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Physiotherapy in a Danish private context – a social and ethical practice

Jeanette Præstegaard

DOCTORAL DISSERTATION

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Abstract

Physiotherapy is a social and ethical practice which unfolds under specific historical, political, socio-cultural and economic circumstances. Danish physiotherapy in a private context is practiced, administered and managed within a neoliberal ideology which generates challenges for both physiotherapists and their patients. This thesis aims to explore how physiotherapy in a Danish private context socially and ethically is practiced from the perspective of physiotherapists.

The thesis, which consists of four parts, is based on the same empirical material consisting of interviews with twenty-one physiotherapists and observation notes on the physical environments. The specific research aims in the studies have successively been developed through different epistemological approaches and analysis strategies.

The main findings show that physiotherapists in Danish private practice have a general interest in ethics which primarily is based on personal common sense arguments and intuitive feelings of ethics. The physiotherapists' practices are ethically grounded which are shown in many situations. Their consciousness on ethical issues is discursively constructed in the first sessions as these sessions arouse both ethical and economic considerations to keep the client. Further ethical issues arise when the physiotherapists' clientele are regarded as being at risk: in the meetings with the so-called 'difficult' patients as these situations do not just flow, they require ethical reflections and pedagogical strategies in order to keep them in the business. Beneficence is seen as the core value and as having importance in different relationships: towards the patient, the physiotherapists themselves and their businesses. To secure beneficence a paternalistic approach emerges towards the patient, where disciplining the patient into their 'regimes of truth' becomes a crucial element of practice in order to exploit the politically defined frames for optimising profit, showing how being beneficent seem to be led by structures of the neoliberal ideology which work behind the backs of the physiotherapists. Physiotherapy private practice in Denmark seems to reproduce the Western medical logic and practices whereby the physiotherapists unconsciously oppose their own political intentions to be an autonomous profession. Thus, physiotherapy in private practice inscribes itself as a 'wanna-be' profession. The thesis has several limitations as it built solely on Danish physiotherapists' articulations of their practices, their understandings of these and the researcher's observation notes. This means that choosing a specific context for the thesis the findings can only be transferred to similar contexts and neither to other private or public physiotherapeutic contexts in Denmark nor to other Western countries.

Key words

Physiotherapy, professional ethics, ethical issues, practice, Foucault

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Abstract

Physiotherapy is a social and ethical practice which unfolds under specific historical, political, socio-cultural and economic circumstances. Danish physiotherapy in a private context is practiced, administered and managed within a neoliberal ideology which generates challenges for both physiotherapists and their patients. This thesis aims to explore how physiotherapy in a Danish private context socially and ethically is practiced from the perspective of physiotherapists.

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the researcher's observation notes. This means that choosing a specific context for the thesis the findings can only be transferred to similar contexts and neither to other private or public physiotherapeutic contexts in Denmark nor to other Western countries.

Dansk sammenfatning

Fysioterapi er en social og etisk praksis som udfolder sig under specifikke historiske, politiske, socialkulturelle og økonomiske forhold. Dansk fysioterapi i en privat kontekst er praktiseret, administreret og håndteret indenfor en neoliberal ideologi, der genererer udfordringer for både fysioterapeuter og borgere: Det forventes implicit at begge parter understøtter den neoliberale ideologi, da fysioterapeuter i privat praksis har viden og færdigheder, som de tilbyder for penge og konverterer til behandling indenfor de givne rammer og forhold, hvilket deres patienter accepterer og støtter op omkring.

Denne disputats har som formål at undersøge, hvordan fysioterapi i en dansk privat kontekst socialt og etisk er praktiseret, set fra fysioterapeuternes perspektiv.

Denne disputats, som udgøres af fire dele, er baseret på det samme empiriske materiale, der består af interviews med 21 fysioterapeuter og af forskerens observationer af de fysiske omgivelser. De specifikke forskningsspørgsmål er successivt blevet udviklet gennem forskellige espistemologiske tilgange: fænomenologisk hermeneutik, hermeneutik, social konstruktivisme og strukturel tilgang og gennem tre forskellige analyse strategier: Malterud's 'systematiske tekst kondensering', Ricoeur's 'textual interpretation of distanciation' og en social konstruktivistisk analyse foretaget gennem Foucault's begreber om disciplin, selv-disciplin, modstand og magt er anvendt.

Hovedresultaterne viser, at fysioterapeuter i dansk privat praksis har en overordnet interesse i etik, som primært baserer sig på personlige 'sund fornuft' argumenter og intuitive følelser om etik. Fysioterapeuternes praksisser er etisk funderet, hvilket viser sig i mange situationer. Fysioterapeuternes bevidsthed om etiske problemer er diskursivt konstrueret i det første møde i privat praksis, da mødet giver anledning til både etiske og økonomiske overvejelser for at fastholde klienten i klinikken. Fysioterapeuternes bevidsthed om etiske problemer vækkes også, når fysioterapeuternes klientel vurderes til at være de såkaldte 'besværlige' patienter, da den fysioterapeutiske proces ikke bare glider gnidningsløst, men kræver etiske refleksioner og pædagogiske strategier for at fastholde patienterne og derved indtægten i klinikken. Godgørenhed ses som kerneværdien i fysioterapeutisk privat praksis og viser sig vigtig i forskellige sammenhænge: I forhold til patienten, fysioterapeuterne selv og deres forretning. For at sikre godgørenhed viser der sig en paternalistisk tilgang til patienterne. Patienterne

disciplineres ind i fysioterapeuternes ’sandhedssystemer’, med det forhold at kunne optimere indtægten på patienten indenfor de politisk definerede rammer, hvilket overordnet understøtter den neoliberale ideologi og relaterer til en nytteetisk forståelse. Fysioterapi i dansk privat praksis viser sig at reproducere vestlige medicinske logikker og praktikker, hvorved fysioterapeuterne ubevidst modsætter sig deres egne politiske intentioner om at være en selvstændig profession. Herved indskriver fysioterapi i privat praksis sig selv som værende en ’wanna-be’ profession. Fysioterapeuternes opfattelse af deres etiske forpligtelser om at respektere patientens autonomi og være godgørende, synes at blive ført af neoliberale ideologiske strukturer, der arbejder bag om ryggen på fysioterapeuterne.

Denne disputats har flere begrænsninger, da den kun bygger på danske fysioterapeuters artikulationer om deres praksisser, forståelser af disse og forskerens observationer. Det betyder, at analyserne kun adresserer, hvordan fysioterapeuter på et givet tidspunkt artikulerer deres praksisser og ikke problemstillinger i forhold til funktionen af kliniske praksis indenfor praktisk realitet. Det at vælge en specifik kontekst betyder endvidere, at resultaterne kun kan overføres til sammenlignelige kontekster og ikke til andre private eller offentlige danske fysioterapeutiske kontekster eller til andre vestlige lande.

Lists of publications

This thesis is based on the following papers, referred to in the text by their respective Roman numerals. Permission to reprint the published papers in this thesis has been obtained from the respective journals.

Study I

Praestegaard J, Gard G. The perceptions of Danish physiotherapists on the ethical issues related to the physiotherapist-patient relationship during the first physiotherapy session: A phenomenological approach. BMC Medical Ethics 2011, 12:21

Study II

Praestegaard J, Gard G. Ethical Issues in Physiotherapy – Reflected from the perspective of physiotherapists in private practice. Physiotherapy Theory and Practice 2013 Feb;29(2):96-112

Study III

Praestegaard J, Gard G, Glasdam S. Practicing physiotherapy in Danish private practice – an ethical perspective. Medicine, Healthcare and Philosophy 2013 16(3):555-564

Study IV

Praestegaard J, Gard G, Glasdam S. Physiotherapy as a disciplinary institution in modern society - A Foucauldian perspective on physiotherapy in Danish private practice. Submitted, revised and re-submitted to Physiotherapy Theory and Practice

Thesis at a glance

	The aim of the study	The philosophical and theoretical framework	Design
I	To explore whether ethical issues rise during the first physiotherapy session discussed from the perspective of the physiotherapists in private practice	A phenomenological hermeneutic approach. Analysed within the frame of 'The four principle approach'of Beauchamp and Childress	Interview study with 21 physiotherapists performed twice
II	To explore the nature and scope of ethical issues as they are understood and experienced by Danish physiotherapists in outpatient, private practice	A phenomenological hermeneutic approach. Analysed within the frame of 'The four principle approach' of Beauchamp and Childress	Interview study with 21 physiotherapists performed twice
III	To explore how physiotherapists in Danish private practice, from an ethical perspective, practice physiotherapy	A hermeneutic approach according to a Nordic interpretation of Ricoeur. Analysed within meta-ethical frame of understanding right and wrong, what is inherent in the understanding of right and wrong toward the other	Interview study with 21 physiotherapists performed twice
IV	To explore how physiotherapy is practiced from the perspective of physiotherapists in Danish private practice within a Foucauldian perspective	A social constructivist and structural approach. Analysed within the dialectics between the structural frame and possibilities for articulating the discourses on private practice from the perspective of the physiotherapists through the lens of Foucault's theoretical concepts of disciplining, self-disciplining, power and resistance	Interview study with 21 physiotherapists and observations of the clinic

Findings of study I – IV	Main findings
Four themes were constructed: (1) general reflections on ethics in physiotherapy (2) the importance of the first physiotherapy session (3) the influence of the clinical environment on the first session (4) reflections and actions upon beneficence towards the patient within the first session.	Physiotherapists in Danish private practice have a general interest in ethics which primarily is based on personal common sense arguments and intuitive feelings of ethics
One main theme was constructed 'The ideal of being beneficient towards the patient' under which three sub-themes were constructed: (1) Ethical issues related to equality (2) Feeling obligated to do one's best (3) Transgression of boundaries.	The physiotherapists' practices are ethically grounded and are shown in many situations. Consciousness on ethical issues is discursively constructed when their clientele is at risk
Four main themes were constructed: (1) Beneficence as the driving force (2) Disciplining the patient through the course of physiotherapy (3) Balancing between being a trustworthy professional and a businessperson (4) The dream of a code of practice.	Beneficence is understood as the core value and has importance for the relationship towards the patient, the physiotherapists' professional image and self-understanding and, their businesses
Three themes were constructed: (1) The tacit transition from person to patient (2) The art of producing docile bodies (3)Practicing in private homes inhibits freedom of actions.	Physiotherapy in private practice seems to reproduce the Western medical logic and practices

1.0 Introduction

For more than a century physiotherapy has been practiced throughout the world and has established itself as one of the largest professions allied to medicine (Williams, 2005) and has more than a quarter of a million clinicians (Nicholls, 2008). Physiotherapy is a social practice which unfolds under specific historical, political, socio-cultural and economic circumstances. It is a relational practice where physiotherapist and patient meet in a specific contextual setting. Bodily movement is the core of physiotherapeutic practice. Accordingly physiotherapy is about identifying and teaching patients how to maximize their movement potential and functional capacity (The Association of Danish Physiotherapists, 2012ab; WCPT, 2011abd). To examine, diagnose, develop treatment plans and to determine the need for interventions and assess outcomes and simultaneously be open for the patient's complex experiences are core elements of the physiotherapeutic work process (WCPT, 2011b; Lund, Bjørnlund and Sjöberg, 2010; Jones, Jensen and Edwards, 2008; Schriver, 2007; 2003). Thus, physiotherapy practice builds on a belief that the individual patient has the potential capacity to change and that the physiotherapist through his/her knowledge, skills and reflectiveness can facilitate the process. This thesis explores how physiotherapy in a Danish private context functions as a social and ethical practice.

On a general level, the practice healthcare services, such as physiotherapy in private practice, takes place in contexts (Fioretus, Hansson and Nilsson, 2013; Thornquist, 2011; Schriver, 2007; Mik-Mayer and Villadsen, 2007; Greenfield, 2006; Lindgren, 2005; Bayer, Henriksen, Larsen and Ringsted, 2002; Barnitt and Partridge, 1997; Album, 1996; Foucault, 2008; 1977a; 1973). As physiotherapeutic contexts clearly differ from country to country, even though some countries resemble each other considerations about the historical, political, sociocultural and economic frame and the frame of meaning needs unfolding in order to set the context of this thesis.

Today, like other Western countries, Danish healthcare is practiced, administrated and managed within a neoliberal ideology; a political philosophy whose fundamental idea is to minimize public costs, to encourage the development of a growing private market of social and healthcare services and to emphasise individual freedom, especially acting and expressing oneself freely (Rostgaard;

2011; Bjornsdottir, 2009; Boas and Gans-Morse, 2009; Hamann, 2009; Harvey, 2005; Rose, 2003; Evers, 2003; Lemke, 2001; Pollitt and Buckaert, 2000). Neoliberalism refers to normative ideas about the proper role of individuals versus collectivities and a particular conception of freedom as an overarching social value (Boas and Gans-Morse, 2009; Harvey, 2005). Neoliberalism comprises a web of practices which is spun over forms of production, governmental policies and ways of administering values and norms which all support forming the individual human being's identity and ways of being. Within this web of power, techniques support and supply each other, and, as a capillary web spun through society, form a hegemony which in turn forms the world from global structures to the individual human being. Within this ideology, the neoliberal subject is an individual who is morally responsible for navigating the social realm using rational choice and cost-benefit calculations grounded on market-based principles (Mik-Mayer, 2012; Hamann, 2009; Harvey, 2005). An implication of this is that practicing healthcare services within a neoliberal ideology generates challenges for both professionals and citizens. The professionals are implicitly expected to facilitate the citizen's self-development and risk management: not to solve his/her problems, but to generate the best possible opportunities for the citizen to problem-solve themselves, thereby minimizing public costs. The relation and the close cooperation between the professional and the citizen are not in focus (Lauersen, 2005). On the other hand the citizen is expected actively to act and take responsibility for his/her situation and problems (Lehn-Christensen and Holen, 2012; Holen, 2011; Rostgaard, 20011; Magnussen, Vrangbæk, Saltman and Martinussen, 2009; Mik-Mayer and Villadsen, 2007), implying an individualization of the services. The relation between professional and citizen is characterized as articulated and inscribed in certain forms of identities (Miller and Rose, 2008; Foucault, 2006; 1977; Rose, 2003) which make power relations possible and negotiable (Fallov and Nissen, 2010; Foucault, 2006; 1977). As the majority of Danish citizens are employed by the state or receive welfare payments there is an implicit expectation that professionals in both private and public businesses' should speed up in order to enhance efficiency. A further implication is, increasing political pressure for public and private effectiveness and an increased focus on how to facilitate institutions to promote effectiveness: for instance by privatizing more healthcare services (Fallow and Nissen, 2010), or by offering employees healthcare insurances, which enable the services they need to be quickly offered so that they can return to work as soon as possible.

Danish physiotherapists are authorized by the state to deliver physiotherapeutic services according to best available evidence and experiences, within an ethical and collegial frame of understanding (The Association of Danish Physiotherapists, 2013b; 2012ab; 2010). In Denmark about 40% of all physiotherapists are employed in private practice. The remaining 60% of Danish physiotherapists are

employed within the public sector (The Association of Danish Physiotherapists, 2012b). The majority of physiotherapy clinics are owned by one physiotherapist, often a senior, who leases space to one or several physiotherapists at the clinic. Each physiotherapist operates as an independent practitioner and has his own business within the clinic-owner's business. However, their business is not a completely private enterprise since the free market mechanisms in Denmark, like other Western countries since World War II, have been limited and ruled by collective bargaining between the state and the professional associations (The Association of Danish Physiotherapists, 2013ad; Husted and Lübcke, 2001). In practice this means that the associations and the state negotiate the professional services and charges. By law, physiotherapy in Danish private practice is granted federal subsidies, whereby people receiving physiotherapy pay half the cost and the state covers the rest. The subsidies are specified in different categories: first consultation, individual treatment, group treatment and short treatment (The Association of Danish Physiotherapists, 2013ac). As in most Western countries, Danish physicians have been supervisors and medically responsible for the physiotherapists' professional performances, but around the millennium Danish physiotherapists, like other Nordic physiotherapists, have been given the right to make diagnosis within the musculoskeletal area (Ministry of Health, 2010) and free access to physiotherapeutic private practices (The Association of Danish Physiotherapists, 2013a).

These general politics clearly strengthen the responsibility of the individual citizen and the fight against state guardianship which necessarily generate reflections about how the relation and close cooperation between the physiotherapist and the patient takes place in practice. It excites reflections about whether ethical issues rise in physiotherapeutic private practice, the nature and scope of the issues and further it excites an exploration of how physiotherapy is ethically reflected and practiced.

1.1 The ethical starting point of the thesis

Within modern western contexts we usually talk about ethics and morals as synonyms and through many years doubt has been casted on whether there is difference between the two. However the concepts historical origin is certain: Ethic is derived from the Greek ethikós, and Aristotle (384-322 BC) is thought to be the first to formulate an actual theory of ethics; the theory of good character (Aristoteles, 1995). Ethics connects to ethos, habits and norms (Christensen, 2011a; Aadland, 2000; Jensen, 1995). Basically, ethics are systematic reflections

about what is good and bad, what is right and wrong. Moral is derived from the Latin moralis, which was used to translate the Greek ethikós and accordingly it historically has the same content of meaning (Christensen, 2011a; Shafer-Landau, 2007; Birkler, 2006; Aadland, 2000; Svenaeus, 2000; Purtillo, 1999). Anyway, in this thesis the term ethical and moral are used synonymously, and mainly the word ethical is used.

Central to normative ethics is the question: what ought I to do? The question not only concerns what might possibly be done or what it is lucrative to do, but is also reflections about what it is right and justified to do (Beauchamp and Childress, 2009; Vetlesen, 2007; Birkler, 2006), and it is expressed in what we think and do (Jensen and Mooney; 1990). Ethics is systematic reflections on human conduct (Adland, 2000) Since the 1980's an increasing interest in ethics has been seen in more areas - amongst others professional ethics, research ethics, bioethics, company ethics - which indicates that questions about what is right and what is good have come to focus in new ways (Christoffersen, 2013a; Dige, 2011; 2009). In physiotherapeutic private practice, as in any other healthcare profession private practice, one of the central ethical questions is: how ought I to balance benefice between the patient and myself; which implies the further question how can I have an ethically sound business?

Our ethical understandings express themselves in our actions. When we say that an action is ethic it means that it is consistent with what we consider right and justified (Christensen, 2011a; Beauchamp and Childress, 2009; Vetlesen, 2007; Birkler, 2006; Aadland, 2000; Henriksen and Vetlesen, 2000). We have written and unwritten normative rules and guidelines for what are right and wrong professional actions and we assess accordingly; The Associations of Danish Physiotherapists published their ethical guidelines in 2002, revised in 2012 (Association of Danish Physiotherapists 2012a). Yet, there seem not to be any consensus about which position within normative ethics is 'the right one' at any given situation, and several influential and well-argued positions are given; for instance ethics of care, deontology, and utilitarianism (Christensen, 2011b; Shafer-Landau, 2007; Driver, 2007; Darwall 1998; Vetlesen and Nortved, 1997; Løgstrup, 1997).

Professional ethics concern professional meetings between human beings face to face; the professional and the patient, where the professional is obligated, reasoned and professionally skilled to do something with the other; the meeting is action-oriented (Christoffersen, 2013b; Henriksen and Vetlesen, 2000). The situation is based on the professional's competences and ability to ensure the patient equal status within the meeting despite the conditional asymmetry of power (Thornquist, 2011; Birkler, 2006; Henriksen and Vetlesen, 2000). In general, ethic is defined as a certain form of normative reflection, but professional ethics are not only about

reflection, but also about action. From this it can be deduced that ethical questions within professional ethics are not just theoretical but also practical (Christoffersen, 2013a; Henriksen and Vetlesen, 2000). This requires that the professional reflect, in so far as the concrete situation seems to necessitate reaching a decision about how to act (Schriver, 2007). As professional reflection and assessment is subject to a certain imperative of action, including time pressure, it implies a need for processing choices. Thus it seems relevant to explore and analyse situations in which ethical issues arise in order to enhance collective awareness of professional ethical issues.

The thesis is based in the understanding that ethical issues are relational situations where one needs to weigh alternative actions towards a ethical problem (Beauchamp and Childress, 2009; Jacobsen and Kristiansen, 2006; Aadland, 2000; Henriksen and Vetlesen, 2000; Purtillo, 1999) and that ethical issues are embedded in every clinical encounter, reasoning process and practice situation (Christensen 2011a; Jones, Jensen and Edwards, 2008; Sandström 2007; Poulis, 2007ab; Purtillo, 1999; Praestegaard, 2001; Carr, 2000). The term 'ethical issues' (here used synonymously with 'ethical problems') is used as an overriding concept and includes ethical vagueness and dilemmas. Vagueness refers to that it is not clear what a particular ethical idea means or what a specific ethical value implies in a situation. Ethical dilemmas are situations in which two or more ethical reasons come into conflict where it is not immediately obvious what the involved persons should be doing (Beauchamp and Childress, 2009; Gabard and Martin, 2003; Aadland, 2000; Henriksen and Vetlesen, 2000).

Normative directions for how physiotherapy ought to be have been published in various textbooks (for example Purtilo and Doherty, 2011; Jones, Jensen and Edwards, 2008; Raja, Davies and Sivakumar, 2007; Swisher and Page, 2005; Purtilo, Jensen and Royeen, 2005; Gabard and Martin, 2003; Purtilo and Haddad, 2002). Clinical guidelines which offer physiotherapists directions for treatments of several diagnosis (Association of Danish Physiotherapists, 2014), ethical guidelines (Association of Danish Physiotherapists, 2012a) and codes of conduct (Association of Danish Physiotherapists, 2010) have been published and further, questions about how physiotherapy ought to be has also been a focus of physiotherapy research.

1.2 Researching professional ethical issues in physiotherapy practice

Since 1970 several studies on ethical issues related to aspects of physiotherapy have been published. In a review of 90 publications Swisher examined the knowledge on ethics present in physiotherapy literature from 1970-2000 (Swisher, 2002). She found that most publications were predominately philosophical, primarily using 'the four principles' perspective (Beauchamp and Childress, 1979); and she also found a shift in issues and topics moving from moral sensitivity to moral judgment, with a focus developing from self-identity to patient-focused to a growing societal patient-focus. She only identified six publications (Barnitt, 1998; Barnitt, 1994; Triezenberg, 1996; Barnitt and Patridge, 1997ab; Guccione, 1980; Purtilo, 1978) which attempted to define the uniqueness of physiotherapeutic ethical issues important to physiotherapeutic practice (Swisher, 2002). These studies revealed a practice with a growing professional consciousness towards its unique ethical issues (Purtilo, 1978) in the physiotherapist-patient relationship (Barnitt, 1998; Triezenberg, 1996; Barnitt, 1994; Guccione, 1980). Moral obligation and economic issues (Triezenberg, 1996; Guccione, 1980) and maintenance of clinical competence by physiotherapists (Triezenberg, 1996) were also identified as ethical issues. Inter-professional collaboration (Guccione, 1980), lawful obligations such as taking informed consent in practice (Triezenberg, 1996) and, a study of occupation therapists' and physiotherapists' moral reasoning further reinforced the importance of identifying ethical issues in practice (Barnitt and Partridge's, 1997ab).

