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Towards radical praxis through a new formation in practice development

ABSTRACT

Background: This paper argues that achieving social and cultural transformation in healthcare, and beyond, needs to come from an orientation of explicit ethical stance around critical awareness and articulation of the affects of historical, political, social and cultural structures of oppression. There is discussion around how practice development language forms a discourse of harm, and how practice development environments reproduce and maintain structures of oppression.

Aim: Drawing on the work of feminists critical social praxis concerned with corporeal experiences and the affects emanating from embodied practices, this paper will bring to the fore marginalisations and oppressions experienced by particular bodies, and ask what do practice developers need to consider and act on to make practice development more socially just?

Method: Application of feminist critical social praxis, a theoretical dimension thus far unexplored in the practice development field, as a framework for asking what practice development can learn. Particular attention is drawn to the benefits of orientating a new formation in practice development around the work of Black feminist and feminists of colour – of looking to the margins and bringing those centre.

Findings: Illumination of new insights into how to build a feminist critical social justice oriented practice development through the explicit practice of naming and raising consciousness around the lived experiences and materiality of oppressed and marginalised peoples.

Conclusion: Achieving radical cultural, social, political and economic transformation needs to come from an orientation of explicit critical awareness and recognition of the politics of affects of neoliberal, neo-colonial capitalist systems.

Implications for practice: A feminist critical social justice ethical stance can enable practice development, as a methodology, and practice developers as implementers of that methodology, to respond to this paper's invitation to stand in solidarity against systematic

structural oppressions and form a new more reflective, critical and socially just practice development.

Keywords: Feminist; critical social justice; practice development

INTRODUCTION

The critical question at the foundation of this paper is: what can we learn from black feminists, feminists of colour in particular working in critical social theory and activism (a praxis of feminism) to bring up new insights towards creating a feminist critical social justice practice development?

It is important to caveat that the philosophy underpinning the critique offered in this paper comes from Butler's (2001) understanding of critique. Of critique not as judgement or criticism, but as virtue, of seeing the potential for progression towards a greater illumination of truth. Of critique that is ethically imbued, that is about revealing the relationship of knowledge to power on a path, potentially of uncertainty and one that may cause insecurity, but nevertheless, a path full of possibilities for radical transformation.

This paper is structured in the following way; firstly, the paper explores feminist critical social theory with particular reference to black feminist and feminist of colour work before foregrounding the underpinnings of practice development in traditional critical social theory. From here is asks what a different genealogy of critical social theory, namely the work of black feminists and feminists of colour, can offer in enabling practice development to be more reflexive, critical and socially just. In this section particular attention is drawn to the language used to describe practice development's philosophy and principles as this will be returned to later in the discussion section in identifying some limitations to it. Secondly, the paper provides some contextualisation of local and global health inequalities, focusing on the most marginalised and oppressed peoples, to illustrate these have not diminished and require consideration and acting on. This contextualisation draws together examples of the local (UK) and global (across a number of international borders) to illustrate how these are interconnected and cannot be treated as mutually exclusive. Thirdly, bringing together the previous two previous sections, there is an analysis of practice development language and how as a discourse it has concerning affects for oppressed and marginalisation peoples. There is also exploration of how conditions/ environs affects form a politics of practice development that can be harmful for oppressed and marginalised peoples. The conclusion

invites a feminist critical social justice oriented practice development that is open to explicitly recognising systemic structural injustices and inequalities, and bringing that truth into its theory and practice.

Situating the Knowledges

Feminist Critical Social Praxis

Feminist critical social praxis is theory and activism that articulates and raises consciousness around oppressions and marginalisations. It pays particular attention to the lived experiences of the most marginalised in society, namely women experiencing the multiple and interlocking oppressions of being black, of colour, poor and/ or LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, questioning intersex, asexual) (Crenshaw, 1989; Hill-Collins, 2000; hooks, 2000; Hesse-Biber, 2011; Lorde, 2013; Carastathis, 2016). It is also interested in being attentive to corporeal experience, and to materialisms such as the non-human, the natural world and relational spaces in relation to corporeal experiences, explorations of ways of being in the world that focus on the body and its relation to social spaces (Fannin et al, 2014; Frost, 2014). It is a consideration of bodies and how they are affected, of how bodies take up and experience spaces, and how they are affected by ecologies (environs and bionetworks) and the resultant social structures encountered within them (Ahmed, 2006). It illuminates and explores the affects (the material affects of oppressions) that systemic structural inequalities have by pointing to structures, showing how those structures are felt, and how they materially affect the lives of the most marginalised and oppressed (Ahmed, 2017). Berlant's (2007) work has illuminated how environments, and specifically in the context of this paper, healthcare environments, are repetitions of everyday practices that become normalised. So what appears as singularity, as a phenomenon somehow produced away from and outside of wider social environments, is in fact a reproduction of those pre-existing wider social conditions of systematic structural oppressions. Berlant's (2007) work helps us to recognise that micro-systems are reproductions of macro-systems, smaller versions of wider social systems.

