Danish University Colleges

Ethical issues in physiotherapy – Reflected from the perspective of physiotherapists in private practice

Præstegaard, Jeanette; Gard, Gunvor

Published in:
Physiotherapy Theory and Practice

Publication date:
2013

Document Version
Pre-print: The original manuscript sent to the publisher. The article has not yet been reviewed or amended.

Link to publication

Citation for published version (APA):

General rights
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal

Download policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.
Ethical issues in physiotherapy – Reflected from the perspective of physiotherapists in private practice

Jeanette Praestegaard, PT, MSc, Stud.PhD¹,² and Gunvor Gard, PT, MSc, PhD¹,³

¹Department of Physiotherapy Health Sciences, Health Sciences Center, Lund University, Lund, Sweden
²Lecturer, Department of Physiotherapy, Metropolitan University College, Copenhagen, Denmark
³Assistant Professor, Department of Health Sciences, Luleå University of Technology, Luleå, Sweden

ABSTRACT

Background: An important aspect of physiotherapy professional autonomy is the ethical code of the profession, both collectively and for the individual member of the profession. The aim of this study is to explore and add additional insight into the nature and scope of ethical issues as they are understood and experienced by Danish physiotherapists in outpatient, private practice. Methods: A qualitative approach was chosen and semi-structured interviews with 21 physiotherapists were carried out twice and analyzed, using a phenomenological hermeneutic framework. Results: One main theme emerged: The ideal of being beneficent toward the patient. Here, the ethical issues uncovered in the interviews were embedded in three code-groups: 1) ethical issues related to equality; 2) feeling obligated to do one’s best; and 3) transgression of boundaries. Conclusions: In an ethical perspective, physiotherapy in private practice is on a trajectory toward increased professionalism. Physiotherapists in private practice have many reflections on ethics and these reflections are primarily based on individual common sense arguments and on deontological understandings. As physiotherapy by condition is characterized by asymmetrical power encounters where the parties are in close physical and emotional contact, practiced physiotherapy has many ethical issues embedded. Some physiotherapists meet these issues in a professional manner, but others meet them in unconscious or unprofessional ways. An explicit ethical consciousness among Danish physiotherapists in private practice seems to be needed. A debate of how to understand and respect the individual physiotherapist's moral versus the ethics of the profession needs to be addressed.

INTRODUCTION

In this study, we wanted to explore the ethical dimension in physiotherapy outpatient, private practice due to a growing focus on professional autonomy within the physiotherapy profession (Rothstein, 2003; Sandstrom, 2007; Swisher, 2002). Professional autonomy can be defined as a social contract based on public trust in an occupation to meet a significant social need (Sandstrom, 2007). To keep up the autonomy of the profession, it is therefore important for the given profession to accommodate the requirements from politicians, patient organizations and researchers for direct communication, co-management, and decision-making within every aspect of physiotherapy (Amtsrådsforeningen, 2003; Potrer, Gordon, and Hamer, 2003a, 2003b; Scott, 2000; Solomon and Miller, 2005), together with the requirements for solid, evidence-based practice (Carr, 2000). Within the last four decades, the physiotherapy profession has experienced an increase in professional autonomy. An important aspect of professional autonomy is to have a prominent ethical dimension (Carr, 2000), both collectively and for the individual members of the profession. The growing autonomy thereby increases the need for formal ethical considerations for physiotherapists and serves to focus more clearly on the individual physiotherapist’s ethical competence: the ability to identify; to examine; to assess; and to decide in relation to the ethical issues in daily practice.

The increased interest in ethical issues and dilemmas facing physiotherapists is, on one hand, reflected in the recent years of formal codifications of and
Physiotherapy in private practice

In this study, we focused on private practice physiotherapy since almost 40% of all physiotherapists in Denmark are employed in private practice (Association of Danish Physiotherapists, 2008). The rest are employed within the public setting: hospitals; municipal institutions; or university colleges, which are fully subsidized by government funds.

Physiotherapy in private practice must be considered both within an organizational frame and a frame of meaning (Thornquist, 2010), both of which must be unfolded to set the context of this study.

According to Danish law, physiotherapy in private practice is granted federal subsidies, so that people that receive physiotherapy pay about half the cost and the government covers the rest. The subsidies are specified within different categories: first consultation; individual treatment; follow-up treatment (requires a physician's referral); and group treatment (Association of Danish Physiotherapists, 2007). A typical private clinic in Denmark is owned by one physiotherapist, often senior, who has two to four physiotherapists leasing in at the clinic. Each physiotherapist operates as an independent practitioner.

People receiving private practice physiotherapy in Denmark may have all sorts of acute problems such as sports injuries, pain in the neck or back, tennis elbow, or sub-acute problems such as low back pain and muscle tension/spasm. Also, people with severe physical handicap or functional limitation due to progressive illness are offered treatment in private practice physiotherapy free of cost through a physician's referral. Furthermore, some private clinics offer home treatment to people who are too ill to go to the clinic or palliative patients. The nature of the physiotherapy process includes examination, diagnostic assessment, evaluation, prognosis, plan of treatment, and re-examination in close interaction with the patient. From this follows that physiotherapy is relational (Schriver, 2004).

The ethical frame of understanding of the study

In this study, we use the term Ethics in reference to Purtillo (1999), who states

Ethics is a systematic reflection on morality: Systematic because it is a discipline that uses special methods and approaches to examine moral situations and reflection because it consciously calls into question assumptions about existing components of moralities that fall into the category of habits, customs, or traditions.

The term moral refers to a group of notions about what is right or wrong, in connection with one's own or others' actions (Aadland, 2000).

We base ourselves on the understanding that ethical issues are relational situations where one needs to weigh alternative actions toward a moral problem (Beauchamp and Childress, 2009) and that ethical issues are embedded in every clinical encounter, reasoning process, and practice (Poulis, 2007a, 2007b; Praestegaard, 2001; Purtillo, 1999). Ethical issues in physiotherapy can be about how to maintain a professional proximity in the close and, mostly, continued relationship between physiotherapist and patient where both physiotherapist and patient are being touched by one another, bodily, mentally, and emotionally (Poulis, 2007a, 2007b) without entering the personal sphere in which friendships occur. Ethical issues can be about how to manage the given power asymmetry; the patient comes to the physiotherapist in a vulnerable state and since imbalance in knowledge, power, and authority is a condition, the physiotherapist must constantly be aware of the inherent vulnerability of the patient, even when there is a need to engage in a process of mutual partnership. Also, ethical issues can be about how to communicate in a respectful manner with all clients regardless of age, level of education, ethnicity, or how to live up to the patients' right to self-determination and privacy during all aspects of the course (Potter, Gordon, and Hamer, 2003a, 2003b, 2003c; Praestegaard, 2001).
Ethical issues can entail ethical dilemmas which we define as relational situations, filled with doubt and ambivalence; where the physiotherapist has to choose between action alternatives that will have negative consequences for the patient (Aadland, 2000). In Denmark, the health care offers are administrated and managed within a neoliberal ideology where the fundamental idea is to minimize the government spending by privatizing as many welfare services as possible. One of the purposes of the government is to control and manage the services that are not privatized, or only partly privatized (e.g., physiotherapy in outpatient, private practice) to ensure efficiency and financial profitability (Harvey, 2005). In the neoliberal logic, this means that there is an inherent, evident ethical dilemma in relation to physiotherapy in private practice: How can the patient be certain that his/her treatment is finished? And that he/she has been offered the optimal treatment and is not just a safe source of revenue where another couple of treatments would be needed? – a dilemma also discussed by Poulis (2007a, 2007b).

