen, E., Walters, J., & Howes, F. (2016). Whole person care, patient-centred care and clinical practice guidelines in general practice. *Health Sociology Review*, *25*(2), 157–170. https://doi.org/10.1080/14461242.2016.1170625

Hartsock, N. (1990). Foucault on power: A theory for women? In *Feminism/Postmodernism*. Routledge.

Hearn, J., Dewji, M., Stocker, C., & Simons, G. (2019). Patient-centered medical education: A proposed definition. *Medical Teacher*, *41*(8), 934–938. https://doi.org/10.1080/0142159X.2019.1597258

Hebdon, M., Foli, K., & McComb, S. (2015). Survivor in the cancer context: A concept analysis. *Journal of Advanced Nursing*, *71*(8), 1774–1786. https://doi.org/10.1111/jan.12646

Henneman, E. A. (1995). Nurse-physician collaboration: A poststructuralist view. *Journal of Advanced Nursing*, *22*(2), 359–363. https://doi.org/10.1046/j.1365-2648.1995.22020359.x

Henriksen, A.-H., & Ringsted, C. (2014). Medical students' learning from patient-led teaching: Experiential versus biomedical knowledge. *Advances in Health Sciences Education*, *19*(1), 7–17. https://doi.org/10.1007/s10459-013-9454-8

Herxheimer, A., & Goodare, H. (1999). Who are you, and who are we? Looking through some key words. *Health Expectations*, *2*(1), 3–6. https://doi.org/10.1046/j.1369-6513.1999.00034.x

Home. (n.d.). Retrieved May 15, 2025, from https://www.cmto.com/

Home. (n.d.). College of Dietitians. Retrieved November 17, 2024, from https://collegeofdietitians.org/

Home—CRTO. (n.d.). Retrieved August 24, 2025, from https://www.crto.on.ca/

Homepage. (n.d.). College of Chiropodists of Ontario. Retrieved June 2, 2025, from https://cocoo.on.ca/

Home—The College of Opticians of Ontario—COO. (n.d.). Retrieved November 17, 2024, from https://www.coptont.org/

Hoyt, M. F. (1979). "Patient" or "client": What's in a name? *Psychotherapy (Chicago, Ill.)*, *16*(1), 46–47. https://doi.org/10.1037/h0085873

Hull, M. (2016). Medical language proficiency: A discussion of interprofessional language competencies and potential for patient risk. *International Journal of Nursing Studies*, *54*, 158–172. https://doi.org/10.1016/j.ijnurstu.2015.02.015

Hunter, J., Majd, I., Kowalski, M., & Harnett, J. E. (2021). Interprofessional communication—A call for more education to ensure cultural competency in the context of traditional, complementary, and integrative medicine. *Global Advances in Health and Medicine*, *10*, 21649561211014107. https://doi.org/10.1177/21649561211014107

Jonas, W. B., & Rosenbaum, E. (2021). The case for whole person integrative care. *Medicina*, *57*(7), Article 7. https://doi.org/10.3390/medicina57070677

Kangasjarvi, E., Forsey, J., Simpson, J. S., & Ng, S. L. (2023). "We're back in control of the story and we're not letting anyone take that away from us": Patient teacher programs as means for patient emancipation. *Advances in Health Sciences Education*. https://doi.org/10.1007/s10459-023-10255-6

Kania-Richmond, A., Reece, B. F., Suter, E., & Verhoef, M. J. (2015). The professional role of massage therapists in patient care in Canadian urban hospitals – a mixed methods study. *BMC Complementary and Alternative Medicine*, *15*(1), 20. https://doi.org/10.1186/s12906-015-0536-4

Kelly, D., Horseman, Z., Strachan, F. E., Hamilton, S., Jones, A., Holloway, A., Rafferty, A. M., Noble, H., Reid, J., Harris, R., & Smith, P. (2023). Strengthening the role of the executive nurse director: A qualitative interview study. *Journal of Advanced Nursing*, *79*(10), 3809–3823. https://doi.org/10.1111/jan.15699

Kramer, R. (1995). The birth of client-centered therapy: Carl Rogers, Otto Rank, and "The Beyond." *Journal of Humanistic Psychology*, *35*(4), 54–110. https://doi.org/10.1177/00221678950354005

Kumagai, A. K., Murphy, E. A., & Ross, P. T. (2009). Diabetes stories: Use of patient narratives of diabetes to teach patient-centered care. *Advances in Health Sciences Education*, *14*(3), 315–326. https://doi.org/10.1007/s10459-008-9123-5

Lawrence, C. (2008). Patient. *The Lancet*, *371*(9606), 21. https://doi.org/10.1016/S0140-6736(08)60055-0

Leidner, C., Vennedey, V., Hillen, H., Ansmann, L., Stock, S., Kuntz, L., Pfaff, H., Hower, K. I., Albus, C., Ansmann, L., Jessen, F., Karbach, U., Kuntz, L., Pfaff, H., Rietz, C., Schubert, I., Schulz-Nieswandt, F., Stock, S., Strupp, J., & Voltz, R. (2021). Implementation of patient-centred care: Which system-level determinants matter from a decision maker's perspective? Results from a qualitative interview study across various health and social care organisations. *BMJ Open*, *11*(9), e050054-. https://doi.org/10.1136/bmjopen-2021-050054

Leonard, P. (2003). "Playing" doctors and nurses? Competing discourses of gender, power and identity in the British National Health Service. *The Sociological Review (Keele)*, *51*(2), 218–237. https://doi.org/10.1111/1467-954X.00416

Lynch, R. A. (2016). *Foucault's critical ethics*. Fordham University Press. https://muse.jhu.edu/pub/93/monograph/book/46468

Machi, L. A., & McEvoy, B. T. (2016). *The literature review: Six steps to success*. Corwin. https://doi.org/10.4135/9781071939031

Maclaran, P., & Stevens, L. (2019). *Chapter 10: Thinking through feminist theorising: poststructuralist feminism, ecofeminism and intersectionality*. https://www.elgaronline.com/edcollchap/edcoll/9781788115377/9781788115377.00015.xml

MacLeod, A., Ellaway, R. H., & Cleland, J. (2024). A meta-study analysing the discourses of discourse analysis in health professions education. *Medical Education*, *58*(9), 1058–1070. https://doi.org/10.1111/medu.15309

Martin, A. K., Green, T. L., McCarthy, A. L., Sowa, P. M., & Laakso, E.-L. (2022). Healthcare teams: Terminology, confusion, and ramifications. *Journal of Multidisciplinary Healthcare*, *15*, 765–772. https://doi.org/10.2147/JMDH.S342197

Massage. (n.d.). Ontariocolleges.ca. Retrieved July 24, 2025, from https://www.ontariocolleges.ca/en/programs/health-food-and-medical/massage

Massage Therapy. (n.d.). Cambrian College. Retrieved July 20, 2025, from https://cambriancollege.ca/programs/massage-therapy/

Massage Therapy Act, 1991, SO 1991, c 27. https://www.ontario.ca/laws/statute/91m27

Massage Therapy Full-time Ontario College Advanced Diploma. (n.d.). Retrieved July 20, 2025, from https://www.conestogac.on.ca/fulltime/massage-therapy

Massage Therapy Registered Massage Therapist Courses Durham College. (n.d.). Retrieved July 20, 2025, from https://durhamcollege.ca/programs/massage-therapy

Massage Therapy (Accelerated) Fanshawe College. (2015, August 4). https://www.fanshawec.ca/programs/msg2-massage-therapy-accelerated/next

Massage Therapy: Fleming College. (n.d.). Retrieved July 21, 2025, from https://flemingcollege.ca/programs/massage-therapy

Massage Therapy Program Niagara College. (n.d.). *School of Allied Health*. Retrieved July 19, 2025, from https://www.niagaracollege.ca/alliedhealth/program/massage-therapy/

Massage Therapy Mohawk College. (n.d.). Retrieved July 20, 2025, from https://www.mohawkcollege.ca/programs/community-services/massage-therapy-469

Massage Therapy—Loyalist College. (n.d.). Retrieved July 19, 2025, from https://loyalistcollege.com/program/massage-therapy/

Massothérapie. (n.d.). *Collège Boréal*. Retrieved July 20, 2025, from https://collegeboreal.ca/programme/massotherapie/

Massé, J., Grignon, S., Vigneault, L., Olivier-D'Avignon, G., & Tremblay, M.-C. (2024). Patients' perspectives on their motivations for participating in non-clinical medical teaching and what they gain from their experience: A qualitative study informed by critical theory. *Advances in Health Sciences Education*, *29*(1), 217–243. https://doi.org/10.1007/s10459-023-10262-7

Mcguire-Snieckus, R., Mccabe, R., & Priebe, S. (2003). Patient, client or service user? A survey of patient preferences of dress and address of six mental health professions. *Psychiatric Bulletin*, *27*(8), 305–308. https://doi.org/10.1192/pb.27.8.305

McIntyre, J. R. S., Burton, C., & Holmes, D. (2020). From discipline to control in nursing practice: A poststructuralist reflection. *Nursing Philosophy*, *21*(4), e12317. https://doi.org/10.1111/nup.12317

McLaughlin, H. (2009). What's in a name: 'Client', 'patient', 'customer', 'consumer', 'expert by experience', 'service user'—what's next? *The British Journal of Social Work*, *39*(6), 1101–1117. https://doi.org/10.1093/bjsw/bcm155

Mead, N., & Bower, P. (2000). Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine*, *51*(7), 1087–1110. https://doi.org/10.1016/S0277-9536(00)00098-8