Taking a feminist critical social perspective illuminates those pre-exiting oppressive conditions, and, from seeing, acknowledging and naming those oppressions, bringing them front and centre (Crenshaw, 1989; Hill-Collins, 2000; hooks, 2000; Hesse-Biber, 2011; Lorde,

2013; Carastathis, 2016) it is possible to reimagine and transform them (Davis, 2016). Such a perspective can help us foreground a new formation in practice development.

In the spirit of feminist critical social methodology this paper turns to bring those who live on the margins front and centre (Crenshaw, 1989; Hill-Collins, 2000; hooks, 2000; Hesse-Biber, 2011; Lorde, 2013; Carastathis, 2016). The autobiographic narrative of Black writer, feminist, lesbian, *womanist*, and civil rights activist Audre Lorde works particularly well as a method for this. *Womanist* is a feminist concept and term given by African-American writer, poet, feminist and activist Alice Walker (Phillips, 2006). It refers to critical social praxis that centres on the gender and racial oppressions of Black women and women of colour. Lorde's pertinent words elucidate the importance of turning to the experiences of the most oppressed in society as a way of working towards securing liberation and flourishing for all,

> *Those of us who stand outside the circle of this society's definition of acceptable women; those of us who have been forged in the crucible of difference – those of us who are poor, who are lesbians, who are Black, who are older – know that survival is not an academic skill. It is learning how to stand alone, unpopular and sometimes reviled, and how to make common cause with those others identified as outside the structure in order to define and seek a world in which we can all flourish* (Lorde, 2013, p 112).

We will return to Lorde's words at various points throughout this paper as a reminder of the importance of what we can learn through the practice of continuously returning to the margins and bringing them centre.

The following section looks at the critical social theories underpinning practice development, and by examining that particular genealogy suggest how they may be limiting the possibilities for practice development to be more reflexive, critical and socially just.

Emancipatory Practice Development

Emancipatory practice development methodology will be familiar to the readership of this paper, but it is important to give a general overview to situate it in terms of the paper's thesis. *Emancipatory* practice development is systematic and purposeful in working with and

through organisations to deliver positive sustainable change and *transformation* for service users, practitioners and organisations. E*mancipatory* practice development enables *person centredness*, commitment to action in the long term, involvement of all those with an interest in fostering *collaboration, inclusion and participation*, working with and clarifying values and beliefs, defining issues and best practice locally from the practitioner to patient experience, and understanding contexts and *cultures* of care to enable *transformation* (Manley and McCormack, 2003).

In a brief history, practice development came into existence in the 1980s, with the main objective of focusing on fostering environments that enable *person-centred* and *evidence* based care. Since 2010 that focus has been extended to incorporate the notion of fostering environments that support *human flourishing* (Titchen and McCormack, 2010) and of creating and sustaining workplace cultures that facilitate and support *flourishing for everyone* (Manley et al, 2011; Manley et al, 2014). At the heart of practice development lies *person-centred* critically creative research approaches developed from an *emancipatory/ liberation* perspective that focus on questions generated from the front line of practice about what matters to patients, service users and front line practitioners. Successful *emancipatory* practice development and implementation of change also takes account of *evidence*, context and facilitation (Rycroft Malone et al, 2004).

Understanding these aspects of practice development is useful for outlining its approach, and for illuminating some of the language, discourse and conditions/ environs/ ecologies (in italics) that an alternative genealogy of critical social theory can support to be more critical, reflexive and socially just.

