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## **The singular patient in patient-centered care: Physiotherapists' accounts of treatment of patients with chronic muscle pain**

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## The singular patient in patient-centered care: Physiotherapists' accounts of treatment of patients with chronic muscle pain

### Abstract

A patient-centered approach has gained increasing interest in medicine and other health sciences. Whereas there are discussions about the meaning of a patient-centered approach and what the concept entails, little is known about how the patient as a person is understood in patient-centered care. This article investigates understandings of the patient as a self in patient-centered care through physiotherapy of patients with chronic muscle pain.

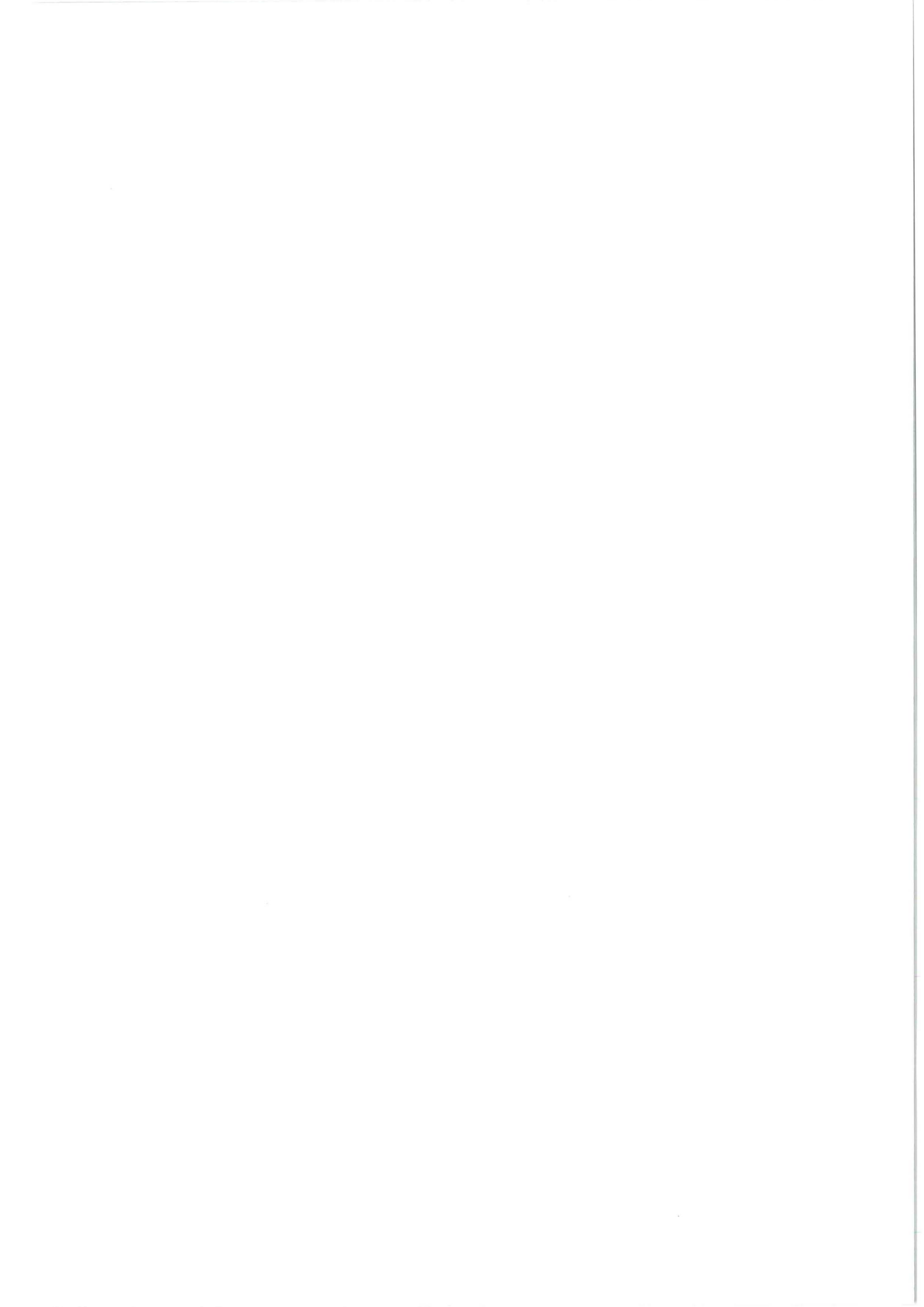
The material consists of interviews with five Norwegian physiotherapists working in a rehabilitation clinic. Drawing on Kristeva's discussion of subjectivity in medical discourse, the study highlights two different treatment storylines that were closely entwined. One storyline focuses on open singular healing processes in which the treatment was based on openness to a search for meaning and sharing. In this storyline, the "person" at the center of care was not essentialized 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 center 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-centered 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 standardized terms designed to focus on more stable notion of outcome of illness. Therefore, our study suggests that the therapists' will to recognize the individual in patient-centered care had a counterpart involving a marginalization of the singular.