In 2008 Carpenter and Richardson built on Swisher's analysis in a narrative review by synthesizing the physiotherapy literature published in peer-reviewed journals from 2000 – 2008 (Carpenter and Richardson, 2008). They identified six publications (Delaney, 2007; Greenfield, 2006; Finch and Geddes and Larin, 2005; Carpenter, 2004; Geddes, Wessel and Williams, 2004; Cross and Sim, 2000) which focused on how ethical issues are identified and managed in physiotherapeutic practice and how ethical practice is taught. The studies revealed a burgeoning professional consciousness towards broader aspects of physiotherapy practice. The issues were about respecting legal obligations, especially practices about taking informed consent (Delaney, 2007; Geddes, Wessel and Williams, 2004; Cross and Sim, 2000), how to manage ethical issues about professional responsibilities in the physiotherapist-patient relationship (Finch, Geddes and Larin, 2005; Geddes, Wessel and Williams, 2004; Carpenter, 2004; Cross and Sim, 2000), the practices of balancing fiscal accountability with the professional obligation to fidelity (Greenfield, 2006) and issues related to interdisciplinary collaboration (Geddes, Wessel and Williams, 2004; Carpenter, 2004) were all

found ethical issues of importance. Further, ethical issues related to allocation of limited resources are reported (Geddes, Wessel and Williams, 2004).

In the last five years publications about ethical issues related to physiotherapy have focused on philosophical aspects of practice: the ethics of implementing evidence into practice (Watt-Watson et al, 2013; Kumar, Grimmer-Somers and Hughes, 2010), suggestions about how to move beyond a code of ethics (Swisher et al, 2011; Edwards, Delaney, Townsend and Swisher, 2011ab; Greenfield and Jensen, 2010), and how to close the gap between ethics knowledge and practice (Delany, Edwards, Jensen and Skinner, 2010). In addition, research has focused on ethical issues in different contextual clinical practices, for instance in pediatric practice (Jakubowitz, 2011), issues around moral distress in practice (Rowe and Carpenter, 2011; Carpenter, 2010) where one knows the right course of action but is not authorized or empowered to perform it, ethical issues relating to incidences of sexual attraction and dating of patients (Cooper and Jenkins, 2008), issues about being solely in charge, professional isolation and lack of peer support (Rowe and Carpenter, 2011; Sheppard, 2001) and challenges of practicing rehabilitation in battlefields (Rowe and Carpenter, 2011). Further, research has focused on issues related to whistleblowing internally and externally (Mansbach, Bachner and Melzer, 2010), issues about informed consent (Delaney and Frawley, 2012; Fenety, Harman, Hoens and Basset, 2009; Delaney, 2008), documenting practice (Harman, Basset, Fenety and Hoens, 2009) and conflicts in research ethics (Sim, 2010). In conclusion, the review of research on important ethical issues in physiotherapeutic practice paints a picture of a profession striving for increased ethical awareness, yet limited in the amount of empirical research.

1.3 Professional ethical issues in the context of physiotherapy private practice

Normative professional guidelines originate in the belief that physiotherapists place professional fidelity to their patients as their first priority, whatever the context of their employment. However, physiotherapists employed in private practices are explicitly asked to balance their professional obligation to fidelity with fiscal accountability. Given this, ethical knowledge and reflections have to keep pace with the increasing complexity and evolving professional autonomy of physiotherapy, which is why exploration of the uniqueness of ethical issues in the context of private physiotherapeutic practice becomes relevant.

Few researchers have focused their work on ethical issues in the context of physiotherapy private practice.

In 2003 Potter, Gordon and Hamer published three studies about physiotherapy in private practice. They discovered several ethical issues, but the authors did not refer to them as such. They reported: mutual normative expectations, which were both met and not met within the physiotherapist-patient relationship (Potter, Gordon and Hamer, 2003a); that patients' negative experiences of physiotherapy in practice related to poor communication skills (Potter, Gordon and Hamer, 2003b); and, finally they offered a typology of the difficult patient in physiotherapy private practice (Potter, Gordon and Hamer, 2003c). Greenfield (2006) pointed out the difficulty of balancing an ethics of care approach within a cost-effectiveness and profit context. Delaney (2007) found that physiotherapists in private practices defined informed consent as an implicit component of their clinical routines.

Normative directions given in textbooks and research about what physiotherapists ought to do are one thing; another thing is what they actually do. In addition physiotherapists' reflections on ethics, reflections about how physiotherapy is practiced are also evoked within the context of private practice.

1.4 Researching physiotherapy practice

From the turn of the millennium, a burgeoning focus on what physiotherapy practice is has evolved and physiotherapists have, as have other healthcare researchers (Glasdam, Praestegaard and Henriksen, 2013; Glasdam, Henriksen, Kjaer and Praestegaard, 2012; Campbell, 2011; Nielsen and Glasdam, 2011; McCarthy, 2010; Fisher, 2010; Kokaliari and Berzoff, 2008; Traynor, 2007; Fox, Ward and O'Rourke, 2005; Roberts, 2005; Gilbert, 2003; Riley and Manias, 2002; Holmes and Gastaldo, 2002; Cheek, 2000; 1995; Cheek and Gibsen, 1996; Armstrong, 1995; 1994), directed their attention to postmodern approaches, which emphasize the cultural and historical contingency of knowledge and thereby offer different ways of viewing clinical practices and the locations they occupy.

In physiotherapy the approaches have been used by researchers to give alternative and challenging ways of viewing traditional physiotherapeutic concepts. Researchers have explored the intersection between philosophy and physiotherapy and they demonstrate in their studies how applied philosophy can inform an array of practice areas and issues. Central issues, such as movement, walking, rehabilitation, disability, normality and touch in the practice of physiotherapy are

discussed in new ways that destabilize and disrupt common understandings about what physiotherapy practice is. These studies allow consideration of multiple creative ways of approaching the complexity of physiotherapy practice.

In explorative philosophical studies researchers show how the concept of body and ontology of body movement - for instance the symbolic value of walking (Gibson and Teachman, 2012) and understandings about the learning of movement (Schriver, 2003) in physiotherapeutic practice - is disciplined into a biomechanical and medical view of body-as-machine, and how the body as a philosophical and theoretical construct has been almost entirely bypassed by the profession (Wikström-Grotell, 2012; Shaw and DeForge, 2012; Nicholls and Holmes, 2012; Nicholls and Gibson, 2010; Darnell, 2007; Engelsrud, 2007; Schriver and Engelsrud, 2007; Rugseth and Engelsrud, 2007; Engelsrud, 2006; Jørgensen, 2000; Thornquist, 1998). Through different postmodern approaches they suggest future physiotherapists to be open to and utilize alternative 'thought figures' which entail investigation of patient's emotional, social, and political experiences of injury or illness to provide a more holistic approach to practice. This may support physiotherapists in their efforts to arrive at more sustainable and shared decisions with their patients. Through a Foucauldian lens Nicholls (2012) shows how historic, socio-political dimensions convey meaning to a seemingly benign device, the physiotherapy treatment bed. Gibson and Teachman (2012) draw from Bourdieu's sociology of practice to illuminate how socially ingrained notions of normality and disability about walking are reflected in rehabilitation practices. Eisenberg (2012) shows how relations of power perpetuate hierarchal divisions between patient and physiotherapist and researchers show how social and cultural conditions develop and determine physiotherapists', patients' and inter-professional colleagues' understandings and interpretations of their own and the others actions (Thornquist, 2011; Bartlett, Lucy, Bisbee and Conti-Becker, 2009; Foord-May and May 2007; Smith, Roberts and Balmer, 2000; Higgs, Refshauge and Ellis, 2001; Noronen and Wikström-Grotell, 1999).

From ethical reflections and perspectives and these, for physiotherapy, rather new, alternative and challenging postmodern approaches to viewing traditional physiotherapeutic practice, the overall aim of this thesis and its four specific research aims have been developed.

2.0 Aims

The general aim of the thesis is to explore, from the position of physiotherapists, how physiotherapy in a Danish private context socially and ethically is practiced.

Through the process of exploring the general aim of the thesis the following four specific aims have successively been developed:

- To explore whether and how ethical issues arise during the first physiotherapy session in private practices.
- To explore the nature and scope of ethical issues as they are understood and experienced by Danish physiotherapists in outpatient, private practices.
- To explore how physiotherapists in Danish private practices, from the perspective of the physiotherapists practice physiotherapy within an ethical perspective.
- To explore how physiotherapy is practiced from the perspective of physiotherapists in Danish private practices within a Foucauldian perspective.

3.0 Material and method

This is an explorative thesis based on one general aim and four specific research aims which are all examined through the same empirical material consisting of interviews with twenty-one physiotherapists. Observation notes have also been taken. The specific research aims are based on different epistemological approaches, and three different analysis strategies are used on the empirical material. The data collection methodology, the recruitment procedures, the procedures for the interviews and observational notes, and ethical considerations concerning the data collection will be presented first, followed by an unfolding of the philosophic approaches and strategies of analysis used in studies I - IV.

3.1 Methods of data collection

3.1.1 Recruitment procedure

For research, strategies to select interviewees have carefully to be decided. A purposive sampling strategy was chosen (Malterud, 2011; Kvale and Brinkmann, 2009; Silverman, 2005; Patton, 2002; Kuzel, 1999; Kvale, 1996). The purpose was to obtain a broad sample of physiotherapists in private practices with a wide range of experiences, based on the overall presumption that practicing physiotherapy gives rise to real ethical issues in every clinical meeting between physiotherapist and patient, which are often tacitly understood.

To recruit physiotherapists from private practices, an invitation letter introducing the subject of the study and asking for interested participants was sent out to 31 clinics across all five regions in Denmark. The clinics were selected from The Association of Danish Physiotherapists' list of private practices which is available from the association's homepage (The Associations of Danish Physiotherapy, 2006). I contacted the first five clinics in region one, the last five clinics in region two, the sixth to tenth in region three etc. After one week, the clinics were contacted by telephone and asked if they wanted to participate. Nine clinics found

the study important but lacked time for participation. The rest of the clinics had passed the letter around and several physiotherapists showed interest in participating. The physiotherapists decided amongst themselves whether they wanted to participate. With this strategy we aimed at optimizing geographical variation and to have no direct influence in choosing either clinics to contact or physiotherapists to participate.

For selection, the physiotherapists had to: speak fluent Danish, work in a private practice, and represent a variation in gender, age, work position, work experience and geographical region. Twenty-two participants, from 22 different clinics, willingly agreed to take part in two interviews and signed a written informed consent. One of the twenty-two was excluded due to upcoming maternity leave.

3.1.2 Interview procedures

I regard an interview as a dynamic, meaning-making occasion, where focus is on how meaning structures about situations are constructed, the circumstances of the constructions, and the meaningful linkages that assemble the situations. Accordingly the role as an interviewer becomes one of actively exploring and supporting in the interviewing process: both interviewer and interviewee are inevitably implicated in making meaningful constructions, in producing knowledge (Kvale and Brinkmann, 2009; Holstein and Gubrium, 2006; 2005; 2004; Kvale, 2006; Järvinen, 2005; Andersen, 2003; Gubrium and Holstein, 2002; 2000). Through the interviews I search for knowledge about the interviewees' ethical meanings structures – what makes sense and what governs their actions in practice.

Studying ethical issues in professional practices is difficult because human beings live and act out their morals, i.e. internalised habits and customs, values and attitudes, without necessarily knowing about them (Lindseth and Norberg, 2004; Praestegaard, 2001). For this reason it is not possible simply to ask people what morals they have or how they practice them (Lindseth and Norberg, 2004; Lindseth et al, 1994). Accordingly I chose to build up the interviews around stories of situations and events of practice; narratives rich in descriptions (Brinkmann and Kvale, 2009; Kvale, 2006) rather than normative statements. The narratives were seen as retrospective constructions of a linear causal chain of events which bring about a structure of the multitude of events whereby meaning is produced.

I chose to carry out two interviews with each interviewee as a means to plant 'a reflection seed' in the interviewee, in the expectation of facilitating the interviewees' awareness of the ethical dimension of their practices. The Interview

is seen as a production of knowledge from the time that the invitation letter had been read, to the first and the second interview.

From this, an interview guide (see table 1) was constructed to support the conversation and the idea of generating narratives of practicing physiotherapy; not as one single narrative but as shorter narratives of different practice-related situations and events within the same interview (Frank, 2012; Czarniawska, 2010; Andrews, Sclater, Squire and Tamboukou, 2007; Järvinen, 2005; Chase, 2005). The guide was prepared around the overall presumption that both the interviewee and interviewer form and produce knowledge within the interaction of the concrete interview situation, which is in line with several authors specifications (Kvale and Brinkman, 2009; Holstein and Gubrium, 2006; 2004; Järvinen, 2005; Andersen, 2003b; Gubrium and Holstein, 2002; 2000).

At the first interview the interviewee was asked to present him/herself, his/her motivation for being a physiotherapist in private practice and to describe the organisation and everyday life at the clinic and/or workday. In both interviews I asked for situations or events which the interviewee found constructed the best ever or regrettable situations of physiotherapy and to unfold them from beginning to end. In the process I facilitated the interviewee to construct the different happenings recounted into coherent stories by questions like: ‘what’, ‘when’, ‘who’, ‘how’, ‘with whom’, ‘to whom’ and ‘for whom’ to stimulate and to shape their narratives. I focussed on what was being said and what was not. I also asked the interviewees to share their understanding of ethics related to the narratives, if any relationship was identified. I facilitated their meaning structures of private practice situations to be constructed. I regarded the person being interviewed as not only holding facts and details of experience, but, in the very process of offering them up, constructively adding to, taking away from and transforming them into artefacts of the occasion. I wanted for my colleagues to share their experiences and reflect about situations and events in practice that they valued as ethically important. I strived to facilitate their stories without rendering judgmental utterances but to provide both understanding as to how meaningful or difficult the situation must have been (Dickson-Swift, James, Kippen and Liamputtong, 2009; 2007) and to facilitate them to tell more; to thicken their narratives of practice.

TABLE 1 Interview guide

Interview themes for the first interview

1. Introduction
- *Presentation of the study, the purpose, myself.*
- *Please present yourself; your motivation for choosing physiotherapy as a carrier? Your motivation for choosing to work in private practice?*
- *Please describe a typical workday in your private practice.*
2. Narratives of physiotherapeutic practice.
- *Can you cast your mind back and describe one or more situations from your private practice that you would describe as being the absolutely best physiotherapy you have ever given any patient?*
  What happened, who, when, how, with whom, to whom and for whom; an ethical issue?
- *Can you cast your mind back and describe one or more situations from private practice which you have experienced as regrettable?*
  What happened, who, when, how, with whom, to whom and for whom?
- *Can you describe the values you strive to protect in daily private practice physiotherapy?*

Interview themes for the second interview

1. Introduction
- *Please, tell me about your thoughts since we met last*
2. Narratives of physiotherapy in private practice.
- *Can you cast your mind back and reflect on and describe further reflections and narratives about the best ever and/or regrettable situations or professional conduct related to physiotherapy in private practiceWhat happened, when, who, how, with whom, to whom and for whom; an ethical issue?*

The majority of the interviews were carried out in private clinics which gave a solid frame of reference for understanding the comprehension of the interviewees' mind set and examples. A few interviews were carried out in private homes or in a

neutral office according to the participant's preference. All interviews were audiotaped.

The first interview lasted 45 – 60 minutes, and the second 30 – 45 minutes. The time span between the two interviews varied between one and two months. One interview had a five month span between the two interviews due to the interviewee's business. Some of the interviewees had prepared for the second interview by having written down situations they wanted to speak about. In the second interview, some interviewees refined their earlier statements by adding reflections and insights to them.

A secretary and I developed rules for the transcription process. Audiotapes of the interviews were transcribed 'slightly verbatim mode' (Malterud, 2003) by a secretary immediately after each interview. The transcriptions were checked by letting the first author read the texts while re-listening to the interviews: misunderstandings, sarcastic and ironic phrases were marked if they were found to carry meaning. This process of reading while re-listening generated a filtration and shaped a first step of an immediate and naïve interpretation. The transcribed interviews filled on average 23 pages, a total of 966 pages.

3.2 Observation notes

Observations were made as simple outline drawings and as written notes.

The outline drawings sketched the building of the clinic and the rooms inside, and functioned as open memory boards of the architecture, organisation and décor of the rooms in the clinic.

The notes were constructed around the architecture of the building and clinic, the décor in the waiting room, the décor in the treatment room, the organisation of the clinic - what and who could be seen in each room, by the nature of the walls, ceiling and floor and what could be heard. Notes about the atmosphere of the interview, the immediate impressions of the interviewee's choices of words and ethical awareness were also constructed.

Both drawings and the notes were constructed immediately after the interviews with the seventeen participants who had invited me to their clinic. The notes were utilised to contextualise the narrated situations and events and to help with orientation and understanding during the analysis in study I and II, as suggested by Riese (2007), and together with the outline drawings as empirical data in study IV. The notes consist of 103 pages.

3.3 Ethical considerations

This kind of study does by law not need approval by The Danish Research Ethics Committee (The Danish Research Ethics Committee, 2005). The study is subjected to a Danish Act on Processing of Personal Data and there is, according to chapter 13, §48, exempt obligation to notify The Danish Data Protection Agency (The Danish Data Protection Agency, 2005).

All four studies followed the principles of the Code of Ethics of The Association of Danish Physiotherapists (The Association of Danish Physiotherapists, 2002) and the World Confederation of Physical Therapy's Code of Ethics (World Confederation of Physical Therapists, 2011d) both based on the Helsinki Declaration (World Medical Organization, 2008).

All interviewees were informed verbally and in writing about the general aim of the study and consent was obtained from all participants. They were informed that they could withdraw from the interview or from answering, or expand on, a question, at any time without explanation. They were informed that their statements would be treated in confidence, that the results would be presented at a group level and that no individual would be identified in the results. All found this satisfactory. The transcribed interviews and the code to identify each statement used in the study are being kept in a safe locker and will be stored according to the rules in force.

One of the greatest concerns about doing interviews with the physiotherapists was how to gain their confidence without them sensing collegial pressure for participating (Dickson-Swift, James, Kippen and Liamputtong, 2009; 2007) or for them to think me superior in knowledge about ethics and physiotherapy. I wanted them to willingly share their professional conduct for good or bad without any sense of prejudgment or condescension to. I regarded their reality as more than just words. To ask for their informed consent felt like much more than asking colleagues to sign a form saying that they willingly offered information. The feeling was further enhanced as some interview statements went beyond the level of confidentiality I had expected. This is why, at the end of each interview, I asked again for informed consent to use their statements as quotes: all the interviewees willingly agreed.

3.4 Study I and II

The aim was to explore the nature and scope of ethical issues arising during the process of physiotherapy discussed from the perspective of physiotherapists in private practice. Early in the interview process, it became clear that the interviewees found it important to distinguish between ethical reflections relating to the first session and the general process of physiotherapy, as they found the first session to specific ethically important. In consequence, the guiding questions in the interview guide was adjusted and pursued through two separate aims:

In study I, the aim was to explore whether and how ethical issues arise during the first physiotherapy session discussed from the perspective of the physiotherapists in private practice, and in study II, the aim was to explore the nature and scope of ethical issues as they are understood and experienced by Danish physiotherapists in outpatient private practice.

Based on this, Malterud's qualitative research approach (Malterud, 2012; 2011; 2001ab) which takes origin in the paradigms of phenomenology and hermeneutics (Jacobsen, Tanggard and Brinkmann, 2010; Denzin and Lincoln, 2005; Birkler, 2005; Gadamer, 2005; 2004; Giorgi, 2005; 2003; 1975; Dahlberg, Drew and Nyström, 2001; Malterud; 2001a; Føllesdal, Walløe and Elster, 1993) was chosen. The ambition of this approach is to explore and present vital examples from peoples' life worlds (Malterud, 2012) and it is suitable for generating new, or expanding, descriptions, or even concepts and theories, which offer understandings of diversity, common features or typical qualities and characteristics (Malterud, 2011). The approach has previously been used in healthcare research especially within the healthcare context (Beck, Bager, Jensen and Dahlerup, 2013; Thorsen, Hartveit and Baerheim, 2012; Bjorkman and Malterud, 2012; Johansen, Carlsen and Hunskaar, 2011; Berthelsen, Hjalmers, Pejtersen and Söderfeldt, 2010; Kjølseth, Ekeberg and Steihaug, 2010).

3.4.1. A phenomenological hermeneutic approach to study I and II

In this thesis phenomenology is used as a research strategy, as a way of working with a science of the unique, of the conditional situation and of practice (Flyvbjerg, 1991) where it is assumed that the life world exists before people are present and that it will be there after they depart (Holstein and Gubrium, 2005). In this understanding a phenomenological research approach aims to be as clear and illustrative as possible and to describe lived experiences of individuals without preconceived apprehensions. The approach seeks, through intuiting, analysing and

describing the phenomenon under investigation, to gain understanding and insight into the varied appearances of human beings' life world and situations (Greenfield and Jensen; 2010; Jacobsen, Tanggard and Brinkmann, 2010). It means having non-critical open mind, looking and listening in an attempt to grasp the uniqueness of specific phenomena. This is achieved by a temporary bracketing of earlier theories, abstractions and prejudices (Malterud, 2011; 2003; Giorgi, 2005; 1986). The phenomenological analysis is closely tied to intuitions and descriptions of the uniqueness of a phenomenon, often using negations (what is and what is not), metaphors or analogies (Malterud, 2012; 2001b; Hall, 2000; Halldórsdóttir, 2000).

Hermeneutics means the art of interpretation and was originally used to interpret the Bible and theological works (Birkler, 2005). Today there are different approaches within hermeneutics; traditional, methodical, philosophic and critical hermeneutics (Højbjerg, 2004) and this thesis is based in methodical hermeneutics.

The basis of hermeneutics is that understanding is fostered from pre-understandings. Hermeneutics does not allow the researcher to be without assumptions. Hermeneutics are approaches to the analysis of texts that stress how prior understandings and prejudices - understood as: i.e. human beings' experiences, knowledge, and theories - take part in shaping the interpretive process: (Denzin and Lincoln, 2005; Birkler, 2005; Gadamer, 2005; 2004; Højbjerg, 2004). The human understanding is seen as a circular process, the so-called 'hermeneutic circle'. The human being is interwoven into a world which is given, in advance, as a result of historic-social tradition (the past). And in this world, given in advance, the human being relates immediate understandings and interpretations (the present) to his/her own mortality (the future) and to the outside world. We as human beings are part of history and are conditioned by traditions we understand through prejudice. Our understanding is existentially conditioned by time, situations and each other, and as such we cannot avoid prejudice. Prejudices are seen as the possible conditions for understandings, not as something negative. One's understandings of the other will always start in one's own understanding. In Gadamer's wordings of hermeneutics, a mutual understanding occurs when horizons of understandings merge, by moving one's borders of understanding through constantly challenging one's prejudices. In the moment of merging two understandings, the interpreter is moved; the horizon is broadened and new possibilities for understandings arise (Gadamer, 2005; 2004).