Emancipatory practice development's philosophical, methodological and theoretical underpinnings stem from critical social theory (Manley, McCormack & Wilson, 2008). Whilst interdisciplinary in nature, critical social theory has traditionally emerged from the fields of sociology and philosophy. It is broadly a critique of society - that is critique of social structures, cultural norms and the ways in which power operates in society - with ideological purpose and the intent to drive progressive social change and empowerment for oppressed groups. Practice development has tended towards being influenced and informed by the work of Habermas (Manley, McCormack & Wilson, 2008; McCormack, Manley & Titchen, 2013) and Fay (Smith, 2016; McCormack et al, 2014; Hardiman & Dewing, 2014; Manley, McCormack & Wilson, 2008; McCormack & Titchen, 2006). Whilst there has

been work around expansion and modification of the critical social theories at practice development's foundations (Manley, McCormack & Wilson, 2008), the lineage of those theories has not yet been explored or critiqued. If we think of critical social theory and traditional lineage, we may think of Marx, Freud, Gramsci, Habermas, Lacan, Derrida, Foucault, Bathes etc. These figures and their work have become identified as the body of work described as critical social theory, as the place we traditional go to to learn about critical social theory and to find the framework that underpin our work. But, as Ahmed (2017) has recognised, this framework is a structure, it is a very particular type of critical social theory, it is a White male critical social theory. It comes from a history and continuing genealogy of White men. So, it is important to ask what a turn to a different critical social theory family could bring about for practice development? How can a feminist critical social justice praxis genealogy support us in rethinking practice development? To demonstrate this I go back to Audre Lorde's words at the end of the previous section, what we learn from these words is a glimpse of the materiality of Lorde's life, the life of a poor, Black, lesbian, older woman. White male critical social theory comes from the historical, social, cultural and political privilege enjoyed by White men. It is born of, and framed by them. It does not come from the voices of those living at the margins; it therefore does not, and cannot, authentically articulate the conditions and experiences of oppressed lives, and name the structures that affect those experiences (Ahmed, 2017). It does not talk about the materiality of oppressed and marginalised peoples' lives and so cannot teach us whose needs in particular need to be met in order to transform oppressive systems. How can we go to the place we need to go to, connect to, listen to and to hear from unless we know where to go? Feminist critical social praxis is the place where we can find the materiality of the lives of the most oppressed and marginalised (Crenshaw, 1989; Hill-Collins, 2000; hooks, 2000; Hesse-Biber, 2011; Lorde, 2013; Carastathis, 2016). It is the place practice development needs to go to to be more critical, more reflexive and more socially just.

The next section of this paper looks at the similarities in articulations of the values and principles of practice development and feminist critical social praxis.

Feminist Critical Social Praxis and Practice Development Fusion

Much of what practice development stands for – the values and principles of:

- *emancipation* (Manley & McCormack, 2003; Murray, Magill & Pinfold, 2012; Smith, 2016),
- *flourishing* (McCormack & Titchen, 2006; Manley, McCormack & Wilson, 2008; Titchen & McCormack, 2010; Manley et al, 2011; Manley et al, 2014),
- *participatory* (McCormack & Titchen, 2006; Manley, McCormack & Wilson, 2008),
- *empowerment* (Manley & McCormack, 2003; McCance et al, 2013) Smith, 2016),
- *transformation* (Manley & McCormack, 2003: Manley, McCormack & Wilson, 2008),

are not incommensurate with those of feminist critical praxis.

- *emancipation* (Davis, 1991, Crenshaw, 1989; Hill-Collins, 2000; hooks, 2000), and *Liberation* (Hooks, 2000; Lorde, 2013; Davis, 2016),
- *flourishing* (Lorde, 2013),
- *participatory* (Hankivsky, 2012; Hole et al, 2015;),
- *empowerment* (Hill-Collins, 2000; Ahmed, 2014; 2017),
- *transformation* (Hill-Collins, 2000; Davis, 2003; Lorde, 2013; Ahmed, 2017).

We can see the same language, expressions and concepts articulated. They seem obvious accomplices.

So, what could this mean in terms of possibilities for practice development? When practice development is looking to enable transformation of workplace cultures by recognising toxicities that result from ineffective systems, it is in effect looking to do similar transformational work that feminist theorists and activists struggling for socially just transformation are doing. They are also both ideological driven in seeking liberation and emancipation of the oppressed. This paper recognises the parallels between the work of practice development and the work of feminist critical social justice praxis; the work of upending damaging cultures and systems and transforming them for the benefit of everyone and the liberation of all. But, this paper also recognises how some of the language, discourse and ecologies of practice development are dangerously close to being contrary to this end. So, it proposes ways in which practice development can be more closely align and associate with feminist critical social justice praxis as a way of countering any contrary move.

