Care in physiotherapy – a ghost story

Birgitte Ahlsen[1]

Department of physiotherapy, OsloMet- Oslo Metropolitan University, Oslo, Norway

Alette Ottesen

Department of physiotherapy, OsloMet- Oslo Metropolitan University, Oslo, Norway

Clemet Askheim

Centre for Sustainable Health Care Education (SHE), University of Oslo, Oslo, Norway

[1] OsloMet, Oslo Metropolitan University, PO. Box 4, St. Olavs plass, NO-0130 Oslo,
Phone: +47 67236690/90501583 Email: birgitte.ahlsen@oslomet.no

This is an Accepted Manuscript of a book chapter published by Routledge/CRC Press in Mobilizing Knowledge in Physiotherapy: Critical Reflections on Foundations and Practices on 26 October 2020, available online: https://doi.org/10.4324/9780367855338

Birgitte Ahlsen is an Associate Professor at OsloMet – Oslo Metropolitan University, Department of Physiotherapy. Her research interests include critical perspectives on medicine, healthcare and physiotherapy. Birgitte's doctoral research focused on the role of gender in illness narratives of chronic pain. Her present research project focuses on the first clinical encounter between patients and physiotherapists and relates to issues of knowledge production and translation, as well as how the patient is constituted in physiotherapy practice. She is a physiotherapist with 25 years of diverse clinical experiences and a specialist in (Norwegian) psychomotor physiotherapy.

Alette Ottesen is a physiotherapist and specialist in (Norwegian) psychomotor physiotherapy, with her own practice and almost 40 years of experience from working as a clinician. She is an assistant in FYSIOPRIM, a research program at the University of Oslo which aims to improve research in primary healthcare and bridging the gap between research and clinical practice. Alette also works as a lecturer at OsloMet – Oslo Metropolitan University, teaching practical skill to students in professional development courses in the area of psychomotor physiotherapy. Alette's interests are related to issues concerning physiotherapy practice and questions about what physiotherapy is and could be.

Clemet Askheim is a researcher at Centre for Sustainable Health Care Education (SHE), Faculty of Medicine, University of Oslo. He is a philosopher (MA) and is currently exploring the history of the concept of sustainability. His research interests include philosophy of science, political philosophy, history of science, environmental history, medical humanities, care, evidence-based medicine, sustainable development and the Sustainable Development Goals. He occasionally lectures on philosophy of science for Master students in physiotherapy at OsloMet – Oslo Metropolitan University. A recent publication focused on the lost legacy of Archie Cochrane (2017).

Care in physiotherapy – a ghost story

The role of care in physiotherapy has largely been ignored in research and professional discussions. We explore the causes and consequences of this neglect as an attempt to rethink what care is and can be in physiotherapy. We draw on a variety of perspectives and sources, which we assemble into a story about what physiotherapy is, has been, and can become. The basis of the story is a case narrative about an elderly woman treated by a physiotherapist. The case is developed into a broader story in which the physiotherapy profession itself becomes the patient. By subjecting our 'patient' to Freudian psychoanalysis, we show how care becomes repressed during the practice of physiotherapy, only to return as something uncanny: a pang of conscience, a sense of shame, or a ghostly presence haunting the profession. Inspired by an ancient Graeco-Roman myth and the theories of Heidegger and Mol, we argue that care is central to what it means to be human, and thus, that care should be recognized as an integral part of physiotherapy. By making latent and repressed content manifest and visible, we hope to open a discussion about the necessity of making space for care in physiotherapy.

Keywords: physiotherapy; care; Freud; the uncanny; Heidegger

Introducing care

During the early days of imperial Rome, the writer and grammarian Gaius Julius Hyginus (64 BC – 17 AD) collected and wrote down ancient myths and fables. Among them was the myth of the goddess Cura (in Latin, *cura* means 'care' or 'concern'). In the translation provided by Mary Grant, the story runs thus:

> "When Cura (Care) was crossing a certain river, she saw some clayey mud. She took it up thoughtfully and began to fashion a man. While she was pondering on what she had done, Jove (Jupiter) came up; Cura asked him to give the image life, and Jove (Jupiter) readily granted this. When Cura wanted to give it her

> name, Jove forbade her, and said that his name should be given it. But while they were disputing about the name, Tellus (Mother Earth) arose and said that it should have her name, since she had given her own body. They took it to Saturn to judge; he seems to have decided for them: Jove, since you gave him life take his soul after death; since Tellus offered her body let her receive his body; since Cura first fashioned him, let her possess him as long as he lives, but since there is controversy about his name, let him be called homo [human being], since he seems to be made from humus [earth].” (Hyginus, Undated).

