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Practicing physiotherapy in Danish private practice –an ethical perspective

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Abstract

Background:

Despite an increasingly growth of professional guidelines, textbooks and research about ethics in health care, awareness about ethics in Danish physiotherapy private practice seen vague. This article explores how physiotherapists in Danish private practice, from an ethical perspective, perceive to practice physiotherapy.

Methods:

The empirical data consists of interviews with twenty-one physiotherapists. The interviews are analysed from a hermeneutic approach, inspired by Ricoeur's textual interpretation of distanciation. The analysis follows three phases: naïve reading, structural analysis and comprehensive analysis.

Results:

Four main themes are constructed: Beneficence as the driving force; Disciplining the patient through the course of physiotherapy; Balancing between being a trustworthy professional and a businessperson; The dream of a code of practice.

Conclusions:

Private practice physiotherapy is embedded in a structural frame directed by both political and economical conditions that shape the conditions for practicing physiotherapy. It means that beneficence in practice is a balance between the patient, the physiotherapists themselves and the business. Beneficence towards the patient is expressed as an implicit demand. Physiotherapeutic practice is expressed as being an integration of professionalism and personality which implies that the physiotherapists also have to benefit themselves. Private practice seems to be driven by a paternalistic approach towards the patient, where disciplining the patient is a crucial element of

practice, in order to optimise profit. Physiotherapists wish for a more beneficent practice in the future by aiming at bridging 'to be' and 'ought to be'.

Keywords

Beneficence, Denmark, ethic, hermeneutic, physiotherapy, private business, qualitative interview

Introduction

This study describes how Danish physiotherapists perceive their work in private practice from an ethical perspective.

Today, about 40 % of all Danish physiotherapists are employed in private practice. The remaining 60 % of Danish physiotherapists are employed within the public setting (The Association of Danish Physiotherapists, 2008). Students also attend clinical courses in private clinics, and it is increasingly popular to choose a career in private practice rather than in public employment. Reasons for this may be feelings of professional freedom, the opportunity to make a solid profit, or by a consciously deselecting, due to a public sector more and more ruled by bureaucracy and decreasing finances (Praestegaard, 2001; The Association of Danish Physiotherapists, 2008). By Danish law, physiotherapy in private practice is granted federal subsidies, so that people who receive physiotherapy pay half the cost and the government covers the rest; it just requires a physician's referral (The Association of Danish Physiotherapists, 2007).

In Denmark, the majority of clinics are owned by one single physiotherapist, often a senior who, in turn, has two to four physiotherapists leasing in at the clinic. Each physiotherapist operates as an independent practitioner. A study shows that the organisation of private physiotherapeutic practice itself produces ethical issues as a consequence of the granted federal subsidies and the appertaining market economical thinking and its management tools. This implies that economical considerations may generally overrule ethical considerations or decision-making in the choice of the therapy offered to the patient (Praestegaard, 2001; Glasdam et al, 2013).

In physiotherapy, as in other relational practices, ethical issues can be understood as a situation in which one has to weigh alternative actions to a problem (Beauchamp and Childress, 2009). They

are embedded in every clinical encounter, reasoning process and practice (Carr 2000; Purtilo and Haddad, 2002; Sandström 2007). Obvious ethical issues in physiotherapy are the handling of the given asymmetry of power (Thornquist, 2010), the strive of how to benefit patients (Delany et al, 2010; Praestegaard and Gard, 2013) and the inadequacies of professional argumentation when faced with ethical issues (Swisher, 2002; Carpenter and Richardson, 2008; Greenfield and Jensen, 2010; Delany et al, 2010; Lattanzi and Pechak, 2011; Delany and Frawley, 2012).