The next section discusses local and global health inequalities, positioning these as persistent, interconnected and concerns that should be the consideration of any project

focused on interrogating systemic social systems, practicing emancipatory approaches and the creation of environs that enable flourishing of all.

Health Inequalities - Looking to the Margins

At a Medical Committee for Human Right convention in 1966, Dr Martin Luther King Jr said, 'Of all the forms of inequality, injustice in health care is the most shocking and inhuman' (King Jr, 1966). Fifty years later, societal and health inequalities continue, and so this paper proceeds by providing context and background to current understandings of how and why health inequalities exist and persist. The following statement from NHS England (2016) provides a useful starting point to understanding the structural and systemic inequalities operating in society that work in deliberate ways to discriminate against the disadvantaged in society to produce unjustifiable health inequalities,

> *Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs* (NHS England, 2016).

This statement recognises health inequalities are created by unequal societies and that there is correlation between those disadvantaged by society and their health outcomes. It also recognises those inadequate health outcomes as indefensible. Critical social theorists like Berlant (2007) have been explicit about exactly who the disadvantaged in society are, naming Black, minority ethnic, and the working poor from Western industrialised rich democracies as bodies marked out for 'slow death' (Berlant, 2007, p 754) – those for whom living is mostly about just surviving in an increasingly hostile neoliberal capitalist system. Just surviving for those living at the margins is an everyday struggle against a socially, culturally, politically and economically interdependent system that is psychically, emotionally and mentally, over time, degree by degree, gruelling for health and wellbeing; that is bodily, emotionally and mentally exhausting (Ahmed, 2017).

Hole et al's (2015) paper on Canadian Aboriginal peoples' experiences of culturally safe and unsafe healthcare discusses how stress, distress and trauma are the lived

experience of marginalised groups as a result of structural discriminatory care practices, interpersonal relationships and physical environments. Aboriginal women, in particular, experience simultaneous multiple and intersecting discriminations based on gender, race and first nation identity. A sense of being invisible, overlooked and excluded are a commonplace experience for those encountering health care systems founded on a biomedical model of care provision that works to reinforce White Western patriarchal imperialist capitalist historical, cultural, social and political 'norms'. Hole et al, (2015) advocate for elevating the experiences and perspectives of marginalised peoples because this is central to making visible discriminations and oppressions that have negative consequences for the physical, emotional and mental health of people living at the margins.

Berlant (2007) and Hole et al's (2015) research is important because it shows that what is key to more socially just approaches to healthcare is the recognition of health inequalities brought about by systemic structurally based social oppressions. They teach us that by naming and raising consciousness about oppressions, and for Hole et al (2015) of understanding oppressions as often multiple and interconnected, is the way of making visible otherwise implicit and concealed oppressions existent within, through and across social systems and systems of healthcare.

Since 2004 in England people whose asylum claims have been refused and where they have exhausted the appeals process, free healthcare is no longer a right (Taylor, 2009). In 2009 a Palestinian man suffering from chronic liver failure appealed this policy in the Court of Appeal, but the policy was upheld (R (YA) v Secretary of State for Health, 2009). We know, that because of systemic structural poverty and racism, if you are Black or from a minority ethnic group living in the UK you are more likely to be diagnosed with mental trauma/ distress. You are also more likely to be admitted to a mental health hospital, be at increased risk of poor mental health outcomes, experience worsening mental health and experience social exclusion (Mental Health Foundation, 2017). These are just some examples from England and the UK of structurally based systemic health inequalities, but these do not exist in isolation, as localised and unconnected to the wider world. We know, that in the USA, Canada, New Zealand and Australia, first nation and indigenous peoples experience systematic structural barriers to accessing healthcare, and when they are able to access healthcare they experience poorer outcomes (Gray, 2016; Hole et al, 2015; Reynolds & White, 2012). We know, that for Palestinians living under Israeli occupation access to