## Introduction

Patient-centered approaches have been growing in popularity in health care practice in recent years, partly because they suggest ways of reducing the gap between the world of medicine and the world of the patient.<sup>1 2 3 4</sup> Although definitions vary, the concept of patient-centeredness is commonly described as understanding the patient as an autonomous human being with particular experiences and needs.<sup>5 6</sup> Through patient-centered 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.<sup>7</sup> Mead and Bower argue that patient-centeredness in medicine encompasses various dimensions including the recognition of the patient-as-person, and the active sharing of power and responsibility with the patient through a therapeutic alliance.<sup>8</sup> 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-centered care in recent years.<sup>9 10 11</sup>

However, studies on patient-centeredness in medicine and health sciences have highlighted several challenges in providing patient-centered approaches in clinical settings.<sup>12 13 14 15</sup> Bensing points out that disease and illness belong to two different worlds: with 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.<sup>16</sup> In general, studies of patient-centeredness 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.<sup>17 18</sup>

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.<sup>19</sup> The study shows that the physicians, through a patient-centered approach, are not just relating to the patient, but also the patient's social network. Hence, the author conclude that cultural bridging is cultural labor, which requires time and recourses.<sup>20</sup>



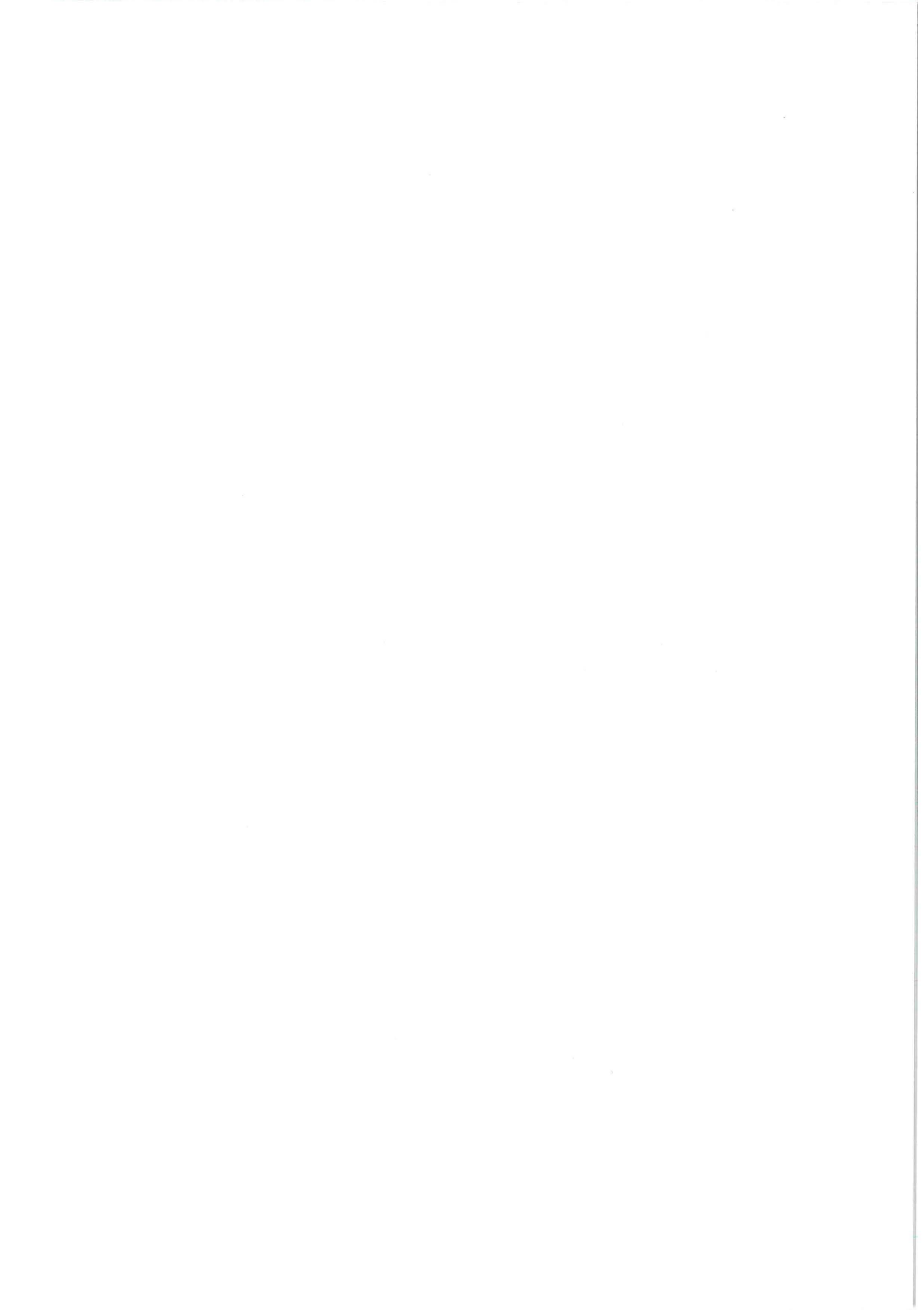
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3 Similarly, Naldemirci and colleague show that patient-centeredness in health care  
4 practice is performed in many different creative ways.<sup>21</sup> However, the authors claim  
5 that patient-centeredness is based on the assumptions that a person is independently  
6 capable of reasoning and verbal expression and is willing to provide clear and  
7 genuine narratives and cooperate with health care professionals. Hence, the authors  
8 warn that tenacious assumptions of person-centered care, may distract attention  
9 away from the variety of ways that professionals and persons find for translating the  
10 ideal of person care into practice.<sup>22</sup>