**METHODS**

Based on the purpose of this study, we choose to use a qualitative research approach based on phenomenological hermeneutics (Malterud, 2003). Phenomenology is a philosophical approach to the study of experience. Hermeneutics is the theory of interpretation. As a phenomenologist one seeks patterns of experience in order to grasp the meaning of the phenomena in question (Malterud, 2001a). When having described the meaning of the phenomena in question, as faithfully as possible to the interviewees' understandings and experiences, one is as analyst implicated in facilitating, making sense of, and interpreting this appearance (Dahlberg, Drew, and Nyström, 2001).

**Study design**

Studying lived ethics can be difficult because human beings live and act out their morals (i.e., internalized habits and customs, values and attitudes) without necessarily knowing about them as they mostly are tacit knowledge for the individual. For this reason, you cannot just ask people what morals they have (Lindseth and Norberg, 2004), and as previous research has shown that physiotherapists in Denmark generally have a vague ethical awareness (Praestegaard, 2001), we have chosen to carry out two interviews with each interviewee. By giving our interviewees time to reflect upon the subject of the study between the two interviews, we assumed that time would provide deeper and more reflected answers.

To gain access to the physiotherapists' ethical awareness, we were inspired by Lindseth, Marhaug, Norberg, and Udén (1994) and Udén, Norberg, Lindseth, and Marhaug (1992) method of asking doctors and nurses to tell stories about ethically regrettable situations and issues they either had done, participated in or witnessed as these questions led to exciting stories. But of course their morals or ethical thinking are not expressed in the stories, but remain for the researcher to analyze and interpret (Lindseth and Norberg, 2004). First, we asked the interviewees to narrate about good situations they themselves had experienced. Situations where they would say: “Yes, here I really did the best. Here I met the patient both professionally and humanly”. By telling the good story first, the physiotherapists were able to present their most positive understanding of themselves and we assumed that this would make it feel less provocative and more legitimate to talk about difficult and regrettable stories. When the story was told, the first author asked if the interviewee could identify an ethical issue within the story. What was important for us was to find out if the interviewee was able to identify an ethical situation in the first place; it was less important whether the interviewee was able to define the situation as an ethical issue or dilemma. The first author then asked the interviewee to reflect about the constitution of “the best” physiotherapy both professionally and ethically and about situation(s) from private practice which the interviewee experienced as ethical issues. In the second interview, the first author focused on: in-depth reflections and/or adjustments to the first interview, further reflections and narratives about “the best” and/or regrettable situations and/or professional conduct related to the process of physiotherapy (see Appendix for elaboration). To strengthen the validity of internal meaning, the second interview was furthermore regarded as a triangulation tool (Malterud, 2003).

**Sampling**

The purpose of our sampling strategy was to obtain a sample of physiotherapists in private practice with a wide range of experiences, due to our assumption that ethical issues can emerge in any clinical meeting.

**Procedure**

An invitation letter introducing the subject of the study and asking for interested participants was sent out to 31 clinics across all regions in Denmark. Then, 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 selected physiotherapists should: speak fluent Danish and work in private practice irrespectively of gender, age, work position, experience, or geographical region. Twenty-two participants, from 22 different clinics, willingly agreed to take part in two interviews related to professional issues, all of which signed a written informed consent. One of the 22 was excluded due to upcoming maternity leave. For the characteristics of the interviewees see Table 1.

Ethical considerations

The study followed the principles of the Helsinki declaration and all participants were informed about the purpose of the study and told that they could withdraw from the interview at any point without explanation. Verbal and written 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 not legally required for this type of study (http://www.cvk.sum.dk).

Procedures of the interviews

Face-to-face, semi-structured, tape recorded interviews were conducted twice with each participant by the first author. Emerging themes from the first interviews were explored in the second interviews in order to stimulate the participants' ethical awareness and in this way stimulate thickened descriptions of reflected and deeper understandings. At the second interview, it was possible further to explore, verify, refine, and add reflections and acts to earlier descriptions. The majority of the interviews were carried out in the clinic which gave a solid frame of reference for understanding and validating the comprehension of the interviewees' life world and example. A few were carried out in private homes or in a neutral office according to the participant's preference. The first interview lasted 45–60 minutes, and the second 30–45 minutes. The time span between the two interviews varied between 1 and 2 months to allow time for settling the understanding of ethical issues within the initial encounter. One interview had a 5 month span between the two interviews due to the interviewee's business. Notes about the interview situation, the process and other impressions were written down immediately after both interviews with each participant and were used to contextualize the accounts and to help with orientation and understanding during the analysis.

Audiotapes of the interviews were transcribed verbatim by a secretary and were validated by letting the first author read the transcripts while re-listening to the interviews to promote validity.

Analysis

All interviews were analyzed as a whole according to Malterud (2001b and 2003) which presents a four step modification of the principles of Giorgi's (1985, 2000) phenomenological analysis. The first author followed the strategy called editing analysis style (Miller and Crabtree, 1999).

(1) Reading all the transcripts to get a general sense of the whole statement. In this step, one keeps an open mind to any impressions given by the material and to whatever knowledge bearing themes one may discern in the material, and one strives actively to put aside one's preconceptions and theoretical frames of reference. The first author hereby identified five themes: 1) being and acting beneficently; 2) equality issues within the situations; 3) transgressing boundaries; 4) special situations; and 5) information.