healthcare is severely restricted and that Palestinians suffer poorer health outcomes as a result (Watt, Giacaman & Zurayk, 2014). We know, that multinational baby formula companies promote bottle-feeding babies over breast-feeding in low-income countries, specifically in the Middle East and Africa, resulting in ill health and the deaths of babies and children, especially those from poor communities. We know, they do this for corporate profit not for improved health (Kent, 2014). We know, that today similar exploitations continue. The excessive pricing of HIV and Aids drugs by the pharmaceutical industry means those most in need, those living in the Global South, cannot access the medication they need (Ellis, 2006). We know, first nation Standing Rock Sioux are fighting to exercise sovereignty of their land and water (Davis, 2017). We know, poor communities in Flint, Michigan continue to suffer a contaminated water supply resulting from cost-cutting measures (Davis, 2017). We know, that House Bill 2 (also known as the bathroom bill) approved in North Carolina is putting transgender, gender non-confirming and non-binary peoples', and those more especially from the black LBGTQIA+ communities, health and wellbeing at risk (Cavanagh, 2010; Hunt, 2016). We know, that defunding of international development groups advising on abortion has begun, a move that will disproportionately affect Black women, women of colour and poor women around the world, and especially in the Global South (Crane & Dusenberry, 2004; Pugh et al, 2017; Singh and Karim, 2017).

Mapping these health inequalities from the local (UK) to global (across international borders) reminds us of how they are interconnected through global capitalism. Global capitalism is a system of neoliberal neo-colonialism, of free markets, of the internationalisation of economies and workforces and of pathological individualism (Puar, 2012) that has created a world built on 'destructive divisions of gender, race, class, sexuality, and nation' (Mohanty, 2003, p 43). Understanding capitalism as a destructive global force helps us to see that injustices are not isolated, but are interconnected and relational to each other and to globalised capitalism. Health inequalities exist because the structures (Berlant, 2007; Ahmed, 2017) of racism, hetro-patriachy, islamophobia, antisemitism, ableism and capitalist exploitation of the environment exist. The structures of racism and sexism that have been pointed out here: reproductive health, immigration, poverty etc. constitute a health system that does not work, or care, for oppressed and marginalised peoples (Ahmed, 2017). Transforming this globally destructive force requires collective action and is the responsibility of everyone (Mohanty, 2003; Davis, 2016). Fighting

to change one form of injustice is an inconsistency of purpose, because fighting for one struggle by necessity means it is incumbent upon us to stand in solidarity with and fight against all injustices (Davis, 2016).

Having framed the evidence around inequalities that should be the concern of those working in health and social care environments this paper now moves forward by considering how practice development language, discourse and environs form a politics of affect that can work to exclude oppressed and marginalised peoples.

DISCUSSION

Language and Discourse and Environs

Acknowledging and naming the inequalities that exist in the social world is a place from which to understand how they are historically constituted, culturally produced, politically oriented, and socially maintained (Rimke, 2016). Drawing on theories from feminists writing on social materialisms and the politics of affect (Berlant, 2007; Gregg & Seigworth, 2009; Puar, 2012; Ahmed, 2014; 2017; Fannin et al, 2014; Frost, 2014) provides a useful framework for understanding the ethics and politics of practice development language. Critical awareness of historically constituted, culturally produced, politically oriented, and socially maintained oppressions (Rimke, 2016) can come from such an understanding, as can an understanding of practice development's complicity in reproducing those. For practice development to enable, support and transform healthcare communities and collectives so that they are united in solidarity against systemic structural oppressions, it is invited to take an explicit ethical stance oriented around those who live on the margins, bringing them front and centre (Crenshaw, 1989; Hill-Collins, 2000; hooks, 2000; Hesse-Biber, 2011; Lorde, 2013; Carastathis, 2016).

Language and Discourse

Language becomes discourse through patterns of speech acts that create '*ecologies of sensation*' that have affects, and those affects are felt most greatly by oppressed and marginalised peoples (Puar, 2012, p. 150-1; 157). But, we can reclaim language for the marginalised and oppressed by understanding the power underlining it and by using it as a site of action, a site of conscious radical intellectual struggle (Mohanty, 2003). Thinking about the language and discourse used in practice development can help us unpack where it may be complicit in not only maintaining, but also reproducing oppressive *ecologies of*

sensation. Taking examples of practice development language this section will think through how it becomes a discourse, a politics of affect. The language examples drawn on are scattered throughout the principles of practice development (Manley, McCormack & Wilson, 2008): *inclusive*, *person centred, emancipatory, participatory, practice & evidence based, human flourishing, systematic transformation* and *empowerment*. By asking critical questions around who these terms are orientated towards and who they are oriented away from (Ahmed, 2006) can illuminate how language becomes a discourse that works to conceal, rather than reveal affects of marginalisation and oppression (Ahmed, 2000).