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18 In the context of rehabilitation, Leplege et al. discuss a number of ethical aspects  
19 with person-centered care in clinical practice.<sup>23</sup> The authors particularly point out  
20 that clinical practice is characterized by a dissymmetry between the patient and the  
21 clinician, with the latter being responsible for acquiring knowledge about the  
22 patient's health problems and finding means for the patients to reach their goals.  
23 The authors argue for a need for the concept of person-centered care to be  
24 translated or "transferred" from medicine and the biomedical model, where the  
25 concept originated, into the field of rehabilitation.<sup>24</sup> In this context, studies point out  
26 how the role of the professionals need to be discussed in the face of patient-  
27 centered care, and suggest that healing, caring and compassion should have a higher  
28 place in rehabilitation if the person is truly to be in the center of rehabilitation.<sup>25</sup>

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

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Physiotherapy is deeply rooted in the culture of medicine, and along with medicine  
has engaged in the recent discussions about patient-centered care.<sup>26</sup> Physiotherapy,  
under a patient-centered 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.<sup>27</sup> Compared with medicine, the patient's participation in



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3 physiotherapy is not related to choice of treatment, but rather to the setting of  
4 individual treatment goals and the training phase of rehabilitation or treatment.<sup>28 29</sup>  
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6 <sup>30</sup> Several studies on patient-centered approaches in physiotherapy, however, point  
7 out obstacles related to goal setting, both from the point of view of the patient and  
8 the therapist.<sup>31 32</sup> In physiotherapy, a patient-centered approach has been  
9 particularly discussed in relation to patients with chronic muscle pain.<sup>33 34 35</sup> This  
10 may be because there are often few physical findings that can explain the patients'  
11 prolonged pain condition, and as such, illness has been stubbornly resistant to  
12 'standard' biomechanical physiotherapy treatment approaches. Consequently,  
13 physiotherapy's focus for patients with problems like chronic muscle pain has  
14 moved away from "curing" the disorder, to helping the person live with the pain.<sup>36</sup>  
15 This approach necessarily implies a search for the meaning of pain for the  
16 individual patient in his or her life, and an active role for the therapist in trying to  
17 enter the world of the patient. In this context, narrative competence with the  
18 physiotherapists is argued as valuable with regard to developing critical reflections  
19 on clinical practice and making clinical decision with the individual patient.<sup>37 38</sup>  
20 Not unlike the field of medicine, studies of patient-centeredness in physiotherapy  
21 conclude that therapists should improve their communication skills.<sup>39 40</sup> Studies  
22 fail, however, to address the reasons why therapists lack the necessary skills to be  
23 fully patient-centered in the first place. We argue here that what is missing is a  
24 discussion about the gap that exists between the world of objective facts – so  
25 familiar to physiotherapists – and the patients' subjective experiences as suggested  
26 in patient-centered care. Specifically, the question to be illuminated in this paper is:  
27 how do physiotherapists make sense of the patient as a self in patient-centered  
28 practice?  
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## 48 **Theoretical framework**