Metersky, K., Axenciuc, R., Mitchell, E., & Nyathi, S. (2022a). The need for clarification of terminology and labels in interprofessional care: A commentary. *International Health Trends and Perspectives*, *2*(1), 80–87. https://doi.org/10.32920/ihtp.v2i1.1627

Metersky, K., Orchard, C., Adams, T., & Hurlock-Chorostecki, C. (2022b). Patient roles in primary care interprofessional teams: A constructivist grounded theory of patient and health care provider perspectives. *Journal of Interprofessional Care*, *36*(2), 177–185. https://doi.org/10.1080/13561820.2021.1892616

Molina-Mula, J. (2021). Grounded theory qualitative approach from Foucault's ethical perspective: Deconstruction of patient self-determination in the clinical setting. *World Journal of Clinical Cases*, *9*(28), 8312–8326. https://doi.org/10.12998/wjcc.v9.i28.8312

Monrouxe, L. V. (2010). Identity, identification and medical education: why should we care? *Medical Education*, *44*(1), 40–49. https://doi.org/10.1111/j.13652923.2009.03440.x

Morgan, H. (2022). Conducting a qualitative document analysis. *The Qualitative Report*, *27*(1), 64–78. https://doi.org/10.46743/2160-3715/2022.5044

Mortenson, W. B., & Dyck, I. (2006). Power and client-centred practice: An insider exploration of occupational therapists' experiences. *Canadian Journal of Occupational Therapy*, *73*(5), 261–271. https://doi.org/10.2182/cjot.06.008

Moulin de Souza, E., & Parker, M. (2022). Practices of freedom and the disruption of binary genders: Thinking with trans. *Organization*, *29*(1), 67–82. https://doi.org/10.1177/1350508420935602

Naidu, J., Paolucci, E. O., & Turin, T. C. (2023). A critical lens on health: Key principles of critical discourse analysis and its benefits to anti-racism in population public health research. *Societies*, *13*(2), NA-NA. https://doi.org/10.3390/soc13020042

Naseem, A., Balon, R., & Khan, S. (2001). Customer, client, consumer, recipient, or patient. *Annals of Clinical Psychiatry*, *13*(4), 239–240. https://doi.org/10.3109/10401230109147388

Neuberger, J., & Tallis, R. (1999). Do we need a new word for patients? Let's do away with patients; Commentary: Leave well alone. *BMJ Open*, *318*(7200), 1756–1758. https://ocul-uo.primo.exlibrisgroup.com

Nguyen, J., Hunter, J., Smith, L., Forth, A., Tyler, A., Furney, L., Ee, C., & Harnett, J. E. (2021). Can we all speak the same 'language' for our patients' sake? Feedback on interprofessional communication and related resources. *Global Advances in Health and Medicine*, *10*, 2164956121992338. https://doi.org/10.1177/2164956121992338

Oben, P. (2020). Understanding the patient experience: A conceptual framework. *Journal of Patient Experience*, *7*(6), 906–910. https://doi.org/10.1177/2374373520951672

OCPInfo.Com. Retrieved November 17, 2024, from https://www.ocpinfo.com/

Occupational therapists, CIHI. (n.d.). Retrieved July 4, 2025, from https://www.cihi.ca/en/occupational-therapists

Officer, T. N., & McBride-Henry, K. (2021). Perceptions of underlying practice hierarchies: Who is managing my care? *BMC Health Services Research*, *21*(1), 1–11. https://doi.org/10.1186/s12913-021-06931-1

Ontario colleges, ontario.ca. (n.d.). Retrieved April 26, 2025, from http://www.ontario.ca/page/ontario-colleges

Ontario expanding the role of nurse practitioners and registered nurses. (n.d.). News.Ontario.Ca. Retrieved August 24, 2025, from https://news.ontario.ca/en/release/1005415/ontario-expanding-the-role-of-nurse-practitioners-and-registered-nurses

Oudshoorn, A. (2005). Power and empowerment: Critical concepts in the nurse–client relationship. *Contemporary Nurse*. https://doi.org/10.5172/conu.20.1.57

Our Accreditation Process. (n.d.). CMTCA Website. Retrieved August 25, 2025, from https://www.cmtca.ca/ouraccreditationprocess

Petriwskyj, A., Gibson, A., & Webby, G. (2014). Participation and power in care: Exploring the "client" in client engagement. *Journal of Aging Studies*, *31*, 119–131. https://doi.org/10.1016/j.jaging.2014.09.007

Petrovskaya, O. (2022). *Nursing theory, postmodernism, post-structuralism, and Foucault*. Routledge. https://doi.org/10.4324/9781003194439

Powell, J. (2023). New perspectives: Foucault and applicability to health and social care. In *New Perspectives on Health and Social Care* (pp. 19–37). Springer, Cham. https://doi.org/10.1007/978-3-031-25432-1_2

Reeder, L. G. (1972). The patient-client as a consumer: Some observations on the changing professional-client relationship. *Journal of Health and Social Behavior*, *13*(4), 406–412. https://doi.org/10.2307/2136833

Reeves, S., Nelson, S., & Zwarenstein, M. (2008). The doctor-nurse game in the age of interprofessional care: A view from Canada. *Nursing Inquiry*, *15*(1), 1–2. https://doi.org/10.1111/j.1440-1800.2008.00396.x

Regulated health professions, ontario.ca. (n.d.). Retrieved October 11, 2024, from http://www.ontario.ca/page/regulated-health-professions

Regulated Health Professions Act, 1991, S.O. 1991, c. 18, ontario.ca. (n.d.). Retrieved August 25, 2025, from https://www.ontario.ca/laws/statute/91r18

Request for proposal to modernize Canadian massage therapy competency profile. (n.d.). Retrieved August 25, 2025, from https://www.fomtrac.ca/modernization-of-rmt-competencies/

Ripat, J., Wener, P., Dobinson, K., & Yamamoto, C. (2014). Internalizing client-centredness in occupational therapy students. *Journal of Research in Interprofessional Practice & Education*, *4*(2), 1–12. https://doi.org/10.22230/jripe.2014v4n2a173

Ristić, A. J., Zaharijević, A., & Miličić, N. (2021). Foucault's concept of clinical gaze today. *Health Care Analysis*, *29*(2), 99–112. https://doi.org/10.1007/s10728-020-00402-0

RMT Clients. (n.d.). Retrieved May 16, 2025, from https://www.cmto.com/rmt-clients/

Roberti di Sarsina, P., & Tassinari, M. (2015). Person-centred healthcare and medicine paradigm: It's time to clarify. *The EPMA Journal*, *6*(1). https://doi.org/10.1186/s13167-015-0033-3

Robinson, J. H., Callister, L. C., Berry, J. A., & Dearing, K. A. (2008). Patient-centered care and adherence: Definitions and applications to improve outcomes. *Journal of the American Association of Nurse Practitioners*, *20*(12), 600. https://journals.lww.com/jaanp/abstract/2008/12000/patient_centered_care_and_adherence__definitions.4.aspx

Rowen, L. (2010). The medical team model, the feminization of medicine, and the nurse's role. *AMA Journal of Ethics*, *12*(1), 46–51. https://doi.org/10.1001/virtualmentor.2010.12.1.oped1-1001

Rowland, P., & Kumagai, A. K. (2018). Dilemmas of Representation: Patient engagement in health professions education. *Academic Medicine*, *93*(6), 869. https://doi.org/10.1097/ACM.0000000000001971

Royal College of Dental Surgeons of Ontario (n.d.). Retrieved June 2, 2025, from https://www.rcdso.org/

Saito, D. Y. T., Zoboli, E. L. C. P., Schveitzer, M. C., & Maeda, S. T. (2013). User, client or patient?: Which term is more frequently used by nursing students? *Texto & Contexto - Enfermagem*, *22*, 175–183. https://doi.org/10.1590/S0104-07072013000100021

Saldana, J. (2009). *Coding manual for qualitative researchers*. SAGE Publications. http://ebookcentral.proquest.com/lib/ottawa/detail.action?docID=585421

Santana, M. J., Manalili, K., Jolley, R. J., Zelinsky, S., Quan, H., & Lu, M. (2018). How to practice person-centred care: A conceptual framework. *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, *21*(2), 429–440. https://doi.org/10.1111/hex.12640

Sawatsky, A. P., & Monrouxe, L. V. (2023). When I say … Identity. *Medical Education*, *57*(4), 303–304. https://doi.org/10.1111/medu.15027

Scholl, I., Zill, J. M., Härter, M., & Dirmaier, J. (2014). An integrative model of patient-centeredness – a systematic review and concept analysis. *PLOS ONE*, *9*(9), e107828. https://doi.org/10.1371/journal.pone.0107828

Selway, J. (2009). Should doctorally prepared NPs use the title "doctor" in clinical settings? *Journal for Nurse Practitioners*, *5*(5), 350–351. https://doi.org/10.1016/j.nurpra.2009.03.007

Sheehan, D., Robertson, L., & Ormond, T. (2007). Comparison of language used and patterns of communication in interprofessional and multidisciplinary teams. *Journal of Interprofessional Care*, *21*(1), 17–30. https://doi.org/10.1080/13561820601025336

Shevell, M. I. (2009). What do we call "them"?: The "patient" versus "client" dichotomy. *Developmental Medicine and Child Neurology*, *51*(10), 770–772. https://www.proquest.com/docview/195605090/citation/28036DCD42A04048PQ/1

Shutzberg, M. (2021). The doctor as parent, partner, provider… or comrade? Distribution of power in past and present models of the doctor–patient relationship. *Health Care Analysis*, *29*(3), 231–248. https://doi.org/10.1007/s10728-021-00432-2