A central function of myths is to tell us something about ‘the human condition’, and presumably give some meaning to it. The creation myth of Cura, which involves at least three different deities (Cura, Jupiter, and Tellus), tells of the manifold nature of our origin as human beings. The myth also speaks of our being created in such a way as to be somewhat out of tune with our own elements, putting us constantly at risk of dissolving. The primordial role of Cura, or Care, is to keep our body and our soul temporarily together, as a whole, throughout our life. This makes the myth a suitable inspiration for dealing with dualisms and an interesting starting point for rethinking care, both in the health sector as a whole (Kristeva, Moro, Odemark, & Engebretsen, 2018) and more specifically within physiotherapy (Nicholls, 2018a; Nicholls & Cheek, 2006).

While there has been an ongoing conversation about the role of care within nursing (Martinsen & Kjerland, 2006), this has been largely absent within physiotherapy (Nicholls & Gibson, 2010; Nicholls & Holmes, 2012). Could this silence derive from the profession’s tendency to focus primarily on *curing* patients, rather than offering them care? Does this emphasis on ‘cure’ have something to do with the invisibility of care in both clinical practice and research?

In an attempt to answer such questions, and begin a wider reflection on the role of care within physiotherapy, we want to tell a story: a complex ghost story inspired by the philosopher Jacques Derrida's writing on 'hauntology' (Derrida, 2006). Our story comprises several seemingly unrelated episodes and elements, which will be woven back together as the story unfolds. Some parts of it are stories in their own right, as in the case of the ancient creation myth involving Cura. There is also a case narrative drawn from clinical practice, starring a patient and a physiotherapist. Finally, there are episodes from the history of physiotherapy as a profession, including the fateful liaison between physiotherapy and medical science.

Sara, the patient in the case narrative, is a real individual who has actually been treated by one of the authors (AO). Sara's name and some details have been changed to preserve her confidentiality. In *our* story, however, the 'patient' is the physiotherapy profession itself. For the purposes of this chapter, we place the entire profession on the psychoanalyst's couch. Our story can thus be read as itself a symptomatic reading of physiotherapy (Althusser & Balibar, 2009). As is the case in Freudian psychoanalysis, the ambition is to make latent and repressed content manifest and visible, and by that means open it up to being consciously interpreted and dealt with. We argue that *care constitutes the latent content in our analysis.* By making it manifest, we hope to start a conversation on the role of care in physiotherapy.

Towards the end of the article, we return to the myth of Cura (Care). Inspired by the philosophers Martin Heidegger and Annemarie Mol, we seek to identify some fundamental aspects of care in physiotherapy: aspects that could contribute to a revaluation of the role of care in our profession.

The case history

Sara is an elderly woman well into her eighties, with children and grandchildren. She is a widow and lives alone in an assisted living facility. A sociable individual, she leaves the house almost every day, supported by two crutches and with her knee well bandaged. In-home nursing care is provided to her daily. After a couple of falls she now has a safety alarm in her living space. Sara feels dizzy at times and worries that she is becoming forgetful. She has received several diagnoses, including one of osteoarthritis in her hips and knees. When she walks her hips and knees are slightly bent, and she suffers from stiffness with kyphosis in her back. She sleeps badly. Her body is very tense, and she experiences chronic pain in various parts of her body, particularly her knees. Because of this she was referred to physiotherapy by her general practitioner (GP). AO has treated Sara periodically for several years. Sara comes for treatment only once or twice a month.

To justify the need for physiotherapy, the treatment offered should yield some measurable effect (Jamtvedt, Dahm, Holm, & Flottorp, 2008; Mikhail, Korner-Bitensky, Rossignol, & Dumas, 2005). Such evaluations are often made through assessments of the patient's pain experiences, functionality, working capacity, independence and quality of life (Jamtvedt et al., 2008; Pencharz & MacLean, 2004). In other words, physiotherapy, like other health care practices, is required to work from an evidence-based perspective (Herbert, Jamtvedt, Hagen, & Mead, 2011). In general terms, physiotherapy is associated with short-term, goal-oriented interventions aimed at alleviating physical impairment and restoring mobility to the patient (Ahlsen, Engebretsen, Nicholls, & Mengshoel, In press).

In Sara's case, however, her health issues make it difficult for treatment to fulfill these objectives. She is elderly and her illness is complex. She is probably not going to

recover in the sense of having less pain and increased body function. She will probably not become more active or less dependent on help from others in her daily living. Her condition will most likely not improve significantly. Instead, Sara needs ongoing care and support in order to manage her daily life. The best that can be expected of treatment is that it may prevent her from falling, slow down her rate of decline, and mitigate the need for her to seek a greater measure of (expensive) help from the healthcare system.