### 49 **The patient as a singular subject**

50 Julia Kristeva criticized what she claims to be a dominant notion of the self as a  
51 substance – a definite unit - in Western philosophy.<sup>41</sup> Her alternative concept of a  
52 subject in process (*sujet en procès*) has two significations. On the one hand, it  
53 points out that the subject or the self is not stable but in constant movement. The  
54 self is not a being but a becoming. On the other hand, the unity of the self is always  
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3 under threat of dissolution, negativity and destruction (en procès). According to  
4 Kristeva, this fundamentally processual, threatened character of the subject is  
5 marginalized in medical discourse, which objectifies health as a 'definitive state' –  
6 a condition of 'full being' (health) – while illness is conceived as the privation  
7 (steresis) of this original state. This schematism has separated health from healing  
8 as a process 'with twists and turns in time'.<sup>42</sup> By the same token, biomedicine's  
9 concern with cure is separated from the 'durative idea of care', and the liminal  
10 period between birth and death. In line with this logic, biomedicine understands  
11 cure in terms of "repairment" and a recreation of a condition of full being (health).  
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20 However, such a cure is impossible, Kristeva argues, because the person/self never  
21 was a 'full being' in the first place, but a continuous process of becoming; a process  
22 that is constantly in motion; threatened by dissolution and destruction. Sickness and  
23 health are therefore not understood as opposite conditions but rather as part of the  
24 life/self-forming continuum. By creating this false dichotomy, modern medicine has  
25 separated health from the self. Instead of a cure that tries to recreate a condition of  
26 full being cleansed of all sickness and destruction, we need a concept of care that  
27 considers people as being in a constant process of healing.  
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34 Kristeva's arguments have profound implications for how we understand the person  
35 in person-centered care. The person is not a substance, either in terms of being a  
36 unified illness experience or a rational actor. "What is the subject?", Kristeva asks  
37 rhetorically: "That which in a man or woman remains open to a search for meaning  
38 and sharing".<sup>43</sup>  
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44 If we apply Kristeva's concepts of health and healing to clinical practice it allows  
45 for a person-centered approach that is open ended and for a patient's self to be in  
46 constant movement. In this paper, we use this understanding of the subject in  
47 motion as an analytical lens through which to read the various understandings of the  
48 person underpinned in our physiotherapists accounts.  
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## 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 center. 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 specializing 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 health care 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.<sup>44 45</sup> The choice of clinic was purposeful.<sup>46</sup> Being part of an inter-disciplinary team we assumed that the physiotherapists working at the clinic would have integrated a patient-centered 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 study was sent to all the

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3 physiotherapists working at the clinic, and all participants volunteered to take part  
4 in the study.  
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8 In total five physiotherapists, two men and three women, aged between 30 and 45  
9 years, were recruited from the clinic. While the physiotherapists work experience  
10 varied in terms of both content and length, all had worked at the clinic for between  
11 two and five years. Two of the physiotherapists had extensive experience treating  
12 patients with chronic muscle pain before starting work at the clinic (5 and 15 years),  
13 while the other three had gained experiences working mainly at the clinic. We  
14 hoped that by including both men and women, with rich experiences working in a  
15 multi-disciplinary team, we would gain access to information-rich cases that would  
16 illuminate how the physiotherapists made sense of the patient's individuality in a  
17 patient-centered way.<sup>47</sup>  
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## 26 Interviews

27 Data collection consisted of semi-structured interviews. Participants were invited to  
28 talk about their practice, after an initial prompt to "Tell [me] about your  
29 experiences with treatment of patients with chronic muscle pain at the clinic".  
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31 Although the physiotherapists formed part of an inter-disciplinary team and  
32 cooperated regularly with colleagues in other professions, the focus of the  
33 interviews was on the therapists' particular experiences of treating patients with  
34 chronic muscle pain.  
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39 All interviews were conducted and analyzed by the first author. The interviews  
40 were conducted at the clinic in a room used for patient consultation. The  
41 participants were not explicitly asked about their views of the patient as a subjective  
42 self. Rather, approaches to this question were made by inviting the participants to  
43 reflect upon their role as a therapist; the patient's participation in the treatment; and  
44 the treatment process. As a physiotherapist herself, the interviewer was familiar  
45 with the setting, the language and the culture of physiotherapy, which made  
46 accessing and engaging with the participants easier. However, to meet the challenge  
47 of going beyond what was taken for granted by both parties, the interviewer tried to  
48 keep her questions open and asked for specific examples. The interviews lasted  
49 approximately 60 minutes, and were recorded, to be transcribed verbatim by the  
50 author shortly after each interview had taken place. The interviews were conducted  
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3 in Norwegian, and the quotes from the interviews were translated by the first  
4 author.  
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### Data Analysis

Analysis of the transcribed material was inspired by Kristeva's discussion of the subject in medical discourse and narrative inquiry. Narrative theory centers 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 consequence of another.<sup>48 49</sup> 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 treatment of patients with chronic muscle pain. We analyzed the therapists' stories with regard to content and structure.<sup>50 51</sup> 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-centered 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 analyzing the narrative structurally, we confronted the material with Kristeva's concept of health and healing, with a view on the patient as self, asking following questions to the material: 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

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3 Subjects in search of meaning  
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5 The first storyline that grew from our analysis could be characterized as an  
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7 openness on the part of the physiotherapists towards the meaning of pain for the  
8  
9 singular patient. In this storyline, the therapist's approach to treatment was not  
10  
11 based on the assessment and treatment of some physical absence or lack, deficits or  
12  
13 limitations in the patient, but rather, it was governed by a mutual search for  
14  
15 meaning and sense-making. For example;

16  
17 *I try to talk to [the patients] in order to understand what they feel are their own*  
18  
19 *limitations and challenges, and then I try to understand what they see as good*  
20  
21 *progress, what they see as an opportunity and what they enjoy doing, both in terms*  
22  
23 *of activities and in terms of their work. [...] For example, some patients say that "I*  
24  
25 *should perhaps exercise, and I should maybe do this particular exercise, but I'd*  
26  
27 *rather prefer to go for a walk in the forest". Then I try to play further on what they*  
28  
29 *say and show them that there are plenty of opportunities in walking in the forest*  
30  
31 *also, which may give the same effect as doing specific exercises. I try to minimize*  
32  
33 *the "I should", and instead focus on what they want and what their interests are*  
34  
35 *and what they enjoy doing ... instead of me wanting something for them. [PT1]*