(2) Re-reading the material to discriminate units with meaning from an ethical perspective. At this step, units of meaning were identified, consisting of the first author's interpretation of text

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>12 (57)</td>
</tr>
<tr>
<td>Male</td>
<td>9 (43)</td>
</tr>
<tr>
<td>Years of service in private practice</td>
<td></td>
</tr>
<tr>
<td>1–5</td>
<td>3 (14)</td>
</tr>
<tr>
<td>5–10</td>
<td>6 (29)</td>
</tr>
<tr>
<td>10–15</td>
<td>4 (19)</td>
</tr>
<tr>
<td>15–20</td>
<td>4 (19)</td>
</tr>
<tr>
<td>20–25</td>
<td>3 (14)</td>
</tr>
<tr>
<td>25–30</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Type of conditions of service</td>
<td></td>
</tr>
<tr>
<td>Owner</td>
<td>11 (52)</td>
</tr>
<tr>
<td>Renter</td>
<td>6 (29)</td>
</tr>
<tr>
<td>Employed</td>
<td>2 (9.5)</td>
</tr>
<tr>
<td>Self-employed</td>
<td>2 (9.5)</td>
</tr>
<tr>
<td>Individual or working together with in a clinic</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>3 (14)</td>
</tr>
<tr>
<td>Working in a clinic</td>
<td>18 (86)</td>
</tr>
<tr>
<td>Having continuing education</td>
<td>20 (95)</td>
</tr>
<tr>
<td>Having further education (academic)</td>
<td>2 (10)</td>
</tr>
</tbody>
</table>

TABLE 1 Characteristics of participants (N = 21).
units from the themes from step one that would represent statements made by the interviewees that contained a single idea about the phenomenon in question. All the units were labeled with a code. This is a modification from Giorgi's original description where significant statements are identified from all the text (Malterud, 2001b, 2003). By coding the units of meaning, it became possible to start classifying the units. As Malterud (2003) describes, this process opens the possibility that the intuitive classification of themes from step one may have to be altered or reversed as one theme may represent two themes of different underlying understandings, or two themes may represent different sides of the same understanding.

Step two entailed a systematic de-contextualization. We composed a matrix of organization to secure a survey of the process. The matrix showed each interviewee horizontally and the emerging code-groups vertically. At each cross-section of the two columns, the units of meaning where placed. Hereby, it was visualized how each interviewee contributed to develop the coming code-groups.

(3) This step Malterud (2003) calls Condensation. When condensing the content of the units of meaning, code-groups, and various subgroups emerged.

The text was hereby interpreted from the first author's professional perspective and standpoint. To strengthen internal validity, the first author discussed the emergence of each code-group and subgroups with the second author to make room for alternative interpretations and possible approaches. The discussions resulted in one main theme with three code-groups and their subgroups (Table 2). The theme, the code-groups, and the subgroups were validated for each interviewee along both interviews and across all interviews in discussions with the second author.

(4) In the fourth step, the theme, code-groups, and subgroups were synthesized into a consistent description of content for each. From the matrix, quotes from each code-group and subgroup were selected together with the second author in order to document and root the descriptions. Quotes were translated from Danish to English by the first author and then retranslated and
discussed with an external translator to maximize agreement on the content of meaning. Finally, the theme, code-groups, and subgroups were given a conclusive headline.

RESULTS

Generally, the interviewees revealed a great overall interest in ethics and a great diversity in the understanding of what constitutes ethical issues in physiotherapy private practice.

The results of the analysis emerged as one main theme: the ideal of being beneficent toward the patient. This main theme expressed how looking out for the best interests of the patient was the central focus of ethical care in private practice. The theme expressed itself in various ways and to a varied degree of depth by all interviewees and represents all forms of reflections and actions intended to benefit the patient.

The ethical issues uncovered in the interviews were embedded in the following code-groups and their appertaining subgroups: 1) ethical issues related to equality; 2) feeling obligated to do one's best; and 3) transgression of boundaries, please see Table 2 for illustration.

Ethical issues related to equality

This code-group contains the interviewees reflections on how the understanding of ethical issues was related to equality in the physiotherapist–patient relationship and on how the interviewees acted upon these from a perspective of beneficence. The code-group encompassed three appertaining subgroups: 1) being equal partners in the relationship; 2) patient advocacy; and 3) relating unreflectedly toward one's role.

Being equal partners in the relationship

Some interviewees argued for an interactive role in professional practice from an ethical perspective. They considered themselves and their patients as morally equal partners. They took pride in identifying the needs of the patient through dialogue and had many examples of how they struggled to ask the right questions in order to improve patient resources and autonomy.

I see the patient as an equal partner; he knows about his symptoms and life and I know about physiotherapy. If I don't have the patient bring forward his resources, thoughts and expectations, how can I succeed? Physiotherapy must be interactive – otherwise it is expert pressure (paternalism).

Some further argued in favor of an interactive role in consequence of the professional status given by society. They felt obligated to care for the patient as an equal human being and considered their conscious professional role as equal partners as a means of avoiding or minimizing some ethical dilemmas:

We have to be aware that as professionals we have to meet the demands and expectations of society. That's an obligation we have. Otherwise society has every right to withdraw its acceptance of our professional autonomy. ... Patients want to be involved, ... we have to involve them, and also because research shows that the patients' understanding, insight and activity contribute to the healing process. In my experience this also helps to avoid basic ethical conflicts.

Patient advocacy

Patient advocacy was an important part of ethically sound professionalism for most interviewees. Advocating implied recognizing that for some patients it was difficult to obtain a fair and equitable healthcare on their own and in these cases the interviewees told that they felt ethically obligated to take action. They related using their professional power to push the way for the patient:

Sometimes I act on behalf of the patient (e.g. I phone the physician for a quicker service for the patient).

Some considered themselves as experts who had to take special care of their (vulnerable) patients and they found it crucial to do so despite other demands on their time.

I see it is as a professional duty to reflect holistically on the child's situation; attending meetings, being active when the family has to choose institutions or assistive technologies, when there needs to be taken action on grant application for lost earnings, ... I act as an advocate for the individual patient – no matter how much time it requires.

Their actions varied: making contact with the physician; ensuring referral to medical specialists; or writing letters to insurance companies. Some further told about doing personal favors like shopping or visiting former patients to ensure their well-being.

A particular ethical call to advocate for patients with learning disabilities or cognitive deficits was expressed:
I cannot live with myself if I don't act upon the troublesome and tiresome issues these patients and their families are subjected to. I have to act. It is a personal moral drive. I sometimes act even before the family becomes aware of the issues. In this way I try to prevent them from more pain and distress than absolutely necessary.

