The singular patient in patient-centred care: physiotherapists’ accounts of treatment of patients with chronic muscle pain

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ABSTRACT
A patient-centred approach has gained increasing interest in medicine and other health sciences. Whereas there are discussions about the meaning of a patient-centred approach and what the concept entails, little is known about how the patient as a person is understood in patient-centred care. This article investigates understandings of the patient as a self in patient-centred care through physiotherapy of patients with chronic muscle pain. The material consists of interviews with five Norwegian physiotherapists working in a rehabilitation clinic. Drawing on Kristeva’s discussion of subjectivity in medical discourse, the study highlights two different treatment storylines that were closely entwined. One storyline focuses on open singular healing processes in which the treatment was based on openness to a search for meaning and sharing. In this storyline, the “person” at the centre of care was not essentialised in terms of biological mechanisms, but rather considered as a vulnerable, irrational and moving self. By contrast, the second storyline focused on goal-oriented interventions aimed at restoring the patient to health. Here, the person in the centre of the treatment was shaped according to model narratives about “the successful patient”; the empowered, rational, choosing and self-managing individual. As such, the findings revealed two conflicting concepts of the individual patient inherent in patient-centred care. On the one hand, the patient is seen as being a person in constant movement, and on the other, they are captured by more standardised terms designed to focus on a more stable notion of outcome of illness. Therefore, our study suggests that the therapists’ will to recognise the individual in patient-centred care had a counterpart involving a marginalisation of the singular.

INTRODUCTION
Patient-centred approaches have been growing in popularity in healthcare practice in recent years, partly because they suggest ways of reducing the gap between the world of medicine and the world of the patient.1–4 Although definitions vary, the concept of patient-centredness is commonly described as understanding the patient as an autonomous human being with particular experiences and needs.5–6 Through patient-centred care, health professionals are encouraged to respect the patient and take his/her particular interest into account; entering the patients’ world, and seeing their illness through their eyes.7 Mead and Bower argue that patient-centredness in medicine encompasses various dimensions including the recognition of the person-as-person, and the active sharing of power and responsibility with the patient through a therapeutic alliance.8 Shared decision making and goal planning, inter-professional collaboration, an open dialogue forging a therapeutic alliance, and active listening directed towards the individual patient’s needs have all been highlighted as important contributors to patient-centred care in recent years.9–11

However, studies on patient-centredness in medicine and health sciences have highlighted several challenges in providing patient-centred approaches in clinical settings.12–15 Bensing points out that disease and illness belong to two different worlds: the first belonging to the world of best evidence, based on empirical studies of large groups of patients; and the second being based on experiential, subjective knowledge of the patient as a unique human being.16 In general, studies of patient-centredness in medicine conclude that physicians need to improve their communication skills with the patients in order to bring together the world of medicine and the world of the patient.17 18

Lo’s study on how cultural bridging between cultures of medicine and the patient’s lifeworld is performed in cross-cultural clinical settings highlights how physicians perform the bridging work in different ways.19 The study shows that the physicians, through a patient-centred approach, are not just relating to the patient, but also the patient’s social network. Hence, the author concludes that cultural bridging is cultural labour, which requires time and recourses.20

Similarly, Naldemirci and colleague show that patient-centredness in healthcare practice is performed in many different creative ways.21 However, the authors claim that patient-centredness is based on the assumptions that a person is independently capable of reasoning and verbal expression and is willing to provide clear and genuine narratives and cooperate with healthcare professionals. Hence, the authors warn that tenacious assumptions of person-centred care may distract attention away from the variety of ways that professionals and persons find for translating the ideal of person care into practice.22

In the context of rehabilitation, Leplege et al discuss a number of ethical aspects with person-centred care in clinical practice.23 The authors particularly point out that clinical practice is characterised by a dissymmetry between the patient and the clinician, with the latter being responsible for acquiring knowledge about the patient’s health problems and finding means for the patients to reach their goals. The
authors argue for a need for the concept of person-centred care to be translated or “transferred” from medicine and the biomedical model, where the concept originated, into the field of rehabilitation. In this context, studies point out how the role of the professionals need to be discussed in the face of patient-centred care, and suggest that healing, caring and compassion should have a higher place in rehabilitation if the person is truly to be in the centre of rehabilitation.