As a philosophical basis, I wanted to search for the unique and situation-conditional practices of physiotherapists in private practice, to find out how physiotherapeutic practice is made meaningful for the physiotherapists without letting my prejudices blind the analysis. Malterud (2012; 2011) recommends that the interviewer should temporarily set aside; bracket theories, principles, abstractions and prejudices and aim to have a non-critical intuitive sensitivity and

openness towards the physiotherapists' narratives of experiences of their life world and situations. Accordingly, I felt obligated to identify my origin of departure, to examine what influences my entry to the knowledge, and draw up a list of my experiences, understanding of position, expectations of the findings, definitions of central concepts, theoretical frameworks etc. and then to consciously try to bracket my pre-understanding and from this to let the data speak for itself; believing that I, as the researcher, can listen 'as a fly on the wall' and afterwards recount the interviewee's descriptions without rendering any interpretation. Quite early in the interview process I realised that the professional theoretical foundation can hardly be parenthesised. I was unable to set aside my understandings of ethics, as ethics is an integrated part of my professional theoretical foundation. I experienced this to be just as impossible as it is to ask a reader to bracket his or her reading skills: black signs on a sheet of paper will for the reader inevitably become meaningful patterns of letters, words or sentences; only when changing the context fundamentally will the reader 'only' see black signs on a sheet a paper - as most Western readers do when seeing Chinese signs on a piece of paper. They cannot recognize the signs as meaning patterns, and might even be unsure about if the signs are words or drawings.

Accordingly, an editing analysis style (Miller and Crabtree, 1999), often referred to as data-based analysis, was used. Using this strategy I stayed as open as possible to the texts in the first step of the analysis, and made use of an ethical definition as theoretical framework in Study I, and "The four principal approach" (Beauchamp and Childress, 2009) in Study II. With these theoretical frameworks I could break with my prejudices in the following steps of the analysis. This was achieved in an analytic process between data – the theoretical framework – me – the second author – data, etc. (Kvale and Brinkmann, 2009).

3.4.2 The theoretical framework in study I

The ethical perspective applied in study one originated in the overall understanding of ethics as described in section 1.1. and Purtilo's statement: "Ethics is a systematic reflection on morality: Systematic because it is a discipline that uses specific methods and approaches to examine moral situations and reflections because it consciously calls into question assumptions about existing components of moralities that fall into the category of habits, customs, or traditions (Purtilo, 1999:12).

We began from the understanding that ethical issues are relational situations where one needs to weigh alternative actions towards a ethical problem (Beauchamp and Childress, 2009) and that ethical issues are embedded in every clinical meeting

(Poulis, 2007ab; Praestegaard, 2001; Purtilo, 1999). Ethical issues in relation to physiotherapy private practice can be about how to manage the power asymmetry to ensure both parties feel humanly equal, how to communicate in a respectful manner with all clients, how to live up to the right of self-determination and privacy, how to handle different views on disease and health, or how to deliver client-orientated therapy to all kinds of patients (Carpenter and Richardson, 2008; Poulis, 2007ab; Potter, Gordon and Hamer; 2003abc; Swisher, 2002; Praestegaard, 2001; Cross and Sim, 2000).

3.4.3 The theoretical framework in study II

As a means to guide professionals Beauchamp and Childress (1979) have contributed to normative ethics with a framework of moral norms. "The four principle approach", also called principalism, provides a common set of moral commitments, a common moral language, and a common set of moral issues to be considered in particular cases. Principalism has proved widely influential in both teaching and writing about medical ethics, particularly amongst medical clinicians and nurses with little or no philosophical knowledge (Ross, Capozzi and Matava, 2012 Duncan, 2010; Seedhouse 2009; Sen, Gordon, Adshead and Irons, 2007) and also in physiotherapy (Edwards, Delany, Townsend and Swisher, 2011b; Townsend, Cox and Li, 2010; Sim, 2010; 1998).

Without proposing any ranking or hierarchical structure the four principles are: (1) respect for autonomy, (2) beneficence, (3) non-maleficence and (4) justice (Beauchamp and Childress, 2009).

The principle of autonomy refers to a statement of moral obligation to respect and support a person's autonomous decisions free from both controlling interference and from certain limitations such as an inadequate understanding that prevents meaningful choice.

The principle of beneficence refers to a statement of moral obligation to act for the benefit of others. It includes all forms of actions intended to benefit other persons. Within biomedicine the principle of beneficence supports an array of moral rules of obligation, e.g. protect and defend the rights of others; prevent harm from occurring to others; remove conditions that will cause harm to others; help persons with disabilities; rescue persons in danger (Beauchamp and Childress 2009;199). Beneficence means that one ought to prevent evil or harm, one ought to remove evil or harm, and one ought to do or promote good.

Within biomedicine the principle of non-maleficence is an injunction against harming others. It gives rise to prohibitions of certain actions that must be

followed impartially. The first moral rule Beauchamp and Childress address is "Negligence and the standard of due care" which relates to lawful and moral standards of due care. Due care is understood as taking sufficient and appropriate care to avoid causing harm. This standard requires that the goals pursued justify the risks that must be imposed to achieve those goals, and negligence is the absence of due care (2009;153). Beauchamp and Childress furthermore state five moral rules specified to establish a presumption in favor of providing life-sustaining treatments for sick and injured patients (2009;155): these rules are not directly relevant for physiotherapy in private practice. Non-maleficence means that one ought not to inflict evil or harm and also ought not to impose risks of harm (2009; side 153).

The principle of justice is a statement of moral obligation to fairly distribute benefits, risks, and costs. Distributive justice refers broadly to the distribution of all rights and responsibilities in society, including civil and political rights (Beauchamp and Childress, 2009). The principle of justice is often accused of lacking substance and it is often referred to as a principle that human beings should be treated equally, unless the professionals can argue for a relevant difference (Rawls, 1971).

3.4.4 The strategy of analysis in study I and II

Malterud's 'systematic text condensation' consists of four steps which are presented below along with an explanation of how the steps were addressed in study I and II respectively:

Step 1: In this step all the transcripts are read as openly as possible to get a general sense of the texts. I read all the transcripts and the second author read some. We separately identified themes and discussed our suggestions until we reached mutual agreement.

Step 2: In this step the text of the themes from step 1 are re-read 'line-by-line' to identify units of meaning from an ethical perspective. This is a modification from Giorgi's original description (1975) where significant statements are identified from the whole text (Malterud, 2001b; Malterud, 2003).

Step 3: In this step units of meaning within the texts are condensed through further interpretations by using the theoretical framework and our professional theoretical foundation. From this, themes and various sub-themes are constructed.

Step 4: In the fourth step the 'condensed analysis' was synthesised into consistent descriptions of content for each theme and sub-theme. The themes and sub-themes

were given conclusive headlines for each study. The primary and secondary author selected quotes from each code-group and subgroup to document and root the descriptions. To ensure credibility I translated the quotes from Danish to English after which they were retranslated and discussed with an external translator to maximise agreement on the content of meaning. Step 4 is presented as the result section in study I and II.

Using Malterud's 'systematic text condensation' in study I

Using step 1 in study I: Six themes were identified and marked in the text: reflections on ethics in physiotherapy; the importance of the first physiotherapy session; the influence of the clinical environment; beneficence towards the patient; personal prerequisites for beneficence; some patients do not fit private practice.

Using step 2 in study I: With the thematic background from step 1 and the ethical framework, units of texts that contained ideas about ethical issues relating to the first session of physiotherapy were identified. All the units were labelled with a code and a preliminary classification of the units was constructed.

Using step 3 in study I: The primary and secondary authors carried out separate interpretations and mutual discussions by going back and forth between the underlying understandings in a dialectic process through the theoretical framework. This resulted in coding of the units of meaning in relation to the themes from step 1. In this process the themes 'reflections on ethics in physiotherapy' and elements of 'personal prerequisites for beneficence' were interpreted to represent different aspects of the same understanding - 'general reflections in physiotherapy'. The themes 'beneficent towards the patient', 'some patients do not fit private practice' and elements of 'personal prerequisites for beneficence' were constructed into one theme - 'reflections and actions upon beneficence towards the patient within the first session'. Consequently the analytic discussions resulted in four themes: general reflections on ethics in physiotherapy; the importance of the first physiotherapy session; the influence of the clinical environment on the first session; and reflections and actions upon beneficence towards the patient within the first session (see Study I). The themes and the sub-themes were secured for each interviewee along each interview and across all interviews in discussion with the second author.

To secure a survey of the process a matrix of organisations was composed representing each interviewee horizontally and the constructed themes and sub-themes vertically. At each cross-section of the two columns, the units of meaning where placed and accordingly a visual representation was made of how each interviewee contributed to the themes and sub-themes. According to Malterud (2011; 2003) This enhances trustworthiness of the analytic process.

Using Malterud's 'systematic text condensation' in study II

Using step 1 in study II: Five themes were identified and marked in the text: being and acting beneficently; equality issues within the situations; transgressing boundaries; special situations and information.

Using step 2 in study II: With thematic background from step 1 and the ethical framework, units of texts that contained ideas about the nature and scope of ethical issues were identified. All the units were labelled with a code and a preliminary classification of the units was constructed.

Using step 3 in study II: Separate interpretations and mutual discussions took place by the authors going back and forth between the underlying understandings in a dialectic process using the theoretical framework. The units of meaning were then coded in relation to the themes from step 1. The discussions between the authors made room for alternative interpretations and possible approaches. In this process 'the ideal of being beneficent towards the patient' was constructed as one main theme within which the earlier themes were interpreted and discussed. The analytic discussions resulted in one main theme 'The ideal of being beneficent toward the patient' and three themes: Ethical issues related to equality; feeling obligated to do one's best; transgression of boundaries, and their subgroups (see Study II). The main theme, the themes and the sub-themes were secured for each interviewee along each interview and across all interviews in discussions with the second author.

To represent the process a matrix of organisation was composed to show each interviewee horizontally and the constructed themes and sub-themes vertically. At each cross-section of the two columns, the units of meaning where placed and accordingly a visual representation was made of how each interviewee contributed to the themes and sub-themes. According to Malterud (2011; 2003) this enhances trustworthiness of the analytic process.

3.5 Study III

Through the dialectic analytic process of Study I and II new and challenging questions kept emerging. The concept of beneficence seemed to evolve questions about its construction in private practice physiotherapy. These questions opened our curiosity to explore what constitutes 'the good' within physiotherapy in private

practice. Accordingly study III aims to explore how physiotherapists in Danish private practices, from a meta-ethical perspective, perceive physiotherapy practice.

3.5.1 The philosophical approach in study III

Based on this purpose, we choose a hermeneutic approach (Denzin and Lincoln, 2005; Birkler, 2005; Gadamer, 2005; 2004). The used strategy of analysis is inspired by a Nordic interpretation (Lindseth and Norberg, 2004; Dreyer and Pedersen, 2009) of Ricoeur's 'textual interpretation of distanciation' that objectifies the interview by releasing it from the researching subject's intentions and meanings and gives it a life of its own (Ricoeur, 1995; 1979). In this tradition essential meaning is something with which humans are familiar in the practices of life, and this familiarity is expressed through the mode of living, through actions, through narratives and through reflection. For research purposes lived experience has to be fixed in texts, which then need interpretation (Lindseth and Norberg, 2004). To be able to understand our practice, we have to start with our lived experience, and we have to express it to become aware of its meaning. The meaning we need to reflect on is a meaning we take part in. And in the work within physiotherapy private practice, we participate in the meaning of physiotherapy as it manifests itself historically in actions, activities, considerations, buildings, technologies and so on. Such meanings are called discourses. We can engage in discourses with enthusiasm, or suffer under participation in them, work against them or step out of them; but seldom are we individually in a powerful enough position to change them. For these reasons it is important to show reflections on private practice physiotherapy and its essential traits. Without such reflections it is difficult to become aware of unfortunate practices we are part of, and it seems impossible to implement fruitful discussions that may change such practices and through discourse lead to improvements.

The analytic strategy has previously been used in healthcare research (Højskov and Glasdam, 2013; Kristensen, Borg and Hounsgaard, 2012; 2010; Mamhidir et al, 2010; Højskov, 2009; Dreyer and Pedersen, 2009).

Ricoeur regarded the relation between phenomenology and hermeneutics as a relation of mutuality: phenomenology draws attention to consciousness as directed at something and that this something has meaning. In Ricoeur's thinking the use of hermeneutics is like an argumentative discipline. A text never has only one meaning and therefore only one probable interpretation, but one interpretation can be more suitable than another (Ricoeur, 1995; 1979). Ricoeur acknowledged the presence of the interpreter's prejudice due to tradition and stressed the importance

of self-understanding and the dialectic movement between explanation and comprehension (Dreyer and Pedersen, 2009; Ricoeur, 2005; 1995; 1979).

Central to Ricoeur's works is that he objectified the text instead of subjectifying it through 'distanciation' in the interpretation. Methodologically, 'distanciation' objectifies the text by releasing it from the author's or research subject's intensions or meanings, from the situation and the original context and gives it a life of its own (Ricoeur, 2005; 1979). He directed the attention to what the text talks about and not on who the author was. He regarded the text as a communication of a cause (Ricoeur, 2005). Thus, the 'distanciation' makes it possible to leave the individual level and to investigate and highlight aspects of importance for the implementation process at a group level which is the analytic level of study III.

3.5.2 The theoretical framework in study III

The theoretical framework of the analysis is a meta-ethical frame of understanding which relates to questions about the limitations and foundations of ethics where traditionally ethical concepts have been analysed; what is right and what is wrong, what is inherent in the understanding of the right or wrong action toward the other (Binderup, 2011; Beauchamp and Childress, 2009/1979; Birkler, 2006; Ross, 1930/2002; Aadland, 2000; Wulff et al, 1990). Central questions in meta-ethics are whether ethics are something we experience as existing independently from us or if it is something we construct. Ethics can be regarded as a social construction; meaning a product of impersonal historical and sociological processes (Husted and Lübcke, 2001; Aadland, 2000). Meta-ethical questions are as such very general but simultaneously they relate directly to our immediate ethical practice (Binderup, 2011).

3.5.3 The strategy of analysis in study III

In study III the texts were created from transcriptions of the narratives told in the interviews and the method of analysis consists of three phases: the first naïve reading, a thorough, systematic and explanative reading; the structural analyses and a comprehensive understanding; leading to an enhanced understanding (Ricoeur, 1979).

The naïve reading: according to Ricoeur (1979) the naïve reading requires that the text be read non-judgementall using a phenomenological approach. The transcribed interviews were read as a whole to grasp an initial, holistic meaning about what the text was about. Short meaning-bearing sentences were noted for the initial themes.

The structural analysis: at this level the analysis aims to clarify any dialectics between the holistic understanding of the naïve readings and explanation of what the text means prior to deeper critical interpretation. The structural analysis is a shift from what the texts say to what it actually means. From here the analysis moves from describing units of meaning (what was said), to identifying and formulating units of significance (what the text talks about) and finally, to develop themes for critical interpretation. The whole text was read carefully and interpreted by going back and forth between the underlying understandings in a dialectic process through the theoretical framework. Consequently, we read and analysed the texts through the optics of the meta-ethics, not in the search for causal relationships or effects but for frequent connections, patterns and regularities between the different elements of the narratives. From this we constructed four themes; beneficence as the driving force; disciplining the patient through the course of physiotherapy; balancing being a trustworthy professional and a business person; the dream of a code of practice, and sub-themes as shown in the results section of study III. Quotes were selected across the material to serve as illustrations for the analysis.

In the third phase, a comprehensive understanding was developed. Lindseth and Norberg (2004) state that, in this phase, the themes and their sub-themes are condensed and reflected on in relation to the study's aim and context. Critical theoretical reflections and discussions of the structural analysis were made in discussions between the all three authors and are presented in the discussion section of study III.

3.6 Study IV

Through the dialectic analytic process in Study III, we came to realize that a meta-level of meaning structures was at play behind the explicit reflections. We became curious about how to explore the seeming self-evidence of the physiotherapists ethically understandings and practices; a practice unfolded within a specific political economic context. We wanted to get behind the conscious constructive meanings and the interviewees subjective level and to decode and analyse the

powers inherent in the constructions of clinical practices. Through the analysis of Study III, we wanted to explore how the physiotherapists use their power to discipline the patients and construct their practices. The power that resides beneath the things we take for granted in our everyday world: they challenge our assumptions about what we understand to be true, and question what we understand to be true, what we know and how we go about in our lives, and they ask how the present has become historically and socially possible. Therefore study IV aims to explore how physiotherapy is practiced from the perspective of physiotherapists in Danish private practice within a Foucauldian perspective.

3.6.1 A social constructivist and structural approach in study IV

Based on this purpose, we place ourselves in a social constructivist and structural understanding which is part of the social paradigmatic understandings (Andersen, 2011; Philips, 2010; Esmark, Laustsen and Andersen, 2005; Andersen, 2003). The social constructivist understanding dissociates from realisation which pretends to encompass its subject and mark it with a definitive concept; realisation is dependent and characterised by the context is takes as starting point. All social action involves structure, and all structure involves social action. Agency and structure are inextricably interwoven in ongoing human activity or practice. Thus, activities are not produced by consciousness, by the social construction of reality, nor are they produced by social structure. Rather, in expressing themselves as agents, - physiotherapists, people are engaging in practice, and it is through that practice that both consciousness and structure is produced: practice is seen as the outcome of the dialectical relationship between structure and agency (Philips, 2010; Esmark, Laustsen and Andersen, 2005; Andersen, 2003; Ritzer and Goodmann, 2003). The basis of this understanding of social reality is never organised in unambiguous causes and effects but is a relation between enabling and limiting structures and reflective subjects which both can avoid and change the structures (Foucault, 1977a; 1972). Social constructivism gives concepts for enabling and limiting structures on the one hand and reflective agents on the other hand (Esmark, Laustsen and Andersen, 2005).

Structuralism is an approach which looks at society through a macro-level orientation. The approach has a broad focus on the social structures that shape society as a whole, and believes that society has evolved like organisms. It looks at both social structure and social functions and addresses society as a whole in terms of the function on its constituent elements; norms, customs, traditions and institutions. Structuralism is an approach which position elements of human culture to be understood in terms of their relationship to a larger, overarching

system or structure. It works to uncover the structures that underlie all the things that humans do, think, perceive, and feel. There are different outlined systems behind all kinds of expressions in the social world. This system is what brings different expressions meaning. The relationship between the different expressions within a given system is the structure of the system, and structuralism seeks to explore this structure (Kaspersen and Blok, 2011; Foucault, 1977ab; 1972).

Several theorists have contributed to postmodern thinking, and as Foucault's works and theoretical concepts address the relationship between power and knowledge, and how they are used as a form of social control through societal institutions (Foucault, 2008; 2006; 1977ab; 1973; 1972; Hamann, 2009; Mik-Mayer and Villadsen, 2007; Lindgren, 2005; Rabinow and Rose, 2003) they were chosen. Accordingly, a Foucauldian perspective became the meta-analytic optic tool for analysing physiotherapeutic private practice in study IV. This kind of analysis does not ask about what something is, but how something has become what it is or how someone talks about something (Andersen, 2003): noticing how others notice.

A Foucauldian perspective challenges faith in the seeming self-evident truths presently valued in thought and practice systems. The theoretical concepts of disciplining, self-disciplining, power and resistance have through many years given an alternative view for different clinical practices (Glasdam, Praestegaard and Henriksen, 2013; Campbell, 2011; Nielsen and Glasdam, 2011; McCarthy, 2010; St-Pierre and Holmes, 2008; Roberts, 2005; Fox, Ward and O'Rourke, 2005; Snyder and Mitchell, 2003; Riley and Manias, 2002; Rainbow and Rose, 2003; Rose, 2003; 1994; Armstrong, 1994), and also for physiotherapy practice (Eisenberg, 2012; Fadyl and Nicholls, 2013; Nicholls, 2012; 2009; 2008; Nicholls and Holmes; 2012).

3.6.2 The theoretical framework in study IV

The theoretical framework was inspired by Michel Foucault, French philosopher, historian of ideas, social theorist, philologist and literary critic.

Foucault has been influential in shaping understandings of power. Through his studies of the administrative systems and social services that were created in 18th century Europe, such as prisons, schools and mental hospitals, he showed how their systems of surveillance and assessment no longer required force or violence, as people learned to discipline themselves and behave in expected ways. For instance, he showed how in the eighteenth century 'madness' was used to categorise and stigmatise not only the mentally ill but the poor, the sick, the

homeless and, indeed, anyone whose expressions of individuality were unwelcome (Stokes, 2004; Foucault, 2006). Foucault had a particularly critical eye for what characterises power in modern liberal societies and he showed how actors in modern liberal societies are interwoven in institutional structures, which pin down and form the actors' actions (Mik-Mayer and Villadsen, 2007).

Foucault's analysis of power relations led his work away from the analysis of actors who use power as an instrument of coercion, towards the idea that 'power is everywhere', diffused, invisible and tacitly embodied in discourse, knowledge and 'regimes of truth' (Rose, 2003; 1994; Rabinow, 1991; Foucault, 1977ab). Foucault regarded power not as a thing but as a relation; not simply as repressive but as productive. Power is not only localised in government and the State; power is also exercised throughout the social body, where it operates at micro levels of social relationships. Power is omnipresent at every level of the social body. Foucault showed that power is constituted through accepted forms of knowledge, scientific understanding and 'truth'. These constructions of power in form of 'regimes of truth' are the result of history, scientific discourses and institutions and are reinforced (and redefined) through the education system, the media, and the flux of political and economic ideologies; they are never absolutes. From this Foucault deduced that power is not just a negative, coercive or repressive matter that forces us to do things against our wishes, but it is also a necessary, productive and positive force in society (Foucault, 2008; 1977ab; 1973; Mik-Mayer and Villadsen, 2007; Rose, 2003; 1996; 1994; Patton, 1998; Rabinow, 1991). Power is understood as the ability to bring things into action; therefore it has productive forces. As such, power will always generate some kind of resistance and Foucault argues that resistance is co-extensive with power; as soon as there is a power relation, there is a possibility of resistance (Foucault, 1977a).

Foucault regarded discipline as a mechanism of power which regulates the behavior of individuals in the social body. He emphasized that power is not a discipline, but discipline is one way in which power can be exercised (Foucault, 1977a). Disciplining is done by regulating the organization of space (architecture etc.), time (timetables) and people's activity and behavior (drills, norms, posture, movement). The institutions, their systems and their roles as bodies of knowledge, even today, define norms of behavior and deviance, and Foucault showed how physical bodies are subjugated and made to behave in certain ways; a disciplining technology which Foucault calls 'bio-power' (Foucault, 2008). Bio-power takes two main forms. First, the discipline of the body, where the human body is treated like a machine: productive, economically useful etc. This form of bio-power appears in the military, in education, in the workplace, in healthcare and seeks to create a more disciplined, effective population. Secondly, the regulation of the population which focuses on the reproductive capacity of the human body. This form of bio-power appears in demography, wealth analysis, and ideology, and

seeks to control the population on a statistical level, as a microcosm of social control of the wider population (Foucault, 2008; Hamann, 2009; Stokes, 2004; Lemke, 2001). One of Foucault's major influences was to point to the ways that norms can become so embedded that they are beyond perception – causing the individual to discipline themselves without any willful coercion from others (Rabinow, 1991).