During the last decades, there have been published political and normative descriptions of professional ethics (The Association of Danish Physiotherapists 2004; WCPT 2011), textbooks seeking to describe normative frameworks for how to identify and handle ethical issues in healthcare practice in general (for instance Aadland 2000; Driver, 2007; Beauchamp and Childress 2009; Duncan 2010), and in physiotherapeutic practice in particular (Purtilo and Haddad, 2002; Gabard and Martin, 2003; Swisher and Page, 2005; Purtilo et al, 2005). An increasing number of research articles relating to ethical issues in physiotherapy have been published (Purtilo, 2000; Cross and Sim, 2000; Swisher, 2002; Geddes et al, 2004; Greenfield, 2005; Finch et al, 2005; Poulis, 2007a; 2007b; Delaney, 2007; Delany, 2008; Carpenter and Richardson, 2008; Kelly and Mackay-Lyons, 2010; Delany et al, 2010; Edwards et al, 2011a, 2011b; Praestegaard and Gard, 2011; 2013). Only sparsely research has focused on the specific private practice within a Nordic context (Praestegaard and Gard 2011; 2013).

On the basis of political and normative descriptions and the limited research on the topic in question, the aim of the present study is to explore how physiotherapists in Danish private practice, from an ethical perspective, perceive to practice physiotherapy.

Methodical considerations

This is an explorative empirical study, which consists of interviews with twenty-one physiotherapists performed twice.

Procedure of recruitment

To recruit physiotherapists from private practice, an invitation letter introducing the subject of the study and asking for interested participants was sent out to thirty-one clinics scattered throughout Denmark. The clinics were then contacted by telephone and asked for participation. Nine clinics found the study important but lacked time to participate. The rest of the clinics had passed the letter around and several physiotherapists had shown interest in participating. For selection, the physiotherapists must: speak fluent Danish, work in 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 her upcoming maternity leave.

Procedures of interviews

Twenty-two face-to-face, semi-structured, tape-recorded interviews were conducted twice at a place and time convenient for the interviewee. Studying lived ethics can be difficult because human beings live and act out their morals, i.e. internalised norms, values and attitudes, without necessarily being aware of them, and for this reason you cannot just ask people what ethics they have or practice (Lindseth and Norberg, 2004). In the first interview the physiotherapists were asked to narrate as freely as possible about their working days and especially the days they

experience as successful. A thematic interview guide was constructed to support the conversation, and inspired by Ricoeur the interview persons were stimulated by questions like: 'what', 'why', 'who', 'how', 'with whom', 'to whom' and 'for whom' to shape their stories (Ricoeur 1979, 1995). The second interview was a following-up with the purpose of reflecting on the first interview. The first interview lasted about 60 minutes, the second 30 – 45 minutes.

The time span between the two interviews varied from one to two months to allow time for further reflections on the topic. Some of the interviewees had prepared for the second interview by having written down situations. In the second interview, several interviewees refined their earlier statements and added reflections to them. Audiotapes of the interviews were transcribed verbatim.

Ethical considerations

The study followed the principles of the Code of Ethics of The Association of Danish Physiotherapists (The Association of Danish Physiotherapists, 2004) based on the Helsinki Declaration (World Medical Organization, 2008) and the World Confederation of Physical Therapy's Code of Ethics (World Confederation of Physical Therapists, 2011).

All participants were informed personally and in writing about the purpose of the study and that they could withdraw from the interview at any time without explanation. Informed consent and an agreement that quotes from the interviews could be used anonymously were obtained for both interviews. Approval by The Danish Research Ethics Committee is by law not needed for this kind of study (The Danish Research Ethics Committee, 2005).

Method of analysis

The analysis of the interviews is inspired by a Nordic interpretation (Lindseth and Norberg, 2004; Dreyer and Pedersen, 2009) of Ricoeur's textual interpretation of distancing that objectifies the interview by releasing it from the researching subject's intentions and meanings and gives it a life of its own (Ricoeur, 1979; 1995). Other researchers have used Lindseth and Norberg's interpretation in health care research (Højskov, 2009; Mamhidir et al, 2010). The analysis consists of three phases: The *naïve reading*, *structural analyses* and a *comprehensive understanding*.

Interview 1 and 2 were treated together as one narrative for each interview person.