Few studies have questioned the concept of the individual patient inherent in patient-centred care, however. Who is the individual or the “person” on whom the treatment is supposed to be centred? In this article, we examine health professionals’ understanding of the patient as a self, using physiotherapists’ treatment of patients with chronic muscle pain as our point of departure.

Physiotherapy is deeply rooted in the culture of medicine, and along with medicine has engaged in the recent discussions about patient-centred care. Physiotherapy, under a patient-centred model, implies active work on the part of the therapist as they get to know their patient; communication and an ongoing dialogue between therapist and patient; goal setting as a way of motivating and empowering the patient than may have been evident in more traditional approaches to physiotherapy. Compared with medicine, the patient’s participation in physiotherapy is not related to choice of treatment, but rather to the setting of individual treatment goals and the training phase of rehabilitation or treatment. Several studies on patient-centred approaches in physiotherapy, however, point out obstacles related to goal setting, both from the point of view of the patient and the therapist.

In physiotherapy, a patient-centred approach has been particularly discussed in relation to patients with chronic muscle pain. This may be because there are often few physical findings that can explain the patients’ prolonged pain condition, and as such, illness has been stubbornly resistant to “standard” biomechanical physiotherapy treatment approaches. Consequently, physiotherapy’s focus for patients with problems like chronic muscle pain has moved away from “curing” the disorder, to helping the person live with the pain. This approach necessarily implies a search for the meaning of pain for the individual patient in his or her life, and an active role for the therapist in trying to enter the world of the patient. In this context, narrative competence with the physiotherapist is argued as valuable with regard to developing critical reflections on clinical practice and making a clinical decision.

We use this understanding of the subject in motion as an analytical lens through which to read the various understandings of the person underpinned in our physiotherapists accounts.

THEORETICAL FRAMEWORK

The patient as a singular subject

Julia Kristeva criticised what she claims to be a dominant notion of the self as a substance—a definite unit—in Western philosophy. Her alternative concept of a subject in process (sujet en procès) has two significations. On the one hand, it points out that the subject or the self is not stable but in constant movement. The self is not a being but a becoming. On the other hand, the unity of the self is always under threat of dissolution, negativity and destruction (en procès). According to Kristeva, this fundamentally procedural, threatened character of the subject is marginalised in medical discourse, which objectifies health as a “definitive state”—a condition of “full being” (health)—while illness is conceived as the privation (steresis) of this original state. This schematism has separated health from healing as a process “with twists and turns in time”.

By the same token, biomedicine’s concern with cure is separated from the “durable idea of care”, and the liminal period between birth and death. In line with this logic, biomedicine understands cure in terms of “repairment” and a recreation of a condition of full being (health).

However, such a cure is impossible, Kristeva argues, because the person/self never was a “full being” in the first place, but a continuous process of becoming; a process that is constantly in motion; threatened by dissolution and destruction. Sickness and health are therefore not understood as opposite conditions but rather as part of the life/self-forming continuum. By creating this false dichotomy, modern medicine has separated health from the self. Instead of a cure that tries to recreate a condition of full being cleansed of all sickness and destruction, we need a concept of care that considers people as being in a constant process of healing.

Kristeva’s arguments have profound implications for how we understand the person in person-centred care. The person is not a substance, either in terms of being a unified illness experience or a rational actor. “What is the subject?”, Kristeva asks rhetorically: “That which in a man or woman remains open to a search for meaning and sharing”.

If we apply Kristeva’s concepts of health and healing to clinical practice it allows for a person-centred approach that is open ended and for a patient’s self to be in constant movement. In this paper, we use this understanding of the subject in motion as an analytical lens through which to read the various understandings of the person underpinned in our physiotherapists accounts.