36 The therapists tried to get to know the patient, understand the meaning of pain, and  
37  
38 the things that affected the life of the patient. Rather than developing a treatment  
39  
40 regimen based on general training principles, the therapists tuned in to the  
41  
42 individual patient's narrative. The therapists asked the patient what he or she  
43  
44 enjoyed doing with regard to movements and physical activity; what mattered to  
45  
46 them; and what were their hopes for the future. These questions formed the basis of  
47  
48 the therapists' approach to treatment. The patient's voice and experiences were  
49  
50 important in clinical practice, not only as a carrier of the patient's interests and  
51  
52 needs, but as part of the construction of new meanings. Echoing Kristeva's concept  
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54 of the subject in process, therapist and patient were portrayed to interact in an open  
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56 manner, with neither of them knowing necessarily what was ahead of them and  
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58 where they were going. The treatment was itself a movement in constant  
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60 development, with patient and therapist in a constantly shifting state of becoming.

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

21  
22 *The main activity is not exactly training, but rather building body awareness of how*  
23 *[the patient] uses his neck, for example. "How is the tension in your muscles?"*  
24 *"Can you feel the difference between tension and relaxation". I spend more time*  
25 *talking with them. Ask them if they have much pain when coming home from work.*  
26 *Ask them "Are you able to take breaks during the day"? [...] We want to build their*  
27 *confidence that activity can be good, but that is has to be adjusted to their level of*  
28 *tolerance. [PT2]*

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

54  
55 *I try to make [the patients] feel for the first time the joy of playing, where they*  
56 *forget their worries and fear and where they race around in the gym, in joy. When I*  
57 *see that I have done a lot. Or when they get out in the nature on Nordic walking*  
58 *and realize "this is for free", "this I can do myself", "it's so simple". [PT3]*  
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5 In general, the therapists' treatment storyline focused on creating moments in  
6 clinical practice in which the patients were allowed new experiences of themselves  
7 and their own bodies whilst at the same time living with pain and illness. The  
8 approach aimed at strengthening the patient's sense of self.  
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13 Further, this storyline focused on ordinary conversations between therapist and  
14 patient during the therapy sessions. The therapist and patient spent time together  
15 talking about all sorts of things quite unrelated to strict goals of physical function,  
16 for example;  
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22 *We have individual talks with all the patients, both at the beginning and at the end*  
23 *.... So you become more than a physiotherapist in a way, yes you do. People talk*  
24 *about almost everything, some talk about their job, right, some talk about*  
25 *psychological functioning, some talk about their family life, so in many cases we get*  
26 *the role of a guide more than a therapist. [PT4]*  
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32 In order to follow the singular patient and what mattered most to them, the therapist  
33 often had to go beyond their perception of their traditional physiotherapy role, with  
34 its focus on bodily structures and functioning, and venture down less clearly  
35 defined paths. The treatment was an open journey. The patients were involved in  
36 clinical practice as vulnerable subjects in need of recognition and care. As one  
37 therapist explained;  
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44 *[One patient] had a lot of resources which were not really revealed, because she*  
45 *felt she was opposed, and that nobody understood what she really wanted. She felt*  
46 *opposed in very many ways. And then she said that here [at the clinic] she was met*  
47 *... with a kind of respect. And this lifted her up in a way ... I learned that maybe*  
48 *one should risk going, for example, into conversations with patients; dare joining*  
49 *the patients in their frustration; not being afraid and stop thinking this is not my*  
50 *field of competence, but daring joining the patients in these talks, I think that is*  
51 *important. [PT1]*  
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3 The therapist's storyline focused on the individual's own actions and interests in  
4 their healing process, based on a careful listening to the singular patient's illness  
5 story, and openness to a search for meaning and sharing with the individual patient.  
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7 The patients were not essentialized, in terms of biological mechanisms and deficits,  
8 rather they were involved in clinical practice as bodily and vulnerable selves in  
9 constant movement.  
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#### 15 Ideal images of the successful patient