3.6.3 Strategy of analysis in study IV

Social constructivism and structuralism starts with the conception of (true) knowledge being a social phenomenon, with the focus on unfolding concepts which make a difference in the construction of social reality. Analytic strategies within this understanding are basically about identifying for whom the social realm is constructed by using certain observational-guiding concepts; concepts, which form the perspective on a section of the social realm which leads to a certain construction of this realm. The concepts are not tested in reality, they manifest reality. Thus, a social constructive strategy of analyses neither confirms nor denies a thesis, it is a type of compilation of the made construction.

The analysis is based on the dialectic between the structural frame as the context and possibilities for articulating the discourses on private practice from the perspective of the physiotherapists. The strategy for the analysis is to account for the construction of social reality in the structural context through the chosen concepts of Foucault. This kind of analysis does not ask about what something is, but how something has become what it is or how someone talks about something: noticing how others notice. Foucault's concepts of discipline, self-discipline, power and resistance (Foucault, 2008; 2006; 1977a; 1973) have been chosen as the analysing concepts; they form a perspective on a section of social reality which leads to the construction of the physiotherapists' reality. The concepts are not proved against reality, but manifest reality. Firstly, a naïve reading of the transcribed interviews and the observational drawings and notes were carried out to grasp the meaning of the texts from the speech position of physiotherapists in private practice.

Then the texts were read thoroughly, like a text analysis, through the lens of Foucualt's concepts of discipline, self-discipline, power and resistance (Foucault, 2008; 2006; 1977a; 1973), with the aim of getting behind the narrated stories of physiotherapists' practices. To construct the articulations about how the physiotherapists spoke about and form their practices, the text was read through questions such as: of which physical rooms is the clinic comprised, what do the rooms consist of, what do people do in the rooms, how do physiotherapists meet

patients and what do they do together? Through this three themes were constructed within which the analyses are carried out. Quotes were selected from the empirical material to serve as illustration for the analysis. Quotes from observational notes are marked [Observational notes].

4.0 Main findings

In the following the findings from study I – IV have been merged and abstracted across all four studies to formulate the main findings of the present thesis.

Physiotherapists in Danish private practice have a general interest in ethics and they consider awareness of ethical issues to be an important aspect of physiotherapeutic professionalism (Study I; II; III). Through the analytic processes a great diversity in understandings of what constitute ethical issues is shown (Study I; II). The physiotherapists' reflections about ethical issues in physiotherapeutic practice are primarily based on personal common sense arguments, intuitive feelings of ethics and reflections about professional obligation (Study I).

On a general level the physiotherapists' practices seem ethically grounded (Study I; II; III). The physiotherapists seem to enhance care for their patients as they strive to arrange their clinics in order that the patients feel welcomed in a friendly, trustworthy and professional environment (Study I) and that they meet their patients in respect and as equal human beings, respecting patient autonomy (Study I; II; III). The physiotherapists use several tools to provide professional examinations, diagnostics and treatments (Study I; II), and at times they act in ways which may be ethically and legally questioned when enhancing care for their patients (Study II). The physiotherapists are aware of several inherent understandings of ethics and they strive to keep updated through post-graduate education, as it is seen as a means to benefit the patients – and as a moral obligation to avoid harm or risk – but also as a means to provide oneself with professional arguments for being an ethically sound businessperson (Study II; III). The physiotherapists propose several suggestions for how to bridge the 'to be' and the 'ought to be' in future political strategies and organization of Danish physiotherapeutic private practice (Study III). Their explicit consciousness on ethical issues is primarily constructed when their clientele are regarded as being at risk. In the first sessions (Study I) and in meetings with the so-called 'difficult' patients, the physiotherapists' ethical consciousness seem aroused as these situations do not just flow; they require conscious reflections about ethical reflections and pedagogic strategies (Study I; II) in order to keep the patient in their businesses (Study IV).

The physiotherapists' ethical reflections on beneficence seem to be driven by a paternalistic approach towards the patient (Study II; III), where disciplining the patient through the course of physiotherapy seems to be a crucial element of practice in order to optimize profit (Study III). This is especially expressed towards patients from other cultures, traditions or languages other than Danish who had different understandings, views and expectations, or patients who were overweight, dirty, cognitive damaged or in the terminal phase of life; the so-called 'difficult' patients seemed to give rise to ethical issues (Study I; II). The physiotherapists find themselves lacking pedagogic tools towards these patients (Study I) who are not able to live in and accept the political defined, normative 'healthy' way: accordingly they are disapproved as they are not regarded as taking actively responsibility for their own lives, being out of control and careless about themselves (Study IV). The physiotherapists find them disobedient (Study III) as they resist being disciplined into the physiotherapists 'regimes of truth' (Study IV). If the physiotherapists disciplining technologies fail to convert the 'difficult' patients, they seem to accept the patients as inevitable but as necessary source of income, or they exclude them (Study IV). The physiotherapists find it difficult to be beneficent towards them: they find themselves in a dilemma, caught between being a professional physiotherapist with knowledge, skills, personal psychological and bodily consciousness and being a trustworthy businessperson (Study III).

The physiotherapists understand beneficence as the core value of their practices and beneficence is expressed as being important in different relationships: towards the patient, towards the physiotherapists themselves and towards their business (Study III). Awareness about "who I am" as a person and professional is understood as a prerequisite for being beneficent towards the patient (Study I). Beneficence towards the patient is stressed as the ideal of physiotherapeutic practice and the physiotherapists have many examples of how they strive to have an ethical practice (Study I; II; III) and how to manage patient autonomy within a setting of power asymmetry and they express a variety of understandings of how to fulfill their professional role in order to enhance patient autonomy (Study II). Regarded from a postmodern perspective, beneficence is expressed especially towards patients who seem to share the same fundamental understandings and look and live like the physiotherapists: patients who can be seen as predisposed to conform to the dominate logic of the physiotherapists'; predisposed to become docile bodies (Study IV).

The physiotherapists in private practice seem mostly to be a reproduction of the medical atomized binary understanding of normality and body. They accept cause and effect causality, and the medical disciplinary technologies (Study II; III; IV). The architecture, design and décor of the clinic, the medical language and Latin terminologies, the use of standardized plans (often build on WHO's 'International

Classification of Functioning'), are disciplining technologies which aim to discipline both the patient and the physiotherapists into the Western medical logic and practices. Unconsciously, the physiotherapists in private practice seem to oppose their own political intentions about physiotherapy being an autonomous profession (Study IV). The disciplining technologies seem strong as the physiotherapists' legitimate rights and freedom of actions seem to dissolve when they practice outside the frames of the private clinic, in the home of the patients (Study IV). The physiotherapists in private practice produce docile bodies which enable their businesses to become effective, reliable and profitable whereby they underpin the neoliberal ideal about citizens being effective and self-responsible (Study IV).

5.0 Discussion

The discussion contains two parts. Firstly, there is a discussion of the main findings of the present thesis and secondly, a discussion of the method with specific focus on general trustworthiness of the interviews, the different philosophical and theoretical approaches and analytic strategies presented in this thesis.

5.1 Discussion of the main findings

The physiotherapists seem to have a general interest in ethics (Study I) and they speak about various ethical considerations towards the arrangement of the clinics, the patients, relatives, colleagues and, the overriding organisation of private practice (Study I; II; III), which is concordant with previous findings (Carpenter and Richardson, 2008; Praestegaard, 2001; Swisher, 2002).

The physiotherapists express great diversity in their understandings of what constitute ethical issues and these are primarily based on personal common sense arguments, intuitive feelings about ethics or on reflections about one's professional duty (Study I; II). The reflections about one's professional duty refer to deontological understandings (Nielsen, 2011; Davies, 1991). The physiotherapists display an ethically common sense grounded practice which also has been seen in other Western physiotherapeutic practices (Bellner, 1999; Carpenter and Richardson, 2008; Praestegaard, 2001; Swisher, 2002; Trienzenberg, 1996). It seems unnecessary for the physiotherapists to ground their reflections and reasonings in ethical theories, principles and values, which opposes normative directions for physiotherapeutic practice (Purtilo and Doherty, 2011; Jones, Jensen and Edwards, 2008; Raja, Davies and Sivakumar, 2007; Swisher and Page, 2005; Purtilo, Jensen and Royeen, 2005; Gabard and Martin, 2003; Purtilo and Haddad, 2002) and physiotherapeutic programme in Denmark (Ministry of education, 2008; 2001). The physiotherapists' practices seem to be directed by traditions, feelings or entrenched habits without conscious connection between the action and its mainspring and they seem to work as a smooth running business in

relation to most patients. The physiotherapists do what needed for their practices to unfold under the given circumstances. The physiotherapists mainly express their consciousness of ethical issues in the first sessions (Study I) and when their clientele are regarded as being at risk: and in meetings with the so-called ‘difficult’ patients (Study II; III), which previously have not been specified in physiotherapy. The physiotherapists’ ethical reflections seem to arise when practice situations are not frictionless as these situations require consciousness in order to both respect the patient and to keep the patient as a paying customer (Study I; II; III; IV).

From an ethics of care approach (Christoffersen, 2013b; Wyller, 2013; Birkler, 2006; Henriksen and Vetlesen, 2000; Løgstrup, 1997) an ethically common sense grounded practice may be seen as the physiotherapists acting out their spontaneous ethics. The underlying basis of this approach is that a human being lives in mutual life with other human beings and as such is dependent on human intercourse, which is why caring and taking care of the other in the actual meeting is the core of ethics of care theories. Løgstrup (1997) claims that we spontaneously and constantly give ourselves, in the broad sense of the word, for each other in an active ‘I-you-relation’ in an ongoing dialectic process for the mutual third. In this perspective physiotherapeutic practice can be understood as practicing the spontaneously given mutual third. The physiotherapeutic practices unfold within a common sense logic of right and wrong: both physiotherapist and patients act automatically and unconsciously together. The patient tacitly appeals to the physiotherapists for actions and support which they meet spontaneously. Thus, practice opposes international and national normative directions for how physiotherapists ought to reflect about their practices (The Association of Danish Physiotherapists, 2012a; WCPT, 2011acd). In addition, it reflects Weber’s statement, made about a hundred years ago, about the in principle differentiation between realisation of what is and what ought to be (Weber; 2003:68). Every human being has its values and the choice of these values is always subjective. This thesis can never state which thoughts, reflections and actions the physiotherapists ought to choose. There will always be a difference between practical knowledge and valuations; a difference between ’what is’ and ’what ought to be’ (Månson, 2005; Ritzer and Goodman, 2003; Weber; 2003).

From a Foucauldian perspective a frictionless and common sense grounded physiotherapeutic practice can be seen as physiotherapy being practiced within a Western neoliberal frame, similar to other areas of healthcare, for example dentistry, medicine, nursing and psychology (Glasdam, Praestegaard and Henriksen, 2013; Glasdam, Henriksen, Kjaer and Praestegaard, 2012; Järvinen and Mik-Mayer, 2012; 2003; Holen, 2011; Fries, 2008; Shulamit, 2008; Traynor, 2007; Walkerdine, 2003). In general, both physiotherapists and patients support the physiotherapeutic private practice in their way and for their own purpose. The physiotherapists underpin, adapt and are subject to the neoliberal ideology (Boas

and Gant-Morse, 2009; Hamann, 2009; Mirowski and Plewe, 2009; Mik-Mayer and Villadsen, 2007; Harvey, 2005; Rose, 2003; Evers, 2003; Pollit and Buchaert, 2000) and set values and norms for how to run a healthcare practice on market-based principles (Association of Danish Physiotherapists 2013ad; The Danish Ministry of Health, 2010; Hamann, 2009; Harvey, 2005). They offer their knowledge and skills for payment; knowledge and skills which they convert to treatment under certain frameworks and conditions. In principle the patient can accept or deny the knowledge and skills of the physiotherapists, but the physiotherapists only meet the people in their practices who, as a starting point, have accepted to sign up to this treatment (Study IV), which previously has been shown in other health care practices (Holen, 2011; Järvinen and Mik-Mayer, 2003), but in physiotherapy. In practice, the only patients met are those who have accepted the premises and frameworks for private practice physiotherapy and the way it is practiced in advance; they are the ones who flow frictionless through the physiotherapeutic regime of treatment. From a Foucauldian perspective these patients can be considered to be pre-disposed to be transformed into the kind of patient the physiotherapists wish to meet in their clinic; they let themselves be disciplined into the physiotherapists 'regime of truth' (Foucault, 1977a): a phenomenon which other researchers have described as: "becoming an intelligible patient" or "creating a patient" (Lehn-Christensen and Holen, 2012; Holen, 2011; Rostgaard, 2011; Magnussen, Vrangbæk, Saltman and Martinussen, 2009; Mik-Mayer and Villadsen, 2007; Järvinen and Mik-Meyer, 2003).

Some of the meetings within physiotherapy private practices do not always seem to build on trust and compassion. Løgstrup (1997) states that sometimes movements of thoughts and emotions like hate, distrust, affront and envy take over and go in circles around one's ego; one stops acting spontaneously and becomes selfish and unable to extend beyond one self, as seen in Study II; III and addressed in another physiotherapeutic private practice (Potter, Gordon and Hamer, 2003a). When meetings between human beings do not evoke spontaneous actions then an ethical demand comes forward. The ethical demand is about taking care of the other human being, a point which has been given in every meeting. The ethical demand is an obligation when the spontaneous actions fail to happen. The ethical demand requires independent actions; one has to find the best actions towards the other in the given situation – unselfishly (Løgstrup, 1997). In continuation of this it is seen that ethics are not first and foremost a questions about choosing right in the situation: ethics are rather a certain way of being humanly present. Further it positions the physiotherapists to influence, to some degree, how well another person's life goes: they are in a position of power (Løgstrup, 1997:53).

The first sessions of physiotherapy seem to be of significant importance for the physiotherapists and consciously ethical reflections arise (Study I; III; IV). The physiotherapists strive to arrange a friendly and trustworthy professional

atmosphere in their practices, as previously shown (Thornquist, 1992; Westman Kumlin and Krooksmark, 1992). They want to be appreciated as professionals wanting to care for their patients, in line with textbooks normative directions for how one ought to be a physiotherapist (for example Purtilo and Doherty, 2011; Jones, Jensen and Edwards, 2008; Raja, Davies and Sivakumar, 2007; Swisher and Page, 2005; Purtilo, Jensen and Royeen, 2005; Gabard and Martin, 2003; Purtilo and Haddad, 2002) and for clinical management (The Association of Danish Physiotherapists, 2013bc; WCPT, 2011ac). From an ethical perspective this relates to ethical commitment towards the patient as the physiotherapists seem to strive for their actions to be ethical, which means that their actions are consistent with what they consider to be right and justified (Christensen, 2011a; Birkler, 2006; Aadland, 2000; Henriksen and Vetlesen, 2000). Such striving has previously been reported within other contexts of physiotherapeutic private practice (Potter, Gordon and Hamer, 2003a), and also from medical and nursing practices (Pilnick, Hindmarch and Gill, 2009; Kopelman, 2006; Sjostedt, Dahlstrand, Severinsson and Lutzen, 2001). Immediately, the importance of the first session can be understood from an ethics of care perspective (Wyller, 2013; Henriksen and Vetlesen, 2000; Løgstrup, 1997) where the core notion is caring for and taking care of others. The theoretical approach emphasises traits valued in personal relationships such as trustworthiness, sympathy and compassion. In particular, the term caring refers to care for, emotional commitment to, and deep willingness to act on behalf of the persons with whom one has a significant relationship (Løgstrup, 1997). But given the overall finding that the physiotherapists' personal intuitive feelings of ethics seem to rule their practices, the importance of the first session may also be viewed from a business perspective: the physiotherapist needs clients to run a successful private practice, and if clients do not feel welcome in the clinic, then they might not return (Study IV), which Greenfield (2006) mentions too.

Even though the physiotherapists seem to be aware about how a clinical environment may be used to reflect trustworthy professionalism, they seem unaware that their practices take place in contexts (Fioretos, Hansson and Nilsson, 2013; Gibson and Teachman, 2012; Jakubowitz, 2011; Thornquist, 2011; Schriver, 2007; 2004; 2003; Larsen, 2005; 2002; 2001; Bayer, Henriksen, Larsen and Ringsted, 2002; Siegumfeldt, 2001; Foucault, 2006; 1977a; 1973) and that practices are not objectively determined, nor are they the product of free will: they are the outcome of the dialectic relationship between structure and agency (Esmark, Laustsen and Andersen, 2005; Ritzer an Goodman, 2003; Foucault, 2006; 1977a; 1973). Structuring and organizing the clinic demonstrate a professional image of matter in modern society, in line with Nicholls (2012) and thus, an underlying general mutual contextualised understanding of professionalism seems to exist in physiotherapeutic private practice. This

understanding of professionalism seems important to show clients entering the clinics, which is why the first session becomes pivotal for displaying one's self-understanding of professionalism and for setting the frame for the people entering: showing the physiotherapists' unconscious considerations for themselves and their practices. On the other hand it also shows how physiotherapists in private practice seem to reproduce the medical understanding of how to structure and organize a clinical practice – as similar architecture, design and décor permeates both the waiting room and the treatment room (Study IV) in providing physiotherapy professional legitimacy, which have not been displayed previously. The clinical impression is structured with an esthetic of vital importance for the person entering, who from the first session is subject to the medical gaze by the design, décor and examination and thereby becomes socialized and created into the reigning cultural truth (Fioretis, Hannson and Nilsson, 2013; Larsen, 2005; 2002; 2001) of physiotherapy. They become 'intelligible patients' (Lehn-Christensen and Holen, 2012; Holen, 2011; Rostgaard, 2011; Magnussen, Vrangbæk, Saltman and Martinussen, 2009; Mik-Mayer and Villadsen, 2007; Järvinen and Mik-Mayer, 2003). The patients are controlled, regulated and treated by the physiotherapists within the sessions of treatment and are subject to a clinical 'gaze', whereby they are transformed into a medical object (Bradbury-Jones, Sambrook and Irvine, 2007; Gilbert, 2001; Foucault 1973). In that way physiotherapy in private practice accidentally supports the omnipresent power of medical surveillance and discipline in modern Western societies (Nugus et al, 2010; St-Pierre and Holmes, 2008; Stokes, 2004; Foucault, 1977ab; 1973)

The physiotherapists' ethical awareness seems also to be aroused when meeting patients from ethnic origin other than Danish and patients who they regard as being overweight or cognitive damaged; the so-called 'difficult' patients (Study II; III; IV). These patients do not seem to acknowledge the physiotherapists' conceptual universe; their fundamental view on human nature, health, disease, etc. These meetings make the physiotherapists become aware about their own fundamental views: the rhythm of practice gets disturbed and requires conscious reflections to keep the practice flowing. Some physiotherapists have problems in selling their framework conditions for physiotherapeutic private practice; making their conceptual framework comprehensible for these patients. From this it may be argued that in their own way the so-called 'difficult' patients strive to maintain their autonomous right to decide their understandings and choices (Beauchamp and Childress, 2009) in healthcare matters. In the effort of convincing the patients to come on track, the physiotherapists seek by the use of diverse verbal and visual, tacit and invisible disciplining technologies, to educate the patients into their conceptual understandings, their 'regimes and practices of truth' (Study II; III; IV): actions of practice which can be regarded as paternalistic (Beauchamp and Childress, 2009; Jensen and Mooney, 1990) as they intentionally override the

autonomous patient's conceptual frameworks and preferences. This kind of education can be regarded as being in conflict with the ethical principle of autonomy, which has grounded several rights for patients, including rights to receive information, to consent to and to refuse procedures (Beauchamp and Childress, 2009; Delaney, 2007; Geddes, Wessel and Williama, 2004; Cross and Sim, 2000) and physiotherapeutic guidelines (The Associations of Danish Physiotherapists, 2012a; WCPT, 2011d). The physiotherapists seem to accept these 'difficult' patients as inevitable or 'abnormal' but as a source of necessary income, or they try to exclude them (Study III; IV). In this respect physiotherapy in private practice can be seen as a continuation of the societal disciplining exclusion of the already so-called marginalised people in modern Western societies (Wright and Stickley, 2013; Fallov and Nissen, 2010; Mik-Mayer and Villadsen, 2007; Roberts, 2005; Frank and Jones, 2003; Järvinen and Mik-Mayer, 2003; Foucault, 2006; 1977a; 1973). It can be discussed whether physiotherapists, through their use of rational choice and cost-benefit calculations ground on marked-based principles, support and consolidate themselves in priority over marginalized people in society. The ethical principle of patients' autonomy (Beauchamp and Childress, 2009) seems to bear a limited meaning: one only has the right to self-determine in physiotherapeutic practice if it is in line within the conceptual framework of the physiotherapists. This shows a practice which is contrary to the international political strategy "health for all" (World Health Organisation, 1998; European Commission, 2007), to the Danish government's healthcare policy "free and equal access for all" (Ministry of Health, 2010) and to ethical guidelines for physiotherapists (The Association of Danish Physiotherapists, 2012a; WCPT, 2011acd). It shows the insuperable gap between practical knowledge and valuations; a difference between 'what is' and 'what ought to be' (Månson, 2005; Ritzer and Goodman, 2003; Weber; 2003).

From a Foucauldian perspective the so-called 'difficult' patients can be regarded as patients who resist the Danish, and Western, healthcare discourse (Foucault, 2008; 1977a), which is expressed here as the institution of physiotherapy in private practice. The physiotherapists may overlook the possibility that some patients' resistance can be seen as a rebellion against the (bio)powers which control their lives (Norvoll, 2009; Foucault, 2008), and at the same time they seem to be short of the linguistic skills and societal position to discuss this. It is by means of discourses that people define the contents of concepts, and as reflections primarily are linguistic, language becomes the tool of reflections (Kaspersen and Blok, 2011). When discourse has determined the content of its' separate concepts, then the possible ways of thinking have been determined; the power of the discourse has been determined – which is the core of neoliberal ideology (Boas and Gans-Morse, 2009; Hamann, 2005; Harvey, 2005; Faucault, 1977a; 1973).

Study I, II and III show how the motivating drive for being a physiotherapist unfolds as a genuine wish for being beneficent towards the patient: a motivation in accordance with previous research and statements (Carpenter and Richardson, 2008; Swisher, 2002; Praestegaard, 2001; Jensen, 1995). Beneficence seems to have a far greater span than only the medical discourse about being beneficent towards the patient (Beauchamp and Childress, 2009; Wulff, Pedersen and Rosenberg, 1990), as beneficence towards the physiotherapists themselves and their business's, and vaguely also the collective of physiotherapists seem to be encompassed.