When we consider the language utilised in practice development it is unclear who it includes and for who that inclusion matters, and therefore what emerges is ambiguity about who matters to practice development. The use of *inclusive* (Manley, McCormack & Wilson, 2008) signifies all encompassing, of being for everybody, and yet feminist critical social praxis (Ahmed, 1998; Crenshaw, 1989; Hill-Collins, 2000; hooks, 2000; Hesse-Biber, 2011; Lorde, 2013; Carastathis, 2016; Davis, 2016) is clear that some bodies are marked out by society as being less worthy of inclusion. It is clear that in the social world a reference to 'everybody' does not extend to all bodies, it only extends to privileged bodies (Berlant, 2007). It is clear that we need to be clear that our expression of 'everybody' extends in particular to oppressed and marginalised peoples. This means explicitly and unambiguously referencing the experiences and struggles of oppressed and marginalised peoples.

We need to be cautious of assumptions around the neutrality of language too and seek to reveal the relationship knowledge as language has to power (Butler, 2001) and how that manifests in practice development. *Person centred* (Manley, McCormack & Wilson, 2008; McCormack et al, 2014; McCormack, 2015; Slater, McCance & McCormack, 2015) may be assumed to be a 'neutral' term. A term that can capture and account for all peoples' experiences and situatedness (Haraway, 1991). But, when the terms we use do not explicitly recognise the very particular experiences of subjugated people, then what that supposed 'neutrality' does is collapse and disappear their experiences of oppression. 'Neutrality' does the very work opposite to the definition of the word. It conceals; it does the politics of concealment by actively negating oppressed and marginalised peoples' experiences and voices (Ahmed, 1998). *Person centred* is un-neutral because using it enables the conflation of identities, ways of being. It works to disappear inequities and injustices. For practice development moving away from signifying singular experience, has had the tendency to

homogenise people rather then focus on differences that matter, and on unity through those differences that matter (Ahmed, 1998; Lorde, 2013). The risk through homogenisation is to be at best disconnected from, and at worst in denial of, the oppressions and violences marginalised people experience and a complicity in reproducing and maintaining those. Bringing front and centre the experiences of oppressed and marginalised peoples (Ahmed, 1998; Crenshaw, 1989; Hill-Collins, 2000; hooks, 2000; Hesse-Biber, 2011; Lorde, 2013; Carastathis, 2016; Davis, 2016) is part of doing the work of standing in solidary with interconnected human, environmental and species liberation struggles (Mohanty, 2003; Davis, 2016).

'Human flourishing' (McCormack & Titchen, 2006; Manley, McCormack & Wilson, 2008; Titchen & McCormack, 2010; Manley et al, 2011; Manley et al, 2014) also presents us with an overly inclusive language, of all humans mattering. But, by proposing that all humans matter there is a failure to see that oppressed and marginalised peoples are often subject to experiences of dehumanisation, and situated as those who do not matter. As Rimke (2016) points out, that their experiences and very being are disregarded by being historically, socially, politically and culturally denied full membership of civic society. What we know from feminist critical social praxis (Berlant, 2007; Rimke, 2016; Ahmed, 2017) is that 'flourishing' for oppressed and marginalised people's is more likely to be about just surviving, just maintaining themselves day to day than being about prospering and self-making (McCormack & Titchen, 2006; Titchen & McCormack, 2010). We see this in the quotation at the beginning of this paper where Lorde points to how she is not free to flourish because of the oppressions and exclusions she has experienced as a poor, Black lesbian, older woman (Lorde, 2013). *Flourishing* as a term that refers to fulfilling potential and being full members of civic society is not always possible because systemic structural barriers experienced as day-to-day living for oppressed and marginalised peoples prevent this. For oppressed and marginalised peoples *flourishing* is about the struggle to just exist a process of maintaining yourself in a world that does not want you to prosper (Berlant, 2007; Ahmed, 2017).

When practice development refers to its tenants as '*participatory*' (McCormack & Titchen, 2006; Manley, McCormack & Wilson, 2008) and '*practice and evidence based*' (Manley, McCormack & Wilson, 2008; Rycroft-Malone et al, 2014), what we have to ask are critical questions around who has the social and cultural capital, the power to participate

and thereby have their voices and experiences positioned front and centre? Whose evidence and practice are being elevated, held up and supported as the exemplar and referent marker by which all others are measured?