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17 The second storyline had a different structure and focused on the patients'  
18 progression in the treatment and outcomes. The process started with the act of  
19 setting goals for treatment. The patients were expected to move on in life; a point  
20 frequently reinforced by the therapists. The treatment was individualized, designed  
21 according to the patient's wishes and needs to reach the mutually developed and  
22 agreed upon treatment goals. It was up to the individual patient in collaboration  
23 with their therapist, to decide what they wanted to achieve for themselves, both in  
24 the short and long term. The patient as a person was assumed to be rational, making  
25 autonomous choices in managing their illness;  
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36 *Here at the clinic we always have a goal-setting in the initial conversation with the*  
37 *patients. It is my job to point out to them that this is a collaboration between them*  
38 *and us and that they also are responsible whether this is a fruitful process or not. It*  
39 *requires that they show up and that they try to see their situation and that they*  
40 *make an effort ... I expect that they are conscious and active actors in this process.*  
41 *"What do you need to do more of? What do you need to become more aware of?"*  
42 *... "What do you think, in three months ... you can do more of"? Or "How can you*  
43 *adjust the burden in your daily life in order to get there"? [PT5]*  
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51 This storyline focused on clarification of roles and distribution of responsibilities  
52 between the therapist and patient. The clinical encounter seemed to be dominated  
53 by discussions of how to reach the patient's individual goals – how best to get  
54 there.  
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58 In particular, this storyline about treatment of patients emphasized the patient's own  
59 responsibility to adhere to the treatment plan. Improvements did not come by  
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3 themselves or through the therapists' knowledge and actions alone. Rather, in order  
4 for the treatment to be successful and the patient to achieve their goals, the patients  
5 had to make an effort. This storyline was governed by images of an 'ideal person';  
6 the rational, motivated and compliant individual, showing up for their  
7 appointments, and doing their exercises which is valued as important for patients.  
8 "We don't do miracles", as one therapist put it;  
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15 *In the examination [of the patient] we try to find out if the patient believes in*  
16 *recovery; believes that he can return to work; believes that this treatment may be*  
17 *sensible. Then I think we actually can help. Because we don't do miracles here. We*  
18 *rely on people to do something, and those who want to try and believe it works, they*  
19 *seem to make it. While those who believe that "No, I should have been operated*  
20 *[on]", and "This treatment approach is completely wrong", and seem rigid on that,*  
21 *well then it may not be relevant with this kind of treatment. [PT4]*  
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29 The storyline that focused on open singular healing processes and the co-  
30 construction of new and shared meanings, were frequently replaced by purposeful  
31 interventions aiming at restoring function so that patients could return to work. The  
32 sense of an open dialogue between the therapist and the patient, with mutual  
33 developed treatment was often replaced by general information given to the patient  
34 about the treatment, particularly the rehabilitation center's ambition for vocational  
35 rehabilitation. Individual patient choices were limited by the information given to  
36 them and the context in which it was received. This means, in order to be heard and  
37 form the basis for decisions about the treatment, the patient's voice had to be  
38 informed by the right knowledge. The effect of this was a subtle 'moulding' of the  
39 patient into an idealized person; the health literate individual, making rational  
40 choices about his or her own health, based on the information provided by the  
41 physiotherapists and others.  
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55 By contrast with the storyline of the patients as bodily subject in search of meaning,  
56 this storyline focused on the patients' lack of physical activity and physical fitness.  
57 In this context, the therapists appeared as guides, giving exercise advice and  
58 exercise support to the patient;  
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5 *Activity is good and [the patients] have to do the work themselves while we [the*  
6 *physiotherapists] act as guides. [The patients] need to try things out and make*  
7 *mistakes, to experience themselves: “Now I’ve done too much, okay, next time I*  
8 *have to do a little less.” [PT02]*  
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13 The focus on the patient’s singularity as a bodily and vulnerable subject was  
14 replaced by ideals of the self-managing and physical active individual. The patient  
15 as a person was shaped according to ideal images of the ‘successful patient’. The  
16 therapists provided the patient with effective self-managing support; their pain was  
17 not to be explored as much as managed. However, the focus on treatment goals and  
18 ideals of the successful patient did not necessarily imply expectations of “happy  
19 endings”. On the contrary, the therapists commonly emphasized the patient’s  
20 recovery as a lifelong learning process. All we can do is get people started, the  
21 therapists said. In this context, the treatment was often described using a classic  
22 “toolbox” metaphor.  
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32 *[I don’t think] anybody leaves this place fully recovered or fully rehabilitated. What*  
33 *we want is to give people a toolbox. [The patients] need to continue the work*  
34 *afterwards. So, regardless of whether they are here for four, seven or eleven*  
35 *months, in that time all we can do is to get people started. We teach them what they*  
36 *need, give them the insight they need and the training experience they need, the*  
37 *confidence. Then, when they are finished here, they can continue with the work and*  
38 *I think that is really a lifelong perspective. [PT4]*  
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46 The person on which the treatment centered was shaped into an ideal individual  
47 through the use of specific tools or instruments, external to the patient’s self. Such  
48 tools could be general information, exercise and confidence in using the tools on  
49 their own, for example, but they always centered on support for self-management.  
50 As such, the treatment program aimed at helping the patients to help themselves.  
51 Hence, whilst distancing themselves from the idea of fixing the patient’s problem,  
52 the therapists’ storyline of treatment were still governed by the medical discourse of  
53 repairing a defect with the patient, in this case, lack of exercise and physical  
54 activity, and of returning the patient back to work and their former life situation.  
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3 However, it was the patient – and not the therapist – that was responsible and left  
4 alone to do the repair, because it was the patient that had the tools with which to  
5 manage the pain. The patient as a self in constant movement was replaced by ideals  
6 of an autonomous, independent and self-managing individual.  
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## 10 11 12 13 **Discussion**