The naïve reading: The transcribed interviews were read as a whole to grasp an initial meaning about what the text was about. Short meaning bearing sentences were noted for the initial themes.

The structural analysis: The whole text was read carefully and interpreted by going back and forth between the underlying understandings in a dialectic process. The theoretical frame of analysis is a meta-ethical frame of understanding what is right and what is wrong, what is inherent in the understanding of the right or wrong action toward the other (Beauchamp and Childress, 1979; 2009; Wulff et al, 1990; Singer, 1991; Aadland, 2000; Ross, 1930/2002). Ethics is culture dependent and may be defined as customs, unwritten rules and norms about how people should act and relate to one another (Aadland, 2000; Beauchamp and Childress, 2009). Consequently, we carefully read and analysed the texts by going back and forth between the underlying understandings in a dialectic process through the optics of the meta-ethics. Based on this, four main themes and subthemes were constructed as shown in the results section. *Quotes* are selected from the individual interviews 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 subthemes are summarised and reflected on in relation to the study's aim and context. Critical theoretical reflections and discussions of the structural analysis were made. This part of the analysis is presented in the discussion section of this article.

Results

The results are presented within the four constructed main themes; (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 as the driving force

Beneficence is understood as the core value and as the crucial take off for choosing a career within the healthcare sector. Being beneficent and acting out beneficence seems to be the core motivation for being a physiotherapist serving in private practice: *'Physiotherapy, it was because I have always wanted to work with people, wanted to do somebody something good, to heal them, and this I do here in my clinic.'*

Beneficence expresses itself in various ways and in varied depths and has importance for several relationships. Firstly, it matters to be beneficent to the other; *'I see it as my duty to do my best for the patient. To remove pain and harm.'* Secondly, beneficence seems for some to be a way to promote the physiotherapist himself or herself as being good, offering good services and being self-sacrificing in relation to others; being able to set aside oneself and one's needs in order to care for the other – at least for a while: *'Well, seen from the outside, I too benefit from doing the*

patient good. At the moment the patient is in focus but afterwards I receive the appreciation. [...] Both from the patient and from the people the patient recounts his experience to.’ Some further express that beneficence implies being skilled moneymakers: ‘If I don’t deliver real and honest therapy then I have no business.’ Thirdly, beneficence seems to fill a societal need as physiotherapists’ benefit society by offering important health professional services: ‘Physiotherapy contributes to the citizens’ fitness and healthiness. I mean we treat children and adults, young and old, we make workplace assessments, we fix sports injuries [...].’

Disciplining the patient through the course of physiotherapy

The first step in practicing physiotherapy is expressed to be the shaping of the patient from the first meeting through education. It appears that within the first meeting the physiotherapist sets the informative frame and expresses what the patient needs to understand in order to accommodate the therapy offered: *‘I always start to explain the frame. I mean I start to explain what the patient has to know and understand [...] It’s of the uttermost importance that the patient understand from the first meeting what physiotherapy is all about.’*

For some this differs as they take pride in identifying the needs of the patient through dialogue and quote many examples of how they struggle to ask the right questions to coach the patient to identify and develop his/her resources and self-care capacity: *‘I see the patient as an equal partner; he knows about his symptoms and life and I know about physiotherapy. If I don’t get the patient to bring forward his resources, thoughts and expectations, how can I succeed? Physiotherapy must be interactive – otherwise it is expert pressure.’*

Disciplining the patient through education

Patient education is expressed as a unique element of physiotherapeutic practice. The physiotherapists teach and coach their patients: *'We teach people to sense themselves [...]. With the patient, I strive to bring about bodily experiences of how to move [...] and then I teach them how to take their body into consideration, I teach them how to take responsibility of body signals – otherwise they will be eternal patients. I teach them into my understanding.'* In the coaching process, the physiotherapists use verbal explanations, visual illustrations, movement guiding with or without words, and a combination of group work and individual training.

