



Legitimacy in clinical practice: How patients with chronic muscle pain position themselves in the physiotherapy encounter

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Abstract

Rationale, Aims & Objective: Patients who seek healthcare for long-lasting pain and symptoms without a detectable disease must put in extra work to be taken seriously and gain recognition as a patient. However, little is known about how patients' help-seeking is performed in clinical practice. The aim of the current study was to gain knowledge about the ways in which patients with chronic muscle pain position themselves as help-seekers during their first physiotherapy encounter.

Method: The material consisted of observation of 10 therapist-patient clinical interviews in primary care clinics and was analyzed using perspectives from discourse theory and the concept of positioning.

Results: The study highlights how the patients positioned themselves in continually shift between two discourses: that of disease (considering the patient as an object under study) and that of illness (positioning the patient as an active and participating but also troubled individual). This shifting of position was negotiated in interaction with the therapist: patients' opportunities to position themselves within the discourse of illness were limited by therapists' focus on facts and causal relationships within the discourse of disease.

Conclusion: Patients with chronic muscle pain seek to establish their legitimacy through the positivistic discourse of medicine and also through their compliance with the moral discourse of the patient as someone active, willing to take responsibility for their own health—and therefore worthy of treatment.

KEYWORDS

chronic muscle pain, clinical encounter, discourses, medically unexplained symptoms, physiotherapy, positioning

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1 | INTRODUCTION

The presence of prolonged pain and symptoms without a detectable disease, often referred to as a medically unexplained symptoms (MUS), is a challenge to medical categorization and diagnosis and poses problems for interaction between patients and health professionals in clinical encounters.^{1,2} Patients with MUS often claim they are not taken seriously by healthcare professionals; their suffering is belittled or ascribed psychological explanations.^{3,4} Such patients feel blamed for their condition and for failing to get better; they are left to manage their problems alone.⁵⁻⁷

It follows that, when seeking help, persons with MUS must put in extra work to be taken seriously and gain credibility as a patient.^{4-6,8,9} To get help, they often argue their case by emphasizing objective facts rather than their illness experiences.⁹⁻¹¹ However, patients' help-seeking takes place in interaction with health professionals, and little is known about how patients actually perform this help-seeking in real life situations in clinical practice.

In the absence of effective medical treatment, patients with MUS, such as chronic muscle pain, often turn for help to physiotherapy.^{12,13} Physiotherapy as a profession is heavily rooted in a biomedical tradition, with focus on identifying the cause of the patients' physical problems and tailor their treatment to normalize what is wrong for the purpose of restoring loss of physical function. Exercise programs and protocols remain an essential part of physiotherapy practice, along with a strong emphasis on informing and motivating the patients' individual efforts to actively engage during the treatment process.^{14,15} Over the years, physiotherapy has developed considerable professional autonomy, including the right to diagnose functional problems and make independent decisions about treatment. Physiotherapists thus serve as important gatekeepers for access to care and treatment.

Studies on physiotherapy encounters commonly highlight how the patient's health problem often is discussed and evaluated within the discourse of disease; the therapist's perspective and focus on physical aspects of the patient's health problem usually takes precedence over the patient's illness experiences.¹⁶⁻²⁴ This means, patients with MUS generally have limited opportunities to present their illness experiences and their need for help. However, questions remain about how patients with MUS present themselves and their pain and symptoms in physiotherapy practice.

To investigate how patients with MUS perform help-seeking in clinical practice, the research on which this article draws used the example of first encounters between physiotherapists and patients suffering from chronic but undiagnosed muscle pain. The core research question addressed was: How do patients with chronic muscle pain position themselves as help-seekers in the physiotherapy encounter?

1.1 | Theoretical perspective

To investigate this question, the researchers drew on the concept of positioning, as derived from discourse theory. This proposes

that an individual is constituted or interpellated as a subject through language and the various discursive practices in which they participate.²⁵ As individuals, we participate in different discursive practices, which in turn create opportunities for various positions and multiple selves.²⁶ Different discourses offer different ways of being in the world. For example, a clinical encounter can provide the patient with various possible positions: the self-managed patient, or the active patient, or even the patient claiming his/her rights while marginalizing the possibility of being judged vulnerable or irrational.