METHOD

Design and ethics

The material presented in this article forms part of a larger study of the illness experiences of patients with chronic neck pain, the aim of which was to provide a broader understanding of the treatment/physiotherapy of people with these kinds of problems, mainly from the perspective of the patients, but also from the therapists’. To investigate the physiotherapists’ understanding of the patient as a self, the study was designed using qualitative interviews. The empirical data of this article consists of five semi-structured interviews with physiotherapists working in a Norwegian rehabilitation centre. The study was conducted in line with the Helsinki Declaration Act and was approved by the Regional Committee for Medical and Health Research Ethics in Norway (ref. 2009/1017) and Norwegian Social Science Data Services (ref. 19429). All participants gave written informed consent to take part in a recorded interview.
Recruitment and participants
The study was performed in a Norwegian clinic specialising in rehabilitation of people with musculoskeletal problems. The treatment at the clinic was developed by an inter-disciplinary team, consisting of professionals with expertise in various fields of medicine, physiotherapy, nursing, psychology, nutrition and sport. Inter-professional collaboration—seen as a healthcare practice in which different health and social care workers collaborate for the delivery of holistic or comprehensive care involving the patient as a person—is regarded as essential for delivering patient care that takes into account the complexity and multi-faceted terms of health problems.44 45 The choice of clinic was purposive.46 Being part of an inter-disciplinary team we assumed that the physiotherapists working at the clinic would have integrated a patient-centred approach in their practice and that they would have made this a cornerstone of their approach to rehabilitation. The clinic was chosen because of good reputation and because it followed current guidelines of treatment of patients with chronic muscle pain. In addition, the actual clinical was chosen because of large premises and a high number of employees, and as such gave access to a rich sample of both patients as well as physiotherapists. An information letter describing the aim and purpose of the study was sent to all the physiotherapists working at the clinic, and all participants volunteered to take part in the study.

In total five physiotherapists, two men and three women, aged between 30 and 45 years, were recruited from the clinic. While the physiotherapists’ work experience varied in terms of both content and length, all had worked at the clinic for between 2 and 5 years. Two of the physiotherapists had extensive experience treating patients with chronic muscle pain before starting work at the clinic (5 and 15 years), while the other three had gained experience working mainly at the clinic. We hoped that by including both men and women, with rich experience working in a multi-disciplinary team, we would gain access to information-rich cases that would illuminate how the physiotherapists made sense of the patient’s individuality in a patient-centred way.47

Interviews
Data collection consisted of semi-structured interviews. Participants were invited to talk about their practice, after an initial prompt to “[t]ell (me) about your experiences with treatment of patients with chronic muscle pain at the clinic”. Although the physiotherapists formed part of an inter-disciplinary team and cooperated regularly with colleagues in other professions, the focus of the interviews was on the therapists’ particular experiences of treating patients with chronic muscle pain.

All interviews were conducted and analysed by the first author. The interviews were conducted at the clinic in a room used for patient consultation. The participants were not explicitly asked about their views of the patient as a subjective self. Rather, approaches to this question were made by inviting the participants to reflect on their role as a therapist; the patient’s participation in the treatment; and the treatment process. As a physiotherapist herself, the interviewer was familiar with the setting, the language and the culture of physiotherapy, which made accessing and engaging with the participants easier. However, to meet the challenge of going beyond what was taken for granted by both parties, the interviewer tried to keep her questions open and asked for specific examples. The interviews lasted approximately 60 min, and were recorded, to be transcribed verbatim by the author shortly after each interview had taken place. The interviews were conducted in Norwegian, and the quotes from the interviews were translated by the first author.

Data analysis
Analysis of the transcribed material was inspired by Kristeva’s discussion of the subject in medical discourse and narrative inquiry. Narrative theory centres on the way people give meaning to experiences by configuring a set of events and experiences into a temporal sequence in which one thing happens as a consequence of another.48 49 We used narrative analysis in order to grasp the treatment processes in the therapists’ accounts, as well as how the therapists drew on or resisted the medical discourse when they narrated their experiences with the treatment of patients with chronic muscle pain. We analysed the therapists’ stories with regard to content and structure.50 51 The researcher started by reading all the interviews to gain an overall impression and identify common themes. These were associated with concepts embedded in patient-centred care, such as “the patients as active participants in decisions about the treatment”, “the setting of individual treatment goals” and “the sharing of power and responsibility”. As such, the therapists’ accounts appeared superficially to be framed by one common treatment narrative. When analysing the narrative structurally, we confronted the material with Kristeva’s concept of health and healing, with a view on the patient as self, by asking the following questions: How is the patient as a self expressed in the story? How is the therapists’ treatment story structured with regard to temporality? By doing so, the researcher identified two distinctive storylines operating within the accounts. The analysis proceeded through the development of the two different storylines, in a constant shift between working with the empirical material and the theoretical framework, with a view to the process and the patient as a self. Importantly, the two storylines were intertwined and integrated in the therapists’ common narrative of treatment of patients. However, in order to show how the concept of the individual patient is expressed in the therapists’ treatment narrative, we have chosen to present the two storylines separately here. The first is titled “Subjects in search of meaning”, and the second “Ideal images of the successful patient”.