An often-mentioned ethical aspect of patient education is the physiotherapist's ability to assess how much the patient is able to cope with the situation: *'You have to consider, [...] to give the diagnosis in small doses. It all depends on the patient's or the parents' resources and the actual diagnosis, a label, brings about many restrictions in people's way of thinking. They lose sight of the possibilities (when given a diagnosis).'*

Another ethical aspect concerns painful treatments. Some physiotherapeutic manual (e.g. trigger point massage) or electrical (e.g. shockwave) treatments inflict harm to the muscular and tendon structures and thereby produce pain. The physiotherapists argue for allowing pain and harm for a brief moment if the treatment seems to have a beneficent therapeutic effect in the long run: *'I believe that the goal justifies the means. Theoretically, I know that the harm induced to the structure of the tendon will lead to free movement and less pain [...] I teach the patient so he can endure the possible pain I have to induce in order to cure.'*

As long as the professional argument is evident, and is followed by extensive information to the patient, painful treatments are accepted as part of clinical practice: *'I know the treatment [shockwave] hurts but since it is only in the short run and I can argue professionally for beneficial consequences in the long run then I do not hesitate. I just provide more information to the patient.'*

Only a well-educated physiotherapist can benefit the patient

Being updated on knowledge and skills seems to be of great importance and is understood to benefit the patient. Some physiotherapists spend much time and money on postgraduate courses and education: *'I spend 10 % of my earnings every year on further education [...] and a lot of spare time. And I have done so for almost 20 years. Otherwise I am not being honest with myself or with the patient about giving the optimal treatment.'* The reasons for postgraduate education are seen as a professional obligation to benefit the patient with the best evidence-based treatments, or as a moral obligation to avoid harm or the risk of harm by not knowing or not being able to perform the most appropriate treatment to the patient's problem: *'If I don't know about evidence, if I haven't attended some educational courses, I mean in the broad sense [...] I find lifelong learning necessary for providing physiotherapy in the patients' best interests.'* It seems that these physiotherapists perceive promotion of practice as actively stepping out of clinical practice and entering constructed settings as skill labs; far away from the daily clinical practice. Then they return to practice and extract the newest knowledge and skills with an almost magic implication on the patient.

Some differ in their attitude towards postgraduate education as they consider their clinical practice as craftsmanship, not as a scientific ruled practice: *'Science here, science there. It's all bullocks! The only thing that counts is that the patient feels better. We have to assess our success by doing something that works.'*

Distinction: education as a function of the patient's social status

It seems as if the amount and content of information given varies according to the patients' status and culture, so that patients who are ascribed a lower status than the physiotherapists are the main target group for patient education. Some physiotherapists express insecurity when they have to enter relationships with patients whom they perceive as having equal or higher status than themselves. *'Yesterday I treated a doctor. She had a tennis elbow. I kind of lose control because I feel insecure and inferior. Per definition, she is much more qualified than I am.'* In other words, there seems to be a personal perception of status asymmetry in practice, which rests on social position. Patients from other cultures than Danish are seen by some physiotherapists as a category beyond therapeutic reach: *'Well, these Muslim males. They just stand there and wait for me to serve them. They expect that I am almost able to give them the diagnosis without an examination. And they expect me to lay out the sheet for them, and afterwards to fold it nicely, [...] that I put on their socks and shoes for them [...]. Those are impossible terms [for physiotherapeutic practice].'* Some physiotherapists seem to give up on cultural differences.

The physiotherapists often state that patients must understand their co-responsibility for the therapy to be successful: *'It is easy to treat a patient who has a crick in his back but it's difficult to avoid that the patient returns with a new crick. The most important for the patient is to realise why the back hurts, the given explanation for the pain. Actually, I can't change the attitudes of the patients unless they themselves have found out that they have a problem and have to decide that they want to get rid of it.'* This has the following implication: Successful practice depends on the patient's willingness to collaborate actively, both mentally and physically, and on the physiotherapist's informative and relational competences.