Simmons, P., Hawley, C. J., Gale, T. M., & Sivakumaran, T. (2010). Service user, patient, client, user or survivor: Describing recipients of mental health services. *The Psychiatrist*, *34*(1), 20–23. https://doi.org/10.1192/pb.bp.109.025247

Skyberg, H., & Jenssen, D. (2024). What professionals say and do: The tension between egalitarianism and hierarchy in interprofessional teamwork. *Journal of Interprofessional Care*, *38*(2), 200–208. https://doi.org/10.1080/13561820.2023.2289512

Sluzki, C. E. (2000). Patients, clients, consumers: The politics of words. *Families, Systems & Health*, *18*(3), 347–347. https://go.gale.com/ps/i.do?p=AONE&sw=w&issn=10917527&v=2.1&it=r&id=GALE%7CA66881870&sid=googleScholar&linkaccess=abs

Smith, J. M., Sullivan, S. J., & Baxter, G. D. (2009). The culture of massage therapy: Valued elements and the role of comfort, contact, connection and caring. *Complementary Therapies in Medicine*, *17*(4), 181–189. https://doi.org/10.1016/j.ctim.2009.05.003

Soon, Y. E., Murray, C. M., Aguilar, A., & Boshoff, K. (2020). Consumer involvement in university education programs in the nursing, midwifery, and allied health professions: A systematic scoping review. *International Journal of Nursing Studies*, *109*, 103619–103619. https://doi.org/10.1016/j.ijnurstu.2020.103619

Spadafora, P., & Tsotsos, L. E. (2016). Canada. In B. Findsen & M. Formosa (Eds.), *International Perspectives on Older Adult Education* (pp. 75–86). Springer International Publishing. https://doi.org/10.1007/978-3-319-24939-1_7

Stewart, M. (2001). Towards a global definition of patient centred care: The patient should be the judge of patient centred care. *BMJ*, *322*(7284), 444–445. https://doi.org/10.1136/bmj.322.7284.444

Strive. (n.d.). Retrieved August 25, 2025, from https://www.cmto.com/rmts/quality-assurance-program/strive/

Suijker, C. A. (2023). Foucault and medicine: Challenging normative claims. *Medicine, Health Care and Philosophy*, *26*(4), 539–548. https://doi.org/10.1007/s11019-023-10170-y

Sumsion, T. (2000). A revised occupational therapy definition of client-centred practice. *British Journal of Occupational Therapy*, *63*(7), 304–309. https://doi.org/10.1177/030802260006300702

Susilo, A. P., Riskiyana, R., Lestari, E., & Yanti. (2022). Interprofessional collaboration and education in the hierarchical and collectivistic culture. In *Challenges and Opportunities in Health Professions Education* (pp. 245–265). Springer, Singapore. https://doi.org/10.1007/978-981-16-7232-3_11

The Application Service for Ontario's Public Colleges. (n.d.). Ontariocolleges.Ca. Retrieved July 24, 2025, from https://www.ontariocolleges.ca/en

The College of Massage Therapists of Ontario—Annual Report 2024. (n.d.).

The College of Occupational Therapists of Ontario (COTO). (n.d.). Retrieved August 24, 2025, from https://www.coto.org/

Timmermans, S. (2020). The engaged patient: The relevance of patient–physician communication for twenty-first-century health. *Journal of Health and Social Behavior*, *61*(3), 259–273. https://doi.org/10.1177/0022146520943514

Towle, A., Bainbridge, L., Godolphin, W., Katz, A., Kline, C., Lown, B., Madularu, I., Solomon, P., & Thistlethwaite, J. (2010). Active patient involvement in the education of health professionals: Medical Education. *Medical Education*, *44*(1), 64–74. https://doi.org/10.1111/j.1365-2923.2009.03530.x

Towle, A., Brown, H., Hofley, C., Kerston, R. P., Lyons, H., & Walsh, C. (2014). The expert patient as teacher: An interprofessional Health Mentors programme: Clinical Teacher. *Clinical Teacher*, *11*(4), 301–306. https://doi.org/10.1111/tct.12222

Towle, A., Farrell, C., Gaines, M. E., Godolphin, W., John, G., Kline, C., Lown, B., Morris, P., Symons, J., & Thistlethwaite, J. (2016). The patient's voice in health and social care professional education. *International Journal of Health Governance*, *21*(1), 18–25. https://doi.org/10.1108/IJHG-01-2016-0003

Turcotte, P.-L., Holmes, D., & Murray, S. J. (2023). The shiny new object: Deconstructing the patient-oriented paradigm in health sciences. *Journal of Evaluation in Clinical Practice*, *29*(5), 700–708. https://doi.org/10.1111/jep.13823

Vinson, A. H. (2016). 'Constrained collaboration': Patient empowerment discourse as resource for countervailing power. *Sociology of Health & Illness*, *38*(8), 1364–1378. https://doi.org/10.1111/1467-9566.12480

Welcome to CNO. (n.d.). Retrieved August 24, 2025, from https://www.cno.org/

Willett, A., & Etowa, J. (2023). A critical examination of epistemological congruence between intersectionality and feminist poststructuralism: Toward an integrated framework for health research. *Nursing Inquiry*, *30*(4), e12564. https://doi.org/10.1111/nin.12564

Winfield, C., Sparkman-Key, N. M., & Vajda, A. (2017). Interprofessional collaboration among helping professions: Experiences with holistic client care. *Journal of Interprofessional Education & Practice*, *9*, 66–73. https://doi.org/10.1016/j.xjep.2017.08.004

Wing, P. C. (1997). Patient or client? If in doubt, ask. *Canadian Medical Association Journal (CMAJ)*, *157*(3), 287–289.

Wodak, R., & Meyer, M. (2001). *Methods of Critical Discourse Analysis*. SAGE Publications, Ltd. https://doi.org/10.4135/9780857028020

Woodward-Kron, R. (2020). Let's talk about discourse analysis for health professional education: What, why and how. *Focus on Health Professional Education*, *21*(2), 63–74. https://doi.org/10.11157/fohpe.v21i2.470

Yin, P. (2024). Unraveling the myth of Western supremacy: A critical discourse analysis of U.S. news reporting on international student migration from China. *Journal of Diversity in Higher Education*, *17*(5), 761–774. https://doi.org/10.1037/dhe0000465

Zhou, A. E., & Grant-Kels, J. M. (2023). Ethics of using the honorific title 'doctor.' *Journal of the American Academy of Dermatology*. https://doi.org/10.1016/j.jaad.2023.09.047

Appendix A: Terminology for the Regulatory Colleges of Ontario's 27 Regulated Health Professions

This appendix provides the complete dataset supporting findings in Chapter 5. The table below presents each of Ontario's 27 regulated health professions, the terminology ("patient," "client," or both) used on the regulatory college's primary public-facing webpage, and the most recent publicly available member counts.

Terminology reflects the term(s) identified through the data collection procedure outlined in Chapter 4, which involved capturing the regulatory college homepage or, if neither term appeared there, the first page returned by an internal search for "patient" or "client." Member counts were gathered from annual reports and demographic summaries current at the time of data capture (May to July 2025). Numbers have been rounded off to the closest hundred.

Table A1

Terminology Used by Ontario's Regulated Health Professions, with Member Counts

Profession and Regulatory College	Terminology Used ("Patient", "Client", or Both)	Member Count	Source for Member Count	Last Updated
Nursing College of Nurses of Ontario	**"patient"**	198,900	https://www.cno.org/what-is-cno/nursing-demographics/registrant-statistics#id-RegistrantsintheGeneralandExtendedClasses	2025
Physicians and Surgeons College of Physicians and Surgeons of Ontario	**"patient"**	49,400	https://viewer.joomag.com/annual-report-2024/0853397001738697538/p6?short=	2024
Massage Therapy	**"client"**	16,200	https://www.cmto.com/wp-content/uploads/2025/06/2024	2025

College of Massage Therapists of Ontario			-CMTO-Annual-Report-Word-EN.pdf	
Physiotherapy College of Physiotherapists of Ontario	**“patient”**	11,900	https://cpo.my.canva.site/2023-2024-annual-report	2024
Psychology College of Psychologists and Behaviour Analysts of Ontario	**both “patient” and “client”**	4,900	https://cpbao.ca/cpo_resources/2023-2024-annual-report/	2024
Traditional Chinese Medicine & Acupuncture College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario	**“patient”**	2,900	https://www.ctcmpao.on.ca/	2024
Occupational Therapy College of Occupational Therapists of Ontario	**both “patient” and “client”**	7,000	https://www.coto.org/	2024
Optometry College of Optometrists of Ontario	**“patient”**	2,000	https://collegeoptom.on.ca/	2024

Opticianry College of Opticians of Ontario	**“patient”**	3,400	https://coptont.org/sites/default/uploads/files/COO-2023%20annual%20report_V8.pdf	2023
Pharmacy Ontario College of Pharmacists	**“patient”**	18,600	https://www.ocpinfo.com/	2024
Midwifery College of Midwives of Ontario	**“client”**	1,100	https://cmo.on.ca/wp-content/uploads/2024/09/2023-2024-Report.pdf	2024
Medical Laboratory Technology College of Medical Laboratory Technologists of Ontario	**“patient”**	6,700	https://www.cmlto.com/wp-content/uploads/2024/05/2023_hhr_report_eng.pdf	2024
Medical Radiation and Imaging Technology College of Medical Radiation and Imaging Technologists of Ontario	**“patient”**	11,000	https://www.oamrs.org/	2024
Dietetics College of Dietitians of Ontario	**“patient”**	4,500	https://collegeofdietitians.org/wp-content/uploads/2025/02/CDO-Annual-Report-2023-24-ENG.pdf	2024