When practice development speaks of '*systematic transformation*' (Manley & McCormack, 2003: Manley, McCormack & Wilson, 2008), '*empowerment*' (Manley & McCormack, 2003; McCance et al, 2013) Smith, 2016), of being '*emancipatory*' (Manley & McCormack, 2003; Murray, Magill & Pinfold, 2012; Smith, 2016), we need to ask the critical questions: Who is already empowered? Who is already liberated? Who does the system already work for? Who is excluded from the system? Who do we need to transform the system for? When practice development talks of '*culture*' (Manley & McCormack, 2003; Manley, McCormack & Wilson, 2008; Manley et al, 2011; Murray, Magill & Pinfold, 2012; Sanders & Shaw, 2015), we needs to ask the critical questions: What and whose 'culture' are we referring to? By doing the work of revealing and naming the affects of dominant cultures on oppressed and marginalised peoples we can begin to orientate practice development towards a more critical social justice praxis.

Returning to the very beginning of this paper, and the method of looking to the margins of society and naming the oppressions that are the everyday lived experience of the disenfranchised (Lorde, 2013), provides a methodology and method for practice development. That of elevating marginalised voices and bringing them front and centre (Crenshaw, 1989; Hill-Collins, 2000; hooks, 2000; Mohanty, 2003; Hesse-Biber, 2011; Lorde, 2013; Carastathis, 2016). This methodology and method is important because using it validates that all people matter because those who all too often matter least are shown to matter the most (Ahmed, 1998; hooks, 2000) to practice development.

In conclusion of this section, inclusive *gamp* language, gamp because it is shading many things, when utilised by practice development fails to speak of the experiences of oppressed and marginalised peoples, thereby conflating all lived experiences. It works to flatten out, overlook, and conceal the differences that matter, the differences that matter to the bodies that matter, and matter so much more specifically because they experience oppression and violence, oppression and violence that is so often not recognised (Ahmed, 1998; 2006). That language of *gamp* inclusivity is without articulation of whom it excludes.

Environs

When we think about practice development environs (the ethics and politics of affect, of emotional connections across the human and non-human), practice settings, micro-healthcare systems (Manley, McCormack & Titchen, 2013), we need to think about how environments, conditions and cultures can potentially do harm. Feminist critical social praxis (Berlant, 2007; Gregg & Seigworth, 2009; Puar, 2012; Ahmed, 2014; 2017; Fannin et al, 2014; Frost, 2014) is helpful for framing this new formation in thinking. Puar's (2012, p. 150-1; 157) work in particular is helpful, referring to these phenomena of harm as '*ecologies of sensation'*, and focusing on marginalised and oppressed bodies as the ones most harmed. In reframing what and who practice development is for, and what and how it can embody a new formation towards social justice, feminist critical social praxis helps us to explore what is meant by environments, conditions and culture in different terms; as bodily assemblages (Ahmed, 2017), as affects that have accumulative damaging affects for oppressed and marginalised peoples (Puar, 2012). One of the most important aspects of feminist critical social praxis is the practice of looking to the margins (Crenshaw, 1989; Hill-Collins, 2000; hooks, 2000; Mohanty, 2003; Hesse-Biber, 2011; Lorde, 2013; Carastathis, 2016). So, when we think about what a radical praxis for practice development looks like we know it must recognise and explicitly look to raise consciousness about the lived experiences of those most marginalised in society. That is Black women, women of colour, lesbian woman, poor women, transgender people (Davis, 2016). This will help us to map power as historical constituted, socially maintained, politically oriented and culturally produced (Rimke, 2016), and to understand the consequences of such structural systems as a politics of affect (Puar 2012; Ahmed, 2010; 2014; 2017). From acknowledging the politics of affect can come hope and action towards reimagined and transformed healthcare systems and cultures, towards radically transformed anitracist, anti-hetro-patriarchal and anticapitalist environments and worlds (Mohanty, 2003).

In addition to practice development thinking through the affects of healthcare spaces, places and the encounters that take place within them, reflexivity around the landscape of practice development is also required; so a mapping of who theorises, who researches and who practices practice development is also necessary. To what extent is practice development challenging itself to be more diverse and representative of diverse peoples? Observation at a large practice development conference last year led me to ask

why there were so few Black people and people of colour present. All the keynote speakers were White, and for the most part I heard and saw White authored literature discussed and presented. I *observed* this as a White woman. *Observed* is the right adjective, as I have no way of knowing the affect all that Whiteness would have for a Black person, a person of colour; the harmful marginalising and oppressive affect of *gamp* language and discourse, and an environment dominated by White faces (Ahmed, 2017). What we can learn from feminist critical social justice praxis is that such an ecology made for a very exclusive type of practice development conference. Of a White practice development. Of a practice development that was doing the work of excluding those at the margins. Failure to be reflexive, think critically and take action about the Whitewashing of the conference constitutes complicity in that Whitewashing (Ahmed, 2017). Whilst the intentions of practice development are worthy, the intension to be *all* inclusive, ignoring the differences that matter (Ahmed, 1998), effaces the struggles, histories and materiality of oppressed and marginalised peoples and our own collusion in practicing and reproducing these.