Another ethical aspect of patient advocacy revealed itself; some private clinics offered home treatment to patients who were too sick to get to the clinic and, in this setting, these interviewees had several reflections on ethics. They felt that the power balance was altered when the therapy took place in the patient's private home where the patient defined the setting. They expressed difficulty coping with this. They further expressed the feeling of being alone, insecure, and in lack of tools when dealing with very sick and/or palliative patients:

Then it turns out that the patient has a severe cancer. And three weeks later I take her as a terminal patient, and treat her in her home. She specifically asks for me. It turns out she has only weeks to live – it can only go in one direction, and here I must transgress myself into some of her territory of death and sickness, … and this disregarding the fact that I usually help patients. Now I cannot do this. I can't heal her. And the patient clings to me as a hope, as the miracle. It is so difficult. I find it very difficult. I lack the tools for handling such a process. … How to do the best for the patient?

Relating unreﬂectedly to one’s role

A few interviewees did not express themselves about this subject in either interview and, when asked, they had no comments.

Feeling obligated to do one’s best for the patient

This code-group has eight appertaining subgroups, which are presented below.

It is my duty to do the best

All interviewees claimed to do their absolute best for their patients, and when asked “Why?” they referred to the professional obligation.

I see it as my duty to do my best for the patient. That's what I have learned. To remove pain and harm. Do my absolute best. … I don't really know why. Is it tradition? Culture? Morality? Christianity? I don't know – but I have to do my best.

Some favored systematic tools and they mentioned McKenzie's examination manual as an applicable guide to do one's best and to minimize ethical issues of occurring. Some, who used the manual systematically, addressed the ethical issue a systematic tool could encompass; physiotherapy by habit without having the unique patient in focus:

Well, I can see one ethical issue in this; physiotherapy by habit … due to business. Maybe forgetting the patient as a person … Maybe primarily focus on diagnosis …

Some expressed a daily ethical dilemma; not knowing how to do one's best for the patient and not really knowing how to cooperate with the patient due to lack of experience. They felt that they did not live up to their professional obligation. In these cases, they turned to more experienced colleagues but as the colleagues often were busy, they described it as an ethical dilemma and a personal frustration:

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 the time … he is treating patients so then I have to wait. Sometimes until after the patient has left. The day ends … I don't know. I don't feel well. I don't know if I have benefitted the patient … it's frustrating.

Another ethical aspect of lack of experience appeared as surprise at realizing how important psychosocial issues are in the process of physiotherapy. Some interviewees felt unprepared to deal with these:

Physiotherapy is about all aspects of human life, but I have never realised the amount of psychosocial issues involved. I feel so unprepared. So many questions, feelings and knowledge I don't know what to do about and … not knowing if it is beneficial. Whether it is physiotherapy (I am providing)?

They considered their lack of competence in coping with psychosocial issues as a major ethical dilemma, often resulting in handling the situation too rapidly as a means to reduce their own emotional stress.

Some interviewees only considered their physiotherapy intervention to be successful when the physiotherapy had benefitted the patient, and therefore found it very stressing and frustrating when they were not able to live up to their own expectations about beneficence:
I find it an ethical issue not to be able to deliver successful treatment to all the patients that enter my clinic. I mean what is that? ... I see it as my professional duty to provide beneficence to all.

*Postgraduate education is the road to achieving and maintaining professionalism*

Some interviewees sought to become capable of acting out their obligation to beneficence through further education. They found it essential that physiotherapists were able to respond to patients' and society's demands for evidence-based treatments and beneficence and they invested their earnings to gain knowledge and skills in a broad range of different education offers.

I see it as a means towards beneficence. If I don't know about evidence, if I haven't attended some education courses, I mean in the broad sense; ... how do I really know how to treat the patient right? I find lifelong education necessary for providing physiotherapy in the patients' best interests.

Others reflected differently:

Of course we attend further education. But we don't make a big fuss about it. I have taken a few courses, but I do not really feel I have learned anything. So I haven't participated in any for the last several years.

A few told that they did not bother about further education:

Well, I have a lot of patients. They must feel satisfied otherwise they wouldn't return.

They leaned on experience.

Science here, science there. It is all bullocks! The only thing that counts is that the patient feels better. We have to assess our success by doing something that works.

For some interviewees it was important to express worries about ethical dilemmas related to the lack of scientific evidence in physiotherapy.

I regard it as a disaster that so many elements of physiotherapy aren't evidence-based. Without this we can never gain optimal acceptance (from society) because we can't explain what we are doing. We don't know why the interaction was successful, just that it was. How can we consider this to be in the patient's best interest? That's not professionalism... That's the professions ethical dilemma.

Obligatory participation in supervision groups was mentioned as a method by which personal or professional difficulties, successes, or new knowledge could be shared among the employees in a clinic in order to promote consciousness in a daily practice:

I tell my physiotherapists that if they want to work here they have to undergo supervision. We touch people and we are touched by people. That is very important to be aware of in order to truly benefit the patients.

One told about having contracted a psychologist to work with his team monthly to ensure the personal, professional, and ethical well-being and standard.

*Feeling forced to circumvent the rules*

Another ethical dilemma of enacting beneficence toward the patient revealed itself. Several interviewees explained how they circumvent rules of governmental subsidies in order to ensure beneficence toward the patient even though it was illegal:

Private practice is subjected to rules; very specific rules about how many times a person can receive treatment per week and so on. So, when we have patients that need more treatments than the rules allow, who are really in pain and agony, ... then I kind of mingle dates and bills in order for them to seem correct ... Yes, it's illegal. And why do I bother? ... In the patients' best interest, of course.

*Being respectful of patient autonomy*

Some interviewees described respect for patient autonomy as an essential part of beneficence.

They stressed the importance of incorporating patient education strategies and insight into their efforts to provide beneficence toward the patient. They told of teaching patients how to perceive, interpret, respect and accept body signals and emotions, and explained how these abilities can become tools for the patient and increase patient autonomy. Others did not articulate reflections upon patient autonomy.

*Being beneficial by telling or not telling the truth*

Some told that they were doing their best to tell the truth to all patients and found it ethically right and natural to express it when they felt uncertain or insecure. In these situations, they would try to find the right answers for the patient – or for themselves – before the next session. Some expressed considerations about how to keep a patient informed about his/her condition or progress of treatment or how to answer difficult questions truthfully, and they considered this an ethical dilemma:

8 Praestegaard and Gard

*Copyright © Informa Healthcare USA, Inc.*
Especially when I have eager patients I can feel trapped. They want so much to have all the answers, but sometimes there just are no answers to when this symptom will end or how the prognosis will turn out. I don't know what to say, and I feel inferior. I feel I am not being honest with the patient – I can't say that I don't know because it sounds unprofessional and I can't invent an answer. But since the patient expects an answer I sometimes make one up. To their benefit. But, ... This, I assume, is an ethical dilemma?