Physiotherapy appears as a social and ethical practice in which the physiotherapists seem to engage with all their wholehearted honesty, compassion, trust and openness to be beneficent towards the patients (Study I; II; III). It seems as though the physiotherapists' perception of personal commitment is embedded in their understanding of beneficence towards the patient; they engage their personal ethos (Study II; III). This is in line with Laursen (2003) and with Riesman's ascertainment that the underlying understanding of Western healthcare services is based on the idea that 'the goods in demand arise neither raw material nor machines; it's personality' (Riesman, 1985). It appears that the physiotherapists strive to integrate professionalism and personality in both their understandings of physiotherapeutic practice and in their reflections about what is required of being a professional. As Callewaert (2003) states, the care of people is a job, which, in the professionals' self-understanding, demands that you engage with all of your unique personality, as well as with human, social and professional knowledge; in line with the Western modern patient's search for inner welfare (Pittelkow 2001; Potter et al. 2003ab; Gard et al. 2000). It has the implication that physiotherapists define attributes and characteristics as professional which previously have been confined to the personal sphere: an implication which is reflected in the daily job adverts for physiotherapists. Here, it is legitimate to require that the individual physiotherapist must commit and be committed with his or her own personality in everyday practice. Furthermore, it has the implication that in the effort to be and act out beneficence the physiotherapists seeks ongoing postgraduate education (Study III). These efforts are crystallized into diplomas: visual evidence for competences; a sign of the ongoing trend of lifelong learning (Hager 2004; Jørgensen 2007; The European Commission 2011). Education seems to be the answer to many questions in Western modern society and within the healthcare sector; confer the pervasive concept called education of or empowering patients and relatives in both continuing education courses for professionals and in research (Kuijpers et al, 2013; Bruun, 2010; Glasdam, Timm and Vittrup, 2010; Miller and Rose, 2009; Bartholdy, 2003). A further aspect of the physiotherapists' understandings of beneficence towards the patient seem closely related to understandings of their own physiotherapeutic conceptual universe and aspects of

paternalism (Beauchamp and Childress, 2009); as they, due to superior training, knowledge, and insight (Study II; III) – conferring an authoritative position – seem to influence the patient's best interests. Some physiotherapists even transgress professional and legal boundaries in their engagement of beneficence (Study II; III), which is also shown by others (Cooper and Jenkins, 2008; O'Sullivan and Weerakoon, 1999; Weerakoon and O'Sullivan, 1998, de Mayo, 1997; McComas, Kaplan and Giacomin, 1995).

Beneficence towards the patient within physiotherapeutic private practice can also be seen as a consideration towards the physiotherapists themselves, with the implicit expectation that this will result in being professionally acknowledged and making a profit. A trustworthy first impression may imply a returning patient, with the tacit expectation of future recommendations. These expectations connect with utilitarianism; the end justifies the means (Shaw, 2007; Birkler, 2006; Goodin, 1999). The inner logic is that when the patient benefits from the physiotherapist's examination and treatment, and the physiotherapist benefits from being acknowledged professionally and business wise, they both benefit. The patient supports the neoliberal project of achieving the greatest possible privatisation of the healthcare services and the physiotherapist offers healthcare skills for payment: both physiotherapist and patient practice the core of neoliberalism whereby society benefits (Rostgaard, 2011; Bjornsdottir, 2009; Boas and Gans-Morse, 2009; Hamann, 2009; Harvey, 2005; Rose, 2003; Evers, 2003; Lemke, 2001; Pollitt and Buckaert, 2000). From this, it can be argued that in general an ethics of care approach to beneficence seems to rule physiotherapy private practice when both physiotherapists and patients benefit from the practice: implying that utilitarian ethics overrule both the spontaneous and the ethical demand in the ethics of care approach.

The social science of professions has explored and shown how since the Age of Enlightenment knowledge has equaled power (Christoffersen, 2013b; Molander and Terum, 2008; Slagstad, 2008; Dahl, 2005a; Krejsler, 2005; Laursen, Moos, Olesen and Weber 2005; Laursen, 2004; Hjort, 2004) and others (Foucault; 2006). Traditionally, physicians, lawyers and priests in Western countries have been regarded as the classic professionals (Laursen, 2004; Abbott, 1988). Healthcare services, amongst them physiotherapy, have to a great extent been delegated to the physicians to administer (Lauersen, 2004) and for centuries physicians have been positioned highest in the hierarchy of healthcare. They have knowledge whereby they gain power: they can decide life and death. Through centuries this has had the consequence that within the Western political societies physicians have been given the power to define health and disease (Lauersen, 2004) which is shown in the 'disciplinary society' of WHO (World Health Organisation, 2003), standards of medical ethics (American Medical Association, 2001; WCPT, 2011d) and medical research ethics (World Medical Organisation, 2008; Nilstun, 1994) and their

participation in research ethic committees (Ministeriet for Sundhed og Forebyggelse, 2011). The physiotherapists in private practice seem to acknowledge that knowledge equals power (Study IV), and underpin the disciplinary bio-powers in their striving for a higher power position in society: more knowledge equals more power equals a higher social position (Foucault, 2008; 1977a; 1973; Kaspersen and Block, 2011; Hamann, 2005; Harvey, 2005). Thus, the acknowledgement is not conscious; bio-powers are working behind the back of the physiotherapists. Through subjecting and underpinning medical thinking and logic the physiotherapists unconsciously oppose their sense of professional autonomy as private practitioners in two ways.

Firstly, the physiotherapists in private practice seem to determine only small parts of the discourse (Study IV). They are mainly a product of the societal discourse of health and disease; they are subject to the underlying bio-power (Foucault, 2008) and neoliberal thinking for healthcare (Boas and Gans-Morse, 2009; Hamann, 2009; Harvey, 2005; Rose, 2003; Evers, 2003, Lemke, 2001). Accordingly these findings indicate that the neoliberal idea about total individual freedom (Rostgaard, 2011; Bjornsdottir, 2009; Boas and Gans-Morse, 2009), as the physiotherapists in Danish private practice claim to pose (Study IV), is framed and limited by the underlying social political structures.

Secondly, the physiotherapists seem to oppose their own political intentions about physiotherapy as something special and their association's rhetorical striving for achieving professional status (Association of Danish Physiotherapists 2013d; WCPT, 2011abc; Sandstrom, 2007; Laursen, Moos, Olesen and Weber 2005; Laursen, 2004; Rothstein, 2003; 2002; Carr, 2000; Dean, 1995). Within professional theoretical research, five criteria of professionalism are commonly cited in the literature: (i) professions provide an important public service which is client centred, not focused on the enrichment or aggrandisement of the professional; (ii) they involve a theoretically and practically grounded expertise; (iii) they have a distinct ethical dimension expressed in standards of practice, ethical and intellectual standards; (iv) they require organisation and regulation for purposes of recruitment and discipline; and (v) professional practitioners require a high degree of individual autonomy - the individual professional's right and responsibility to practice and make decisions within the scope of the profession (Fauske, 2008; Slagstad, 2008; Vågen and Grimen, 2008; Laursen, Moos, Olesen and Weber, 2005; Krejsler, 2005; Carr, 2000; Dean, 1995; Larson, 1977). From this understanding of a 'profession', physiotherapy, in the context of private practice in Denmark, must be regarded as only a semi-profession, since a profession must present at least an autonomous theoretical and practical grounded area of expertise (Etzioni, 2005; Laursen, Moos, Olesen and Weber, 2005; Laursen, 2004; Carr 2000; Dean, 1995). The same picture is also shown in nursing (Glasdam, 2003), maternity care (Benoit et al, 2010) and in other semi-professions

(Callewaert, 2003). Some authors go so far as to call this group the “wanna-be”-professions (Alvesson and Billing, 2009; Hjort, 2004). This can be regarded as an invitation to reflect, discuss and develop physiotherapy in the future as a part of a broader scientific discipline (Dahl, 2005b), namely health science, within the medical field rather than to consolidate the rhetoric demands and definitions of physiotherapy as an independent profession. It implies that focus in physiotherapeutic science in the future has to be moved from an understanding where physiotherapeutic private practice is shrouded in a business-oriented policy about ‘physiotherapists and their academia’ to a scientific project about ‘the patients in the healthcare system and their relations and interactions with physiotherapists’.

5.2 Discussion of method

In this thesis I take an inside perspective as I am a physiotherapist myself. Researchers argue that in order to understand, discuss and develop a professional practice, research requires both an inside- and an outside-perspective (Jacobsen and Kristiansen, 2006; Merriam et al, 2001), as demonstrated in many areas of qualitative research, for instance anthropological, ethnographical and research of practice traditions, also within healthcare(Johansen, Carlsen and Hunskaar, 2011; Holen, 2011; Højskov, 2009; Glasdam 2008; 2003; Eriksen and Sørheim, 2002; Eriksen, 2001; Jarvis, 1999), and in physiotherapy (Christensen, 2007; Delany, 2007; 2005; Praestegaard, 2001; Jensen, Gwyer, Shepard and Hack, 2000; Jørgensen, 2000). This is in opposition to positivistic approaches to knowledge production where the researcher takes an outside perspective in order to be as neutral and distanced as possible to the research field to avoid being accused of researcher-bias (Wulff and Gøtzsche, 2006; Hovmand and Praestegaard, 2002; Hicks, 1999).

The advantage of researching within one’s own field of profession is that the researcher knows the culture, knows what is going on, will pay special attention to practice and its conditions, and will have both conscious and tacit theoretical and practical considerations about conceptions of practice. Having an inside perspective on physiotherapy practice positioned me to social closeness and personal confidence and gave me and the interviewees mutual pre-understandings which ment that the basic understanding of physiotherapeutic practice was taken for granted (Bourdieu et al, 1999). This implies that I had the possibility to understand their expressions and to pursue their stories by asking questions about what made the situation important, ordinary, and extraordinary and which aspects

provided openings for constructing trustworthy mutual understandings of the essence of meaning, increasing credibility of the interviews.

However, there are several disadvantages to having an inside perspective: the first risk is that the interviews will turn out as total coincidence (Glasdam, 2003; Bourdieu et al, 1999): it's one thing to break with one's own pre-understanding and another to breake the interviewees pre-understanding of me. I experienced great confidentiality and was trusted as was part of the field and I found it difficult to balance this with being exploring, curious and challenging as a researcher in the field of a physiotherapeutic practice where the interviewees are socialised to be therapeutically knowing in their approach to people. My assumed ethical gaze might have influenced the interviewees in expressing themselves more 'ethically and politically correctly' about the actual situations of practice, but as some interviewees shared ethical and legal aspects of their practices that went beyond my expectations (Study II; III) this seems to have had a minor impact. I cannot discount these aspects which to some extent affect the thesis' trustworthiness, yet outsiders might not have noticed all aspects of a daily hectic physiotherapeutic practice. Further, the reflective questions in the interview-guide had come into their own as they allowed breaking of my pre-understandings and sometimes also those of the interviewees: for instance the significance of the first session of physiotherapy (Study I) was not part of my initial pre-understanding of private practice nor some of the interviewees, and also the three inherent relationships in the concept of beneficence (Study III) seemed to break with both mine and some interviewees pre-understandings. On the other hand, the advantage of an outside perspective is its embedded distance and thereby its possibility to uncover unexpected aspects of the constructions presented in this thesis, - which would have improved general trustworthiness (Rolfe, 2004; Lincoln and Guba, 1985), especially about transferability of the results.

Understanding interviews as dynamic, meaning-making occasions, where both interviewer and interviewee are inevitably implicated in making meaningful constructions and producing knowledge (Kvale and Brinkmann, 2009; Holstein and Gubrium, 2006; 2004; Kvale, 2006; Järvinen, 2005; Andersen, 2003; Gubrium and Holstein, 2002; 2000) of course brings the question of power asymmetry into play (Kvale, 2006; Glasdam 2005; Glasdam, 2003; Birch et al, 2002). I acknowledge having taken the power to frame the dialogue as I initiated the meeting, the topic for the dialogue and asked the questions; but not as predefined specific questions but as questions of curiosity - questions which challenged both the interviewees' and my pre-understandings. The interviewees accepted this and related to me professionally and ethically. The interviewees had the power to decide which of their stories they wanted to share, the length, depth and nuances they wanted to unfold within their story. This means that they told about a construction of practice made in another historic and contextual time than the time

and context for the interview, which is why meanings may have altered and changed as time has passed and new understandings and constructions have been generated. Some situations and events could have been told politically correctly as an imperative norm is embedded: Danish physiotherapists are authorized by the state to deliver physiotherapeutic services according to best available evidence and experiences within an ethical and collegial frame of understanding (The Association of Danish Physiotherapists, 2013; 2012ab; 2010). The question about what can and will be an answer when asked about professional ethics is all the time at play; how far will one expose oneself. Aspects of the unfolded situations could have been told, left out, or improved on reality: this possibility affects the credibility of the interviews (Rolfe, 2004). I framed the stories and the interviewees pictured them in colors. All the time I was aware that in interaction and collaboration we constructed knowledge, and that another researcher or interviewee would not bring forward the same production of knowledge, given the same physical context and interview guide. The interviews must be seen as a down stroke of meaning construction in time and social context.

In general the interviews provided detailed and thick narratives on physiotherapeutic practice; constructed in time and space. For some interviewees it seemed easy to recall and speak about situations and events. Some expressed pride and satisfaction about their practices and some expressed relief when telling their stories; some shared aspects of their practices that they had never shared with anybody and found this almost therapeutic. The interviews show how meaning has an implicit – tacit and intuitive – dimension as some interviewees had difficulties in expressing themselves about situations; they felt a lack of words, but had bodily sensations about the situations: in line with what Kappel (1996) names ‘intuitive ethics’. In these cases the interview technique can be seen as ‘birthing coach’ as the facilitating questions provided words to explicate constructions. Some interviewees expressed shame and felt in moral distress about their actions and reflections. Some of the constructed narratives in the interviews may not as critically as exact wanted for research purposes have opened for alternative possibilities, considerations and views. Being a novice interviewer limited some suggested orientation to, and linkages between, diverse aspects of the interviewee’s experiences and the theoretical frameworks.

Power asymmetry is also at play in the process of analysis as I took the liberty, without any preliminary negotiations, to decide how the interviews would be used afterwards and did not allow the interviewees a function in the interpretation of their expressions. I tried to understand their stories of physiotherapeutic private practice solely from their perspective.

Through the analytic process, from the mutual constructions of narratives in the interviews, the transcriptions and the three different analytic approaches in Study I

– IV questions have emerged and been followed whereby new meanings have been explored and generated, which as a totality increases the trustworthiness of the thesis (Rolfe, 2004; Denzin and Lincoln, 2002; Johnson, 1997). Different explicit perspectives and questions have been posed to the same text in Study I – IV and different analysis and interpretations of the narratives have been concluded which testify to the fruitfulness and the vigor (and not as a weakness) of the thesis (Brinkmann and Tanggard, 2010; Kvale and Brinkmann, 2009).

Through the different approaches to the analyses in Study I - IV I have worked on breaking with my pre-understanding in the process of this thesis. In Study I and II we chose Malterud's approach (2012; 2011; 2003) which is based within phenomenology and hermeneutics (Jacobsen, Tanggard and Brinkmann, 2010; Denzin and Lincoln, 2005; Gadamer, 2005; 2004; Dahlberg, Drew and Nyström, 2001; Malterud, 2001ab; Føllesdal, Walløe and Elster, 1993). In Study I a definition of ethics (Beauchamp and Childress, 2009; Vetlesen, 2007; Birkler, 2006; Aadland, 2002) and explicated understandings of possible ethical issues (Carpenter and Richardson, 2008; Poulis, 2007ab; Swisher, 2002; Praetsegaard, 2001) were adopted as a conscious framework of reference for the interviewees' understandings. This may be regarded as a vague framework, which is why Study I may be criticized for being a sophisticated enlarged reproduction of my pre-understanding; decreasing credibility of the study (Rolfe, 2004; Denzin and Lincoln, 2002; Johnson, 1997). As the aim of Study I was aroused during the early process of interviewing in relation to the aim of Study II and thus was not part of my pre-understanding, some credibility may be claimed. In striving to move beyond my pre-understanding I prepared a mind-map of expected findings before analysing the interviews within the aim of Study II. Beauchamp and Childress's four principles of ethics were chosen as the analytic theoretical framework; not as 'template analysis style' where data is analysed through themes decided in advance (Polit and Beck, 2008; Miller and Crabtree, 1999) but as a dialectic process of identifying patterns, condensing interpretations and recontexualising constructions. The advantage of applying a theoretical perspective to the process of analysing is the possibility for open for one's pre-understanding and risk it, and also for others to understand and follow how the analyses are made; enhancing confirmability (Rolfe, 2004). As analysis is dependent on one's ability to construct patterns of all aspects of the theoretical framework, Study II may be claimed limited in its interpretative analysis of all four principles of ethics, as the principle of justice never really seems at play, and as such a decline of general trustworthiness (Rolfe, 2004; Lincoln and Guba, 1985) has to realised. As both authors in Study II have an inside perspective it may bring forth the risk to be blinded for our mutual pre-understandings and thus producing knowledge already known or none at all. Having an inside perspective entails the risk to be seduced by the physiotherapeutic theoretical literature, normative guidelines and the

association's rhetoric of ethics and from these be locked, leading and manipulating the interviews into our views and opinions and selective interpreting and reporting statements justifying our conclusions (Kvale and Brinkmann, 2009. Study II showed ethical issues which have previously been reported (Watt-Watson et al, 2013; Rowe and Carpenter, 2011; Carpenter, 2010; Kumar, Grimmer-Sommers and Huges, 2010; Harman et al, 2009; Delaney, 2007; 2005; Cooper and Jenkins, 2008; Greenfield, 2006; Finch, Geddes and Larin, 2005; Carpenter, 2004; Geddes, Wesssel and Williams, 2004; Cross and Sim, 2000; Triezenberg, 1996; Barnitt, 1994; Guccione, 1980). Nevertheless some trustworthiness of the study may be claimed as new ethical issues in physiotherapeutic practice unfolded; especially issues about transgressing boundaries, about how to apply benefice to all patients (Study II) where some issues went beyond our pre-understandings of physiotherapeutic practice. These new findings provided new pre-understandings and raised new questions about the material which we pursued in Study III. The hermeneutic analytic approach in Study III (Lindseth and Norberg, 2004; Ricoeur, 1995; 1979) opened for new and challenging understandings of what constitutes 'beneficence' within physiotherapy private practice. The analyses show that beneficence seems to relate to three different relationships which opened our pre-understandings of the concept of beneficence reaching out of the medical discourse (Beauchamp and Childress, 2009; Wolff, 1990): aspects which broke with our pre-understandings.

Several philosophers and researchers distinguish between reflections of first, second and third order (Bertelsen, 2005; Andersen, 2003). First order are conscious and active thoughts and reflections which are explicitly present in the reflection's 'foreground' (Wacherhausen, 2008; Argyris and Schön, 1978): the level of reflections seen in Study I and II. Second order reflections are not explicit and only implicitly expressed in our thoughts and reflections, as 'background-concepts' which only exist and come into play indirectly and implicitly as cognition - and discourse delimiting concepts and conceptions (Wacherhausen, 2008; Argyris and Schön, 1978): the level of reflection in Study III. The new understandings in Study III opened reflection on the need to explore reflections of a third order: reflections on reflections of the political, social-cultural and economic aspects (Bertelsen, 2005) which structures and discipline physiotherapists in private practices. Becoming aware of these 'background-concepts' in Study III, we broke our pre-understandings to get behind the conscious constructive meanings and the interviewees subjective level; and decoded and analysed the powers inherent in the constructions of physiotherapeutic practices in Study IV; which shows perspectival subjectivity through the thesis (Kvale and Brinkmann, 2009).

The advantage of choosing an explicit theoretical perspective in Study I – IV is to be able to work stringently and transparently through all phases of the studies;

increasing trustworthiness and confirmability (Kvale and Brinkmann, 2009; Rolfe, 2004; Denzin and Lincoln, 2002) of the interpretations, and to obtain other levels of abstraction; to come above the immediate representations of the interviews.

The general implication of choosing physiotherapy in Danish private practice as the context for the thesis is that the main findings can be transferred to similar Danish or Western private contexts. The main findings cannot be transferred to physiotherapeutic public contexts in Denmark nor to any other Western country because of differences in historical time, societal history, the ruling political ideology, governmental and practice organisation, norms etc. (Lehn-Christensen and Holen, 2012; Mik-Mayer, 2012; Nicholls, 2012, Nicholls and Holmes, 2012; Shaw and DeForge, 2012; Rostgaard, 2011; Magnussen, Vrangbæk, Saltman and Martinussen, 2009; Hamann, 2009; Harvey, 2005; Kvale and Brinkmann, 2009; Rolfe, 2004; Denzin and Lincoln, 2002). Nevertheless, the findings of the present thesis may inspire and facilitate physiotherapists' reflections in other contexts.

Transferability of the thesis is further limited as only the speech position of the physiotherapists is presented. In order to catch all meaningful aspects of the social, ethical practices in private physiotherapeutic practice the observed and narrated experiences from both the physiotherapist and the patient are needed, as are analysis of the contexts and artefacts related to private practice physiotherapy.

6.0 Conclusions

Physiotherapy in private practice has many ethical issues embedded and the physiotherapists' consciousness about ethical issues seem primarily to be based on individual common sense arguments, intuitive feelings of ethics, of reflections about professional obligations and a spontaneous ethics of care understanding. Their explicit consciousness on ethical issues seems primarily constructed when their clientele are regarded as being at risk: in the first session of physiotherapy and in meetings with the so-called 'difficult' patients as these situations do not just flow, they require ethical reflections and pedagogical strategies in order to keep the patient in the business. Beneficence is seen as the core value of physiotherapeutic private practice and is expressed as having importance in different relationships: towards the patient, the physiotherapists themselves and their business. To secure beneficence a paternalistic approach emerges towards the patient, where disciplining the patient into their 'regimes of truth' become a crucial element of practice in order to exploit the politically defined frames for optimising profit which relate to utilitarianism. Both physiotherapists and patients support the neoliberal ideology as the physiotherapists have knowledge and skills which they offer for payment; knowledge and skills which they convert to treatment under certain frameworks and conditions which the patients accept and take part in. Physiotherapy private practice in Denmark seems to reproduce the Western medical logic and practices as they unconsciously oppose their own political intentions for physiotherapy to be an autonomous profession: in this way physiotherapy in private practice inscribes itself as a 'wanna-be' profession. The physiotherapists' perceptions of ethical obligations about respecting the patients' autonomy and being beneficent seem to be led invisibly by structures of neoliberal ideology working behind the backs of the physiotherapists. The physiotherapists in Danish private practice seem to be competent social agents in a social constructive modern Western world governed by a neoliberal ideology.

The thesis has several limitations as it built solely on Danish physiotherapists' articulations of their practice, their understanding of this and observation notes. This means that the analyses only address how the physiotherapists choose to articulate their practices in a moment of time and accordingly the thesis does not address the issues of the functioning of clinical practice within practical reality. Further it means that as a specific context was chosen for the thesis, the findings

can only be transferred to similar contexts and not to other private contexts or to physiotherapeutic public contexts in Denmark nor to other Western countries.