The concept of subject position originates in Foucault's discourse theory, where the philosopher argues that the subject is created, or positioned, through language.²⁷

But whereas Foucault's primary interest lay in historical eras and more stable and formal roles, we take our inspiration from the concept of positioning as developed by Davies and Harré,²⁶ who highlight the dynamic aspects of social interaction and the shift of positions that occurs during encounters. Davies and Harré argue that positioning occurs during a conversation, when one participant raises a question and receives a reaction from other person(s). Here, one participant's question and the other participant's reaction serve to position the participants in relation to each other in that phase of the conversation. Multiple positionings may occur in the course of a single conversation; rather than static and stable, positionings are fleeting episodes in the setting where they are produced.

That said, the same kind of positioning may appear in several settings. To emphasize the dynamics of positioning, Davies and Harré describe how a conversation can be both a discussion of a given topic and a narration (explicit or otherwise) of one or more personal stories. Stories are how people make sense of their experiences; storylines are reflected in fragments of the participants' telling of themselves and their lives. When narrating fragments of their own history, speakers assign parts and characters—to themselves and others, including those taking part in the conversation. By including people in a story, a speaker makes available a subject position which the other speaker may take up or refuse. In this way, a person can be said to have been 'positioned' by another speaker.

Storylines are organized through conversation and around various poles, such as events, characters and moral dilemmas. They may draw on cultural resources and stereotypes: for example, the 'expert' therapist, the 'obedient' patient or therapist and patient as equal partners. During a conversation, these stereotypes are activated or modified and thus spoken into existence. Positioning can be actively negotiated and renegotiated during encounters.

Viewed through the lens of positioning, how do patients with chronic muscle pain position themselves in the context of a clinical interview with a physiotherapist? Using this question as a lens we will do a close analysis of a clinical encounter focusing on how the positions are negotiated and renegotiated through several twists and turns in the conversation.



2 | METHOD

2.1 | Design and ethics

The material presented in this article forms part of a larger study that examined first encounters between physiotherapists in Norway's primary healthcare system and patients with chronic pain. The study adopted a qualitative approach to investigate how patients with chronic muscle pain positioned themselves in their first encounter with their physiotherapist. Data was generated through observation and the video- and tape-recording of nine first encounters between physiotherapists and patients.

The study was conducted in line with the Helsinki Declaration Act and was approved by the Norwegian Social Science Data Services (ref. 38954). Participating physiotherapists and patients provided written informed consent. Throughout the research process, the researchers sought to ensure the integrity of both patients and physiotherapists: for example, by anonymizing and concealing the identity of participants and by presenting information in a sensitive manner.

2.2 | Participants and recruitment

All the physiotherapists who participated in the project were based in primary healthcare. The study aimed for strategic sampling to create heterogeneity in terms of sex and professional expertise.²⁸ Information letters were sent to a number of physiotherapy clinics located in primary healthcare settings; while some were chosen at random, others were selected on the basis of their reputation or because they formed part of the authors' wider network.

In total nine physiotherapists, all of Norwegian ethnicity, were approached. Four were men and five were woman; all were in their forties or fifties. Located in seven different institutes spread across five different regions, all were highly qualified, experienced and enthusiastic practitioners. Eight of the nine were specialists in either manual therapy or psychomotor physiotherapy. All nine ran their own private business, with financial support from the Norwegian government.

Patient participants were recruited by the therapists, who passed on information verbally and via an information sheet. All patients had been referred to physiotherapy by their general practitioners. Of the nine patients recruited as participants, four were women and five were men. The women were aged between 35 and 70 years, while the men's ages ranged from 32 to 70 years. All were suffering from prolonged muscle pain.

In physiotherapy practice, the first encounter usually consists of a clinical interview which is followed by a physical examination of the body and its functioning. Although physical examination of the patient is important in decisions about treatment, our research focused on language used in the clinical interview; we wanted to see how patients positioned themselves in this process, one in which they are supposed to play an active role.

Clinical interviews lasted between 30 and 60 min. Each was observed by the first author (herself a physiotherapist) and was also audiotaped and video recorded. Recordings were transcribed verbatim by the first author, with equal weight accorded to therapists' questions and patients' responses. Transcripts included forms of expression such as laughter, tone of voice (eager, serious, cheerful) and pauses. Since interviews were conducted in Norwegian, the translation of quotes into English was undertaken by the first author.