The treatment

Sara is often very tired when she arrives for her physiotherapy and will ask to lie down on the plinth. The session usually begins with Sara talking about the pain she's been experiencing, along with her health problems in general. "I don't like complaining," she says, "But it's very good for me to come here and talk about it. I can't always be bothering others with my problems." An average session with Sara begins with AO helping her find a good resting position to allow her to relax. Then AO massages Sara's legs and gives assisted movements to her hips and knees. Together they work on knee extensions to help Sara maintain her walking function. Sara states that she feels whole-body relief during the session. Towards the end of the treatment, Sara is allowed to rest for a while on the plinth, during which she often falls asleep. When she is woken, she describes the fact that she has slept as "fantastic".

Touch is one of the defining characteristics of physiotherapy (Bjorbaekmo & Mengshoel, 2016; Moffatt & Kerry, 2018; Nicholls & Holmes, 2012; Roger et al., 2002). Physiotherapists utilize different forms of touch through massage, assisted movements, mobilization, and manipulation. However, the profession tends to frown upon passive forms of therapy that do not require an active effort on the patient's part, and where the purpose is simply to create relief and increase the patient's well-being (Nicholls, 2018b; Nicholls & Holmes, 2012).

The origins of physiotherapy as a profession date back to the late nineteenth century, when a controversy related to massage treatment surfaced in London (Nicholls & Cheek, 2006). Massage institutes were flourishing at that time, but the business was unregulated, and practices were subject to considerable variation. Then, in 1894, it was alleged by an editorial in the *British Medical Journal* that many of the massage institutes were actually brothels in disguise. In order to legitimize massage as a health-related practice, its practitioners entered into an alliance with medicine by which it was agreed that massage would only be administered under medical direction. Consequently, the biomedical model was adopted as the basis for massage practices. Through the application of this model, massage was rendered a legitimate part of health care practice and the body was stripped of its sensuality (Nicholls & Cheek, 2006).

Subsequent events, particularly polio epidemics and the multiplicity of injuries generated by the First World War, contributed to the further development of physiotherapy as a profession (Nicholls, 2018a). Along with dramatically increasing the demand for massage services, these events also reinforced the search for treatments that required fewer resources -- while being capable of returning soldiers speedily to the front and rehabilitating polio patients. In this context, massage was seen as excessively comfortable and passive, even as something that might discourage patients from making the effort necessary for recovery (Nicholls, 2018a). Overall, these events tended to reinforce the focus on cure and recovery. Repairing injuries and restoring loss of function became the watchwords of the profession. The aim was to restore the patient to leading a productive and useful life.

In Norway (and Sweden) the history of the profession came to be dominated by a struggle for position and power between the various health professions, a struggle which had a pronounced gender inflection (Ottosson, 2016). In both countries, physiotherapy

practice was closely affiliated with medicine. Recovery was seen to result from physical exercises (gymnastics), discipline, and the individual's own motivation to make an effort (Nicholls, 2018a; Nicholls & Holmes, 2012; Ottosson, 2016; Thornquist, 2014). This tended to involve a conscious demarcation, a reconfiguring of both the ends (recovery) and the means (exercise) to enable both to conform with clear categories and measurable standards – drawn largely from a biomedical vocabulary.

It is evident, however, that Sara does not easily fit into such a treatment regime. Her enjoyment of physiotherapy can neither be properly measured nor legitimized, and it certainly has no place in professional journals (Mattingly & Lawlor, 2001). Sara does not have the strength and energy for physical exercises outside her routine daily activities. She is tired, sleeps poorly and needs rest, something she experiences during the treatment session with AO. Sara describes her physiotherapy sessions as "fantastic". But her therapist is experiencing growing unease and uncertainty about the treatment of Sara.

That which must not be named

Sara truly enjoys her physiotherapy treatment; she always shows up on time and never misses a session. She always tells AO how important it is for her to come to physiotherapy, every time adding: "It is such good care. You don't know how much it means to me". "Care!?" The very word makes AO feel a bit irritated but also a little ashamed. "Yes, care is what it is," she tells herself. "I can hardly call it physiotherapy!"

While its alliance with medicine has endowed physiotherapy with respect as well as recognition as an indispensable part of health care and the health care system (Nicholls, 2018a; Thornquist, 2014), it has also created a circumscribed understanding of what physiotherapy is and can be. This has reached the point at which offering care is

seen to be beyond the frontiers of professional practice (Nicholls, 2018b; Nicholls & Gibson, 2010; Nicholls & Holmes, 2012). In effect, care is out of bounds.

There is a necessary reductionism within the biomedical paradigm, where the patient is primarily conceived as a body to be treated, and the body is likened to a machine (Nicholls & Gibson, 2010). Related to this is the seemingly inescapable separation between soul and body, mind and matter. This dualism, often framed in terms of 'Cartesianism', is reproduced in specific ways in the biomedical worldview (Nicholls & Gibson, 2010). Even when medical practice draws on psychological and social insights, holistic interpretations or other alternative viewpoints, the hierarchy remains in place, with the body and the physical/biological firmly at the summit.