FINDINGS
Subjects in search of meaning
The first storyline that grew from our analysis could be characterised as an openness on the part of the physiotherapists towards the meaning of pain for the singular patient. In this storyline, the therapist’s approach to treatment was not based on the assessment and treatment of some physical absence or lack, deficits or limitations in the patient, but rather, it was governed by a mutual search for meaning and sense-making. For example:

I try to talk to [the patients] in order to understand what they feel are their own limitations and challenges, and then I try to understand what they see as good progress, what they see as an opportunity and what they enjoy doing, both in terms of activities and in terms of their work… For example, some patients say that “I should perhaps exercise, and I should maybe do this particular exercise, but I’d rather prefer to go for a walk in the forest”. Then I try to play further on what they say and show them that there are plenty of opportunities in walking in the forest also, which may give the same effect as doing specific exercises. I try to minimise the “I should”, and instead focus on what they want and what their interests are and what they enjoy doing… instead of me wanting something for them. [PT1]

The therapists tried to get to know the patient, understand the meaning of pain, and the things that affected the life of the patient. Rather than developing a treatment regimen based on general training principles, the therapists tuned in to the individual patient’s narrative. The therapists asked the patient what he or she enjoyed doing with regard to movements and physical activity;
what mattered to them; and what were their hopes for the future. These questions formed the basis of the therapists’ approach to treatment. The patient’s voice and experiences were important in clinical practice, not only as a carrier of the patient’s interests and needs, but as part of the construction of new meanings. Echoing Kristeva’s concept of the subject in process, therapist and patient were portrayed to interact in an open manner, with neither of them knowing necessarily what was ahead of them and where they were going. The treatment was itself a movement in constant state of becoming.

The “subjects in search of meaning” storyline offered by the therapists also focused on the patient’s body, not only as the place where the pain was located, but as the patient’s source for insight about themselves and illness. The body was seen as the site for the creation of new meanings. Hence, the treatment did not primarily aim at building up the patient’s muscle strength, or increasing range of motion in specific joints in order to eliminate the pain or reduce it. Rather, the treatment aimed at building bodily awareness and developing a deeper sense of how the patient’s body functioned in everyday life. The patients were involved in clinical practice as bodily subjects with singular bodily experiences and habits. As this therapist explained when talking about working with patients with complex health problems:

The main activity is not exactly training, but rather building body awareness of how [the patient] uses his neck, for example. “How is the tension in your muscles?” “Can you feel the difference between tension and relaxation”. I spend more time talking with them. Ask them if they have much pain when coming home from work. Ask them “Are you able to take breaks during the day”? […] We want to build their confidence that activity can be good, but that is has to be adjusted to their level of tolerance. [PT2]

The therapists inquired into the individual patient’s world, and acted as interpreters between the patient’s body and their self-concept. For example, if the patients experienced pain from certain movements or activities and were anxious about moving, the therapists comforted them and proposed alternative ways to move that were adjusted to their individual level of tolerance. The therapists focused on providing the patient with new bodily experiences. For example, they would arrange for physical activities in the form of play, in order for the patients to experience moments in which they forget or overcome pain. Or, the therapists accompanied the patients for walks outdoors in order for them to experience the feeling of fresh air and the joy of being in motion:

I try to make [the patients] feel for the first time the joy of playing, where they forget their worries and fear and where they race around in the gym, in joy. When I see that I have done a lot. Or when they get out in the nature on Nordic walking and realise “this is for free”, “this I can do myself”, “it’s so simple”. [PT3]

In general, the therapists’ treatment storyline focused on creating moments in clinical practice in which the patients were allowed new experiences of themselves and their own bodies while at the same time living with pain and illness. The approach aimed at strengthening the patient’s sense of self.