Another aspect of the distinction relates to health promotion. It appears as if some subjects of health promotion are taboo for some physiotherapists as they express difficulty in broaching themes when it is required for the patient to change health related habits, e.g. weight loss, in order to gain therapeutic effect. Hereby, the physiotherapists enroll themselves in a dilemma about how to fulfill their expectations of beneficence: *'I find it difficult to tell the patient that she has to lose weight. I mean is it really my business? And she has to lose weight in order to receive efficient treatment [...] but I also have to avoid offending her [...] and of course I want her to stay as my patient.'* And they seem to be unaware of how to practice health promotion without either violating the patient or failing to meet their professional standards and/or losing earnings.

Balancing between being a trustworthy professional and a businessperson

Being a physiotherapist in private practice implies two different roles; being a professional physiotherapist and being a businessperson, which both have to be balanced in consideration of his/her personality.

Personality and professionalism – two sides of the same matter

For some physiotherapists, the consciousness of balancing between professionalism and personality seems significant in order to unfold practice. They emphasise professionalism to entail closeness and attentiveness towards the patient, carried forth by scientific knowledge, skills and the ability to perceive the patient on the spot. That is to say that the physiotherapists see, listen to and perceive the patient's signals and reactions: *'I seek eye contact and I notice if it isn't there; I notice the facial expressions, [...] or the body language – everything; I listen a lot, [...] both to the spoken and the unspoken.'* They include these informations together with pedagogic

considerations in their clinical reasoning process about what to do next and how to do it. This they understand as living out professionalism. Professionalism hereby seems to depend on personal insight. Having insight into one's own personal competences and non-competences appears to be crucial for several physiotherapists: *'Good physiotherapy for me is when I mix my personal perceptions of the patient with my knowledgebase, my manual skills and my pedagogical skills. When I am utilising all my sources of information, then things really happen. Situations where I realise I fail to read and percept the patients - they never bring good physiotherapy.'* The physiotherapist's physical, emotional and mental perceptions of the patient's verbal and non-verbal expressions seem to account for this closeness and attentiveness; the situation requires both psychological and bodily consciousness. Professional closeness can therefore be seen as therapeutic for both the patient and the physiotherapist at the same time: *'I must accept sacrificing some of myself in the meeting with the patient; otherwise an equal contact is not possible. It is poor physiotherapy if one is only involved professionally and not personally [...] From this I learn about myself.'*

A trustworthy professional makes business safe

A recurring dilemma for the physiotherapists is balancing between being a trustworthy healthcare provider whose main concern is the consideration for the patient, and doing business. This balancing is expressed itself in various ways. For some physiotherapists, the balance is a conscious struggle as they consider beneficence towards the patient to be the main element of professionalism. They stress that if beneficence towards the patient is not in focus, patient satisfaction and professional satisfaction will be lacking, implying financial depression: A patient equals income. A satisfied patient is a returning customer and equals a solid income and,

furthermore, a satisfied patient may also generate new patients, which equals more income:

'When the patient is satisfied I am satisfied [...] both professionally and financially. Perhaps the patient returns [...] or his wife shows up.' Others contrast on patient satisfaction as being an indicator of beneficence and find practice to encompass measurable and perceived effects, which both the patient and the physiotherapists agree upon: *'If we don't both assess the therapeutic effects in the same way I haven't delivered ethical good physiotherapy and have not provided myself a returning customer.'*

Another aspect on the balance seems to consist of patients who have difficulties understanding or following the physiotherapist's perception of health and illness due to cultural or linguistic barriers: *'Sometimes I feel I do more harm than good to the patient because we don't seem to understand each other. I try to explain why she has to do this exercise or why this position is needed for the examination and if she refuses [to participate] I must rely on the second best. But it is not the best! In a way I am being caught between a rock and a hard surface.'* When the patient does not comply, s/he seems to be perceived as disobedient or s/he is classified as being abnormal in the wide sense of the word: being a difficult patient, i.e. a patient that does not fit the physiotherapist's understanding of how a good and decent patient should be. Indirectly, this confronts the physiotherapist with a potential loss of income.