The imagery of the body as a machine fits well with the notion of physiotherapy as a curative enterprise (Nicholls & Gibson, 2010; Thornquist, 2006). When a functional body is broken, it can be brought to the physiotherapist, who is then supposed to diagnose the problem and find a solution to it. Ideally the patient will regain their previous functional abilities, return to work, and move on (Ahlsen et al., In press). Such is the way the biomedical model, with its Cartesian tendency to separate mind and body and prioritize the latter, creates a situation where cure is emphasized at the expense of care (Askheim, Sandset, & Engebretsen, 2017). Within the physiotherapy profession, the dualism and the focus on the body has led to an unconscious blindness towards other dimensions of human experience, such as the soul or the mind. The resulting inattention to care can be seen as a result of subconscious processes of repression.

In physiotherapy research, there is little mention of care as a component of practice (although there are indications of a growing interest in the issue) (Dahl-Michelsen, 2015; Nicholls & Holmes, 2012). And while care may find its way into

clinical settings, it will not be named as such. Viewing themselves through the lens of biomedicine, where cure eclipses care, physiotherapists are unable to recognize themselves as providers of care, as we shall argue.

This situation threatens to create real problems in clinical practice. Conflict can arise between what is actually happening (the reality of everyday practice) and what has been instilled in practitioners by prevailing discourses, theory, guidelines and norms (including evidence-based practice). As a result of this clash, offering care becomes something ‘one should not do’ – or, if it does happen, ‘one should not talk about it’. It becomes a kind of taboo, something ineffable or beyond comment (Freud, James Strachey, Freud, & Institute of Psycho-analysis, 2001).

Clinical consequences

To make a long story short, AO subsequently finds an opportunity to terminate her work with Sara. As AO explains to Sara, it's difficult to find reasons that would justify further physiotherapy treatment for her. "Perhaps there are other treatment alternatives?" suggests AO. "How about trying a balance group for older adults?"

What happens to the patient in this context? When Sara walks in the door she does so as a person, a complex individual. However, for the purposes of physiotherapy, she must be stripped of her soul. She must become her ‘body’, pure and simple. Sara’s osteoarthritis diagnosis (degeneration of joints), balance issues, and physical pain provide her with a legitimate claim to physiotherapy, since she has problems with her body. In order to maintain the legitimacy of treatment, AO and Sara must collaborate on Sara’s osteoarthritis, her knees, the tenseness of her body, and problems with her balance and her mobility – always towards the goal of improving bodily function. In Sara’s case, however, such improvement can take place only within very narrow limits. Treatment may help prevent falls or slow down Sara’s loss of physical function or

possibly help her cope with the pain. When Sara goes for physiotherapy, she seeks respite for her inner being, perhaps nourishment for her soul. But this does not lie within the accepted boundaries of physiotherapy as presently constituted. It is not what physiotherapists 'do'. Care is not a legitimate wish. The patient must under no circumstances utter the word 'care'. The physiotherapist is there to treat the body, full stop.

But what of the rest? Is Sara simply an 'illegitimate' form of patient? And what happens to the physiotherapist? AO must turn a blind eye to Sara's need for care. She must prioritize her work in accordance with current guidelines (Øyehaug, Paulsen, Vøllestad, & Robinson, 2019). In her journal, she must justify her clinical decisions with reference to effect and goal attainment. After all, Sara is not going back to work, her condition is not improving, and there will be no significant recovery, no future horizon where things change for the better. There is no room for care, since AO must reduce her patients to bodies, to machine-like objects. But in the process, she risks being turned into a machine herself.

If a physiotherapist is reduced to the status of a body-treating machine, this may lead to a sense of powerlessness (Mattingly & Lawlor, 2001). To care too much becomes a transgression. It is not a legitimate option within the prevailing conception of physiotherapy. It is impossible to argue for continued treatment based on care and well-being. As a result, the physiotherapist confronts the same dilemma as that experienced by every other health practitioner: whether to give primacy to the patient and their needs and preferences, or to remain 'loyal' to the guidelines, rules and regulations laid down by the health care system.

The uncanny

In his essay on the uncanny (‘Das Unheimliche’ [1919]), Freud defines something as uncanny when it borders on the well-known and homelike (‘heimlich’ in German), but in a twisted way that feels threatening or uncomfortable. The uncanny is too close for comfort, ‘that class of the frightening which leads back to what is known of old and long familiar’ (Freud, Strachey, Freud, & Institute of psycho-analysis, 1955, p. 220). Freud continues thus:

> In the first place, if psycho-analytic theory is correct in maintaining that every affect belonging to an emotional impulse, whatever its kind, is transformed, if it is repressed, into anxiety, then among instances of frightening things there must be one class in which the frightening element can be shown to be something repressed which recurs. This class of frightening things would then constitute the uncanny; and it must be a matter of indifference whether what is uncanny was itself originally frightening or whether it carried some other affect. In the second place if this is indeed the secret nature of the uncanny, we can understand why linguistic usage has extended das Heimliche ['homely'] into its opposite, das Unheimliche; for this uncanny is in reality nothing new or alien, but something which is familiar and old-established in the mind and which has become alienated from it only through the process of repression (Freud et al., 1955, p. 241).