Further, this storyline focused on ordinary conversations between therapist and patient during the therapy sessions. The therapist and patient spent time together talking about all sorts of things quite unrelated to strict goals of physical function, for example:

We have individual talks with all the patients, both at the beginning and at the end … So you become more than a physiotherapist in a way, yes you do. People talk about almost everything, some talk about their job, right, some talk about psychological functioning, some talk about their family life, so in many cases we get the role of a guide more than a therapist. [PT4]

In order to follow the singular patient and what mattered most to them, the therapist often had to go beyond their perception of their traditional physiotherapy role, with its focus on bodily structures and functioning, and venture down less clearly defined paths. The treatment was an open journey. The patients were involved in clinical practice as vulnerable subjects in need of recognition and care. As one therapist explained:

[One patient] had a lot of resources which were not really revealed, because she felt she was opposed, and that nobody understood what she really wanted. She felt opposed in very many ways. And then she said that here [at the clinic] she was met … with a kind of respect. And this lifted her up in a way … I learnt that maybe one should risk going, for example, into conversations with patients; dare joining the patients in their frustration; not being afraid and stop thinking this is not my field of competence, but daring joining the patients in these talks, I think that is important . [PT1]

The therapist’s storyline focused on the individual’s own actions and interests in their healing process, based on careful listening to the singular patient’s illness story, and openness to a search for meaning and sharing with the individual patient. The patients were not essentialised, in terms of biological mechanisms and deficits, rather they were involved in clinical practice as bodily and vulnerable selves in constant movement.

Ideal images of the successful patient

The second storyline had a different structure and focused on the patients’ progression in the treatment and outcomes. The process started with the act of setting goals for treatment. The patients were expected to move on in life—a point frequently reinforced by the therapists. The treatment was individualised, designed according to the patient’s wishes and needs to reach the mutually developed and agreed upon treatment goals. It was up to the individual patient, in collaboration with their therapist, to decide what they wanted to achieve for themselves, both in the short and long term. The patient as a person was assumed to be rational, making autonomous choices in managing their illness:

Here at the clinic we always have a goal-setting in the initial conversation with the patients. It is my job to point out to them that this is a collaboration between them and us and that they also are responsible whether this is a fruitful process or not. It requires that they show up and that they try to see their situation and that they make an effort … I expect that they are conscious and active actors in this process. “What do you need to do more of? What do you need to become more aware of”? … “What do you think, in 3 months … you can do more of”? Or “How can you adjust the burden in your daily life in order to get there”? [PT5]

This storyline focused on clarification of roles and distribution of responsibilities between the therapist and patient. The clinical encounter seemed to be dominated by discussions of how to reach the patient’s individual goals—how best to get there.

In particular, this storyline about treatment of patients emphasised the patient’s own responsibility to adhere to the treatment plan. Improvements did not come by themselves or through the therapists’ knowledge and actions alone. Rather, in order for the treatment to be successful and the patient to achieve their goals, the patients had to make an effort. This storyline was governed by images of an ‘ideal person’; the rational, motivated and compliant
individual, showing up for their appointments, and doing their exercises which is valued as important for patients. “We don’t do miracles” as one therapist put it:

In the examination [of the patient] we try to find out if the patient believes in recovery; believes that he can return to work; believes that this treatment may be sensible. Then I think we actually can help. Because we don’t do miracles here. We rely on people to do something, and those who want to try and believe it works, they seem to make it. While those who believe that “No, I should have been operated [on]”, and “This treatment approach is completely wrong”, and seem rigid on that, well then it may not be relevant with this kind of treatment. [PT4]

The storyline that focused on open singular healing processes, and the co-construction of new and shared meanings, were frequently replaced by purposeful interventions aiming at restoring function so that patients could return to work. The sense of an open dialogue between the therapist and the patient, with mutual developed treatment was often replaced by general information given to the patient about the treatment, particularly the rehabilitation centre’s ambition for vocational rehabilitation. Individual patient choices were limited by the information given to them and the context in which it was received. This means, in order to be heard and form the basis for decisions about the treatment, the patient’s voice had to be informed by the right knowledge. The effect of this was a subtle “moulding” of the patient into an idealised person; the health literate individual, making rational choices about his or her own health, based on the information provided by the physiotherapists and others.