Denturism College of Denturists of Ontario	**“patient”**	800	https://denturist.org/en/about/members-affiliates/licensed-denturists-per-province-as-of-august-2023	2023
Dental Hygiene College of Dental Hygienists of Ontario	**“client”**	15,000	https://cdho.org/data-dive-week/	2024
Dental Technology College of Dental Technologists of Ontario	**“patient”**	500	https://cdto.ca/wp-content/uploads/CDTO-2022-23-ANNUAL-REPORT.pdf	2023
Dentistry Royal College of Dental Surgeons of Ontario	**“patient”**	11,000	https://cdn.agilitycms.com/rcdso/annual-report-2024/content/index.html#/lessons/RWPcFStRtAK_9MhIKd4rwYgNy6fd6W_y	2024
Chiropractic College of Chiropractors of Ontario	**“patient”**	5,100	https://cco.on.ca/wp-content/uploads/2025/07/CCO-2024-Annual-Report_FINAL-Revised_2.pdf	2025
Chiropody College of Chiropodists of Ontario	**“patient”**	800	https://www.cocoo.on.ca/	2024
Audiology & Speech-Language Pathology College of Audiologists and Speech-Language	**“patient”**	5,000	https://www.caslpo.com/	2024

Pathologists of Ontario				
Homeopathy College of Homeopaths of Ontario	**“patient”**	400	https://www.collegeofhomeopaths.on.ca/	2024
Kinesiology College of Kinesiologists of Ontario	**“patient”**	4,000	https://www.coko.ca/	2024
Psychotherapy College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario	**“client”**	9,500	https://crpo.ca/wp-content/uploads/2024/10/Annual-Report-2023-2024.pdf	2024
Naturopathy College of Naturopaths of Ontario	**“patient”**	1,500	https://www.collegeofnaturopaths.on.ca/	2024
Applied Behaviour Analysis College of Psychologists and Behaviour Analysts of Ontario	**both “patient” and “client”**	1,500	https://cpbao.ca/applied-behaviour-analysis-regulation-update-october-2024/	2024
Respiratory Therapy	**both “patient” and “client”**	4,000	https://annualreport.crto.on.ca/	2025

College of Respiratory Therapists in Ontario				

Note. Total Registered Members Across All 27 Regulated Health Professions in Ontario: Approximately 397,600**.** "Last Updated" reflects the most recent publicly available annual report or demographic dataset at the time of data collection (May to July 2025). Regulatory colleges publish data on differing schedules; therefore, date variations across professions are to be expected and reflect their official release timelines. Additionally, nine regulatory college homepages did not contain the terms "patient" or "client"; in these cases, the first internal search result for the terms was used for inclusion.

Table A2

Summary of Terminology Usage Across Ontario's Regulatory Colleges

Terminology Category	**Number of Health Professions Using Terminology**	**Notes**
"Patient" only	19	Reflects alignment with biomedical authority
"Client" only	4	Corresponds with health professions that are predominantly female
Both	4	Indicates possible internal or interprofessional tension
Total	27 professions (26 regulatory colleges)	One college governs two regulated health professions (Psychology and Applied Behaviour Analysis both share CPBAO as their regulatory college)

Appendix B: NVivo Coding Summary - All Codes

This appendix charts the codes from NVivo and directly supports the findings chapter. The tables in this appendix show the number of times each code appeared across the three document sets (regulatory colleges, CMTO "RMT Clients" section, and public-college program descriptions), as well as the number of documents in which each code was present. This numeric summary reflects the analytic steps described in Chapter 4 and provides the descriptive evidence for the patterns highlighted throughout Chapter 5.

Section 1: Regulatory Colleges (Homepage/First-Term Results)

This section summarizes coding counts across the regulatory documents used to determine terminology patterns (Findings 5.2) and demographic associations (Findings 5.3).

- 26 regulatory colleges represent Ontario's 27 regulated health professions: 22 include "patient", 19 have "patient" only; 7 include "client"; 4 have "client" only

Table B1

Coding Summary for Regulatory Colleges

Code	Number of Coding References	Number of Files Coded
"Client" (includes 3 that also refer to "patient")	7	7
"Patient" (includes 3 that also refer to "client")	22	22

Section 2: CMTO "RMT Clients" Documents

These counts support Findings 5.4 and several patterns described in 5.6 (e.g., prominence of "professional," "ethics," and "sexual misconduct/abuse").

Table B2

Coding Summary for CMTO "RMT Clients" Section

Code	Number of Coding References	Number of Files Coded
Client	79	9
Community and public	26	8
Duties and obligations	27	7

Empowered client themes	26	5
Ethical	33	9
Evidence-based	2	2
Hands-on	1	1
Health	39	10
Interprofessional	1	1
Knowledge and skills	9	6
Misconduct or other failures in duties	20	10
--- sexual misconduct or abuse	30	4
Patient	0	0
Power	9	2
Professional	60	12
Respect and dignity	7	2
Serve, care, compassion	16	5
Soft tissues and joints	5	3
Techniques, modalities	2	1
Therapeutic	7	3

Section 3: Educational Documents (OCAS – ontariocolleges.ca + Public Colleges)

This section summarizes coding frequency across massage therapy education documents. These results inform Findings 5.5 to 5.7, especially the observed mixed usage of "client" and "patient," and the emphasis on themes such as "knowledge and skills."

Table B3

Coding Summary of Educational Documents (OCAS + Public Colleges)

Code	Number of Coding References	Number of Files Coded
Client - ontariocolleges.ca	3	2
Client in massage therapy education	16	6
Patient - ontariocolleges.ca	1	1

Patient in massage therapy education	9	4
Care and compassion	7	4
Ethics	10	5
Evidence-based	5	5
Hands-on	9	6
Health care or healthcare	17	10
Interprofessional	2	2
Interprofessional – ontariocolleges.ca	1	1
--- team	2	2
Knowledge and skills	22	10
Massage therapy exclusion	1	1
Non-massage therapy education – ontariocolleges.ca		
--- esthetician or hairstylist	6	1
--- occupational or physiotherapy assistant	1	1
--- osteopathy	3	1
Not named as healthcare	1	1
Parts of body	10	9
People and public themes	16	9
Power dynamics – exclusion	1	1
Techniques	6	4
Therapeutic	8	7
Workplaces - ontariocolleges.ca		
--- health or sports clubs	8	6
--- hospitals	6	5
--- massage clinic	3	3
--- medical clinics	3	3

--- multidisciplinary clinics	9	6
--- private practice or work from home	8	7
--- spa or resorts	9	6

Summary

Collectively, these coding summaries provide foundations for the descriptive findings in Chapter 5, including terminology distribution, thematic emphases across institutions, and contrasts between regulatory, educational, and CMTO-specific discourses.

Appendix C: Codebook and Coding Summary

This appendix presents the complete codebook used during NVivo analysis and directly supports findings in 5.6 and 5.7. The codes listed here reflect the deductive and inductive coding processes described in Chapter 4. Deductive codes ("patient" and "client") were generated from the research questions, while inductive codes emerged from repeated language patterns and thematic clusters observed across regulatory and educational document sets.

The appendix serves two analytic functions: (1) it shows the full structure of the coding framework used to generate frequency patterns in Section 5.6, and (2) it illustrates how specific codes contributed to descriptive patterns noted in Section 5.7.

Below is the revised codebook, organized by code name, definition, interpretive note, and alignment with thematic categories and CDA dimensions. These codes were applied consistently across all regulatory-college documents, CMTO "RMT Clients" materials, public-college program descriptions, and the Ontariocolleges.ca page.

Code	Description	Interpretive Note	Theme	CDA Dimension
client	Occurrences of "client" on regulatory college homepages and related documents.	Could imply collaborative or service-oriented interpretation and contrasts with biomedical authority implied by "patient." Reflects sociocultural positioning, perhaps ranking of professions.	Terminology & Identity	Textual + Sociocultural
RMT clients	Presence of the "RMT Clients" tab on CMTO homepage.	Signals institutional emphasis on client-centred care; textual choice reinforces professional identity.	Terminology & Identity	Textual + Discourse Practice

Code	Description	Interpretive Note	Theme	CDA Dimension
CMTO – RMT Clients	Documents listed under “RMT Clients” section of CMTO website.	Highlights commitment to client terminology; relevant to CDA’s discourse practice dimension.	Terminology & Identity	Discourse Practice + Sociocultural
client (RMT Clients pages)	Occurrences of “client” within CMTO’s RMT Clients section documents.	Suggests normalization of client language in regulatory discourse; contrasts with dominant patient-centred norms.	Terminology & Identity	Textual + Sociocultural
community and public	References to “community” or “public” in CMTO documents.	Positions care recipients as part of a collective rather than individuals; aligns with sociocultural practice.	Power & Ethics	Sociocultural
duties and obligations	Mentions of professional responsibilities and obligations.	Reinforces hierarchical norms and regulatory authority; textual markers of power relations.	Power & Ethics	Textual + Sociocultural
empowered client themes	Adjectives and phrases emphasizing client empowerment.	Reflects resistance to current dominant models; aligns with CDA’s ideological critique.	Power & Ethics	Textual + Sociocultural
ethical	Mentions of ethics, integrity, and judgment.	Constructs professional identity through moral discourse; indicates expectations of RMTs.	Power & Ethics	Textual + Sociocultural