Following Freud, if an affect associated with care, such as shame, is repressed, it may turn into anxiety. When care comes up on the agenda again, it is likely to be seen or felt as something uncanny. An additional meaning of ‘uncanny’ (unheimlich) is something that ought to remain hidden (Aarseth, Natvig, Engebretsen, & Lie, 2017; Svenaeus, 2000b). In German there is both a phonetic and an etymological similarity between

‘heimlich’ and ‘heimisch’, the latter deriving from ‘geheim’: ‘that which is hidden or secret’. In the context of physiotherapy, this sense of something that ‘ought to remain hidden’ appears applicable to care.

It can be argued that physiotherapy’s adoption of the biomedical paradigm, along with its reliance on ‘hard facts’, is what gives it status and potency. But this requires the repression of the sensual, ‘softer’ aspects of the profession, both in its theoretical formulations and in its everyday practice (Nicholls & Holmes, 2012). A Freudian interpretation might link this with a ‘castration complex’ or a fear of castration (Freud et al., 1955). Here, physiotherapy’s tendency to clutch on to ‘hard’ elements (cure) while repressing softer ones (care) is seen to result from its fear of being rendered impotent as a practice and profession: metaphorical castration, in Freudian terms.

Return of the repressed

One day a few weeks later, well after treatment has ended, AO sees Sara walking along the other side of the street, supported by her crutches. “What a brave woman”, AO says to herself with a pang of conscience. “If physiotherapy means that much to her, why can’t she come and see me every now and again”?

This ‘pang of conscience’ can be likened to an experience of the uncanny. In this scene, the patient becomes a phantom-like presence haunting the physiotherapist in broad daylight. But the specter at the center of *our* story is not the patient -- it is care itself.

In a reappraisal of Freud’s metapsychological theory of the unconscious, Svenaeus asks whether it might not be

> … precisely a sophisticated model for explaining how various phenomena make the individual aware of not being at home in him- or herself? Something that

> belongs to the person, but which is still not known by him or her, presents itself in dreams and slips of the tongue (Svenaeus, 1999, p. 244).

Or perhaps this ‘something’ presents itself in phantom form. In our story, the physiotherapy profession comes face to face with care: a repressed element of its being that continues to haunt it. Sara here becomes symbolic or representative of the illegitimacy and repression of care within physiotherapy. By virtue of its repression, care has turned into something uncanny: a ghost. Upholding the scientific basis, effectiveness and purity of physiotherapy requires the continuous exorcism of the ghost of care, with its blurry boundaries and unclear status. But the spectral presence of care keeps coming back.

The specter of Care

> *... since Care first fashioned him, let her possess him as long as he lives…*(Hyginus, Undated).

As with the Latin term ‘cura’, considerable ambiguity is attached to the English word ‘care’. On the one hand it denotes thoughtfulness, attentiveness, concern. On the other it can mean sorrow, anxiety, and solicitude (Hamilton, 2013). In the myth that began our story, Care personifies all these meanings, thereby rendering herself more complex than the stock figure of the caring mother. What Care creates is human life (homo) – in all its complexity.

Jupiter is the god of the sky, associated with light and lightning (enlightenment). He is also the son of Saturn. Tellus or Terra is ‘Mother Earth’, associated with both agriculture, ground and fertility. She is also the mother of Saturn. Saturn is among other things, the god of time and the old king of the gods. In the myth, humans are both earthbound, grounded creatures and spirit-infused beings who look upwards towards the sky. What unites them, what holds them together in time – temporarily – is Care. When

she thoughtfully picks up some clay, she is at the threshold of change (as symbolized by the river). Humans are born into time with the ability to think and to respond to Care's solicitude. This involves the knowledge of our mortality and the sorrow and anxiety that comes with it. Rather than representing something that is soft and pleasurable, Care is often dark and painful. As long as we live, Care is something we cannot escape.

The ghost in the machine

The myth of Care has featured in European philosophy and literature for many centuries (Reich, 1995). In modern times, the most influential engagement with it remains the reinterpretation offered by Martin Heidegger in *Being and Time* (Heidegger, 1996). Here, Heidegger gives the myth an existential twist. He sees it as conveying the centrality of Care to what it means to be human and to live a human life. In addition, the myth reveals how humankind as a social totality is brought into the world by Care and then sustained by it. Just as it binds humans together, Care binds us to our environments – out of necessity rather than as part of a quest for harmony. Finally, the myth expresses the temporal dimension of human existence, its quality of being 'always already' thrown into the world, and the reality that every human life has an end.