7.0 Perspectives

As this thesis is limited to a presentation of the speech position of the physiotherapists this raises new perspectives and questions about physiotherapy in private practice. In order to catch all meaningful aspects of the social, ethical practices in private physiotherapeutic practice, field studies are needed which embody observed and narrated experiences from both the physiotherapist and the patient, and which analyses the contexts and artefacts related to private practice physiotherapy.

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In September 1997 I took a Master course in Medical Ethics at Lund University, Sweden, and ever since I have been interested in exploring how the ethical dimension is understood and practiced in physiotherapy. This interest has further made me reflect on how to stimulate professional debates, discussions and reflections on ethics in physiotherapy. Upon acquiring my master's degree in physiotherapy I had no intention of writing a doctoral thesis, but as my curiosity evolved it seemed the right way to go. Almost nine years have passed since then, and at last this thesis has reached its final point.

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Frederiksberg, April 2014

Jeanette Præstegaard

9.0 Declaration

I declare that this thesis presents work carried out by myself and does not without acknowledgment incorporate any material previously submitted.

To the best of my knowledge the thesis does not contain any materials previously published or written by any other person except where due reference is made in the text; and all substantive contributions by others to the presented, including jointly authored publications, is clearly acknowledged.

10.0 References

Aadland, E., 2000. *Etik, dilemma og valg* [Ethics, dilemma and choise]. Copenhagen: Dansk psykologisk Forlag (In Danish)

Abbott, A., 1988. *The System of Professions*. Chicago: The University of Chigaco Press

Album, D., 1996. *Nære fremmede. Pasientkulturen i sykehus* [Close strangers. The patient culture in hospitals]. Oslo: Tano (In Norwegian)

Alvesson, M. and Billing, YD., 2009. *Understanding gender and organization*. 2nd edition. New Delhi: Sage

American Medical Association, 2001. *Principles of Medical Ethics*. [online] Available at: https://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page?

Andersen, H., 2011. *Sociologi – en grundbog til et fag* [Sociology – a basic book]. Copenhagen: Hans Reitzels Forlag (In Danish)

Andersen, NÅ., 2003. *Discursive analytical strategies*. Understanding Foucault, Koselleck, Laclau, Luhmann. Bristol: The Policy Press

Andrews, M., Sclater, SD., Squire, C. and Tamboukou, M., 2007. Narrative research, In: C. Seale, G. Gobo, JF. Gubrium, and D. Silverman. *Qualitative Research* Practice. London: Sage

Argyris, C. and Schön, DA., 1978. *Organizational Learning: A Theory of Action Perspective*. Reading, Massachusetts: Addison Wesley Publishing Company

Aristotle., 1995. *Den nikomakæiske etik* [Nichomachean ethics], translated by Niels Møller 1936. Helsingør; Det lille Forlag

Armstrong, D., 1995. The rise of surveillance medicine. *Sociological Health Illness*, 17(3):393-404

Armstrong, D., 1994. Bodies of knowledge/knowledge of bodies. In: C. Jones, and R. Porter, eds. *Reassessing Foucault: Power, medicine and the body*. London: Routledge

Association of Danish Physiotherapists, 2014. *Kliniske retningslinjer* [clinical guidelines]. [online] Available at: http://fysio.dk/kliniske retningslinjer/ (In Danish)

Association of Danish Physiotherapists, 2013a. *Overenskomster* [Collective bargaining]. [online] Available at: http://fysio.dk/praksis/Overenskomst-og-takster/ (In Danish)

Association of Danish Physiotherapists, 2013b. *Klinikhåndbog* [Clinical manual]. [online] Available at: http://fysio.dk/praksis/Klinikhandbog/Klinikdrift/Vardier/ (In Danish)

Association of Danish Physiotherapists, 2013c. *Klinikdrift* [The running of a clinic]. [online] Available at: http://fysio.dk/praksis/Klinikdrift/ (In Danish)

Association of Danish Physiotherapists, 2013d. *Politik og organization* [Policies and organisation]. [online] Available at: http://fysio.dk/org/nyheder/Fysioterapeuter-er-stadig-ikke-sundhedspersoner/ (In Danish)

Association of Danish Physiotherapists, 2010. *Kollegiale vedtægter* [Collegial regulations]. [online] Available at: http://fysio.dk/org/Rad/Det-Kollegiale-Rad/Kollegiale-vedtagter/ (In Danish)

Association of Danish Physiotherapists, 2006. *Klinik guide* [The guide to clinics in Denmark]. [online] Available at: http://fysio.dk/praksis/KlinikGuide/ (In Danish)

Association of Danish Physiotherapists, 2012a./2002. *Etiske retningslinjer* [Codes of Ethics]. [online] Available at: http://fysio.dk/fafo/Etik/Etiske-retningslinjer2012 (In Danish)

Association of Danish Physiotherapists, 2012b; 2008. *Praksis* [Private practice]. [online] Available at: http://fysio.dk (In Danish)

Barnitt, R., 1998. Ethical dilemmas in occupational therapy and physical therapy: A survey of practitioners in the UK National Health Service, *Journal of Medical Ethics*, 24:193-199

Barnitt, R., 1994. Truth telling in occupational therapy and physiotherapy, *British Journal of Occupational Therapy*, 57:334-340

Barnitt, R. and Partridge, C., 1997a. Ethical reasoning in physical therapy and occupational therapy, *Physiotherapy Research International*, 2:178-194

Barnitt, R. and Patridge, C., 1997b. Ethical reasoning in physical therapy and occupational therapy, *Physiotherapy Research International*, 4:250-261

Bartholdy, J., 2003. Styrke til at handle selv [Empowerment]. *Sygeplejersken*, (26):22-24 (In Danish)

Bartlett, DJ., Lucy, D., Bisbee, L. and Conti-Becker, A., 2009. Understanding the professional socialization of Canadian physical therapy students: A qualitative investigation, *Physiotherapy Canada*, 61(1):15-25

Bayer, M., Henriksen, AH., Larsen, K. and Ringsted, C., 2002. *Turnuslægers praksislæring* [The practical learning of the rotating physicians]. Copenhagen: Region Hovedstaden (In Danish)

Beauchamp, TL., and Childress, JF., 2009/1979. *Principles of biomedical ethics*, 6th and 1st edition. New York: Oxford University Press

Beck, A., Bager, P., Jensen, PE. and Dahlerup, JF., 2013. How fatigue is experienced and handled by female outpatients with inflammatory bowel disease. *Gastroenterol Research and Practice* [Epub ahead of print]

Benoit, C., Zadoroznyj, M., Hallgrimsdottir, H., Treloar, A. and Taylor, K., 2010. Medical dominance and neoliberalisation in maternal care provision: The evidence from Canada and Australia. *Social Science and Medicine*, 71:475-481

Bertelsen, P., 2005. Dannelse i fællesskaber og dannelse af fællesskaber [Foundation in communities and foundation of communities]. *Psyke & Logos*, 26:314-346 (In Danish)

Berthelsen, H., Hjalmers, K., Pejtersen, JH. and Söderfeldt, B., 2010. Good work for dentists – a qualitative analysis. *Community Dentistry and Oral Epidemiology*, 38(2):159-170

Binderup, LG., 2011. Metaetik – en oversight [Meta-ethics – a survey]. In: AM. Christensen, ed. *Filosofisk etik. Normativ etik, praktisk etik og metaetik* [Philosophical ethics. Normative ethics, practical ethics and meta-ethics]. Aarhus: Aarhus Universitetsforlag, pp 293-330

Birch, M., Miller, T., Mauthner, M. and Jessop, J., 2002. Introduction. In: M. Mauthner, M. Birch, J. Jessop and T. Miller, eds. *Ethics in qualitative research*. London: Sage, pp 1-13

Birkler, J., 2006. *Etik i Sundhedsvæsenet* [Ethics within the healthcare]. Copenhagen: Munksgaard Danmark (In Danish)

Birkler, J., 2005. *Videnskabsteori* [Theory of sciences].Copenhagen: Munksgaard Danmark (In Danish)

Bjornsdottir, K., 2009. The ethics and politics of home care: a discussion paper, *International Journal of Nursing studies*, 46(5):732-739

Bjorkman, M. and Malterud, K., 2012. Lesbian women coping with challenges of minority stress: a qualitative study. *Scandinavian Journal of Public Health*, 40(3):239-244

Boas, TC. and Gans-Morse, J., 2009. Neoliberalism: From New Liberal Philosophy to Anti-Liberal Slogan. *Studies in Comparative International Development (SCID)*, 44(2):137–161

Bourdieu, P. et al., 1999. *The Weight of the World*. Cambridge: Polity Press

BradburyJones, C., Sambrook, S. and Irvine, F., 2007. Power and empowerment in nursing: a fourth theoretical approach. *Journal of Advanced Nursing*, 62(2):258-266

Brinkmann, S. and Tanggard, L., ed. 2010. Kvalitet i kvalitative studier [Quality in qualitative studies]. In: S. Brinkmann, and L. Tanggard. *Kvalitative metoder. En grundbog* [Qualitative methods. A textbook]. Copenhagen: Hans Reitzels Forlag (In Danish)

Bruun, P., 2010. *Pårørendes liv med kræft i familien – ægtefælle/samlever og børns oplevelser med uhelbredelig prostatakræft* [Relatives lives when cancer is in the family – spouse/partner and children's experiences with incurable prostatic cancer]. Odense: Enheden for Sygeplejeforskning, Det Sundhedsvidenskabelige Fakultet, Syddansk Universitet (In Danish)

Callewaert, S., 2003. Profession og personlighed – to sider af samme sag? [Profession and Personality – Two Sides of the Same Question?]. In: I. Weicher and PF. Laursen, ed. *Person og profession – en udfordring for socialrådgivere, sygeplejersker, lærere og pædagoger* [Person and Profession – A Challenge for Social Workers, Nurses, Teachers and Pedagogues]. Værloese: Billesø & Baltzer, pp 259-277 (In Danish)

Campbell, T., 2011. From aphasia to dyslexia, a fragment of a genealogy: An analysis of the formation of a 'medical diagnosis'. *Health Sociology Review*, 20:450-461.

Carpenter, C., 2004. Dilemmas of Practice as Experienced by Physical Therapists in Rehabilitation Settings. *Physiotherapy Canada*, 57:63–74

Carpenter, C. and Richardson, B., 2008. Ethics knowledge in physical therapy: A narrative review of the literature since 2000. *Physical Therapy Review*, 15(5):366-374

Carpenter, C., 2010. Moral distress in physical therapy practice. *Physiotherapy Theory and Practice*, 26(2):69-78

Carr, D., 2000. *Professionalism and Ethics in Teaching*. London: Routledge

Chase, SE., 2005. Narrative Inquiry. In: NK, Denzin and YS Lincoln. The Sage *Handbook of Qualitative Research*. 3rd edition. Thousand Oaks: Sage

Cheek, J., 2000. *Postmodern and poststructural approaches to nursing research*. Thousand Oaks: Sage

Cheek, J. and Gibson, T., 1996. The discursive construction of the role of the nurse in medication administration: an exploration of the literature. *Nursing Inquiry*, 3(2):83-90

Cheek, J., 1995. Nurses, nursing and representation: an exploration of the effects of viewing positions on the texual portrayal of nursing. *Nursing Inquiry*, 2(4):235-240

Christensen, AM., 2011a. Hvad er filosofisk etik [What is philosophical ethics]. In: AM. Christensen, ed. *Filosofisk etik. Normativ etik, praktisk etik og metaetik* [Philosophical ethics. Normative ethics, practical ethics and meta-ethics]. Aarhus: Aarhus Universitetsforlag, pp 7-18 (In Danish)

Christensen, AM., 2011b. Normativ etik – en oversight [Normative ethics – a survey]. In: AM. Christensen, ed. *Filosofisk etik. Normativ etik, praktisk etik og metaetik* [Philosophical ethics. Normative ethics, practical ethics and meta-ethics]. Aarhus: Aarhus Universitetsforlag, pp 21-54 (In Danish)

Christensen, N., 2007. *Development of clinical reasoning capability in student physical therapists*. PhD thesis. Adelaide: University of South Australia,

Chriostoffersen, SA., ed. 2013a. *Professionsetik. Om etiske perspektiver i arbejdet med mennesker* [Professional ethic. About ethical perspectives in the work with human beings]. Aarhus: Forlaget Klim, pp 7-17 (In Danish)

Christoffersen, SA., ed. 2013b. Professioner og professionsetik – hvad er det? [Professions and professional ethic – what it that?]. In: *Professionsetik. Om etiske perspektiver i arbejdet med mennesker* [Professional ethic. About ethical perspectives in the work with human beings]. Aarhus: Forlaget Klim, pp 18-43 (In Danish)

Christoffersen, SA., ed. 2013c. Professionetik som dømmekraft [Professional ethic as judgement]. In: *Professionsetik. Om etiske perspektiver i arbejdet med mennesker* [Professional ethic. About ethical perspectives in the work with human beings]. Aarhus: Forlaget Klim, pp 65-88 (In Danish)

Cooper, I. and Jenkins, S., 2008. Sexual boundaries between physiotherapists and patients are not perceived clearly: an observational study. *Australian Journal of Physiotherapy*, 54(4):275-279

Cross, S. and Sim, J., 2000. Confidentiality within physiotherapy: Perceptions and attitudes of clinical practitioners. *Journal of Medical Ethics*, 26:447-453

Czarniawska, B., 2010. Narratologi og feltstudier [Narratology and fieldstudies]. In: S. Brinkmann and L. Tanggaard, eds. *Kvalitative metoder – en grundbog*

[Qualitative methods – a textbook]. Copenhagen: Hans Reitzels Forlag, pp 239-262 (In Danish)

Dahl, HM., 2005a. A changing ideal of care in Denmark: A different form of retrenchment? In: HM. Dahl, and TR. Eriksen , eds. *Dilemmas of care in the Nordic welfare state: Continuity and change*. Hants: Ahsgate Publishing Limited

Dahl, HM., 2005b. Fra en klassisk til en (post)moderne opfattelse af professioner? [From a classic ti a (post)modern perception of professions]. In: TR. Eriksen and AM. Jørgensen. *Professionsidentitet i forandring* [The identity of professions in change]. pp 36-57. Copenhagen: Akademisk Forlag, (In Danish)

Dahlberg, K., Drew, N., and Nyström, M., 2001. *Reflective Lifeworld Research*. Lund: Studenterlitteratur

The Danish Data Protection Agency 2005. *Danish Act on Processing of Personal Data*, Lov nr. 429 af 31/05/2000. [online] Available at: http://www.datatilsynet.dk/lovgivning/persondataloven/

Darnell, RE., 2007. Corpus: *The philosophical meaning of body in physical therapy theory and practice*. Flint: University of Michigan-Flint

Darwall, S., 1998. *Philosophical ethics*. Boulder, Colorado: Westview Press

Dean, H., 1995. The Examination of Outcomes: An Evaluation of an Innovative professional Curriculum. quoted in: Dean, JC., What makes a profession? *Fund Raising management*, 26(9):28-31

Delany, CM., 2008. Making a difference: incorporating theories of autonomy into models of informed consent. *Journal of Medical Ethics*, 34(9):3

Delaney, CM., 2007. In private practice, informed consent is interpreted as providing explanations rather than offering choices: a qualitative study. *Australian Journal of Physiotherapy*, 53:171-177

Delaney, CM., 2005. Respecting patient autonomy and obtaining their informed consent: Ethical theory – missing in action. *Physiotherapy*, 91:197-203

Delany, CM., Edwards, I., Jensen, GM. and Skinner, E., 2010. Closing the gap between ethics knowledge and practice through active engagement: an applied model of physical therapy ethics. *Physical Therapy*, 90(7):1068-78

Delany, CM. and Frawley, H., 2012. A process of informed consent for student learning through peer physical examination in pelvic floor physiotherapy practice. *Physiotherapy*, 98(1):33-39

deMayo, RA., 1997. Patient Sexual Behaviors and Sexual Harassment: A National Survey of Physical Therapists. *Physical Therapy*, 77(7):739-744

Denzin, NK., and Lincoln, YS., 2005. Introduction: The Discipline and Practice of Qualitative Research. In: NK. Denzin and YS Lincoln. *Strategies of Qualitative Inquiry*. Thousand Oaks: Sage

Denzin, NK., and Lincoln, YS., eds. 2002. *The Qualitative Inquiry Reader*. Thousand Oaks: Sage

Dickson-Swift, V., James, EL., Kippen, S. and Liamputtong, P., 2009. Researching sensitive topics: qualitative research as emotion work. *Qualitative Research*, 9 (1), 61-7

Dickson-Swift, V., James, EL., Kippen, S. and Liamputtong, P., 2007. Doing sensitive research: what challenges do qualitative researchers face? *Qualitative Research*, (3), 327-353

Dige, M., 2011. Praktisk etik – en oversight [Practical ethics – a survey]. In: AM. Christensen, ed. *Filosofisk etik. Normativ etik, praktisk etik og metaetik* [Philosophical ethics. Normative ethics, practical ethics and meta-ethics]. Aarhus: Aarhus Universitetsforlag, pp 147-182 (In Danish)

Dige, M., 2009. Occupational therapy, professional development, and ethics. *Scandinavian Journal of Occupational Therapy*, 16: 88-98

Dreyer, PS. and Pedersen, BD., 2009. Distanciation in Ricoeur's theory of interpretation: narrations in a study of life experiences of living with chronic illness and home mechanical ventilation. *Nursing Inquiry*, 16:64-73

Driver, J., 2007. *Ethics, the fundamentals*. Oxford: Blackwell Publishing Ltd

Duncan, P., 2010. *Values, Ethics & Health Care*. London: SAGE Publications Ltd.

Edwards, I., Delany, CM., Townsend, AF. and Swisher, LL., 2011a. New perspectives on the theory of justice: implications for physical therapy ethics and clinical practice. *Physical Therapy*, 91(11):1642-52

Edwards, I., Delany, CM., Townsend, AF. and Swisher, LL., 2011b. Moral agency as enacted justice: a clinical and ethical decision-making framework for responding to health inequities and social injustice. *Physical Therapy*, 91(11):1653-63

Eisenberg, N., 2012. Post-structural conceptualizations of power relationships in physiotherapy. *Physiotherapy Theory and Practice*, 28(6):439-446

Engelsrud, G., 2007. Træning på godt og ondt. In: G. Engelsrud and K. Heggen, eds. *Humanistisk sykdomslære. Tanker om helse og velvære, sygdom og diagnose*. Oslo: Universitetsforlaget AS, pp 109-126 (In Norwegian)

Engelsrud, G., 2006. *Hva er kropp?* [What is body?]. Oslo: Universitetsforlaget (In Norwegian)

Eriksen, TH., and Sørheim, TA., 2002. *Kulturforskelle, kulturmøder i praksis* [Cultural differences, practical meetings between cultures]. Copenhagen: Munksgaard Danmark (In Danish)

Eriksen, TH., 2002. *Små steder – store spørgsmål, innføring i sosialantropologi* [Small places – big questions, an introduction to social anthropology]. Oslo: Universitetsforlaget (In Norwegian)

Esmark, A., Laustsen, CB., and Andersen, NÅ., 2005. Socialkonstruktivistiske analysestrategier – en introduktion [Social constructive strategies of analysis – a introduction]. In: A. Esmark, CB. Laustsen and NÅ Andersen, eds. *Socialkonstruktivistiske analysestrategier* [Social constructive strategies of analysis]. Frederiksberg: Roskilde Universitetsforlag, pp 7-30 (In Danish)

Etzioni, A., 2005. The semi-professions and their organization: Teachers, nurses, social workers. New York: Free Press; 1969. In: LL. Swisher and CG. Page. *Professionalism in Physical Therapy. History, Practice & Development*. St. Louis: Elsevier Saunders

European Commission, 2007. *EU Health Programme 2008-2013, The Second Programme of Community Action in the Field of Health 2008-2013*. [online] Available at: http://www.ec.europoa.eu/health/programme/policy/2008-2013/index_en.htm

Evers, A., 2003. *Current strands in debating user involvement in social services*, Discussion Paper for the Group of Specialists on User Involvement in Social Services (CS-US). Council of Europe. Giessen: Justus-Liebig-Universität.

Fadyl, JK. and Nicholls, DA., 2013. Foucault, the subject and the research interview: a critique of methods. *Nursing Inquiry*, 20(1): 23-29

Fallov, MA., and Nissen, MA., 2010. Relationel magt – om forholdet mellem professional og borger [Relationel power – the relation between professional and citizen]. In: SJ. Hansen, ed. *Professionelle i velfærdsstaten* [Professionals in the welfare state]. Copenhagen: Hans Reitzels Forlag (In Danish)

Fauske, H., 2008. Profesjonsforskningens faser og stridsspørgsmål [Phases and controversional issues of professional research]. In: A. Molander and LI. Terum, eds. *Profesjonsstudier* [Studies of professions]. Oslo: Universitetsforlaget, pp. 31-53 (In Norwegian)

Fenety, A., Harman, K., Hoens, A. and Basset, R., 2009. Informed consent practices of physiotherapists in the treatment of low back pain. *Manual Therapy*, 14(6):654-660

Finch, E., Geddes, L. and Larin, H., 2005. Ethically-based clinical decision-making in physical therapy: Process and issues. *Physiotherapy Theory and Practice*, 21:147-162

Fioretus, I., Hansson, K. and Nilsson, G., 2013. *Vårdmöten. Kulturanalytiska perspektiv på möten inom vården* [Healtcare meetings. Cultural analytic perspectives on the meeting in healthcare]. Lund: Studentlitteratur (In Swedich)

Fisher, R., 2010. Nurse prescribing: A vehicle for improved collaboration, or a stumbling block to inter-professional working? *International Journal of Nursing Practice*, 16:579-585

Flyvbjerg, B., 1991. *Rationalitet og magt. Det konkretes videnskab*. Copenhagen: Akademisk Forlag bind I

Foord-May, L. and May, W., 2007. Facilitating Professionalism in Physical Therapy: Theoretical Foundations for The Facilitation Process. *Journal of Physical Therapy Education*, 21(3);6-12

Foucault, M., 2008. *The Birth of Biopolitics: Lectures at the Collège de France, 1978 - 1979* [Naissance de la biopolitique (1979)]. New York: Palgrave MacMillan

Foucault, M., 2006. *Madness and civilization* [Folie et deraison. Histoire de la folie a l'age classique (1961)]. Oxon: Routledge

Foucault, M., 1977a. *Discipline and Punish: The Birth of the Prison* [Surveiller et punir: Naissance de la prisin (1975)]. London: Allen Lane

Foucault, M., 1977b. *The History of Sexuality Volume I: the Will to Knowledge* [Histoire de la sexualite, 1: la volonte de Savoir in French (1976)]. London: Penguin

Foucault, M., 1973. *The Birth of the Clinic: An Archaeology of Medical Perception* [Naissance de la clinique. une archeology de regard medical in French (1963)]. London.; Routledge

Foucault, M., 1972. *The Archaeology of Knowledge* [L'Archéologie du savoir]. New York: Tavistock Publication Limited

Fox, NJ., Ward, KJ. and O'Rourcke, AJ., 2005. The 'expert patient': empowerment or medical dominance?The case of weight loss, pharmaceutical drugs and the internet. *Social Science and Medicine*, 60(6)1299-1309

Frank, AW., 2012. Practicing Dialogical Narrative Analysis. In: JA. Holstein and JF. Gubrium, eds. *Varieties of Narrative Analysis*. Thousand Oaks: SAGE

Frank, AW. and Jones, T., 2003. Bioethics and the Later Foucault. *Journal of Medical Humanities*, 24(3/4):179-186

Fries, CJ., 2008. Governing the health of the hybrid self: Integrative medicine, neoliberalism, and the shifting biopolitics of subjectivity. *Health Sociology Review*, 17:353-367.