Code	Description	Interpretive Note	Theme	CDA Dimension
evidence-based	References to evidence-based approaches.	Positions profession within scientific discourse; enhances legitimacy and authority.	Professional Practice	Textual + Sociocultural
hands-on (RMT Clients)	Literal use of "hands-on" in CMTO documents.	Emphasizes manual, hands-on nature of massage therapy; may reinforce marginalization as "manual" rather than "medical."	Professional Practice	Textual
health	Mentions of health and well-being.	Frames massage therapy within wellness discourse; contrasts with biomedical disease-focused language.	Terminology & Identity	Textual + Sociocultural
interprofessional	References to interprofessional collaboration.	Possible aspiration for inclusion in healthcare teams; relevant to sociocultural practice.	Professional Practice	Discourse Practice + Sociocultural
knowledge and skills (RMT Clients)	Mentions of practitioner competencies.	Constructs professional identity through technical expertise; aligns with CDA's textual analysis.	Educational Positioning	Textual + Discourse Practice
misconduct or failures in duties	Mentions of misconduct or breaches of obligations.	Reflects regulatory power and disciplinary discourse; aligns with Fairclough's sociocultural dimension.	Power & Ethics	Sociocultural

Code	Description	Interpretive Note	Theme	CDA Dimension
sexual misconduct or abuse	Mentions of sexual abuse or misconduct.	Highlights regulatory focus on safeguarding; discursively constructs trust and authority.	Power & Ethics	Sociocultural
patient (RMT Clients)	Occurrences of "patient" in CMTO documents.	No occurrences of "patient" in CMTO documents which does not completely align with massage therapy education documents.	Terminology & Identity	Textual + Sociocultural
power	Mentions of power or power imbalance.	Explicit acknowledgment of power dynamics within healthcare aligns with CDA's ideological critique.	Power & Ethics	Sociocultural
professional	Mentions of profession and professionalism.	Constructs legitimacy and authority.	Professional Practice	Textual + Sociocultural
respect and dignity	Mentions of respect and dignity in care.	Positions care as ethical, with obligation; aligns with CDA's sociocultural practice.	Power & Ethics	Sociocultural
serve, care, compassion	Mentions of service, care, and compassion.	Frames the work of the profession within morals and ethics and may reinforce feminized discourse of care.	Power & Ethics	Sociocultural

Code	Description	Interpretive Note	Theme	CDA Dimension
soft tissues and joints	Mentions of anatomical structures.	Emphasizes the scope of practice in terms of the physical body - aligns with textual analysis of practice language.	Professional Practice	Textual
techniques, modalities	Mentions of massage techniques and modalities.	Emphasizes technical expertise in manual therapy approaches; relevant to educational positioning.	Professional Practice	Textual
therapeutic (RMT Clients)	Occurrences of “therapeutic” in documents.	Positions massage therapy as clinical; contrasts with wellness framing.	Terminology & Identity	Textual + Sociocultural
interprofessional – massage therapy	Mentions of massage therapy in interprofessional contexts.	Possibly an aspiration for inclusion; reflects sociocultural positioning.	Professional Practice	Discourse Practice + Sociocultural
team	Mentions of healthcare teams.	Indicates collaborative ideals; contrasts with marginalization in practice.	Professional Practice	Discourse Practice
massage therapy education language	Phrases seen in massage therapy education (e.g., therapeutic, evidence-based).	Language that may help form/forge educational identity; aligns with CDA’s discourse practice.	Educational Positioning	Discourse Practice
care and compassion	Mentions of care and compassion.	Reinforces notions of ethics and obligation in	Power & Ethics	Sociocultural

Code	Description	Interpretive Note	Theme	CDA Dimension
		care and may intersect with gendered discourse.		
client – ontariocolleges.ca	Occurrences of "client" on OCAS website.	Positions massage therapy as service-oriented in a website used for applications for post-secondary education.	Educational Positioning	Textual + Discourse Practice
client in massage therapy education	Use of "client" in college program websites.	Reflects alignment with regulatory norms – those of the CMTO. This contrasts with healthcare discourse beyond massage therapy.	Educational Positioning	Textual + Sociocultural
ethics	Mentions of ethics in educational contexts.	Possibly implies moral identity; aligns with CDA's ideological critique.	Power & Ethics	Sociocultural
evidence-based (education)	Mentions of evidence-based practice in education.	Where curriculum is placed within scientific, biomedical discourse to possibly enhance legitimacy.	Educational Positioning	Textual + Sociocultural
hands-on (education)	Mentions of hands-on practice in education.	Emphasizes manual, hands-on learning; may reinforce marginalization as "manual."	Educational Positioning	Textual

Code	Description	Interpretive Note	Theme	CDA Dimension
health care or healthcare	Mentions of healthcare terminology.	Positions massage therapy within healthcare discourse; aims for inclusion and legitimacy.	Terminology & Identity	Textual + Sociocultural
interprofessional (education)	Mentions of interprofessional collaboration in education.	Emphasizes inclusion; aligns with sociocultural practice.	Educational Positioning	Discourse Practice
knowledge and skills (education)	Mentions of competencies in education.	Constructs educational identity; aligns with CDA's textual analysis.	Educational Positioning	Textual
not named as healthcare	Instances where massage therapy is excluded from healthcare framing.	Exclusion, marginalization - relevant to sociocultural critique.	Educational Positioning	Sociocultural
parts of body	Mentions of muscles, joints, and anatomy.	Emphasizes massage therapy's practice in terms of the physical body; aligns with textual analysis.	Professional Practice	Textual
patient – ontariocolleges.ca	Occurrences of "patient" on OCAS website.	Suggests tension between educational and regulatory norms.	Educational Positioning	Textual + Sociocultural
patient in massage therapy education	Use of "patient" in college program and OCAS websites.	Indicates possible shift toward biomedical alignment; contrasts with CMTO norms.	Educational Positioning	Textual + Sociocultural

Code	Description	Interpretive Note	Theme	CDA Dimension
people and public themes	Mentions of "people" or "public" in education documents.	Frames care recipients as populations; aligns with sociocultural practice.	Power & Ethics	Sociocultural
techniques (education)	Mentions of techniques in education.	Learning and gaining technical expertise; aligns with CDA's textual analysis.	Educational Positioning	Textual
therapeutic (education)	Mentions of therapeutic language in education.	Positions massage therapy as clinical; contrasts with wellness framing.	Educational Positioning	Textual + Sociocultural
massage therapy exclusion	A general collection of codes where massage therapy is excluded from listings.	Hints at marginalization; relevant to sociocultural critique.	Educational Positioning	Sociocultural
Non-massage therapy education	Mentions of other programs in OCAS listings in a search for massage therapy.	Highlights comparative positioning; aligns with CDA's sociocultural dimension.	Educational Positioning	Sociocultural
esthetician or hairstylist	Mentions of esthetics or hairstyling programs in a massage therapy program search.	Reinforces massage therapy as grouped with service industries instead of healthcare; possibly suggests marginalization – massage therapy as outside of healthcare.	Educational Positioning	Sociocultural

Code	Description	Interpretive Note	Theme	CDA Dimension
Occupational assistant or physiotherapy assistant	Mentions of assistant programs in a massage therapy program search.	Indicates possible hierarchical positioning of massage therapy within healthcare education – massage therapy as an "assistant" in healthcare.	Educational Positioning	Sociocultural
osteopathy	Mentions of osteopathy programs in a massage therapy program search.	Suggests alternative healthcare positioning; relevant to sociocultural critique.	Educational Positioning	Sociocultural
patient	Appearance of "patient" on regulatory college homepages.	Signals biomedical authority; dominant healthcare discourse.	Terminology & Identity	Textual + Sociocultural
power dynamics	Explicit or implicit references to power dynamics.	Highlights hierarchical structures; aligns with CDA's ideological critique.	Power & Ethics	Sociocultural
exclusion	Mentions of exclusionary language or practices.	Reflects marginalization; relevant to sociocultural critique.	Power & Ethics	Sociocultural
inclusion	Mentions of inclusionary language or practices.	No occurrences - aligns with CDA's sociocultural dimension.	Power & Ethics	Sociocultural

Code	Description	Interpretive Note	Theme	CDA Dimension
public	Mentions of "public" prior to becoming client/patient.	No occurrences; aligns with sociocultural practice.	Power & Ethics	Sociocultural
workplaces	Section title for mentions of practice settings for RMTs.	Places that may influence professional identity.	Professional Practice	Discourse Practice
health or sports clubs	Mentions of clubs or centres as workplaces.	Positions massage therapy within wellness rather than medical discourse.	Professional Practice	Sociocultural
Hospitals	Mentions of hospital settings.	Possible aspiration for biomedical legitimacy; relevant to sociocultural critique.	Professional Practice	Sociocultural
Massage clinic	Mentions of massage-specific clinics.	Reinforces profession-specific identity; alludes to not being part of interprofessional care teams.	Professional Practice	Sociocultural
Medical clinics	Mentions of non-hospital medical settings.	Indicates proximity to biomedical authority; relevant to sociocultural critique.	Professional Practice	Sociocultural
Multidisciplinary clinics	Mentions of collaborative, and/or interprofessional clinics.	May indicate inclusion, acceptance by other healthcare professions; aligns with CDA's sociocultural dimension.	Professional Practice	Sociocultural

Code	Description	Interpretive Note	Theme	CDA Dimension
private practice or work from home	Also includes mentions of solo practice settings.	Reflects autonomy but may reinforce marginalization; relevant to sociocultural critique.	Professional Practice	Sociocultural
Spa or Resorts	Mentions of spa or resort settings (non-clinic-based workplaces).	Positions massage therapy within leisure discourse; contrasts with healthcare.	Professional Practice	Sociocultural

Note. This codebook provides the structural and analytic foundation for the descriptive patterns presented in Chapter 5, including the word-frequency contrasts between CMTO and education documents, as well as patterns relating to ethics, boundaries, professionalism, and terminology.