*Being in special situations – insurance claims*

Some interviewees identified ethical issues relating to one special situation (i.e., insurance claims). These situations were especially difficult to handle since they appeared so rarely and it would thus be difficult to obtain routine and hard to keep up with the latest knowledge in the area. The interviewees felt alone and under pressure while having important decisions to make concerning patients' life and future economical situation and they expressed great vulnerability toward patients' wishes and pushy demands.

I reflect when a patient comes to me and says “my job is too hard, it makes me sick, please help me”. It is always a weighing between the person not getting sick from his job, and the fact that all jobs wear people out. We cannot manage the same at age 55 as at age 25. This I find is an ethical dilemma; when is it fair to put one's foot down, and when is it not? ... Or how long is it acceptable to wait when the patient needs his pension today? How can we best support the patient?

They acted by cooperating with the referring physician and/or performing extensive, time-consuming examinations, and often it would take years to reach a final conclusion:

it can take years to reach a decision and this I believe is another ethical issue, because how long time is appropriate when the patient is in pain and distress?

*To be or not to be obliged to document the process*

Some documented their interventions, and argued on basis of beneficence toward the patient and professional duty. They primarily documented successful functional measures, treatments and/or process descriptions. One explained that, for the last 25 years, she had written journals on every patient. Others never documented their examinations or treatments, giving as reasons lack of time and lack of governmental subsidies for documentation. They further explained that they felt able to remember their treatments and successes. Only a few of these interviewees regarded their lack of documentation as entailing ethical aspects.

*The dilemma of being beneficent versus doing business*

Some interviewees narrated about the interface between beneficence toward the patient versus doing good business, and were aware of their personal and professional honesty and role:

If I don't deliver real and honest therapy then I have no business.

They found that if the professional argument for physiotherapy was missing, it gave bad, bad business. Others did not have much to say on this issue and became quiet when pushed.

Some commented on an ethical issue that the rest of the interviewees did not address. They expressed great responsibility toward their patients and worried about whether the patients got good value for their money. They felt that their patients were not getting better as quickly as if they had been treated by more experienced colleagues and therefore felt it difficult to ask for payment for their service. They described this as a difficult ethical issue to handle:

The patient does not know if they “buy a pig in a poke”.

*Transgressing boundaries*

This code-group contains the following three subgroups: 1) transgressing bodily boundaries; 2) transgressing cultural boundaries; and 3) transgressing privacy.

*Transgressing bodily boundaries*

The interviewees had numerous reflections on the risk of humiliation and violation due to the necessity for patients to uncover parts of their body for the physiotherapy examination and treatment. Some were able to recall actual situations at first but when given time all were able to identify many examples. They described several strategies to prevent affront, humiliation, violation, or abuse toward either the patient or themselves. Their main strategy was information: information about the setting; the need for examination and examination positions; treatment and treatment positions; the professional rationale for closeness to the skin, muscles, and joints to optimizing the therapy; offering explanation to findings; and ensuring the patients' understanding of this.
Some further expressed the need of a firm hand, eye contact and a matter of fact approach as main strategies to avoid transgression of bodily boundaries.

Transgressing cultural boundaries
The most difficult situations of protecting patients’ boundaries were described as situations with patients from other cultures than Western, where the understandings of sickness, health, responsibility, and gender differed fundamentally. In these situations, some felt in lack of professional power and of proper tools and the sessions often ended with a feeling of inflicting more harm than beneficence.

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, but then she refuses to participate and then I try the second best. But it is not the best! In a way I am being caught between a rock and a hard place. This ethical issue is relentless.

Some further expressed frustration, embarrassment, disbelief, annoyance, helplessness, or difficulties in putting their foot down toward male patients from other cultures than Western.

It was not long ago. I had a male patient. He was very nice but he had this attitude that he had to stand with his legs apart. He was not tall. He needed space to appear big. His first question was whether I had any children, and my first reaction was: What is it to you? Had it been another male patient, I would have answered that I have three boys. I don’t know what triggered me; body-language or attitude.

Another female interviewee explained:

Sometimes I get really mad about this male attitude about having the power. I mean what kind of terms are those! Once or twice I have forced a male patient [from a non-Western culture] to take a position needed for the examination but a position potentially humiliating for him. I then use my professional force … Afterwards I feel awful … I feel ashamed.

One interviewee coped with the situations of feeling that boundaries had been transgressed by male patients (e.g., by dressing and styling plainly, in order to appear less attractive). One told that she coped by dressing in a uniform to radiate professionalism. Some interviewees did not address these cultural issues.

Transgressing privacy
All interviewees reported that they occasionally accidentally had violated patients’ privacy and were aware about the ethical issues and dilemmas this could entail. They described it as a feeling of unpleasantness more than an active conscious reflection. The violation was often caused by asking questions which the patients did not find relevant or by asking too much about personal matters without really wanting to know – just wanting to talk:

Sometimes I just find myself asking questions where I suddenly wondered: Why do I ask this? What relevance does it have? For instance: How do you plan to arrange your birthday? I mean – this is really not relevant for my training and I feel ashamed because it gives no professional meaning for me to ask.

The ethical issues and dilemmas were also felt the other way around when the patients revealed too much about their private lives, potentially violating both the patient and interviewee.

A major ethical issue mentioned by most was the threat that modern open spaced clinics pose to client confidentiality and secrecy. The interviewees explained that patients frequently are treated next to each other in therapeutic gyms, or on examination couches where only visual inputs are blocked by curtains so every conversation can be overheard. All regarded this as an ethical issue.

How to avoid transgression of all kind of boundaries when everything is open? Everyone can hear everyone else … There is no privacy.

In recognition of this problem, some private clinics had one closed room where they preferably had the first encounter with the patient. One reflected and acted differently:

In our clinic we have curtains for walls between the tables, and this I find very helpful because I just have to call for guidance or help and straight away my colleague is there… We have a very perky and flirty tone, he, he … both with patients and with one another, it gives a feeling of modernity and youth. I often just step into the next room to fetch a bolster or something, and this, I feel, secures that nothing wrong is happening behind the other curtain.
A few interviewees had actively chosen to work in clinics with enough closed rooms where they felt able to establish the necessary privacy. They described this as a professional means of minimizing the occurrence of the ethical issues that are bound to appear in clinical practice.

Another ethical issue considered important concerned the personal attachment of patients to the interviewee. Most interviewees had felt their personal boundaries violated when patients have declared their friendship or love. Mostly, they acted by immediately stopping the treatment and/or by referring the patient to a colleague:

Everybody has experienced this. It is very understandable that the patient feels attracted, or fascinated by all the attention. I have not experienced this often … Accepting an invitation? No, this I cannot. I decline the offer… One of my physios fell in love with her patient. And then she stopped treating him as her patient, and they became sweethearts. This is legitimate. Otherwise … No, never in my clinic!