For some, the balance between being a good professional and having a business primarily expresses itself as an awareness that they compete with colleagues about the patients. They find it important to come across this as serious and honest professionals and they promote themselves by having an accommodating homepage that presents the clinic, the employees and their

physiotherapeutic competences and special interests: *'On the homepage, the patient can see our offers and can see the physiotherapists by photo and a short CV, so they actually have a fair opportunity to choose the right clinic or physiotherapists.'*

The dream of a code of practice

The physiotherapists have several suggestions for future strategy and organisation of private practice in order to enhance beneficence. Some physiotherapists recommend postgraduate courses or education and express incomprehensiveness towards other physiotherapists' attitudes who do not bother. They wish for a code of practice, for recertification as a means of treating negligence of conduct falling below standard of due care: *'In this way, the bad apples can be excluded from the profession!'*

A recommended, less costly way to ensure standards of due care is collegial supervision. Collegial supervision is seen as a way to prevent harm or to prevent evil or unprofessional actions to occur. Some tell of non-formal collegial supervision, by which many potential risks of harm are elaborated, discussed and solved. A few have organised formal supervision as a direct means to avoid inflicting harm or unreflected actions: *'I tell my physiotherapists that if they want to work here they have to undergo supervision. We touch people and people touch us. That is very important to be aware of in order to truly benefit the patients.'* However, collegial supervision seems difficult to practice. The new or novice physiotherapists try to contact more experienced colleagues but these are often busy and so it seems difficult to benefit the patient: *'Of course, I often experience situations where I don't know what to do. Then I ask my colleague – he always knows [...] But often he hasn't got the time, [...] he is treating patients, and then I have to wait. Sometimes until after my patient has left. The day ends [...] I don't know. I don't feel well. I don't*

know if I have benefited the patient.' Some wish for a collective strategy for employing novices at private clinics. Today the conditions are equal for all employees, which some see as an ethical issue with potentially harmful implications: *'I mean, in some cases it turns out to be the second best to have my new employee with two months of experience treating the patient compared with my 20 years. And how can the patient know? [...] This can never be in the patient's interest.'* Lack of sufficient knowledge, skills and experience by the novices is understood as a risk of harm to patients who willingly and freely enter private practice.

Furthermore, some physiotherapists wish for collective cooperation about specialised treatments within each region in Denmark where expertise in specific areas can be achieved, e.g. treatment of children with severe handicaps, treatment of adults with neurological handicaps, work-related injuries and workers' compensation. This is seen as a way to minimise the risk of inflicting harm due to inadequate knowledge and/or experience within these very limited areas of private practice.

Finally, the physiotherapists suggest that The Association of Danish Physiotherapists must put forward both professional and ethical arguments in future collective bargaining in order to avoid risks of harm: *'Some of our ethical issues occur because of conflicting interests in our professional codes of conduct and governmental restrictions and rules [...] Honestly, who can imagine an optimal treatment of patients with severe physical handicaps when government rules restrict how many treatments a patient can receive per week? Maybe the patient this week needs daily treatment whereas he only needs two treatments the next day, [...] or even no treatment.'* The voice of the trade union is seen as a political and powerful voice in relation to doing good physiotherapy in practice.

Discussion

The results show how physiotherapy in private practice is perceived from an ethical perspective. It seems obvious that beneficence in practice means doing well both for the patients and for the physiotherapists and their business. In the immediate, this is contradictory to the normative medical discourse about beneficence in which it is only described as beneficence towards the patient (Beauchamp and Childress, 1979; 2009; Wulff et al, 1990).