Appendix D: NVivo Audit Trail (Evidence of Analytic Process)

This appendix houses a series of items to clearly outline my use of NVivo, and to provide an audit trail. Several of these were impractically large to place within the body of the thesis but are important to have visible as evidence of how, and where, NVivo was utilized.

Figure D1

NVivo Dataset Structure & Capture Window of CMTO, RMT clients

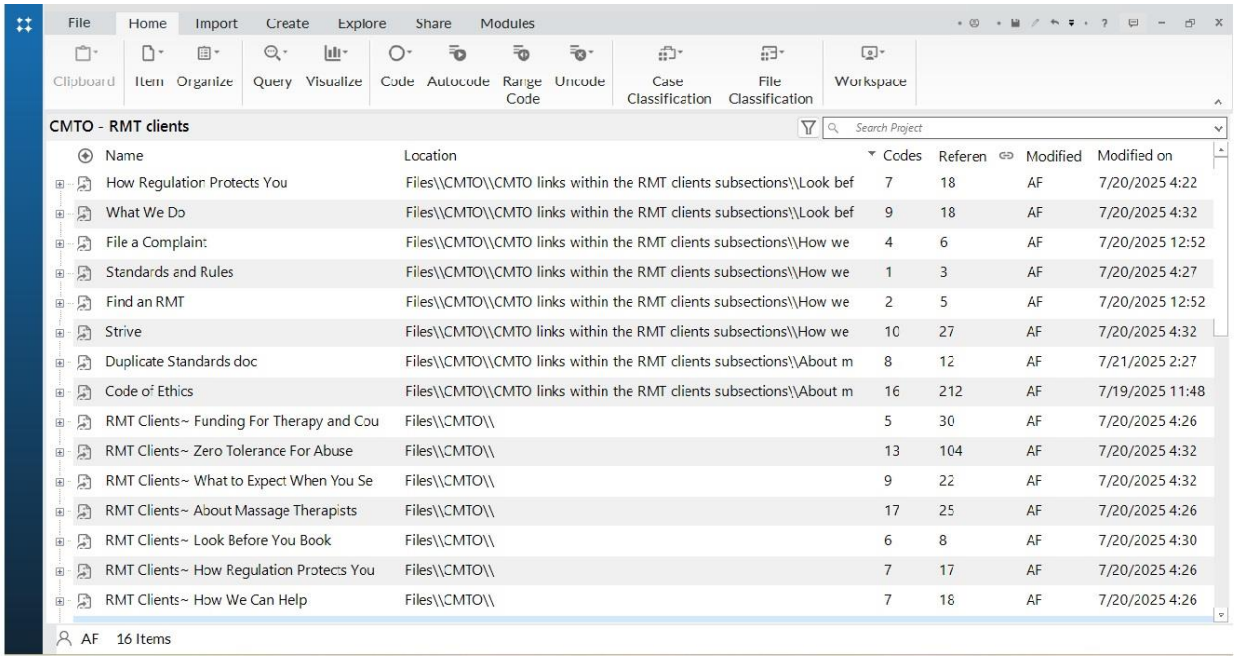
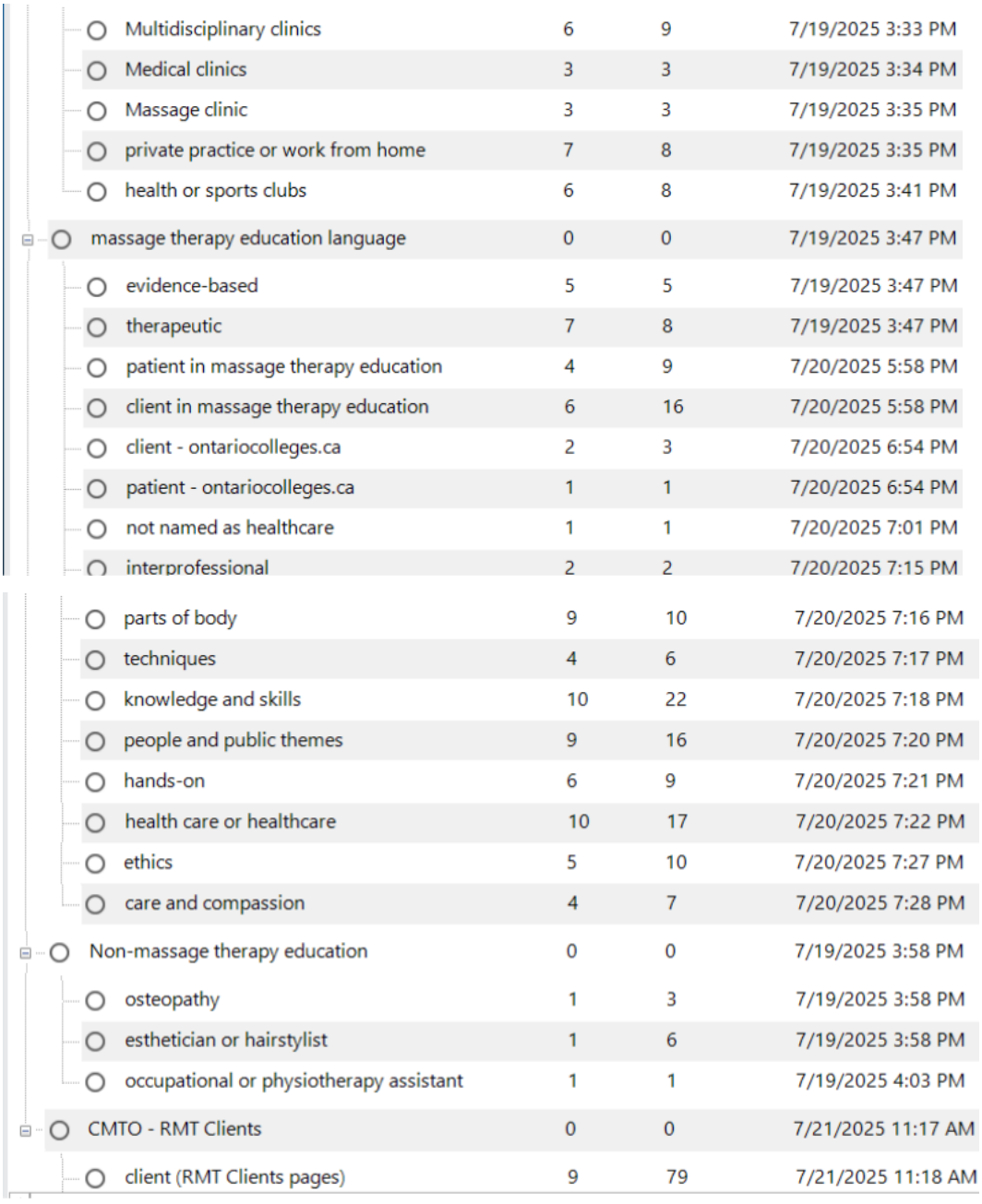


Figure D2

NVivo Node Hierarchy: Code Structure

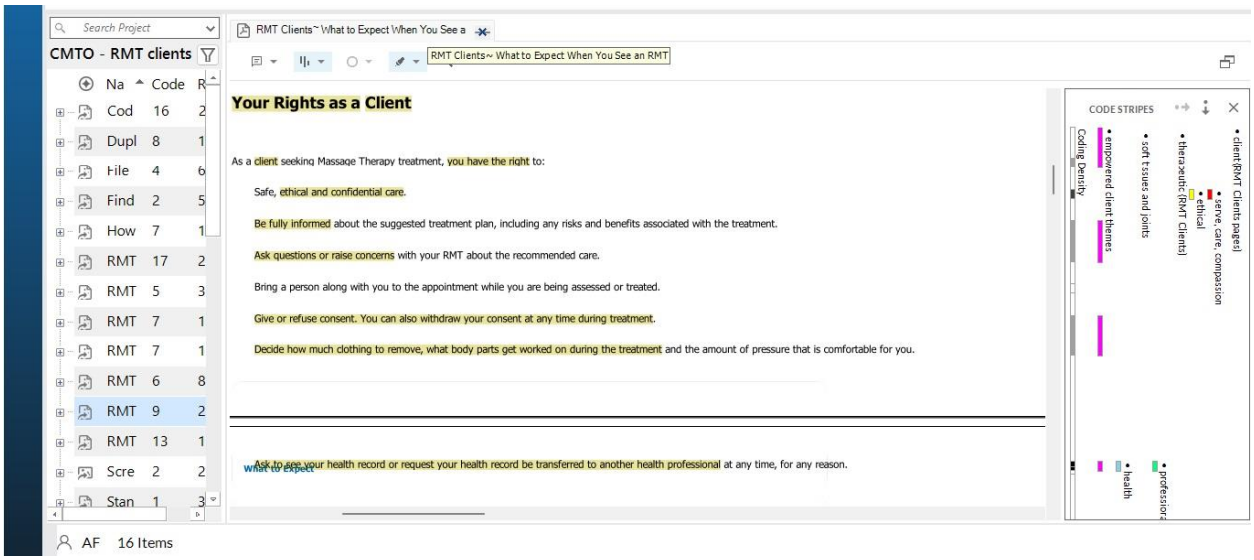


Multidisciplinary clinics	6	9	7/19/2025 3:33 PM
Medical clinics	3	3	7/19/2025 3:34 PM
Massage clinic	3	3	7/19/2025 3:35 PM
private practice or work from home	7	8	7/19/2025 3:35 PM
health or sports clubs	6	8	7/19/2025 3:41 PM
massage therapy education language	0	0	7/19/2025 3:47 PM
evidence-based	5	5	7/19/2025 3:47 PM
therapeutic	7	8	7/19/2025 3:47 PM
patient in massage therapy education	4	9	7/20/2025 5:58 PM
client in massage therapy education	6	16	7/20/2025 5:58 PM
client - ontariocolleges.ca	2	3	7/20/2025 6:54 PM
patient - ontariocolleges.ca	1	1	7/20/2025 6:54 PM
not named as healthcare	1	1	7/20/2025 7:01 PM
interprofessional	2	2	7/20/2025 7:15 PM
parts of body	9	10	7/20/2025 7:16 PM
techniques	4	6	7/20/2025 7:17 PM
knowledge and skills	10	22	7/20/2025 7:18 PM
people and public themes	9	16	7/20/2025 7:20 PM
hands-on	6	9	7/20/2025 7:21 PM
health care or healthcare	10	17	7/20/2025 7:22 PM
ethics	5	10	7/20/2025 7:27 PM
care and compassion	4	7	7/20/2025 7:28 PM
Non-massage therapy education	0	0	7/19/2025 3:58 PM
osteopathy	1	3	7/19/2025 3:58 PM
esthetician or hairstylist	1	6	7/19/2025 3:58 PM
occupational or physiotherapy assistant	1	1	7/19/2025 4:03 PM
CMTO - RMT Clients	0	0	7/21/2025 11:17 AM
client (RMT Clients pages)	9	79	7/21/2025 11:18 AM