2.3 | Analysis

To begin with, transcripts of all the interviews were read several times to get an overall impression of the patients' positioning in the clinical interview and discussed by the authors. At this stage, we noted the similarity of themes emerging from the transcripts, which tended to centre on pain location, pain duration and physical activities. To examine the interaction between therapist and patient and the dynamics of positioning, all the interviews were read again, line by line. This time, we alternated our focus between the therapist's utterances and those of the patient.

In the case of the therapists, we examined the kind of questions the physiotherapists were posing, and which subject position was made available to the patient through their questions.

To analyze the patients' positioning in the clinical interview, each of their responses to the therapists' questions was ascribed a storyline to see which subject position and character they assigned to themselves.

Rigour and reflexivity of analysis was strengthened by the three authors representing different disciplines (physiotherapy and philosophy of science) and different research approaches (clinical research and theoretical research).

3 | RESULTS

The findings highlight two main discourses in which the patients positioned themselves: that of disease as objects under study, and that of illness as active, participating but also troubled individuals. However, these two discourses (and associated patient positions) did not appear clear-cut or fully formed. On the contrary, our analysis detected a continuous shift between the two discourses, with their respective positions.

To illustrate this continuous shift between discourses and positionings, we offer an in-depth analysis of one case. This case was chosen for its ability to demonstrate *how* the patients moved in and out of various discourses and positions during the clinical interview and *how* patient's positioning took place in close interaction with the therapist. The selected case is distinguished by the fact that the clinical interview takes place in a particularly structured way. Still, and although negotiations were carried out in different ways, the selective case is illustrative of patterns found in all the clinical interviews in this study.



3.1 | The case

The physiotherapist (T) is a man in his forties, and the patient (P) a woman in her thirties who has come for physiotherapy because of prolonged neck and shoulder pain. Following registration, the patient is given two standard forms to fill out. One contains a drawing of a human body on which the patient is asked to mark the location of her pain. The second contains several questions; the therapist explains that these seek to build a general picture of the patient and her problem. When the patient has finished, the therapist studies the completed forms for a while. Then, referring to the one with the drawing of a body, he begins questioning the patient about the areas of pain she has marked.

3.2 | Negotiations on pain appearance

T: [pointing at the drawing] *You have marked the neck, upper part of the back and lower back. Do you feel that all these are connected? Or do you feel they are different departments?*

P: *I think it's probably connected; I feel maybe I should have shaded a little more on both sides* [P adds some shading].

T: *Do you feel that this* [pointing at the drawing] *appears simultaneously or more separately?*

[Long pause]

P: *I think this is a little difficult to answer, but this here* [pointing at the drawing] *is probably more connected than those two.*

T: *Okay, so the neck is a separate department, and then this comes and then this. Or does it come as a package all together?*

P: *Actually, what I feel all the time is what's here up in the neck and down on the right side of the shoulder. That's what's constant. And then I have symptoms more or less elsewhere.*

T: [Pointing at the drawing] *Does that mean that this part bothers you the most?*

P: *Yes, absolutely. This is more like an uncomfortable pain* [pointing at the drawing] *-- I have no problem living with it in everyday life. But this* [pointing at the drawing], *I feel, makes me more constantly tense and tired, dizzy, nauseous at times and things like that.*

T: *Yes. Just to clarify things a bit: you are most bothered by the right side of the neck and then down towards the middle part of the back.*

In this sequence, various shifts of discourse and position are evident. The start of the encounter, with the filling in of various

forms, provides the patient within the position of being a data base and an object to be mapped. The patient willingly assumes this position. Concerned to provide data that best reflects her pain condition, she takes her time filling in the forms. In the conversation that follows, the patient remains positioned as a bodily object—literally through the drawing of a body figure. The body object is examined as a site of a plausible painful disease or disorder. Pointing at the drawing, the therapist asks for more information on the location and distribution of her pain. Staying in the data position, the patient corrects her additions to the drawing and explains how the various pain areas are connected. However, while positioning herself within the discourse of disease as data on pain location, the patient at the same time adds information about her subjective illness experiences. She highlights the constant pain she feels in her neck—distinguishing this from other occasionally experienced symptoms, which she describes as tiresome but fully manageable. She describes experiences of being constantly tense, tired and sometimes dizzy and sick. Thus, while positioning herself within the discourse of disease as an object under study, she also validates her need for help by positioning herself within the illness discourse as a person who does not give in to trivialities.