The results indicate that practicing beneficence is perceived as an ongoing balance between the three elements; you, me and my business. The risks of inflicting harm are only broached in relation to the patient and never in relation to the physiotherapists themselves or the business. In practice, inflicting harm to the patient is also in contradiction to the normative medical discourse that you should not harm (Beauchamp and Childress, 1979; 2009; Wulff et al, 1990; Singer, 1991; Aadland, 2000). On the other hand, this norm is attenuated in that it is acceptable to inflict harm in order to do good in the long run: "All wounds must hurt before they can heal." This way of thinking is by no means new in medicine where for example a high level of side effects is acceptable if only the treatment has a curative goal for instance oncological chemotherapy (Beisecker et al, 1997; Matsuyama, 2006). It is not immediately surprising that self inflicted harm is no issue, either in relation to one's person or one's business because it is perceived as self-destructive behavior in western countries (Baumeister and Scher, 1988).

The results show that physiotherapists see professionalism and personality as integrated both in their understanding of physiotherapeutic practice and in their reflections about what it requires being 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. This is in line with Riesman's ascertainment that the underlying understanding of western healthcare services is based on the idea that 'the goods in demand is neither raw material nor machines; it's personality' (Riesman, 1985). The physiotherapists' perception of personal commitment is embedded in their understanding of beneficence towards the patient; they engage their personal ethos, which is in line with the modern patient's search for inner welfare (Pittelkow, 2001; Potter et al, 2003a, 2003b). Obviously it has the implication that physiotherapists define attributes and characteristics that have previously been confined to the personal sphere, as being professionally necessary attributes and characteristics. The need for physiotherapists to be committed and attentive in a bodily, emotional and mental sense is also shown by others (Gard et al 2000; Potter et al 2003a, 2003b), and 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. Supervision seems to be a possible method for integrating the professional and personal dimension. Supervision is here understood as a formal setting where one's personality can be formed, reformed and transformed by the collective of colleagues (Bang and Heap, 1999; Glasdam 2008).

Furthermore, their efforts crystallize into diplomas: visual evidence for competences. This places the physiotherapists within a dilemma: do considerations for beneficence towards the patient or for oneself carry most weight? However, this discussion must be seen in the light of the ongoing trend of lifelong learning (Hager, 2004; Jørgensen, 2007; The European Commission, 2011), where education seems to be the answer to every question in modern society in general, and within the healthcare sector in particular; confer the pervasive concept called education of patients and relatives (Glasdam et al, 2010).

In the efforts of practicing a professional activity, it appears as if the physiotherapists – non-consciously – take on a paternalistic approach towards the patients: The physiotherapists know beforehand what is best and which direction to take. This way of approaching the patient implies an understanding of the patient autonomy as giving or refusing consent. This differs from the normative textbook definitions of the concept of autonomy where for example Beauchamp and Childress (2009) state that to respect autonomous people is to acknowledge their right to hold views, to make choices, and to take actions based on personal values and beliefs. This reveals an embedded conception of the physiotherapists' knowledge as being superior; an implicit and tacit hierarchy of power and knowledge (Foucault, 1979). Furthermore, this reveals an implicit expectation about which patients can or cannot be disciplined, just as some patients are considered 'difficult', a finding also reported by others (Glasdam, 2003; Potter et al, 2003c; Michaelsen, 2012). In the latter study, the 'difficult' patients are apparently people who are positioned with either higher or lower social status than the health professionals themselves. In regard to patients with higher social status, the physiotherapists have to relate to these people; the patients claim their knowledge and competences and hereby they are able to control the physiotherapists due to their knowledge of symptoms and sickness, therapies and treatments. In order to meet these people, the physiotherapist must spend more time than allocated by governmental rules of subsidy. Furthermore, it has been shown that people from higher positions in society have a tendency to make claims on healthcare services; to take time and attention from the professionals and, in general, they succeed (Glasdam, 2003).

The 'difficult' patients with a lower social status, for example uneducated persons from other cultures than Danish, also call for more than the allocated time as the meetings present different

cultural codes for what physiotherapy is all about (Potter et al, 2003c); this is also seen in other health care professions, for instance nursing (Michaelsen, 2012). In the context of being a liberal business, consideration of one's own income carries weight, which is also shown by others (Praestegaard, 2001; Greenfield, 2005; Glasdam et al, 2013). Some patients' need for time is prioritised; especially patients who willingly allow for the physiotherapists to discipline them; who willingly follow 'the rule of the game'; a fact that refers to a daily practice of social exclusion and discrimination of certain patients and groups of patients in healthcare practice in general (Glasdam, 2003; Järvinen and Mik-Meyer, 2003; Michaelsen 2012). As the results show, this also applies for Danish private physiotherapy practice.