By contrast with the storyline of the patients as bodily subjects in search of meaning, this storyline focused on the patients’ lack of physical activity and physical fitness. In this context, the therapists appeared as guides, giving exercise advice and exercise support to the patient:

Activity is good and [the patients] have to do the work themselves while we [the physiotherapists] act as guides. [The patients] need to try things out and make mistakes, to experience themselves: “Now I’ve done too much, okay, next time I have to do a little less.” [PT02]

The focus on the patient’s singularity as a bodily and vulnerable subject was replaced by ideals of the self-managing and physical active individual. The patient as a person was shaped by the production of idealised physical condition, and returning the patient back to work. Here, the patient as a person was shaped by the production of idealised images of “the successful patient”—a rational, compliant and self-managing individual. As such, the findings revealed two conflicting concepts of the individual patient inherent in patient-centred care.

Although both storylines were evident in our data, they were, themselves, in a state of constant flux throughout the narratives. Sometimes we found the beginning of stories dominated by the storyline of patients as singular subjects in search of meanings, with the storyline shifting in the next moment to the therapists talking about model narratives of the “successful patient”. At other times, the two narratives were reversed.

By emphasising themes such as the setting of individual treatment goals, our study resonates with other studies on patient-centredness in physiotherapy. However, drawing specifically on Kristeva’s discussions of subjectivity in medical discourse, our study highlights how the development of individual goals in clinical settings may be based on assumptions that the patient as a person is health literate and able to make rational choices about his or her own health. This means the focus on treatment goals in patient centred care may be an obstacle in providing individualised care that allows for the patient to be in constant movement. By highlighting two different storylines that alternate in the therapists’ treatment accounts, our study shows how the patient on whom a patient-centred care is centred risks being cultivated in the production of ideals of the successful patient.

By emphasising two intertwining treatment storylines, our study resonates with Naldemirci et al’s study on person-centred care in clinical practice. However, drawing on interviews with researchers in three different research projects working in a centre for person-centred care in Sweden, Naldemirci highlights how people recognised as unique and capable varies significantly in practice across different healthcare settings. However, the study points out how the potentially tenacious assumptions about the attributes of personhood risk distracting attention away from the variety of creative ways
that professionals and persons find for translating the ideal of person-centred care into practice. In a similar way, our study of physiotherapists’ accounts of treatment of patients with chronic muscle pain highlights how the focus on the patients as singular, bodily and vulnerable subjects risks being replaced by the medical discourse, focusing on the patient as active, independent and rational choosing individuals.

By highlighting the image of the ideal patient—the successful patient—in the therapists’ treatment accounts, our study resonates with Juritzen et al’s study on empowerment in the context of a nursing home in Norway. By analysing a programme plan on empowerment for nursing home personnel the study highlights how the plan functions as a tool for providing expert assistance to the user’s self-help. Furthermore, the study shows that the plan’s image of empowerment presupposes an “elite user” able to articulate personal needs and desires. The authors discuss how these qualities may not be applicable to the most vulnerable user group, who thereby may end up in an even weaker position.

Similarly, our study highlights how physiotherapists’ treatment of patients with chronic muscle pain presupposes an ideal individual who is health literate, rationally choosing and physically active, and as such, many patients may feel inadequate or excluded from receiving the help they need.

By emphasising the image of the ideal patient who actively participates in the treatment and takes responsibility for his or her own recovery process, our study resonates with Fox and Reeves’ research on inter-professional collaborative patient-centred care. From a power perspective, the study highlights how the sharing of responsibility or the delegation of decisions to the patients may in fact be seen as a removal of the load of professional responsibility. Further, the authors point out how the patients may be seen to be responsible for their own illness should they fail to take responsibility for making the right decisions and doing the right things to maintain health. Hence, as argued by Fox and Reeves, patient-centred care may be seen not as a route to share medical power, but rather as a mechanism to extend its reach even further so that professionals and persons find for translating the ideal of empowerment in the context of a nursing home in Norway.