Situations were described where both male and female interviewees had experienced inappropriate patient behavior from all kind of patients, which they all saw as ethical issues. These experiences were: sexually abusive or degrading language; seductive behavior; deliberate sexual exposure; and personal sexually affronting questions from the patients. Some solved the issues by directly telling the patient to stop or by reassigning the patient to a colleague. Some regarded it as an ethical dilemma they had difficulty in handling. Some interviewees told of becoming friends and about having sexual closeness with patients in the professional setting. One of these interviewees found this being normal behavior.

**DISCUSSION**

The results show a clear picture of physiotherapists in private practice as a whole have many reflections on ethics and that these reflections are primarily based on individual common sense arguments or on deontological understandings. Common sense we define as, “sound and prudent judgment based on a simple perception of the situation or facts” (Merriam-Webster's Online Dictionary, 2012). Thus, “common sense” (in this view) equates to the knowledge and experience which most people already have, or which the person using the term believes that they have or should have. Only rarely do the physiotherapists consciously use arguments from ethical theories or principles or refer to codes of ethics. This is in line with previous research (Bellner, 1999; Carpenter and Richardson, 2008; Praestegaard, 2001; Swisher, 2002; Trienzenberg, 1996). This result uncovers what Kappel (1996) calls an intuitive feeling of ethics; that we act from entrenched habits of what is ethically right. The habits show themselves as feelings of what is right and what is wrong, and often we feel ill at ease or even physically uncomfortable if we act against our intuitive feeling of ethically right actions. As healthcare professionals, Kappel (1996) argues, we ought to be able to express the habits, customs, values, principles, and attitudes on which we base our intuitive ethical sense of what feels right and wrong. As professionals, we ought to make clear whether the habits and customs are well-based, and whether they ought to be maintained, revised, or rejected in favor of other habits or customs.

The results reveal great professional and moral obligation to benefit the patient, which seems to be argued on the basis of a deontological understanding; that beneficence is a universal duty, not a matter of the given circumstances (Birkler, 2006). Birkler (2006) writes that when relating to deontological ethics one shall, in a given ethical situation, ask what are my duties in this given situation, and how is it my duty to act, regardless of the consequences for myself or for the other(s). It is the reflection or the motive behind the action that is vital for whether something is ethically right or not; such reflections were often presented in the results.

The design and the interview questions showed the physiotherapists' ability to discursively construct reflections and discussions upon ethical issues when asked and given time. Some of the described issues can only be understood as ethical in a very broad sense of the concept. Some do fall into the category of implicit novice issues (Dreyfus and Dreyfus, 1980; Jensen, Gwyer, Hack, and Shepard, 1999), where time, knowledge and experiences eventually will lead to more reflected and adequate solutions. Many of the described ethical issues relate to Seedhouse's (2009) description of everyday ethics. The issues are generally described as how to do, how to reflect, how to handle; and the issues arise when the physiotherapists strive to act in the best interest of the patient but are hesitant about how to do so without harming, offending, or violating the patient. This is in line with other results from Western research about ethics in physiotherapy (Barnitt, 1994; Barnitt and Patridge, 1997; Carpenter and Richardson, 2008; Cross and Sim, 2000; Delaney, 2005; Finch, Geddes, and Larin, 2005; Geddes, Wessel, and Williams, 2004; Greenfield, 2006; Guccione, 1980; Purtillo, 2000; Swisher, 2002; Trienzenberg, 1996).
Furthermore, the results seem to indicate that the physiotherapists feel a need for a correct way of reflecting and acting; an implicit search for a correct ethical standard. This search may be understood on the basis of the historical development of physiotherapy from a medical discipline where standards are seen as the ideal and where physiotherapists in the pursuance of professional confirmation, unknowingly, copy this ideal. However, copying another profession's understanding of an ideal, whose explanations, examinations, diagnosis, and treatments are put into words, does not imply that physiotherapy can claim professional autonomy on this basis. Carr (2000) states that to achieve professional autonomy, five criteria of professionalism are commonly cited: 1) professions provide an important public service; 2) they involve a theoretically as well as practically grounded expertise; 3) they have a distinct ethical dimension which calls for expression in a code of practice; 4) they require organization and regulation for purposes of recruitment and discipline; and 5) professional practitioners require a high degree of individual autonomy – independence of judgment – for effective practice. In this view, the result reveals that physiotherapy has difficulty in satisfying the above criteria (#2).

It may be argued that some of the reported ethical reflections arise because of varying understanding or consciousness of the concept of equality. To understand one's professional role as interactive or as being the patient's advocate does not in itself constitute an ethical consideration. However, it can be seen as an ethical issue if one's attitude is rigid and impossible to alter according to the patient's needs or if one is unreflected on how one manages the given professional power asymmetry within the professional setting. The ambition of equality in the physiotherapy–patient relationship can be understood as awareness of the existing power asymmetry and of the principle of autonomy (Beauchamp and Childress, 2009) and can be argued from several ethical perspectives. In a critical theory perspective, focus is on both parties being humans, with roles as mutual moral discussion partners, which relates to some of the physiotherapists' descriptions of being equal moral partners. A critical theory approach does not try to set out the conditions of what makes an act ethical but sets out a procedure for arriving at ethical conclusions based on reasoned agreement among the concerned participants (Habermas, 1998). Discourse ethics is about people learning from one another. Such conversations have obvious characteristics: participants must be sincere; respect each other's views; be fair in examining each other's positions; and be accountable in seeking to question and be questioned (Birkler, 2006); as described by the physiotherapists who struggle to ask the right questions to improve patient autonomy. Furthermore, the striving for equality in the physiotherapy–patient relationship can also be argued from a deontological perspective as some physiotherapists express that they feel obligated to care for the patient as an equal human being. This striving is legally bound to the rights of patients (Sundhedsloven, 2008). In a deontological perspective, focus is on how one behaves professionally, and not on the consequences the actions may imply; it is the intention that counts (Birkler, 2006). Therefore, in these perspectives, we can argue that discussions on the professional role can be valued as ethical reflections.