Articulated within this paper is an invitation for practice development to be a part of the larger project of decolonising healthcare. Doing this work means also being a part of, and standing in solidarity with, the same world changing projects and struggles to decolonise more broadly (Mohanty, 2003; Davis, 2016; Ahmed, 2017). This new formation in practice development is about structural systemic transformation by adopting a feminist critical social justice praxis. This can be done through acknowledgement of privileges (White privilege, cisgender privilege, straight privilege, class privilege, male privilege, and species privilege), a commitment to deconstructing and being accountable for those privileges, to decolonising minds, and to creating and sustaining socially just spaces, places, cultures and environments (Mohanty, 2003). Such an ethic constitutes a feminist critical social justice practice development. Feminist critical social justice practice development by virtue of seeing the potential for practice development to be praxis that is committed to social justice, wilful in its intent to decolonise itself and doing the work of supporting wider decolonisation, as well as working in solidarity across all anti-oppressive projects (Butler, 2001; Ahmed, 2014). So to stand explicitly in solidarity with Palestinian liberation, Black liberation, LGBTQIA+ liberation and to join struggles as accomplices against racist, hetro-patriarchy, capitalist systems of oppression (Davis 2016).

Conclusion

With its roots in critical social theory, practice development should not find it difficult to see the benefits a feminist critical social justice stance can bring to radically transforming it. The current genealogy of critical social theory underpinning practice development has yet to enable it to go to and articulate the materiality of the lives of the most oppressed and marginalised peoples. By reaching within and cracking open normative practice development language, discourse and environs, its relationship to knowledge and power can be revealed, and from revelation transformation can come, because such revelation unlocks what has been obscured but not yet entirely disappeared; the potential in practice development that has always been there.

This paper invites a feminist critical social justice practice development to emerge that is open to recognising systemic structural injustices and oppressions. Bringing that truth into its approach will be a clear signal of a more reflexive, critical and socially just ethical praxis. Where is emancipatory practice development without the freedom and liberation of oppressed and marginalised peoples? If we do not make visible the particularities and materiality of the lives of marginalised and oppressed peoples, we cannot make visible our own privilege, and if we make visible our own privilege and how it is directly bound up and implicated in the oppression of others, we cannot transform, as an ongoing collective effort, ourselves, our communities, our societies, our worlds.

Achieving radical cultural, social, political and economic transformation in healthcare, and beyond, needs to come from an orientation of an explicit ethical stance. Of critical awareness of the affects of neoliberal neo-colonial capitalist systems; of ecologies of oppression. Such an ethic can enable healthcare communities to be united in difference and to stand in solidarity with each other; as accomplices in each other's struggles; as part of a movement for change against structural systematic oppressions.

It is important to acknowledge that what is suggested in this paper is all knowledge mostly learnt from Black feminists and feminists of colour. There is no claim to uniqueness of thought, just the application of existing knowledge to a context that has yet to benefit from it. Black feminists and feminists of colour already know the knowledge imparted in this paper. It is through their generous sharing that I have come to know that their worldview is the truth of this world. I thank all of them for teaching the world about what it is and how it can do and be better. I would encourage all practice developers to seek out and learn from

the many texts and writings of Black feminists and feminists of colour so that they too can travel to the truth.

This paper closes by returning once again to the words of Aurde Lorde because her words are an invitation to recognise material differences and to seek alliance through that recognition. Therefore, towards the recognition and articulation within practice development of the differences that matter, the lives that matter we return to Audre Lorde,

> *Difference must be not merely tolerated, but seen as a fund of necessary polarities between which our creativity can spark like a dialectic. Only then does the necessity for interdependency become unthreatening. Only within that interdependency of different strengths, acknowledged and equal, can the power to seek new ways of being in the world generate, as well as the courage and sustenance to act where there are no charters* (Lorde, 2013, p 111).

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