In a similar way, our study on physiotherapists’ treatment stories of patient-centred approaches suggests that the patients who do not take responsibility by complying with the treatment may be seen to be responsible for not getting better. Furthermore, by emphasising the ideal of the self-managing individual, empowered through various tools external to themselves, our study shows how power may be enforced in clinical practice through the model of patient-centred care.

On the one hand, our findings show how a patient-centred approach to care implies an interest in the patient as a person. By using physiotherapists’ accounts of their treatment of patients with chronic muscle pain as the case, our study highlights an attentiveness to the singular patient’s illness story, and the particular patient’s interests and values with regard to movement and physical activity. The treatment is explorative and shaped in the interaction between therapist and patient. On the other hand, our findings suggest that therapists’ understanding of the patient as a person is also shaped by biomedicine, dominated by goal oriented interventions aimed at restoring the patient to health. Here, the patient’s singularity is replaced by ideals of the empowered, self-managing and health literate patient, who contributes to rational decisions about his or her own health. In her criticism of the notion of subjectivity in medical discourse, Kristeva claims that modern biomedical discourse tends to embrace the individual while marginalising the singular.

Instead of individualised treatment based on the logic of choice, Kristeva argues for the need for singular care based on proximity, sharing and freedom: not in terms of a choice, but “a construction and a bypassing or transcendence of the self with and towards the alterity of the other”.

The therapists’ “will to empower” the patients is clearly present in our data. Cruikshank explains empowerment as a strategy or method used to increase power to the “powerless” by maximising their actions, motivation, interests and participation in social life. In a clinical context, patient empowerment is used to describe the provision of strength and power to the sufferer and the vulnerable, in order to develop the resources of the individual rather than focusing primarily on physical findings and defects. Our findings show how the therapists empower the patients by recognising them as experts of their own illness, by providing the patients with new movement experiences, and by building the patients’ self-confidence in their own body, movements and physical activity. At the same time, the study shows how patient empowerment is carried out in the production of ideals of “the successful patient”; the physical active and rational choosing individual that manages his or her own health. As such, our findings show that the therapist’s will to empower the patient may be accompanied by the marginalisation of the singular.

From our study, we have seen that the two contrasting perspectives of the “patient-self” are incorporated in two different therapeutic processes. The storyline of “Subjects in Search of Meaning” describes a process of learning to know the patient and his/her interests to design meaningful therapy for the patient. This opens up the therapist and the therapy to a process of supporting personal healing and development. Such a process includes a person “becoming”, where discovering where to go is an integrated part of the developmental process and cannot be predetermined. However, the parallel storyline of “Ideal Images of the Successful Patient” closes the personal healing and developmental process. Here treatment goals include encouragement to “do more of things” and “return to work”. In this way, the patient’s freedom to set his or her own goals becomes constrained by the therapeutic context and wider institutional and societal needs. In this way, the patient’s self in patient-centred practice is both framed by the personal relationship between therapist and patient, while at the same time being more instrumentally framed by the stakeholders’ and health authorities’ economic and political concerns. One may say that it is not only the patient’s self and role that becomes complex in this way, but also the physiotherapist’s self and role. In both cases there is a constant movement occurring between the actors being singular and individual.

Regarding the limitation of the study, we are aware that the inclusion of more participants from various fields and institutions would have allowed for more nuances in the therapists’ stories of treatment of their patients. Experience tells us, however, that the findings from such a study might show a similar ambiguity in the concept of the individual patient inherent in a patient-centred care. Although physiotherapy provides the case for our study, we believe that the ambiguity embedded in the physiotherapists’ understanding of the patient as a person is relevant for professionals of other health disciplines as well. As such, we believe our findings may be transferred to other disciplines within the health sciences and make a valuable contribution to the discussion of patient-centred care.

Patient-centred care has been developed within medicine and the health sciences as a way of bridging the gap between the world of medicine and the world of the patient. Our study contributes to the discussion by questioning health professionals’ understandings of the patient as a self. Our findings highlight an ambiguity in the concept of the individual patient inherent in patient-centred care, between the singular and the individual. Further, our study adds to the previous discussion of patient-centredness by claiming the

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need for singular care based on openness to a search for meaning and sharing.

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NOTES
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