Advocating can be a way to facilitate the patient's power to manage (part of) his situation prospectively in referral to his actual overall resources. To advocate for vulnerable patients can be argued from the Christian Golden Rule: *So whatever you wish that others would do to you, do also to them* (Bible, Matthew 7.12), implying a humanistic understanding of doing good to your fellow human being. That some physiotherapists are particularly sensitive to patients' need for advocacy can be explained by some people being more at ease with talking about their professional weaknesses, by a personal instinct to care for the weaker or as a statement of moral obligation to act for the benefit for others, where the later relates to the moral principle of beneficence (Beauchamp and Childress, 2009). If some physiotherapists see advocating for patients as a moral obligation for beneficence, attentiveness to one's professional role seems needed. When actions like shopping for patients or visiting former patients are elements of professional advocacy, it becomes difficult to distinguish between professional and personal morals, thereby two ethical issues constitute themselves: 1) balancing improvements on patient autonomy with the professional obligation for beneficence; and 2) balancing professional and personal morals in the professional setting. When advocacy loses its professional argument and enters into the personal sphere of argumentation, it becomes smothering paternalism/materialism. We find that this kind of advocacy dilutes professional standards and weakens the striving for professional autonomy.

The results uncovered several differences in how beneficence was practiced. Patient education or personal and professional insight seemed as strategies to avoid or minimize the risk of ethical issues to occur, a strategy also supported by Solomon and Miller (2005), and which has similarity to the virtues dimension of expert practice described by Jensen, Gwyer, Hack, and Shepard (1999). Patient education is a strategy that can be related to the moral principle of
Violation of fundamental ethical guidelines and legal requirements

The results show several sound moral actions but also examples of violations of fundamental ethical guidelines and laws which threaten to endanger the growing professional autonomy of physiotherapy in Denmark. There seems to be a lack of knowledge about existing guidelines and laws and also an uncertainty about the interface between ethics and law as the current findings exposed the circumvention of governmental subsidizing rules. This can be considered an immoral as well as an illegal practice. Beauchamp and Childress (2009) state that moral integrity can be understood as the soundness, reliability, wholeness, and integration of moral character. In this light, the act of circumventing rules can be understood as a problem in maintaining professional integrity, not from lack of moral integrity or from a conflict of moral norms, but from moral demands that require the physiotherapist to sacrifice beyond his or her personal understanding of legal actions. The actions can be defended from an ethics of care perspective. In the actual encounter with the patient, the professional responsibility for the physiotherapist is not a choice but an absolute ethical demand of doing good for the patient (Birkler, 2006; Løgstrup, 1991). Sometimes life confronts us with awful choices, and morality requires us to face them and choose the option that will minimize harm (Shafer-Landau, 2007). The first author encouraged the physiotherapists in question to report the reasons for their actions to make them evident, and reported the overall issues to the Danish Association of Physiotherapists. Hereby, the Association can prepare for future negotiations about codes of practice concerning governmental subsidies.

The results reveal examples of unlawful practice. Some of the interviewed physiotherapists do not document their practice. Documentation is a direct legal request, which the first author of course informed the physiotherapists in question about during the interview. We have further reported the overall issue to The Association of Danish Physiotherapists, its Ethical Council and Private Practice Council. Consequently, the Association has strongly emphasized the legal request to document physiotherapy practice to all private clinics in Denmark.

Although it is alarming to find inappropriate sexual behavior and sexual harassment occurring in the process of physiotherapy, it is well documented within medicine and nursing and it has also been reported in a few studies within the context of physiotherapy (Bütow-Dütoit, Eksteen, Da Waal, and Owen, 2006; deMayo, 1997; McComas, Kaplan, and Giacomin, 1995; McComas et al, 1993; O'Sullivan and Weerakoon, 1999; Trienzenberg, 1996; Weerakoon and O'Sullivan, 1998). The findings seem to imply negative consequences on both the professional level (e.g., work performance) and on the personal level (e.g., psychological effects) (deMayo, 1997; McComas et al, 1993; O'Sullivan and Weerakoon, 1999). Therefore, the problem needs to be taken seriously within private practice.
Having sexual closeness to patients in the clinical setting is a provocative and shocking result. When receiving the statement, the first author re-asked for informed consent and addressed the illegality to the physiotherapists in question. Even though they felt shameful about it they argued their actions from an ethics of care approach (i.e., an ethics of care approach interpreted from a personal view) (Birkler, 2006; Logstrup, 1991). The physiotherapists in question realized that they had overstepped the mark some time after the actual session. They wanted us to forward the issue that physiotherapy is relational and that being in professional relations requires recognition of the physiotherapist's emotions as well as the patient's. They recommended supervision, formal forums for discussion of daily practice and knowledge, and discussions of different aspects of professional competence as a means to keep the process of physiotherapy ethically sound, which we recommend also.

One physiotherapist did not find the issue professionally or ethically important, a result we find worrying. Having sexual closeness with patients in the professional setting is appalling and illegal. The rare physiotherapist who might argue the action from an ethics of care or utilitarian perspective; where the end justifies the means (Birkler, 2006; Shafer-Landau, 2007), but this violates the patient's trust in the provision of quality health care and harms the patient at a time of emotional and physical vulnerability. The trust of the colleagues is also violated as the abuse is exposed, and negative publicity can harm the specific private practice and the entire profession. As it thus becomes a serious professional ethical issue, and not merely a personal issue, there seems to be a need for addressing it in educational programs, professional practices, and organizations. Accordingly, we have reported the issue, without naming the physiotherapist, to The Danish Association of Physiotherapy.

The overall results in this study are in line with previous Western research even though a few circumstances are worth noting. Danish physiotherapists express themselves both professionally and personally about their ethical reflections in private practice, and this involves some very personal exposures of physiotherapeutic practice. It seems to indicate that the cut between being professional and being personal ought to be made more conscious for Danish physiotherapy in its strive for increased professional autonomy.

There is a growing focus on professional autonomy and ethical competence within both the general health care sector and the physiotherapy profession (Rothstein, 2003; Sandstrom, 2007; Swisher, 2002). Sandstrom (2007) defines professional autonomy as a social contract based on public trust in an occupation to meet a significant social need. In order to maintain and increase professional autonomy, it is crucial for the physiotherapy profession to accommodate legal requirements, requirements from politicians, patient organizations, and researchers for ethical and evidence-based practice (Amtsrådsforeningen, 2003; May, 2001; Potter, Gordon, and Hamer, 2003a, 2003b; Scott, 2000; Solomon and Miller, 2005). To live up to this, a wide range of professional compartments are needed, and among these are ethical competence. Gabard and Martin (2003) argue that living up to professional moral responsibilities requires having integrity, self-discipline, and commitment, as well as avoiding weakness of will and selfishness. It is essential for Danish physiotherapists to be aware about the distinction between professional and personal boundaries in physiotherapy practice in order to maintain society's trust and respect, in line with Amtsrådsforeningen (2003), Rothstein (2003), Sandstrom (2007), and Swisher (2002).