Per definition, the physiotherapists in private practice depend on the patients' willingness to choose treatment at their clinic and not at the competing clinics of physiotherapy or other comparable professional clinics. This fact makes private practice differ from other physiotherapeutic practices in Denmark, since the latter are 100 % governmentally financed, but resemble other western countries' way of organising physiotherapy (The chartered society of physiotherapy, 2012; The Royal Dutch Society of Physical Therapy, 2012). Thus, private practice physiotherapists inscribe themselves in a self-employed practice, regulated by neoliberal market mechanisms; when the demands increase the supply will as well, and vice versa, in order to maintain balance (Harvey, 2005; Kjellberg et al, 2009). This frame of logic places the physiotherapists in a constant dilemma between consideration for the patient and for themselves as company owners. The physiotherapists are therefore forced to – without their conscious will – to shape the patient, to make the patient manageable within the given structural frame, and this

already within the first meeting (Praestegaard and Gard, 2011) - a characteristic well known from the medical clinic (Foucault, 1973).

Through invisible and unexpressive disciplining, the patient accepts the conditions for physiotherapeutic activity and treatment can start. The circle closes: the patient's experience of good physiotherapy – success – prompts the physiotherapist's professional and personal acknowledgement and financial success. As a way of ensuring new patients the activity has an inherent customer-recruitment-perspective: satisfied patients mean potential new or returning patients. Increased income may result in increased wages, more postgraduate courses and education, improvements or expansion of facilities and clinic. In ethical terms, this relates to a distinction between ethical egoism which holds that one ought to do what has the best consequences for oneself (Driver, 2007), and classic utilitarianism where the scope of relevant consequences is the well-being of all persons considered impartially (Driver, 2007; Shafer-Landau, 2007). The patient benefits from feeling well, the physiotherapist benefits by being of use and by making money, and society benefits from satisfied citizens and an apparently efficient and well-functioning healthcare service. It seems that the physiotherapists fight an individual battle for professional autonomy and acknowledgement and this seems to be intensified by the awareness of the inter-collegial competition for the patients.

Conclusion

Private practice physiotherapy is embedded in a structural frame directed by both political and economical conditions that shape the conditions for practicing physiotherapy. It means that beneficence in practice is a balance between the patient, the physiotherapists themselves and the business. Beneficence towards the patient is expressed as an implicit demand in a relational

profession. The risk of inflicting harm is only an issue in relation to the patient, brought forth by the intension of doing good in the long run.

Physiotherapeutic practice is expressed as being an integration of professionalism and personality, in which the physiotherapists have to engage with all of their uniqueness, as well as with their human, social and professional knowledge. This implies that the physiotherapists also have to benefit themselves.

All in all, private practice seems to be driven by a paternalistic approach towards the patient, where disciplining the patient into 'the rule of the game' is a crucial element of practice, in order to exploit the politically defined time frame for optimising profit. Physiotherapy as a self-employed practice within a neoliberal market orientation has embedded a fight about the same patients, which implies that trustworthiness is regarded as very important by the physiotherapists in order to recruit and keep the patient within their practice.

The dreams of postgraduate education, collegial supervisions, organisational and professional specialisation seems to bridge the actual Danish private practice and the wishes for a more beneficent practice in the future; bridging 'to be' and 'ought to be' from the view of not inflicting harm to the patient and from keeping standards of due care.

The study's transferability is limited as we only present the narrative perspective of the Danish physiotherapists in this study. In order to catch the real relationship in the private physiotherapeutic practice, the observed and narrated experiences from both the physiotherapist and the patient are needed, preferably from different contexts and nationalities of physiotherapy.

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