Heidegger's interpretation of the myth, together with his more comprehensive concept of care, have inspired considerable debate, including within the health sciences (Kleinman & Van Der Geest, 2009). In the field of nursing in particular, the ethics of care has been a central topic of research since the 1970s (Martinsen & Kjerland, 2006). But while several authors have written about Heidegger in relation to physiotherapy, they have largely avoided the topic of care (Shaw & Connelly, 2012).

In the company of ghosts

One reason for this silence could be the 'uncanniness' of care in physiotherapy, a profession which has always focused on the curative dimension of clinical practice. While every physiotherapist is aware of the presence of care, there is a reluctance to acknowledge it or bring it into the discussion. Care is uncomfortable yet strangely familiar: a monster from the 'id' (for Freud the basic level of our subconscious) which 'ought to have remained hidden' (Freud, Strachey, Freud, & Institute of psycho-analysis, 1961, p. 241). And if it does happen to be revealed, then it must be quickly repressed. However, there is also the possibility that this spectral presence could be confronted, embraced and brought into the light of day.

For Heidegger, care is the constitutive element of our humanness. We *are* care! We constantly take care of different issues; we care for others and ourselves. We cannot *not* care, since we exist at the mercy of care. We have never been, and will never be, completely autonomous, self-contained or independent individuals. Instead, we are dependent on others, and this makes us vulnerable, worried, anxious and solicitous. At the moment of birth, we are already in a web of relationships. We are victims of circumstance, surrounded by expectations and obligations. This goes for patients and physiotherapists as much as for anyone else. Yet within physiotherapy, these basic truths appear to go unrecognized. Or worse: they become subjected to a form of denial.

Taking Heidegger's perspective on the human condition as our starting point, we can state that physiotherapy necessarily includes care. Indeed, it is impossible to practice physiotherapy *without* care, given that care is integral to human interaction with the world. The problem is that the preeminence of the biomedical model in physiotherapy makes it difficult for the profession to recognize care or acknowledge its centrality.

In the health sciences, care tends to be viewed as separate from cure. While cure is associated with interventions geared to healing an injury or combating a disease, care is associated with add-on activities: 'friendly extras' (Mol, 2008). While cure is associated with evidence-based practice, technology, science and facts, care is seen as something vague and indistinct – an optional 'soft supplement' (Askheim et al., 2017; Kristeva et al., 2018).

While there is now some recognition that care-related activities (such as communication) can usefully supplement physical exercises in physiotherapy practice, traditionally the profession has tended to view care, and caring, almost as obstacles, as impediments to recovery (Nicholls & Holmes, 2012). If treatment seems too comfortable; not including active effort from the patient, then there's something suspect about it. Something is not quite right; something is just a touch uncanny.

The logic of care

The Dutch ethnographer and philosopher Annemarie Mol argues that care has its own logic: the logic of care (Mol, 2008). In contrast, physiotherapy, with its historical alliance with medicine, is still rooted in what Mol calls the logic of choice. Although resting on different ideological foundations, these two types of logic can coexist and blend in concrete situations (Mol, 2008).

Care is not recognized, Mol contends, when there is not enough time to listen to the patient. Care is not recognized when physical parameters are isolated from their context; when the patient's daily life and values are not taken into consideration, or when measurement of a few discrete parameters diverts attention from the sometimes painful intricacies of day-to-day life with disease. Care is not recognized when the patient is not recognized as such (Mol, 2008).

Mol argues that the logic of choice derives from a specific ideological standpoint: the view that human beings are autonomous, independent, choice-making individuals. This ideology permeates the dominant discourse of medicine and other health sciences, emerging in concepts such as ‘shared decision-making’, ‘empowerment’ and ‘self-management’ (Kristeva et al., 2018). The body, according to the logic of choice, is an object (a machine) to be controlled, kept in order and subjected to treatment. In the case of physiotherapy, treatment is seen as a pre-defined product about which patients can exercise their own free choice. “You could join a balance group for older adults —it’s entirely up to you.” According to the logic of choice, treatment has a beginning and an end; evaluations are made once it is over.

In contrast, the logic of care derives from an understanding of humans as interdependent, vulnerable and profoundly social beings who exist within a network of relationships and require the support of others. From this perspective, care has neither a beginning nor an end. As with the ancient myth and Heidegger’s existential exploration, care is ‘always already’: an ongoing and open process. In Sara’s story, care manifests itself in relation to the open-endedness of her treatment. From Sara’s viewpoint, there is no predetermined end to the treatment she is receiving, and she finds comfort in the fact that she can come for her physiotherapy every now and then.