Føllesdal, D., Walløe, L. and Elster, J., 1997. *Politikens bog om Moderne Videnskabsteori* [Politikens book about modern theories of sciences]. Copenhagen: Politikens Forlag A/S (In Danish)

Gabard, DL. and Martin, MW., 2003. *Physical Therapy Ethics*. Philadelphia: FA Davies Company

Gadamer, HG., 2005. Forståelsens historicitet som det hermeneutiske princip [The historiosm of understanding as the hermeneutic principle]. Translated by Gulddal, J. from Gadamer, HG. Wahrheit und Methode. In: J. Gulddal and M. Møller, eds. *Hermeneutik. En antologi om forståelse* [Hermeutics. An anthology of understanding]. Copenhagen: Gyldendal, pp 238-262 (In Danish)

Gadamer, HG., 2004. *Sandhed og metode* [Truth and method]. Aarhus: Systime Academic (In Danish)

Gard, G., Gyllensteen, AL., Salford, E. and Ekdahl, C., 2000. Physical Therapists' Emotional Expressions in Interviews about Factors Important for Interaction with Patients. *Physiotherapy*, 86:(5);229-240

Geddes, EL., Wessel, J. and Williams, RM., 2004. Ethical issues identified by physical therapy students during clinical placements. *Physiotherapy Theory and Practice*, 20:17-29

Gibson, BE. and Teachman, G., 2012. Critical approaches in physical therapy research: Investigating the symbolic value of walking. *Physiotherapy Theory and Practice*, 28(6):474-484

Gilbert, T., 2003. Exploring the dynamics of power: a Foucauldian analysis of care planning in learning disabilities services. *Nursing Inquiry*, 10 (1): 37-46

Gilbert, T., 2001. Reflective practice and clinical supervision: meticulous rituals of the confessional. *Journal of Advanced Nursing*, 36(2):199-205

Giorgi, A., 2005. The phenomenological movement and research in the human sciences. *Nursing Science Quarterly*, 18(1):75-82

Giorgi, A. and Giorgi, B., 2003. The descriptive phenomenological psychological method. In: J. Camic, J. Rhodes and L. Yardly, eds. *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design*. Washington: American Psychological Association Press, pp 275-297

Giorgi, A., 1986. Theoretical justification for the use of descriptions. In P. Ashworth, A. Giorgi and A. de Konig (Ed). *Qualitative research in psychology*. Pittsburgh: Duquesne University Press, pp 3-22

Giorgi, A., ed. 1975. *Phenomenology and Psychological Research*. Pittsburgh: Duquesene university

Glasdam, S., 2008. Forståelser af supervision hos sygeplejersker og læger i en onkologisk klinik - et sociologisk perspektiv [Understandings of supervision by nurses and doctors in an oncology clinic - a sociological perspective]. *Socialmedicinsk Tidskrift*, 4: 327-339 (In Danish)

Glasdam, S., 2005. Interview. En discussion af ligheder og forskelle i Pierre Bourdieus og Steinar Kvales metodeovervejelser [Interview. A discussion of equalities and differences in Pierre Bourdieu and Steinar Kvale's considerations on methods]. *Vård i Norden*, 4, 74(44)42-47 (In Danish)

Glasdam, S., 2003. *Inklusion og ekslusion af kræftpatienters pårørende i en onkologisk klinisk* [Inclusion and exclusion of the relatives to cancer patient in an oncology clinic]. Ph.D-dissertation. Viborg: Forlaget PUC (In Danish)

Glasdam, S., Praestegaard, J. and Henriksen, N., 2013. Placed in homecare - Living an everyday life in dependence and monitoring. *Nordic Journal of Social Research*, 4:83-89

Glasdam, S., Henriksen, N., Kjaer, L. and Praestegaard, J., 2012. Client involvement in Home Care Practice – a relational sociological perspective. *Nursing Inquiry*, 20(4):329-340

Glasdam, S., Timm, H. and Vittrup, R., 2010. Support efforts for caregivers of chronically ill persons. *Clinical Nursing Research*, 19(3): 233-265

Goodin, E., 1999. Utility and the good. In: P. Singer, ed. *A Companion to Ethics*. Oxford: Blackwell Publishers Ldt.

Greenfield, BH. and Jensen, GM., 2010. Beyond a code of ethics: phenemenological ethics for everyday practice. *Physiotherapy Research International*, 15(2):88-95

Greenfield, BH., 2006. The meaning of caring in five experienced physical therapists. *Physiotherapy Theory and Practice*, 21:147-162

Gubrium, JF., and Holstein, JA., 2002. From the individual interview to the interview society. In: NK. Denzin and YS. Lincoln, eds. *Handbook of Qualitative research*. Thousand Oaks: Sage, pp 3-32

Gubrium, JF., and Holstein, JA., 2000. Analysing interpretive practice. In: NK. Denzin and YS Lincoln, eds. *Handbook of Qualitative research*. Thousand Oaks: Sage, pp 487-508

Guccione, AA., 1980. Ethical issues in physical therapy practice: A survey of physical therapists in New England. *Physical Therapy*, 60:1264-1272

Hager, P., 2004. Lifelong learning in the workplace? Challenges and issues. *Journal of Workplace Learning*, 16(1/2):22-32

Hall, EOC., 2000. Phenemenological methodologies in the service of health. In: B. Fridlund and C. Hildingh, eds. *Qualitative Research Methods in the Services of Health*. Lund: Studenterlitteratur

Halldórsdóttir, S., 2000. The Vancouver school of doing phenomenology. In: B. Fridlund and C. Hildingh, eds. *Qualitative Research Methods in the Services of Health*. Lund: Studenterlitteratur

Hamann, TH., 2009. Neoliberalism, Governmentality, and Ethics. *Foucault Studies*, 6:37-59

Harman, K., Basset, R., Fenety, A. and Hoens, A., 2009. "I think it, but don't write it": the barriers to charting in private practice. *Physiotherapy Canada*, 61(4):252-258

Harvey, D., 2005. *A brief history of neoliberalism*. New York: Oxford University Press

Henriksen, JO., and Vetlesen, AJ., 2000. *Nærhet og distance. Grunnlag, verdier og etiske teorier i arbeid med mennesker* [closeness and distance. Foundations, values and ethical theories within working with human beings]. 2nd edition. Oslo: Gyldendal Akademiske (In Norwegian)

Hicks, CM., 1999. *Research Methods for Clinical Therapists. Applied project design and analysis*. 3rd edition. Edinburgh: Churchill Livingstone

Higgs, J., Refshauge, K. and Ellis, E., 2001. Portrait of the physiotherapy profession. *Journal of Interprofessional Care*, 15(1):79-89

Hjort, K., 2004. Viden som vare? [knowledge as a product?]. In: K. Hjort, ed. *De professionelle – forskning i professioner og professionsuddannelser* [The professionals – research in professions and profession-specific education]. Frederiksberg: Roskilde Universitetsforlag (In Danish)

Holen, M., 2011. *Medinddragelse og lighed - en god idé?: en analyse af patienttilblivelser i det moderne hospital* [Involvement and equality – a good idea? An analysis of patientcreations in the modern hospital]. Ph.D. thesis, Roskilde: Roskilde University (In Danish)

Holmes, D. and Gastaldo, D., 2002. Nursing as means of governmentality. *Journal of Advanced Nursing*, 38(6):557-565

Holstein, JA. and Gubrium, JF., 2006. The active interview. In: D. Silverman. *Qualitative research. Theory, Method and Practice*. 2nd edition. London: Sage

Holstein, JA. and Gubrium, JF., 2005. Interpretive practice and social action. In: NK. Denzin and YS Lincoln. *Strategies of Qualitative Inquiry*. pp 483-505. Thousand Oaks: Sage

Holstein, JA. and Gubrium, JF., 2004. Context: Working it up, down, and across. In: C. Seale, G. Gobo, JF. Gubrium and D. Silverman, eds. *Qualitative Research Practice*. London: Sage

Hovmand, B. and Praestegaard, J., 2002. Kvalitative forskningsmetoder i fysioterapi – en introduktion. [Qualitative methods of research in physiotherapy]. *Nyt om Forskning*, 2:40-58 (In Danish)

Husted, J. and Lübcke, P., 2000. *Politikens filosofi håndbog* [Politikens handbook of Philosophy]. Copenhagen: Politikens Forlag A/S (In Danish)

Højbjerg, H., 2004. Hermeneutik [Hermeneutics]. In: L. Fuglsang and PB. Olsen, eds. *Videnskabsteori i samfundsvidenskaberne* [Theories of science within the social sciences]. 2nd edition. Roskilde: Roskilde Universitetsforlag, pp 309-346 (In Danish)

Højskov, IE., 2009. *Sygeplejerskens fortælling om patienter til kollegaer. Fra indlæggelsessamtale til sygeplejedokumentation* [Nurses' narrative about patients to colleagues. From admission to nursing documentation]. Master thesis no. 194. Aarhus: Aarhus University, Department of Nursing, Institute for Public Heath (In Danish)

Højskov, IE. and Glasdam, S., 2013. Transformation of admission interview to documentation for nursing practice. *Scandinavian Journal of Caring Sciences*, (Epub ahead of print)

Jacobsen, MH., Kristiansen, S., 2006. *Farligt feltarbejde – etik og etnografi i sociologien* [Dangerous fieldwork – ethics and ethonography in sociology]. Aalborg: Aalborg University (In Danish)

Jacobsen, B., Tanggard, L., and Brinkmann, S., 2010. Fænomenologi [Phenomenology]. In: S. Brinkman and L. Tanggard. *Kvalitative metoder – en grundbog* [Qualitative methods – a basic book]. Copenhagen: Hans Reitzels Forlag

Jakubowitz, M., 2011. Ethical issues in a pediatric private practice. *Seminars in Speech and Languge*, 32(4):347-56

Jarvis, P., 1999. *The Practitioner-Researcher. Developing Theory from Practice*. San Francisco: Jossey-Bass Inc.

Jensen, UJ., 1995. *Moralsk ansvar og menneskesyn* [Moral responsibility and view on humanity]. Copenhagen: Munksgaard Danmark

Jensen, UJ. and Mooney, G., 1990. Changing Values: Autonomy and Paternalism in Medicine and Health Care. In: UJ. Jensen and G. Mooney, eds. *Changing Values in Medical and Health Care Decision-Making*. Chichester: John Wiley & Sons Ldt.

Jensen, GM., Gwyer, J., Shepard, KF. and Hack, LM., 2000. Expert practice in physical therapy. *Physical Therapy*, 80:28–43.

Johansson, LG., 2003. *Introduktion till vetenskapsteori*. [Introduction to theory of science]. Stockholm: Thales (In Swedish)

Johansen, IH., Carlsen, B. and Hunskaar, S., 2011. Psychiatry out-of-hours: a focus group study of GP's experiences in Norwegian Casualty clinics. BMC *Health Services Research*, 27:11:132

Johnson, RB., 1997. Examining the validity structure of qualitative research. *Education*, 118(2):282-293

Jones, MA., Jensen, G., and Edwards, I., 2008. Clinical reasoning in physiotherapy. In: J. Higgs, MA. Jones, S. Loftus and N. Christensen. *Clinical reasoning in the health professions*. 3rd edition. Philadelphia: Butterworth Heinemann

Jørgensen, JR., ed. 2007. *Denmark's strategy for lifelong learning – Education and lifelong skills upgrading for all*. Report to the European Commission. Copenhagen: Danish Ministry of Education

Jørgensen, P., 2000. Concepts of body and health in physiotherapy: The meaning of the social/cultural aspects of life. *Physiotherapy*, 16:105-115

Järvinen, M., 2005. Interview i en interaktionistisk begrebsramme [Interview within an interactionistic conceptualisation]. In. M. Järvinen and N. Mik-Mayer. *Kvalitative metoder i et interaktionistisk perspektiv* [Qualitative methods within interactionism. Interview, observations and documents]. Interview, observationer og dokumenter. Copenhagen: Hans Reitzels Forlag (In Danish)

Järvinen, M. and Mik-Meyer, N., 2012. *At skabe en professionel: Ansvar og autonomi i velfærdstaten.* [To create a professional: Responsibility and autonomy in the welfare-state]. Copenhagen: Hans Reitzels Forlag. (In Danish)

Järvinen, M. and Mik-Meyer, N., 2003. *At skabe en klient: Institutionelle identiteter i socialt arbejde*. [To create a client: Institutional identities in social work]. Copenhagen: Hans Reitzels Forlag (In Danish)

Kappel, K., 1996. *Medicinsk etik. En filosofisk diskussion af bioetiske grundproblemer*. [Meidcal ethics. A philosophic discussion about bioethical basic problems]. Copenhagen: Gyldendal Nordisk Forlag A/S (In Danish)

Kaspersen, LB. and Blok, A., 2011. Teorisynteser og nybrud i moderne sociologi [Synthesis of theory and the breakthrough in modern sociology]. In: H. Andersen. *Sociologi – en grundbog til et fag* [Sociology – a basic book]. Copenhagen: Hans Reitzels Forlag (In Danish)

Kjølseth, I., Ekeberg, O. and Steihaug, S., 2010. Why suiside? Elderly people who committed suicide and their experience of life in the period before their death. *International Psychogeriatrics*, 22(2): 209-218

Kokaliari, E. and Berzoff, J., 2008. Nonsuicidal self-injury among nonclinical college women: Lessons from Foucault. *Affilia: Journal of Women and Social Work*, 23(3):259-269

Kopelman, LM., 2006. What is Unique About the Doctor and Patient Medical Encounter? A moral and Economic Perspective. *American Journal of Bioethics*, 6(2)85-88

Krejsler, J., 2005. Professions and their Identities: How to explore professional development among (semi-)professions. *Scandinavian Journal of Educational Research*, 49(4):335-357

Kristensen, HK., Borg T. and Hounsgaard, L., 2010. Facilitation of reserach-based evidence within occupational therapy in stroke rehabilitation. *British Journal of Occupational Therapy*, 74:473-483

Kristensen, HK., Borg, T. and Hounsgaard, L., 2012. Aspects affecting occupational therapists' reasoning when implementing research-based evidence in stroke rehabilitation. *Scandinavian Journal of Occupational Therapy*, 19(2):118-131

Kuijpers, W., Groen, WG., Aaronson, NK. and Harten WH., 2013. A systemtic review of web-based interventions for patient impowerment and physical activity in chronic diseases: relevance for cancer survivors. *Journal of Medical Internet Research* 20;15(2):e37

Kumar, S., Grimmer-Somers, K. and Hughes, B., 2010. The ethics of evidence implementation in health care. *Physiotherapy Research International*, 15(2):96-102

Kuzel, A., 1999. Sampling in qualitative inquiry. In: W. Miller and B. Crabtree, eds. *Doing qualitative research*. Thousand Oaks: Sage, pp 33-45

Kvale, S., 1996. *InterViews: An introduction to qualitative research writing*. Thousand Oaks: Sage Publications

Kvale, S., 2006. Dominance Through Interviews and Dialogues. *Qualitative Inquiry*, 12(3) june

Kvale, S. and Brinkmann, S., 2009. *Interviews. Learning the Craft of Qualitative Research Interviewing*. Thousand Oaks: Sage

Larsen, K., ed. 2005. *Arkitektur, krop og læring: En antologi om rum og artefakters betydning for handling og læring* [Architecture, body and learning. An anthology about room and artefacts meaning for action and learning]. Copenhagen: Hans Reitzels Forlag (In Danish)

Larsen, K., 2002. Rum og rammer som læremester. - Om at opfinde sin handling i kontekst, om rummenes betydning for handling. *Tidsskriftet Unge Pædagoger*, 7(8):17-34 (In Danish)

Larsen, K., 2001. Med arkitektur som læremester: om praktikuddannelse af sygeplejestuderende [Architecture as master: about clinical education of nursing students]. In: KA. Petersen, ed. *Praktikker i erhverv og uddannelse: om pædagogiske og sundhedsfaglige praktikker* [Practices in occupations and education]. Copenhagen: Akademisk Forlag, pp. 440-474 (In Danish)

Larson, MS., 1977. *The Rise of Professionalism*. California: University of California Press

Laursen, PF., 2005. *Professionalisering – en grundbog* [Professionalism – a textbook]. Roskilde: Roskilde Universitetsforlag (In Danish)

Laursen, PF., 2004. Hvad er egentlig pointen ved professioner? – Om professionernes samfundsmæssige betydning. In: K. Hjort, ed. *De professionelle – forskning i professioner og professionsuddannelser*. Frederiksberg: Roskilde Universitetsforlag (In Danish)

Laursen, PF., 2003. Personlighed på dagsordenen [Personality on the agenda]. In: I. Weicher and PF. Laursen, eds. *Person og profession – en udfordring for socialrådgivere, sygeplejersker, lærere og pædagoger* [Person and profession – a challenge for socialworkers, nurses, teachers and pedagogues]. Værløse: Billesø & Baltzer, pp 13-37 (In Danish)

Laursen, PF., Moos, L., Olesen, HS., and Weber, K., 2005. *Professionalisering – en grundbog* [Professionalisation – a basic book]. Frederiksberg: Roskilde Universitetsforlag (In Danish)

Lehn-Christiansen, S., Holen, M., 2012. Ansvar for egen sundhed – som kønnet figur [Responsibility for one's health – as sexual figure]. In: B. Dybbroe, B. Land and SB. Nielsen, eds. *Sundhedsfremme – et kritisk perspektiv* [Health promotion – a critical perspective]. Frederiksberg: Samfundslitteratur (In Danish)

Lemke, T., 2001. The birth of bio-politics: Michel Foucault's lectures at the College de France on neo-liberal governmentality. *Economy and Society*, 30(2):190-207

Lincoln, YS., and Guba, EG., 1985. *Naturalistic Inquiry*. Newbury Park: Sage Publications.

Lindgren, S., 2005. Michel Foucault. In: H. Andersen and LB. Kaspersen, eds. *Klassisk og moderne samfundsteori*. [Classical and modern theory of society]. 3rd edition. Copenhagen: Hans Reitzels Forlag, pp 331-349 (In Danish)

Lindseth, A., Marhaug, V., Norberg, A. and Udén, G., 1994. Registered nurses' and physicians' reflections on their narratives about ethically difficult care episodes. *Journal of Advanced Nursing*, 20:245-50

Lindseth, A. and Norberg, A., 2004. A phenomenological hermeneutic method for researching lived experience. *Scandinavian Journal of Caring Science*, 18:145-153

Lund, H., Bjørnlund, IB., and Sjöberg, NE., 2010. *Basisbog i fysioterapi* [Basic textbook of Physiotherapy]. Copenhagen: Munksgaard Danmark (In Danish)

Lunde, IM., and Ramhøj, P., eds. 1995. *Humanistisk forskning indenfor sundhedsvidenskab. Kvalitative metoder*. [Humanistic research within healthcare sciences. Qualitative methods]. Copenhagen: Akademisk Forlag (In Danish)

Løgstrup, KE., 1997. *The Ethical Demand*. Notre Dame: Notre Dame University Press (The translated version of the Danish original version; Løgstrup 1956)

Magnussen, J., Vrangbæk, K., Saltman, RB., Martinussen, PE., 2009. Introduction: The Nordic model of health care. In: J. Magnussen, K. Vrangbæk and RB. Saltman, eds. *Nordic Health Care System. Recent Reforms and Current Policy Challenges*. European Observatory on Health System and Policies Series. Maidenhead: Open University Press, pp 3-20

Malterud, K., 2012. Systematic text condensation: A strategy for qualitative analysis. *Scandinavian Journal of Public Health*, 40:795-805

Malterud, K., 2011./2003. *Kvalitative metoder i medisinsk forskning – en innføring* [Qualitative methods in medical research – an introduction. 2nd edition. Oslo: Universitetsforlaget (In Norwegian)

Malterud, K., 2001a. The art and science of clinical knowledge: Evidence beyond measures and numbers, *The Lancet*, 358:397-400

Malterud, K., 2001b. Qualitative Research: Standards, Challenges, and guidelines, *The Lancet*, 358:483-88

Mamhidir, AG., Kihlgren, M. and Soerlie, V., 2010. Malnutrition in elder care: Qualitative analysis of ethical perceptions of politicians and civil servants. BMC *Medical Ethics*, 11:11-32

Mansbach, A., Bachner, YG. and Melzer, I., 2010. Physical therapy students' willingness to report misconduct to protect the patient's interests. Journal of *Medical Ethics*, 36(12):802-805

McCarthy, J., 2010. Moral instability; the upsides for nursing practice. *Nursing Philosophy*, 11(2):127-135

McComas, J., Kaplan, D. and Giacomin, C., 1995. Inappropriate sexual behaviour in physiotherapy practice: A qualitative analysis of questionnaire comments. *Physiotherapy Canada*, 47(2):127-133

Merriam, SB., Johnson-Bailey, J., Lee, M.-Y., Kee, Y., Ntseane, G. and Muhamad, M., 2001. Power and positionality: Negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education*, 20(5),405-416

Mik-Mayer, N., 2012. Den forstående læge og evidenssøgende socialrådgiver: Rollebytte i dagens velfærdsstat. [The understanding physician and the evidence-searching socialworker: Changing roles in today's welfare state]. In: M. Järvinen and N. Mik-Meyer. *At skabe en professionel: Ansvar og autonomi i velfærdstaten*. [To create a professional: Responsibility and autonomy in the welfare-state]. Copenhagen: Hans Reitzels Forlag (In Danish)

Mik-Mayer, N. and Villadsen, K., 2007. *Magtens former. Sociologiske perspektiver på statens møde med borgen* [The forms of power. Sociological perspectives on the meeting between state and citizen]. Copenhagen: Hans Reitzels Forlag (In Danish)

Miller, WL. and Crabtree, BJ., 1999. Clinical research. A multimethod typology and qualitative roadmap. In: BF. Crabtree and WL. Miller, eds. *Doing Qualitative Research*. 2nd edition. Thousand Oaks: Sage, pp 20-24

Miller, P. and Rose, N., 2008. *Governing the present*. Cambridge: Polity Press

Miller, WR. and Rose, GS., 2009. Toward a Theory of Motivational Interviewing. *American Psychologist*, 64(6),527-537