However, the therapist does not respond to the patient's subjective illness complaints. He concludes the topic of pain location with a summation of the facts: *Then you are most bothered with the right side of the neck and down towards the middle part of the back.* This keeps the patient firmly in the position of an object under study and a plausible conclusion about where the pain source is sited, limiting her possibilities to position herself as a person in need of help.

3.3 | Negotiations on time

After concluding the issue of *where* the pain appears, the therapist turns to the issue of how long the patient has been experiencing pain:

T: *How long have you had the pain? How long has it lasted?*

P: *I've always had it a bit.... I remember when I was a student, I think I went to the chiropractor then. It was something similar. But in its current form, I think it's been around for the past year and a half, two years.*

T: *You said there was something earlier. Was that different or something similar?*

P: *I've always had problems ...particularly with this shoulder. Then I have maybe...*

T: [Interrupting] *When you say 'always', do you mean from the dawn of time or...?*

P: *No, from the time I was a student. I think I must have been a bit too diligent a student.*



T: Now you're 33 years old. How far back did it start becoming a problem for you?

P: 2003, 2004, you can say.

T: About ten years ago, then...[...]

P: Yes, but not constant, not all the time. But it was then that I first experienced neck and shoulder problems.

T: At that time you were aged about 22, 23 -- something like that. And before that time, did you feel less bothered?

P: Yes, I did.

T: And thinking of the period between 2003 and now, how has it developed?

P: It's been okay for very many years ...ehh (T interrupts)

T: So it seems it was of little trouble and then it came back, a kind of fluctuation...

P: Yes, I'd say so. I think there's a difference between just having a bit of stiffness in the shoulder and neck and that stiffness being troublesome in daily life. There's a difference there.

T: Many people experience pain, but life goes on well enough. But clearly for you a dividing line was crossed a couple of years ago. After that there was a change, is that right?

P: Yes, I've had this type of pain for the past two years. Before that I worked abroad - quite a lot. And during my final year abroad I also had constant pain in the shoulder, but not quite in the same way as now. It cracked a lot when I ...

T: How far back are we now?

P: 2011 maybe.

T: [Typing on the computer]. What has changed in the last couple of years? What has been the difference?

P: You feel tired during the day and feel a need to rest your head. Ehmm...[thinking]...Yes, I got really dizzy for a while and went to a physiotherapist. Ehhh...When was that? - 2014 now ...2013, January or, first half of 2013. I went to a physiotherapist. I received treatment for two months or so and it became bearable, but it was not cured.

Here, the therapist's questions about how long the patient has been in pain develop into a long discussion about time. Time is introduced via words such as 'always', 'earlier', 'before' and 'after' and

through questions about the patient's age, the exact year, the precise date, as facts.

The patient begins by offering her interpretation of how long the pain has been there. 'Always', she says, positioning herself as a subject troubled by pain for a very long time. She then tells of previous problems with a shoulder. However, she then quickly resumes her 'data' position by estimating a time frame for her current problem: a year and a 1/2, 2 years.

Although the therapist responds to the patient's information about previous shoulder problems, he is mainly interested in getting facts about the pain's character (was it like the neck pain?) and establishing a timeline for the patient's past and present pain experiences. He responds to the patient's 'always' with the phrase 'from the dawn of time', thereby signalling a need for more tangible data.

The patient responds by making herself into data structured in a temporal sequence. However, she simultaneously positions herself within the discourse of illness by contextualizing her problem as work-related. She refers to specific periods in her life when her work was particularly intense: her student days (here she throws in the comment that she was a 'too diligent' student), and the period when she worked abroad. She describes a worsening of the pain over the past couple of years and her need for rest every day. She renders her illness experiences concrete by referring to a cracking in the shoulder and to previous treatments. In her response, she therefore switches between positioning herself as an object under study and as an active, working person who has endured pain for a long time and has done her best under the circumstances.

3.4 | Negotiations on causal relationships

Then, after mapping the patient's pain and symptoms in terms of time and place, the therapist presents a question about possible causal relationships.

T: [pointing at the drawing] Taking this area here, neck, shoulder and that area. What typically makes the pain worse? Do you have any ideas?

P: I have more [pain] at the end of the working day. At weekends it's not necessarily that bad.