respect and dignity	2	7	7/21/2025 11:19 AM
professional	12	60	7/21/2025 11:20 AM
ethical	9	33	7/21/2025 11:20 AM
serve, care, compassion	5	16	7/21/2025 11:21 AM
community and public	8	26	7/21/2025 11:21 AM
misconduct or other failures in duti	10	20	7/21/2025 11:26 AM
sexual misconduct or abuse	4	30	7/21/2025 12:25 PM
health	10	39	7/21/2025 11:32 AM
hands-on (RMT Clients)	1	1	7/21/2025 11:33 AM
empowered client themes	5	26	7/21/2025 11:36 AM
duties and obligations	7	27	7/21/2025 11:41 AM
evidence-based	2	2	7/21/2025 11:47 AM
knowledge and skills (RMT Clients)	6	9	7/21/2025 11:47 AM
interprofessional	1	1	7/21/2025 11:52 AM
power	2	9	7/21/2025 11:57 AM
therapeutic (RMT Clients)	3	7	7/21/2025 12:08 PM
soft tissues and joints	3	5	7/21/2025 12:44 PM
techniques, modalities	1	2	7/21/2025 12:46 PM
patient (RMT Clients)	0	0	7/21/2025 2:39 PM

Figure D3

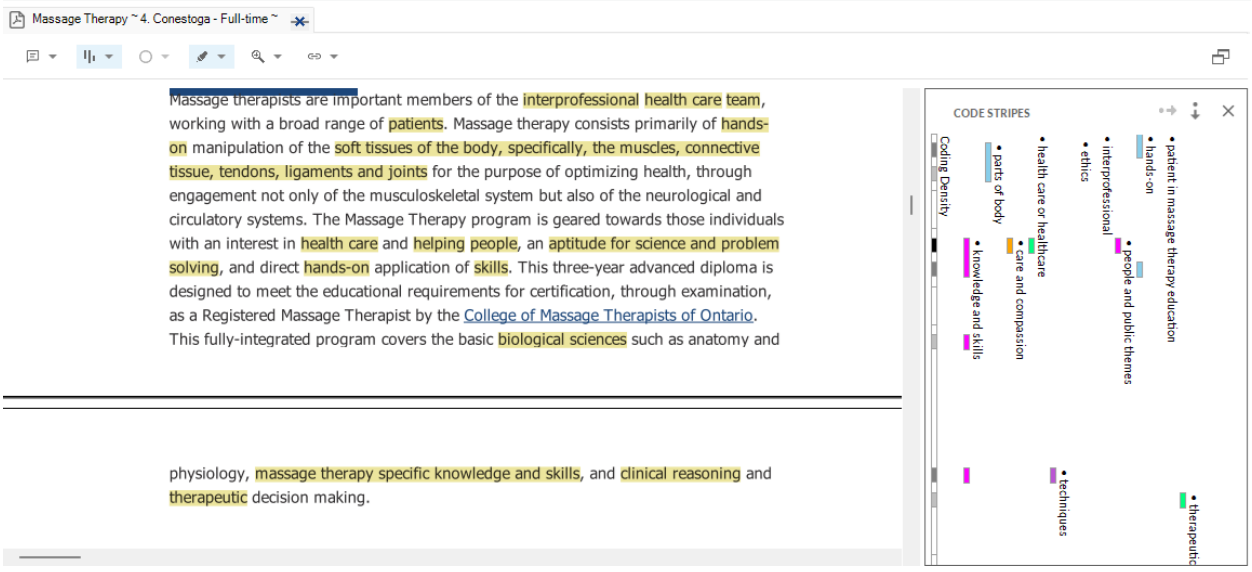
Coded Excerpt with Stripes (CMTO) from "What to Expect When You See an RMT"



Note. Excerpt from the College of Massage Therapists of Ontario webpage "What to Expect When You See an RMT," located under the RMT Clients section, captured July 20, 2025.

Figure D4

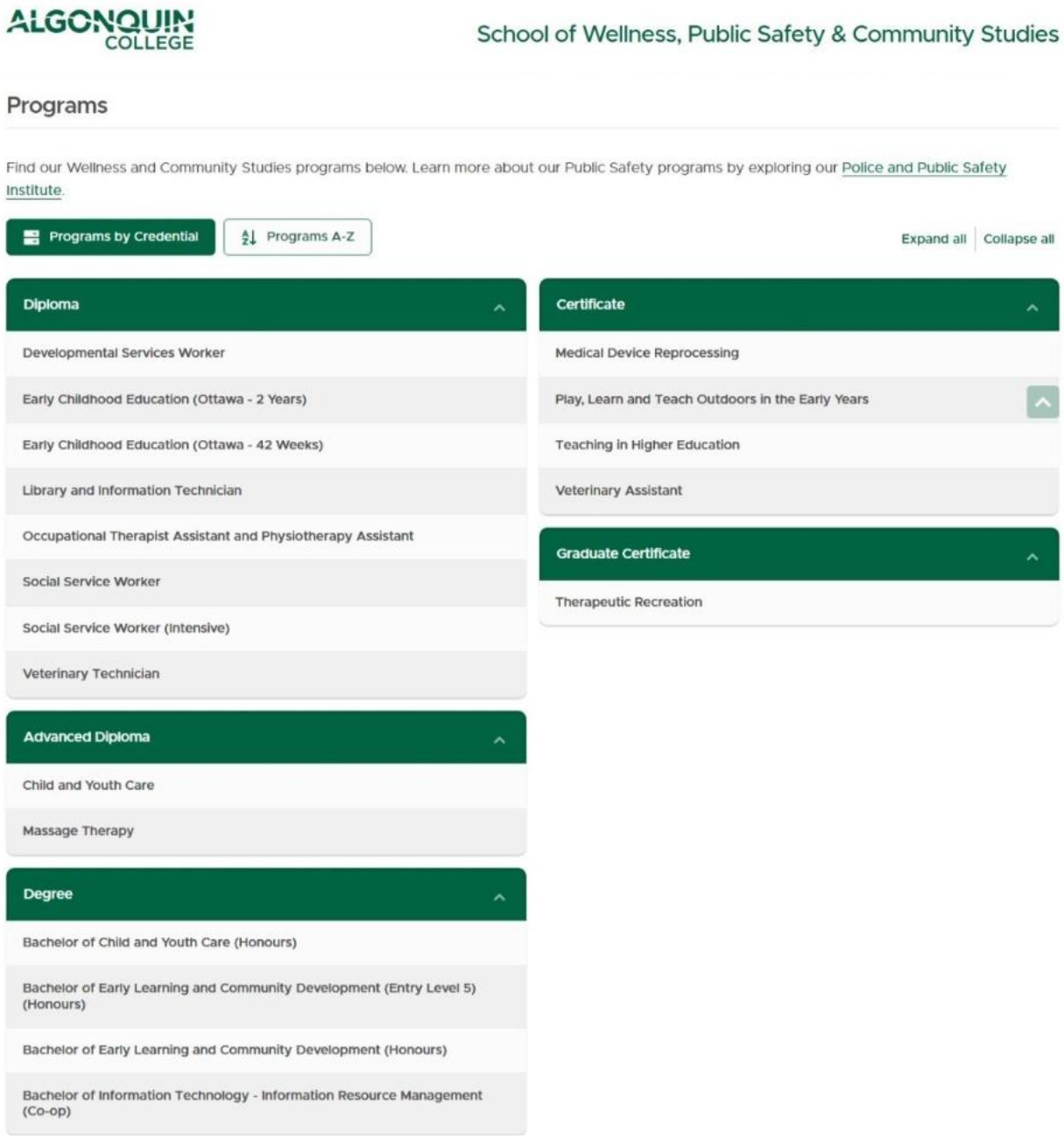
Coded Excerpt with Stripes (Education) from Conestoga College Massage Therapy



Note. Program description (captured July 19, 2025) using "patients" within interprofessional framing. (URL: https://www.conestogac.on.ca/fulltime/massage-therapy)