For Mol, care is not a transaction where something is exchanged (Mol, 2008). Nor is it simply a matter of offering treatment or giving the patient a sheet of paper with descriptions and diagrams of different physical exercises. Instead, care is all about interaction and recognition. Care includes listening to the patient’s problems and worries. Care is when the therapist attunes to the patient’s body and acknowledges the patient’s needs (Svenaeus, 2000a, 2000b). Care is the therapist and patient working together, perhaps exploring various resting positions and movements. In the logic of

care, the patient's body is not separated from that patient's self and approached as something to be fixed. Rather, self and body form a totality that must be acknowledged and nourished. Care is an interactive, open-ended process that constantly evolves and shifts. Rather than existing as pre-fixed entities that are independent of treatment, goals are integral to its practice and evolution.

While it remains possible for the logic of care and the logic of choice to function well together in daily health care practice, Mol argues that very often they come into collision. In the case of physiotherapy, we argue that this clash has resulted in the suppression of care and a failure to acknowledge its centrality.

Coda

Our story presents care in physiotherapy as something uncanny or 'unheimlich': something familiar and well known, yet repressed and hidden. By explicitly acknowledging care as an integral part of physiotherapy, we want to open up more space for the logic of care in clinical practice. It concerns making our profession a place where the patient's pain and problems are recognized, a place of cooperative endeavour where therapist and patient together explore movements and bodily habits and gain new bodily experiences. We foresee the opening up of new paths and possibilities: one which enable the patient to feel 'at home' while making it possible for the physiotherapist to be recognized and acknowledged as one who cares.

Not everyone in need of care is entitled to physiotherapy; physiotherapists will have to continue making difficult choices. But as our evolving profession seeks to improve its practice, we argue that it needs to confront the ghosts from the past that haunt it still. Above all, it needs to embrace the centrality of care, to draw it into the light and welcome its life-enhancing possibilities.

Reference list

Aarseth, G., Natvig, B., Engebretsen, E., & Lie, A. K. (2017). 'Working is out of the question': a qualitative text analysis of medical certificates of disability. *BMC Family Practice, 18*(1), 55. doi:10.1186/s12875-017-0627-z

Ahlsen, B., Engebretsen, E., Nicholls, D., & Mengshoel, A. M. (In press). The singular patient in patient-centred care: physiotherapists' accounts of treatment of patients with chronic muscle pain. *Medical Humanities*. doi:10.1136/medhum-2018-011603

Althusser, L., & Balibar, É. (2009). *Reading Capital*. London: Verso.

Askheim, C., Sandset, T., & Engebretsen, E. (2017). Who cares? The lost legacy of Archie Cochrane. *Medical Humanities, 43*(1), 41-46. doi:10.1136/medhum-2016-011037

Bjorbaekmo, W. S., & Mengshoel, A. M. (2016). "A touch of physiotherapy" - the significance and meaning of touch in the practice of physiotherapy. *Physiotherapy Theory and Practice, 32*(1), 10-19. doi:10.3109/09593985.2015.1071449

Dahl-Michelsen, T. (2015). Curing and caring competences in the skills training of physiotherapy students. *Physiotherapy Theory and Practice, 31*(1), 8-16. doi:10.3109/09593985.2014.949946

Derrida, J. (2006). *Specters of Marx. The State of the Debt, the Work of Mourning and the New International*. New York: Routledge Classics.

Freud, S., Strachey, J., Freud, A., & Institute of psycho-analysis. (1955). *The standard edition of the complete psychological works of Sigmund Freud : Vol. 17 : An Infantile neurosis, and other works : (1917-1919)*. London: Hogarth Press and the Institute of Psycho-analysis.

Freud, S., Strachey, J., Freud, A., & Institute of psycho-analysis. (1961). *The standard edition of the complete psychological works of Sigmund Freud : Vol. 19 : The Ego and the id, and other works : (1923-1925)*. London: Hogarth Press and the Institute of Psycho-analysis.

Freud, S., James Strachey, Freud, A., & Institute of Psycho-analysis. (2001). *The Standard Edition of the Complete Psychological Works of Sigmund Freud : Vol. 13 : Totem and Taboo, and Other Works : (1913-1914)* London: Vintage.

Hamilton, J. T. (2013). *Security: Politics, Humanity, and the Philology of Care.* Princeton and Oxford: Princeton University Press.

Heidegger, M. (1996). *Being and Time: A Translation of Sein Und Zeit*. Albany, NY: State University of New York Press.

Herbert, R., Jamtvedt, G., Hagen, K. B., & Mead, J. (2011). *Practical Evidence-based Physiotherapy* (2nd ed.). Edinburgh: Elsevier.

Hyginus. (Undated). Fabulae Grant, Mary [translater]. Retrieved from https://www.theoi.com/Text/HyginusFabulae5.html#220

Jamtvedt, G., Dahm, K. T., Holm, I., & Flottorp, S. (2008). Measuring physiotherapy performance in patients with osteoarthritis of the knee: a prospective study. *BMC Health Services Research, 8*, 145. doi:10.1186/1472-6963-8-145

Kleinman, A., & Van Der Geest, S. (2009). 'Care' in health care: remaking the moral world of medicine. *Medische Antropologie 21*(1), 159-168.