Ministry of Education, 2001. *Bekendtgørelse om uddannelsen til professionsbachelor* [Executive Order on the Bachelor Degree Programme], BEK nr. 113 af 19/02/2001, i medfør af Lov nr. 481 af 31. maj 2000. [online] Available at: https://www.retsinformation.dk/Forms/R0710.aspx?id=120781 (In Danish)

Ministry of Health, 2011. *Lov om videnskabsetisk behandling af sundhedsvidenskabelige forskningsprojekter* [The law of research ethical treatment of healthecare scientific research projects]. LOV nr 593 af 14/06/2011. [online] Available at: https://www.retsinformation.dk/Forms/R0710.aspx?id=137674

Ministry of Health, 2010. *Sundhedsloven* [The law of Health]LOV nr 319 af 30/04/2008. [online] Available at: https://www.retsinformation.dk/Forms/R0710.aspx?id=130455 (In Danish)

Ministry of Science, Innovation and higher Education, 2008. *Bekendtgørelsen om uddannelsen til professionsbachelor i fysioterapi* [Executive Order on the Bachelor Physiotherapy Degree Programme]. BEK nr 831 af 13/08/2008. [online] Available at: https://www.retsinformation.dk/Forms/R0710.aspx?id=120781 (In Danish)

Mirowski, P. and Plehwe, D., 2009. *The road from Mont Pèlerin: the making of the neoliberal thought collective*. Cambridge: Harvard University Press

Molander, A. and Terum, LI., 2008. Professionsstudier – en introduction [Studies of professions – a introduction]. In: A. Molander and LI. Terum, eds. *Profesjonsstudier* [Studies of professions]. Oslo: Universitetsforlaget, pp 13-27 (In Norwegian)

Månsen, P., 2005. Max Weber. In: H. Andersen and LB. Kaspersen, eds. *Klassiske og moderne samfundsteori* [Classic and modern social theories]. 3rd edition. Copenhagen: Hans Reitzels Forlag, pp. 90-111

Nicholls, DA., 2012. Foucault and physiotherapy. *Physiotherapy Theory and Practice*, 28(6):447-453

Nicholls, DA., 2009. Putting Foucault to work: An approach to the practical application of Foucault's methodological imperatives. *Aporia*, 1(1):1-11

Nicholls, DA., 2008 *Body politics: A Foucauldian discourse analysis of physiotherapy practice*. Doctoral thesis. Adelaide: University of South Australia

Nicholls, DA. and Gibson, BE., 2010. The body and physiotherapy. *Physiotherapy Theory and Practice*, 26(8):497-509

Nicholls, DA. and Holmes, D., 2012. Discipline, desire, and transgression in physiotherapy practice. *Physiotherapy Theory and Practice*, 28(6):454-465

Nielsen, CF., 2011. Deontologi [Deontology]. In: AM. Christensen, ed. *Filosofisk etik. Normativ etik, praktisk etik og metaetik* [Philosophical ethics. Normative ethics, practical ethics and meta-ethics]. Aarhus: Aarhus Universitetsforlag, pp 55-76

Nielsen, KT. and Glasdam, S., 2011. Døden på plejehjem - en Foucault inspireret analyse af diskurser om døden og pleje af døende på danske plejehjem i dette årtusinde [Death in a nursing home – a Foucauldian inspired analysis of discourses about death and caring of the dying in Danish nursing homes within this millennium]. *Vård i Norden*, 31(1):39-44 (In Danish)

Nilstun, T., 1994. *Forskningsetik i vård och medicin*. Lund; Studenterlitteratur (In Swedish)

Noronen, L. and Wikström-Grotell, C., 1999. Towards a paradigm-oriented approach in physiotherapy. *Physiotherapy Theory and Practice*, 15(3):175-184

Norvoll, R., 2009. Magt og modmagt. [Power and resistance]. In: E. Brodtkorb and M. Rugkåsa, eds. *Sociologi og socialantropologi, mellem mennesker og samfund*. [Sociology and socialanthropology, between people and society]. Copenhagen: Munksgaard Danmark, pp 67-98 (In Danish)

Nugus, P., Greenfield, D., Travaglia, J., Westbrook, J. and Braithwaite, J., 2010. How and where clinicians exercise power: interprofessional relations in health care. *Social Science & Medicine*, 71(5):898-909

O'Sullivan, V. and Weerakoon, P., 1999. Inappropriate sexual behaviours of patients towards practising physiotherapists: A study using qualitative methods. *Physiotherapy Research International*, 4(1):28-42

Patton, MQ., 2002. *Qualitative evaluation and research methods*. 3rd edition. Thousand Oaks: Sage

Patton, P., 1998. Foucault's subject of power. In: J. Moss, ed. *The later Foucault: Politics and philosophy*. Thousand Oaks: Sage, pp 64–77

Philips, L., 2010. Diskursanalyse [Discourse analysis]. In: S. Brinkmann and L. Tanggard, eds. *Kvalitative metoder. En grundbog*. [Qualitative methods. A textbook]. Copenhagen: Hans Reitzels Forlag (In Danish)

Pilnick, A., Hindmarch, J. and Gill, VT., 2009. Beyond 'doctor and patient': Developments in the study of Healthcare Interactions. *Sociology of Health and Illness*, 31(6):787-802

Pittelkow, R., 2001. *Det personlige samfund*. [The personalized society]. Copenhagen: Lindhardt & Ringhof (In Danish)

Pollitt, C. and Bouckaert, G., 2000. *Public management reform: a comparative analysis*. Oxford: Oxford University Press.

Polit, DF. and Beck, CT., 2008. *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. Philadelphia: Lippincott Williams and Wilkins

Potter, M., Gordon, S. and Hamer, P., 2003a. Identifying physiotherapist and patient expectations in private practice physiotherapy. *Physiotherapy Canada*, 55:195-202

Potter, M., Gordon, S. and Hamer, P., 2003b. The physiotherapy experience in private practice: The patients perspective. *Australian Journal of Physiotherapy*, 49:195-202

Potter, M., Gordon, S. and Hamer, P., 2003c. The difficult patient in private practice physiotherapy: A qualitative study. *Australian Journal of Physiotherapy*, 49:53-61

Poulis, I., 2007a. Bioethics and physiotherapy. *Journal of Medical Ethics*, 33:435-436

Poulis, I., 2007b. The end of physiotherapy. *The Australian Journal of Physiotherapy*, 53:71-2

Praestegaard, J., 2001. *Etik i fysioterapi* [Ethics in Physiotherapy]. Master thesis. Lund: Lunds University (In Danish)

Purtilo, RB., 1999. *Ethical Dimensions In The Health Professions*. Philadelphia: WB Saunders

Purtilo, RB., 1978. Ethics teaching in allied health fields. The Hastings Center Report 8(2):14–16. In: LL. Swisher. 2002. A retrospective Analysis of Ethics Knowledge in Physical Therapy (1970-2000). *Physical Therapy*, 82(7):692-706

Purtilo, RB. and Doherty, R., 2011. *Ethical dimensions in the health professions*. St. Louis: Elsevier Saunders

Purtilo, R. and Haddad, A., 2002. *Health Professional and Patient Interaction*. 6th edition. Philadelphia: W.B. Saunders Company

Purtilo, RB., Jensen, GM. and Royeen, CB., 2005. *Educating for Moral Action: A Sourcebook in Health and Rehabilitation Ethics*. Philadelphia: F.A. Davis Company

Rabinow, P., ed. 1991. *The Foulcault Reader: An introduction to Foulcault's thoughts*. London: Penguin.

Rainbow, P. and Rose, N., eds. 2003. Introduction: Foucault today. In: P. Rainbow and N. Rose. *The essential Foucault: selections from the essential works of Foucault 1954-1984*, vii-xxxv. New York: The New Press.

Raja, K., Davies, F. and Sivakumar, T., 2007. *Ethical issues: Perspectives for the physiotherapists*. Pee Pee Publishers

Rawls, J., 1971. *A theory of justice*. Oxford: Oxford University Press

Ricoeur, P., 2005. Hvad er en tekst? – forklare og forstå [What is a text? – explanation and understanding]. Translated by Lauritsen L from Ricoeur P. Qu'est-ce qu'un texte? In: J. Gulddal and M. Møller, eds. *Hermeneutik. En antologi om forståelse* [Hermeutics. An anthology of understanding]. Copenhagen: Gyldendal (In Danish)

Ricoeur, P., 1995. The creativity of language. In: R. Kearney, ed. *States of Mind. Dialogues with Contemporary Thinkers*. New York: New York University Press

Ricoeur, P., 1979. *Fortolkningsteori* [Theory of interpretation]. Copenhagen: Vinten (In Danish)

Riese, H., 2007. Observation and interview as interconnected and mutually dependent parts of qualitative research. *Tidsskrift for kvalitativ metodeudvikling*, 42

Riesman, D., 1985. *Det ensomme menneske* [The lonely human being]. Copenhagen: Gyldendal

Riley, R. and Manias, E., 2002. Foucault could have been an operating room nurse. *Journal of Advanced Nursing*, 39(4):316-324

Ritzer, G. and Goodman, DJ., 2003. *Sociological Theory*. 6th edition. New York: McGraw-Hill

Roberts, M., 2005. The production of the psychiatric subject: power; knowledge and Michel Foucault. *Nursing Philosophy*, 6:33-42

Rolfe, G., 2004. Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing*, 53(3):304-310

Rose, N., 2003. At regere friheden – en analyse af politisk magt i avanceret liberale demokratier [To rule freedom – an analysis of political power in advanced liberal democracies]. In: C. Borch and LT. Larsen, eds. *Perspektiv, magt og styring - Luhmann og Foucault til diskussion* [Perspective, power and regulation – discussing Luhmann and Foucault]. Copenhagen: Hans Reitzels Forlag (In Danish)

Rose, N., 1996. *Inventing Our Selves: Psychology, Power and Personhood*. Cambridge: Cambridge University Press

Rose, N., 1994. Medicine, history and the present. In: C. Jones and R. Porter, eds. *Reassessing Foucault: Power, medicine and the body*. pp 48-72. London: Routledge

Ross, JR., Capozzi, JD., and Matava, MJ., 2012. Discussing treatment options with a minor: the conflicts related to autonomy, beneficence, and paternalism. *Journal of Bone Joint Surgery*, 94(1):e3

Ross, WD., 2002./1930. *The Right and the Good*. P. Stratton-Lake (Ed). Oxford: Oxford University Press

Rostgaard, T., 2011. Care as you like it: the construction of a consumer approach in home care in Denmark. *Nordic Journal of Social Research 2*. [online] Available at: https://boap.uib.no/index.php/njsr/article/viewFile/110/93

Rothstein, JM., 2003. Editor's note: Autonomy or professionalism? *Physical Therapy*, 83:206-207

Rothstein, JM., 2002. Autonomy and dependence. *Physical Therapy*, 82(8):750-751

Rowe, P. and Carpenter, C., 2011. Recent experiences and challenges of military physiotherapists deployed to afghanistan: a qualitative study. *Physiotherapy Cananda*, 63(4):453-63

Rugseth, G. and Engelsrud, G., 2007. Overvåkning av vekt. [Surveillance of weight] In: G. Engelsrud and K. Heggen, eds. *Humanistisk sykdomslære. Tanker om helse og velvære, sygdom og diagnose* [Humanistic pathology. Thoughts of health, welness, disease and diagnosis]. Oslo: Universitetsforlaget AS, pp 128-147 (In Norwegian)

Sandstrom, RW., 2007. The meanings of autonomy for physical therapy. *Physical Therapy*, 87:98-110

Schriver, NB., 2003. *Fysioterapi og læring – betydning af rettethed, relationer, rum og refleksion*. [Physiotherapy and learning. The meaning of intentionality, relations, space and reflection]. Phd thesis. Copenhagen, The University of Copenhagen; JCVU Forlag (In Danish)

Schriver, NB., 2004. Patienten som medskaber af egen genoptræning - betydning af relationer, rum, refleksion og dialog. [The patient as co-creator of own rehabilitation – the maning of relations, space, reflection and dialogue]. *Tidsskrift for Sygeplejeforskning*, 2:18-26 (In Danish)

Schriver, NB., 2007. *Når læring bevæger* [When learning moves]. Copenhagen: FADL's Forlag

Schriver, NB. and Engelsrud, G., 2007. Å være redd for å bevege seg – et privat symptom i helsefaglig praksis? [being afraid of movement – a private symptom in healthprofessinal practice?] In: G. Engelsrud and K. Heggen, eds. *Humanistisk sykdomslære. Tanker om helse og velvære, sygdom og diagnose*. [Humanistic pathology. Thoughts of health, welness, disease and diagnosis]. Oslo: Universitetsforlaget AS, pp 79-95 (In Norwegian)

Seedhouse, D., 2009. *Ethics. The Heart of Health Care*. 3rd edition. Chichester, John Wiley & Sons

Sen, P., Gordon, H., Adshead, G. and Irons, A., 2007. Ethical dilemmas in forensic psychiatry: two illustrative cases. *Journal of Medical Ethics*, 33(6):337-341

Shafer-Landau, R., ed. 2007. *Ethical Theory. An Anthology*. Oxford, Blackwell Publishing Ltd.

Shaw, W., 2007. The consequentialist perspective. In: R. Shafer-Landau, ed. *Ethical Theory. An Anthology*. Oxford, Blackwell Publishing Ltd, pp 463-474

Shaw, JA. and DeForge, RT., 2012. Physiotherapy as bricolage: Theorizing expert practice. *Physiotherapy Theory and Practice*, 28(6):420-427

Sheppard, L., 2001. Work practices of rural and remote physiotherapists. *Australian Journal of Rural Health*, 9(2):85–90.

Shulamit, R., 2008. Neoliberalism and its implications for mental health in the UK. *International Journal of Law and Psychiatry*, 31(2):116-125

Siegumfeldt, B., 2001. Skolebygningen som aktør i opdragelsen af den ny generation [The school building as player in the upbringing of the new generation]. In: KA. Petersen, ed. *Praktikker i erhverv og uddannelse: om pædagogiske og sundhedsfaglige praktikker* [Practices in occupations and education]. Copenhagen: Akademisk Forlag, pp. 407-421 (In Danish)

Silverman, D., 2005. *Doing Qualitative Research. A Practical Handbook*. 2nd edition. London: Sage

Sim, J., 2010. Addressing conflicts in research ethics: consent and risk of harm. *Physiotherapy Research International*, 15(2):80-87

Sim, J., 1998. Respect for autonomy: issues in neurological rehabilitation. *Clinical Rehabilitation*, 12(1):3-10

Sjostedt, E., Dahlstrand, A., Severinsson, E. and Lutzen, K., 2001. The first nurse-patient encounter in a psychiatric setting: discovering a moral commitment in nursing. *Nursing Ethics*, 8(4): 313-27

Slagstad, R., 2008. Profesjoner og kunnskapsregimer. [Professions and regimes of knowledge] In: A. Molander and LI. Terum, eds. *Profesjonsstudier* [Studies of professions]. Oslo: Universitetsforlaget, pp 54-68 (In Norwegian)

Smith, S., Roberts, P. and Balmer, S., 2000. Role overlap and professional boundaries: Future implications for physiotherapy and occupational therapy in the NHS: Forum. *Physiotherapy*, 86:397-400

Snyder, S. and Mitchell, D., 2003. The Visual Foucauldian: Institutional Coercion and Surveillance in Frederick Wiesman's Multi-handicapped Documentary Series. *Journal of Medical Hunmanities*, 24(3/4)291-308

Stokes, P., 2004. *Philosophy: 100 Essential Thinkers*. Kettering: Index Books

St-Pierre, I. and Holmes, D., 2008. Managing nurses through disciplinary power: a Foucauldian analysis of workplace violence. *Journal of Nursing Management*, 16, 352–359

Svenaeus, F., 2000. *The Hermeneutics of Medicine and the Phenomenology of Health. Steps towards a Philosophy of Medical Practice*. Dordrecht: Kluwer Academic Publishers

Swisher, LL., Jensen, GM., Delany, CM., Aziz, AA., and Præstegaard, J., 2011. *Forging links to moral action: Reaching beyond boundaries*. Amsterdam; WCPT symposium, Professional Issues

Swisher, LL. and Page, CG., 2005. *Professionalism in Physical Therapy: History, Practice and Development*. St. Loius, Missouri: Elsevier Saunders Inc.

Swisher, LL., 2002. A retrospective Analysis of Ethics Knowledge in Physical Therapy (1970-2000). *Physical Therapy*, 82(7):692-706

The Danish Data Protection Agency, 2005. *Lov om behandling af personoplysninger*, [The Act on Processing of Personal Data]LOV nr. 429 af 31/05/2000 [online] Available at: http://www.datatilsynet.dk/english/

The Danish Research Committee, 2005. *Guidelines about notification*. [online] Available at: http://www.cvk.sum.dk/loveOgRegler/omkomitesystemet.aspx

The European Commission, 2011. *Education and Training. The Lifelong Learning Programme: education and training opportunities for all*. [online] Available at: http://ec.europa.eu/education/lifelong-learning-programme/doc78_en.htm

Thornquist, E., 2011. *Klinik, Kommunikation, Information*. 2nd edition. [Clinic, Communication, Information]. Copenhagen: Hans Reitzels Forlag (In Danish)

Thornquist, E., 1998. *Conceiving Function. An investigation of the epistemological preconceptions, conceptualizations and methodologies in physiotherapy*. Ph.D. dicertation. Oslo; The University of Oslo

Thornquist, E., 1992. Examination and Communication: A Study of First Encounters Between Patients and Physiotherapists. *Family Practice*, 9(2):195-2002

Thorsen, O., Hartveit, M. and Baerheim, A., 2012. General practitioners' reflections on reffering: an asymmetric or non-dialogical process? *Scandinavian Journal of Primary Health Care*, 30(4):241-246

Townsend, A., Cox, SM. and Li, LC. 2010. Qualitative research ethics: enhancing evidence-based practice in physical therapy. *Physical Therapy*, 90(4):615-628

Traynor, M., 2007. A historical description of the tensions in the development of modern nursing in nineteenth-century Britain and their influence on contemporary debates about evidence and practice. *Nursing Inquiry*, 14(4):299-305

Trienzenberg, HL., 1996. The Identification of Ethical Issues in Physical Therapy Practice. *Physical Therapy*, 76(10):1097-1107

Vetlesen, AJ., 2007. *Hva er etikk* [What is ethics about]. Oslo: Universitetsforlaget, pp 88-108 (In Norwegian)

Vetlesen, AJ. and Norvedt, P., 1997. *Følelser og moral* [Emotions and morals]. Copenhagen: Hans Reitzels Forlag (In Danish)

Vågen, A. and Grimen, H., 2008. Professioner i maktteoretisk perspektiv [Professions in a power theoretic perspective]. In: A. Molander and LI. Terum, eds. *Profesjonsstudier* [Studies of professions]. pp 411-428. Oslo: Universitetsforlaget, pp 88-108 (In Norwegian)

Wacherhausen, S. 2008. Erfaringsrum, handlingsbåren kundskab og refleksion [room of experiences, action carried knowledge and reflection]. Aarhus: Aarhus Universitet. *Refleksion i praksis*, 1:4-21 (In Danish)

Walkerdine, V., 2003. Psychologic, Postmoderne und Neoliberalismus [Psychology, Postmodernity and Neo-Liberalism]. *Journal für Psychologie*, 11(2):126-148 (In German)

Watt-Watson, J., Peter, E., Clark, AJ., Dewar, A., Hadjjstavropoulos, T., Morley-Forster, P., O'leary, C., Raman-Wilms, L., Unruh, A., Webber, K. and Campbell-Yeo, M. 2013. The ethics of Canadian entry-to-practice pain competencies: how are we doing? *Pain Ressource Management*, 18(1):25-32

Weber, M., 2003. *Max Weber Udvalgte tekster* (2 vol.) by H. Andersen, HH. Bruun, & LB. Kaspersen. Copenhagen; Hans Reitzels Forlag (In Danish)

Weerakoon, P. and O'Sullivan, V., 1998. Inappropriate patient sexual behaviours in physiotherapy practice. *Physiotherapy*, 84(10):491-499

Westman Kumlin, I. and Krooksmark, T., 1992. The first encounter. Physiotherapist's conception of establishing therapeutic relationships. *Scandinavian Journal of Caring Science*, 6:37-44

Wikström-Gritell, C., 2012. Movement as a basic concept in physiotherapy – A human science approach. *Physiotherapy Theory and Practice*, 28(6):428-438

Williams, L., 2005. Jostling for Position: A Sociology of Allied Health. In: J. Germov (Ed), *Second opinion*, 3rd edition. pp 349-372. Oxford: Oxford University Press

World Confederation of Physical Therapists, 2011a. *Policy statement: Autonomy*. [online] Available at: http://www.wcpt.org/policy/ps-autonomy

World Confederation of Physical Therapists, 2011b. *Description of physical therapy*. Revised and re-approved at the 17th General Meeting of WCPT. London: World Confederation of Physical Therapy. [online] Available at: http://www.wcpt.org/policy/ps-description-of-physical-therapy

World Confederation of Physical Therapists, 2011c. *Policy statement: Direct access and patient/client self-referral to physical therapy*. [online] Available at: http://www.wcpt.org/policy/ps-direct-access

World Confederation of Physical Therapists, 2011d. *Policy Statement: Ethical responsibilities of physical therapists and WCPT members*. [online] Available at: http://www.wcpt.org/policy/ps-ethical-responsibilities.

World Health Organisation., 2003. *International Classification of Functioning, Disability and Health*. T. Dahl and G. Schiøler. (Translators). International Klassifikation af Funktionsevne, Funktionsevnenedsættelse og Helbredstilstand. Copenhagen; Munksgaard

World Health Organisation, 1998. *Health 21 – health for all in the 21st century, European Health for All, an introduction, Series no. 5* [pdf]. [online] Available at: http://www.euro.who.int/_data/assets/pdf-file/0003/88590/EHFA5-E.pdf

World Medical Organization., 2008. Declaration of Helsinki. British Medical Journal, 313(7070):1448-1449.

World Medical Organization, 2000. *Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects* [pdf]. [online] Available at: http://www.wma.net/en/30publications/10policies/b3/

Wright, N. and Stickley, T., 2013. Concepts of social inclusion, exclusion and mental health: a review of the international literature. *Journal of Psychiatric & Mental Health Nursing*, 20(1):71-81

Wulff, HR. and Gøtzsche, PC., 2006. *Rationel klinik - evidensbaserede diagnostiske og terapeutiske beslutninger* [Rational clinic – evidence-based diagnostic and therapeutic decisions]. Copenhagen: Munksgaard Danmark (In Danish)

Wulff, HR., Pedersen, SA. and Rosenberg, R., 1990. *Medicinsk filosofi*. [Philosophy of Medicine]. Copenhagen: Munksgaard (In Danish)

Wyller, T., 2013. Dydsetik, medborgerskab og social praksis [Virtue ethics, citizenship and social practice]. In: SA. Christoffersen, ed. *Professionsetik. Om etiske perspektiver i arbejdet med mennesker* [Professional ethics. About ethical perspectives in the work with human beings]. Aarhus; Forlaget Klim, pp 44-65 (In Danish)