Figure D5

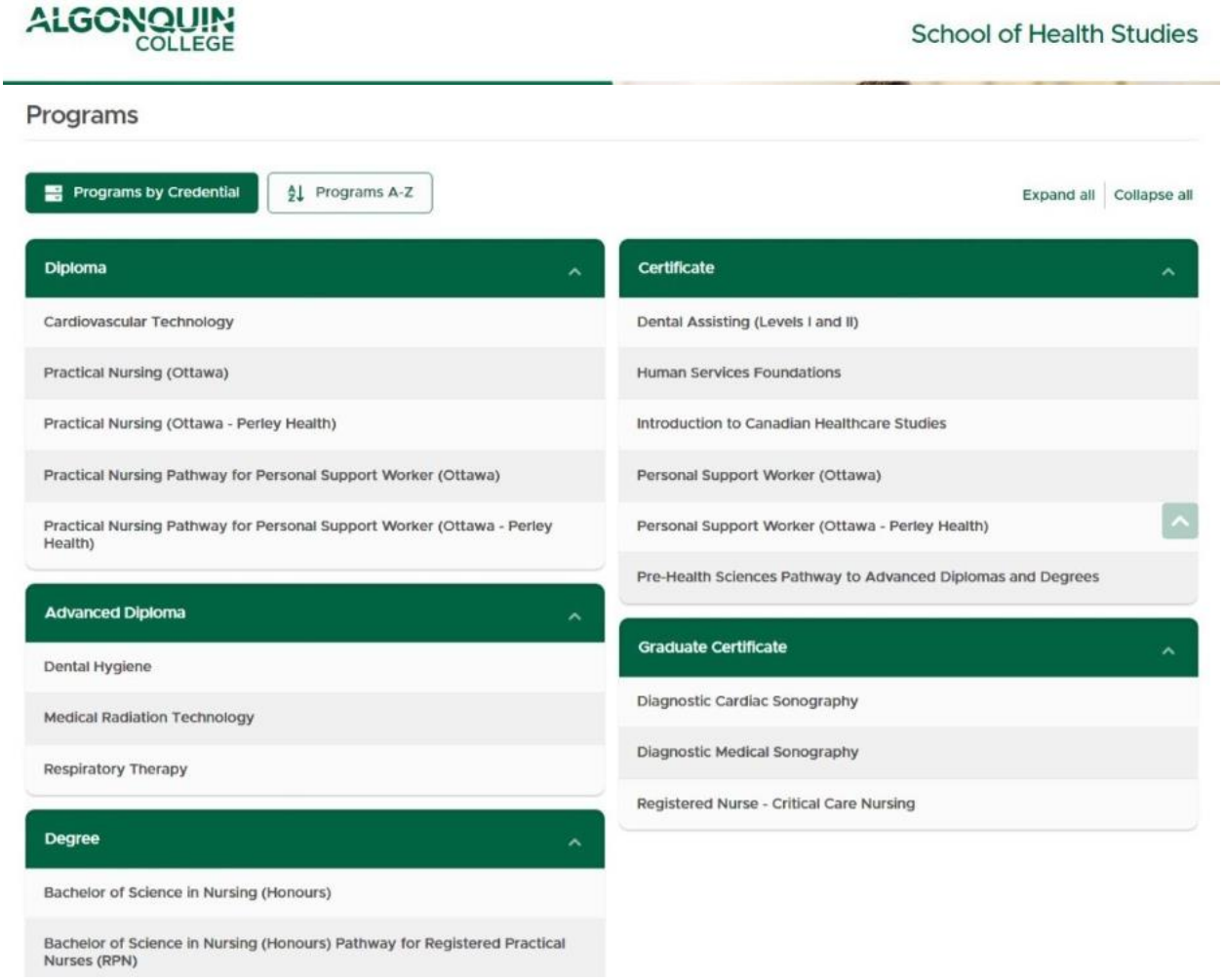
Placement of Massage Therapy in Algonquin College School of Wellness, Public Safety & Community Studies



Note. Algonquin College School of Wellness, Public Safety & Community Studies program list including Massage Therapy (captured July 19, 2025). (URL: https://www.algonquincollege.com/wellness-safety-community/#programs)

Figure D6

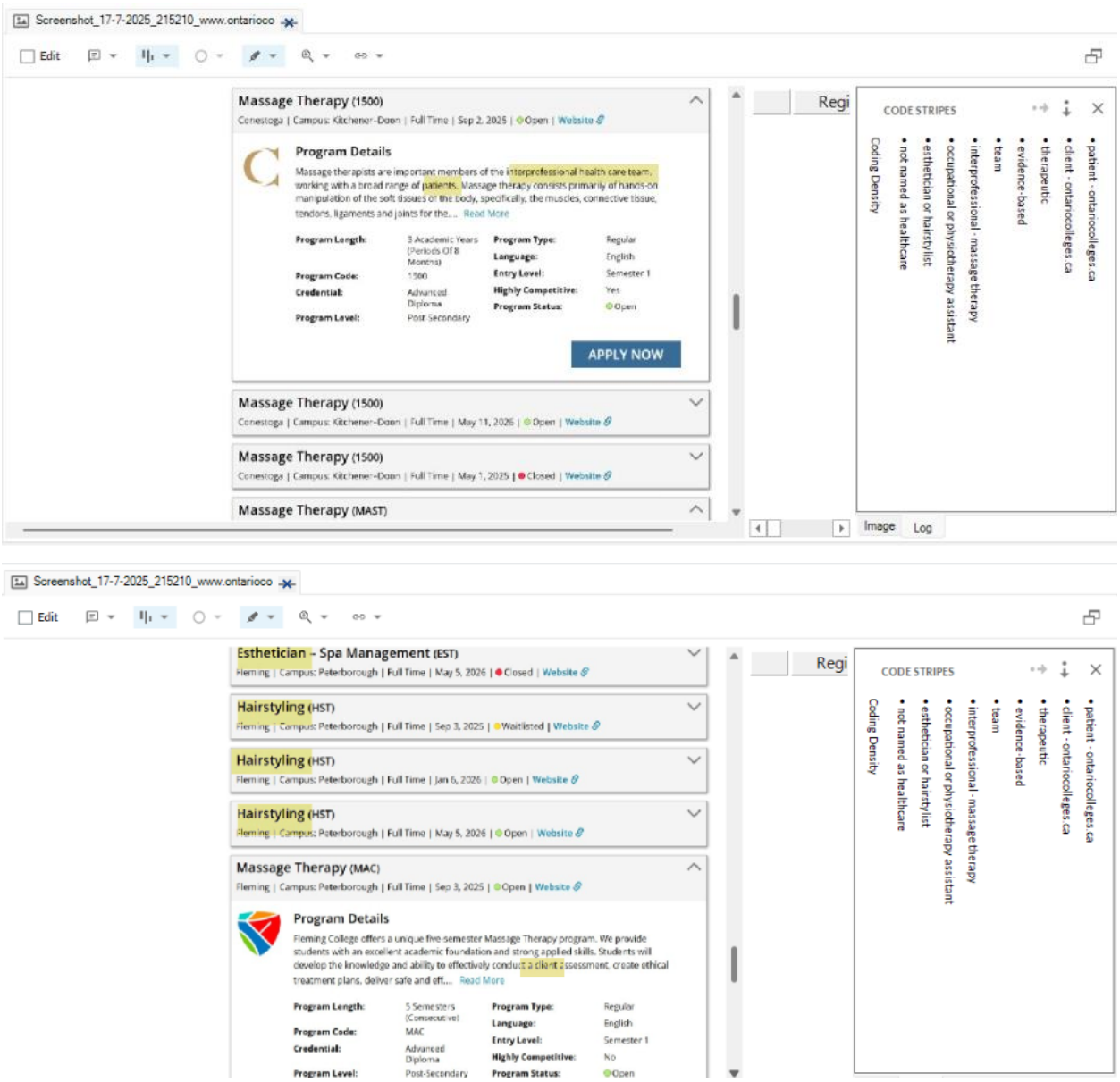
Algonquin College School of Health Studies Program List



Note. Massage Therapy is not listed within this school's program grouping, captured July 19, 2025. (URL: https://www.algonquincollege.com/health-studies/#programs)

Figure D7

OntarioColleges.ca "Massage" Page



Note. Webpages captured July 17, 2025, including top of page and program listing sections. (URL: https://www.ontariocolleges.ca/en/programs/fields-of-interest/massage)

Table D8

NVivo Coded-Text Report Excerpt

	A	G	M	N	O
1	Hierarchical Name	File Type	Coded by Initials	Modified on	Coded Text
143	Codes\\CMTO - RMT Clients\empowered client themes	PDF	AF	7/21/2025 11:36:49 AM	right to be the decision maker
145	Codes\\CMTO - RMT Clients\empowered client themes	PDF	AF	7/21/2025 11:50:28 AM	encourage client engagement
146	Codes\\CMTO - RMT Clients\empowered client themes	PDF	AF	7/21/2025 11:50:49 AM	client goals and preferences
147	Codes\\CMTO - RMT Clients\empowered client themes	PDF	AF	7/21/2025 11:55:14 AM	clients' ethical and legal rights to be the decision makers
148	Codes\\CMTO - RMT Clients\empowered client themes	PDF	AF	7/21/2025 11:56:07 AM	client's right to accept or refuse treatment without prejudice;
158	Codes\\CMTO - RMT Clients\empowered client themes	PDF	AF	7/21/2025 1:56:37 PM	Your Rights as a Client
159	Codes\\CMTO - RMT Clients\empowered client themes	PDF	AF	7/21/2025 2:00:34 PM	Give or refuse consent. You can also withdraw your consent at any time during treatment
165	Codes\\CMTO - RMT Clients\empowered client themes	PDF	AF	7/21/2025 2:12:20 PM	This will open a two-way line of communication to empower you to establish and confirm your expectations about the course of the treatment.

Note. NVivo Coded-text report excerpt showing code name, source file type, capture date, and coded text (filtered to *empowered client themes* within CMTO "RMT Clients" files).