Kristeva, J., Moro, M. R., Odemark, J., & Engebretsen, E. (2018). Cultural crossings of care: An appeal to the medical humanities. *Medical Humanities, 44*(1), 55-58. doi:10.1136/medhum-2017-011263

Martinsen, K., & Kjerland, L. E. (2006). *Care and Vulnerability*. Oslo: Akribe.

Mattingly, C., & Lawlor, M. (2001). The Fragility of Healing. *American Anthropologist, 29*(1), 30-57. doi:10.1525/eth.2001.29.1.30

Mikhail, C., Korner-Bitensky, N., Rossignol, M., & Dumas, J. P. (2005). Physical therapists' use of interventions with high evidence of effectiveness in the management of a hypothetical typical patient with acute low back pain. *Physical Therapy, 85*(11), 1151-1167.

Moffatt, F., & Kerry, R. (2018). The desire for "hands-on" therapy - a critical analysis of the phenomenon of touch. In B. E. Gibson, D. A. Nicholls, J. Setchell, & K. S. Groven (Eds.), *Manipulating practices. A critical physiotherapy reader* (pp. 174-190). Oslo: Cappelen Damm Akademisk.

Mol, A. (2008). *The logic of care. Health and the problem of patient choice*. Abington, Oxon: Routledge.

Nicholls, D. A., & Cheek, J. (2006). Physiotherapy and the shadow of prostitution: the Society of Trained Masseuses and the massage scandals of 1894. *Social Science and Medicine, 62*(9), 2336-2348. doi:10.1016/j.socscimed.2005.09.010

Nicholls, D. A., & Gibson, B. E. (2010). The body and physiotherapy. *Physiotherapy Theory and Practice, 26*(8), 497-509. doi:10.3109/09593981003710316

Nicholls, D. A., & Holmes, D. (2012). Discipline, desire, and transgression in physiotherapy practice. *Physiotherapy Theory and Practice, 28*(6), 454-465. doi:10.3109/09593985.2012.676940

Nicholls, D. A. (2018a). *The End of Physiotherapy*. Oxon/New York: Routledge.

Nicholls, D. A. (2018b). Aged care as a bellwether of future physiotherapy. *Physiotherapy Theory and Practice*, 1-13. doi:10.1080/09593985.2018.1513105

Ottosson, A. (2016). One History or Many Herstories? Gender politics and the history of physiotherapy's origins in the nineteenth and early twentieth century. *Women's History Review, 25*(2), 296-319.

Pencharz, J. N., & MacLean, C. H. (2004). Measuring quality in arthritis care: the Arthritis Foundation's Quality Indicator set for osteoarthritis. *Arthritis and Rheumatism, 51*(4), 538-548. doi:10.1002/art.20521

Reich, W. T. (1995). History of the nation of ‘Care’. In W. T. Reich (Ed.), *Encyclopedia of Bioethics. Revised edition* (Vol. 5, pp. 319-331). New York: Simon & Schuster Macmillan.

Roger, J., Darfour, D., Dham, A., Hickman, O., Shaubach, L., & Shepard, K. (2002). Physiotherapists' use of touch in inpatient settings. *Physiotherapy Research International, 7*(3), 170-186.

Shaw, J. A., & Connelly, D. M. (2012). Phenomenology and physiotherapy: meaning in research and practice. *Physical Therapy Reviews, 17*(6), 398-408.

Svenaeus, F. (1999). Freud's philosophy of the uncanny. *The Scandinavian Psychoanalytic Review, 22*(2), 239-254.

Svenaeus, F. (2000a). The body uncanny--further steps towards a phenomenology of illness. *Medicine, Health Care, and Philosophy, 3*(2), 125-137.

Svenaeus, F. (2000b). Das unheimliche--towards a phenomenology of illness. *Medicine, Health Care, and Philosophy, 3*(1), 3-16. doi:10.1023/a:1009943524301

Thornquist, E. (2006). Face-to-face and hands-on: assumptions and assessments in the physiotherapy clinic. *Medical Anthropology, 25*(1), 65-97. doi:10.1080/01459740500514489

Thornquist, E. (2014). Fysioterapeutene: Fra kosmologi til fagpolitikk. In R. Slagstad & J. Messel (Eds.), *Profesjonshistorier* (pp. 138-176). Oslo: Pax forlag A/S.

Øyehaug, G. A., Paulsen, A. K., Vøllestad, N. K., & Robinson, H. S. (2019). Prioritering og venteliste hos avtalefysioterapeuter - en tverrsnittstudie [Prioritation and waiting times for physiotherapy in private practice. A cross-sectional study]. *Fysioterapeuten, 7*, 22-27.