14 This article has sought to shed light on the concept of the individual patient inherent  
15 in patient-centered care, by using physiotherapists' narratives about the treatment of  
16 patients with chronic muscle pain as a paradigm case. The findings highlight two  
17 different treatment storylines that were intertwined in each other. One storyline  
18 focused on open-ended, singular healing processes and a search for meaning and  
19 sharing. The “person” in the center of care in this storyline was seen as a  
20 vulnerable, relational, and embodied self in constant movement. The second  
21 storyline, on the other hand, was governed by treatment goals, the aim of restoring  
22 the patient's physical condition, and returning the patient back to work. Here, the  
23 patient as a person was shaped by the production of idealized images of “the  
24 successful patient”; a rational, compliant and self-managing individual. As such, the  
25 findings revealed two conflicting concepts of the individual patient inherent in  
26 patient-centered care.  
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39 Although, both storyline were evident in our data, they were, themselves, in a state  
40 of constant flux throughout the narratives. Sometimes we found the beginning of  
41 stories dominated by the storyline of patients as singular subjects in search of  
42 meanings, with the storyline shifting in the next moment to the therapists talking  
43 about model narratives of the “successful patient”. At other times, the two  
44 narratives were reversed.  
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51 By emphasizing themes such as the setting of individual treatment goals, our study resonates  
52 with other studies on patient-centeredness in physiotherapy.<sup>52 53</sup> However, drawing  
53 specifically on Kristeva's discussions of subjectivity in medical discourse, our study  
54 highlights how the development of individual goals in clinical settings may be based on  
55 assumptions that the patient as a person is health literate and able to make rational choices  
56 about his or her own health. This means, the focus on treatment goals in patient centered care  
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3 may be an obstacle in providing individualized care that allows for the patient to be in  
4 constant movement. By highlighting two different storylines that alternates in the therapists'  
5 treatment accounts, our study shows how the patient on whom a patient-centered care is  
6 centered risks being cultivated in the production of ideals of the successful patient.  
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12 By emphasizing two intertwining treatment storylines, our study resonates with Naldemirci et  
13 al.'s study on person-centered care in clinical practice.<sup>54</sup> In this study, Naldemirci and  
14 colleague critically discuss what they see as the basis for person centered care, namely the  
15 assumptions that a person is independently capable of reasoning and verbal expression;  
16 willing to provide clear and genuine narratives; and cooperate with health care professionals.  
17 Drawing upon interviews with researchers in three different research projects working in a  
18 center for person-centered care in Sweden, Naldemirci highlights how people are recognized  
19 as unique and capable varies significantly in practice across different health care settings.  
20 However, the study points out how the potentially tenacious assumptions about the attributes  
21 of personhood risk distracting attention away from the variety of creative ways that  
22 professionals and persons find for translating the ideal of person-centered care into practice.<sup>55</sup>  
23 In a similar way, our study of physiotherapists' accounts of treatment of patients with chronic  
24 muscle pain highlights how the focus on the patients as singular, bodily and vulnerable  
25 subjects risks being replaced by the medical discourse, focusing on the patient as active,  
26 independent and rational choosing individuals.  
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39 By highlighting the image of the ideal patient – the successful patient – in the  
40 therapists' treatment accounts, our study resonates with Juritzen et al.'s study on  
41 empowerment in the context of a nursing home in Norway.<sup>56</sup> By analyzing a  
42 program plan on empowerment for nursing home personnel the study highlights  
43 how the plan functions as a tool for providing expert-assistance to the user's self-  
44 help. Furthermore, the study shows that the plan's image of empowerment  
45 presupposes an 'elite user' able to articulate personal needs and desires. The authors  
46 discuss how these qualities may not be applicable to the most vulnerable user group,  
47 who thereby may end up in an even weaker position.<sup>57</sup>  
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55 Similarly, our study highlights how physiotherapists' treatment of patients with  
56 chronic muscle pain presupposes an ideal individual who is health literate, rational  
57 choosing and physical active, and as such, many patients may feel inadequate or  
58 excluded from receiving the help they need.  
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5 By emphasizing the image of the ideal patient who actively participate in the treatment and  
6 take responsibility for his or her own recovery process, our study resonates with Fox and  
7 Reeves' research on inter-professional collaborative patient-centered care.<sup>58</sup> From a power  
8 perspective, the study highlights how the sharing of responsibility or the delegation of  
9 decisions to the patients, may in fact be seen as a removal of load of professional  
10 responsibility. Further, the authors point out how the patients may be seen to be responsible  
11 for their own illness should they fail to take responsibility for making the right decisions and  
12 making the right things to maintain health. Hence, as argued by Fox and Reeves, patient-  
13 centered care may be seen not as a route to share medical power, but rather as a mechanism to  
14 extend its reach even further so that patients themselves enforce compliance with medical  
15 directives.<sup>59</sup> In a similar way, our study on physiotherapists' treatment stories of patient-  
16 centered approaches suggests that the patients who do not take responsibility by complying  
17 with the treatment may be seen to be responsible for not getting better. Furthermore, by  