T: Do you in any way connect [the pain] with work?

P: Yes, one have to think along those lines. Of course, it's a sedentary office job, so it's lacking in balance. It's not very surprising that after a day at the office the pain is worse than at the start of the day.

T: Are there other things that affect your pain? In everyday life, at the weekend? Things you suspect affect it negatively, that increase your pain?



P: No, I don't think so.

T: Are there things that make it better?

P: Yes, there are – training and exercise [laughter].

T: You're only saying that because you're here, right?

P: No, I haven't been good about exercising in recent years, because I've been working a bit too much. And I regret that.

The therapist's question about what typically worsens the pain is framed by the discourse of disease; the focus is on causal relationships between disease and pain experiences. The question positions the patient as a person with insight regarding her own illness, capable of rationally reflecting on her experiences in terms of possible sources of pain. However, the patient relates her pain to her own behaviour; she engages in what could be perceived as a demedicalization and trivialization of her problem. Rather than positioning herself as someone with knowledge about her own situation, she positions herself as a bodily object by invoking her sedentary, unbalanced office job and the stress it imposes. She also positions herself as a person not to be blamed by using the pronoun 'one' instead of 'I', making the point that such conditions would be stressful for anyone, not just her.

The therapist does not respond to the patient's explanation of what might be causing her pain or her references to her sedentary office job. He signals that he's seeking more specific information. However, noticing the patient's reactions to his question, he tries to lighten the atmosphere by turning the questioning the other way around and asking the patient what eases the pain. Here, the patient positions herself as a knowledgeable person by cheerfully suggesting training and exercise, neither of which she has done much of lately. At the same time, she positions herself as active and responsible by explaining that her lack of time for exercises results from her demanding job.

After a while, the therapist returns to the topic of work by asking what kind of work she does. It becomes apparent from the patient's response that there are things at work she is not happy with. Immediately picking up on this, the therapist asks for more information:

T: Those things that you are not satisfied with, do you have any thoughts about how they have affected this here [pointing at the drawing]? Do you have any thoughts?

P: I think it has affected my level of energy, but not the physical pain, because I had that even before I started this job.

T: Yes. You say it's been worse the past couple of years and is happening more often. Has there been a specific moment in this period when things have changed? Is there anything you can identify that may have affected it?...

P: It may be as simple as the fact that I've been in the danger zone for a long time now. So that as soon as I start giving rather too great a priority to work -- working a bit too much and not being able to exercise for long periods -- so...yes.

The patient's work situation, which she has been emphasizing in her attempts to make sense of her illness experiences, finally becomes the focus of discussion. But the therapist interprets the patient's dissatisfaction with her work within the discourse of disease, viewing it as a possible cause of her neck problem. By asking the patient if that is the case, he again positions her as a well-informed person and an active teammate in solving her problems. The patient then rejects a psychosocial explanation of her problem; she justifies her need for help by positioning herself within the discourse of disease as a body—an object with yet to be identified weaknesses. At the same time, she positions herself within the discourse of illness as an active, responsible person who usually takes care of herself through physical exercises.

4 | DISCUSSION

This article has sought to shed light on how patients with chronic muscle pain position themselves as help-seekers in the physiotherapy encounter. The findings (represented through one case) highlight how patients participating in our research positioned themselves within two main discourses of legitimacy: on the one hand, the objective, positivistic discourse of medicine and on the other a personal story based on a discourse of individual action and participation. The patients' legitimacy work underwent constant shifts and was negotiated in close interaction with the therapist.

By focusing on the interactional aspect of the patients' positioning, the findings highlight how patients' possibilities to position themselves within the discourse of illness as vulnerable and suffering subjects in need of help was limited by the disease discourse and therapists' focus on physical data and causal relationships.

There could be said to be certain parallels between patients' efforts to establish their legitimacy and the concept of the 'deserving poor', as discussed by Georges Midré.²⁹ The 'deserving poor' concept has traditionally served as a means to delimit social benefits by distinguishing between persons who are seen as 'entitled' to welfare benefits and those who are not. 'Deserving' candidates are generally those who show a willingness to work and/or are physically injured/disabled in some way, while those deemed unworthy are often viewed as addicted to laziness and vagrancy.²⁹ Our study sheds light on how patients with chronic muscle pain engage in a similar quest for legitimacy. To present themselves as worthy of treatment, they seek to establish objective credentials (having a detectable deficit) and moral worthiness (being active, participating individuals).