In summary, the results show that physiotherapy in Danish private practice, in an ethical perspective, is on a trajectory toward increased professionalism. The results reveal that physiotherapy, as a profession, is rooted in both humanistic and scientific paradigms of understanding. Numerous ethical issues are embedded in situations characterized by encounters with power asymmetries or in which the parties are in close physical and emotional contact.

Some physiotherapists meet ethical issues in a professional manner, but some meet them in unconscious or unprofessional ways. Without a constant awareness that physiotherapy is characterized by power asymmetry and that beneficence toward the patient should be in focus, the individual physiotherapist may not be able to recognize whether she is using her given professional power to accommodate the patient or to offence or violate the patient.

Increasingly, an explicit ethical consciousness among Danish physiotherapists in private practice seems needed. A debate of how to understand and respect the individual physiotherapist's moral versus the ethics of the profession must be addressed. Furthermore, the profession's responsibility for professional development within the field of ethics calls for discussions and decisions. Finally, the results give rise to further investigations of ethical issues in other contexts of physiotherapy and of how physiotherapy as a profession can deal with ethical issues appropriately and professionally and also to determine whether the ethical themes identified in Danish physiotherapy practice are common to other cultures and national settings.
Acknowledgments

We thank the physiotherapists who participated in this study for their enthusiasm, honesty, and commitment to the profession. We thank Søren Holm, Pia Jørgensen, and Anne-Marie Wium for valued and essential comments, discussions, and support and Claus Fenger for language proofing.

Declaration of interest: This study has received funding from The Association of Danish Physiotherapists and The Department of Physiotherapy, Metropolitan University College, Copenhagen, Denmark and The Danish Rheumatism Association. The authors report no declaration of interests.

REFERENCES

Aadland E 2000 Etik, dilemma og valg. København, Dansk psykologisk Forlag
Amtsrådsforeningen m.fl. 2003 Patientens møde med sundhedsvæsenet: De mellemmenneskelige relationer – anbefalinger for kommunikation, medinddragelse og kontinuitet. Arhus, Amtsrådsforeningen
Association of Danish Physiotherapists 2007 http://fysio.dk/praksis/Overenskomst-og-takster/
Beauchamp TL, Childress JF 2009 Principles of Biomedical Ethics, 6th edn, p 42. New York, Oxford University Press
Bible, New Testament: Matthew Chapter 7, verse 12
Birkler J 2006 Etik i Sundhedsvæsenet. København, Munksgaard Danmark
Dahlberg K, Drew N, Nyström M 2001 Reflective Lifeworld Research. Lund, Studenterlitteratur
Dreyfus SE, Dreyfus HL 1980 A Five-Stage Model of the Mental Activities Involved in Directed Skill Acquisition. Washington, DC, Storming Media
Geddes EL, Wessell J, Williams RM 2004 Ethical issues identified by physical therapy students during clinical placements. Physiotherapy Theory and Practice 20: 17–29
Giorgi A 2000 Concerning the application of phenomenology to caring research. Scandinavian Journal of Caring Science 14: 11–15
Habermas J 1998 Diskurssetik. Helsingør, Det lille Forlag
Harvey D 2005 A Brief History of Neoliberalism. New York, Oxford University Press
Logstrup KE 1991 Den etiske fordring. København, Nordisk Forlag
Malterud K 2001a The art and science of clinical knowledge: Evidence beyond measures and numbers. Lancet 358: 397–400
Malterud K 2003 Kvalitative metoder i medisinsk forskning – en innføring, 2 utgave. Oslo, Universitetsforlaget


Praestegaard J 2001 Etik i fysioterapi (Master thesis). Lund, Lunds University

Purtillo RB 1999 Ethical Dimensions In The Health Professions, 3rd edn. Philadelphia, PA, WB Saunders

Purtillo RB 2000 A time to harvest, a time to sow: Ethics for a shifting landscape. Physical Therapy 80: 1112–1119

Rothstein JM 2003 Editor’s note: Autonomy or professionalism? Physical Therapy 83: 206–207

Sandström RW 2007 The meanings of autonomy for physical therapists. Physical Therapy 87: 98–110


Seedhouse D 2009 Ethics. The Heart of Health Care, 3rd edn. Chester, John Wiley & Sons


Solomon P, Miller PA 2005 Qualitative study of novice physical therapists’ experiences in private practice. Physiotherapy Canada 57: 190–198

Sundhedsloven 2008 https://www.retsinformation.dk/forms/r0710.aspx?id=114054


Thornquist E 2010 Klinik, Kommunikation, Information, 2 udg. København, Hans Reitzels Forlag


**APPENDIX: INTERVIEW GUIDE**

**Interview themes for the first interview**

**Introduction**

Presentation of the study, the purpose, myself.

Please present yourself.

Please tell me: Why have you chosen physiotherapy as a carrier? And why have you chosen to work in private practice?

Please describe a typical workday in private practice.

**Narratives of the process of physiotherapy in private 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, why, how etc.

**Reflections about the constitution of an optimal process of physiotherapy**

Please reflect on what constitutes the best/good in the situation you just have described.

Norms, values, hierarchy of values, traditions, culture etc.

**Discussions of ethical issues/dilemmas emerging within physiotherapy in private practice**

Can you cast your mind back and describe one or more situations from private practice which you have experienced as an ethical issue/dilemma?

Please reflect on what constitutes an ethical issue/ dilemma and the conflict within the ethical issue/dilemma.

Please reflect on the values within the problem/the conflict.

Please reflect on whether this is a new or a returning ethical issue.

Please reflect on the way you resolved the ethical issue/dilemma.
Interview themes for the second interview

Introduction
Presentation of the study, the purpose, myself, the subjects, and situations we talked about last time.

Reflections and/or adjustments to the first interview
Do you have reflections/adjustments about the first interview/your earlier narratives?

Further reflections and narratives about optimal and/or regrettable situations and/or professional conduct related to the process of physiotherapy in private practice
Can you cast your mind back and describe one or more situations/conduct from private practice that you experienced as being regrettable.

Please reflect on whether this is a new or a returning situation and/or conduct.
Do you assess the situation and/or conduct as an ethical issue/dilemma? Why – why not?
Please reflect on the core of an ethical issue for you.
Please reflect on the values in problem/conflict within the ethical issue/dilemma.
Please reflect on the way you resolved the issue/dilemma.
Please reflect on whether the ethical issue/dilemma was resolved satisfactorily.
Please reflect on how it could have been resolved in an ideal world.
Can you describe the values you strive to protect in daily private practice physiotherapy?
Please reflect on what the values mean for you/the profession?
Please reflect on whether you assess the values as common for private practice.