18 emphasizing the ideal of the self-managing individual, empowered through various tools  
19 external to themselves, our study shows how power may be enforced in clinical practice  
20 through the model of a patient-centered care.  
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34 On the one hand, our findings show how a patient-centered approach to care  
35 implies an interest in the patient as a person. By using physiotherapists' accounts of  
36 their treatment of patients with chronic muscle pain as the case, our study highlights  
37 an attentiveness to the singular patient's illness story, and the particular patient's  
38 interests and values with regard to movement and physical activity. The treatment is  
39 explorative and shaped in the interaction between therapist and patient. On the other  
40 hand, our findings suggest that therapists' understandings of the patient as a person  
41 are also shaped by biomedicine, dominated by goal oriented interventions aiming at  
42 restoring the patient to health. Here, the patient's singularity is replaced by ideals of  
43 the empowered, self-managing and health literate patient, who contributes to  
44 rational decisions about his or her own health. In her criticism of the notion of  
45 subjectivity in medical discourse Kristeva claims that modern biomedical discourse  
46 tends to embrace the individual while marginalizing the singular.<sup>60 61</sup> Instead of  
47 individualized treatment based on the logic of choice, Kristeva argues for the need  
48 for singular care based on proximity, sharing, and freedom: not in terms of a choice,  
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3 but "a construction and a bypassing or transcendence of the self with and towards  
4 the alterity of the other".<sup>62</sup>  
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8 The therapist's "will to empower" the patients is clearly present in our data.  
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10 Cruikshank explains empowerment as a strategy or method used to increase power  
11 to the "powerless" by maximizing their actions, motivation, interests and  
12 participation in social life.<sup>63</sup> In a clinical context, patient empowerment is used to  
13 describe the provision of strength and power to the sufferer and the vulnerable, in  
14 order to develop the resources of the individual rather than focusing primarily on  
15 physical findings and defects.<sup>64</sup> Our findings show how the therapists empower the  
16 patients by recognizing them as experts of their own illness, by providing the  
17 patients with new movement experiences, and by building the patients' self-  
18 confidence in their own body, movements and physical activity. At the same time,  
19 the study shows how patient empowerment is carried out in the production of ideals  
20 of "the successful patient"; the physical active and rational choosing individual that  
21 manages his or her own health. As such, our findings show that the therapists will  
22 to empower the patient may be accompanied by the marginalization of the singular.  
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34 From our study, we have seen that the two contrasting perspectives of the 'patient-  
35 self' are incorporated in two different therapeutic processes. The storyline of  
36 'Subjects in Search of Meaning' describes a process of learning to know the patient  
37 and his/her interests to design meaningful therapy for the patient. This opens up the  
38 therapist and the therapy to a process of supporting personal healing and  
39 development. Such a process includes a person "becoming", where discovering  
40 where to go is an integrated part of the developmental process and cannot be  
41 predetermined.<sup>65</sup> However, the parallel storyline of 'Ideal Images of the Successful  
42 Patient' closes the personal healing and developmental process. Here treatment  
43 goals include encouragement to "do more of things" and "return to work". In this  
44 way, the patient's freedom to set their own goals becomes constrained by the  
45 therapeutic context and wider institutional and societal needs. In this way, the  
46 patient's self in patient-centered practice is both framed by the personal relationship  
47 between therapist and patient, whilst at the same time being more instrumentally  
48 framed by the stakeholders' and health authorities' economic and political  
49 concerns. One may say that it is not only the patient's self and role that becomes  
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3 complex in this way, but also the physiotherapist's self and role. In both cases there  
4 is a constant movement occurring between the actors being singular and individual.  
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8 Regarding the limitation of the study, we are aware that the inclusion of more  
9 participants from various fields and institutions would have allowed for more  
10 nuances in the therapists' stories of treatment of patient. Experience tells us,  
11 however, that the findings from such a study might show a similar ambiguity in the  
12 concept of the individual patient inherent in a patient-centered care. Although  
13 physiotherapy provides the case for our study, we believe that the ambiguity  
14 embedded in the physiotherapists' understanding of the patient as a person is  
15 relevant for professionals of other health disciplines as well. As such, we believe  
16 our findings may be transferred to other disciplines within the health sciences and  
17 make a valuable contribution to the discussion of patient-centered care.  
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27 Patient-centered care has been developed within medicine and the health sciences  
28 as a way of bridging the gap between the world of medicine and the world of the  
29 patient. Our study contributes to the discussion by questioning health professionals'  
30 understandings of the patient as a self. Our findings highlight an ambiguity in the  
31 concept of the individual patient inherent in patient-centered care, between the  
32 singular and the individual. Further, our study adds to the previous discussion of  
33 patient-centeredness by claiming the need for singular care based on openness to a  
34 search for meaning and sharing.  
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## 45 **Acknowledgements**

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## 51 **Notes**

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