The findings in our study resonates with Werner et al.'s work on women with chronic muscle pain.^{3,9,30} In their work Werner et al. highlight how the women legitimated themselves as patients in the



medical encounter by making their pain socially visible, real and physical and trying to avoid being categorized as lazy and weak.^{3,9} Similarly, our findings show how patients with chronic muscle pain legitimate their need for help by positioning themselves within the discourse of disease as body objects with certain lacks and weaknesses and a personal story about individual action and participation. However, through its use of the concept of positioning, and the study of clinical practice our research reveals how the process by which patients seek to establish their legitimacy involves a subtle, shifting interplay with their therapist. Taken together, the findings in our study shows that, rather than being static and fixed, patients' legitimacy work in the clinical encounter is a process of negotiation, one in which patients move artfully in and out of various discourses and positions to establish the legitimacy of their appeal for help.

In medical practice and healthcare, expectations around individual responsibility are expressed through concepts such as health literacy and self-management.^{31,32} The implication is that patients should have knowledge about their own illness and should manage their health problems on their own.³³ In line with this, the findings in our study, show how the patients meet requirements of responsibility and self-management by positioning themselves as active individuals with demanding jobs who have done their best to manage their pain over the years. Specifically, in our case, the patient positions herself within the context of work as a dutiful, hard-working person who tries to take care of herself through physical exercises. The findings show how the patients work to accomplish blamelessness in the physiotherapy encounter by shifts of position: from bodily objects with physical deficiencies to active, responsible individuals who usually take care of themselves. The way in which the patients establish their individual responsibility resonates with the findings of research by Hillman on negotiation processes between patients and medical staff in an emergency department.³² Here, patients' success in legitimizing their claim to treatment was found to depend on self-presentation and identity work that (re)produced individual responsibility as a dominant moral category.³² The findings of our study suggest that patients with chronic muscle pain legitimate themselves in the physiotherapy encounter via two distinct means: establishing the objective existence and reality of a physical deficit and complying with the moral imperative to be proactive and responsible.

By highlighting the complexity of clinical encounters and the dynamic and subtle interplay between therapist and patient, our study makes valuable contribution to the development of clinical practice in physiotherapy. While we are aware that the inclusion of more participants would probably have added greater detail and nuance to the findings, our findings reveal patterns in the way patients move in and out of various positions and discourses. The strength of the analysis is also reinforced by its multidisciplinary approach, its carefully described theoretical framework and analytical approach, and the inclusion of extensive excerpts from transcripts. Although our study has specific relevance for physiotherapy, we believe that what it reveals about the legitimacy work undertaken by patients with chronic muscle pain has relevance for clinical encounters in other health disciplines. Overall, we

believe our findings make a significant contribution to the ongoing debate about the assessment of patients with MUS.

5 | CONCLUSION

Legitimacy is a prerequisite for things to happen in healthcare practices, and patients with chronic muscle pain without a detectable disease must work extra hard to be recognized as patients worthy of treatment. Our research highlights the interactional and moral aspects of the patients' legitimacy work in the physiotherapy encounter, and how the therapists many questions about facts, framed in the discourse of disease, limits the patient's possibility to position themselves within the discourse of illness, as vulnerable and troubled subjects in need of help. As such, there is a risk that important information about the patient's illness is lost and that the patients do not receive healthcare that are tailored to their needs. Clinical interviews consist of two active participants who jointly construct stories and meaning. Elliot Mishler³⁴ conceptualizes the encounter between patients and medical professionals as a struggle between the 'voice of the life world' and the 'voice of medicine', in which the first tends to be suppressed by the latter. To empower the patients and give them the opportunity to communicate their illness experiences and position themselves as subjects with specific needs and interests, we suggest, in line with Mishler and others, that the physiotherapists try to keep their questions open-ended and listen to the patients' responses with minimal interruptions, and repeat the patients' own linguistic formulations.³⁴⁻³⁶ This includes giving up control of a fixed interview format or method. We believe, however, that gaining new insight into own practice—the patients' positioning work and interactions with the therapists—in itself may lay the foundation for change and new ways of acting for the therapists. Each consultation is unique, and the therapist's questions and responses must thus be adapted to the individual patient.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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